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Continuous coverage discovery

A 2-stage approach links pre- and post-service analysis in near real time

Eligibility verification has become a moving target for many providers in the post-COVID era.

Millions of workers have changed or lost coverage, while health plans have continually tweaked benefit limits, network structures and provider communications protocols.

The difficulty in determining if and how a patient is covered often translates into denials, balance billing, costly collections and bad debt. These cash-flow risks for providers are compounded by the growth of high-deductible health plans and the rise in patient-owed payments.

By some estimates, more than

90% **of uninsured and**

56% **of insured out-of-pocket obligations go unpaid**[1]

An ever-shifting eligibility landscape

Eligibility verification, while never easy, grew even more complex with the pandemic, which initially put more than 20 million people out of work.[2] Although the U.S. has recovered those jobs, many workers have changed, modified or lost their health insurance coverage, making current verification a challenge.

As it is, between **15% and 20%** of privately and publicly insured individuals **change their health plans or experience coverage disruptions each year.[3]**

And more than half the population **over the age 65 — about 29 million people — have multiple coverages.[4]**

For providers, this churn and overlap creates uncertainty about which coverage may be in force or which may be primary.

Making matters worse, registrars don't always capture accurate or complete information at the point of care. Even something as simple as the wrong date of birth can derail reimbursement. Patients may also present with an expired insurance card, even if a new and different policy is in effect. These problems are especially common with patients coming to the emergency department, since they're typically not subjected to standard eligibility verification processes.

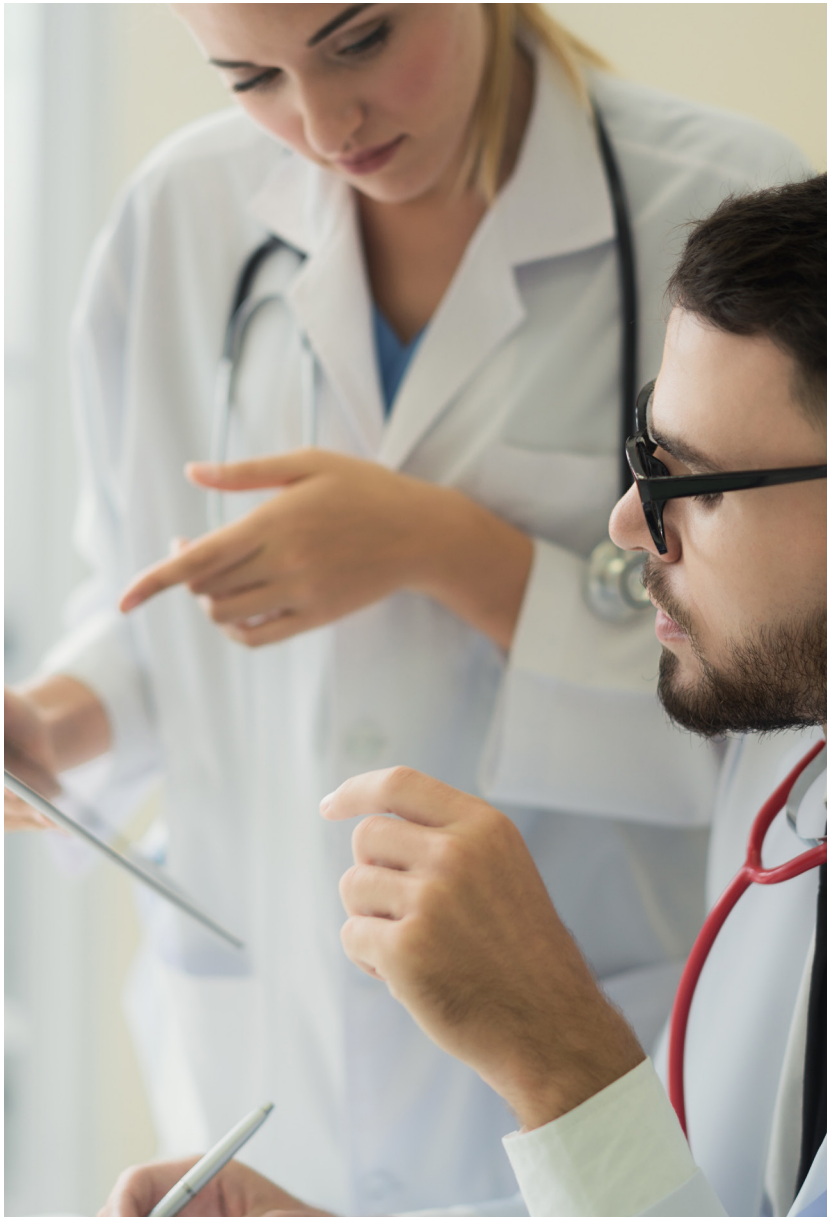
Payer complexity and variation

The growing complexity of plan benefits adds another layer of difficulty to the eligibility and insurance discovery process. Both payers and self-insured employers continually update and modify their benefit structures and databases. For providers, uncertainty is often the result, especially when it comes to:

- **Changes in prior authorization**
- **Patient co-pays**
- **Denial policies**
- **Deductibles**
- **Out-of-pocket maximums for specific care events**

These challenges can be exacerbated by problems accessing coverage details from insurers. The Electronic Data Interchange (EDI) 270/271 transaction set provides a universal standard for handling electronic eligibility queries and responses between providers and carriers. But variations in the way insurers use the standard can render it less than effective.

