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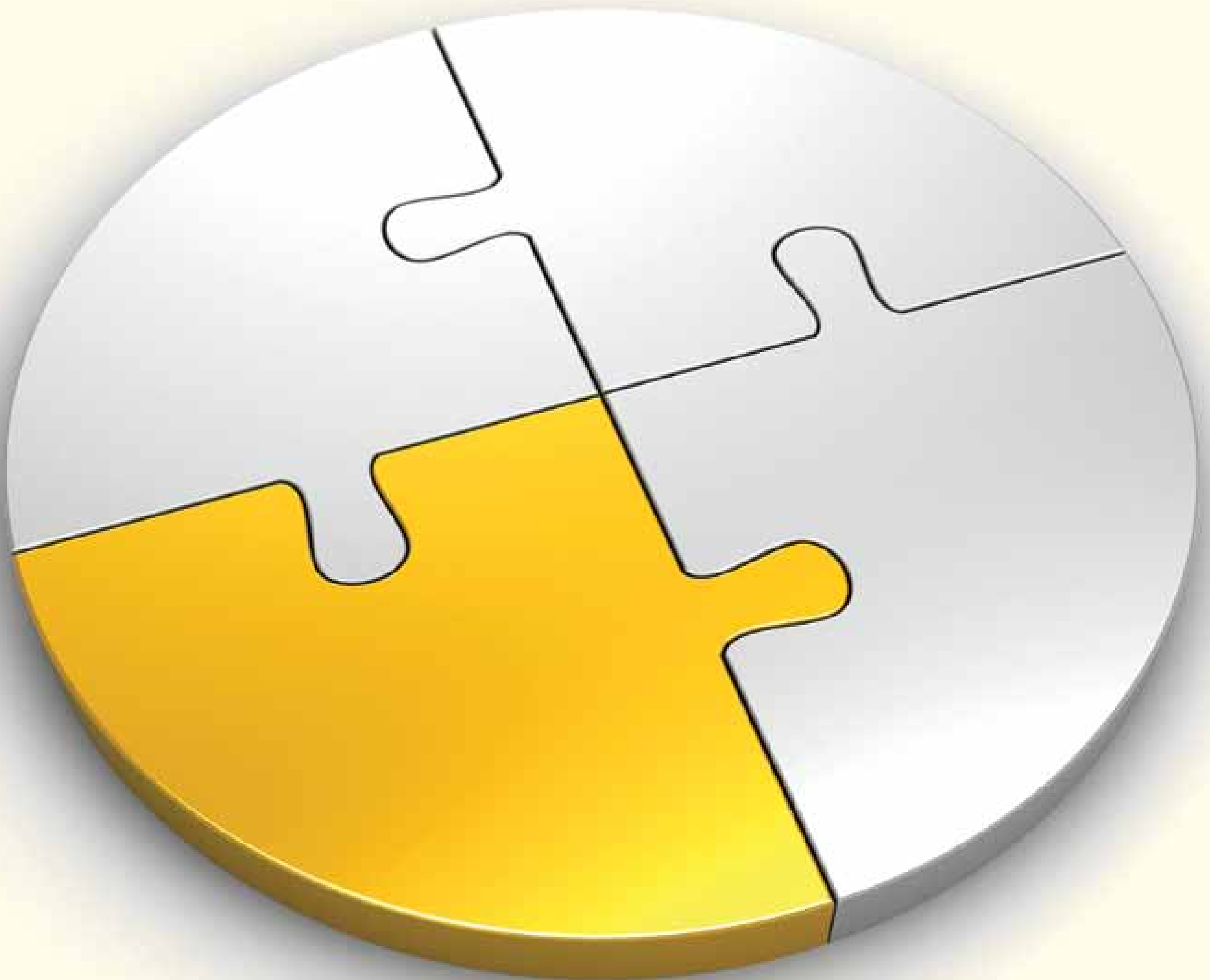
An Outside Approach to Revenue Cycle Improvement



Strategies for managing revenue cycle performance typically involve regularly combing over processes and technology functions to identity opportunities for efficiency. Routine questioning of whether handoffs can be improved or tools can be used more effectively is just part of the day-to-day efforts for driving and sustaining improvement.

