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Revenue Cycle Management

CREATING CASH FLOW ADVANTAGE

“Real news is bad news,” said famous communications theorist Marshall McLuhan. Here’s the real news: Costs to deliver healthcare continue to spiral upward (albeit at a slower pace than during the late 1990s and early 2000s) as increases in labor, real estate, supplies and equipment outpace provider revenue growth.

And like any business, healthcare organizations face increased competition from smaller, more profitable service providers such as outpatient MRI and cardiology centers. According to Daniel Thiry, managing partner of healthcare consulting firm Revenue Cycle Solutions in Pittsburgh, competition has taken a significant portion of a profitable business away from traditional providers. “If this trend continues, they will be in even worse shape than they are now.”

Meanwhile, uncompensated care remains a serious and growing fiscal problem. In 2005, hospitals carried approximately \$28.8 billion in uncompensated care, or 5.6 percent of their total expenses, according to the American Hospital Association. This figure represents a 33 percent increase since 2000.

Adding to the woes, hospitals and physician groups are continually throttled on the managed care front, receiving nominal—if any—annual increases in reimbursement rates. “On top of that, the rates insurers have historically offered are being further eroded by increasing patient co-pays and deductibles, which dramatically affect providers’ reserve calculations,” Thiry notes.

And for good measure, providers are facing a stew of complicated market-driven and regulatory issues that

threatens to further pressure their revenue cycles.

THREATS TO THE REVENUE CYCLE

Consumer-driven healthcare

The nearly uncontrollable rise in healthcare costs, combined with consumer demands for more care options, has led to the so-called “consumer-directed” healthcare model. Punctuated by health savings accounts (HSAs), patients, who are now responsible for a greater portion of their expenses, decide where their money will be spent. As they would look for a car based on price and quality, a growing number of consumers are shopping for more affordable healthcare services.

The burden of consumer-driven healthcare falls on providers to make pricing transparent and to collect at the point of service. “Rising consumerism and the subsequent need for pricing transparency are huge issues,” said Andrew Stefo, CFO of Palos Community Hospital in Palos Heights, Ill., during an executive roundtable on top revenue cycle trends hosted by the Healthcare Financial Management Association (HFMA). “We’ve seen a big pick-up in health savings accounts with \$10,000 and \$12,000 deductibles, and that changes the game dramatically in terms of our front-end and back-end processes.”

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.”

Last December, President Bush signed into law the Tax Relief and Health Care Act of 2006, which authorizes the Centers for Medicare and Medicaid Services (CMS) to establish a system dubbed the Physician Quality

Providers have an opportunity to increase revenues by up to 5 percent through improved RCM practices.

Reporting Initiative (PQRI). “PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program,” reads a statement from CMS. Those who report a designated set of quality measures on claims can earn bonuses of 1.5 percent of their Medicare charges.

According to industry veteran Robert Borchert, revenue cycle management practice leader with Ann Arbor, Mich.-based consulting firm Altarum, pay for performance adds to already heavy documentation loads, forcing providers to place a greater emphasis on monitoring and reporting patient outcomes.

Meanwhile, third-party insurers have become so business and technology savvy that they continue to hold most of the financial cards. “Payers have leveraged the complex formulas that drive healthcare reimbursements so effectively, providers will be left with very little wiggle room,” Borchert says. “And they’ll only use their head start to further burden physicians and hospitals with additional documentation to ensure they are maintaining a high quality of care.”

On top of these issues working against provider finance departments, hospitals and physician groups routinely

lose up to 5 percent (or more in many cases) of revenues from inadequate revenue cycle management (RCM) in the form of inappropriate denials, uncompensated care, mis- or underutilized personnel and technology, and a disconnected supply chain, among other imperfect business practices. Since *good* news is rare in healthcare and bears repeating, here it is again, put another way: Providers have an opportunity to increase revenues by up to 5 percent

through improved RCM practices.

Even more good news: Achieving positive revenue gains with an effective RCM strategy is well within providers’ reach. Consider, for instance, that nearly 70 percent of discrepancies in the form of third-party denials and underpayments are recoverable, and up to 90 percent of discrepancies are preventable, according to revenue cycle management consulting firm Zimmerman, Hales Corners, Wis. Even healthcare executives who are confident in their handling of the revenue cycle cannot afford to dismiss potential RCM improvements as a way to inject greater accuracy, transparency and precious cash flow into their organizations.

