HOSPITAL REVENUE CYCLE: Successful Strategies to Boost the Bottom Line

▶ The revenue cycle has many nooks and crannies, each with its own vulnerabilities. Unseen errors plague the process, from patient registration to claim submission. Too often they can spring leaks, leading to revenue losses, wasted resources, and costly payment delays.

Root causes often boil down to communication deficiencies, poor training, and failure to take action. But it takes more to identify these problems than simply tracking and trending data. The data has to be clear, easy-to-understand, and relevant—and the action taken must be swift, focused, and effective.

This Fierce eBook delves into three critical areas of the revenue cycle from front to back. In this eBook, we spoke with healthcare executives on the payer and provider side about their strategies regarding front-end processes for patient access, eligibility verification, and admitting. In addition, we discuss industry best practices for clinical documentation, charge capture, and coding/transcription. And finally, we reveal strategies for back-end processes, such as billing and patient accounting and patient collections—and how it all affect hospitals' and health systems' reimbursement and quality care. ●

KAREN M. CHEUNG /// Editor /// FierceHealthcare

Centralized Pre-Registration Equals Costs Savings

BY DINA OVERLAND

▶ Centralizing the pre-registration process is one of the most effective changes hospitals and health systems can make to improve the front-end of their revenue cycle. Doing so can not only improve overall patient satisfaction, but it can also reduce claims denials, improve collections, and help the hospital's bottom line.

Many hospitals have 20 to 30 different patient intake areas that are not centrally managed, causing a high degree of variability of information accuracy. Such repetitive registration processes can result in errors in patient and insurance information. It also results in unhappy patients.

For example, Premier Health Partners found that patients were "touched" more than 14 times before they even received medical care. "Multiple handoffs occurred from scheduling, pre-registration, verification, pre-certification, medical necessity, check in, and date of service," says Renee George, vice president of revenue cycle for the Southwest Ohio hospital system.

One way to reduce annoying, repetitious encounters for patients is to avoid collecting patient information, insurance information, and sometimes even payment at the time of service, advises Joel Gardiner, principal and national practice leader of revenue cycle management services at Deloitte Consulting.

"It creates physical bottlenecks and slows down patient throughput," Gardiner says. "Also, quality and data integrity decrease."

PRE-REGISTRATION PROCESS

To centralize the pre-registration process, hospitals should conduct an "honest assessment" of internal capabilities, including technology and personnel, and identify strengths and deficiencies, says Deanna Gray, revenue cycle expert for Avadyne Health, a provider of revenue cycle management services headquartered in Illinois.

"The goal is to maximize net revenue with the least number of touch points [or] corrections and to enhance the patient's experience from exceptional customer service," she explains. "This leads to patient loyalty for many years to come—along with referrals to the patients' friends and family," Gray explains.

Deloitte's Gardiner recommends establishing trigger points throughout the pre-registration process so that, for example, a patient scheduling an MRI triggers the hospital's system to request registration information at the same time. Pre-registering patients allows them to bypass the registration department, thereby significantly reducing the amount of paperwork required and allows them to go straight to their appointment.

Streamlining this process has led to dramatic decreases in claims denials for missing information by 20 to 50 percent at some hospitals, Gardiner says.

Hospital systems with multiple locations in particular can benefit from a centralized pre-registration process. The Cleveland Clinic, which runs several hospitals and family health centers, standardized processes for all front-end interactions with patients. The improved process now allows it to share information throughout all of its facilities, "saving us from repeating the process each time a patient goes to a new facility," says Lyman Sornberger, Cleveland Clinic's executive director of revenue cycle management. "We have realized significant cost savings by sharing information from our front-end patient interactions with our multiple facilities."

Premier Health changed its processes to create an automatic handoff from scheduling to pre-registration in one call, George says. Now, pre-registration staff complete all other transactions, including collecting any out-of-pocket payments from the patient. On the date of service, the patients only need to sign a consent form before heading to their appointments.

Premier Health also recently implemented a module that combines an estimate of charges, contracted rate, and a patient's individual benefit plan design to provide an estimate of the patient's out-of-pocket amount that is due. Staff workers share this information with patients during the pre-registration or registration process. "We use this tool to engage the patients in a discussion about a plan to resolve their patient liability," George explains. "We are not using software to automate the determination of ability to pay for services."

Those changes have paid off, literally, as Premier Health saw a striking increase in patient collections at point of service, George says. In 2010, Premier Health's four hospitals collected $6 million, compared to only $300,000 in 2009.

"In 2011, we are on target for $10 million, thus reducing both bad debt and collection expenses," she says.

As for future improvements, the hospital system is planning to employ even more patient-friendly options, such as self-check-in kiosks for patients.

Regardless of how effective a hospital's pre-registration process is, there will always be some unresolved issues for certain types of patients. In those cases, hospitals can consider following Crozer-Keystone Health System's approach. It designed a "Hospital Registration Daily Check-in Report" identifying patients with appointments that day who also owe money or have payer authorization or referral issues that need to be addressed, says Richard Madison, vice president of revenue cycle operations.

An added benefit of centralizing the pre-registration process, Gardiner says, is that hospitals can conduct marketing and promotional activities alongside the information gathering. For example, they can provide marketing material on services, such as preventive health. They also can enhance the patient experience by, for example, emailing patients specific location and parking directions. "Additionally, if systems are

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advanced and when electronic health record adoption increases, hospitals can have systems prompt for other services, such as required vaccinations," he explains.

ELIGIBILITY VERIFICATION

One major challenge for hospitals attempting to centralize their pre-registration process is that many patients don't understand their insurance coverage. In an effort to take the burden of determining eligibility away from the patient, Cleveland Clinic recently introduced a "real-time eligibility" process. Patients provide their insurance information when they make their appointment, the Clinic verifies their benefits in "real time" and a Clinic staff member discusses the coverage and responsibility with the patient, according to Sornberger.

