Introduction

As the healthcare industry faces new demands on financial management, revenue cycle processes and workflows are evolving from a solely back-end process, when a provider’s encounter with a patient is complete, to the front of the line, when the provider and patient decide to move forward with a care plan.

Emphasis is on management of the revenue cycle along the service continuum, from the initial physician office visit through post-acute care, with unprecedented attention paid to new approaches to achieve patient satisfaction, pricing transparency and quality of care.

To remain competitive, healthcare providers are implementing innovative delivery models such as accountable care organizations and patient-centered medical homes. As part of those efforts, they want to engage patients by giving them more responsibility in a collaborative relationship with their physicians. Patient engagement has the potential to significantly cut costs by helping to eliminate unnecessary procedures and costs on the clinical side, and also provides important financial benefits through:

- **Helping patients** take greater ownership of their financial responsibility
- **Educating patients** earlier and more thoroughly
- **Providing multiple, convenient options** for payment and account management
- **Providing a seamless experience** for patients to engage financially and clinically

These models give patients a more important role in the control and responsibility for their care, but also bring added complexity to billing and collections. They also give added importance to measuring clinical and financial performance through comparative analytics, which supplies more complete decision-making inputs — data detail, timeliness, and breadth of analysis — than typical benchmarking.

This e-book addresses the current status of healthcare revenue cycle management’s most critical opportunities — improving cash collections from patients, and improving service-to-payment velocity from your other payers.
Improving Financial Performance During the Pre-Service Process

**Problem**

The hospital revenue cycle is changing. Because of higher overall healthcare costs and consumer-directed health plans, it must evolve to accommodate larger patient out-of-pocket responsibilities.

The traditional model relies on collecting only the co-pay at the time of service, then determining and attempting to collect the balance post-service. The likelihood that patients will pay their portion of the bill, however, typically diminishes once they leave the hospital. As a result, providers are becoming more proactive and are embracing a new paradigm: collecting from patients at all points of service.
Solution

Improving your financial performance during the pre-service process requires knowing your patients and engaging with them about their financial responsibility. The more you can learn about your patients here, the smoother and faster the rest of the process will go. You can learn about your patients by utilizing technology to:

- Provide a clear picture of their eligibility for benefits and their propensity to pay their bills
- Verify their personal data and identity information
- Screen them for charity assistance

The way you engage with patients upfront sets the tone for financial discussions throughout the revenue cycle. Best practices for getting to know your patients include:

- **Verify eligibility at every phase of the revenue cycle.** Technology and workflows allow for eligibility checking for every patient, at every point of service, including post-service. Regular eligibility checks also help management catch errors or updates earlier in the cycle, which can reduce or eliminate denials later in the cycle.
- **Validate patient data and identity** as early as possible to minimize fraud risk and help the claims process move more quickly.
- **Estimate patient financial responsibility** to accurately calculate the patient’s financial obligation, to attempt to collect a larger portion of the patient’s future balance, and to better set payment expectations with the patient—all resulting in greater patient satisfaction, and an increased likelihood to pay.
- **Screen patients for their inclination and ability to pay** by establishing a patient-specific Propensity-to-Pay Score that can be used to place the patient into the appropriate collection or charity workflow.
- **Assess patients for charity/financial assistance** and enable staff to complete charity applications and gather required supporting documentation.

Healthcare facilities that take this proactive, pre-service approach can increase self-pay collections, and with the proper technology in place can continue to collect in full for a majority of services at the time of service, and can determine upfront which patients are eligible for charity care. Getting things right during pre-service processes not only improves your ability to collect from patients, but also gives you the ability to get a clean claim out faster and get remittance without further work later.

More information

Executive Brief: [Improving Financial Performance During the Pre-Service Process](#)
Improving Point-of-Service and Post-Service Collections

**Problem**

Hospitals typically collect a low amount of self-pay collections at point-of-service, and the likelihood that patients will pay diminishes further once they leave the hospital. Most billing office staff isn’t typically trained, or given the right tools and processes, to fully optimize point-of-service or post-service collections.