WHAT IS RCM?

RCM means different things to different people. In 2006, the American College of Healthcare Executives (ACHE) asked hospital CEOs about the top issues they face. Of the 871 responses, 72 percent indicated that financial challenges were their greatest concern, up from 67 percent in 2005. Increasing costs in staffing, supplies, etc., led the list of financial concerns, followed by Medicaid, bad debt and Medicare. Interestingly, RCM ranked near the *bottom* of financial concerns expressed by hospital CEOs,

REVENUE CYCLE MANAGEMENT

which may indicate that many executives view RCM as merely a cog in a hospital's larger financial wheel.

Others believe that RCM is *the* financial wheel of a hospital, a mindset that is gaining supporters, particularly within finance departments. An HFMA survey of nearly 2,000 financial executives found that day-to-day issues revolving around the revenue cycle were a priority. "Among near-term challenges, revenue cycle improvement was a top concern among CFOs," according to the *HFMA's Healthcare Finance Outlook 2007* report.

The Healthcare Information and Management Systems Society (HIMSS) also weighed in on RCM in its *2007 HIMSS Analytics Report: Care-Based Revenue Cycle Management*, in which it surveyed a variety of hospital executive titles including COO, CIO, director of patient accounting and senior finance executive. It concluded that RCM has traditionally been associated with "tasks related to ensuring payment for a patient encounter" such as registration, charging, billing and payment collection.

Many respondents broadened the definition, however, seeing RCM as a

complete system "having a direct link to the organization's strategic and annual budget cycle." According to one survey participant, "[RCM] means showing that we meet our budget . . . It's all about managing the finances." A few even indicated that RCM includes a relationship between both financial and clinical data.

Considering how tightly integrated RCM has become with all of a hospital's finances, it's easy to argue that RCM has expanded to include a wider range of activities—including payer contract management, supply chain management and even decision support. Regardless of your definition, executives who scrutinize their RCM systems and practices will not only obtain a good picture of their organizations' finances, but also will gain a better understanding of the factors driving their financial situations, both good and bad.

According to Thiry, an analysis of your revenue cycle will reveal:

- » True cost of providing each and every healthcare service
- » Reimbursement adequacy of various services relative to cost
- » Accuracy and timeliness of charge capture
- » Claims submission timeliness

- » Accuracy and completeness of insurance, demographic and relevant medical information capture upon registration
- » Accuracy of code assignment from medical records department and charge description master (CDM)
- » Receipt of insurance payments

BEGIN AT THE BEGINNING

Most experts agree that providers often *react* to the revenue cycle instead of *managing* it. Elizabeth Woodcock's mantra for providers: "Do it right the first time." This consultant from Atlanta believes that long before a service is performed, there are many things providers need to perfect—from credentialing to contract management—to realize the best financial outcomes.

For each revenue cycle pitfall providers encounter on a daily basis, there are a number of solutions.

Patient scheduling/registration

We've come a long way since the early days of care when registration often meant writing a patient's information directly on their body. But considering

CHARGE RECOVERY DONE RIGHT

CHS GAINS \$8.4 MILLION IN ADDITIONAL REVENUE

Carolinas Healthcare System (CHS) knew that lost revenue from missed charges was an issue for their four hospitals. Their past solution was to engage a consulting firm to help recover this otherwise forfeited revenue. Their consultant billed an average of \$156,000 in lost charges per month, significantly boosting the system's net reimbursement.

In April 2004, however, CHS embarked on a focused effort to address missed charges, increase net reimbursement, reduce human error, and eliminate the cost and requirement of a consultant to handle this part of the cash flow process. The goal was to improve charge capture by automating the task of verifying charges and putting a system in place that ensured accurate billing on an ongoing basis.

While researching solutions, Tony Lantzy, CHS assistant vice president of finance, learned of MedAssets' Charge

Capture Audit product, CCA.Net. Part of MedAssets' Net Revenue Systems suite, CCA.Net automatically audits itemized patient bills on a daily basis. It applies rules that run on "pre-bill" data, so potential missed charges or overcharges can be captured prior to submission of the bill to the payer or patient, and it works with the facility's existing IT system to ease the implementation process.

