How a Pre-Service Center at MetroHealth System Improved Satisfaction, Efficiency, and Revenue

Craig Richmond
The MetroHealth System
Associate Chief Financial Officer & Vice President, Revenue Cycle
Introduction

Craig Richmond is the Associate Chief Financial Officer and Vice President of Revenue Cycle at The MetroHealth System.

In his role, Richmond is responsible for the system’s financial functions which include the revenue cycle (hospital and physician), finance, accounting, internal audit, managed care, reimbursement and treasury departments.

Richmond has more 15 years of experience in the industry specializing in multiple areas within both finance and the revenue cycle. His diverse background includes working in academic medical centers, health systems and community providers to optimize revenue cycle and finance operations through process, technology and operating model improvements. He has implemented financial and operational solutions to help health-care organizations increase net revenue, improve work flow processes, reduce costs and accelerate cash flow.

Richmond received a Bachelor of Science in Accounting with a minor in MIS and Decision Support Systems from the University of Delaware. He is a Certified Public Accountant and is a long-standing member of the American Institute of CPAs and the Healthcare Financial Management Association.
Learning Objectives

• Who is MetroHealth?

• Pre-Service Center Business Case

• Strategy & Approach

• Outcomes & Next Steps
MetroHealth has been serving the people of Cuyahoga County for 176 years by investing in its mission.

### Mission

- **Academic Health Care System**
- **Committed to Community**
- **Saving Lives, Restoring Health, Promoting Wellness**
- **Outstanding, Life-long Care**

### MetroHealth Capabilities

- All 500 physicians are faculty in the Case Western School of Medicine
- Committed to teaching a new generation of physicians with residents from Case Western and Ohio University
- Significant clinical/behavioral research
- Provides care across Cuyahoga County with 17 ambulatory locations
- 14th largest employer in the County (6,000 Employees)
- Only Level I Trauma Facility in Cleveland
- State of the Art Burn Center and LifeFlight Air Ambulance
- Northeast Ohio Trauma System (NOTS)
- Emergency Department with 100,000+ visits
- 750+ bed Acute Care Medical Center
- Nursing Magnet Status (granted to top 5% of hospitals)
- Senior Health & Wellness and Skilled Nursing Care Centers
- Strength in Primary Care, Depth in Specialties
- National Pioneer in Use of Electronic Medical Records
MetroHealth is recognized for its high quality care
MetroHealth provided 244,194 uninsured visits in 2012, an increase of 8% over 2011, exceeding projections.

2011 uninsured visits increased 11% over 2010 and by approximately 40% over 2008.
BUSINESS CASE
Revenue Cycle Paradigm Shift

Historically
Back-End
Weighted
Revenue
Cycle

Pre-Service
Service
Post-Service

Pre-Service
Service
Post-Service

Front-End
Weighted
Revenue
Cycle
Our shift and making progress.....

- Scheduling & Pre-Registration
- Financial Counseling
- Financial Clearance
- Registration
- Denial Prevention

- Claims Processing
- AR Management
- Payment Posting
- Denial Resolution
- Managed Care Contracting

- Charge Capture
- Strategic Pricing
- Health Information Management
- Clinical Documentation Improvement
- Coding
- Revenue Integrity
Prior State of Pre-Service Functions

Staff Tasked with Pre-Service and Check-in Functions

Discussion

- No consistency in insurance verification, identifying liability and payment leading to multiple patient touches.
- Patient service was suffering as miscommunications led to delay in patient care.
- Many tasks were left to front end registration staff leading increased check in time and staff and patient frustration.

Source: The Advisory Board Company: Optimizing Front Office Performance
Driving Factors to Establish the Pre-Service Center

<table>
<thead>
<tr>
<th>Business Case</th>
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</thead>
<tbody>
<tr>
<td>Streamline the processes creating a better patient experience</td>
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<tr>
<td>Allow clinical staff to focus on the patient and the clinical care needs</td>
</tr>
<tr>
<td>Provide an opportunity to communicate early with patients about insurance benefits</td>
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<tr>
<td>Educate patients on their out of pocket obligations prior to service</td>
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<tr>
<td>Improve point of service collections</td>
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<tr>
<td>Speed up the check-in process</td>
</tr>
<tr>
<td>Standardize the Patient Access process to ensure the same experience at location</td>
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<tr>
<td>Reduce clinical and technical denials</td>
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<tr>
<td>Reduce bad debt</td>
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</table>
## Alignment with Industry Best Practices

