The MyVisit[SM] Program at Geisinger Health System: A Patient–centric Approach to Consumer-Directed Health Care

Kenneth A. Holdren, CPA
Vice President, Finance
Geisinger Health System

Brenda M. Snow, MPM
Vice President, Strategic Program Development
Geisinger Health System

Gregory M. Snow, MPM
Vice President, Revenue Cycle
Geisinger Health System

Geisinger Health System – An Overview

Geisinger Health System (GHS) is a physician-led, integrated delivery network providing full service medical care to residents within 41 of the 67 counties in northeast and central Pennsylvania. GHS is comprised of a multi-disciplinary group practice of approximately 700 physicians, three hospitals (including Geisinger Medical Center, a large tertiary/quaternary teaching hospital located in Danville, Penn.), and an alcohol and drug treatment center.

Dedicated to serving the community and providing convenient care to the patient, GHS has 41 community practice locations with over 200 primary care physicians. The system also includes Geisinger Health Plan, one of the largest not-for-profit rural managed care companies in the country, serving approximately 210,000 members. GHS also has two research centers dedicated to advances in basic science, as well as population-based healthcare delivery models and clinical trials research. GHS has a fully integrated electronic health record (EHR) with more than three million records. GHS generates approximately $1.6 billion in annual revenues and is one of nine health systems in the United States with an AA bond rating.

The GHS revenue cycle organization consists of approximately 800 management and staff level personnel who manage all billing, collections, charge capture, revenue enhancement, contract administration, information technology support, training, financial reporting, cash application, medical records coding (inpatient, outpatient, and physician), chargemaster, utilization review, patient access, and pre-financial clearance services within this clinically driven program. Currently, the GHS revenue cycle key indicators reflect gross days revenue outstanding (DRO) for all GHS entities at 30.9 days, bad debt and charity care at less than 1.4% of gross revenue, and revenue cycle cost-to-collect (fully loaded) at 3.1%.

The Challenge

As consumer-driven health care and patient satisfaction moves to the forefront of medical care, processes associated with efficient patient flow, wait times, and various administrative functions needed to be addressed. As consumers become more involved in selecting their healthcare services, we felt it important to also encourage a culture in which patients acknowledge their own accountability (including financial accountability).

In 2001 through 2004, GHS's patient access satisfaction indicators were below peer norms. Additionally, financial results indicated there was an opportunity to improve and eliminate the gaps that existed in the financial clearance process (with specific focus on pre-certification and referrals, patient benefit levels, and communication of the patient obligation amount). With payers continuing to require more documentation to justify patient services, GHS recognized an opportunity to improve the patient experience while enhancing revenues by re-engineering the patient access process.

GHS implemented a plan to accomplish three primary goals:

- Separate the clinical encounter from the financial clearance process
- Shift the focus of revenue cycle processes from post-service and point of service to pre-service
- Provide a foundation for subsequent initiatives such as Patient Friendly Billing®, combining billed services on patient statements across entities, on-line statement review and payment, consumer-driven health care, and pricing transparency

Program Name

We named the new GHS pre-service program "MyVisit℠." The name was selected to link this plan to the Geisinger brand and to GHS's web-enabled, patient EHR known as "MyGeisinger." The name emphasizes hospitality throughout the overall patient visit rather than strictly during the clinical encounter. The term itself is also patient-friendly, with the "My" component emphasizing the patient's role as a partner not only in their care, but also in resolving their financial obligations.

Strategy

We identified three primary strategies for the MyVisit℠ program:

- Redefine the patient encounter to align with specific functions:
  - Pre-service (prior to the encounter)
  - Point of service (at the time of encounter)
  - Post-service (after the encounter)
- Separate administrative processes from the clinical encounter, thus:
- Increasing clinical caregivers' focus and time on the clinical encounter

With these key strategies determined, we developed a return on investment (ROI) goal comprised of both "hard cost" improvements related to elimination of gaps in the financial clearance process and "soft cost" improvements (e.g., patient satisfaction, improved caregiver productivity).

GHS managers knew that this initial, pre-service contact in the patient's experience must be treated as a strategic asset with implications for improvements that would affect the patient, the patient's family members, and the internal Geisinger "family."

Process

Simply put, the MyVisit[SM] program accomplishes, on a pre-service basis, many revenue cycle functions that historically were performed at the point of service or after the clinical encounter.

The MyVisit[SM] process completes the following functions *before* the patient's clinical encounter:

- Registration
- Insurance eligibility checking
- Verification of patient insurance benefit levels
- Pre-certification
- Medical necessity checking
- Referral authorizations
- Identification and communication of the patient out-of-pocket obligation (e.g., co-payment and deductibles)
- Financial counseling, including payment plans, alternate payment arrangements, and possible charity care or discounts
- "Special Handling" accounts (package pricing, cosmetics, dialysis, transplants, etc.)

