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The 9th annual Revenue Cycle Consortium: Sharing leading practices to boost financial performance

Scottsdale, Arizona

April 30 & May 1, 2014

Meeting report

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Contents

Background

Now in its ninth year, the Revenue Cycle Consortium (RCC)[1] is an annual gathering of revenue cycle leaders from healthcare systems across the country who come together to share information that can help them enhance their revenue cycle and customer management practices.

To aid in this, before the meeting, PwC asks participants to submit for analysis their organizations' revenue cycle performance data. PwC uses that data to create for each attendee an individualized report that benchmarks them against their colleagues. The information provides an effective segue into productive conversations about leading practices. Participants whose institutions are identified as achieving the best metric in each category are invited to present on their individual processes and procedures. These presentations stimulate thoughtful discussions about the common challenges today's revenue cycle leaders face and how they are confronting them.

Participants in the 2014 annual RCC in Scottsdale, Arizona, discussed a variety of topics, including patient enrollment challenges, price transparency, the rise of retail healthcare, the creation of a new consumer culture, the increasing number of high-deductible health plans, the implications of healthcare reform, staff training and productivity, and AR management. Lively conversations continually reminded everyone that while most revenue cycle offices face similar challenges, they adopt a variety of strategies to deal with them. By coming together, revenue cycle leaders can learn from one another's experiences and take away new strategies and solutions.

[1] Formerly the Central Business Office (CBO) Consortium

Introduction

Participants shared with the larger group the "secret sauce" behind their abilities to achieve their impressive metrics.

The life and death of the kiosk

Not very long ago, the kiosk dominated discussions about optimizing consumer relations and streamlining admissions in clinical settings. The kiosks that remain today—many less than a decade old—stand like dinosaurs collecting dust in admissions rooms crowded with patients interacting with their smart phones. "Just as the smart phone replaced the PC, mobile apps have replaced kiosks," said Dave Harris, a principal with PwC. "Now we want patients to supply their personal and insurance information before they walk through the door. We want patient access staff to determine deductibles and collect copays before admitting patients for services. Technology has given us the tools to do this, but for a variety of reasons, many of us are not there yet."

Discussions about how to maximize efficiency in an industry continually buffeted by evolving technologies, reimbursement models, regulations, and politics dominated this year's RCC. Supposedly comprehensive IT solutions, healthcare reform that aims to cover uninsured patients, and regulations meant to streamline processes have not managed to cure what ails the current revenue cycle process. The executives present discussed their frustrations regarding orchestrating collections activities in the face of these industry currents that, they agreed, portend nothing less than an industry "paradigm shift."

Many of the consortium's participants have demonstrated remarkable progress in their collections activity despite these challenges. One participant explained how his organization manages to collect nearly 3% of its net revenue in point-of-service cash payments. Another participant described how her institution lowered its net days revenue in AR to 36.6. And yet another participant talked about how his healthcare system has reduced its total billed AR aged more than 90 days to 6%.

These participants shared with the larger group the "secret sauce" behind their abilities to achieve these impressive metrics. Their presentations provided new insights and fueled lively debate that often resulted in the revelation of leading practices that can be shared throughout the industry. Such insights may be able to help the health systems represented steer clear of this decade's kiosks and, instead, identify and invest in long-term solutions.