The return on CHS's investment in the MedAssets charge capture tool has been striking. In a 12-month period between 2005 and 2006, CHS recovered more than \$8.4 million in gross revenue (\$3.5 million net) and attributes it to the use of CCA. They also eliminated associated vendor fees and have improved workflow in their billing department. A rewarding combination across the board.

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REVENUE CYCLE MANAGEMENT

the amount of information gathered at the beginning of a patient encounter today, errors are inevitable.

“The healthcare industry lives with 2-to-5 percent of clerical error in gathering patient data,” Borchert says. “If the correct information isn’t captured up front, the whole revenue cycle for that patient falls apart.” One facility he worked with identified \$9 million in undercharges from a single payer due to registration information not being appropriately categorized. Borchert’s solution for providers is to put more resources into “up-front” tasks like registration. “Give me a facility that has seven people doing registration and 14 people doing billing and collections—let me reverse that and I guarantee increased cash flow and fewer denials,” he says.

Insurance eligibility verification

Providers must verify a patient’s insurance eligibility early in the process or

risk getting stuck for the cost of care. “When providers make sure that a patient’s third-party payer will cover the services rendered, they are 70 percent home,” Borchert says.

Coding and compliance

This process is often rife with errors, such as incorrectly identifying or even failing to record procedures. “If revenue codes are not accurate coming out of the CDM, the claim will result in a full or partial denial or an underpayment,” Thiry warns.

Technology solutions can play a significant role in coding quality, according to Woodcock. “The complexity of the process makes it nearly impossible to do it manually. A [provider] with 150 insurance companies might bill 6,000 CPT codes, all with different reimbursement criteria,” she says. “If technology can be integrated into coding, such as assisting the providers to code appropriately and at the proper time, it will prove extremely valuable.”

Claims and denial management

Industrywide estimates put net revenues lost to third-party claim discrepancies at 1-to-3 percent, though for many providers that number is much higher. “Providers we work with are routinely losing 8-to-10 percent on each bill,” says Borchert, adding that many problems with the healthcare claim can traced back to registration and coding problems. “Denial management is an indicator of a problem,” he says. “When you capture the appropriate information up-front, you spend less time managing denials.”

Another issue is that many providers are not fully aware of how much denials cost their organization in revenue. “One of the problems is that denials are a moving target,” said Michael Kittoe, vice president and CFO of Delnor-Community Hospital in Geneva, Ill., during HFMA’s “Revenue Cycle Challenges for Hospital and Health Systems” executive roundtable. “The

STAKE A CLAIM FOR ACCELERATED PAYMENTS

VALLEY HEALTH SHORTENS REMITTANCE TURNAROUND

Valley Health is a network of hospitals and treatment centers serving the residents of Virginia’s Shenandoah Valley, West Virginia and western Maryland. Since 1993, Valley Health has successfully kept A/R days low and has made the most of efficiencies created by ClickON® claims technology from The SSI Group, Inc.

In 2001, says Ann Ryder, corporate director of patient accounts, Valley Health identified a need for additional claims functionalities, including automatic follow-up, real-time corrections, secondary billing and workflow enhancement capabilities. That same year, SSI released its ClickON Claims Status Module (CCSM). By using the 276/277 HIPAA claim status inquiry and response transaction code sets, CCSM provides the status of claims submitted to payers prior to remittance, which helps accelerate secondary billing. Claims can be corrected within many payer systems and workflow capabilities enable billing staff to work claims specific to them.

“We knew we had a need for a claims status product,” Ryder says. “And CCSM was a good fit with other SSI technology already in place. It complemented our existing capabilities and workflow.”

With CCSM workflow and reporting tools, Valley Health experienced improvements in the turnaround of secondary payments and alternative dispute resolutions (ADRs). “We picked up a day in productivity when we went live with CCSM,” Ryder says. “In some cases, payment was received by the secondary payer before the primary payer turned around its payment.”

With a quicker turnaround on ADRs, corrections can be made much sooner than they could with a paper-based process, Ryder adds. “We automated the CCSM notes so they would post directly back to our mainframe. [Now] claim errors can be worked more quickly,” she says. Accelerating Valley Health’s claims process tallied many cash flow benefits, which was Ryan’s aim from the beginning.



