New Revenue Cycle Solutions

Helping you collect more and get ready for accountable care
Today, healthcare financial managers are facing an unprecedented dual challenge. With the number of uninsured and self-pay patients rising and third-party reimbursement declining, they must improve their ability to collect every dollar that their organizations are owed. At the same time, however, they must prepare for new methods of reimbursement that are already starting to emerge as a result of healthcare reform.

According to a recent Advisory Board report, a typical 300-bed hospital that does nothing to address these changes will see its operating margin drop to a negative 16.9% in 2021. Among the factors that will produce that result: a shift to a payer mix that is three-quarters Medicare and Medicaid; a resultant replacement of surgical volume by less profitable medical services; diminishing returns from cost-shifting to commercial payers; continuing cost pressures; and payers putting an increasing portion of hospital revenue at risk for meeting quality and efficiency goals.¹

Accountable care, bundled payments, and “value-based” reimbursement will require an entirely different business model than the one that most hospitals are accustomed to. Yet many have been using the same financial management system to both maximize current reimbursement and get ready for this new world. To be successful in this new era, an advanced financial system must be considered. This solution must adapt to an evolving environment and be tightly integrated with both physician and hospital electronic health records.

CAN OLD TECHNOLOGY AND PROCESSES DRIVE SUCCESS IN THIS NEW ENVIRONMENT?

Multiple Challenges
Hospitals have long had to contend with payers—especially Medicare and Medicaid—that reimburse less than the cost of care. But it has become increasingly difficult to pass on the shortfalls in government payments to private health plans and employers, who are also trying to hold down their costs.

Making matters worse, many hospitals are still not using best practices in billing third parties. As a result, they may lose 3%–5% of their potential revenues.² Bad debt is also on the rise. According to the Healthcare Financial Management Association (HFMA), the percentage of gross hospital revenue that was written off jumped from 63% in 2006 to 67% in 2010.³

This growth in bad debt coincided with an increase in self-pay accounts. Following the financial collapse of 2008, the number of uninsured Americans started to rise as employers shed workers and coverage.⁴ At the same time,
employers passed on more out-of-pocket costs to employees. For example, 27% of employees had a deductible of $1,000 or more for single coverage in 2010, compared to 10% in 2006.5

What this means for hospitals is that self-pay collection has become more important than ever. Yet hospitals continue to struggle in this area. Self-pay accounts contribute just 5% to total net patient revenue but account for more than 40% of outstanding receivables and consume 10% of all collections resources.6 Many facilities don’t have adequate staff training, processes or technology to properly handle self-pay patients.

Today, payment methods and models are beginning to change in ways that could hurt hospitals’ bottom lines. Bundled payments and contracting through accountable care organizations entail varying degrees of financial risk, which could lead to less use of hospitals. Medicare’s value-based reimbursement program will place a portion of hospital revenues at risk for meeting clinical quality goals. And hospitals will have to share risk and collaborate with unrelated providers. And, the chances are good that millions of Medicare patients will be added over the next 5 years due to aging baby boomers and health reform.

From a financial management viewpoint, many hospitals are unprepared to cope with these changes.7 At the same time, they’re still struggling to address the same revenue cycle management trends that have been gathering momentum for the past several years. Combined, these shifts make it absolutely necessary for hospitals and health systems to reassess their financial systems and processes and make sure they have the technology to meet both old and new challenges.

CRITICAL SUCCESS FACTORS FOR REVENUE CYCLE MANAGEMENT

To maximize reimbursement now and prepare for the future, a revenue cycle management (RCM) solution for hospitals and health systems should include these key characteristics:

1. Clinical and financial integration: The ability to capture and share information across care settings to capture more charges, streamline billing and prepare for bundled payments and ACOs.

2. Intelligent automation: The ability to automate and reshape revenue cycle processes, tasks and events to meet changing needs.

3. A flexible platform: Technology that easily adapts to innovation and new revenue cycle processes as well as ever changing reimbursement methods.