If patients need assistance paying their bills, the staffer steers them toward a financial counselor to discuss their options. "With real-time eligibility, we are able to address payment issues in an open, upfront manner," he explains.

In addition, to help ensure they have the patient's correct insurance information, Cleveland Clinic verifies eligibility when an appointment is first made, even if it's six months away, as well as prior to the appointment.

"This allows us to have the most accurate, up-to-date information and saves time later if any changes have occurred," Sornberger says.

Premier Health Partners verifies patients' benefits and eligibility using an alternative method. They contract with a third-party vendor that runs eligibility on every patient in advance of service. "The process is done during pre-registration for scheduled patients and during registration for all others," says George. Captured in work queues, registration staff correct errors within five days. Errors not corrected in that time are escalated to the next responsible team member, usually the team lead or supervisor, she explains.

"We have realized significant cost savings by sharing information from our front-end patient interactions with our multiple facilities."

LYMAN SORNBERGER, EXECUTIVE DIRECTOR OF REVENUE CYCLE MANAGEMENT, CLEVELAND CLINIC

IS TECHNOLOGY NEEDED FOR PRE-REGISTRATION?

Although experts agree that establishing a robust pre-registration process benefits both hospitals and patients, they debate how important technology is to that process. Hospitals using technology can alleviate some of the staff's manual work, improve patient satisfaction, and build efficiencies, according to Romina White, senior director of national patient access operations for revenue cycle solutions at Conifer Health Solutions based in Texas. A subsidiary of Tenet Healthcare, Conifer has helped Tenet re-engineer its front-end process, focusing on enhancing the customer experience and improving revenue efficiencies.

Technology isn't a cure-all, however, to hospitals' front-end revenue cycle problems.

"Hospitals are continually investing in new technology that is sold or marketed as a total solution, and thereby piling technology on top of technology on patient access," says White.

Because this actually causes more work on the front end to track and report on metrics, she doesn't believe that a technology driven overhaul of the revenue cycle's front end is always necessary.

Instead, White suggests hospitals beef up training programs for registration employees or use existing infrastructure, such as call recording, workforce management, and work listing, to develop strong pre-registration processes.

If hospitals do decide to invest in technology, Gardiner recommends that they conduct due diligence to pick the vendors that are right for them. "There's no right or wrong technology," he said. The caveat, however, is that hospitals must ensure they properly train employees using any technology and always keep their technology updated, says Gardiner. ●

Optimizing the Front End Streamlines Entire Revenue Cycle

BY DINA OVERLAND

▶ Manual payment processing, shoddy collection of patient information, and poorly trained staff can cost your hospital millions of dollars in lost revenue. At least, that was the pricey lesson recently learned by Mississippi Baptist Health Systems and Spartanburg (S.C.) Regional Healthcare System.

By making operational and IT systems changes to their revenue cycle operations, both organizations combined saved almost $29 million in unbilled accounts and $7 million in failed claims.

Leaders at Mississippi Baptist wanted to enhance the organization's bottom line through revenue cycle improvements but couldn't afford to implement a whole new revenue cycle system. Instead, they decided to take better advantage of their existing resources and technology to improve performance.

For starters, they improved operations by streamlining their point-of-service collections procedures, improving emergency department patient throughput, and beefing up training and education staff who oversee such functions as patient processing, patient accounting, and contract management. They also added new functions to their existing clinical system, including electronic remittance advice processing, pre-bill edit, and price estimation for medical services.

One year later, Mississippi Baptist recorded a $9.6 million improvement in cash collections, a $813,000 reduction in denied claims, a $406,000 decrease in failed claims, a $1.16 million reduction in claims on hold, and a $825,000 reduction in unbilled accounts.

Identifying and fortifying weaknesses in the revenue cycle's front end can result in a big payoff.

Tweaking processes for capturing patient data and insurance information alone can make a huge difference, says Richard Madison, vice president of revenue cycle operations at Crozer-Keystone Health System. His greater Philadelphia-area-based organization achieved a 97 percent rate of error-free registrations after it recently completed a major overhaul of its front-end revenue cycle operations, including consolidating and standardizing its operations for pre-admission testing scheduling, pre-registration, and financial clearance for scheduled services. That's resulted in a net revenue of $283,000 over an eight-month period from decreased technical/administrative denials.

Similarly, revenue cycle leaders at Spartanburg Regional Healthcare System took on the task of improving their front-end data capture of patient information. An analysis revealed that Spartanburg employees were manually processing payments for each patient's individual account instead of using their existing patient accounting system. Many of the system-trained revenue management staff no longer worked at the hospital, and the new staff members weren't properly trained.

This was a huge loss-leader. Consider that it's not uncommon for hospitals to have a 25 percent registration denial rate, notes Deanna Gray, a revenue cycle expert with Avadyne Health, a provider of revenue cycle management services to hospitals.

"Communicating with payers about what they need up-front can be a differentiator for hospitals to succeed in the future,"

JIM MORRISON, HOSPITAL REVENUE CYCLE SOLUTIONS AT MCKESSON

"As a percentage of total revenue, this is substantial since all of these claims require rework to resolve the issue to get the claim processed by the insurance carrier before residual balances can be billed to the patient," she says.

Spartanburg's analysis also discovered that staff were bypassing fields during the registration process because their existing patient accounting system was too cumbersome and didn't streamline the registration staff's workflow.

To improve this process, the organization established an electronic remittance advice functionality for each payer. The function allows payment amounts for each patient's account to be automatically posted so staff members only need to become involved when specific problems warrant attention. The hospital also reduced the number of categories that staff must review to verify proof of insurance. This helped speed registration and patient flow.

The result: Within six months, Spartanburg saw an eight-day reduction in accounts receivable days, a $28 million reduction of unbilled accounts, and a $6 million decrease in failed claims. Even more, the health system also saw a 30 percent increase in admission speed and a 50 percent increase in admissions accuracy. This helped boost cash flow by $10 million within 12 months.

