



Transaction Services: Beyond Basics to Bolt-Ons

About HFMA Roundtables

This HFMA Roundtable is an edited version of a discussion sponsored by Cerner that took place at HFMA's 2005 Annual National Institute (ANI), held in Las Vegas. In what follows, prominent industry professionals candidly share their experiences and advice about achieving efficiency and effectiveness in transaction services. This HFMA Roundtable is made possible through the support of Cerner.

In recent years, the transaction services industry has advanced beyond the traditional services that handle X12N 270, 271, and 278 transactions for claims, editing, billing, and eligibility verification. Hospitals and healthcare systems now contract for multiple "bolt-on" services, such as denial management, address verification, credit scoring, APC groupings, document imaging, call services, and more. Although such bolt-ons offer valuable features and serve niche needs, they also can pose challenges for both the business office and the IT department.

In this HFMA Roundtable, healthcare executives discuss how they have solved some of the common issues related to transaction services and share best practices from their own organizations.

ROUNDTABLE PARTICIPANTS

Karen Geisler, CHFP, vice president of patient financial services, Mount Carmel Health, Columbus, Ohio. Mount Carmel is a not-for-profit health system based in Columbus. It has three hospitals and is a member of Trinity Health in Novi, Mich.

Frank Gless, FHFMA, director of patient financial services, Spectrum Health, a not-for-profit health system based in Grand Rapids, Mich., with seven hospitals and more than 140 service sites.

Warren Hern, executive vice president and CFO, Unity Health System, Rochester, N.Y. The system includes Park Ridge Hospital, which opened its doors in 1975.

Mary Ann Jones, CPA, CFO, Spectrum Health United Memorial, Greenville, Mich. Spectrum Health has seven hospitals, including the only children's hospital in western Michigan.

Tami Knobbe, assistant director, revenue cycle development, SLUCare, the medical group for St. Louis University. SLUCare is an academic institution, owned by the University, that staffs both St. Louis University Hospital and Cardinal Glennon Children's Hospital but is independent of the two facilities.

Larry Marshall, FHFMA, CPA, senior vice president, finance, Indiana Regional Medical Center, Indiana, Penn., a not-for-profit institution that first opened in 1914.

Alex McFadden, director of patient financial services and patient access, West Virginia University Hospitals, Morgantown, W.V., with multiple facilities, including a children's hospital, cancer center, trauma center, and eye institute.

Chris McGivaren, director of patient financial services, Our Lady of the Lake Regional Medical Center, Baton Rouge, La., the largest private medical center in the state, with 850 licensed beds.

Richard Nagy, FHFMA, director of reimbursement and revenue analysis, Beth Israel Deaconess Medical Center, Boston, Mass., a teaching hospital of Harvard Medical School.

Mike Monahan, FHFMA, director, revenue cycle, Cerner, Kansas City, Mo.

ROUNDTABLE DISCUSSION

► **HFMA: What are some of the challenges of using multiple suppliers in billing and collections?**

► **McGivaren:** The biggest struggle for us is dealing with some issues that pop up from time to time because we're running different systems from different vendors. One day everything is running fine, and then the next day, I've got a bunch of accounts assigned with a VIP code that doesn't even exist. So we try to educate the folks who enter the charges in the departments. In each department, we have a dedicated person who watches the department's revenue every day to see if there are problems. But even then, we still have to do a lot of compliance-related rebills. So each department requires dedicated resources to stay on top of those problems.

► **Nagy:** We have a special IS team whose job is to maintain those systems interfaces. We're also in the process of changing billing systems, and there's at least 15 IS people focused on just the interfaces for the new system. While we're going through this conversion, there are certain system changes and updates that will need to happen, even though we're going to get rid of the system in a year. With all the changes, you can't afford not to get the programming done, because you don't need your days to creep up now, especially with a system down.... So, our IS department manages the different vendors to make sure that everything works the way it's supposed to. And if it doesn't, the vendors don't remain long.

► **HFMA: How do you manage the relationships with the vendor groups that you're interfacing with?**

► **Geisler:** The large contracts with the big HIS vendors are managed by IS, and sometimes your size and the amount of product you have has an impact on how much attention you get. But patient account managers often manage the relationships for the smaller vendors that many of us use to support patient accounting. And it's harder to drive change to the product when you're just one of a thousand clients.

► **Knobbe:** In my organization, both IT and the manager for contracting report under the executive director of patient accounting. It works very well, ensuring that IT's projects are more aligned with our expectations.