Accurate and Shared Information Is Essential

The best option for integration is having a clinical and financial solution that sits on the same platform and database. If it does not, it is absolutely essential that the systems talk to each other, to share information and workflow. As clinical documentation becomes more complex and as payers ask for more documentation of charges, it is more important than ever to tie these two solutions tightly together. In addition, the ability to locate quickly and share accurate data about patients and chargeable events can reduce the amount of time it takes to get bills out the door, accelerating cash flow.
An integrated system makes it easier for coders to find clinical records and can also improve charge capture through a closed-loop charging process. Under the closed-loop approach, the system shows when components of workflow have been completed. This prompts coders to recognize that a chargeable service has been provided, ensuring that those charges get into the patient accounting system so they can be billed.

Integration of clinical, financial and patient access solutions will also be important when hospitals switch to the ICD-10 diagnostic code set, which contains nearly five times as many codes as the ICD-9 set. Easy access to clinical documentation can help staff select the right codes for both hospital and professional billing. And when the government mandates the use of new HIPAA transaction standards for electronic attachments, integrated systems will help billers find the clinical documents they need to attach to claims.

In the future, it will be necessary not only to integrate hospital solutions, but also provide easy access to information and shared workflows with ambulatory and post-acute solutions. When healthcare organizations take financial responsibility for a patient population and have to calculate the total cost of care, they will have to break down their information silos and communicate across care settings. A platform that offers solutions across the continuum of care will become indispensable.

**Tailor Workflow to Your Needs**

Legacy revenue cycle systems offer hospitals varying degrees of automation. Business offices have a very limited ability to customize their workflow features. As a result, financial managers and staff members must do manual tasks and create workarounds in order to get their work done. With the increasing financial pressures on providers, however, that degree of inefficiency is no longer acceptable.

An innovative solution maximizes efficiency by allowing financial teams to quickly build and execute the workflow that fits their specific needs. Additionally, the RCM solution should automate repetitive tasks and interact with members of the financial team so that the system, in effect, becomes a team member. While the computer does the routine work, staff are freed up to concentrate on jobs that require human attention.

This is not just a matter of sending out batches of claims in the middle of the night. Instead, by defining events, tasks and processes and defining workflow to these processes, rather than the other way around, financial managers can orient the system to take staff members from step to step, making each process consistent and repeatable no matter who is performing it.

For example, customer service representatives might be instructed to ask for payments when patients call with questions about their statements. But they all do it differently, depending on their comfort level, and they get varying results. Prompts on their computer screens, specified by a designated manager, can take the staff through the required series of steps, from looking up the patient’s outstanding balance to going to the payment entry screen to documenting what was done. By guiding the process, the system increases the consistency of their approach and the likelihood of payments being made.

Most RCM solutions today require programming by the hospital’s IT department or the vendor. That makes it difficult for managers to obtain the results they want, and might take longer than they would like. But in an advanced RCM
solution, where the workflow features are like puzzle pieces that can fit together in numerous ways, a financial manager or a super-user can redirect or recombine those elements without programming assistance by using a visual “drag and drop” approach. Once the proper components are in place, the prompts in the system function as a kind of “auto-pilot” for the staff.

**Innovate with a Flexible Platform**

An advanced RCM solution should be based on an open or service-oriented architecture (SOA). An SOA provides an extensibility that traditional systems lack. For instance, if a hospital’s IT department developed a useful application for the business office that an SOA-based financial management system did not include, they could plug that application into the system without creating a special interface. And by using the process described earlier, they could easily imbed that solution into the system’s workflow.

Open architecture also lends itself to risk sharing with other providers. For example, it allows end users to launch other financial systems within their own system, so that they can have the experience of two disparate applications sitting side by side on their desktop. This could be very helpful, as we’ll see when claims must be combined across different providers for situations like bundled payments.

Third parties can use an RCM solution with an open architecture to plug into some of its services. For example, an outside physical therapy provider could use an SOA-based system to generate charges. This open architecture approach is ideally suited to a future in which disparate providers must share cost and quality information to take on bundled payments or more extensive financial risk.