GARBAGE IN, GARBAGE OUT

To help decrease claims denials and ensure proper payments, hospitals first must identify weaknesses within their revenue cycle's front end. A likely suspect: Patient payment information. Twenty to 40 percent of patients provide bad data to staff when registering for medical services, notes Joel Gardiner, a revenue cycle expert with Deloitte Consulting.

Why? Many of the systems that hospitals use to conduct front-end business, including patient access, eligibility verification, scheduling, registration, and admitting, were installed 10 to 15 years ago and now are outdated, says

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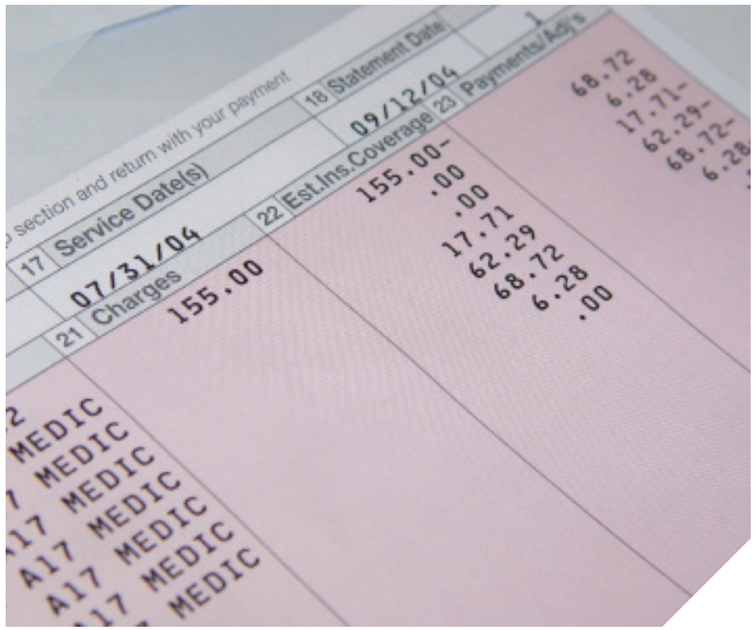
Jim Morrison, who specializes in hospital revenue cycle solutions at McKesson. Not only are these front-end systems outdated but much of the patient data is erroneous—about 4 percent of patient entries within a hospital's registry are duplicates. "So of course there are errors," he says.

Additional obstacles to hospitals optimizing their front-end revenue systems, according to Gray, include:

- Missing essential billing requirements and data entry errors
- Inadequate preparation for collection of point-of-service payments and/or financial counseling to set patients' expectations before service
- Lack of or inadequate technology to provide a safety net for the pre-admission process
- Poor patient flow throughout the hospital due to decentralized registration sites and processes
- Personnel without the right temperament or personality who do not appropriately address sensitive patient concerns and questions

STRATEGIES FROM THE FRONT LINES

Having recently centralized the pre-registration unit at Crozer-Keystone's five hospitals, Madison found up-front buy-in from senior and operational leaders was critical. The key is carefully assessing the organization's ability to handle the changes, including identifying and rapidly resolving any unforeseen issues that will arise, he says.



Other vital strategies Madison recommends include the following:

- Execute a robust communication plan about the new changes for employees
- Cross-train all staff affected by the changes
- Plan mock go-lives of any new systems and technologies
- Maintain a 10-business day post-live "freeze" period
- Track and report on key performance indicators, including employees' post-training test scores, data quality percentages, staff productivity measures, and pre-point-of-service collection tracking
- Hold weekly individualized staff feedback sessions.

Gray also recommends these training and technology strategies:

- Screen front-end personnel to assess their "soft skills" and ability to meet with patients and their families
- Invest in quality training programs provided by respected healthcare training organizations (e.g., National Association of Healthcare Access Management, American Association for Healthcare Administrative Management) that provide customized training for hospital and/or clinical staff
- Consider partnering with outsourced vendors that specialize in the pre-admission process. This can improve the likelihood of highly trained personnel using the best technology to provide a safety net for the pre-admission process

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best possible outcome.
- Invest in technology to provide insurance verification and patient balance estimation on or before the date of service.

IMPROVE RELATIONSHIPS WITH PAYERS

Another major obstacle to hospitals improving their revenue cycles is a weak or strained relationship with their healthcare payers. Payment discrepancies are at the heart of many denied claims. If hospital finance staff can't communicate openly with the organization's payers to address these issues, the hospital will lose a significant amount of revenue.

"The best way to resolve specific payer issues is for hospitals to meet regularly with the large insurance companies they contract with to establish trust and accountability," Gray advises. Collaboration is particularly important with anticipated changes coming down the pike under healthcare reform, including a shift toward quality-based reimbursement and delivery arrangements, such as accountable care organizations.

"Communicating with payers about what they need up-front can be a differentiator for hospitals to succeed in the future," Morrison says.

Cleveland Clinic management, for example, meets with major payers on a regular basis to discuss any problems, says Lyman Sornberger, executive director of revenue cycle management for the hospital system. The meetings provide a forum for addressing large contract-related issues, as well as specific payment discrepancies. To support any concerns about payment, Gardiner recommends hospitals bring claims submitted to the payer and documentation to back up claims.

"Hospitals and payers seek good business answers because they recognize that it's the patient who is ultimately on the hook for payment," Gardiner says.

Hospitals also should consider inviting payer representatives to association meetings to provide high-level quarterly updates to hospital personnel.

"Healthcare leaders are inundated with new information every day and can't possibly keep up with everything that comes across their desk," Gray says. "When this information is shared in person with provider representatives, it is reinforced both verbally and in writing."

Additionally, providers should take advantage of education offered by payers, including webinars, to stay updated. Larger hospital systems, such as Cleveland Clinic, also can consider using a third-party vendor who has a relationship with payers.