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REVENUE CYCLE MANAGEMENT

rules are changing constantly at payers' discretion; and they change without notice. So, that's where a lot of this chasing comes in. You're going to resolve it eventually, but it will cost you."

While challenging inappropriate denials is an uphill battle, the onus lies on the hospital or practice to better educate itself on the true costs of delivering healthcare services today, Thiry says. "Hospitals provide many services that they're actually losing money on. They must take the time to work the cost figures relative to what they're being reimbursed."

Contract management

Insurers supply the contracts that define how much a provider will receive, so it stands to reason that they'll generally be more favorable to the payer. "The major payers wield significant bargaining power, and it may

be difficult—although not impossible—to avoid becoming one of their participating providers on a 'take-it-or-leave-it' basis," Thiry says.

At the heart of the problem is a general lack of familiarity with third-party contracts. "The data you need to determine the profitability of any MCO contract are in the contract itself," he says. "Many hospitals don't fully understand the terms of their MCO contracts and may have little idea how those terms affect the net income generated from the contracts."

A number of vendors deliver contract management solutions that help analyze payer contracts and compare terms in the contracts with reimbursements to combat underpayments.

Supply chain management

Many providers don't equate the supply chain with RCM, but perhaps they

should. According to *Essentials of the U.S. Hospital IT Market*, a 2006 report published by HIMSS Analytics, "costs and operational efficiency pressures will continue to drive improvements in supply chain management." The relationship between providers' care delivery costs—including office and medical supplies and equipment—and their reimbursements are inseparable. Moreover, the healthcare supply chain is increasingly dynamic; constant price fluctuations make timely supply chain data critical to providers.

Credit and collections

Even if you haven't completely lost payment on a claim—fully expecting reimbursement by correcting denial issues, for instance—you still miss out on cash flow advantages due to the delay in collecting that money, Borchert says.

MANAGE YOUR SUPPLY CHAIN

LEVERAGING CURRENT AND ACCURATE INFORMATION TO IMPROVE FINANCIAL PERFORMANCE

Most hospital executives are bracing for greater financial challenges and scrutiny in coming years. As the population ages, demand for more sophisticated and higher-priced medical devices is increasing at a much faster pace than reimbursement rates. Meanwhile, hospitals are being pressured to report on both the quality and cost of care at their institutions. Now, more than ever, hospitals need to analyze their supply chain expenditures and their relationship to overall financial performance.

The critical information that drives healthcare is dynamic, making it nearly impossible for hospitals to get their arms around their true costs.

- » **Products**—Suppliers continually introduce, change or discontinue products
- » **Organizations**—More mergers, acquisitions and divestitures are certain for suppliers and providers
- » **Reimbursement**—Whether public or private, reimbursement rates are often out of synch with actual costs and charges

- » **Contracts**—Both procurement and reimbursement contracts change daily

By better controlling and capturing supply costs, hospitals can put systems and processes in place to analyze the relationships between total costs, charges and reimbursements, all contributors to sound financial performance.

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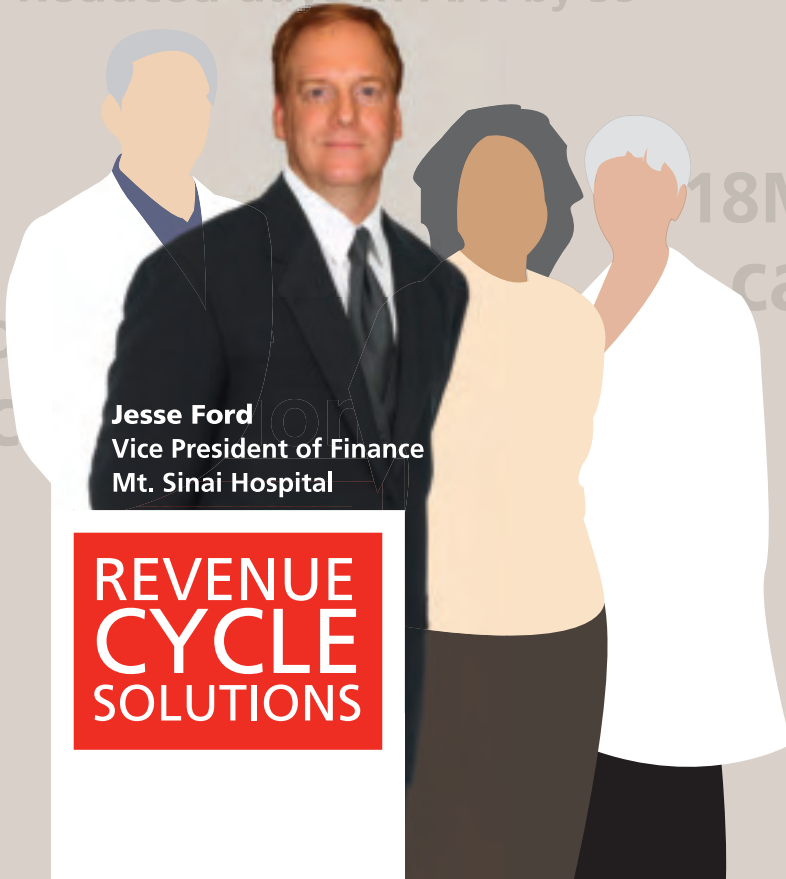
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“Results are really forefront in my mind in terms of the benefits of revenue cycle solutions with Perot Systems”