Ensuring that patients have positive interactions throughout the billing process can help facilitate collections while building loyalty and engagement. Providing ease and convenience for post-service bill payment and ensuring that language is relevant and easy to understand can go a long way toward supporting goals of increased collections and enhanced patient satisfaction.
Solution

With the right tools and processes, providers can improve patient satisfaction and engagement while managing patient financial expectations and increasing payment collection at all stages of the revenue cycle. Patients highly satisfied with the billing process, compared to those less than satisfied, are more than five times as likely to recommend the hospital to a friend.¹

Steps organizations can take to improve point-of-service collections:

- **Streamline processes** to make collections easier and more seamless
- **Offer more sites** for collections to encourage more patients to pay
- **Integrate an estimation/verification tool** with a collection tool to facilitate focused, educated discussion about patient responsibility
- **Implement processes and goals** to reinforce patient education and communication at point of service

To increase collections from patients after discharge, consider these strategies:

- **Leverage patient data** to customize statements with targeted, relevant messages with a clear call to action
- **Use statement formats** with visual appeal and a proven, patient-friendly layout
- **Consolidate approach to billing** from all providers at the hospital, for everyone on the patient’s plan, for easier management
- **Offer online bill payment and account management**, and promote the payment website on paper statements
- **Leverage other industries’ successful e-billing practices** such as payment plans, e-mail reminders and scheduled payments

More information

**Case Study:** [Building a Better Business Office](http://www.prweb.com/releases/2011/12/prweb9014561.htm)
Accelerating Service-to-Payment Velocity

Problem

After the patient receives care and is discharged, billing and account resolution work remains. Ideally, a productive financial discussion with the patient before service resulted in collection of co-payments or appropriate amounts of the patient’s responsibility. But, post-service billing processes and patient interaction still contribute heavily to overall revenue cycle success, even with thorough pre-service efforts.

The speed in which payment can be received from payers after service is critical to financial performance. Efficient management of claims is the first line of defense in speeding service-to-payment velocity, but can be labor-intensive, complex, and an often underutilized tool that can offer real results.
Solution

While most organizations have claims management processes and technology in place, a renewed focus in areas of great impact can present opportunities for improvement in payment velocity.

One facility in the Midwest found that 29 percent of claims denied or delayed were due to eligibility issues or lapses in coverage. In addition to robust, traditional editing capabilities, they also added the practice of running a final eligibility check before submission. This facility was able to prevent more than 9 percent of eligibility-related denials in their Emergency Department.

Another large network in the southwestern United States reassigned eight FTEs working eligibility-related rejections to other aspects of their business.

On average, Medicare claims represent 30 percent or more of a hospital’s total revenue. Improving efficiency in managing these claims can help accelerate cash flow while delays and errors can have a significant negative impact on the bottom line. Direct entry to Medicare and integrating Medicare claims processing into the same system used for all other claims workflow reduced one provider’s Return-to-Provider claims by 91 percent.

It is widely believed that increasing efficiency in managing Medicare secondary claims can provide a significant return. Triggers to generate a secondary claim immediately upon adjudication of the primary Medicare claim can reduce the time of payment from 14 days to one or two days.

From January-June 2012, the average service-to-payment velocity across the industry, from the time of patient discharge until payment resolution, was 45.3 days. This important metric is a top-level performance indicator measured by performance in the following areas of claims process:

- Service-to-release of claim
- Service-to-submission of claim
- Submit to Transmit
- Transmit to Payment

By localizing process delays, identifying specific issues, and monetizing the value of each improvement opportunity, the speed of payment can be increased and the greatest financial gains can be realized.

More information

Case Study: Strong Relationship Based on Customer Service, Satisfaction

2. HFMA Revenue Cycle Strategist, September 2010.
3. Ibid
Comparative Analytics: Benchmark Financial Performance, Improve Strategic Decision-Making

Problem

Availability of data has exploded across industries over the past two years. In healthcare, more than a decade of EDI transactions and the introduction of electronic medical records (EMRs) have created a body of data that can be mined to help achieve the goals of healthcare quality improvement, increased efficiency, and reduced cost and errors.

Roadblocks remain however, for elements of our healthcare system to take advantage of this body of data. Existing analytics systems are either relatively basic — offering standard operational reports — or extremely complex, requiring statisticians’ expertise. Also, incompatible systems, data structure and management of privacy and security are challenges to seamless integration.

As the healthcare system updates technology to better manage changes brought about by health reform initiatives, it will transition from legacy systems that focus on internal data repositories to a more collaborative, outward-facing, patient-centric model that integrates healthcare data from claims, electronic health records (EHRs), personal health records (PHRs), analytics technologies, customer relationship management systems and health insurance exchanges. This approach will present hospitals the opportunity to measure performance against their peers as well as their pasts, and provide a picture based more on real-time data than estimations and gut feelings.
Solution

Comparative analytics uses standardized data to give organizations an objective and timely performance measurement, against their peers as well as their past. This data complements an organization’s internal performance management tools that answer the question “Are we improving or degrading our performance?” by answering additional questions of “Is our performance in line with industry leaders?” and “Are there factors beyond our control influencing our performance?” With such benchmarks, staff can develop clinical workflows that are more efficient and productive, and can also measure and manage financial strengths and weaknesses.