<table>
<thead>
<tr>
<th>Best Practice Processes</th>
<th>Metric</th>
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</thead>
<tbody>
<tr>
<td>Use single on-line scheduling software enterprise-wide</td>
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<tr>
<td>Processes and IT systems are integrated with pre-registration</td>
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<tr>
<td>Dedicated unit for pre-registration &amp; pre-authorization</td>
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<tr>
<td>Dedicated unit for insurance verification</td>
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<tr>
<td>Financial counseling is part of the patient access process</td>
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<tr>
<td>Patient balances &amp; payment obligations discussed</td>
<td></td>
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<tr>
<td>Point of service payment policy is explained</td>
<td></td>
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<tr>
<td>Patient is reminded to bring payment &amp; insurance information to appointment if not collected in advance</td>
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<tr>
<td>Outstanding balance collections are attempted</td>
<td></td>
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<tr>
<td>Use an on-line insurance verification system/application</td>
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<tr>
<td>Use an on-line or web-enabled patient self-registration system</td>
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</table>

<table>
<thead>
<tr>
<th>Best Practice Metrics</th>
<th>Metric</th>
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</thead>
<tbody>
<tr>
<td>Pre-registration rate of scheduled patients / services</td>
<td>≥ 95%</td>
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<tr>
<td>Insurance verification rate of pre-registered patients</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Deposit request rate for co-pays, deductibles and prior balances</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Insurance verification rate of unscheduled admissions within 1 business day</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Insurance verification rate of unscheduled high dollar outpatient services within 1 day</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Authorization compliance</td>
<td>≥ 96%</td>
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</tbody>
</table>

Source: Healthcare Financial Management (HFMA) Self Assessment tools for scheduling, pre-registration, insurance verification, and registration.
Advantages & Disadvantages of a Pre-Service Center

**Advantages**

- Simplistic staffing model for better management of financial clearance
- Increased payments of patient liability
- One call experience for patients for greater satisfaction
- Reduction of Point of Service Collections decreasing wait time

**Disadvantages**

- Departments feel “loss of control”
- Difficulty in integrating processes and systems
- Additional investment to set-up a central location

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**Pre-Service Center**

**Decentralized Pre-Service Activities**

- Greater flexibility within individual clinics
- Clinics maintain control of resources and patient contact

- No standardization of process / procedures
- Training inconsistent and ability to flex staff limited
- Limit the ability to provide “one touch” concept
Strategic Goals of the Pre-Service Center

Positive Patient Experience

- Standardized training and delivery programs to accommodate development needs of staff
- Consistent time-off policies for workforce management
- Standardized KPIs for improved representative productivity

Separate Administrative and Clinical Aspects of the Visit

- Process redesign across all workflows to increase efficiency
- Improved reporting methodologies and processes for increased operational insight and management

Financially Cleared Patient

- Optimization of verification and estimation software for improved staff efficiency
- Consistent process to ensure there is no delay to patient care
- Standardized reporting and metrics for effective management

Securing of Payment Prior to Service

People

Process

Technology
APPROACH
Pre-Service Center: An Overall Better Experience

Administrative processes are accomplished separate from the clinical encounter allowing focus on the patient and the patient’s care at the point of service.

**Pre-Service Center**

- **Verify Insurance & Eligibility**
  - Verify insurance plan eligibility via payer website, call center or batch processing

- **Secure Authorization**
  - Identify required authorization and ensure request from physician office
  - Use automated medical necessity checks

- **Collect Patient Obligation**
  - Combine insurance info with charge data to produce estimate
  - Patient obligation (including outstanding balances) collected

- **Provide Financial Assistance**
  - Match eligible patients to available assistance programs

Positive Patient Experience & Financially Cleared Patient
- No patient hand offs
- Patient education regarding their liability
- Collect full amount possible from patient and payer

Prior to Service:
- Patient scheduled and registered
- Insurance eligibility and coverage verified
- Any necessary authorizations obtained and tracked throughout visit
- Patient obligation collected
- Financial assistance options presented to those unable to pay

Source: Graphics used by permission from The Advisory Board Company
Graphics used by permission from Healthcare Business Insights
Concierge Approach

Migrating the administrative processes to a “One Stop Shop” for our patients

Source: Graphics used by permission from The Advisory Board Company
A primary advantage in transitioning to the PSC model is allowing the sites and caregivers to focus on patients, while patient administrative processes such as financial clearance can occur in the background.