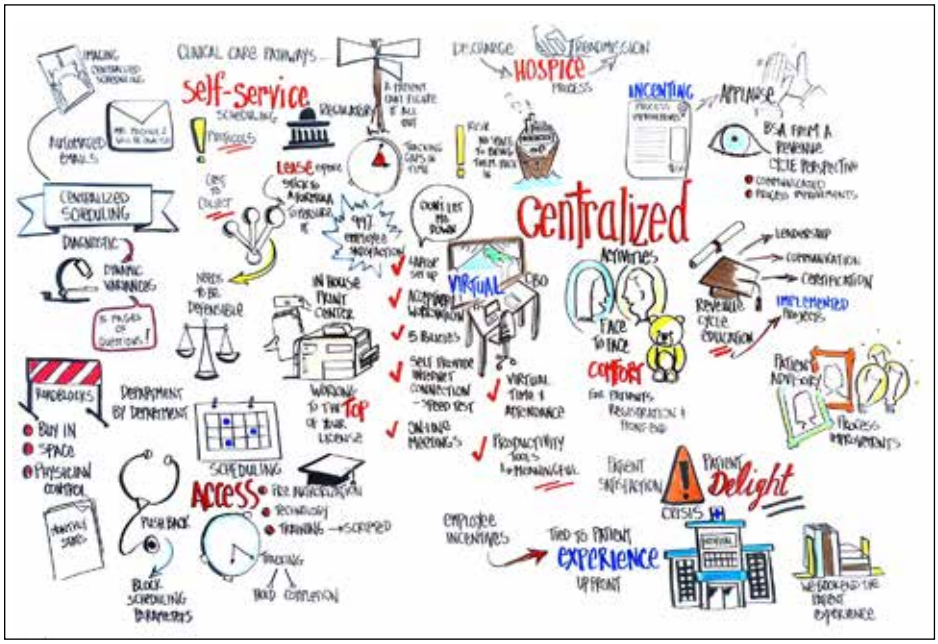
Part I
Navigating the new consumer culture

Accurate, streamlined patient enrollment continues to be a challenge in the healthcare industry. One participant observed that while providers once relied on payers to take responsibility for this task, the current convergence of payers and providers has now made enrollment the domain of the revenue cycle. Participants agreed that obtaining accurate patient information is no easy task. "Enrollment is a tough thing," said Harris. "That's why the exchange enrollment was such a disaster. They couldn't do in one year what the industry has worked on for decades."

One participant said that the industry is undergoing a paradigm shift. "Most of us started with handling inpatient admissions," he explained. "Then we concentrated on ER admissions, and now we are mostly concerned with outpatient services." The participant added that until recently his customer was the physician, since providers catered to doctors because they brought in the patients. "But now," he said, "patients are starting to shop. They want to know, 'What is close to home?' 'What can I afford?' 'What is recommended?' And we have been slow to respond."

The situation is compounded by the industry's lack of price transparency. Now that patients are paying more out of pocket for their healthcare services than ever before, price tags matter. "More employers are offering only high-deductible plans, and the exchange plans are all deductible-based," said Harris. "As a result, many patients are becoming self-pay unless they are admitted and go beyond their deductible."

Several participants remarked that they are indeed seeing an increasing number of patients call ahead for price quotes. "And from the patient's perspective, it's one size fits all," added Todd Craghead, vice president of revenue cycle at Intermountain Healthcare. "If I have to choose between a $1,000 CT scan and a $5,000 CT scan, and the dollars are coming out of my pocket, I'm going to go with the less expensive option. It's harder to meet patient expectations when they aren't clear on what they are buying."



"Today's providers need to be comfortable sharing information with patients. They need to accommodate patients with hours and processes that meet their expectations."

– Jenni Colapietro, PwC

Jenni Colapietro, a principal with PwC, observed that patients are applying what they have come to expect in other industries to the healthcare sector. The financial and retail industries in particular have made customer service a priority, and consumers expect the convenience afforded by debit cards and ATMs to follow them to other services. Based on the results of a recent PwC consumer survey, respondents said that they want from their physicians what they have come to expect from other industry sectors: "They want call centers outside of business hours," Colapietro said. "They want personalized information. They want you to know who they are and what their needs are. They want to actively participate in their care and treatment."

Colapietro noted that consumers will pursue these things with or without their physicians' assistance. The Nike Fuel Band and Fitbit have had a tremendous reception in the marketplace, with individual consumers collecting biometrics that they would ultimately like to share with their clinicians. These consumers are going online to find the physicians who they believe will most likely meet their caregiving preferences. To stand out in the marketplace, providers need to meet these new, sophisticated healthcare consumers on their own ground. Consumers know what they want, and, for a growing number of them, the costs are coming out of their own pockets. And in the age of social media, dissatisfied consumers are able to broadcast their complaints to a wide audience.