A next-generation RCM solution should offer additional flexibility to accommodate the growth of healthcare systems. As hospitals acquire physician practices, for instance, they may decide to bill for professional as well as hospital services. On the most basic level, that means their RCM solution must be able to handle different kinds of claims forms. But it also requires that the system have the ability to distinguish between hospital and professional payments when remittance advice arrives from payers. Hospital payments for multiple services are typically posted as a whole, whereas professional payments need to be allocated at the individual claim level so that the staff can work the denied claims.

**IMPROVING THE TRADITIONAL REVENUE CYCLE**

**Patient Access and Financial Clearance**

Traditional billing and collection based on fee for service and DRGs will continue to be at the heart of healthcare systems for some time to come. Providers need a solution that can perform these functions at a consistently high level.

Because of the growth in patient financial responsibility and self-pay accounts, patient access systems—including scheduling and registration—have become increasingly important to providers. To start building a strong foundation, you need more than just an average solution. An excellent patient access system with individually tailored workflow features can increase pre-service collections and reduce claims denials. It is an essential part of an effective RCM solution that ties together scheduling, registration and patient accounting.
A clean claim starts with patient access. A strong patient access solution prevents problems that may emerge in claims later on. For example, a solution that enables staff to verify insurance eligibility and benefits in batch and real-time modes and spot errors immediately greatly increases the likelihood that the claim will be paid. The system can also be used to search for alternative sources of payment. For example, some uninsured patients may be eligible for Medicaid. The ability to discover that at the point of care can reduce the amount of charity care that a hospital must provide.

Hospitals with a sophisticated RCM solution can use it to identify patients who may not pay their bills when they schedule a visit or present at the ED. If a patient has previously been treated at the hospital or one of its ambulatory care clinics, the system should be able to create a collector task list that shows whether a patient has not paid, not paid on time or not paid enough in the past. If a patient or guarantor falls into one of these categories, he or she can be identified and referred to a financial counselor.

As previously noted, hospitals can also use their RCM solution to guide staff through the process of pre-service collection at the point of care or during registration.

**Billing at Episode Level**

The workflow and rules in a new-model RCM solution allow the patient's account to be managed at the level of a financial “episode.” This approach simplifies the billing process, increases revenue capture, and reduces friction between clinicians and the business office.

For example, most payers require hospitals to bill for delivery and postnatal pediatric care in a single claim for the mother’s hospital visit. But the services are provided by OB-GYNs and pediatricians, who define their own episodes of care separately for their own billing purposes. The best RCM solutions can drop all facility charges—regardless of which clinician generated them—into a specially constructed financial “episode” for billing according to payer rules. In that kind of workflow, it is unnecessary for financial staff to bother physicians with billing details.

Beyond that, thorough eligibility verification on the front end and comprehensive edits in the system help ensure that claims are clean when they are transmitted to a clearinghouse or a payer. Additionally, the RCM solution should include alerts about coding errors, such as mismatches between diagnosis and procedure codes.

**Denial Management**

When a payer sends back an electronic remittance advice (ERA) form, any good billing system can post the payments automatically and sequester the denied claims. But hospitals need to balance the cost of working denied claims against the additional revenue that might result from that activity, bearing in mind that the average cost of collections should be no more than 2 or 3 percent.

The RCM solution you want provides additional flexibility in managing denials. First, it automatically identifies the claims adjustment reason codes and remark codes. The hospital might want to track every one of those or only certain codes from particular payers. Once that has been established, only the appropriate denials will be raised during the payment posting process. Then they will be routed to the appropriate staff or team so that the claim can be reworked and resolved.
At that point in the cycle, workflow automation can help increase revenues. For example, after the staff person handling the denied claim corrects the coding, he or she might forget to resubmit the claim. Rather than rely on the staff's memory, that task can be assigned to the system, which executes it automatically as part of the pre-programmed workflow.

