Optimizing the Revenue Cycle With Technology and Professional Services

I’m often asked what advantages a professional services team creates in healthcare financial management. After all, sophisticated technology solutions can be found at nearly every stage in the revenue cycle to efficiently help drive cash flow. Likewise, I have the utmost respect for the hospital-based patient access and financial services team. These groups work incredibly hard on behalf of both patients and their institutions to add integrity to revenue management.

But the truth is that hospitals are staring down fiscal challenges like never before. For one, more and more self-pay patients are walking through hospital doors, placing a strain on charity programs and adding to bad debt loads. And those who have insurance are being asked to pay more for their care out-of-pocket, which is not always possible. Furthermore, today’s healthcare system is astonishingly convoluted, making it difficult for many healthcare organizations to get paid accurately for the services they offer, if at all, regardless of the internal solutions they deploy.

While I appreciate the role that fundamentally enabling technologies and dedicated financial services staff serve within hospitals and health systems, it can be difficult to keep up with constant changes with limited resources. This is why so many hospitals today are seeking to outsource many revenue cycle activities to experienced professional services teams that apply leading technology to create optimal processes. The right partner will not only be able to boost revenue for an organization, it will reduce the costs of achieving the desired result.

Emdeon is pleased to offer this white paper explaining the value of a professional services team that is highly qualified to both identify a hospital’s revenue shortcomings and institute the appropriate improvement measures. When strategically combined with the appropriate technology solutions, this approach will drive greater results and improve the overall health of the revenue cycle.

Sincerely,

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Senior Vice President, Emdeon and CEO, Chamberlin Edmonds
Introduction

They say what doesn’t kill you makes you stronger. Healthcare leaders have shown their grit in the midst of eroding margins, cash constraints, increasing numbers of self-pay patients, declining reimbursements and a host of other financial issues. But while the recent recession played a significant role in healthcare’s fiscal struggles, the industry cannot use it as a scapegoat. It’s becoming increasingly clear that, regardless of the economic climate, fundamental revenue cycle pressures will become only more acute as providers bear greater responsibility for controlling costs and elevating care quality.

Providers must respond to current and upcoming challenges by gaining control over revenue “leakage,” a politically correct term for leaving money on the table due to inadequate Revenue Cycle Management (RCM) processes, including eligibility and benefits verification, application and enrollment into government, charity care and community benefit programs; denial/underpayment management; and payer contracting activities. Given that the already complex healthcare system will become increasingly convoluted with evolving HIPAA standards, the ICD-10 conversion and healthcare reform, hospitals are looking for, and finding, a fresh approach to RCM by incorporating a robust mix of professional services, outsourced expertise working alongside revenue cycle staff, to their technology-driven revenue cycle strategy.

The most effective RCM professional services model combines highly-trained specialists with sophisticated workflow technology located on-site at hospitals. These experts are able to focus on specific revenue cycle issues with which providers historically lacked the tools or resources to adequately address. The result of this combined approach is that healthcare organizations can benefit from quicker, more accurate and increased reimbursements, which translates to enhanced profitability for the organization.
Ongoing Challenges to Revenue Cycle Optimization

Placing a strain on the revenue cycle, hospitals are currently dealing with the dual pressures of declining reimbursements from payers and increasing patient loads, particularly among the uninsured/underinsured, whose numbers remain high as the economy struggles to add jobs with commensurate health benefits. Meanwhile, patients with health insurance are responsible for greater out-of-pocket costs in terms of higher co-pays and deductibles, which have elevated self-pay balances. According to data from the Centers for Medicare and Medicaid Services (CMS), consumer payments rose nearly 50 percent between 2000 and 2010 to an all-time high of $299.7 billion.

Additionally, Medicaid expansion promises to create new challenges for healthcare providers. The Patient Protection and Affordable Care Act (PPACA), commonly known as the Affordable Care Act (ACA) includes provisions to make Medicaid funds available for nearly everyone under age 65 with a household income at or below 133 percent of the federal poverty level (which, for 2012, is equal to $14,856 for an individual and $30,656 for a family of four). Hospitals must be prepared for an influx of an estimated 16 million currently uninsured, Medicaid-eligible, but not necessarily enrolled, patients and the accompanying administrative challenges the increase poses.

Payer contracts are also becoming increasingly complex, further testing hospitals’ claims management capabilities. Claims adjudication is a multilayered, event-driven process dependent on many, often subjective, contractual provisions, including bundling edits, carve-outs, modifier rules and alternate fee schedules. With a bundling edit, for instance, a payer might reimburse 100 percent on a hip surgery but only 50 percent on follow-up procedures administered during the episode of care, claiming that it is far less costly to perform multiple services at one time. It is incumbent upon providers to gain a better understanding of the terms of their payer contracts to ensure they are maximizing their reimbursement potential.