Customer relationship management (CRM) refers to the strategies, capabilities, and tactics organizations use to effectively engage and connect customer interactions across sales channels (e.g., employer, payer, and provider). It is the ability to continually leverage customer insights to expand reach, engagement, profitability, relationships, and value.

From patient to customer

In response, many players in the healthcare industry are attempting to refashion themselves into consumer-centric organizations. Nine out of ten of the global CEOs PwC polled said that they are focused on improving their customer relationship programs. And customer relationship management (CRM) is no longer solely about IT solutions: Today's providers are seeking to define their own unique customer engagement style. To what degree do they want to engage patients in their own care? What tools can they give them to do so?

Changing patient access processes can go a long way toward making the patient experience a positive one. Patients who can go online for appointment scheduling, review and select physicians, access forms and information, and obtain estimates for services prior to their appointments are much more likely to report a positive experience. "Right now, health system websites are not well organized," said Colapietro. "Patients who cannot find the information they need on one website will quickly go to another."

Several participants agreed that healthcare providers are a long way from acknowledging the power of patients as consumers. One problem, said one participant, is the word "patient." "All of the time I hear, 'We don't have customers or consumers; we have patients,'" he explained. "We need to break out of this way of thinking. We are telling those we serve that they don't know what they are talking about because they are 'only patients.' But the patient is now the customer, and the customer is in charge."

Mary Brannigan-Lowe, vice president of revenue cycle management at Western Connecticut Health Network, agreed, saying that once-passive patients are now active consumers, as evidenced by the increasing volume of calls her organization is fielding from patients asking for price quotes. "More money is coming out of their own pockets, so they are taking more of an interest in their care," said Brannigan-Lowe. "They are interested in looking at their charges; they are more educated as consumers. Even if they have full coverage, they ask a lot more questions."

Shawn Gronlund, senior director of revenue cycle services at University of Pittsburgh Medical Center (UPMC), added that his organization is likewise seeing a surge in calls to its price hotline. A few years ago, said Gronlund, the line would field about 600 calls per month. Now it averages 1,100 calls. UPMC is in the process of implementing a robust estimation tool, but currently relies on business intelligence tools to estimate costs, backed up by three full-time employees dedicated to answering calls and providing estimates.

Jim Logsdon, vice president of business office operations at Texas Health Resources (THR), added that complicating the situation is the fact that the patient is not the only one in charge: "In healthcare, the physician is in charge, the government is in charge, the payer is in charge. There are so many stakeholders that it's hard to please everyone. In the retail business, there's only the customer to please. And, unlike the healthcare business, retail companies aren't merging with one another every other day. They don't have to continually try to bring together people who are used to working in silos."

From business-to-business to business-to-consumer

Regardless, said Colapietro, the healthcare industry must begin mirroring the retail sector if it wants to cater to today's consumer. The biggest challenge, she says, is managing the necessary transformation from a business-to-business industry to a consumer-directed industry. "In the past, the healthcare industry was more focused on its internal process efficiencies than on the patient experience," said Colapietro. "Changing that mindset is hard. Today's providers need to be comfortable sharing information with patients. They need to accommodate patients with hours and processes that meet their expectations."

While the RRC participants agreed, several noted the difficulty of obtaining buy-in to monitor patient satisfaction. "I want to promote patient satisfaction with new tools, but they cost money," said Brannigan-Lowe. "How do you measure the ROI? Are these tools going to help me eliminate any staff positions? Can I reduce costs with them? Of course, they would be nice to have, but how do I quantify the benefit?" Sarah Knodel, vice president of revenue cycle in the North Texas Division of Baylor Scott and White Health, agreed. "That's one of the challenges of obtaining buy-in to purchase and implement these solutions at a time when we need to reduce costs," she said. "How can we monetize patient satisfaction?"

"We are always being asked to reduce costs," another participant added. "But how do you measure cause and effect? Why did a patient leave us and go elsewhere? Because he wasn't satisfied, or because our competitor was $200 cheaper?"

But while providers are looking for the metrics to justify new investments to promote a more consumer-friendly culture, some non-traditional players see an opening in the industry.