**Pre-Service Center Process Flow**

**Step 1:**
Critical Data Elements obtained during scheduling submitted to PSC.

**Step 2:**
Reviews & completes missing data, verifies demographics, insurance benefits, co-pay, deductible, etc.

**Step 3:**
Contact patient: review & complete missing information; collect over the phone; discuss financial obligations, etc.

**Step 4:**
PSC notifies site of "cleared" or "non-cleared" status.

Source: Graphics used by permission from The Advisory Board Company
# Pre-Service Center Project Timeline

<table>
<thead>
<tr>
<th>Key Project Initiatives</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
<th>Month 6</th>
<th>Month 7</th>
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<tbody>
<tr>
<td>Define project structure:</td>
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<td>Steering Committee</td>
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<td>Work Group</td>
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<td>Subcommittees</td>
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<td>Operational / Functional Design:</td>
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<td>Define and standardize processes</td>
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<td>Develop formal policies and procedures</td>
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<td>Finalize pre-registration staffing, management</td>
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<td>Technology &amp; Automation Enhancements:</td>
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<td>Implement Patient Liability Estimation solution, and other enabling technologies</td>
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<td>Coordinate testing of proposed modifications</td>
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<td>Obtain go-live approval, support</td>
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<td>Physical Space Planning:</td>
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<td>Identify space needs</td>
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<td>Design future layout</td>
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<td>Review proposal with stakeholders</td>
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<td>Build-out space</td>
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<td>Change Management:</td>
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<td>Staff readiness planning &amp; execution</td>
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<td>Communication strategy, game plan</td>
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<td>Stakeholder rollout</td>
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<td>Implementation planning and post go-live support</td>
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<td>Monitor and validate performance</td>
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<td>Process &amp; technology modifications</td>
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<td>Patient satisfaction monitoring</td>
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Our Project Team Structure

Program Sponsorship
- Oversight and Direction
- Leadership commitment to project
- Sign-off on interim and final recommendations

Engagement Management
- Overall responsibility for project management
- Conflict resolution
- Coordination of key activities
- Liaison to Steering Committee

Engagement Team
- Day to day project management
- Primary source of data collection and analyses
- Ownership for refining the strategic options

Project Leadership
- Leadership – Patient Access
- Project Manager
- Project Manager - Consultant

VP of Revenue Cycle

Steering Committee
- Key Leaders

Engagement Team
- Process & Technology Resources
- Functional Advisors
- Training Advisors
- Subject Matter Experts
- HR Advisors
- Physician Advisors
Workflow and Policy Development

- Subject Area Experts
- Patient Access Leadership
- Consultants

POLICY
Technology Solutions – Patient Workqueues

Patients scheduled in System

Workqueues populated with patient appointments 5 days out

Staff works out of workqueues for insurance verification and authorization

A collaborative effort between Information Services and Revenue Cycle leveraged existing system technology to streamline the process.
Technology Solutions – Estimator Software

**Patient Liability Estimation Solution** generates clear and concise estimates of the patient’s cost of care for use in providing quotes for services and use in establishing estimates for point-of-service collections.

Source: Used by permission from PMMC
# Staffing Structure Volume Analysis

<table>
<thead>
<tr>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Insurance Verifications</strong></td>
<td>Determine how many insurance verifications will be completed by PSC staff and how they will be completed. 85% completed by PSC • 75% through HIS • 20% completed online • 5% completed over the phone</td>
</tr>
<tr>
<td><strong>Total Authorizations</strong></td>
<td>Determine how many authorizations will need to be completed by the PSC 52% of procedures require an authorization • 80% completed online • 20% completed on the phone</td>
</tr>
<tr>
<td><strong>Total POS Collections</strong></td>
<td>Determine how many visits require a POS collection and determine the percentage to be collected by the PSC. 39% of visits require collections • 10% of collections will be done by the PSC</td>
</tr>
<tr>
<td><strong>Total Visits to be Cleared</strong></td>
<td>Determine the total visits and subtract any reoccurring visits Walk-in and scheduled non-reoccurring appointments were counted.</td>
</tr>
</tbody>
</table>
Pre-Service Center Staffing

Manager Hired

Prior Authorization Staff become PSC Staff

HR involved to bring aboard new staff

Training plan formulated

PSC
The lessons learned during the operation and implementation of Pre-Service Center contributed to a successful “go-live” but with a lot more to accomplish.