"The benefit of this is that the vendor is compensated by Cleveland Clinic and therefore has a vested interest in maintaining a strong partnership with the payer," Sornberger says.

TRAINING FRONT-END STAFF

Another critical aspect to improving hospitals' front end is the employees needed to manage it. Despite the indispensable nature of revenue cycle jobs—particularly regarding patient registration and eligibility verification—they are prone to turnover.

"They are typically some of the lowest paid and most stressful jobs in the hospital, therefore causing high turnover rates," McKesson's Morrison says. Combine high turnover with poor training, which he says plagues many hospitals, and organizations are almost certain to lose money.

That's why Avadyne's Gray recommends that hospitals hold managers and staff accountable for providing the most current training opportunities and methods available.

"Employees need to be held accountable when benchmarks aren't met and/or maintained and should be rewarded for exceeding expectations that ultimately lead to the achievement of system-wide mission and vision goals," Gray explains.

Staff in the Cleveland Clinic's revenue department undergo 40 hours of rigorous training, including an observational period where new employees learn by observing how an experienced member of the registration staff handles various situations, says Sornberger.

Similarly, Premier Health Partners employs a training team devoted to patient access system training programs, who review and update training whenever systems and processes change, explains Renee George, Southwest Ohio Health System vice president of revenue cycle.

By providing quality, consistent training for all revenue cycle staff, hospitals can help optimize their front-end systems while also reducing errors, resolving patient accounts faster, and improving the patient experience with the billing process. ●

GUIDING PRINCIPLES FOR FRONT-END IMPROVEMENTS

Crozer-Keystone Health System's five hospitals recently consolidated and standardized their pre-admission testing scheduling, pre-registration, and financial clearance for scheduled services. As a result, they have decreased claims denials, improved point-of-service collections, and improved staff productivity. To help ensure the success of its newly centralized processes, Richard Madison, vice president of revenue cycle operations, established guiding principles and operating characteristics for the major overhaul. They include:

- A value-added patient experience and quality outcomes are the number-one priority
- Synergy of operations (scheduling, registration, financial clearance, case management, and other hospital ancillary departments) are a must
- Existing staffing models and technology requirements will not be a barrier to process redesign

Patient access redesign operating characteristics:

- All areas performing registration functions will be guided by the same operating characteristics
- Procedures will be standardized and all staff trained accordingly
- Ninety-five percent of all scheduled services will be pre-registered
- Lack of pre-registration will not contribute to treatment delays
- Insurance clearance processes will drive a decrease in payer denials
- Patient payment expectations will be communicated to the patients and (except for emergency room services) collected prior to or at the time of service
- All uninsured patients will be offered a self-pay discount package or will be screened for medical assistance and/or charity care
- Quality monitoring will be performed on a monthly basis with feedback to employees
- Physicians' offices will be notified of any non-covered services to make decisions regarding continuing with services
- Denials will be work-listed for identification and resolution

Quality-Based Reimbursements Put Pressure on Documentation

BY ELIZABETH GARDNER

▶ With upcoming changes in documentation requirements, hospitals and health systems must ensure that providers are neither over- nor undercharged. As the industry shifts to value-based reimbursement, institutions need to examine whether charges are necessary and appropriate, thus creating new responsibilities for those who gather the information and put the bills together. At risk are the hospitals' reimbursements.

Starting in 2012, Medicare will reallocate 1 percent of its inpatient payments based on a hospital's performance on certain quality indicators. Half of all eligible hospitals will see their total Medicare payments increase, while the other half will see their payments decrease. The amount at risk will ramp up to 2 percent over several years.

"It doesn't sound like a lot, but it could be the bottom line for a lot of hospitals," says John Dugan, U.S. provider revenue performance management practice leader for Pricewaterhouse Coopers.

In 2013, Medicare will require hospitals to use the ICD-10 system to code diagnoses and services, which will put the onus on physicians to be more precise in documenting the care and treatment they provide. The coding, 10 times more detailed than the currently used ICD-9, will make it easier for payers to determine whether a treatment was appropriate to a patient's condition.

Hospitals hoping to earn incentive payments from the federal government for installing electronic health record (EHR) systems must use those systems to report quality care data in such areas as emergency department throughput and treatment of stroke and venous thromboembolism.

"Back in the day, you just had to see the patients in order to get paid, but now you have to see them well," says Jan Convis, senior manager at Los Angeles-based consulting firm The Camden Group. "Payers are looking at quality indicators, and they want to see improvement. With that improvement comes reimbursement."

In anticipation of the changes, hospitals are taking proactive measures. At Novi, Mich.-based Trinity Health, for example, clinical experts must review each patient's record within 24 hours of admission to make sure the documentation is complete enough for reimbursement, compliance and quality metrics. The $7 billion, 47-hospital system uses those metrics to meet payers' requirements and to improve internal quality.

"We are putting emphasis on case management and standards so that patients are getting treated in the right setting and the ser-

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Unlock the Value of Capture Driven Records

▶ Health organizations around the globe are facing an urgent need to cut healthcare costs while improving quality at the same time. Eliminating paper and paper-based processes is key to achieving these seemingly conflicting goals. Printing, shipping, storing and searching paper documents is not only costly but also makes it impossible to share and access real-time information and make well-informed healthcare decisions.

According to First Research, document management and electronic forms solutions that can generate discrete data (optical character recognition for document management and natural language processing technologies for electronic forms) will be of great value to hospitals in support of reporting requirements (ARRA/HITECH) for meaningful use.

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vices they receive are medically necessary," says Shelly Foster, vice president of quality health record and coding for Trinity. "All the payers are starting to look at that carefully, and denial activity has increased substantially from all payers. And with value-based purchasing, we need to make sure our quality metrics are accurate and that we are representing severity and risk of mortality in our coding."

One of Trinity's strategies for dealing with the ICD-10 transition is requiring physicians to use templates and voice recognition systems when entering data into the EHR system. The dual-entry approach minimizes the physicians' need to type, while capturing the discrete data elements needed for coding and billing. It also gives physicians the option to describe patient cases in the narrative format that they are accustomed to.

