the economy-busting revenue cycle

5 Top Issues Facing RCM and What to Do About Them
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the economy-busting revenue cycle

5 top issues facing RCM and what to do about them

Financial hardship has touched the healthcare industry, along with the rest of the U.S. economy. According to a report from the Healthcare Financial Management Association (HFMA), more than half of hospitals surveyed reported negative total margins between June and December 2008. Facilities with more than 500 beds were the hardest hit; 80 percent had negative total margins attributed to declines in patient revenue, among other financial pressures.

Other distressing indicators from HFMA's survey of more than 300 hospital financial executives include:

- **Declines in patient revenue.** Just under half (43 percent) of all participants said patient revenue had fallen, with rural hospitals affected most acutely—60 percent indicated lower patient revenue, compared with 37 percent of facilities in large cities.

- **Drop in nonoperating revenue.** Seventy-eight percent of respondents reported a negative trend, with 64 percent experiencing a decline of more than 20 percent. More specifically, forty-three percent indicated their investment portfolios had dropped 25 percent or more during the second half of 2008.

- **Eroding days cash on hand.** Nearly 75 percent of all hospitals' days cash on hand decreased. Larger hospitals fared worst; 96 percent of 500-plus-bed facilities lost ground, and 50 percent of those experienced a greater than 20 percent decline.

And it's not just hospitals—group practices, specialists, and independent physicians alike are feeling the pinch of higher costs and lower reimbursements, coupled with higher patient balances that are less quickly being converted to cash, if at all. Always critical to an organization's viability as a quality healthcare provider, the revenue cycle has taken on new meaning for providers not only stricken with fiscal uncertainty, but also facing increased regulatory, competitive, and operational demands.

**Balancing people, processes, and technology**

Healthcare providers require innovative solutions to combat these downward pressures and maximize the revenue cycle. But they should not expect it to come easy or with a one-pronged approach. "The best maximization of the revenue cycle is a good balance between people, processes, and technology," says Judith Myers, an interim director of revenue cycle with executive placement and leadership consulting firm B. E. Smith. "Unfortunately, many hospitals today can't seem to find the appropriate equilibrium."

One organization might have the appropriate IT and decision support systems in place, but fail to thoroughly train its staff in how to best exploit the technology, leaving components unused or, worse, misused, which can lead to severe data integrity problems. Another might be dedicating too many resources to back-end collections, failing to communicate and collect patient liabilities beforehand through the patient access team. And a third provider may be losing money and wasting time with claim remediation, rather than fixing the root cause of repeated denials.

Each provider has dealt with these problems—and many more—at one time or another. Perhaps they've even successfully addressed front-end collections, claims management, or IT troubles and are feeling relatively secure that they're maximizing cash flow. Rest assured, there are many more quandaries on the horizon—from capital access to RAC audits to pay-for-performance initiatives—that promise to keep healthcare organizations scrambling well into the future.

This article covers five top RCM issues that affect the healthcare revenue cycle today and offers suggestions from top revenue cycle experts on how
Several years ago, Cooper University Hospital management addressed its accounts receivable (A/R) days, which then stood at 60 days. With millions of claims processed annually at the 500-bed, not-for-profit hospital in Camden, NJ, Cooper University wanted to improve all aspects of the revenue cycle.

Beginning in 2005, Cooper began to systematically maximize performance in key areas, leveraging tools and services from MedAssets to improve billing and compliance, claims and payment processing, contract management, payment verification, and recovery of underpayments.

The more, the better
Cooper has implemented a suite of solutions from MedAssets over the last several years, including chargemaster and coding/compliance content tools, which provide the intelligence needed to ensure accurate charging and billing for timely reimbursement. Departments access coding and compliance regulations online to support billing practices and payer appeals.

“With MedAssets, we have the ability to run daily reports, showing payment activity, including any variance from the expected reimbursement.”
—Bob Perry, director of patient financial services, Cooper University Hospital

With a fully integrated contract management tool, Cooper effectively addresses payer coding; models payer contracts; processes claims against payer rules to determine expected reimbursement and net revenue; identifies where payment received is not as expected; and addresses these claims for denials, underpayments, and inappropriate discounts. Reviewing these payment trends helps the hospital identify internal breakdowns or repeat payer problems.

Cooper also relies on MedAssets to bill compliant and accurate claims for timely reimbursement from payers. Using the claims management capability, Cooper improves its first-pass claims rate and operational effectiveness. Cash flow is accelerated, and the payment cycle is shortened.

Additionally, work flow capabilities allow Cooper to effectively manage unbilled or rejected claims initiated in upstream departments. Cooper holds these departments accountable for timely resolution, ensuring minimal disruption to cash flow and improvements in net collections.

“With MedAssets, we have the ability to run daily reports, showing payment activity, including any variance from the expected reimbursement,” said Bob Perry, director of patient financial services at Cooper. “As a result, we have a snapshot of who is underpaying, allowing us to proactively address these issues with the payer.”

To maximize its effectiveness, Cooper also draws upon the expertise of MedAssets Recovery Services. Working on a contingency basis, a team of experienced MedAssets professionals collects identified underpayments on aged accounts. These efforts have resulted in the recovery of $1.8 million in underpayments from 2007 alone.