But when is the last time your team stopped to question whether the right person was performing the function to begin with? Pairing the right person with the right task is integral to performance efficiency and effectiveness, and it's becoming more common today for that pairing to involve someone outside of the hospital's walls.

At Philadelphia's Hospital of the University of Pennsylvania, for example, use of external revenue cycle expertise is a key strategy to allow internal resources to focus on aspects of performance that provide the best return—higher dollars associated with lower volume.

By shifting low-dollar, high-volume accounts to an outside partner, the staff can focus on improvements with the most significant impact on key metrics. The approach to open accounts has resulted in improved cash collections, with 95 percent of cash collection occurring through internal hospital resources and 5 percent through the combined outsourced efforts.

One reason this outsourcing has been successful is that it allows the hospital to drill down into lower dollar accounts that used to fall through the cracks or age out.

"I'd much rather give a $1,000 account to a vendor at day 60 and let them go after it as opposed to having my staff use up any more time when we could be focusing on higher dollar accounts," notes Thomas McCormick, associate vice president of patient financial services. "And I would rather pay a premium to a vendor than lose dollars to bad debt or uncompensated care because of the inability to collect."[a]

The organization also has used external assistance for project-based efforts, such as an 11-month initiative that brought net days in accounts receivable (A/R) from the mid-70s to 50. A consultant helped the organization shift focus to the front end of the revenue cycle and provided tools to help leadership set appropriate targets for performance for medical records, utilization review, billing, and collections. Staff also used the firm's metric-based management to improve financial clearance targets for scheduled and unscheduled services. And with the benefit of this expertise and associated resources, the organization was able to continue improvements on its own, regularly hitting mid-30s in net days in A/R.

Such experiences are increasingly common. As revenue cycle leadership determines the most effective way to use resources, many organizations are turning to the strategic application of external assistance.

Why Look Outside the Organization?

Hiring outside the organization may seem counterintuitive to saving money or providing better service. But when such arrangements are approached properly and selectively, hospitals can achieve a variety of benefits, such as:

- Access to specialized expertise, resources, or technologies
- Enhanced ability to respond or accelerate business efforts in specific areas
- Easier navigation of an increasingly complex regulatory environment
- Improved accountability or transparency around metric-based performance
- Cost efficiencies (for example, external providers may take on acquisition and maintenance cost of technologies or pass-along benefits from economies of scale)

However, the strategy is not a panacea. To control costs and be effective, external assistance needs to be engaged under the right circumstances and with proper controls. Leadership needs to evaluate whether effective results and ROI would be better achieved through improved internal processes. Also, particular care should be taken to ensure the arrangement best meets the desired objectives and supports the organization's quality and service goals. What's more, ongoing monitoring of the arrangement is important to ensure performance improvements are sustained.

Hospitals weighing a move toward external assistance can benefit from recognizing several key considerations at the outset, examining successes of peers in particular areas of the revenue cycle, and considering basic dos—and don'ts—that others have learned while pursuing approaches at their organizations.

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Key Considerations When Seeking Outside Assistance

Whether bringing in a one-time consultant to provide a fresh eye to an ongoing problem, such as inefficient scheduling processes, or calling on a vendor to completely oversee a particular function on an ongoing basis, such as medical necessity review or collections of aged receivables, revenue cycle leadership should assess level of need and carefully consider the organization's goals, options, project scope, and potential effects—financial and other.

Here are just a few initial questions when determining whether to seek external assistance:

- What barriers is the hospital encountering to achieving its objectives? How would someone external address these barriers differently or more effectively?
- What are the anticipated financial benefits and true costs of outsourcing the function?
- What are the key benefits to be achieved? (For example, is the organization anticipating access to lower-cost computer capabilities, greater expertise, or lower labor costs?) How will these benefits be realized?
- What impact would outsourcing the function or bringing in a consultant have on hospital employees? Would the strategy be viewed as a positive step or one that has to be "sold" within the organization?
- What effect would outsourcing the function have on patient service and satisfaction?