Trinity also uses code editing software to ensure all necessary procedure codes appear on a bill.

"Often if you have one CPT code present, you would expect to see another one, and if you don't, it gets flagged as a gap," Foster says. The clinical department that provided the service reviews and double checks such gaps before the bill is sent out. "It does increase cycle time, but we've reduced rebills and denials," she says.

"Physicians don't like to hear that we want them to document so that reimbursement is better. [So] we tell them it's for patient care and for risk and legal reasons."

JANICE REDDEN, ASSISTANT DIRECTOR OF REVENUE INTEGRITY FOR NORTON HEALTHCARE

Though the documentation demands on physicians will increase significantly during the next few years, so will their motivation, says Janice Redden, assistant director of revenue integrity for Louisville, Ky.-based Norton Healthcare, a five-hospital system with almost $1.5 billion in revenue in 2010. In the past, physicians generally were paid even if hospital documentation of their services was somewhat vague. Coders usually could fill in the blanks.

But because ICD-10 coding is more precise, it requires much more detailed clinical information about which side of the body is affected, or the specific type of implant that was used. Consider that peripheral angioplasty, which has one code under ICD-9, will have more than 700 unique codes under ICD-10; breast cancer codes jump from nine to 54; and hip fractures soar from six to 200, Redden says.

"We'll need better and better documentation just to send a bill out," she says.

Norton is building cues into its EHR system so that prompts will notify physicians to fill in the necessary details. Most specialists will be able to rely on customized templates, but general surgeons and internists, in particular, have too broad a scope of practice to use the same strategy. In those cases, they will need intense education and computerized aids, Redden says.

"Physicians don't like to hear that we want them to document so that reimbursement is better," she says. "[So] we tell them it's for patient care and for risk and legal reasons. If we have all the information we need for those things, the money will follow." ●

Evidence-Based Revenue Cycle: Using Predictive Analytics in Healthcare

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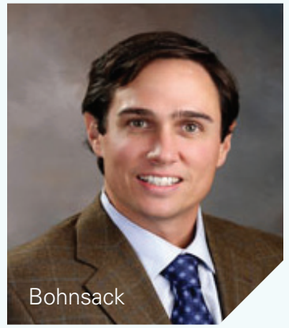
BY JAMES C. BOHNSACK, VICE PRESIDENT, TRANSUNION HEALTHCARE



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▶ Given the current economic climate and continued scrutiny on the healthcare industry, hospitals and physician practices must learn to adapt their business or fall behind the curve in information technology and analytics. Consequently, healthcare financial executives are taking a page from their clinical counterparts.

In the clinical field, evidence-based medicine is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.[1]" Healthcare financial executives are now leveraging these best practices and applying them to ensure the effective management of their operations. Their decisions include how to leverage multiple data sources using analytics to determine where to apply and maximize their finite resources, to improve the financial health of their organizations.

The use of predictive analytics is commonplace in other industries. Financial, insurance and marketing organizations rely heavily on credit and other third-party data assets to segment customers, limit risk and predict outcomes. Identifying account-level characteristics allows an organization to predict outcomes and allocate resources to customers offering the greatest return.

However, the healthcare industry is reticent to utilize credit data for predictive analytics due, in part, to industry misconceptions.

Misconception: Pulling a credit report will negatively impact my patient's credit score.

Fact: Credit reporting agencies utilize a "soft inquiry" when accessing a credit report for a healthcare organization. It does not affect a consumer's credit score and the inquiry itself is only viewable by the consumer

Misconception: Patients are required to give consent when a credit report is pulled.

Fact: Healthcare organizations have "permissible purpose" to access credit reports under the Fair Credit Reporting Act since they are frequently extending credit for services to be rendered.

Misconception: Financially screening patients, using credit data, does not support the mission to treat the community.

Fact: A comprehensive financial screening process will assist in identifying patients with the means and ability to pay, ultimately increasing the organization's financial health. The process also helps to identify those who cannot meet their financial obligations. Organizations discover the "true" charity care patients and provide greater benefits to their communities.

Applying predictive analytics will yield both quantitative and qualitative results. The quantitative results are measured by increased point-of-service collections, a reduction in bad debt and the cost to collect, all while maintaining or lowering operating expenses. While the qualitative results come from employees who are empowered with the information to work smarter, not harder; and patients who receive individualized care.

In summary, applying predictive analytics using credit data or other related data assets can vastly improve the financial health of your organization. The data itself is not a silver bullet, but utilizing data to build predictive analytics into your process will allow you to efficiently allocate your resources. ●

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Easy, Updated Documentation Key to Reimbursement

BY ELIZABETH GARDNER

▶ Comprehensive clinical documentation is the key to getting paid at the provider level. As far as payers are concerned, if it wasn't charted, it didn't happen. And ideal charting depends on engagement from all clinical stakeholders, and a collaborative commitment to keeping each patient's electronic health records (EHR) up to date.

"We have a saying that all roads lead to documentation," says Drew Swiss, vice president of finance for Montefiore Medical Center in Bronx, N.Y., which posted revenues of $2.7 billion in 2010. With a patient population that is predominantly covered by Medicare or Medicaid (private payers make up only 20 percent of its payer mix), Montefiore's errors can translate into huge losses, according to Swiss.

"If you can eliminate those errors, you can increase your cash flow and your bottom line," he says.

GAIN PHYSICIAN BUY-IN

The primary source of clinical documentation errors is usually the clinician, partly due to a lack of training, according to Swiss.

"They're there to do clinical care, and we're trying to work with them to make documentation part of their process flow," Swiss says.

Providers also are apt to delay documentation. The ideal time for charting to occur is at the time of diagnosis and when treatment is given—not hours, days or even weeks later, when memories are fuzzy and the patient has returned home.