Rounding out the revenue cycle program, a patient bill estimation tool helps Cooper to improve the accuracy and transparency of pricing prior to service, increasing patient satisfaction and up-front collections.

A wholesale improvement
Cooper has seen a reduction in its A/R days from 60 to 37 days and added an estimated $43 million to the bottom line. Cooper continuously fine-tunes its patient financial services processes, improving individual and organizational performance to meet the challenges presented by new dynamics in healthcare regulations, as well as in payer and service mix.

“It is the combination of the suite of tools and services that allows us to manage our business more effectively,” Perry explained. “MedAssets is a strategic partner for Cooper, and we work closely with them to maximize our effectiveness and to increase the automation of consistent business rules to eliminate human intervention. By strategically managing and planning these ongoing projects, we’ve been able to sustain our momentum and achieve significant return on investment.”
to address them through a healthy combination of people, processes, and technologies.

**Issue 1: Strapped for capital**

Capital markets aren't tight, they're virtually closed to anyone without an investment-grade debt rating. This has led to significant decreases in capital spending—between 30 and 60 percent—by healthcare providers, according to Joel Gardiner, principle in Deloitte Consulting's national revenue cycle practice. "Providers of all sizes are in capital-rationing mode, whether it's for bricks-and-mortar expansion, IT procurement, or other projects."

Further, decreases in nonoperating income such as philanthropy and investment returns are taking their toll on healthcare providers. According to American Hospital Association's (AHA) Report on the Capital Crisis: Impact on Hospitals, nine out of 10 CEO's indicated that attracting charitable donations had become harder over the last year.

At the same time, most all of a hospital's investments have dropped significantly. "Declines in hospital's investment portfolios are a particular problem area given that more than half of a provider's bottom line income can be derived from their investment portfolio," Gardiner says.

Healthcare organizations are now forced to fund projects such as upgrades to their physical plant or IT systems with operational income. As a result, cash is once again king. "There is a renewed emphasis on cash acceleration and days reduction in A/R by provider organizations," Gardiner says. "Contrast this with trends of just over one percent when providers greatly focused on improving net patient service revenue by addressing problem areas such as denials and underpayments."

Providers can improve cash flow through investments in patient access technologies and processes such as insurance eligibility verification systems, up-front collections of co-pays and/or deductibles, and financial counseling staff that can help patients sign up for government programs or qualify for charitable assistance well before they are admitted.

Further, healthcare organizations should pay closer attention to their managed care contracts, which may have been favorable years ago but are underperforming in today's ultra-complex and increasingly restrictive market. "Hospitals need to make sure they get a fair deal and competitive rates on every single contract," attests Mike Evans, former hospital CEO and current COO of the consulting firm Revenue Cycle Solutions. "In one particular contract, I was able to negotiate a 10 percent increase with good analysis of the contract."

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5 tips for improving revenue cycle management in your organization

**Establish a strategic/defensible pricing strategy.** National initiatives, advocacy groups, and others have a growing interest in giving the public access to hospital pricing and chargemaster information. Healthcare facilities must take appropriate measures to better prepare for this pricing transparency and work to establish optimum, yet defensible, pricing.

**Increase up-front cash collection.** Increase point-of-service payment by creating patient-friendly estimates and improving the medical necessity/beneficiary notification process. Some hospitals have seen a dramatic increase in point-of-service collections after including financial counseling in the patient access function.

**Ensure the chargemaster is compliant.** Because of constant regulatory changes, it is crucial that hospitals consider technological solutions to assist in coding and chargemaster compliance. These applications provide a simpler process for an organization's clinical teams to have involvement in chargemaster management to ensure accurate billing for services provided.

**Provide linkage between the supply item master and the chargemaster.** By linking expensive supply purchases and their chargemaster utilization, hospitals can ensure accurate reimbursement and work to negotiate carve-out reimbursements for high-cost physician preference items.

**Improve denials management.** Hospitals can reduce denials in payment by tracking and analyzing denied claims to enhance cash position and decrease accounts receivable.

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Source: VHA Inc., Irving, TX.
the 12-month turnaround
High Point reorganizes its revenue cycle with some impressive fiscal results

Two years ago, High Point Regional Health System, a 400-bed hospital in North Carolina, was operating in the red. Through careful analysis of its financials, the organization found patient volume to be adequate and expenses in check. The organization looked elsewhere, eventually identifying revenue as the culprit.

"Benchmarking our performance against similar organizations revealed that our revenue cycle wasn’t functioning at optimal levels," said Jeff Miller, president and CEO of High Point. "This was of great concern for us because it meant we were leaving money on the table."

In particular, High Point was experiencing a higher-than-normal rate of denials from its payers. Additionally, metrics indicated that an unacceptable percentage of revenue was going to bad debt, a clear sign the organization was not effectively managing its collections process.

A multifaceted approach
Networking with counterparts from other organizations that had similar financial struggles paid off for Miller; he learned of a professional services company called FTI Healthcare that specializes in helping healthcare organizations achieve financial and operational improvements. Miller invited FTI’s team of experts to High Point to help identify ways the provider could improve its fiscal performance.

