relsolution

"INSOURCING" HOSPITAL REVENUE CYCLE MANAGEMENT

Executive Summary

Hospital management is evolving and becoming increasingly complex; combining the seemingly impossible need to deliver quality affordable care in a manner that addresses the needs of the community while doing so in a way that safeguards the facility's financial performance.

The revenue cycle management (RCM) process, the life of a patient account from the time their case is opened until final payment is received, acts as the custodian to ensure a hospital's financial health. High-performance RCM that reflects best practices and yields excellent results demands systems, resources, experience, knowledge, and acumen that is too often either unrecognized by or unavailable to many facilities, large and small.

Historically, hospitals engage consultants to put out fires or provide patchwork remedies to problems in the RCM process. These efforts can yield short-term results but too often fall short of guaranteeing that best practices are followed, and they rarely guard against another cash flow challenge in the future.

Recently, in an effort to employ best practices continuously and protect against revenue and cash flow challenges, larger hospitals have started to outsource their revenue cycle operations to firms dedicated to the practice of RCM. These outsourcing decisions often mean turning complete control of the RCM process over to a company whose systems and staff are located outside the community.

Outsourcing may be an option for rural and community hospitals; however, it's important to recognize the differences between large facilities and the smaller rural and community facilities such as Critical Access Hospitals (CAH). These thousands of smaller facilities around the country may benefit from a hybrid solution that yields the extensive benefits of outsourcing, while also reflecting the unique needs of the rural and community hospital, its executives, board of directors, and the local community.

Introduction

A successful RCM process enables healthcare organizations to improve revenue cycles by reducing the number of denied claims, avoiding insurance underpayments, eliminating billing errors, improving operational efficiencies and reducing the number of days in accounts receivable (A/R). The result; improved financial health.

Regardless of size, every hospital faces the same complexities, challenges, and risks to their RCM, and subsequently, to their financial performance and health. The scope of the challenge is very nearly identical for every facility, even though the resources available to address this complexity will vary based

on size and geographic location. Rural, community, and CAHs often face substantially more risk than urban facilities.

Hospital executives face threats to their facility's financial performance on many fronts. Many of the obvious demands and influences are heaped upon facility administration through forced regulation, community profiles, and the natural evolution of healthcare delivery. **Moody's Investor Service reports that 20% of all hospitals are operating in the red, while another 63% report operating between break-even and 5% operating margins**.

Three primary outcomes from the Affordable Care Act will certainly affect RCM:

1. The number of patients with a balance after insurance (BAI) will increase
2. Hospitals will witness more complicated payment responsibilities
3. Payment methodologies will become increasingly complex

Ad hoc approaches to the development of strategies or solutions designed to correct inefficiencies, meet regulatory requirements, and implement best practices rarely address the needs of the rural or community facility in such a way as to help protect and extend the hospital's ability to deliver the quality of care demanded by their constituents.

Problem Definition

The list of challenges faced by every hospital is on the rise with little chance of abatement; complexity, scope, and risk will continue to increase, often at what seems to be an unrestrained pace.

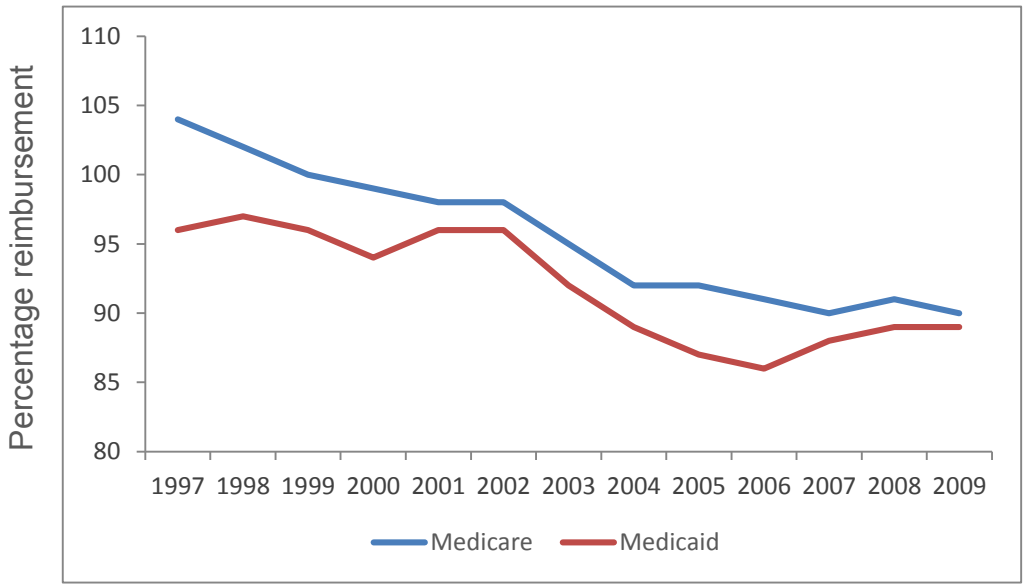
- **Self-pay is on the rise** and timely collection will become increasingly important to the hospital's financial health, while incumbent or traditional collection methodologies may not be successful. Research from the Rural Health Research and Policy Analysis Centers suggests that rural workers are less likely to have an employer that offers coverage and rural employers are more likely to offer plans with higher deductibles and higher employee cost sharing requirements.