► **HFMA: Has anyone added an FTE or a part-time position to help manage some of these relationships?**

► **Gless:** Yes. In our organization, we have five people to manage these systems. They report to the manager of patient accounts for the facility. It's working out well. We do get into difficulties with IT every now and then. For example, some of our equipment needs dedicated servers, but the servers are under the IT department's control and IT decisions sometimes encroach on them. When such uses aren't communicated, the electronic bill scrubber may blow up. So it's a challenge from that standpoint. But as far as maintaining the relationships with the vendors, we're not having any problems.

► **McGivaren:** I don't have a dedicated staff in my office. Every year, I try to put one in the budget to see if I can get one. And every year, my request is denied. But I'm trying to do the same thing, because I've got a whole list of things a person can do for me to make us more efficient. And I firmly believe that if you're in a large system or hospital, you need to have a dedicated person for your patient accounting/IS needs.

► **McFadden:** I do have a full-time FTE in my department whom we call an EDI coordinator. This person acts as the go-between for our department and IT, and as a liaison between vendors and IT to make sure that our needs are met. We're going through an RFP process now in which we're looking at changing our clinical and revenue cycle systems. And one of the things that I did notice when I went on several site visits last year is that there's a lot more IT staff coming back into the business office or into revenue cycle operations, because the technology is so much easier to support.

► **HFMA: What would you say is critical about having these coordinator-type positions?**

► **Geisler:** Without those positions, we would never get it done. I have a director of revenue cycle EDI. We're in the process of hiring another project manager who will assist with systems in maintaining the profiles and tables, and allow us to rapidly install new eligibility systems. We have a list of 19 projects that have an IS "twist" to them that will support patient accounting.

► **Nagy:** We have a vice president of IS for finance whose office is right next to mine, so he's a part of our group. His staff is an integral part of what we do. It's good to know I can walk into his office and get what we need right away. Most of what he does is focused on the patient accounting side and the interfaces to the system.

► **HFMA: Do any of your vendors provide that service?**

► **Gless:** We've had people offer, but IT won't let them touch the legacy system, so they can't do anything for us. The only time we can use vendors is when a niche player programmer can come in and help us—as long as the programmer doesn't touch anything in the legacy system.

► **HFMA: Do you experience bottlenecks when revisions to one technology application don't necessarily transfer over to other areas?**

► **McFadden:** We just went through our Medicare audit, and we had to go back to our state Medicaid offices and get something in writing for each patient receiving eligibility. Even though Medicare is pushing us to automate, they consider it unacceptable for us to perform an electronic verification with a payer and pull the information back into our system. They want it on paper.

► **HFMA: How do you ensure that staff in your various departments are using the systems effectively?**

► **Marshall:** One way that we have found to be very effective is using a productivity monitoring system.

► **McGivaren:** I agree. And if the staff doesn't input charges, then they don't have units of service for the productivity monitoring system, which gets the managers' attention. For us, the challenge has been ongoing, requiring the involvement of our top leaders. For example, until two years or so ago, pharmacy staff did not watch their charges very closely. There wasn't anything set up for them, and they didn't take ownership of the process. It wasn't until top leadership got involved that that changed. And we've managed to build a relationship through the give and take involved in going in, helping them out, and setting it up.

► **HFMA: Let's ask the big question. What return on investment are you finding from bolt-on services?**

► **Hern:** Regarding ROI, I don't think it has necessarily reduced denials. But it is helping us process the claims faster.

► **McGivaren:** I agree—it's just more efficient. You're still going to have the problems that are out there, and this is just a way that you can handle it more efficiently so you can get more volume or you

can fix those problems sooner. But no matter how good the technology is, it still all comes down to your people and how they use it.

► **McFadden:** We had an older claims processing system that transmitted the claims out, and two years ago we brought on a new bolt-on technology. We were able to decrease the time it took for the billers to get the claims out the door by about five days. The old system wasn't very user-friendly. So now we're trying to manage the exceptions instead of looking at every claim. With some of that newer bolt-on technology, we're able to manage those exceptions better and let the clean claims go. And because of that, we've also shifted some of our billing staff into more follow-up functions. As a result, we've increased collections.

► **Geisler:** The core IS systems don't perform certain functions, such as electronic billing, well or at all. We could get statements out of our core HIS system, but doing so isn't an ideal option since most of our outsource statements so that they are nicer looking and more patient-friendly.

► **HFMA: Why is that important to you?**

► **Geisler:** Well, it can put you at a competitive advantage. But I don't think for us it's been so much about competition in our market. It's a better way to communicate with our patients. We try to let them know how to contact us if they need our assistance, and we build that into the content of the statements.