"We gained a much better understanding of what we should be paid according to our contracts vs. what we were paid."

— Jeff Miller, president and CEO, High Point Regional Health System

Following the review, FTI helped High Point focus on financially clearing patients early in their encounters with the hospital by gaining a better understanding of insurance eligibility requirements. High Point also implemented technology to help segment the self-pay population to identify the level of risk and the patient’s ability to pay, according to implementation project consultant Richard LaForge.

"Armed with this information, High Point staff were able to clearly communicate with patients their portion of the bill," he said. "As a result, they were able to collect more revenue in copays and deductibles up-front."

On the denial management side, FTI assisted High Point in collecting claim information that could indicate the source of its high number of denials. In addition to identifying common registration mistakes, the data was also used to identify denial and payment issues outside the revenue cycle department’s control, such as problems inherent in the managed care contracts. The results enabled High Point to appeal many previously rejected claims and implement operational changes to help prevent future denials.

"Between these improvements and a focus on better vendor management through outsourcing, the hospital realized a huge swing in its financials," LaForge recalled.

An immediate turnaround
With improvements in registration, eligibility verification, and other aspects of its revenue cycle, High Point increased its cash collections by $12.5 million over the previous year, despite net revenue being flat and decreases in patient volume. Other revenue cycle improvements that helped fuel the turnaround included reducing Medicare denials by 77 percent and Medicaid denials by 35 percent.

High Point was able to improve its contract compliance efforts as well. "We gained a much better understanding of what we should be paid according to our contracts vs. what we were paid," Miller said. "FTI really helped us maximize the value of our contracts."

Although proud of High Point’s improvements, Miller knows the organization cannot get complacent, which is why it has retained FTI to continually monitor its key revenue cycle indicators. "Given healthcare’s increasing complexities, we require a long-term partner that can help us remain competitive in an evolving market and economy," he stated. "An independent hospital such as ours can really benefit from outside expertise to help keep their revenue cycle up to snuff."
Issue 2: The collections conundrum

Two segments of the population are placing greater strain on healthcare providers: the uninsured/underinsured, whose numbers are increasing with the rising unemployment rate, and the fully insured, who are responsible for a greater portion of their bill out-of-pocket in higher copays and deductibles.

Uncompensated care costs grew proportionately to the number of uninsured individuals, according to AHA data. Between 2001 and 2007, total hospital uncompensated care costs rose from $21.5 billion to $34 billion, while the number of uninsured individuals increased from 39.6 million to 47 million. The worst-case scenario for many providers is more bad debt and greater charity burdens. A better case is that it’s simply taking longer to collect from a certain segment of the population.

Although many operational and technological solutions offer providers a means to improve their collection rates or trim days in A/R, the best tactics, most experts would agree, involve collecting a portion of the bill before admissions. Yet with all the talk about up-front collections, healthcare still has a long way to go. “In many organizations we’ve worked with, the dollars collected prior to patient presenting are less than 5 percent,” says Bill Poole, a principle with Revenue Cycle Solutions and its patient access arm H-Pass.com. “With the luxury of time, that number could and should be closer to 50 percent.”

Healthcare providers must become more sophisticated in the patient access arena to secure patient payments up-front. This often requires investment in a greater number of individuals experienced in collections. And deploying technologies, including credit card transaction processing and credit scoring solutions, certainly has its benefits.

“Providers must be able to determine what the probability is of receiving the patient’s share of the medical procedure and deciphering what the best strategy is for collecting this bill,” Gardiner says. “There are a number of financial clearance tools emerging that take a very traditional consumer-finance view of credit scoring, estimating the likelihood of collecting payment and even offering guidance for structuring lending arrangements with a patient.”

And with benefits for both patient and provider, healthcare must adopt transparent pricing models that not only provide patients with more information about the true costs of their care, but also establish a baseline so providers know beforehand what they need to collect directly from their patients.

Issue 3: Unclean claims

For all practical purposes, claims management is a misnomer. Healthcare organizations would rather prevent claim denials than manage them, and for good reason: Net revenues lost to third-party claim discrepancies average 3%-5%, according to some estimates.

Although there are myriad reasons a claim can be denied—thus the need for real-time eligibility verification systems and sophisticated claims editing technologies—providers can help themselves greatly by improving data integrity on the front end. “More than 50 percent of claims denied by payers are a direct result of patient access errors,” according to Poole. “With better up-front processes, we’ve seen organizations cut those denied claims by up to 80 percent.”

Problems arise when hospitals fail to dedicate enough staff to the patient access function, or place individuals who are insufficiently qualified or trained in this specific discipline. “From the CEO’s perspective, when your organization is pressed with financial pressures, the first thing you look at is cutting expenses, with training and education near the top of the list,” Evans says. “Because of how tight things are now, it’s tough for hospitals to allocate enough resources to training, but failure to do so can result in some dire financial consequences.”

Issue 4: RAC (real and coming) audits

An expansion of the three-state pilot project that aims to identify Medicare over- and underpayments to hospitals, the Recovery Audit Contractor (RAC) program brings about stiff penalties if a hospital is accused of overbilling Medicare any time during the past three years by submitting claims without proper documentation.