"Walgreens and CVS know that there is money in healthcare," said Colapietro. "They are already filling prescriptions, so they figure there's an opening to provide other patient services. The same is true for market entrants new to the healthcare industry. AT&T and Verizon are taking their share of the business. If healthcare can't adjust to a consumer culture, other industries will join the playing field."

Logsdon agreed. "Walmart is apparently on a mission to take over primary healthcare in America," he declared. "And Walgreens and CVS are right behind it." Addressing the importance of consumer satisfaction, Logsdon added, "They can do everything we haven't been able to pull off yet. My dentist texts me when I am due for an appointment. Even my vet emails me and wishes my dog a happy birthday. We are not doing that well in our industry yet, but my vet has figured it out."

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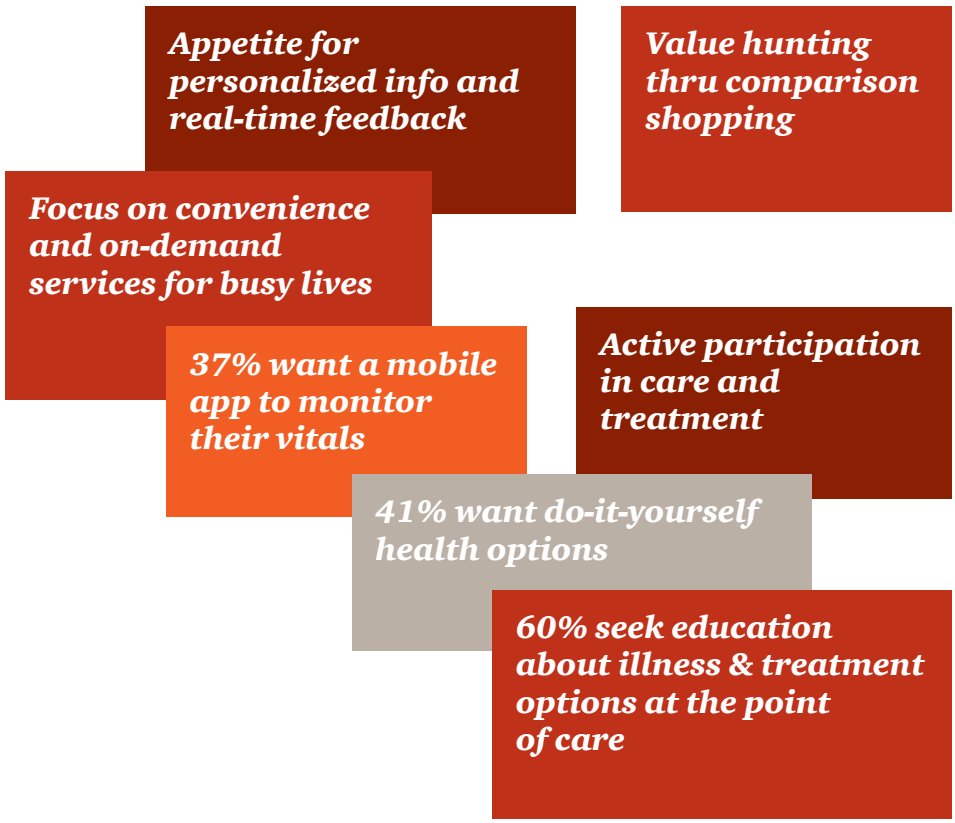
Some organizations are meeting the new competition on their own turf. Gronlund said that UPMC's outpatient services are competing directly against the retail walk-in clinics like those in Walgreens. UPMC established several urgent care centers three years ago, said Gronlund, and it has plans to expand: "If hospitals are not prepared to compete in this arena, they will lose their outpatient services."

Other healthcare systems are joining forces with their new competition. "The retail providers need our clinical expertise," said Michael Bennett, systems executive of Patient Business Services at Memorial Hermann Health System. "We are already in grocery stores; we were part owners of Redi-Clinic for a while." Bennett said that Memorial Hermann has invested in convenient care clinics with ERs incorporated, so patients can choose to see a clinician right away or wait to see one of Memorial Hermann's employed physicians in an emergency setting.