  Self-pay and increased balance after insurance (BAI) will also increase the volume of transactions passing through the RCM. Recent McKinsey MPACT provider research suggests that volumes could increase by as much as 20% and the cost to collect would also rise – "on average, healthcare consumers pay twice as slowly as commercial payers and require more manual intervention."

  In August 2014, Fair Isaac, the firm responsible for defining FICO score rules, announced that medical related debt would no longer be a consideration in determining individual FICO scores. This decision suggests that consumer medical payments could be pushed further toward the bottom of the priority to pay scale.

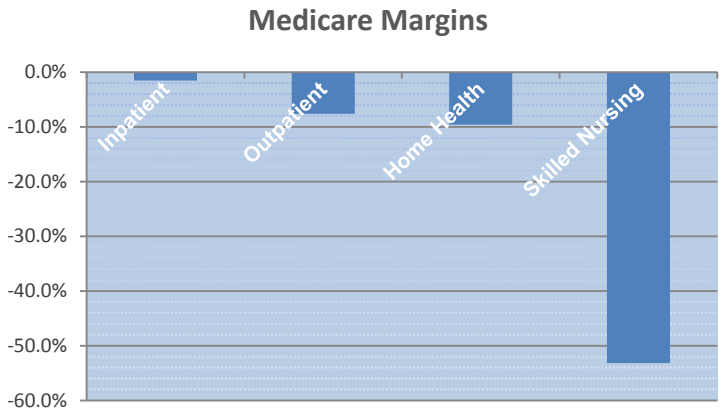
- **Reimbursement will continue to decline** with the rigorous focus on healthcare costs. The challenges may be greater for facilities located in those states where legislatures chose to forego Medicaid funds available through the Affordable Care Act. According to American Hospital Annual Survey Data, rural and community hospitals may face much bigger challenges since nearly 60 percent of rural hospital revenues come from public programs whose payments are increasingly falling short of costs. The Kaiser Commission on Medicaid and the Uninsured

forecasts Medicaid enrollment will increase by more than 30 percent in many rural communities.



American Hospital Association Annual Survey data, 1997-2009, for community hospitals

Congress created the Critical Access Hospital (CAH) program in 1997 to preserve access to health care for rural beneficiaries. Today, the CAH program permits the smallest rural hospitals to receive Medicare reimbursement at 101 percent of allowable costs, up from 100 percent of costs when the program was initiated. As of September 2010, more than half of all rural hospitals – 1,325 hospitals – converted to CAH status. Other types of rural hospitals that receive an adjusted Medicare payment include sole community hospitals, Medicare-dependent hospitals, and rural referral centers.



Source: Center for Medicare and Medicaid Services. HCRIS Database

- **Demand for capital spending will continue to increase** as best practices and regulatory mandate dictate the use of technology solutions to improve reporting, compliance, and deliver care. Internal competition for financial resources will create tension as the demand for capital

expenditure increases. The Rural Health Research Center reports that rural and CAH adoption of Electronic Medical Records (EMR), Computerized Physician Order Entry (CPOE), and Medication Administration Records (MARs) lags urban facilities by 25-45%. The scarce resources and declining reimbursement hinder a facility's ability to adopt and support hospital information technology and the ability to support and upgrade in the future, may be in doubt, placing these facilities at an immense disadvantage.

A broad study recently conducted by HIMSS Analytics, discovered that rural and community hospitals lag the broader healthcare segment in information technology expenditure as a percentage of operating costs.