Perhaps the greatest benefit of RAC audits will be the forced integration of a hospital’s clinical and financial departments. “Historically, it’s been a ‘we versus them’ mentality,” B. E. Smith’s Myers says. “We now have to learn to be best friends, communicating and supporting each other.”

According to Myers, a provider’s three most critical components to ensuring RAC audit success are documentation, documentation, and documentation. “Make sure your patient access staff identifies everything that’s required during registration. Also, involve case managers and coding personnel upon intake with active participation and documentation throughout the cycle of care. Finally, revisit your technology and information systems...
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to ensure they will help you record the appropriate and adequate amount of data in a timely manner.”

Healthcare providers’ fourth, fifth, and sixth most important RAC audit considerations, therefore, should be to gain cross-functional buy-in from clinical and financial staff alike, emphasizing both the clinical and financial pitfalls and rewards. Employ analytics that can help guide you through some of the high-risk areas that have been examined and determine where you need to prioritize and form a team of senior management to assess what will be audited, your risk areas, and the approach you will take to doing an internal RAC audit, according to Altarum Institute’s Jamie Solak and Robert Borchert.

And don’t despair about the RAC audit. History indicates that 60%-65% of an audit’s results can be overturned through the right appeals process, Borchert says. “As a bonus, you’re already prepared with an appeal if you’ve done your own internal audit.”

Issue 5: Excellence in healthcare delivery, aka pay for performance

In an effort to help consumers stretch their healthcare dollar while ensuring that providers don’t lose their focus on patient safety, employers and third-party payers—government and private—are driving initiatives to compensate providers based on their performance.

According to a report from Accenture titled Achieving High Performance in Health Care: Pay for Performance, the time is right for these efforts. “There is general agreement that quality of care is not advancing as quickly as it should. … Providers and payers have an opportunity to move beyond thinking about the administrative burden and immediate financial risk, to a discussion of how pay for performance can transform care delivery and outcomes and contribute to high performance for their organizations as a whole.”

Many providers are somewhat behind the curve in their implementation of technologies and solutions that not only help them improve

managing the revenue cycle

Advanced RCM methodologies enhance cash collections, reduce A/R days and improve work flows

Faced with technical and financial challenges, New York Downtown Hospital (NYDH) began to search for the best way to successfully transition its revenue cycle management on-site from an existing outsourcing vendor’s billing and collections service.

“When we examined our cash flow, we knew we needed to improve business processes to ensure we collected every dollar available,” said Frank Vutrano, senior VP and CFO for New York Downtown Hospital.

NYDH turned to Perot Systems for technology and process improvements to drive cash collection. The company now handles all the hospital’s billing and collection of patient receivables and provides support in other areas such as patient access.

“This engagement provides NYDH a new source for improvements in the revenue cycle with Perot Systems providing the additional resources to achieve higher performance,” Vutrano said. “It is a comprehensive solution that addresses the entire revenue cycle, especially the front end processing, to bring technology, process improvement and revenue cycle professionals to drive cash collection improvement.”

During the first nine months of the engagement, the NYDH achieved the following business office results:

- Enhanced cash collections by an estimated $5.5 million
- Improved the clean claims billing rate from 67 percent to 78 percent
- Reduced expenses by approximately $55,000 annually
- Corrected and rebilled more than $3.5 million in A/R

Ancillary and support departments throughout the hospital also worked with Perot Systems to enhance results through improved sustainable cash from operations.

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patient outcomes but also recover the proper reimbursement for the care they deliver in an environment of rising costs and competitive pricing. With much of the focus of clinical documentation directed at surviving the RAC audit, providers shouldn’t discount the financial incentives for documenting quality care levels as well.

The future delivery model
Although today’s emphasis is on cash flow, the next evolution of the revenue cycle may be focused on managing margins by reducing revenue leakage and controlling costs, says Amy Fein, a Deloitte Consulting principal. “In order to achieve this next wave of revenue cycle improvement, hospitals will need to make sure their processes and technology utilization span across all revenue cycle areas.”

Also, we’ll see more efforts by hospitals to improve the patient experience, something that many providers have begun today but not to the level that patients will demand in the future. “Our research indicates that healthcare consumers desire security, transparency, and a personal touch,” Fein says. “They also want provider organizations to operate like a business and won’t hesitate to go elsewhere if they believe they will receive better service or care.”

In the increasingly competitive healthcare marketplace, providers are well advised to become familiar with their patients, just as a retailer would with its customers, learning their habits, needs, and desires. Armed with this intelligence, healthcare organizations will be better positioned to target their customers with strategic acquisition and retention tactics.

ending the paper chase
Care New England reduces costs with document management technology

Like many healthcare providers, Care New England relies heavily on extensive medical documentation. Producing more than 47,000 reports at an average of 40 pages each, the Providence, RI, organization was spending millions of dollars each year on print costs alone.

Further, the reports required distribution, storage at another facility, and on-demand access, meaning reports had to be located, picked up, and delivered by a courier service. In addition to the added expense, it proved a time-consuming and inefficient process.

“We are continually searching for ways to save money,” said Carl Lindewall, application specialist at Care New England. “One area we focused on was reducing the overall costs of producing reports.”

