



Revenue Cycle Challenges for Hospitals and Health Systems

About the HFMA Executive Roundtable Series

The HFMA Executive Roundtables are a series of discussions among healthcare leaders who have come together to share their experiences and solutions to pressing healthcare finance issues. This roundtable, addressing revenue cycle challenges for hospitals and health systems, is sponsored by McKesson.

With reimbursements shrinking and costs rising, it is increasingly vital that hospitals and health systems have an effective, efficient revenue cycle process.

However, rapidly evolving technology, new legislation, tighter budgets, and payers' changing rules present a growing number of challenges. Additionally, revenue cycle issues such as billing and coding, denial management, collection tactics, and patient satisfaction reach far beyond the hospital's business operations—they affect clinical practices as well.

HFMA recently brought together a group of Chicago-area healthcare executives to discuss their revenue cycle challenges and how their organizations are addressing them. The following is a transcript of their discussion.

THE PARTICIPANTS IN THIS HFMA ROUNDTABLE WERE:

Michael Arnold, associate director of finance for John H. Stroger Hospital, Chicago, Ill., a unit of the Bureau of Health Services of Cook County, which is a public-integrated healthcare network.

Ken Baxter, director, patient financial services, of Centegra Health System, a two-hospital, 338-bed system based in Woodstock, Ill.

Peter Bury, CPA, vice president, finance, for Advocate Good Samaritan Hospital, a 312-bed facility in Downers Grove, Ill.

James Doyle, FHFMA, CPA, senior vice president and CFO of Elmhurst Memorial Hospital, Elmhurst, Ill., a 427-bed community hospital.

Gary Fennessy, revenue cycle manager for Northwestern Memorial Hospital, a 744-bed medical center based in downtown Chicago, Ill.

Michael Kittoe, vice president and CFO of Delnor-Community Hospital in Geneva, Ill. The hospital is part of the Delnor-Community Health System.

Pete McCanna, senior vice president and CFO of Northwestern Memorial Hospital.

Greg Pagliuzza, Jr., CPA, senior vice president and CFO of Centegra Health System.

Richard Powell, CPA, CFO of John H. Stroger Hospital.

Shaun Walder, director, patient financial services, for Delnor-Community Hospital.

Henry Zeisel, corporate controller for Elmhurst Memorial Hospital.

The moderator for the discussion was **Richard L. Clarke, FHFMA**, president and CEO of the Healthcare Financial Management Association.

Representing the roundtable sponsor was **Travis Marr**, vice president of revenue cycle management services, central region, for McKesson Corp., St. Charles, Ill.

ROUNDTABLE DISCUSSION

► **Clarke: What are your primary revenue cycle improvement initiatives for the coming year?**

► **Pagliuzza:** We are overhauling our charge master. It has not been attended to in quite a while, so there are a lot of codes that are mismanaged. And we have seen shortfalls in our revenue just because of a lack of integrity in the charge master itself. So for us, that initiative is going to yield some significant improvements and improved accuracy.

► **Doyle:** We've lost enough money at this point that we're past that and moving back out into the physician offices, to the origin of a lot of these things. We're going to try to bring in technology to set up the Advance Beneficiary Notice process, and to equip physicians with enough information about diagnostic and procedural coding combinations so that they are sending us things that are payable.

► **Fennessy:** I would say that for the past year our focus has been on production and improving throughput in the organization from the front-end

perspective—not from the patient care areas, but from the clinical areas associated with things like local medical review policies, ABNs—and getting compliance in place, which speeds up the whole revenue cycle initiative.

Going into next year, I think we're going to be working on customer service, looking at how the scheduling and registration process works and trying to streamline it. We've been thinking about the revenue cycle from a hotel industry standpoint: In a hotel, you settle your bill when you check out of the property, so is it possible for us to similarly receive payment from the payer at the time of discharge? We're looking into that for three or four years in the future.

► **Powell:** We have a number of what I call heterogeneous points of registration. Ambulatory care has a separate process, the emergency department has a different process, hospital clinics have a different process. We want to standardize those processes, because we think that is going to help our throughput on the back end.

► **Arnold:** One of the many things that we're working on is the 837I and 837P transmittals to the EDI transactions—the new electronic format—so we just installed a new billing system. We want to make sure that, as the information flows from the front to the back, we check the edits to make sure it goes out the door with the correct coding. Everyone here is mentioning different issues they're working on, but you really have to have all those things in place for that final bill to come out the correct way. So you look at one aspect of the revenue cycle process, but you must take into account everything else that can be affected.