Such considerations, as well as a thorough cost-benefit analysis, are key to recognizing strategy feasibility.[b]

If the organization decides to pursue external assistance, then it should use standard vetting processes and contractual review. As is done when outsourcing any other function, vendors should be put through a rigorous selection process based on criteria such as level of service offerings, cost, track record of performance, reputation in the industry, satisfaction of past customers, and transitional support. The organization's legal team should carefully review the structure and execution of arrangements, giving attention to such issues as performance expectations, compensation, contract length, and opt-out protections.

Successful organizations are selective about when and how to use external resources. They've learned to leverage assistance where greatest benefit can be realized and where use of internal resources would be less effective or strategically desirable.

Although each organization will need to weigh its strategy based on its particular strengths and needs, several areas of the revenue cycle are particularly suited to being outsourced:

- Navigating disability assistance enrollment
- Pursuing payer underpayment
- Managing Medicaid eligibility processes
- Bridging gaps in medical necessity coding and documentation

Navigating Disability Assistance Enrollment

Applying for federal disability assistance is known for being a time-consuming and arduous process that can take as long as 18 months for approval and requires a high level of expertise. Knowing the necessary information to gather from patients, recognizing what sources to use for guidance, and having access to legal advice are all part of the undertaking.

"It would be expensive to perform this function in-house," says Diane Settle, executive director of revenue cycle at Sarasota Memorial, an 806-bed regional healthcare provider.

For this reason, the organization has supplemented its existing financial assistance processes and tools with use of a full-time employee specifically devoted to helping patients qualify for disability assistance programs. The employee doesn't work directly for the health system but for an outside firm that specializes in disability eligibility.

For the patient, the process is the same. The disability specialist works on-site at the hospital, meets directly with patients to gather demographic and clinical information, and then files a claim. "They're on-site, and they act as if they are representing us," Settle says. The specialist also ensures that the patient appears at any court hearing required to prove the disability. Settle notes that such claims can easily end up at the bottom of the pile if there is missing or incorrect information.

Sarasota Memorial pays a contingency fee only when claims are approved, which has continuing payback because disability patients often return for additional care, Settle says. "Let's say they return once a year. I'm getting paid for that, and I'm not paying any contingency fee," she says.

Settle says the vendor collects about $3.5 million annually in disability claims that would otherwise only end up as bad debt. In addition to the reclaimed revenue, the process also provides an invaluable service for the growing population of disabled patients—helping them receive appropriate financial assistance. "There's a large portion of that patient population that really appreciates the help—getting that application filled out because it's not the easiest thing to do," she says.

Pursuing Payer Underpayment

Sarasota Memorial also relies on outside expertise to fill gaps in the organization's resources around recovery of managed care underpayments, which generally amount to about 3.3 percent, or about $4 million, of its total annual managed care payments.

Settle's three-person internal recovery team takes the first crack at the claims, focusing on high-dollar underpayments. But with limited time, contractual time constraints, and technology tools, the team cannot recover all of the potential underpayments, she says.

Revenue cycle staff send the remaining claims electronically to the vendor, which sifts through them using proprietary technology. The software analyzes the different payment terms included in each contract from Sarasota's managed care payers, calculates what a payment should be, compares that with the payment received, and then attempts to retrieve any underpayment. The vendor receives a fee, based upon the quantity recovered. "We let them pursue payment on the most difficult claims," Settle says.

The vendor sends Settle a monthly report detailing the number of total claims, the number being audited, the potential amount of underpayment such claims represent, and the amount that has been recovered over time.
In addition to the reclaimed revenue, such reports provide information that Sarasota Memorial can use to hone its recovery efforts. The internal team reviews the underpaid claims for common occurrences or themes.

"Then we try to build a better mousetrap on our side to catch the underpayments before we give the claims to the vendor," says Settle. "So it's kind of a learning opportunity for our staff." About once or twice a year, the vendor provides a more detailed report on trends by payer. The goal is to identify areas where the staff should be focusing their efforts and offer suggestions for improving internal recovery efforts.

The vendor's findings, which document a payer's track record, can also be used as leverage in contract negotiations. For example, a timely payer that pays according to contract may receive a lower rate increase, while a payer that required additional resources to recover full payment may receive a higher increase, Settle says.