Care New England decided it could best trim report production and distribution costs with an electronic document management system. The provider researched potential vendors, and with a host of product demonstrations under its belt, selected SSI’s ClickON® Document Management System (DMS).

“Our standards were pretty high when we chose SSI’s technology for document management,” according to Lindewall, whose organization was already an SSI customer, using the ClickON® Claims Editor for billing. “We did look at other vendors, but the technology in SSI’s solution met our needs.”

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Care New England’s long-term document management strategy is already paying dividends. “In many cases, only the summary page is needed in the report, and we used to produce volumes of paper just to get to that one page,” Lindewall said. “Now that one page can be accessed online, and only that page can be printed.”

Utilizing SSI’s DMS, the healthcare provider saved more than $61,000 in 2007 and an estimated $100,000 since. Further, the electronic report distribution and online access capabilities of the DMS have created numerous operational efficiencies for Care New England staff.
lower your a/r costs

Third-party billing solution aggregates paper-based and online statement processing

The healthcare revenue cycle is in transition. With patient financial responsibility on the rise—even among the fully insured—self-pay balances account for an ever-greater portion of providers' receivables. Further, collecting on these accounts is an increasingly complex and expensive process, as healthcare organizations attempt to control patient liability risks, devise payment plans, and manage both paper-based as well as online account settlements.

The question for providers becomes, “How do we streamline billing so it's easy for patients to provide multiple partial payments via different mediums, all while reducing collection costs?” The answer has emerged in an innovative third-party A/R solution that streamlines a provider's entire billing function, whether paper-based or electronic.

Automating the invoice-to-payment process

Healthcare billing is still largely a paper-based process, requiring significant resources to generate and mail statements. Automating even a small portion of these bills via a Web interface cuts cost and injects efficiency into the billing process. Yet in-house solutions still require healthcare organizations to actively manage all the tasks associated with electronic payments, such as pushing patient files out to the Web, thus ensuring that personnel and administrative costs are still part of the equation.

Bank of America has streamlined all healthcare billing activities with Healthcare Revenue Manager, a new solution that offloads both paper-based and electronic billing functions from the healthcare organization, freeing them to focus more resources on their core revenue cycle competencies, such as patient access and claims/payer management.

Healthcare Revenue Manager segments a provider's entire billing file according to whether each patient receives a paper statement or has enrolled in an online payment portal, sending bills via the appropriate medium. Electronic statements are recreated in a PDF file, allowing the patient to view a host of important information, such as all charges aggregated under one guarantor, insurance payments that have been applied, and even a pending insurance amount.

Printed statement coupons returned by the patient are directed to the company's highly secure and controlled retail lockbox payment processing environment, specifically designed for healthcare organizations. Even credit, debit, or HSA card numbers are processed through a lockbox that automatically credits a provider's account.

And Healthcare Revenue Manager automatically merges captured invoice identification data with payment data into a single remittance file that is sent to the provider on a daily basis so it can be posted in the patient accounting system. Providers are freed from the costly billing process while maintaining full control and ownership over their A/R records.

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Lower costs, improved customer service

Healthcare Revenue Manager is completely transparent to the provider, regardless of how a bill is paid. And consolidated payment data sent to the provider in a timely fashion ensures the organization will always know the status of its outstanding accounts.

Healthcare Revenue Manager also seamlessly facilitates an organization's shift from paper-based to electronic billing and payment processing, which can save providers millions of dollars in printing and postage costs. To encourage this transition, Healthcare Revenue Manager works with its clients to promote online account management via strategic messages placed on paper statements and other communication efforts.

Further, Bank of America ensures it is especially easy for patients switch to online account settlement by preloading all of a client's patient account data into the electronic payment system, meaning patients can immediately make an electronic payment upon enrollment. Patients also benefit from Healthcare Revenue Manager's automatic payment capabilities, whether settlement is made via credit card, HSA, FSA, or direct debit to a bank account.

Automated, third-party billing solutions such as Healthcare Revenue Manager can speed patient payments, increase transaction accuracy, trim administrative costs, and improve customer satisfaction levels, all translating into improved cash flow for the healthcare provider.
Seemingly lost among the enormous amount of data that is available to healthcare providers are five key patient access (PA) metrics. Unlike some metrics that are difficult to compare across various hospitals and health systems, these PA metrics can be valuable to any organization. “A data-driven approach to managing the revenue cycle, including careful focus on the right metrics, can help healthcare leaders improve both the patient experience and financial results,” stressed Ron Kelley, a senior director at Conifer Revenue Cycle Solutions.

Metric 1: POS collections as a percentage of all patient collections
This metric allows healthcare providers to track patient liability collections in total, where the payment originated and payment trends over time. For example, POS collections typically trend down throughout the calendar year as patients satisfy their deductibles. Conifer worked with its clients to dramatically reverse that trend — actually increasing the percentage of patient liability collected on or before delivery of service as the year progressed. The average of Conifer’s clients’ POS collections as a percentage of all patient collections approached 40 percent, while some individual clients are now obtaining 75 percent or more of all patient liability either prior to or at the POS.