"Years ago someone in pediatrics was complaining that we weren't collecting the charges," Swiss recalls. "I looked and the oldest charge was posted 729 days after the date of service. Someone must have put it in their lab coat and forgot about it."

PRIORITIZE EHR IMPROVEMENTS

One way to engage providers and ensure timely entry is to make the EHR system easy to use. Montefiore's EHR system added custom templates that change data entry fields based on the patient's chief complaint. The templates make it easier for emergency department physicians to document their care of "treat-and-release" patients, which has generated $3.5 million per year in additional revenue, Swiss says. Montefiore and its EHR vendor hope to translate that revenue to inpatient areas by developing similar templates.

Of course, docs actually have to use your EHR system. Montefiore encouraged electronic use over paper documentation by implementing an automated charge capture process that physicians could use in place of the index cards they typically carried around in their pockets to jot down services performed throughout the day.

PROVIDE EHR AND CODING TRAINING

Along with the electronic system comes the need for training. Software needs to be supplemented by education, says Janice Jacobs, director of regulatory compliance for IMA Consulting in Chadds Ford, Pa. Intense instruction will be particularly important as the industry shifts to the more complex ICD-10 coding system starting in 2013. Although Jacobs recommends re-educating coders closer to the time when they'll have to use the new system, physician training should begin right away.

"There's never a bad time to get their documentation to be more robust," she says. "They need to understand that if their documentation isn't sufficient so that the coders can code it, it's going to come back to them. They're not going to be pleased when the same charts come back three or four times."

To improve training and education, healthcare organizations typically assign clinical documentation improvement teams to work with clinicians to capture those elusive notes and charges that can add up to millions in lost revenue. Over the next few years, those teams will face new challenges.

"This is an area going through significant refinement and change," says John Dugan, U.S. provider revenue performance management practice leader for PricewaterhouseCoopers. "As hospitals implement electronic health records and build in prompts that drive documentation, the need for documentation specialists is going to change."

Instead of reporting through case management or finance, as many do now, clinical documentation experts need to report to the health information management department, whose business is to make sure documentation adheres to all requirements for reimbursement, he says.

"As hospitals implement electronic health records and build in prompts that drive documentation, the need for documentation specialists is going to change."

JOHN DUGAN, U.S. PROVIDER REVENUE PERFORMANCE MANAGEMENT PRACTICE LEADER FOR PRICEWATERHOUSECOOPERS

"What doesn't work is for the organization to try to put documentation on the shoulders of its case management and utilization management staff," Dugan says. "Operations people aren't as invested in looking at reimbursement results as they are in charges that are captured in their areas." Instead, it's up to clinicians and the health information management team to work together.

EXAMINE BILLING SYSTEMS

Multiple billing systems are another big challenge. Catholic Health in Buffalo, N.Y., has started a migration from five different inpatient billing systems to one, which should be fully integrated with its clinical information systems by the end of 2012. The combination will help clinical documentation specialists and the revenue management center get on the same page, says Chief Financial Officer James Dunlop.

The four-hospital system also is linking the chargemaster with its supply chain for solid cost accounting. This will help Dunlop figure out whether the $800 million institution is making money on its case-based reimbursement, including from high-cost areas such as implant surgery.

However, all units will have a person responsible for making sure charges are entered correctly.

"It's a crucial role that's often lost because it doesn't seem crucial to patient care at that moment," Dunlop says.

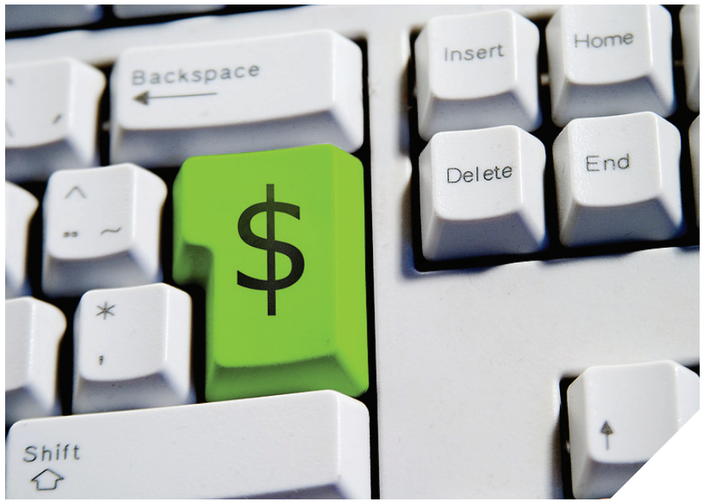
Without them monitoring the unit charges, meaningful analysis isn't possible, he says.

"We're always concerned about leaving money on the table, but we need to be able to show that the clinical documentation matches the bill," Dunlop says. "Capturing all information in a standardized way will help on the back end. Our people spend far too much time cleaning errors up that could have been addressed proactively." ●

Propensity to Pay Offers Versatile Revenue Cycle Solutions

BY DARCY LEWIS

▶ With a close eye on collections, hospitals and health systems are exploring software solutions that scrutinize patients' finances, including bank loans, car loans, and property ownership, to weigh their ability and willingness to pay. Software tools for propensity to pay, also known as presumptive eligibility, rate individual patients' likelihood of paying their medical bills. The analyzed data seem to be a welcome idea as institutions must capture more of their earned dollars from patients to stay financially viable in this tough climate.



Although propensity-to-pay data offers real-time soft credit checks, the results yield much deeper data than a credit score would, says Rebecca T. Black, vice president of revenue cycle at Saint Joseph's Hospital of Atlanta. "Propensity to pay lets us put people who have recently fallen on hard times in a different financial bucket versus the person who has never owned a home or earned more than minimum wage," she says. "This is an excellent model because it gets the 'noise' out of a population we can't truly define right now."