Consumers know what they want, and, for a growing number of them, the costs are coming out of their own pockets.

PwC Experience Radar Series 2013 surveyed consumers to highlight what they value relative to healthcare



Part II
Changing the way we pay

"Patients with good insurance are very valuable. We don't want them going across town. We want to keep that population extremely happy and returning to us."

– Jim Logsdon, Texas Health Resources

There's little doubt that of all the aspects of healthcare that the Affordable Care Act will touch, how we pay for care is high on, if not at the top of, the list. One of the chief ways this will happen is through the proliferation of high-deductible health plans, which were on the rise long before the exchanges made them available to millions of previously uninsured consumers.

The extent to which this growing phenomenon is affecting healthcare systems depends largely on their geography. While Bennett said that Memorial Hermann of Texas is not yet feeling the impact of the relatively small number of that state's newly insured, he expects that to change in the coming years. "It's going to be gradual," he said. "As more people sign up, it will have an impact on our point-of-service collections because patients will owe more."

Conversely, Brannigan-Lowe said that she expects increased patient volume in the immediate future as a result of Connecticut's success in encouraging large numbers of uninsured to purchase coverage on the state's exchange. "Connecticut signed up twice the number of people it anticipated," she said. "So we do expect more of our patients to have coverage."

Gronlund said he also expects increased volume at UPMC, which currently has just a small number of patients with high-deductible plans. "Western Pennsylvania has historically been a few years behind the rest of the country in terms of the number of high-deductible plans we have," he said. "As recently as 1-2 years ago, only about 4% of our patients had these types of plans." But healthcare reform is quickly catching UPMC up with the rest of the nation. "With the exchanges, the number of insured in Western Pennsylvania has jumped significantly," said Gronlund. "And most of those newly insured patients have high-deductible plans."

The influx of the newly insured brings with it a host of new challenges to the revenue cycle. "We are changing our processes in response," said Gronlund, "and focusing more on front-end collections and adequately training our staff to educate patients about what benefits they signed up for." UPMC is also in the process of shoring up its estimating tool to accurately inform newly insured patients what their liability will be. For now, said Gronlund, his team is struggling just to validate whether those claiming to be newly insured do in fact have coverage and what that coverage consists of. "It's not always a straightforward process," he said.

Several participants surmised that patients with particularly high deductibles may not make much difference to their collections. "If I have a $5,000 deductible, I might choose to take the uninsured discount of 40% if I'm nearing the end of the year and won't meet my deductible," said Craghead. "That would mean less out-of-pocket for me. The patients who are currently calling for estimates have high deductibles, and they are more astute. Healthcare exchange customers with high deductibles are not that astute yet, but over the next several years, they will become so."

Logsdon said the proliferation of high-deductible plans should spur healthcare systems to provide excellent customer service to their well-insured population, lest they go elsewhere. "Patients with good insurance are very valuable," he affirmed. "We don't want them going across town. We want to keep that population extremely happy and returning to us." With that rationale in mind, Logsdon said he is hesitant to pursue well-insured patients for their more nominal deposits: "We don't want to hassle them for $1,000. Volume is more important than ever. How do we become a kinder, gentler organization to do business with? We need to be asking for money during the pre-service functions, so that on the day of the procedure, it is all about the patients' health and healing."

Not all providers share this point of view, however. "Banner is going the other way," said Betsy Sullivan, vice president of revenue cycle at Banner Health. "Our c-suite wants to know why all of our hospitals aren't being equally aggressive with collections. They are giving our physicians more paperwork to prove that services are medically emergent. They want to know why we aren't collecting as much at some facilities as at others."

Regardless of a health system's approach, participants agreed that the rise of high-deductible plans means a corresponding increase in self-pay patients. "Self-pay has always been a challenge," said Logsdon, "and it's going to get worse. It's a big part of our evolving healthcare system."