– Jesse Ford

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Jesse Ford
Vice President of Finance
Mt. Sinai Hospital

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MANAGING CONTRACT PERFORMANCE

HPA SAVES TIME AND MONEY WITH CONTRACT ANALYSIS AND MODELING TOOLS

Hospital Partners of America (HPA) used to use a manual method to analyze managed care contracts. But, like any manual method, it was slow and susceptible to error. Concerned they were leaving money on the table, HPA replaced their manual contract analysis method with a contract modeling system that allows the national hospital operator to instantly evaluate the financial impact of even the most complex contracts. The ultimate goal? Improving the revenue cycle by negotiating better terms with payers.

HPA, based in Charlotte, N.C., is a privately-held health-care services company established to own and operate general acute care hospitals in partnership with physicians. Founded in 2003 to deliver patient-focused healthcare in hospital settings, the company engaged IMACS, an Accuro solution, a year later to analyze and model contracts for its two largest hospitals.

A Web-based software application that evaluates existing payer contracts, IMACS' MACS Performance Workbench module helps providers accurately identify and understand the effect of contract terms and provisions before they sign. It also enables providers to compare new or existing contracts against actual patient data; understand and determine the impact of new reimbursement methodologies;

combination of the people and the technology that make our contract analysis and modeling so successful."

MACS Performance Workbench also produces specialized modeling reports to analyze the impact of various factors that contribute to overall profitability. The most powerful analytical tool, according to Hiller, is the function that links summary results to actual patient accounts, highlighting the impact of key reimbursement terms on real patient claims.

HPA is able to negotiate contracts more effectively and report financial status more confidently, Hiller says. "When a patient is discharged, for instance, we can accurately identify what the reimbursement should be. We can go back to the payer with a great degree of confidence if there is a discrepancy between what we expected to get paid and what was allowed on the EOB. When we're sure the payer is wrong, we can go back and explain why."

HPA can also evaluate managed care proposals by modeling them against current data. "We can say with confidence that a proposal would perform at 'X' percent of Medicare—information that CFOs request all the time. They also ask how we know we're getting paid correctly," Hiller says. "We now have great confidence in our ability

to calculate expected payment and haven't run across an error in the automated calculations yet, unlike manual calculations that are highly prone to error."

In addition to managed care contracts, HPA relies on MACS Performance Workbench to model Medicare, Medicaid, Medi-Cal and other government programs such as

"We now have great confidence in our ability to calculate expected payment and haven't run across an error in the automated calculations yet . . ."

model multiple scenarios for side-by-side comparison; cross-model between payers; model scenarios against multiple patient populations; and compare the financial impact of proposed agreements to existing contracts or other proposals. In short, it allows HPA to measure the impact of contract variables, a necessary first step to managing them.

HPA has yet to encounter a term, provision or problem that the MACS Performance Workbench tool can't resolve, says Mark Hiller, HPA vice president of finance and managed care. "We've challenged the team with complex problems several times and always get an answer that is logical and can be supported by analysis," he says. "It's the

workers compensation and TriCare—to the dollar. HPA performs all contract modeling out of the corporate office in Charlotte, N.C. If Hiller has questions, he contacts the modeling team, which reviews the contract and typically responds within 24 hours.