The identification and recovery of contractual underpayments is another major challenge for providers. Depending on the complexity of contract terms, underpayments can account for a loss of three to five percent of net managed care revenues, with some hospitals experiencing much higher rates. The good news is that experts project that 69 percent of discrepancies are recoverable and 90 percent are preventable.

Finally, the conversion from ICD-9 to ICD-10 code in 2014 sets promises to increase payment complexity for hospitals. The Department of Health and Human Services (HHS) claims that conversion to ICD-10 will create a cost-savings for the collective industry in excess of $2 billion over a 15-year period by decreasing the number of rejected claims, reducing fraud, waste and abuse and helping to promote disease management efforts. But the conversion to the exponentially more complex coding system will likely be bumpy in the near term adding additional sources of leakage to the revenue cycle.
How Professional Services Can Improve RCM Processes

A patient’s encounter begins when, or even before, they arrive at the hospital. Utilizing scheduling and registration technology, providers are capturing comprehensive patient information, which helps streamline eligibility and benefits coordination. Since this data populates the patient record in the Hospital Information System (HIS) and starts the revenue cycle workflow, it’s vital for patient access staff to capture accurate demographic, financial and clinical information. Many healthcare organizations have found that even the slightest error could lead to a billing delay or outright claim denial.

Armed with this data, personnel responsible for patient access can begin a financial “triage” of the individual, designed to determine how the account will ultimately be settled. Healthcare organizations increasingly are implementing financial clearance processes that involve screening and probability-scoring of a patient to determine the most effective collection activities. Assisting in this process are credit scoring technologies and patient responsibility estimation tools that not only provide individuals with more information about the true costs for their care, but also establish a baseline so providers know beforehand what they need to collect directly from patients.

Robust technology is also essential in the billing and collections process, including initial claim submission and secondary billing. Top performing hospitals consistently utilize electronic claim submission technologies with tools to ensure claim accuracy to prevent denials and monitor the transaction until it is settled by the health plan.

Where existing revenue cycle staff and technology end, a professional services team begins as a supplemental strategy to improvement and achieving best practices. Many hospitals are exploring the importance of dedicated experts that can assist in verifying an individual’s benefits information, including the extent of coverage and a determination of the patient’s financial liability in the form of a co-pay and/or deductible.
Many patients neither have the financial means or insurance to cover a medical bill, meaning the onus is on the provider organization to determine if there are any alternative funding sources, including Medicaid or federal disability programs, which could cover a patient’s healthcare costs. This activity can be overlooked with the assumption that the patient has likely already tried to qualify for government assistance. A high percentage of self-pay patients though are simply not aware of the programs available, or lack the capabilities to complete the complex application and follow-up process.

To assist self-pay patients in need, many organizations bring in professional services staff focused on eligibility and enrollment that are well-versed in government assistance programs and dedicated to screening patients for available coverage, typically on the same day an individual is admitted to the hospital. It’s a process that ensures patients are vetted while still at the facility, which helps avoid delays associated with contacting patients after they are discharged. Those individuals who qualify are then guided through the application process, with specialists serving as patient advocates throughout the sometimes lengthy approval period.

But even after coverage has been secured and claims submitted, hospitals must understand that there is no guarantee that a claim will be paid in the right amount, or at all, for that matter. This situation can result from contractual discrepancies with health plans. For these situations as well, many hospitals are deploying professional services efforts focused on payment integrity to help identify, recover and correct underpayments. The goal is to ensure that payers are sticking to the letter of the contract to ensure the hospital gets paid accurately and in a timely fashion. Beyond underpayment recovery, healthcare organizations are utilizing professional services to strengthen their payer contract management activities. Dedicated, experienced staff can be proactive in identifying problems that lead to contractual underpayments, which not only helps to prevent future underpayments and denials but also will empower an organization to negotiate more favorable contracts.
Why Outsource the Revenue Cycle?

Unfortunately, hospitals can put a strain on their internal resources by attempting to capture revenue that statistics say they are unlikely to collect, according to the CMS Healthcare Cost Report Information System which provides online data on more than 6,000 hospitals. The most recent data, as noted by HFMA, indicates that net revenues billed by hospitals are getting harder to collect.