Defining charity

Logsdon emphasized the importance of streamlining the process of accurately identifying patients for charity care. "We've practically gotten rid of our charity care paper form," he said. "Charity processes are an expense we need to reduce. We need to identify community benefit in the cheapest way possible and make it defensible. We need to know how much of our charity care is buried in bad debt. I need to quickly be able to identify those who truly cannot pay so I don't waste money trying to collect from them."

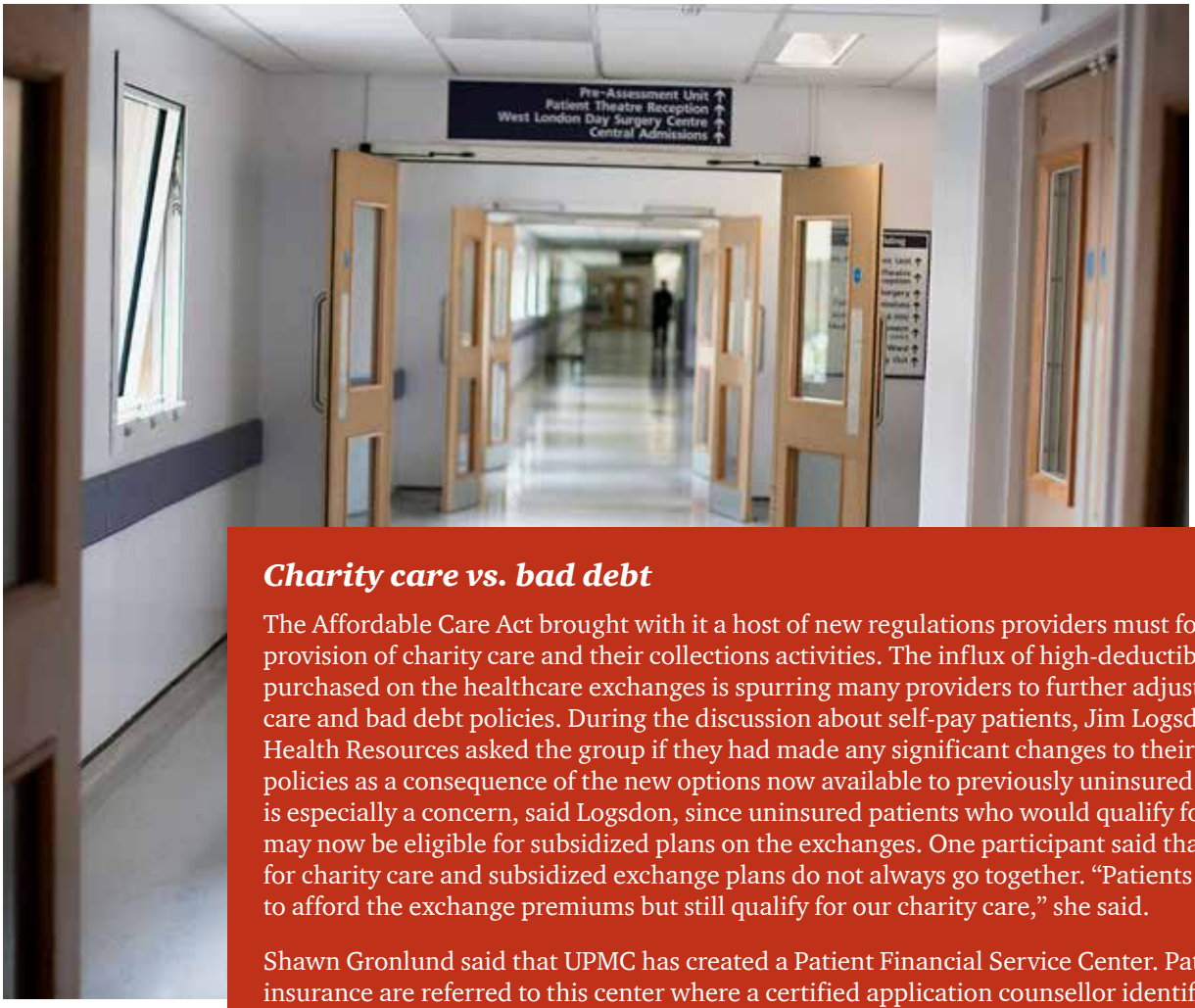
Separating charity patients from bad debt patients was a problem long before the dawn of subsidized exchange plans. In 2009, one study found that as much as 31% of providers' self-pay revenue assigned to bad debt actually met the guidelines for charity care.[2] To counteract that trend, several panelists said that they now rely on presumptive policies to qualify patients for charity care. Logsdon said THR's presumptive charity care policy has proven very effective. "In a recent audit, every single one of our presumptive charity care cases passed," he said.