Completion of these processes allows for a patient to be "financially cleared" before services are rendered. Patients are deemed financially cleared if the above processes have been completed satisfactorily and if they have signed all required insurance forms in advance of the encounter, or no later than the point of service in cases where sufficient turnaround time does not permit forms to be signed before the encounter.

The process is started fifteen to thirty days before the encounter, when patient information that has been electronically obtained from the Epic® scheduling and ADT systems is used to populate a series of automated daily work queues for the MyVisit[SM] staff. This staff consists of approximately 100 FTEs whose offices are located in a centralized, off-site location separate from the GHS main campus.

Each patient is contacted via telephone before his or her appointment to obtain needed insurance, authorization, and other information. The information is reviewed and given "financial clearance," and then the patient is advised of his or her payment obligations

and asked to make arrangements or pre-pay any out-of-pocket amounts. Referral and pre-certification information is obtained and all forms sent in advance (by regular mail, facsimile, or electronic mail) and returned by mail, electronically, or at the point of service. Scheduled visits are financially cleared, and we have begun administratively processing urgent and emergent encounters through MyVisit[SM]. It is anticipated that approximately 2.6 million registrations will be processed through MyVisit[SM] in FY06 (July 1, 2005 – June 30, 2006).

Benefits

Three primary benefits have resulted from implementation of the MyVisit[SM] program:

Patient Satisfaction

- The patient encounter is now focused on the clinical experience, thus eliminating or reducing patients' perception of too much focus on financial matters
- The "hassle factor" of patients having to register multiple times for same-day services is eliminated
- Patient privacy is protected through information being communicated from a patient's home rather than in a public environment
- Check-in wait times are reduced, with a corresponding reduction in patient anxiety and frustration

Operational Benefits

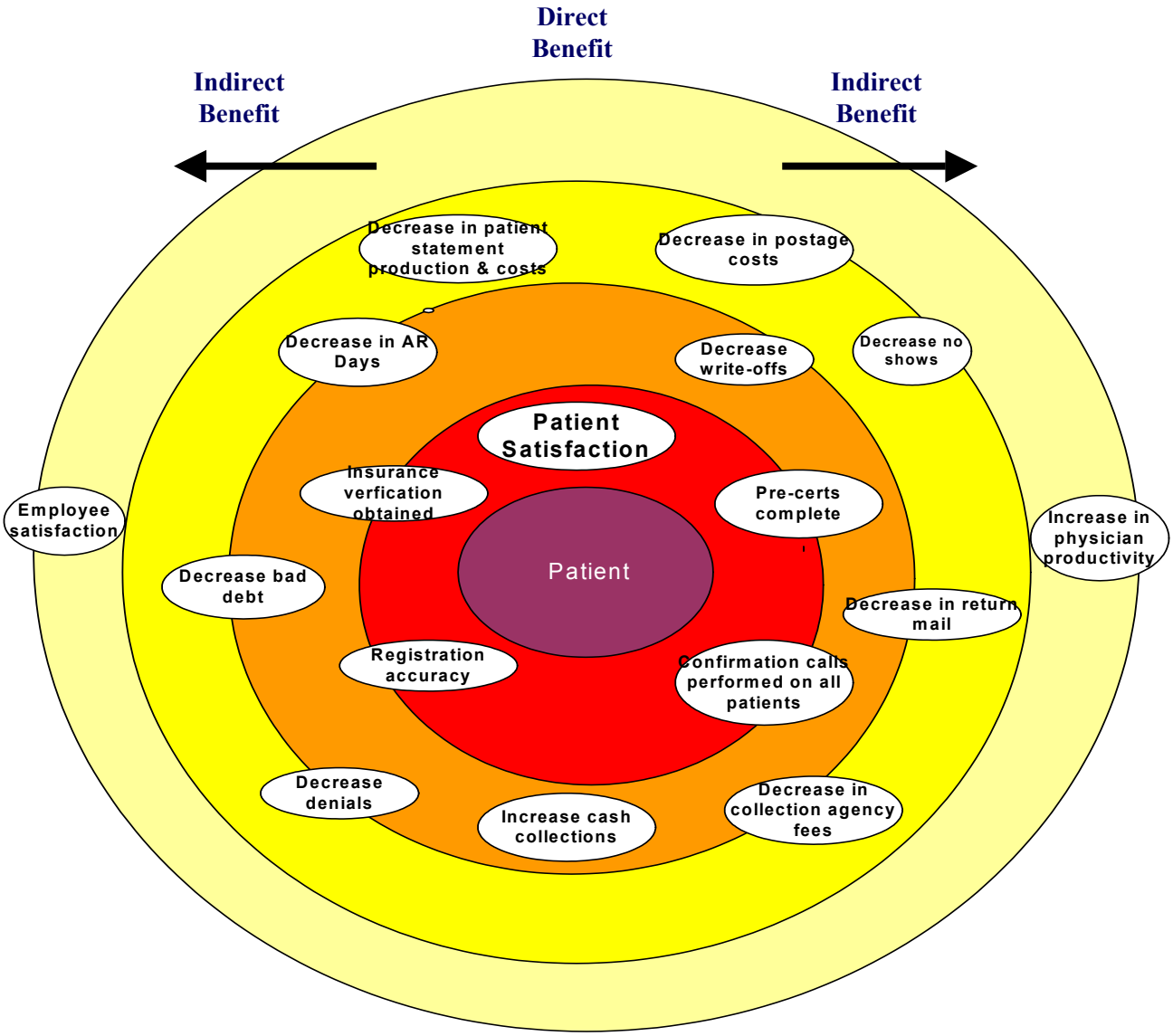
- Physicians' schedules are maintained, with no delays due to the registration process
- Clinical scheduling and productivity are optimized through reduction in "no-show" rates; scheduling slots are better managed
- Employee satisfaction is improved through a reduction in administrative tasks and increased time spent on patient needs