"If you're a payer that generally doesn't pay on time or accurately, that's going to result in more of an increase when you come to the table to negotiate your contract," she says.

Managing Medicaid Program Eligibility Processes

At Sentara Healthcare, an integrated delivery network based in Norfolk, Va., the eligibility function used to be handled internally. Now, the function is outsourced to external agency staff working on-site at Sentara's 10 hospitals, spread throughout southeast and parts of northern and northwest Virginia.

According to Andy Weddle, Sentara's vice president of revenue cycle, the change has definitely improved Sentara's overall eligibility approval rates.

"We know that the number of approvals increased, and we know that the amount of Medicaid revenue increased," Weddle says. He acknowledges that market changes, such as a rise in unemployment and the area's disability population, make it difficult to enumerate how much of the increases are due to the transition to outsourcing and how much is a result of organic growth. "But I can tell you they have been very beneficial to us in having accounts approved for Medicaid," he says.

Finding internal expertise capable of handling complex cases that require clinical knowledge as well as knowledge of intricate state Medicaid requirements is challenging, Weddle says. By outsourcing, Sentara gains access to the infrastructure, such as compliance and legal expertise, needed to maximize approvals. Agencies with such expertise have also built strong relationships with state Medicaid agencies and the department of social services, which can

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also be challenging for an individual hospital. "You have to have those relationships to be able to get as high an approval level as they get," Weddle says.

Weddle says that, although the eligibility work is not directly managed by Sentara, the health system manages the performance of external agency staff through monthly meetings with their management teams in which approval rates are reviewed and any issues are discussed. Weddle also receives weekly month-to-date reports on approval rates for each hospital.

Sentara, with the help of outsourcing, has targeted an 80 percent approval rate. Some failure is expected because some patients do not complete applications or are unable to be reached after discharge.

Weddle says external agency staff can also be aggressive in interpreting the eligibility requirements of the approval agencies, which do not always agree with those interpretations. Vendors often appeal denials after gathering more information, such as documentation that provides proof of eligibility.

"That's the difference between what an outsourcing agency will do for the patient versus what internal resources will do," Weddle says. "They continue to work complex or time-consuming cases because they're incented for these efforts."

Bridging Gaps in Medical Necessity Coding and Documentation

At Saint Francis Health System in Tulsa, Okla., one strategy for keeping days in A/R and insurance denials in check has been the use of an external physician with coding expertise to perform medical record coding audits. The outsource representative serves on the organization's insurance denials committee and ad hoc committees focused on coding issues. A key benefit has been that revenue cycle staff and physicians are advised on admission necessity issues.

"We used to use our medical director to perform these functions," says Renee Edwards, director of patient financial services for Saint Francis. "And while internal resources were really good at providing us with the benefit of clinical expertise, having someone external provides additional insight. We're not just looking at what we are experiencing here in Oklahoma or at Saint Francis. We're more in tune with larger trends throughout the industry."

Working with the external physician also may help Saint Francis respond if payers are downcoding claims, misidentifying codes, or inaccurately stating that a secondary diagnosis is not appropriately coded for particular services. "Because this physician participates with us as a coding expert as well, we're better positioned to recognize and

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When it comes to negotiating the outsourcing agreement, hospitals would be wise to seek legal counsel and help from consultants who can give an unbiased assessment of the negotiations. The following considerations affect the hospital's control of the relationship.

Contract length. Terms should be specific and not lock the organization in for too long, since the relationship and reasons for its existence should be continually reassessed. Hospitals, for example, may want to work out a transitional arrangement with a short-term contract of two or three years, which allows for the flexibility of bringing the work back in-house.

Role. Outsourcing arrangements can be structured in several ways: Employees of the outsourced department may remain as employees of the hospital and only the management staff is outsourced. Staff may become employees of the outsourcing firm and work either at the hospital or off-site. The outsourcing firm may also lease the employees from the hospital. No matter the structure, access to the vendor and contractual protections regarding the vendor's availability and responsiveness are a must.