For example, EDI response protocols frequently differ from payer to payer and even within the same payer. And specific coverage details can be buried and difficult to uncover in the payer's EDI response. Some payers have also shifted coverage information from EDI-accessible databases to web portals, further complicating the verification process.



An end-to-end solution

Taking control of eligibility verification and insurance discovery requires a comprehensive approach that automatically links both pre- and post-service analysis in near real time.

Step 1.

Verify eligibility prior to service.

Eligibility verification is the starting point for all downstream revenue cycle functions. So it's essential that providers employ best practices to ensure accurate coverage determinations. That means establishing a robust system to verify eligibility prior to service. It also requires solutions that can scrutinize uninsured and self-pay accounts after the patient encounter to determine if, in fact, coverage is truly absent.

Step 2.

Scrutinize accounts after the patient encounter to determine if there is coverage.

This second step relies on advanced analytics to locate any missed or hidden payment sources. It's a process that can generate reimbursement for services that would otherwise be designated self-pay or uninsured. For providers, that means incremental, optimized revenue across their entire patient population.

A cascading insurance verification and discovery process that includes both pre- and post-service analysis and requires minimal IT lift generates multiple benefits. These include:

- **Fewer denials**
- **Faster payment**
- **Less backend rework**
- **Reduced burden on both registration and IT staff**

Optimized verification can also improve the patient experience by helping patients better understand their coverage and potentially reduce their self-pay or out-of-pocket obligations.

Best-in-class verification

Optum® Patient Financial Clearance, at its core, is an eligibility verification solution that is easily accessed from the registration workflow. It uses advanced automation to connect with payers via both the 270/271 transaction protocol and through payer portals.

Importantly, Patient Financial Clearance uses robotic process automation (RPA) to build out rule catalogs defining how each payer returns relevant data through the 270/271 standard. For payers that are not EDI-connected, the solution creates similar payer-specific rules to consistently extract accurate coverage details from payer portals. These rules can be further tailored to provider and patient requirements.

The platform also has an automatic retry system that continues to ping the payer until the necessary information is returned. This is an important feature for overcoming the payer-driven downtimes that frequently occur during peak demand times.

For registration staff, standardized, detailed payer response screens provide a consistent, user-friendly interface that includes a range of critical, patient-specific details, including:

- **Key notifications**
- **Specialized Medicare and Medicaid views**
- **Coverage dates**
- **Data by patient visit**
- **In/out of network views**
- **Eligibility history**

The solution also provides up-to-date benefit data, including co-payments, co-insurance, deductibles, out-of-pocket maximums and year-to-date benefit accumulation status. This information is invaluable to improve point-of-service collections.

No-touch integration provides maximum value

If initial eligibility verification returns a no-coverage result, the account is seamless integration allows for more in-depth analysis following the initial encounter. **The Optum® Coverage Insight solution uses advanced analytics to search for undisclosed medical coverage, systematically screening patients for missed payment sources, including the full spectrum of public and private payers.**

The application combs a range of public and private data sources. Visibility into each patient's previously unbilled insurance coverage helps quickly target the most appropriate funding source.

Coverage Insight can also search known Medicaid patient data for other primary insurance sources. This can result in higher reimbursement rates while preventing Medicaid coordination of benefits (COB) denials and recoups.

Coverage Insight helps providers convert uncollected self-pay accounts into revenue by:

- Enhancing provider data to create robust patient profiles
- Analyzing each patient profile to pinpoint funding sources
- Using a targeted collection approach to support CMS and anti-phishing rule compliance
- Verifying that target policies have coverage for the date of service
- Suppressing unusable coverage to ensure billing staff remains focused on accounts with a higher probability of recovery

For organizations that adopt a pre- and post-service, cascading approach to insurance verification and discovery, the payoff in "found" revenue can be substantial. While individual results may vary, Optum Coverage Insight clients typically realize a 3%–15% conversion rate of self-pay and underinsured accounts. A 10% conversion rate delivers an ROI of 10:1. Equally important, confirming that a patient is truly uninsured helps guarantee that a provider's charity care is available for those who truly need it. It also opens the door for enrolling uninsured and self-pay patients in Medicaid and other safety net programs.

A 2-stage, defense in depth

Rapid, accurate insurance verification is the cornerstone of a healthy revenue cycle and vital for consistent cash flow. But verification alone, no matter how effective, is not enough. Hidden payers can still exist beyond the reach of an initial eligibility check. That's why an automated, cascading solution that flags no-coverage accounts for deep data queries is the key to producing correct coverage results.

By adopting this 2-stage approach, the burden on hard-pressed administrative staff is reduced, along with denials, collections and bad debt. The bottom line? Basic eligibility verification only goes so far. Providers need to include a coverage discovery solution that will catch payment sources that otherwise will be missed. This combination can drive bottom-line results and ensure you're paid every dollar you're entitled to for services rendered.

Contact Optum today to learn more

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3. Fang H, Frean M, Sylwestrzak G et al. Trends in disenrollment and reenrollment within US commercial health insurance plans, 2006-2018. JAMA Network. Feb. 24, 2022.
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