CUSTOMIZE TO FIT GOALS, PROCESSES, CULTURE

The propensity-to-pay trend is catching on, according to Ken Saitow, managing director and revenue cycle solution leader at Chicago-based consulting firm Huron Healthcare. "For a while, we were seeing only the largest, most sophisticated organizations using propensity to pay. Now we're seeing it in all markets, from the largest health systems to standalone hospitals," he says. "There's a feeling of wanting to leverage all that patient data out there to determine which ones are going to yield the best outcome financially and which ones will drain the organization's collections resources."

A major reason for propensity to pay's rise is that the technology is exceptionally versatile these days, which allows propensity to pay to be used at any point in the revenue cycle. "Some institutions deploy it upfront so financial counselors can advise patients before they receive any elective care," says Julie Ingraham, Huron's Healthcare director. "Others deploy it during the billing process or later to determine what sort of collection tactics to use or when to declare bad debt. There's not so much a standard 'right' answer as being thoughtful about what best suits the organization's needs."

Deciding when to deploy propensity to pay often comes down to the organization's goals, processes and even its mission. For example, every institution surely welcomes the efficiency gains in collections that propensity to pay can provide. "Based on propensity-to-pay data, that might affect the type of letter you send or how often you contact the patient," Ingraham says. "If the tool indicates someone really doesn't have the means, you'll want to put instructions about applying for charity care front and center on all bills. And you might decide to follow up more often if the data suggest a particular patient has the means to pay but hasn't done so."

Some institutions also benefit greatly from the ability to more accurately identify patients who are eligible for charity care. Mark Bogen, vice president of finance at South Nassau Communities Hospital in Oceanside, N.Y., explains. "New York State has a long-time requirement that hospitals must file a community service plan, including their charity care policy and actual charity activity," he says. "We have so much pressure to provide charity care on the not-for-profit side of the healthcare delivery system—it's very helpful to be able to get credit for everything we do."

SOUTH NASSAU ZEROS IN ON CHARITY CARE

Since 2008, a propensity-to-pay tool has helped South Nassau increase collections and more accurately distinguish between charity patients and bad debt. According to Abdool Razack, senior director of patient financial services, a big obstacle to proper classification is patients' reluctance to complete the charity care application. This is often due to pride and privacy concerns and, in many cases, worries about immigration status, he says. But propensity to pay arms hospital staffers with information as they encourage patients who truly can't pay to apply for charity care and assist with the paperwork.

"Prior to implementing propensity to pay, we showed 85 percent bad debt and only 15 percent charity care. Since then, we've shifted to only 35 percent bad debt and 65 percent charity care."

MARK BOGEN, VICE PRESIDENT OF FINANCE AT SOUTH NASSAU COMMUNITIES HOSPITAL

After deciding to proceed with propensity to pay, South Nassau worked with a vendor to analyze its 2007 bad debt patient files. "A significant amount of what we had classified as bad debt actually met the criteria for charity care," Bogen says. "The results were accepted by our external auditors and included as an adjustment to our 2007 financial statements, which meant we started realizing the benefits of presumptive eligibility right away."

In the years since, South Nassau has experienced an impressive shift in how it categorizes its uncompensated care. "Prior to implementing propensity to pay, we showed 85 percent bad debt and only 15 percent charity care," Bogen says. "Since then, we've shifted to only 35 percent bad debt and 65 percent charity care, which is hugely beneficial to us in terms of meeting our mission."

South Nassau also uses the software tool to validate each patient's address at registration. "The report is available within two minutes, but we don't use it until after the billing process starts, which is five to 10 days after the discharge date because our IT systems are not fully integrated," Razack says. "All patients get the same number of letters, but patients deemed more likely to pay may get more phone calls—we find that's what makes the difference in getting people to pay."

Clearly, the hospital benefits from using propensity to pay, but the patients do, too. "We've found presumptive eligibility also helps from a patient satisfaction standpoint," Bogen says. "If patients truly can't afford to pay, there's no point wasting our finite resources in hounding them for payment, and they feel better about their experience with the hospital, too."

Elizabeth Guyton, revenue cycle lead at Accenture Health in Chicago, is hard-pressed to think of a health organization that wouldn't benefit from adding propensity to pay to its revenue cycle arsenal. "Even though propensity-to-pay tools are not foolproof, they will be correct much of the time. I think every organization should be at least considering propensity to pay because it increases collections and drives down collections costs by eliminating those who can't pay from the collections process," she says. "If you want to improve your hit rate on self-pay, you should absolutely look at this technology." ●

"Propensity to pay lets us put people who have recently fallen on hard times in a different financial bucket…it gets the 'noise' out of a population we can't truly define."

REBECCA T. BLACK, VICE PRESIDENT OF REVENUE CYCLE AT SAINT JOSEPH'S HOSPITAL

5 Tips for Increasing Self-Pay Patient Collections

BY DARCY LEWIS

▶ It's no secret that the number of self-pay patients has increased dramatically in recent years. The current state of the sluggish economy means that fewer people receive health insurance through employers, and nearly all of those who are lucky enough to be insured must pay higher copays and deductibles. These increases mean patients' self-pay portions of their bills go up, often leaving providers struggling to collect from them.

"So many patients have higher deductible plans, they're effectively becoming self-pay patients," says Ken Saitow, managing director and revenue cycle solution leader at Chicago-based Huron Healthcare. "Healthcare organizations may need to adjust their collections policies to reflect this different patient profile."

In these changing times, it always pays (literally) to keep focus on the collection basics. Consider these five tips for collecting from self-pay patients:

1. IMPROVE UPFRONT COMMUNICATION WITH PATIENTS

Provide patients with advance estimates of financial obligations based on their insurance coverage. "It is vitally important to treat patients with financial excellence before they experience the clinical excellence," says Rebecca T. Black, vice president of revenue cycle at Saint Joseph's Hospital of Atlanta. "Our financial counselors will explain options upfront like payment plans and discounts for early cash pay and help them understand their health savings account, for example." Having these upfront communications can benefit both patient and provider.