► **Kittoe:** A lot of what I just heard is what I've lived for about the last two years. Two years ago, we began a major initiative of ambulatory care euphoria, our ACE project, to revise all of our pre-service processes—scheduling, pre-cert, check-in, and medical necessity. It cleaned up a lot on the front end. It's not perfect; we've still got a lot of issues to contend with there. But it seems like things cycle back around, because now one of our major priorities coming up is payment compliance. We really want to get back into payment compliance and work with our payers to tackle the traditional 10 percent to 15 percent underpayments that are out there.

► **Bury:** A huge opportunity that we've seen is in the business practices and the revenue cycle practices of the emergency department (ED), and the revenue capture that has been lost through the years. At our organization, the ED has been a separate clinical operation with no business accountability, so we're in the midst of changing that.

► **Zeisel:** One thing that we're doing on the registration side is looking at self-registration. We want to move the registrars up from clerks who are entering information to representatives who can really interact with the patient on a higher level. Then we can leave some of the data entry to the patient themselves, where they will have more comfort that their data remains private and is being entered accurately.

► **Clarke:** **Are your staff who are using the new revenue cycle technology using it as effectively as possible? How do you address that?**

► **Doyle:** We have very dedicated people in medical records whose response to the challenge of lots of claims kicking back was to roll up their sleeves and work hard, while a computer system sat idle. The problem was that they basically were uneducated consumers of computing. So as we were converting our revenue cycle process, we brought along the information systems staff to show the records staff how technology could help them solve some of their problems more easily.

And I think that's happening in a lot of hospitals outside of the business areas. They don't make the systems and the information technology department do more for them. They just don't see problems in computing terms. They work hard instead, and then, oddly enough, organizations reward them for doing whatever it takes, which is kind of counterproductive.

Also, we're not really taking advantage of what the Internet has to offer. The Internet is a good way to engage the customer—they could potentially self-register and self-book appointments. We can also provide pre-procedural information once the appointment is made. It just opens it up in a way that many other industries have taken advantage of, but here we are in health care, behind the times in that regard, because we lack some technologies and processes that everything else is built upon. That's ultimately a part of the solving the cost problem. You can't deliver this level of service without automation.

► **Powell:** But using the Internet obviously drives down the transaction cost itself, which is one of the things we were all struggling with, particularly with conflicting regulation. So I think extending the Internet, not just to the front end, but even to the back end supply side, would be something that would really help us as well.

► **Arnold:** Information systems are one of the key components of the revenue cycle process, but what has happened is that the technology has grown faster than the knowledge base. So you have a bell curve where the technology is up here and the know-how is still back there, so your IT staff and your people who are using the technology have to work hard to come up to where the technology is. And a lot of times hospitals buy more technology than what they can use at the time.

► **Fennessy:** This is something that came to my attention in the past couple of weeks: We were looking at the percentage of bills that go out with manual intervention, and it was around 70 percent. So next year we're going to be putting a lot of focus on what is driving that 70 percent, and what can we do as an organization to use our technology better and get that number down to maybe 30 percent or 35 percent. If you really dig in to find out how much of the billing goes out with manual intervention of some kind, you'll be shocked to see the numbers.

► **Bury:** Your technology isn't going to solve your problems. It may help, but if the people aren't doing what they're supposed to be doing, you can throw a million dollars in technology at it and all you're going to be is out a million dollars.

► **Clarke:** **Over the next few years, do you predict that your cash flow will go up, go down, or stay the same? How will changes in cash flow affect your long-term plans?**

► **Doyle:** I think for many of us, costs are the problem. The whole mindset has got to change to produce the cash because, as the surveys point out, where capital spending is concerned, you ain't seen nothin' yet. Many of us are living in older buildings, so there will always be a lot of costs with keeping them up to date.

We have a physician, who's intensely interested in operations and is now part of the management team, who came to us three years ago with an interesting, liberating thought. He said that the problem in trying to get through the budgeting cycle is its constraint on deeper thinking. We're all in this annual cycle of taking ourselves and our organization to the crisis moment of

balancing the budget. People do what they can do, but it's necessarily short-term thinking; whereas to really address our overall budgeting issues, what has to happen is that we have to fundamentally change how we do business, and largely in the factory. The factory is where the action is, and when you look at that, it's just crying for overhaul. So that's where we see the cash flow opportunities.