THE NEW WORLD OF REIMBURSEMENT

Many healthcare organizations are forming or already belong to accountable care organizations (ACOs). These ACOs may contract with the Medicare Shared Savings Program and/or private payers. While ACOs in the Medicare program have the option of upside-only shared savings for the first three years, they will have to take downside risk later on. Some commercial plans are already delegating financial responsibility to ACOs.

The Center for Medicare and Medicaid Innovation (CMMI) is also testing bundled payment approaches that may eventually become widespread. While only one of Medicare's four bundled payment pilots involves a prospective budget, this methodology offers another way to transfer risk to providers.

Whether it's in the form of shared savings, bundled payments or capitation, financial risk requires providers to reduce the cost of care rather than trying to wring as much revenue as possible out of billable services. Moreover, instead of looking at their margins in terms of inpatient, outpatient or ambulatory-care services, financial managers must consider the total margin of care across their enterprise. And, if they are collaborating with other providers, as may be the case in ACOs, they have to keep track of the services their partners are providing and the payments owed them for those services.

Under payment bundling for an episode of care, such as inpatient care plus 30 days of post-acute care, the number of variables is limited. A hospital taking such a payment may have to account for its own services plus the services of physicians, home care nurses, and skilled nursing or rehab facilities involved in that episode. But from a financial accounting standpoint, this is still quite complex. And it is difficult or impossible for most hospitals to combine their financial data with data in physician practice management systems and long-term-care/post-acute systems.

In a full-risk or global capitation arrangement, the challenges are even greater. Financial systems must be set up to track capitation payments on a per-member-per-month (PMPM) basis for all the patients enrolled in an ACO. There must be a mechanism to monitor “leakage” of patients to providers outside the ACO. And, if a hospital is leading the ACO, it must account for all the payments to providers inside or outside the organization. This accounting must cover not only the payments to date, but also an estimation of the “incurred but not reported” (IBNR) charges that will have to be posted later on against the capitation payments for that period. What this means is that healthcare providers will need advanced, flexible RCM systems to succeed under the new reimbursement methods.

The most innovative solutions are integrated with hospital and ambulatory-care financial and clinical systems, as mentioned earlier. This allows the organization to apply clinical analytics to financial data to measure the costs associated with the
utilization of services for particular episodes, patients or providers within the organization.

If the healthcare system is part of an ACO, this data must be combined with information from other providers to evaluate the ACO’s financial performance. The RCM solution should allow business office staff to view disparate financial systems of ACO and bundling partners. An RCM system with an open architecture is best equipped to bring these systems together.

The financial solution must be capable of tracking provider payments and IBNR against capitation revenue. The system should also be able to parse the prepayments or bundled payments to figure out how much is owed to each member of the team covered under the contract.

An advanced RCM solution can recognize the groupings of services covered by a bundled payment. Then, when the payment comes in, it can use a pricing methodology to determine how much each provider should receive. A similar approach could also be used to disburse shared savings to participating providers.

The trickiest part is billing for all of the different services that make up an episode of care when that episode extends beyond the hospital. Choosing the right revenue cycle solution will allow the hospital—if it is the contracting party—to break down the services within visits or encounters and funnel them into a separate artifact set up for billing.

Most current revenue cycle solutions lack the ability to take services from two different businesses and join them together in order to bill the bundled payment properly. Likewise, they can’t break down the payment for division among the providers. But in the future, financial systems will have to be able to do this effectively for multiple payers and, in the case of bundling, for multiple care teams. One way to approach this challenge is by using an RCM solution with a service-oriented architecture.

**Conclusion**

This is a difficult time for healthcare providers that have to prepare for healthcare reform while collecting as much as possible under the traditional reimbursement methods. A recent survey shows that about a fifth of healthcare organizations are planning to replace their current RCM solution.15

When they do so, they should consider acquiring an SOA-based solution that will give them the flexibility they need to switch gears smoothly as they move to the new business model. They should also choose a solution that increases the automation of tasks related to eligibility verification, claims preparation, account reconciliation and denial management. Finally, the best solution is one that gives hospital financial managers an easy way to tailor the application to the workflow needs of their institutions.
REFERENCES


14. Ibid.