	2009		2010		2011	
	Avg. %IT vs. Total Operating Expense	N	Avg. %IT vs. Total Operating Expense	N	Avg. %IT vs. Total Operating Expense	N
0-100 beds	1.92%	136	1.82%	183	1.97%	171
101-200 beds	2.72%	76	2.09%	77	2.17%	91
201-300 beds	3.40%	63	2.97%	78	2.52%	74
301-400 beds	2.82%	39	3.07%	55	2.81%	60
401-500 beds	3.12%	44	3.43%	41	3.35%	37
501-600 beds	2.88%	8	2.53%	13	3.16%	17
600+ beds	4.17%	17	2.54%	24	2.72%	25
All	2.97%	383	2.40%	471	2.39%	475

Many suppliers of healthcare technology solutions have announced their intent to focus future development on integrated platforms, signaling an end to their efforts to support stand-alone applications glued together by difficult to support interfaces and rapidly evolving programming interfaces and databases. Unfortunately, integrated platforms are expensive and often require wholesale changes to a hospital's applications and business processes.

By 2014, hospitals will need to have enhanced their EMRs to meet Stage 2 meaningful use criteria and, by 2015, Stage 3 or they will begin to face financial penalties for non-compliance. Further, demand will continue to rise to address the emergence of shared savings bundled reimbursement models, and in response to pay-for-performance initiatives from federal programs as well as private insurers. The focus on consumer/patient satisfaction in the form of pricing transparency, friendlier billing formats, on-line bill paying, self-scheduling, and pre-registration will further burden IT and hospital budgets. Finally, the complexity and evolution of healthcare will demand that even the smallest facilities begin to address the needs for business analysis, government reporting, and the need to integrate financial decision support into the RCM environment.

- **Developing, adopting, deploying, and maintaining best practices**, requires resources not readily available at every facility. Failure to capitalize on optimum practices may result in increased costs, inefficient operations, weaker RCM performance, and substantial financial challenge.
- **Federal and state regulatory activity** surrounding compliance, audit quality and practice, and financial health requires time, capital, and leadership resources that could otherwise be used to focus on RCM performance at each facility.

- **Access to the quality of human capital** (staff) required to lead and manage RCM programs based on ever-evolving best practice is often limited or unavailable. The revenue cycle is becoming more complex and requires talent that is more sophisticated. Rural communities are especially hard hit as they experience the natural "brain drain" from the migration of better-educated families to urban communities where earning potential is often better.

  Attracting and maintaining qualified RCM staff may be complicated by the overarching need to closely manage costs. According to the American Hospital Association Annual Survey data, 2011, for community hospitals, nearly one-third of all community hospitals experience negative total margins and negative operating margins, which necessarily results in pressure to reduce labor costs when demand for investment in labor and training is increasing.

  It's also no secret that consulting firms continue to offer sign-on bonuses to experienced hospital staff making the retention of trained resources at hospital salaries extremely difficult.

A Choice: Project or Partnership

Facilities may choose to continue to conduct business as usual in the face of declining revenues, longer revenue-to-cash cycles, and reductions in cash collection while facing increases in costs associated with compliance, risk management, and inflation. Such an approach could be considered a high-risk strategy for any community dependent upon their local hospital for healthcare services and jobs. Remember, hospitals are trying to manage a complex environment:

1. Smaller operating margins and escalating costs
2. Shortage of skilled resources
3. Competing priorities, including meaningful use, ICD-10, declining reimbursements, clinical documentation education
4. Continuous need to examine and optimize revenue cycle processes

It's been a common practice to hire RCM consulting services to address serious pain points during short-term engagements. Larger facilities may hire firms who look at strategy and higher-level areas of need, including accounting, compliance, and risk. The rural and community hospital market, unable to afford the costs that come with strategic, high-level consulting, has focused primarily on short-term "projects" to address critical issues like a reduction in cash collections, extended vacancies in key positions, system-related problems, coding backlog, reviewing charge capture data, and coding transitions. Rarely do these engagements represent the change catalyst required to improve performance, instill new business processes, and guarantee future performance. Too frequently, the benefits of a consulting engagement are lost and forgotten, only to be required again later.

Equally, important, project-based consulting rarely leads to the development of innovative or proven operating models that remain persistent and deliver improved efficiencies, remain scalable, and flexible as market, regulatory, and facility needs change. Transformative change requires a combination of thought leadership, in-depth knowledge of best-practice methodologies, insight into evolving operating models, and experience.

HFMA provides specific examples of best practices, which make clear that episodic or project-based consulting, may not address the need for hospitals to pursue and maintain the levels of performance required to ensure persistent financial health:

Pre-registration rate of scheduled patients	95%
Insurance verification rate	95%
Collection of co-pays prior to service	95%
Bill hold days 3-4 days post discharge	3-4 days
Late charges as % of total charges	<3%
Overall denial rate	<4%
Appeals overturned at rate	>50%

Hospital executives must be able to identify where value creation opportunities exist and in so doing, uncover the risks presented by RCM functions that appear to operate in a silo; the limited usefulness of benchmarks; and lags of more than six months in measuring performance improvement.