2. GIVE PATIENTS EVERY OPPORTUNITY TO PAY

Provide patients with multiple choices and opportunities to pay. Julie Ingraham, director at Huron Healthcare, says this is an area where hospitals have made huge strides, but there is usually more that can be done. Even though the days of patients having to stand in line to write checks with multiple forms of ID have passed, hospitals still can make the experience easier on patients. "Most hospitals aren't doing everything they could, either. That includes taking money upfront, check-in kiosks, online payments, payments by phone, e-checks—anything that streamlines the process will help."

> **"So many patients have higher deductible plans, they're effectively becoming self-pay patients."**
>
> KEN SAITOW, MANAGING DIRECTOR AND REVENUE CYCLE SOLUTION LEADER AT HURON HEALTHCARE

Patients often feel more satisfied when they have more payment options too, Ingraham adds. "It may feel like collecting from patients isn't providing good customer service, but it is because this can allow them to focus only on their medical situation without financial distractions."

3. CONTINUE TO EVALUATE CURRENT PRACTICES

This is no time to rest on your laurels. For example, if you're not asking your emergency department patients to pay their copays upon admission, you're missing out.

"For years, we wouldn't even consider asking for money in the ER, but now we collect $20,000 per month," says vice president of finance Mark Bogen at South Nassau Communities Hospital in Oceanside, N.Y. "Anything we can do to cut collection costs later is a huge victory on the back end."

Other hospitals that traditionally have questioned collection upon admission are also considering changing their policies.

"Faith-based hospitals have been the laggards on this because they worried it distracted from their mission," says Elizabeth Guyton, revenue cycle lead at Accenture Health in Chicago. "But now, even they're realizing how important it is."

Guyton also is seeing more willingness to outsource various parts of the revenue cycle. "People are getting much more comfortable from a cost perspective with outsourcing," she says. "Even offshoring is now more widely accepted. CFOs who told me five years ago they would never do that are considering it because they have nowhere else to cut costs."

4. DON'T IGNORE ANY OF YOUR ACCOUNTS

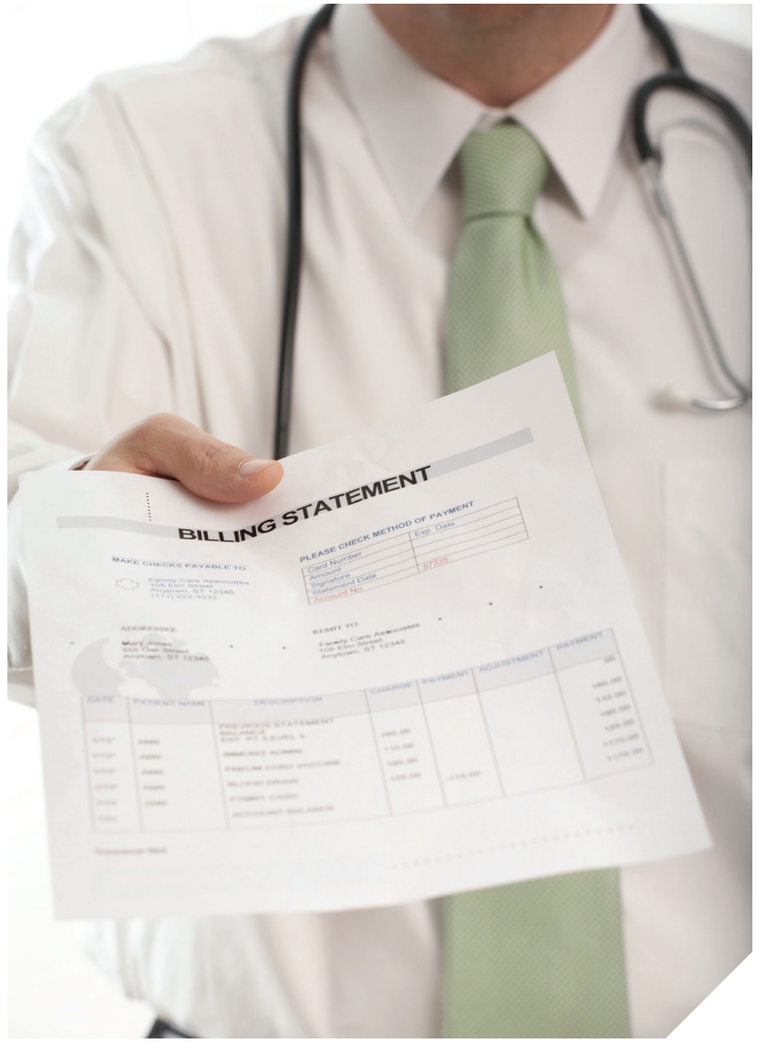
With today's increasing transaction volume and leaner staff headcounts, it can be tempting to let some accounts slide, but be wary not to.

"I want 100 percent of my clients' accounts being worked regularly, whether that means running them through the system, putting them up on the dialer, or looking at collection strategies," Guyton says. Every account counts. In addition, be willing to pay a percentage to the person checking the accounts as well, Guyton suggests.

5. KEEP CURRENT WITH VENDORS

You may not have time to stay up to date with every technological improvement that can help ease your revenue cycle woes, but your vendors do. One technology garnering a lot of attention now is positive biometric authentication.

"It's well known that NYU has implemented a biometric hand-scanning system to combat fraud," says Guyton. "Now we're getting a call a week from potential clients who want to know if this technology will work for them because they know we're up to date."



Your vendors can prove their worth on other issues, too. "My vendors help me do my job as efficiently as possible," says Black. "From correcting patient addresses on up in complexity, it's hard to increase your collections if you can't even contact your patients properly. My vendors know which of the latest technologies might streamline things for me, and I appreciate it."

By improving internal processes, such as communications with your patients and vendor, as well as external processes, such as paying careful attention to accounts and current practices, your hospital or health system could reap the rewards that you've been missing out on. ●