► **Pagliuzza:** Medicare is bankrupt, even though they don't say it is, because they keep borrowing against it to feed the deficit. So it's bankrupt; the state's bankrupt. The insurers, they keep consolidating, and any dime they get, they keep nine cents and they might give a penny back to providers in general. So as a provider industry, we are under a lot of constraints on the revenue growth side. There's obviously going to be some volume growth, but the margin we're going to get on each dollar that we invest is going to come back smaller and smaller. I think we're going to be challenged on the cost side, and probably the on investment side. With all of these older facilities, at some point, we're going to have another round of closures. It's going to happen; it's inevitable.

And do we all need to have every service line in the world? It seems that today hospitals feel that we have to be specialists at everything. There are some winners and some losers. There may be a certain amount of "You know what? You can take care of that line of service and we'll take care of this one, and we'll work together," so maybe there will be another round of consolidations. There are going to have to be efficiencies brought in the system, and on the operational side, I would concur with that 100 percent.

► **Bury:** In our market, we do focus on costs, and the revenue cycle has been a huge add-on to our bottom line the last couple years, but our operations are driven toward new products and volume. And we need the volume growth, we need that incremental revenue; most healthcare organizations' fixed costs are around 50 percent, give or take a little bit, so for every dollar we bring in on new programs and services, 50 percent of that's going to fall if you price it right. That's what generates our revenue, and has over the last year or two.

► **Powell:** Another phenomenon that's taking place that I think is affecting or will affect revenue growth is this notion of tax-exempt status and the challenge to tax-exempt status.

The accusation that hospitals are billing non-insured at rates that are greater than those provided to the insured, and the negative press that's associated with that, I believe will negatively affect our ability to generate or grow revenue, because we're not in charge of the public relations part of that. We're actually losing that battle. And I think that's going to be a real thorn in the industry's side before it's all said and done.

► **Clarke:** **What are the trends you're seeing in insurance denials? What are you doing to address them?**

► **Doyle:** We were clearly losing so much in denials, it took a new accounting process to figure out what was a denial and then say, "Well, okay, how can we fix it?" That has been the major area of improvement for us—controlling the volume of denials we were receiving.

To do this, we made medical records the center of attention. We would identify the most frequent loss and then go backwards into our process and find out where it was coming from. For example, we found that we had a lot of standing order sets that produced lab tests that could never get paid because they didn't match up with the diagnosis, things like that. So it was kind of hierarchical, just simply sorting lists.

► **Fennessy:** In terms of denials, my reaction is that typically, if you're willing to work at them and can get to the issue, you'll get reimbursed for them. But I also look at the cost-effectiveness of that level of effort: How valuable is that whole process of having to fight for every dollar you can get?

► **Kittoe:** One of the problems is that denials are a moving target. And the rules are constantly changing at payers' discretion, and they change sometimes with-

out notice, so that's where a lot of this chasing comes in. You're going to resolve it eventually, but that will cost you.

► **Arnold:** Denials *are* a moving target, and the problem has only grown more complex. Submitting the proper codes is not just an issue for your medical records department to address—the level of service that the patient received must also match what the physician has ordered. A lot of insurance companies now, especially Medicare, are reviewing the physician decisions and diagnoses to see if the procedures done or the clinical pathway matches. If any clinical service provided seems out of line with the diagnosis, they will not pay you for everything that comes across on your claim. So you have to educate the physician on one end, and you have to make sure your coding mechanism is up to par on the other end. The cost factor of all this education and review is enormous.

► **Walder:** On the managed care side, we run into the same problems with the refusal on the part of some payers to even deal with denials in an efficient manner. When you bring the denials forward and you bring the payers in to review the issues involved in your denials, they still want to deal with it on a claim-by-claim basis. So you've gone through all of that work, used all of that manpower, and put it all together in a nice package, and then it's still, "No, no, no, no, we want to split it, we want to break it down, and we want to attack it one by one." So it makes it that much more difficult.

► **Doyle:** What caught us ill equipped was the volume of denials, because we have no mechanism to have an internal accounts receivable report sent to the medical records department and to the quality review department. So when the volume gets to a certain point, it becomes chaotic.

► **Clarke:** How are you addressing the rising tide of bad debt and the number of uninsured and underinsured patients?

► **Fennessy:** On a self-pay side, I think all of the public relations related to the uninsured and so forth is changing patient relations and how we deal with them directly. Even today, getting documentation to support free care has turned into just a much more difficult process. Patients just come now to us and expect that they're going to get a discount. Then there are the folks who have made intentional decisions not to purchase insurance, and you try to work with them, but they just feel now because of all the publicity that they don't have to do anything.