Back-up plan. Because a relationship may turn out to be more of a lose-win situation, contracts should have very specific out provisions, and hospitals should be prepared to regroup quickly. No matter how sound the contract, hospitals that outsource should always hope for the best but prepare for the worst. Ending a relationship, even in the best of circumstances, requires more than simply canceling a contract. The hospital also needs to be able to have the service ready to go either with internal resources or someone else.

appeal such issues because you have someone able to bridge gaps of understanding between clinical and revenue cycle worlds."

Edwards notes this role has taken on increased importance as many payers have begun using outpatient coders to assess inpatient coding. "As we know, inpatient and outpatient coding aren't the same," she says. "And it's not that our medical director couldn't recognize instances where a payer inaccurately assessed inpatient coding. But someone chiefly devoted to understanding new coding law and coding intricacies is better positioned to address such instances. That's another reason why having someone external with this expertise has been a great resource."

In the same way, clinical knowledge sharing has aided financial staff in payer communications. "A big issue for us is assessing sepsis as a secondary diagnosis," says Edwards. "The physician expert can recognize and challenge when sepsis should have been a primary diagnosis or note why a patient needed admission. So having someone who recognizes how to communicate clinical necessity and impact on revenue cycle with payers definitely has helped us win some cases."

Dos and Don'ts of Outsourcing

Of course, selecting the right area for external assistance is only part of positioning the organization for success. Consider the following lessons learned from those that have successfully leveraged the strategy.

Do set specific performance goals, and vet both service and tools of the vendor for achieving them. One common challenge for front-end operations is that clinical information systems often do not integrate with revenue cycle tools, notes Frank Congdon III, director of patient access for Einstein Healthcare Network, Philadelphia, which includes a 783-bed tertiary teaching hospital, 60-bed acute care hospital, and several outpatient facilities. "You really can't get one-stop shopping for payer eligibility, cash posting, medical necessity, or authorization," he says.

While in the process of converting to a new clinical information system (CIS) in 2010, Congdon and his team began searching for outside eligibility expertise that would integrate with the network's new system. Specifically, Congdon was looking for a vendor that would provide a response regarding patient eligibility within seconds and benefits data for areas other than acute care. He also wanted a response that was concise and easy to read.

As such, when the organization began negotiating a service-based contract for its eligibility functions, building in parameters for performance goals was essential. One of the parameters that the organization wanted with an eligibility service for confirming patient benefits was a response time of 30 seconds or less for 90 percent of transactions. Congdon also stipulated that the service provide benefits information for the different types of care provided within the Einstein network, such as rehabilitation and behavioral health services.

Congdon says before signing on the bottom line it is also important to vet the product for all the capabilities touted by the vendor. For example, in his search for an eligibility tool, Congdon found that some vendors claimed that their products could perform additional functions. But after some research, Congdon learned that the tools were often not robust enough to perform these extra functions adequately.

One way to gauge whether a tool will function sufficiently is to determine how well it will integrate with an existing CIS. For example, Congdon says a medical necessity checking function will require a lot of manual input unless the CIS includes computerized physician order entry. A cash posting function necessitates the ability to interface with a patient accounting system, he says.

"Don't jump at the chance to implement other systems unless you are sure they will work for you," he says. He also advises a long testing period to ensure the vendor lives up to the user's requirements.

Such efforts have paid off for the organization. Einstein found a real-time interface in which hospital registration staff send patient data electronically to an off-site service and then receive an automatic response with 30 seconds for 90 percent of transactions.

"It's really cut down on the amount of time that access staff has to spend processing an account," Congdon says. "You're talking in the past sometimes up to three or four minutes just to establish that a patient has eligibility with a certain plan. Just the time savings there alone has been helpful."
In contrast, the previous eligibility process involved accessing five different web sites, which meant managing five different log-in user names and pass codes. "It was very cumbersome and time-consuming," Congdon says.

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UTILIZING TECHNOLOGY AND PROFESSIONAL SERVICES FOR AN OPTIMIZED REVENUE CYCLE

Ed Caldwell, Emdeon Senior Vice President of Provider Services, discusses the importance of implementing a technology-enabled services strategy for the revenue cycle.

Q Which areas of the revenue cycle experience the most success in applying both technology solutions and professional services and why?