"We've never had anything like this for modeling proposed contracts before," Hiller says. "We used an Excel worksheet, ran data queries, then modeled on Excel. That was a slow process prone to potential error. In some cases, our people tended to just accept the payment and move on, potentially leaving money on the table. [Now], I'd be afraid to do business without an automated contract analysis tool."

The cost to collect payments is “typically reported between 2 and 3 percent,” according to HFMA’s research paper *Understanding Your True Cost to Collect*. “However, the fully loaded cost to collect may be much higher from strictly a business office perspective, not including any other revenue cycle departmental cost.”

One way providers can reduce their exposure to overdue accounts is to enact measures that enable greater up-front collections from patients, such as charts that indicate what payers will cover for procedures vs. what the patient is responsible for paying. Many technology vendors and consultants specialize in workflow solutions that inject efficiency into this collection process.

FOCUS ON SOLUTIONS, THEN OUTCOMES

“Healthcare providers have many more technology options today than they did just five years ago, including real-time insurance verification, more robust legacy system edits, improved claim system edits, an increased number of payers accepting electronic claims and automated remittance posting, to mention a few,” Thiry says.

According to a 2006 report by Frost & Sullivan, we are nearing a future characterized by the blurring of lines between RCM and clinical systems, by comprehensive “care management” solutions that serve patients, payers and practitioners. “Integration is definitely the way forward in the healthcare industry. Billing and claims modules are expected to continue to form an important part of these new technologies as they work at shaping the future integrated health system.”

Thiry offers this advice for providers looking to technology to improve RCM: “First develop a sound plan on how best to optimize process flow, then decide which IT solutions best support this plan. It is usually more desirable to limit the number of separate IT solutions used, as this can

easily become very cumbersome to install and manage.”

Solutions are delivered in a variety of ways, from complete enterprise patient financial system software to an application service provider model in which the vendor hosts the systems and data, providing system access and RCM reports to the hospital or physician practice via the Internet or an intranet.

Another alternative is business process outsourcing (BPO), turning some or all RCM functions over to a third party, who often develops custom technologies to meet specific needs. Or, another option is to keep RCM operations in-house and seek short-term expertise in the form of consultants.

An organization has many needs—clinical, administrative, financial, etc.—and a limited budget. If faced with prioritizing, executives are well advised to remember the legitimate financial outcomes RCM can provide. According to the HIMSS Analytics report, a majority of survey respondents believe that improved financial outcomes should be the goal of RCM. “In fact, approximately half of the respondents indicated that this was the single most important factor driving RCM strategy.”

Perhaps the best method of enhancing cash flow is through a combination of improvements: fewer registration and coding errors, better information to dispute denials, greater contract transparency, more efficient supply chain management and increased emphasis on up-front patient collections.

Beyond cash flow, an effective RCM program will lead to less quantifiable yet no less important benefits such as enhanced workflow, better documentation and greater worker productivity. Effective RCM will not only give providers valuable insight into their financial situation but also effect a positive change in their methods. ■

5 Keys to Improving Revenue Cycle Management

1) 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 pricing transparency and work to establish optimum yet defensible pricing.

2) 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.

3) Ensure chargemaster compliance.

Because of constant regulatory changes, it is crucial that hospitals consider technology solutions to assist in coding and chargemaster compliance. These applications also provide a simpler process for clinical teams to have involvement in chargemaster management, to ensure accurate billing for services provided.

4) 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.

5) Improve denials management.

Hospitals can decrease denials in payment by tracking and analyzing denied claims, to enhance cash positions and decrease accounts receivable.

Source: VHA Inc., Irving, Texas

BUSINESS PROCESS OUTSOURCING

SINAI HEALTH SYSTEM IMPROVES PROFITABILITY WITH REVENUE CYCLE OUTSOURCING

Mount Sinai Hospital, a 432-bed Level 1 trauma center in Chicago, and its sister facility, the 125-bed inpatient and outpatient Schwab Rehabilitation Hospital—one of *U.S. News and World Report's* 'Best Hospitals' in 2004—faced a host of revenue cycle challenges in 2001 and 2002.