Financial Benefits

- Financial risks are reduced by closing the financial clearance gap(s)
- A foundation for proactive patient financial policies is laid
- Organizational risks are managed in response to payers' increased requirements for medical justification for patient services

Indirect Benefits

In addition to the direct benefits realized through MyVisit[SM], the following summary of indirect benefits achieved through MyVisit[SM] include such things as greater physician productivity and reduced postage and statement-production costs. The graph below illustrates direct and indirect benefits achieved (although not quantified) as part of the ROI statement.



Return on Investment

In the first nine months of the implementation of MyVisit[SM], approximately $420 million in net revenues were financially cleared, resulting in nearly $6.7 million in avoided losses or increased net revenues. Expenses associated with the MyVisit[SM] program during this implementation period were $2.8 million. The MyVisit[SM] process has enabled GHS to reduce rejection rates to approximately 0.3% for all areas that require financial clearance. Furthermore, Patient Access satisfaction scores improved by 3% within this period, and GHS experienced a 98% satisfaction rate for patients who were financially cleared through the MyVisit[SM] program.

MyVisit[SM] Now and in the Future

The MyVisit[SM] program today is approximately 60% implemented and applies to 100% of GHS's scheduled inpatient visits and approximately 80% of scheduled outpatient visits. Similarly, 30% of physician visits undergo pre-service information processing. The implementation of the MyVisit[SM] program for urgent and emergent patient encounters is underway. This will ensure the timely completion of all required administrative functions for this patient category. All financial classifications are processed through the MyVisit[SM] program; however Medicare patients are excluded from the "pre-collect" component of the program.

For FY07, GHS has approved additional funding of $2.1 million for the MyVisit[SM] program. This funding will allow full implementation of the program for all hospital and physician services by September 1, 2006. Areas of focus for future program development include electronic referral capture, electronic batch insurance eligibility and benefit levels, electronic submission of requests for pre-certification, medical necessity checking and ABN production using order data from the EHR, and patient express kiosk check-in using a "smart card." The final component to be implemented in FY07 is expansion of MyVisit[SM] to include automated calculation of patient payment responsibility amounts through the web (in conjunction with the contract management system) and the MyGeisinger portal, as well as providing the patient with a written statement and a guarantee of the patient out-of-pocket obligation, price comparisons, and the collection of prior bad debt and patient past due balances.

Summary

The MyVisit[SM] program has been successful in achieving its original objectives of improving patient satisfaction and reducing GHS's financial exposure. The MyVisit[SM] program now serves as a proactive and patient-centric platform upon which GHS can execute its response to consumer-driven health care. MyVisit[SM] has provided the rare opportunity to delight our patients, not only through their clinical care, but through their revenue cycle experience at Geisinger.

Note: The Geisinger Health System Foundation is a 501(c) (3) not-for-profit corporation that coordinates and supervises the activities of all of Geisinger's affiliated entities. The foundation is not a licensed healthcare provider, nor does it provide healthcare services to patients. It serves to ensure the system-affiliated entities have adequate financial resources to fulfill their missions, and the foundation initiates and administers grants and philanthropic support for all Geisinger entities.

Visit the Patient Friendly Billing web site at www.patientfriendlybilling.org for more information about Patient Friendly Billing processes and tools, or e-mail info@patientfriendlybilling.org for additional information.