CMS Healthcare Cost Report Data 2006-2010

<table>
<thead>
<tr>
<th>Percentage of gross revenue written off by hospitals</th>
<th>2006</th>
<th>2010</th>
<th>Net increase (decline)</th>
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</thead>
<tbody>
<tr>
<td>Percentage of gross revenue that hospitals expected to collect</td>
<td>63.2%</td>
<td>66.9%</td>
<td>5.9%</td>
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<tr>
<td>Percentage of A/R reserved for write-off</td>
<td>36.8%</td>
<td>33.1%</td>
<td>(10.1%)</td>
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<td>Percentage of collectible A/R</td>
<td>46.1%</td>
<td>52.3%</td>
<td>13.4%</td>
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<tr>
<td>Net A/R days outstanding</td>
<td>53.9%</td>
<td>47.7%</td>
<td>(11.5%)</td>
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* Likely due to increases in gross revenue write-offs and reserves for uncollectible accounts

The takeaway is that healthcare organizations find it difficult to appropriately staff their financial services functions to perform effectively in today’s tumultuous economic climate. Furthermore, many hospitals lack the necessary training expertise to ensure that staff is meeting ongoing performance improvement standards and keeping up with the fast-pace of healthcare reform changes. Providers with high-performing revenue cycles are increasingly utilizing and effectively managing outsourcing relationships for patient access, denials management and receivables activities. By bringing in professional services staff, hospitals can focus on the delivery of quality healthcare rather than investing time and money in hiring and providing continuous training to employees.

Hospitals should consider bringing in professional services when they realize their internal efforts are exceeding the potential benefits to be gained. With individuals dedicated to a sole activity, hospitals are virtually assured of optimal performance from experts who are not only knowledgeable about complex reimbursement rules and regulations, but are also better equipped to keep up with industry changes. Many companies offering professional services for the revenue cycle also deliver staff with diverse financial and clinical expertise capable of handling medical necessity checks or reviewing medical records to assist in the claims appeals process. And depending on the nature of the contract, many of these arrangements are contingency-based, meaning a vendor only gets paid when they enroll an individual in Medicaid or recover payment from a previously denied claim.
Services to Complement Revenue Cycle Technologies

While professional services staff is vital to a healthy revenue cycle, the expertise must be coupled with advanced technologies to help hospitals address their most pressing financial challenges. Hospitals are increasingly utilizing eligibility verification technologies that gather insurance eligibility and benefits information, authorizations and pre-certifications. Some software even has the capability to determine whether a self-pay patient may qualify for Medicaid or another government assistance program. Other technologies that fit well with a professional services model are financial clearance tools that assist in credit scoring and help staff estimate the likelihood of collecting payment.

Intuitive patient responsibility estimation tools enable providers to increase revenue collection, decrease A/R days and reduce patient bad debt by delivering accurate and timely information about patient collectible amounts. And by automating front-end data collection, providers will experience fewer claim denials, increasing overall billing efficiency. Advanced solutions can even offer guidance for structuring lending arrangements and payment plans with a patient.

Additionally, with appropriate RCM technology in place, all the available patient data, including demographic and financial information, should have the ability to flow from the patient registration system to other financial platforms, such as an eligibility and enrollment system, which would replace current manual, paper-based methods for exchanging information. With patient data pre-loaded, eligibility representatives can begin their patient interactions with much more intelligence. This allows outsourced professionals to focus on helping an individual with the more complex application and follow-up activities.

Leveraging claims analysis technology, professional services staff focused on payment integrity have the ability to define a hospital’s contract terms and accurately value them with the claims submission system. Technology and service solutions provide optimal claims management opportunities for institutions that must consider dozens of variables when submitting a claim, including carve-outs, modifier rules and bundling edits. This enables providers to compare payer-determined allowed amounts against what they should expect to receive based on contract terms, a valuable tool for correcting underpayments and other contract discrepancies.
Addressing Revenue Cycle Challenges, End-to-End

With increasing regulations, new data standards, changing patient demographics and evolving reimbursement models, complexity in the healthcare revenue cycle is steadily on the rise. Healthcare providers require innovative solutions to combat these pressures and maximize the revenue cycle. But they should not expect it to come easy or with a one-pronged approach.

While healthcare organizations utilize technology solutions to help manage revenue cycle functions, including eligibility and benefits verification and denials and contract management, more and more institutions are realizing that to be the most effective, they must apply professional services along with their digital solutions. An effective combination of these components, from scheduling and patient access to claims and receivables management, will ensure hospitals are able to convert an outstanding balance into cash more quickly and efficiently.

Emdeon is the leading provider of intelligent revenue cycle solutions that combine advanced technology with highly trained professionals, enabling hospitals and health systems to maximize revenue and profitability. With growing bad debt and increasing pressure on reimbursement rates, Emdeon’s full suite of solutions and technology-enabled services help ensure healthcare businesses succeed. To learn more about how Emdeon’s complete line of technology and services can help hospitals improve the health of their revenue cycle, visit www.emdeon.com/hospitals or call 866.211.1209.

In addition, hospitals interested in finding out more information on how to best augment their revenue cycles are invited to view a webcast featuring industry experts from Gartner and Emdeon titled, “The IT Remedy for Healthcare Revenue,” at www.emdeon.com/gartner.


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