Metric 2: POS collections as a percentage of potential patient liability
Most healthcare providers set goals for POS collections based on historical collection rates. A better POS collections goal is based on a percentage of the total estimated patient liability, which should include copayments, deductibles, and coinsurance.

The estimate for total patient liability can easily be calculated by using a patient liability payment estimator tool. This tool combines eligibility/benefit data and managed care contracts to help PA staff quickly determine how much to collect from patients. Knowing the potential patient liability amount and comparing that to actual collections will give healthcare leaders a good indicator of the effectiveness of their PA efforts.

Metric 3: Percentage of accounts not financially cleared
Trending the root cause of why accounts are not financially cleared can help you focus on gaps in the process. PA operations can fill these gaps by creating and implementing policies and procedures detailing activities and results required to financially clear an account. Ultimately, the root-cause analysis can provide a clear picture of why a department may be allowing patients to slip by without complete financial clearance. The tracking, trending, and analysis of the percentage of accounts with incomplete financial clearance every month can help leaders create results-oriented strategic plans to address the root causes.

“A data-driven approach to managing the revenue cycle, including careful focus on the right metrics, can help healthcare leaders improve both the patient experience and financial results.”
— Ron Kelley, senior director, Conifer Revenue Cycle Solutions

Metric 4: Cycle time
Patient wait times are routinely scrutinized by healthcare executives. However, many leaders do not realize these wait-time metrics underreport the real time patients spend waiting prior to service. Healthcare providers can develop comprehensive cycle-time measurements by segmenting and tracking each component of the patient’s experience, including prior-to-service date, initial arrival, registration time, and clinical service times.

Metric 5: Plan ID changes
Repeated, unanticipated changes of the insurance plan identification (ID) code on an account are indicative of inefficiencies in the revenue cycle. Whether an incorrect insurance carrier was documented by registration, or billing erroneously changed the primary payer information, plan ID changes can lead to denials and extra days in accounts receivable.

Healthcare providers can measure this statistic by comparing the number of accounts that have a plan ID changed as a percentage of all account volume. The ability to analyze and understand plan ID changes by payer, by department, or even by registrar can help revenue cycle leaders identify failure points and correct root causes.
rcm overhaul translates into large-volume results

UNC Health Care increases cash flow by $8 million with a new receivables management system

With well over 1 million patient visits annually and more than $1 billion in gross charges, the University of North Carolina Health Care System places a high priority on revenue cycle efficiency. There was a time when the organization struggled with an inefficient, paper-based payer follow-up, forcing staff to spend much of its time on unnecessary and unprofitable work.

To increase efficiency, UNC turned to Muncie, IN–based Ontario Systems and its Revenue Savvy receivables management system. The software helps hospitals identify problematic claims immediately and automates the work flow necessary to facilitate the claim resolution. Keeping collections in-house can have the added benefits of increasing collection rates, retaining control of patient relationships, and improving the provider’s public image.

Revenue Savvy can even help administer charity write-offs and identify eligibility for financial assistance. The system’s self-pay collections, third-party insurance follow-up, and agency management features ensure accounts are integrated into each client’s standards.

The clean claim challenge

Revenue Savvy helps reduce patients’ demographic and insurance-related errors by automatically validating critical information, confirming insurance coverage, and automating work flow when errors are found. Revenue Savvy also helps to gather treatment authorizations and pre-certifications, as well as alert account representatives when specific patients are admitted, verification work is incomplete, or financial counseling may be warranted.

The system is a “bolt-on” rather than a replacement for a provider’s patient accounting system and automates collection practices by managing account work flow and allowing account representatives to focus on payer and guarantor follow-up. It also incorporates business rules and work flow strategies to manage correspondence, patient contacts, and credit information, allowing clients to identify trends, mistakes, and misinformation before they become problems. The result is a reduced number of write-offs and days outstanding; optimized efficiency and productivity; increased cash collections; and more focused patient care.

Financial counselors and case managers use these tools as well. Whether referring and authorizing medical procedures, apprising patients of their financial responsibilities, or working with them to find financial assistance, the system provides the functionality and options to facilitate work flow on every account.

“The financial results have been nothing short of phenomenal. But we’re also improving customer service and the way we interact with patients.”

— Matt Castellano, IT director, revenue cycle, University of North Carolina Health Care System

Another module of the system is Guaranteed Contacts, an inbound/outbound dialer designed to create a highly efficient and cost-effective method to contact account holders. The system can improve productivity by relieving account representatives of the dialing function and providing them with a steady flow of contacts. The dialer screens no-answers, answering machines, and triple tones, providing only live contacts to hospital account representatives, so they deal only with calls that can result in action.

The results are in

The implementation of Ontario Systems’ self-pay module allowed UNC to touch more accounts daily without increasing staff. The electronic system segments accounts by payer, allowing account representatives to discuss multiple accounts during a single payer call. The system’s work flow manager automates portions of the secondary billing process to expedite submissions with little human intervention. It also provides timely payer updates and trend reports, triggering appropriate actions in real time.