And so what we find now is our self-pay growing, and we're chasing patients to find out whether this is truly a good, collectable dollar or not. It goes back to cost and the amount of money that we're investing in it. So I see bad debt probably creeping up in the next couple years.

► **Powell:** I have to chuckle a little bit, because since we are a county facility, many of our patients come in looking for care to be *free*. And, of course, when you have unlimited demand against a limited resource, you're going to have a big queue.

The issue of bad debt for the county is a little bit different, because we have a "charge to the public," and there's an expectation that we have to assume what we call "charity care." Actually, they don't even use the term "bad debt" in the county anymore—it's all charity care. So the expectation is a little bit different, but it is growing.

I think one of the biggest issues that we face is that we've got this apparent conflict between what CMS is telling us we must do in terms of billing and what the politicians are saying—that we're discriminating in billing. We've got to somehow seize control of that argument so that we can reconcile the perception.

► **McCanna:** The fear I have is that this trend may be providing the opportunity for some employers to walk away from their obligation to provide health insurance.

Now, they may say nominally, "I'm providing health insurance coverage," but it's not much coverage and it has a deductible of \$1,000 or \$1,500. And that burden is pushed back to the cities, counties, and private not-for-profit part of the sector, and we're catching it. That's why I'm fearful of it—I think it's guaranteed that that charity care is going to grow as some employers walk away from that obligation.

► **Bury:** Advocate has revamped their policy in the last year because the initial impression was there would be basically a transfer out of bad debt into free care, and that maybe there would be some add-on bleed to that. Well, whether it's the employers dropping out or whether we've underestimated how smart some of the consumers are, I think that small bump is going to be many times bigger than any of us expected it to be.

► **Zeisel:** One of the things that I've seen that we've had to do is more education on the staff side to help them tell the difference between a person who's unable to pay and someone who's unwilling to pay. It used to be that you could put clear-cut guidelines down and someone could easily refer them, but now the unwilling payers are a bit smarter about it. They can meet the letter of your policy but not the spirit of it, and so the staff needs to be able to catch on to those nuances and be able to ferret through it and really distinguish between those unable and those unwilling.

We have guidelines for this, but we've also given the staff other questions to ask, things to look for in making sure that the applications for free care are complete, suggestions for where people might hold back and where they may be hiding assets. They may come to us and say, "I'm unemployed, I don't have any income," but they may have plenty of assets that they could tap into. Or they say, "I don't have a W-2," but they're actually self-employed and they don't file a tax return. It seems like people are trying this sort of thing a lot more today than before. You used to be able to give more people the benefit of the doubt—you could count on them to uphold their responsibilities.

► **Arnold:** One of the issues in our patient population, which we're trying to educate the front-end staff on, is that a lot of patients that come in *do* work but don't want to use their insurance because of the deductibles. So we have to educate the staff to ask the right questions to obtain that information. But on the flip side of that, we have a couple of programs for inpatient and outpatient, which are based on a charity care or sliding-fee scale based on the poverty guidelines. The front-end staff gives the initial applications out, but the back-end staff implements it with documentation that patients have to bring in before we can put them on the sliding-fee scale for payment. We have just so many patients coming in that fall into the charity care category, but we are attempting, and *have* attempted for a long time, to address it.

► **Bury:** I'm in upper middle class suburbia, and I've got a position-and-a-half that didn't exist a year ago designed to process all this stuff. So if you're in a different area, I can't imagine the number of staff and the amount of resources you're going to need to comply with this and to do what you're supposed to do.

► **Clarke:** **Are there any particular tools that any of you are using to get at this issue?**

► **Baxter:** I think out in our environment the thing I'm seeing is a lack of a process. We try to use a common sense approach, but when you take things case-by-case, there's no standard—sometimes we do this, sometimes we do that. We're going to look at redesigning the financial application process and make sure that we follow the process exactly the same way each time, because now we're going to be held responsible for that process.

There are some tools we use, but I have not seen any new tools in years on this issue. I mean, you check a credit report, what else can we do? How do you really qualify a patient for charity when you don't have a process that you're going to follow?

► **Walder:** I think you have to start, too, with changing the expectations of your patients and communicating with them up front so that you put them on notice

that the requirements of them are increasing. They need to know that if they really are unable to pay, they have a responsibility to notify you or to come forward to let you know that. The people who drain your resources are the ones who you spend all of your time chasing—the ones that never call, never respond. The problem isn't the people who step forward and say, "Hey, I need the help."