Not only were they undergoing a \$30 million turnaround program after A/R initiatives with other vendors failed, but they also lost key members of their financial team when the hospitals' vice president of finance, director of patient accounts and director of medical records all resigned.

At the end of 2002, the two Sinai Health System providers grossed more than \$515 million in annual revenue, with approximately 50 percent of the revenue generated by Medicaid patients. They had an immediate need for cash due to numerous issues, including A/R days exceeding 100, billing and follow-up concerns and high numbers of accounts aging more than 90 days from their bill date.

After reviewing various options for consulting support, management services, managed care recovery, self-pay programs, technology solutions and ongoing training and education, Mount Sinai and Schwab Rehabilitation engaged Perot Systems in February 2003 to provide interim management services. That scope soon expanded to include an on-site cash acceleration team focused on increasing the cash flow necessary to fund further initiatives. The team began by redesigning the hospitals' revenue cycle processes.

A provider of consulting, business process outsourcing and technology-based solutions for the healthcare industry, Perot Systems helps providers confront their revenue cycle challenges through a variety of services, from business and technology analysis and counsel to facilitating an on-site, blended-team solution to delivering a fully outsourced service. Perot Systems identifies problems in the revenue cycle and also provides resources to help customers follow up on and correct the problems—to keep them from recurring.

In September 2003, Mount Sinai and Schwab Rehab decided to outsource all their business office processes

to Perot Systems, including billing, denial processing and follow-up; cashiering, cash posting and credit balance processing; collections, statements and bad debt management; chargemaster review and recommendations; call-center activities, patient inquiries and complaint resolution; business metric and operations progress reporting; and training and education on business functions and patient relations.

With business process outsourcing, Mount Sinai was able to reduce gross days in A/R from 96 to 64, raise \$53 million in incremental cash from March 2003 to February 2007, decrease denial write-offs as a percent of net rev-

Mount Sinai reduced A/R days from 96 to 64, shrank unbilled receivables by 54 percent and dropped open accounts from 97,000 to 62,210.

enue from 2.4 percent to 1.4 percent, reduce billed A/R over 90 days by 27.3 percent, shrink unbilled receivables by 54 percent, decrease bad debt as percent of gross revenue from 8.4 percent to 6.4 percent, and reduce the number of open accounts from 97,077 to 62,210.

"In any situation, change is hard," says Larry Volkmar, president, Mount Sinai Hospital and Schwab Rehabilitation Hospital. "The consistent application of processes for the staff and the increased expectations have made a big difference, and Perot Systems helped drive those changes in a big way. I honestly don't know what the formula to our outsourcing success has been, but from my standpoint, Perot Systems' employees worked as much for the hospitals as they did for their own company. I think that is a key part of the success."

The improvements in Mount Sinai and Schwab Rehabilitation Hospitals' financial positions have enabled them to expand cardiac services to include open-heart surgery. In addition, they were able to add a state-of-the-art linear accelerator for radiation therapy and reduce the cost for chemotherapy patients by bringing that service back to Mount Sinai. In short, better revenue cycle management resulted in improved patient care.

Providers lose up to 5 percent of revenues to inadequate revenue cycle management processes. How do your RCM tools and/or services reduce that loss, and what results can your customers expect?



Brent McCarty
President and COO
Accuro Healthcare Solutions



“Accuro offers comprehensive, Web-based healthcare applications to streamline processes, optimize operating margins and improve patient satisfaction. Specifically, our solutions help providers identify missed revenue opportunities. For example, a provider collected more than \$7 million in underpayments in just seven months using our solutions. With Accuro, providers leverage their information as well as competitive data to improve financial performance. Our solutions enable them to look at a service and drill down to payer, physician and patient levels to manage profitability. In addition, we help improve coding efficiencies, create patient estimates that increase the likelihood of payment and facilitate accurate charge capture to reduce A/R days. One physician practice reduced days in A/R from 90 to 14, while another provider using our point-of-access pricing estimator reported increased patient satisfaction, staff productivity and cash collections.”

