

Rutland Regional Medical Center Establishes Financial Responsibility Using Real-time Eligibility Verification Technology

Located in Rutland, Vermont, Rutland Regional Medical Center (RRMC) is Vermont's second largest health care facility with 188 licensed beds and more than 120 physicians trained in 35 specialty areas. Providing preventative, diagnostic, acute and rehabilitative services, RRMC has 33,234 emergency department, 40,594 outpatient rehabilitation, 128,128 outpatient, and 7,133 inpatient admissions annually.

Situation

In this tumultuous healthcare climate, facilities like RRMC have difficulty establishing responsibility for payment, accurately billing and collecting on services rendered, and maintaining a patient friendly billing environment while increasing the hospital's bottom line. RRMC believed a major barrier that prevented collecting on rendered services early in the revenue cycle was the difficulty in determining the patient portion due at the time of service.

Due to time and staffing constraints, eligibility verification at RRMC occurred after the service was rendered, usually the next business day. Acquiring eligibility information via traditional methods such as calling the payer directly or through individual websites proved to be problematic. Health plan websites were complicated due to different systems and interfaces, and immediate access while registering the patient was not reliable. Entering the information found in the registration system into health plan websites then re-keying the 271 data back into the registration system was time consuming and rarely occurred at the first point of patient contact. As this process was not immediate, access to important information needed by other departments was delayed. Verifying by phone was just as cumbersome. It was not immediate, nor predictable, as wait times varied from minutes to hours, and still required manual entry of the 271 data back into the registration system by the registrar.

Kathy Peterson, Patient Accounting Manager for RRMC, also noticed how this negatively impacted

the back end of the revenue cycle. For each patient portion not collected up front, there were staff time and wage costs on the back end, including researching, creating, producing, and mailing the bill to the patient. Producing a bill in this manner nationally averages approximately \$25 per bill. Studies show that hospitals often send three bills to the patient before they receive the payment due – thus neutralizing the amount of the co-pay, or worse yet, costing more to collect than the billed amount.

Peterson recognized that in order to meet her goal for creating patient friendly billing for her hospital, processes and technology used at the point of registration needed to change.

Peterson determined that if the verification process was to work, it had to be automatic, real-time and seamlessly integrated with their health information system (HIS) in order to achieve her goals. As RRMC was using QuadraMed's Affinity HIS for registration, they purchased the Affinity 270/271 module and decided to use a third-party intermediary, Provider Advantage, to gain access to health plan eligibility and benefit data.

Approach

Provider Advantage's product, *VeriLink* was selected for the following reasons:

- Tightly integrates with the Affinity registration system, supplying an invisible single connection point for communication with health plans.

- Gives the user immediate eligibility and benefit information while the patient is presenting
- Provides translation capabilities to process non-HIPAA compliant transactions currently being used by many health plans
- Delivers additional reporting complimentary to Affinity
- Easily implemented, providing access to a large number of health plans with minimal effort on their part
- Allows customization based on RRMC business rules
- Transfers responsibility for handling individual health plan issues to Provider Advantage support staff

“Prior to selecting *VeriLink*, we had an issue trying to directly connect to a particular health plan,” said Peterson. “We had problems getting communications set-up and continued to go back and forth with the health plan for 12 months on this issue. All the while, we were unable to verify electronically. The issue was never resolved. This was a waste of valuable staff time and money.”

Results

RRMC established procedures to improve patient relations, decrease A/R days, increase cash collections, and reduce bad debt, and trained their staff accordingly to adhere to these new business rules. With the new procedures in place, staff properly trained, and *VeriLink* integrated with their Affinity system, they found they were able to accomplish much more than just facilitating patient collections up front. Within 11 months of implementation, they experienced:

- **98% reduction in no coverage for commercial insurances**

Claim denials have more costs associated besides not receiving the amount owed for the

service. Hidden costs include the price of re-working the claim (FTE time/pay), and the price of re-submitting the claim. Deferring receipt of income due to re-working the claim increases A/R days and lowers interest amounts.

- **57% increase in POS collections within one fiscal quarter using *VeriLink*:**

Verifying eligibility information while the patient is presenting facilitates the collection of co-pays at the time of service, without adding additional work to the registration staff.

- **27% average drop in A/R days**

By submitting accurate information the first time, thus allowing for a faster return of payment, A/R days in Outpatient Medicaid days dropped from 56 to 33, Outpatient Commercial days dropped 62 to 48, and Inpatient Commercial days dropped from 77 to 63.

Summary

This automated and integrated technology plays a key role in helping RRMC identify the patient portion owed at the time of service, and has contributed to a reduction in post-service collection expenses. Statement costs, including staff time, production and postage have diminished, posting costs on the back-end have decreased, and fewer accounts are being sent to an outside collection agency (which receives a percentage of the amount collected).

“The cash is in the door faster so I have a reduction in A/R,” said Peterson. “We’ve also seen studies that it improves patient satisfaction if you manage patient expectations upfront and if they know what they have to pay. Knowing their options improves their satisfaction.”

For more information contact Provider Advantage at 800.203.5465 or www.provider-advantage.com