► **McFadden:** We used to produce our own statements, and we now outsource that work. And we have looked at the HFMA-sponsored PATIENT-FRIENDLY BILLING® project for guidance. And we have an engagement right now with an organization regarding self-pay processing. When they reviewed our statement, they said it was one of the most patient-friendly statements they had ever seen. But it's only by using an outsource vendor and getting those transactions

electronically to the vendor that we were able to achieve that result. We didn't have the capabilities on our system.

► **Gless:** We've also started using patient-friendly statements, and we've found another benefit—improved patient satisfaction. We track our phone calls, and Monday typically is a heavy call day because of the mail that goes out on Thursday and Friday. Since we've been using the new statements, calls have dropped off about 25 percent.

► **McFadden:** When we redid our statements, we put more focus on the front end. Because it's an easier statement to read, our financial counselors are better able to explain it to patients. We also measure patient satisfaction. One of our survey questions now is, "Did you understand the billing process?" Three years ago, positive responses to that question were at about 71 percent. But now we're up to 95 percent. So that has been a tremendous success.

We don't have an electronic copy of the statement or comparable visual corresponding with what the patients receive, that collectors or follow-up people can easily review, but we are looking into developing something like that. There's an extra cost involved, and we intend to evaluate it along the way. Our customer service staff has said they don't need such an image, because the statement is so simple. But we will continue to look into it.

► **Marshall:** Has anyone tried putting statements on the Internet for patients to view?

► **Gless:** We put our statements on the Internet, and patients can print them. Our patients also can pay their bills online now. It's been really slick. That's all been done by the vendor that handles our statements. As a result, we're seeing a big increase in our credit-card payments. But we haven't been on it long enough to know whether it's going to make a difference in

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what we collect. The other benefit we realized from using an outside vendor for statements was that we didn't have to lay out the cash for a quarter-million dollar printer.

► **HFMA: With the uninsured being such an issue nowadays, does having these outsource services have any effect?**

► **Gless:** We hired a vendor that does front-end screening for Medicaid, and they do everything else for us, too—victim of crime, charity care, and so forth. And it's been very successful for us. We've realized about \$750,000 a year in additional cash from Medicaid over what before was just going to bad debt.

► **McFadden:** We also have implemented a process like that, and we have seen a \$2 million improvement to our bottom line using an eligibility company that manages the up-front process. The other piece that's been of benefit is in our reserve model for our financials. We've typically reserved 88 percent for self-pay. But we now have a financial class for these "refer to Medicaid" patients that this company is managing, and we reserve a lot less bad debt on that financial class because the company has already been so successful and made so many improvements. And our auditors have approved of this approach, so we've continued it for the past two years.

► **HFMA: Knowing what you know now, what would you change about your transaction services if you could build them from scratch? What's worked and what hasn't?**

► **McFadden:** The newer bolt-on technologies are much easier for staff to use. The people that you're hiring in these entry-level positions now in your front-end of patient access—or even in the billing office—have grown up on Windows-based technology. They're not used to “backspace, tab, tab”—in other words, the applications that we're still using in the business office. So it's very challenging to train these people on these older technologies. That's where we get a lot of benefit out of some of these bolt-on technologies—they are much easier for the staff to learn and use.

► **Knobbe:** What works really well for us is outsourcing our self-pay collections. We have two bad debt agencies we work with and two precollect companies we use as well. We've swapped their alphas (precollect A gets alpha A-L and their bad debt agency gets M-Z), and the precollect does not receive any credit for the insurance that they find. If we miss insurance, they notify us and we bill the carrier. It sets up a lot of competition between them, because if you collect more in your precollect files, then your competitor gets less in their bad debt write-off. Also, all of our statements have the precollect company's phone

number, so we route our customer service calls that are related to the statements to them. And for our patients, it's seamless—they don't know that the people they are communicating with aren't our employees.

► **Geisler:** We could use more exception processing, and I think that's probably the next wave of things that will be out there—software that will show that it has intelligence, by identifying, for example, that the wrong number of digits for that Blue Cross plan was entered and alerting the registrar right then rather than having the error be discovered three weeks later. We're also looking at kiosks for registration, so when patients are preregistered, they just have to come in and sign in like they do at an airline. My frustration is that the implementation of these technologies is not moving fast enough.

► **Jones:** The problem is this: You might invest in niche software because your core provider doesn't offer it at the time, but then a year or two later your primary software vendor might come out with software that addresses the niche need. It's not necessarily cost-effective to switch over. Ideally, it would be better to have the primary software provider be able to meet that niche need in a timely fashion.

► **McGivaren:** I believe faster cash collections is the benefit. Implementing bolt-on technologies is the cost of doing business—the *new* cost of doing business.



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