Accuro Healthcare Solutions, Dallas, 1-877-321-0500, www.accurohealth.com

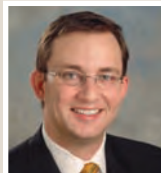


“The two biggest challenges for most healthcare organizations are the currency and accuracy of their product and price information, combined with the ability to match information across systems. Providers need a way to fill gaps between existing systems and leverage the most current information available. GHX helps hospitals optimize systems and business processes using advanced tools that compare, validate and match data in systems throughout the enterprise. By ensuring product, vendor and contract data are accurate, hospitals benefit from the most reliable and current view into their supply chain and can link activities to key revenue drivers. Since 2000, we’ve been helping hospitals and suppliers reduce costs and improve margins through supply chain solutions and business intelligence services. By partnering with GHX, hospitals can achieve greater control over their revenue cycle.”

Global Healthcare Exchange, Westminster, Colo., 1-800-YOUR-GHX, www.ghx.com



Bill Carlson
Vice President,
Product Management
GHX



Neil Hunn
Senior Vice President,
Business Development
MedAssets



“MedAssets Net Revenue Systems helps providers increase net revenues by 1-to-3 percent. Our innovative combination of technology, benchmark data and consulting services provides revenue integrity, ensuring hospital charges are accurate, complete and defensible. MedAssets provides a safety net protecting healthcare providers from overpricing, while creating an opportunity for them to improve net revenues by maximizing gross charges according to their payer contracts. We’ve also developed solutions that continuously and automatically link supply chain data with a provider’s chargemaster information, ensuring that hospitals adequately charge for supplies to cover their acquisition costs with a reasonable markup. Leveraging Internet and intranet technologies, we deliver our solutions via an application service provider model, which eases installation and speeds implementation.”

MedAssets, Alpharetta, Ga., 1-800-950-4722, www.medassets.com



“Perot Systems is one of the largest providers of consulting, business process and technology analysis and counsel, facilitating an on-site blended-team solution or delivering a fully outsourced service, we seek a cultural fit with our customers that supports their long-term success. In the provider market, for instance, we use a tool that allows us to model and analyze all contracts hospitals have with their payers, to ensure they are appropriately reimbursed for their services. Other outsourced solutions we provide include denial management, business process and workflow management and application and infrastructure development. As a complete business and technology solutions provider, we not only identify problems in the revenue cycle, but we also provide resources to help our customers follow up on and correct the problems to keep them from recurring.”

Perot Systems Corp., Plano, Texas, 1-888-31PERO, www.perotsystems.com



Terry Armstrong
Vice President,
Revenue Cycle Solutions
Perot Systems



Doug Bilbrey
Executive Vice President,
Sales and Marketing
The SSI Group, Inc.



“SSI’s ClickON® family of healthcare EDI software is designed to improve revenue cycle efficiencies while reducing staffing requirements. Our complete solution accelerates the revenue cycle by streamlining workflow, reducing A/R days and enabling two-way integration with hospital information systems. In particular, we help manage payer denials through timely identification of any non- or short-paid claim so the provider can take immediate action to rectify and resolve the situation. Our EDI solutions are delivered via traditional client/server or ASP technology. We leverage these technologies and the Internet for key functionalities such as electronic claims transmission, eligibility transactions, provider/payer connectivity and client support. When providers have the ability to quickly identify and act on denial problems, before the payment cycle is complete, they realize greater productivity, operational efficiency and cash flow.”

The SSI Group, Inc., Mobile, Ala., 1-800-881-2739, www.thessigroup.com

WHEN IT COMES TO
TRANSPARENT PRICING,
THE CHOICE IS CLEAR:
LEAD OR FOLLOW

Contrary to popular belief, there is not always room at the top. So your best option is to get there first. Accuro Healthcare Solutions is your clear choice to lead the way. As a forerunner in transparent pricing solutions, Accuro offers a comprehensive suite of innovative applications — from the revolutionary Accuro CarePricer®, enabling providers to create accurate estimates at the point of access, to a full suite of Web-based pricing modules including Accuro Strategic Pricing. These solutions help providers increase profitability by establishing optimal, yet rational pricing based on comparative pricing to other hospitals, meet revenue objectives and more.

Accuro Healthcare Solutions — because you didn't get where you are today by standing still, and neither did we.

To learn more about Accuro Healthcare Solutions and its suite of transparent pricing tools, visit www.HospitalTransparentPricing.com, www.accurohealth.com/HL, or call 1.877.321.0500.



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