Discussion

- The focus of the implemented best practices had three areas of interest:
  1. Patient Experience
  2. Physician feedback on the operating model and approach
  3. Associates’ freedom to contribute and suggest operational improvements
Program Buy-In

Bring together the key stakeholders and staff within the MetroHealth community to support the Pre Service Center

<table>
<thead>
<tr>
<th>Communication Method</th>
<th>Description</th>
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<tbody>
<tr>
<td>Internal Announcement #1</td>
<td>Introduced the overall PSC concept, including key purpose and goals</td>
</tr>
<tr>
<td>Internal Announcement #2</td>
<td>Highlighted the PSC design session outcomes; provided purpose and overview of the PSC workgroup</td>
</tr>
<tr>
<td>Management Meeting</td>
<td>Director of Patient Access provided a general update on PSC initiative progress</td>
</tr>
<tr>
<td>Physician Meetings</td>
<td>VP of Revenue Cycle continues to meet with Physician leaders regarding the establishment of the PSC</td>
</tr>
<tr>
<td>Revenue Cycle Town Hall Meeting</td>
<td>Revenue Cycle leadership reviewed PSC initiatives with staff</td>
</tr>
<tr>
<td>Departmental Management Meetings</td>
<td>Ongoing discussions with departmental leadership around PSC initiative including roll-out plan</td>
</tr>
</tbody>
</table>
Listening to Feedback

Change Control Group (aka Steering Committee) – Formed under the leadership of the Vice President of Revenue Cycle; meets to discuss and approve Pre-Service Center process changes.

Staff submit recommendations to Change Control Group for reviews.

Change Control Group recommends changes to processes (if needed) and carries out the implementation.

Change Control Group involved key members of Medical Staff, Operations, Revenue Cycle administration and Staff.
Proposed Program Roll Out

- **Pilot**
  - High dollar areas
  - Example: Radiology and Heart and Vascular

- **Feedback**
  - Pilot areas provide feedback
  - Necessary changes made prior to phased roll out

<table>
<thead>
<tr>
<th>Phase I</th>
<th>Phase II</th>
<th>Phase III</th>
<th>Phase IV</th>
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<tbody>
<tr>
<td>• 4 weeks</td>
<td>• 4 weeks</td>
<td>• 2 weeks</td>
<td>• 2 weeks</td>
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Patient Education & Contact – Outbound Calls

• Staff are trained to
  • Verify the patients cost sharing (out-of-pocket) portion
  • Educate patients on their financial obligation required based on their insurance and benefits
  • Offer them opportunity to pay prior to their clinical encounter
  • Process the payment
  • Schedule arrangement for payment at POS

• About 15 percent of the identified patient balances are being collected prior to the clinical encounter.
Patients Contacted by Pre-Service Center

Oct-Dec
Jan-Mar
Apr-Jun

+397%

June 2013 Projection
Patient Liability Identified and Collected

![Chart showing patient liability identified and collected over different quarters with a projected increase of +297% in June 2013.]

- Liability Identified: Oct-Dec, Jan-Mar, Apr-Jun
- Cash Collected: Oct-Dec, Jan-Mar, Apr-Jun

June 2013 Projection

hfma national institute 2012
Pre and Point of Service Collections (Hospital)

![Graph showing Pre and Point of Service Collections from 2011 to May 2013 YTD with an increase of 56.9%]

Thousands

- 2011
- 2012
- May 2013 YTD
Authorizations Needed and Obtained

- **Bar Chart:**
  - Y-axis: Millions
  - Colors:
    - Blue: Auths Needed
    - Light Blue: Auths Obtained

- **Line Chart:**
  - Y-axis: Percentage
  - Colors:
    - Blue: Authorization Rate
    - Red: Benchmark
  - Key Points:
    - 2010: 96.6%
    - 2011: 96.9%
    - 2012: 96.9%
    - 2013 YTD: 98.0%
Insurance Verified

Bar chart showing millions of insurance verified from 2010 to 2013 YTD:
- Verification Need
- Insurance Verified

Line chart showing verification rate and benchmark from 2010 to 2013 YTD:
- Verification Rate
- Benchmark
Questions
Graphics & References

1. The Advisory Board Company
2. Healthcare Business Insights
3. PMMC