We also need to change the expectations for those folks who have insurance: *if* you have a copay, *if* you have a deductible, the expectation is that you're going to take care of it at the point of service, not later on down the process. I think it starts with that communication with a patient.

► **Powell:** As far as tools are concerned, I did see something a couple weeks ago of an online subscription service that allows you to do credit checks, credit scoring, and to do financial profiling. I'm investigating that.

► **Pagliuzza:** I agree that we're going to see more and more self-pay, higher copays, higher deductibles. That's going to be a way of life. And somehow I need technological support in that, because our process is still very manual. There's got to be a better way of doing it, but I don't think right now the tools exist to make it easy.

► **Clarke:** **Do you have any initiatives underway in the area of collections?**

► **Fennessy:** Because of the way we're organized, we're very decentralized in terms of our scheduling, registration, outpatient services, and other functions. This whole issue of point of service collections, culturally it's something that Northwestern's never dealt with. It's not our approach to ask for cash at point of service. But I think that as this grows, we're going to have to address that issue and evaluate it. It's going to come back to the cost of it, too, because there's a major cost of going to these clinical areas and starting to get them educated in terms of point of service and cash management at those sites.

► **Baxter:** We've got a fairly aggressive, up-front collection process, compared to other facilities I've been at, but it's also becoming a big patient dissatisfier. We've trained staff to do the pre-registration processing and collections. They're asking for the money and they're getting it, but now we're getting lots of backlash. So I feel like we went down one road and we went a little more aggressively than we should have.

► **Kittoe:** We have started that process, and we took the obvious place—the emergency room—as the pilot area. It's a whole new paradigm for the staff, and we've really had to do a lot of intensive training with the staff. Then you run into the clinical staff resistance and that whole culture, but we've worked through that. I'd say we still have a lot of room for improvement, but it's amazing that the clients come in and know that payment is expected there—they are very familiar with the process from their office visits. It's all in how you handle the scripting, how you talk to the patient. It's been fairly successful. I'm not ready to go on the road with it, but it's working in emergency. And then we're ready to roll it out to some other places.

► **Baxter:** Really, it ties back into the whole verification process. If we're doing a good job at the verification level, we can do a good job of up-front collections. So you have to have both. You really have to rely on the verification process.

► **Clarke:** **How do you think the revenue cycle process in general could be improved in the future?**

► **Doyle:** Consider what the banking world would be like if the organizations under MasterCard hadn't agreed on a standardized card number and means of identifying the user. Yet we've been operating a health-care system which is probably of similar size, with absolutely no agreement on how to identify who you are and what insurance you've got.

As much as I'm for small government, it is probably a government need at this point to lay down a standard, just like the transaction sets, which have been helpful in that regard. If we could know, with the swipe of a card, who your insurance company is and who you are, the efficiencies gained would be amazing.

► **McCanna:** I think one of the complexities is the benefit structure in commercial insurance. There are thousands of interpretations of it, so absent insurance reform of some sort, it makes it extremely difficult to get to a standard because of the various benefit structures.

► **Arnold:** That's true, because each company has its own set of rules and regulations. And it's hard to have your staff figure out which company covers which services. But I think that as new technologies become available, as we continue to educate staff and clinicians on coding, collections, and other vital issues, we can continually improve our individual revenue cycle processes even if we don't have a nationwide standard.

► **Marr:** **Where does customer satisfaction come into play in the revenue cycle?**

► **Bury:** Well, I think we consider customer service in all our decisions. I think we're all sensitive to it and we keep it as a high priority.

► **Arnold:** Under the COO, we have a patient satisfaction department that actually sends a representative out to the inpatient rooms to distribute satisfaction surveys. The information we gather from those surveys is published in the hospital bulletin. So we are very proactive in patient satisfaction—we're even classified as a safety net facility. But it's primarily focused on the clinical experience.

► **Pagliuzza:** Getting satisfaction data on the billing process is a logistical nightmare in that the whole revenue cycle can run anywhere from 30 to 150 days.

► **Doyle:** We're measuring it through indirect measures, which we assume translate into satisfaction to the patient. For example, how promptly does the bill finally get to them? Are the phones ringing, relatively speaking? How quickly do we answer the phone? What is the volume of calls that bounce into voice mail? What are callers talking to us about? What is the nature of their questions? So we analyze that kind of information.

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