Knodel said that the extensive paperwork her organization previously required of potentially indigent patients sometimes resulted in frustration and patients not returning the information necessary to qualify for charity care. "We have moved toward a simpler process that is still accurate and defensible but reduces the time it takes for a patient to apply for financial assistance and receive a determination," said Knodel. "Gone are the days of patients completing a lengthy paper application and returning extensive amounts of supporting documentation like tax returns or pay stubs. We need to allocate resources more effectively, not spend time on patients who are unable to pay. Our electronic process allows us to gather key pieces of information directly from the patient and then validate that information against third-party sources to make an efficient and accurate determination. We have automated the determination, adjustment posting, and imaging processes associated with our financial assistance process."

But one participant expressed concern that his organization's efficient charity determination processes may in fact drive indigent patients into charity care rather than to the exchanges. "One patient told me he would rather apply with us for charity care because our process is so much easier than applying for exchange plans," said the participant. "We don't want to become the victims of our own success."

In 2009, one study found that as much as 31% of providers' self-pay revenue assigned to bad debt actually met the guidelines for charity care.

[2] "Study: 31 percent of patient bad debt misclassified, should be charity," Healthcare Finance News. March 26, 2009. (http://www.healthcarefinancenews.com/news/study-31-percent-patient-bad-debt-misclassified-should-be-charity) accessed May 21, 2014.



Charity care vs. bad debt

The Affordable Care Act brought with it a host of new regulations providers must follow in their provision of charity care and their collections activities. The influx of high-deductible plans purchased on the healthcare exchanges is spurring many providers to further adjust their charity care and bad debt policies. During the discussion about self-pay patients, Jim Logsdon of Texas Health Resources asked the group if they had made any significant changes to their charity care policies as a consequence of the new options now available to previously uninsured patients. This is especially a concern, said Logsdon, since uninsured patients who would qualify for charity care may now be eligible for subsidized plans on the exchanges. One participant said that qualification for charity care and subsidized exchange plans do not always go together. "Patients may not be able to afford the exchange premiums but still qualify for our charity care," she said.

Shawn Gronlund said that UPMC has created a Patient Financial Service Center. Patients with no insurance are referred to this center where a certified application counsellor identifies patients who qualify for exchange plans or government programs. These counsellors assist the patients with the application process. New processes at UPMC also put more emphasis on qualifying self-pay patients for charity care, rather than writing their services off as bad debt.

Mary Brannigan-Lowe at Western Connecticut Health Network said that her institution's centralization of its registration, insurance verification, scheduling, revenue integrity, and financial counseling processes has gone a long way toward distinguishing bad debt patients from charity patients. "Weekly meetings between our collection supervisor and financial counseling supervisor maintain the integrity of our accounts receivable and ensure all avenues of collection have been exhausted," she said.

> ***"We need to allocate resources more effectively, not spend time on patients who are unable to pay."***
>
> *– Sarah Knodel, Baylor Scott and White Health*