In the first year of operation, avoidable losses decreased by $6.6 million and cash on hand increased by $7.9 million. “The financial results have been nothing short of phenomenal,” said Matt Castellano, UNC’s IT director, revenue cycle. “But we’re also improving customer service and the way we interact with patients. This technology has helped us become a better healthcare organization.”
a complete rcm solution

Atlantic Health gets quick results with leading-edge claims management technology

With 9,700 employees, 1,200 beds, and nearly 150,000 emergency visits annually, Atlantic Health is one of the top healthcare providers in New Jersey and the New York City metropolitan area. Consisting of the Morristown Memorial Hospital, Overlook Hospital, Goryeb Children’s Hospital, a cancer center, and cardiovascular and neuroscience institutes, Atlantic Health leaves no stone unturned when it comes to quality healthcare.

The same can be said about its revenue cycle. In 2007, when its previous claims management vendor began to drop the ball in service quality and payer connectivity, the Atlantic Health Patient Financial Services (PFS) team set about finding a new technology partner.

Many needs, one solution

Following a traditional request for proposals process and a handful of product demonstrations, Atlantic Health selected the ePREMIS® claims management service from RelayHealth. “We went with RelayHealth because of its ability to offer comprehensive tools for managing the claim process and extensive direct-to-payer connectivity,” said Nancy Kaminski, corporate director of PFS and patient access for Atlantic Health. “Among them, integration with our current McKesson HIS and real-time submissions for Medicare Direct were very important factors.”

Available through a software as a service (SaaS) platform in which RelayHealth hosts provider data, the advanced editing service supports both institutional and professional claims and Medicare compliance edits, combined with customer-specific editing and work flow management. Other features include:

- Up-to-date medical necessity compliance rules
- Payer claim status reporting
- Direct-to-payer connectivity
- Flexible and scalable work flow and reporting
- Accelerated and automated secondary billing
- Medicare Direct Entry for real-time claims processing

Quick returns

Since Atlantic Health went live with RelayHealth in May 2008, it has already achieved desirable results. For starters, days in A/R have come down and medical denial write-offs have decreased.

“Our bills are going out cleaner and in a timelier manner,” Kaminski stated. “With a higher clean-claim rate, we’ve realized a subsequent increase in cash flow coupled with a reduction in billing cycle time.”

Atlantic Health is also an early adopter of RelayHealth’s new eligibility claim editing service. With this capability, Atlantic Health can identify patient and insured coverage and demographic issues post-service and fix them in-house prior to claim submission, avoiding the normal turnaround time for addressing a payer rejection. This added check “closes the loop” on eligibility checking throughout the patient’s stay.

For example, within a recent 90-day period, actionable tasks were identified on more than 2,000 accounts, representing over $9 million in gross charges. This alone saved the organization more than $50,000 in labor costs. “By using eligibility claim edits to submit cleaner claims, our staff was able to recover additional revenue and save time,” Kaminski said. “This also frees staff to follow up on problem accounts and more complex issues.”

According to Kaminski, the ability to perform two eligibility checks—one at the point of service and one at the point of billing—ensures Atlantic Health’s claims are as clean as possible. With this innovative service, the provider is capturing an additional 3%-4% of eligibility changes. “We’re in a better place with our electronic billing functionality than we’ve ever been, and we’re very well positioned to move forward with our revenue cycle improvement goals.”

Among its goals, Atlantic Health wants to improve its analytics capabilities and is a development partner for RelayHealth’s new business intelligence tools that will help Atlantic Health gain an in-depth graphical interpretation of key financial metrics with customized and flexible enterprise-level reporting on a regular or ad hoc basis. The provider is also working closely with McKesson and RelayHealth to integrate both revenue cycle and clinical data into its Horizon Enterprise Revenue Management solution.

“We have a great relationship with RelayHealth and consider them strategic business partners over the long term,” Kaminski stated. “We expect RelayHealth to continue helping us create an ideal future state for our revenue cycle.”
on-target eligibility verification

Northwest Ohio hospital improves reimbursements and customer service with a new, user-friendly solution

Like most organizations, Lima Memorial Hospital, a 300-bed critical care facility, employs various tactics to maximize its reimbursements, including performing insurance eligibility verification checks when patients register.

The organization was growing increasingly agitated, however, with an unreliable and disjointed eligibility verification system it had been using for five years. For one, the system was often unavailable when needed most. And when a payer's site was down—even for an instant—admissions staff had to start the entire registration process over when it came back online, according to Lima Memorial Registration Manager Vicki Geddings.

Further, responses were never displayed in a uniform format. "Registrars often found it difficult to locate information they required in a timely fashion," she recalled. And the system was unable to perform multiple tasks simultaneously, meaning patient registration would be put on hold while the eligibility check was being done, wasting staff and patients' valuable time.

Not only creating headaches, Lima Memorial's eligibility verification system was costing the organization money. With its limited capabilities, the system did not store historic response data long-term. "If we received a denial, we often couldn't go back and check the eligibility system for a cause because records were purged after only a short time," Geddings said.

Search for a resolution

A team from Lima Memorial viewed several demonstrations from different eligibility verification solution providers, and one system in particular rose to the top, according to Geddings: Passport Health Communications' OneSource eligibility verification solution. "It offered everything we were looking for," she said.