Evaluating a provider’s performance through traditional benchmarking analytics has historically presented several issues. For example, specific key performance indicators (KPIs) may be calculated differently by different organizations, preventing a true “apples-to-apples” comparison. Additionally, most current benchmarking methodologies rely on manual processes for gathering data, making insights obsolete before they are available to decision-makers. Finally, traditional benchmarking analytics allows leaders to compare imprecise KPIs, but doesn’t answer the question “What is the root cause of variance in the data?”

Comparative analysis accomplishes two things:

• Establishes a useful baseline for performance along processes that are uniform enough to be compared

• Identifies whether macro influences beyond an organization’s control are influencing performance

With these benchmarks, staff can develop workflows that are more efficient and productive, and financial strengths and weaknesses can be measured and managed. If payment velocity decreases, or claims denials from a particular payer rise, it can be determined whether your organization is unique, or whether other organizations are having the same experience.

With information for healthcare systems pooled and categorized without identifiers, performance benchmarks can be produced that will allow all participating systems to obtain near real-time, accurate insights. This objective performance analysis and comparison of above- or below-average performance can help an organization set strategy, as well as monitor progress against internal and external targets.

More information

Conclusion

If you’d like to hear more information about solutions that can help you manage processes and workflows across the entire revenue cycle, contact a RelayHealth solutions advisor today. Our solutions can help you improve cash collections from patients, as well as service-to-payment velocity from your other payers, and help keep you competitive in a changing healthcare landscape.
Solutions Summaries

**RelayClearance™**
RelayClearance™ helps maximize reimbursement and helps reduce claim denials by identifying previously undiscovered insurance coverage. With RelayClearance, providers can efficiently verify insurance eligibility, estimate patient financial responsibility, accept point-of-service collections, validate patient identity, and find financial assistance for patients who are unable to pay.

**RelayAccount™**
RelayAccount™ helps improve your patients’ ability to pay their bills by providing easy-to-understand patient statements and 24/7 online account management access. RelayAccount consolidates billing (hospital, physician, medical group, lab, etc.) and merges billing information from multiple family members under one guarantor. Through RelayAccount WebPay, providers are able to collect POS payments quickly and easily. Providers are rewarded with increased cash flow, reduced self-pay A/R days and improved patient satisfaction. RelayAccount Online has been designated as “Peer Reviewed by HFMA” for the third year in a row.

**RelayAssurance™**
RelayAssurance™ helps manage all claims, including Medicare, Workers Comp and Property & Casualty, in a single web-based system. With connections to 1,900 health plans, comprehensive and current edits, and user-friendly workflow, users can efficiently manage the claims and remittance process to help keep cash flowing. By delivering an Operational Dashboard, 90+ standard reports, and advanced analytics capabilities, including an iPad app, RelayAssurance is the source of actionable data to refine your financial performance.
RelayAnalytics™

**RelayAnalytics Pulse™** provides visibility into strategic financial trends within and outside of your facility. Leveraging RelayHealth’s unique data assets, RelayAnalytics Pulse improves upon traditional benchmarking by automatically providing consistent calculations across peer groups, and helps ensure accurate comparisons of “like” hospitals to identify opportunities for improvement or showcase excellence. These insights help analyze productivity, align and motivate staff, compare revenue and cash flow, and justify investments.

**RelayAnalytics™ Acuity** provides a robust business intelligence solution that, when added to claims and remittance management, delivers actionable analytics to complement revenue cycle needs. RelayAnalytics Acuity adds strategic value to RelayAssurance™ Plus (ePREMIS®) by providing the ability to analyze billing efficiencies, reimbursements, payer relations, charge processes, and clinical services. The solution provides access to historical data and trends within and across facilities, with drill-down capability to micro levels. It also provides instant access to existing RelayAssurance Plus data, allowing analysis of financial performance and operational results in minutes without burdening IT resources.

**RelayAnalytics™ Spectrum** is an iPad® application that delivers the revenue cycle information necessary to run any organization. RelayAnalytics Spectrum provides mobile access to data via intuitive, visual KPIs and allows users to monitor operational and end-user performance from anywhere, anytime.