New Operating Models

Revenue Cycle Outsourcing (RCO)

RCO is the process of delegating the hospital's business processes of the revenue cycle to third parties or external agencies, leveraging benefits ranging from, improved cash flow and service quality to business and service innovation. In RCO, most local hospital staff becomes redundant since the providing vendor will use their own on-shore or offshore staff to perform most functions. Existing hospital systems and applications are replaced by those in use by provider, with most records and data moving offsite to the provider's hosted facility. Additionally, the facility will sideline current business processes; replaced by business processes defined by the providing vendor.

A hotly debated topic with pros and cons, outsourcing can have a direct impact on a facility's top and bottom line and has become a key component of defining how larger, successful hospitals are run.

Larger facilities cite the following benefits to outsourcing:

1. Lower operational and labor costs are among the primary reasons why hospitals choose to outsource.
2. Hospitals also choose to outsource so that they may heighten the focus on their core healthcare services while delegating time-consuming and frequently changing processes to external agencies.
3. Outsourcing enables hospitals to tap into and leverage a much broader knowledge base, having access to world class, or best-practice capabilities where the facility gains access to innovative ideas.
4. Many times, stranded with internal resource crunches, world-class facilities outsource to gain access to resources not available internally or even locally. External agencies often provide faster deployment of changes and new services.
5. By delegating responsibilities to external agencies, hospitals can disown functions that are difficult to manage and control while still realizing their benefits.
6. Outsourcing also enables hospitals to realize the benefits of re-engineering to best-practice models where cash flows and business performance improves.

Rural, community, and critical access hospitals may derive similar benefits to those shown above; however, a complete outsourcing of a business office or RCM might not fit with many unique needs and desires of facility executives and board of directors.

- While outsourcing can reduce the cost to collect, it too often overlooks the benefits of increasing yield – or increasing the amount of cash collected
- Full outsourcing unnecessarily insulates executives from understanding operational performance and reinforces the perception that RCM is a "black box" and may prohibit allocating related resources correctly
- Outsourcing too often heightens attention paid to lagging indicators of performance improvement, which are frequently more than six months old
- Outsourcing unnecessarily obsoletes a facility's investment in technology
- Jobs and employment opportunities leave the community

Managed Services, or Insourcing

Insourcing is a hybrid approach to RCM that combines the benefits of outsourcing while supporting many primary objectives of rural and community hospital executives and boards. Like RCO, the hospital's business processes of the revenue cycle are delegated to third parties or external agencies, yielding improved cash flow, better service quality, improved vendor management, and business and service innovation. Unlike RCO, local hospital staff involved in supporting RCM, are employed by the vendor, and remain at the facility. Existing hospital systems and applications are retained or even enhanced and continue to be used by the vendor providing managed services. Records and data remain onsite with the facility. The facility sidelines many existing business processes, which are replaced by best-practice models defined by the providing vendor.

- Hospital executives and board members maintain their commitment by keeping jobs in the community
- Investments in existing technology are retained and often enhanced
- Current staff are augmented with leadership steeped in experience with best practices and the unique needs of rural and community hospitals
- Greater visibility into performance and standardization in the approach used for key RCM functions can improve compliance and a facility's ability to meet regulatory and payer requirements, such as those for coding, documentation, and records management
- The partnership created between managed services and the hospital often leads to improved effectiveness (quality of work), which in turn yields improved efficiency – Best Practices
- Insourcing enables investment in culture as well as process and technology. Since local staff are retained, they remain integrated into the hospital's culture, values, and vision while benefiting from being able to share the broader perspective derived from best practices with other staff
- The partnership philosophy enabled through insourcing, can lead to the development of new processes that deliver a better service to consumers in the community

Business Benefits of Managed Services (Insourcing)

The future of hospital revenue cycle management is about increases in costs, complexity, volume, regulation, risk…and opportunity. Facilities can benefit by capitalizing on a "risk-free" hybrid approach to managed services that offers the following:

- Retention of your key technology assets
- Retention of RCM staff, now employed by your vendor
- Improved RCM performance as measured by increases in cash, resource optimization and efficiency,
- Additional, onsite leadership steeped in RCM experience and best-practice performance
- Assured compliance with federal and state regulations
- No A/R or system conversion risks
- No interruptions to cash flow
- Improved comprehensive reporting
- Guaranteed continuity and risk abatement created by a safety net of people and processes when changes occur with local staff, regulation, and recognized best practices

Call to Action

Contact re|solution to learn more about how the managed services of re|store (insourcing) can help your rural, community, or critical access hospital improve the performance the its revenue cycle.

For more information

Visit us at www.ereso.com, or call us at 1.800.355.0410

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