A real-time, stand-alone solution that can be accessed from any workstation with an Internet connection, OneSource incorporates solid firewall and SSL encryption technologies to keep data secure. While Lima Memorial uses the product primarily for eligibility verification, Passport clients can also use OneSource to perform real-time address verification, claim status, referral, credit card processing, and other services.

The hospital also deployed Passport's IntelliSource integrated patient data validation system, that identifies critical patient information when patients pre-register, register, or arrive for a procedure. Highlighting data discrepancies, the system automatically verifies that patient demographic, clinical, and benefits information are accurate, thereby improving claim accuracy, ensuring healthcare providers get reimbursements quickly and in full.

Initial implementation of OneSource and IntelliSource went off without a hitch, and training proved noninvasive, according to Geddings. "The Passport team did very thorough testing of the system before it went live. And since it's such an easy product to use, staff were trained on the system only an hour."

Results come quickly

With the OneSource eligibility verification and IntelliSource data validation solutions, Lima Memorial realized immediate benefits. Uptime has greatly improved, and when a payer's site is offline, Passport continues to send the verification request until it receives the results, unlike the old system that required admissions personnel to restart the registration process.

Further, data is received on a timely basis and is presented in a uniform, easy-to-read manner. "We receive a response about eligibility while the patient is in front of us, which is the best time to ask patients further questions about their insurance when needed," Gedding stated. "And staff no longer waste time searching reports for the information they need—it's all presented in the same place and in the same format every time."

Additionally, OneSource historical response is made available for 90 days, allowing Lima Memorial to research causes of a denial within the remediation period.

Geddings and her team anticipate the Passport solution to prove especially useful as regulations increase and reimbursement activities become increasingly complex. For instance, one payer Lima Memorial works with now requires that the hospital notify it within 24 hours of every admission, or reimbursement will be cut by half.

"Timeliness in eligibility verification is critical, particularly over a weekend when we have limited staff," according to Geddings. "Passport has built in a way to notify our insurers of an admission, cutting our risk of noncompliance dramatically."
practice management pays dividends

The transition from a hospital-owned organization to an independent practice with affiliation ties to the health system is a financial boon for one group of Pennsylvania physicians.

Health Associates of Western Pennsylvania (HAWP) is a primary care, family medicine practice based in Pittsburgh. HAWP has nine providers, with another three joining the organization shortly with the planned opening of a new primary care/urgent care practice site.

A relatively young organization, the hospital-owned group had a combined net loss of roughly $600,000 annually. "We had come to realize that employed physicians have very little control over their destinies when sweeping decisions are made by the hospitals that control their practices," said William Johnjulio, MD, HAWP president.

Looking for a way to regroup and become profitable, while maintaining ties to the health system, HAWP turned to MED3000 for management assistance. MED3000's operational and management experts find that many hospital-owned groups are drowning in hospital "overhead" expense costs that can typically not be supported by physician groups.

The practice transformation

After discussions with the health system and an analysis of HAWP's financial situation, it was mutually decided the best scenario was to transfer the group to an independent practice, while maintaining the affiliation with the health system. In 2004, HAWP physicians, with assistance from MED3000, began the transition.

MED3000 advised HAWP on establishing a governance structure and compensation plan. The company also performed operations assessments and implemented practice improvement initiatives to enhance the practice's revenue stream and reduce overhead. Services MED3000 provided HAWP include:

- **Practice assessment**: Measuring the practice's financial and operational condition and identifying opportunities for improvement.
- **Transition management**: Managing the processes involved in transitioning away from hospital ownership and establishing an independent practice.
- **Practice management and oversight**: Providing financial, administrative, and human resources management and support.
- **Revenue cycle management**: Handling the billing and collections for the practice.
- **ASP technology for practice management**: Providing the technology needed to streamline and support practice operations, plus additional M3/Connect technology to automate appointment confirmation and recall patients for needed services.
- **M3/IQ™ data warehousing**: Consolidation of practice information for decision support and use in patient recall programs.

Immediate financial results

As a self-run group, HAWP saw 20 percent growth in its first year, and by the third year had become a completely private, self-sufficient 'S' corporation. "By using MED3000's resources, we were able to move quickly into a profitable corporate structure that proved to be sustainable," said Dr. Johnjulio.

With MED3000's assistance, HAWP reduced overhead expenses and streamlined its revenue, all while maintaining a strong relationship with the health system. As a result of the consolidation, the practice reduced its expenses by 60%-70% in the first year of operations alone. And, using the MED3000 data warehouse and decision support tool, along with the M3/Connect patient communication tool, HAWP has improved its population health management efforts by reaching out to patients to ensure they receive needed services.

The provider organization automated the recall of nearly 400 noncompliant patients with disease states that required monitoring and improved both clinical and financial outcomes. Proactively recalling patients back for needed care not only improved patient care, but also helped improve the group's financial position, producing a hard-dollar return on investment of 6.2 times the total cost of the initiative.

"Thanks to the MED3000 experts, our practice is now profitable," Dr. Johnjulio stated. "We are seeing more patients because of the M3/IQ™ reports and M3/Connect technologies, and our physicians' salaries have increased by 33 percent."