A Technology-enabled services, or web-based technology solutions coupled with professional services, are successful as a strategy in both the patient access and claims payment areas of the revenue cycle. These two areas are critical touch points in the revenue cycle that ensure a provider gets paid fully for services rendered, whether that's payment from the patient, government or charity care programs, payer, or some combination.

Specifically, some patient cases are difficult particularly around validating eligibility and benefits information correctly and identifying and applying for funding sources when needed. Managing a complex payer contract, let alone managing payer contracts for the top ten most commonly billed insurances, is very challenging as well.

Q What is the impact of a technology-enabled services strategy on patient relations?

A Technology-enabled services can improve patient relations, especially in the area of patient access. Right away, eligibility and benefits information is more accurate—which means less stress for the patient. For those patients that are true self-pay or underinsured, technology-enabled services allow providers to be seen as true patient advocates in taking on the application and resolution process on behalf of the patient for financial assistance—instead of patients having to try this on their own, especially when they are seeking medical treatment.

Source: Emdeon.

All clinical areas with the Einstein healthcare network, including acute care, rehabilitation services, and behavioral health, are using the tool. Data can be easily transferred from the external source and automatically posted into the patient's account within Einstein's patient management system. "Obviously, there are many advantages to that. If we're going to challenge a payer on a denial, we can go back and retrieve the eligibility information from that particular data service and use it to leverage our appeal," Congdon says.

Don't underestimate the need for ongoing management. Of course, even under the best circumstances, arrangements with vendors can be challenging. Overall, Sarasota's Diane Settle says using outside expertise is beneficial, but there can be a few downsides.

One is managing vendor invoices. "The real time-consuming part is to make sure that I'm paying for what I got," says Settle, noting that it can be challenging to determine whether one vendor billed twice for the same patient.

Revenue cycle staff also sometimes find discrepancies through monthly audits of invoices. For example, a note in a patient account may show that a patient was initially deemed Medicaid eligible and the hospital started the eligibility process internally, but the process was then taken over and completed by the vendor. In reality, the vendor should not have handled the account, Settle says. The problem is that such random audits are not conducted on 100 percent of invoices, which are sent in paper form. Going through each invoice manually would be extremely labor intensive, she says. The goal is to have the invoices sent in electronic form. "We working on that right now," she says.

Do make cultural fit an imperative. Sentara's Andy Weddle notes that one important aspect of successfully outsourcing is that cultures of the organizations should be very similar. "Sentara has a culture of high performance. We utilize Lean methods constantly, and we rely heavily on metrics. The external agency staff that we use are very similar to us in that regard," he says. "We expect a lot, but they expect a lot as well."

Agency staff must also fit in with the internal culture of the hospital because they often work closely not only with registration and billing staff but also with care managers, nurses, physicians, and administrators, such as the vice president of medical affairs, Weddle says. A well-managed agency understands that it serves a number of different cultures and must build positive working relationships within each.

"That's the difference between a very professionally run organization and the mom and pop shops. The well-managed ones have been in a lot of hospitals. They recognize the politics and the culture, and they know very quickly that they need to understand it," Weddle says.

The key to ensuring a good fit with outsourced staff is employing an agency manager that melds with Sentara's culture, Weddle says. "We're very sensitive to making sure the manager that coordinates the relationship between the agency and Sentara is very Sentara like." Weddle notes that accessibility and working well with others are particularly important.

He says that outsourcing the eligibility function is truly a win-win-win situation, especially for patients, who, when approved, gain access to other care sites, providers, and home health services. "This whole eligibility program, it's driven basically to assist our patients," he says. "Yes, we do get some financial benefit for it, but it's far more beneficial for us in terms of being able to assist our patients."

Endnotes

[a] Healthcare Financial Management Association, "MAP Award Winner Profile: University of Pennsylvania Health System," *Revenue Cycle Strategist,* April 2011.

[b] Healthcare Financial Management Association, "Outsourcing: Finding the Right Fit for Your Organization," special section, *hfm,* April 2008.

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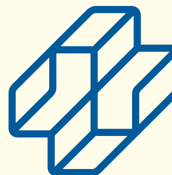

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