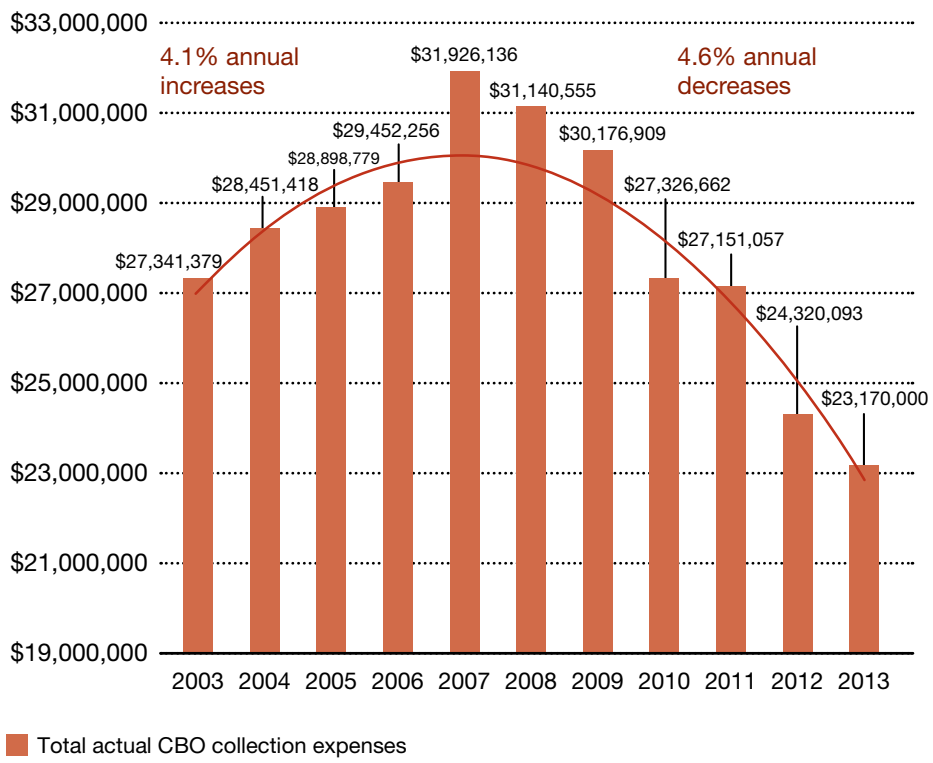
Part III
Maintaining patient satisfaction and staff productivity

The success of a health system's revenue cycle is not measured by the number of claims collected on alone. Revenue cycle staff interact with patients every day, and the impression those staff members make can go a long way toward increasing patient satisfaction—and repeat business. "We are the bookends of the patient experience," said Logsdon. "We are the first and last people patients interact with, and in many cases, that interaction follows them when they return home."

Logsdon said that, not too long ago, his patient access group was weighing down patient satisfaction scores within his health system as a whole. "We were at 17% for patient satisfaction in the admission process," he said. Logsdon gathered his managers to brainstorm solutions to the poor customer service, and they came up with 17 projects aimed at increasing patient satisfaction that Logsdon subsequently piloted. Among those projects was his idea to tie his employees' cash incentives to patient satisfaction scores rather than the amount of money staff members collect.

The program is simple. Registrars are incentivized based on the results of Press Ganey scores for patient satisfaction. Incentive payments are paid quarterly based on whether or not an employee achieves the 75th or 90th percentile within the registration suite of question on the Press Ganey survey. Since the implementation of the program, almost all THR hospitals have ranked at least in the 75th percentile, and a few are in the 90th percentile. "Incentives must be aligned to improve the patient experience," Logsdon affirmed.

Texas Health Resources reduced its collections expenses considerably after tying employee incentive payments to patient satisfaction scores



Logsdon said this is a deviation from the way in which THR has historically determined incentives, and from the way the majority of health systems reward their employees today. "Typically in registration, incentives are tied to quality or productivity or cash collections," Logsdon explained. "Rarely, if ever, and possibly never, have they been tied to patient satisfaction scores. Doing this will promote customer service in an industry that is becoming increasingly sensitive to the needs of the patient."

Logsdon said his patient access employees can earn up to $400 a quarter and $1,600 a year based on patient satisfaction scores. He added that the investment is small, given that a percentage of Medicare reimbursement is now tied to patient satisfaction scores. "Value-based purchasing will more than pay for it," he said. "What we pay for this program is dwarfed by the percentage of Medicare payments we stand to lose with poor patient satisfaction scores."

Identifying the right motivation

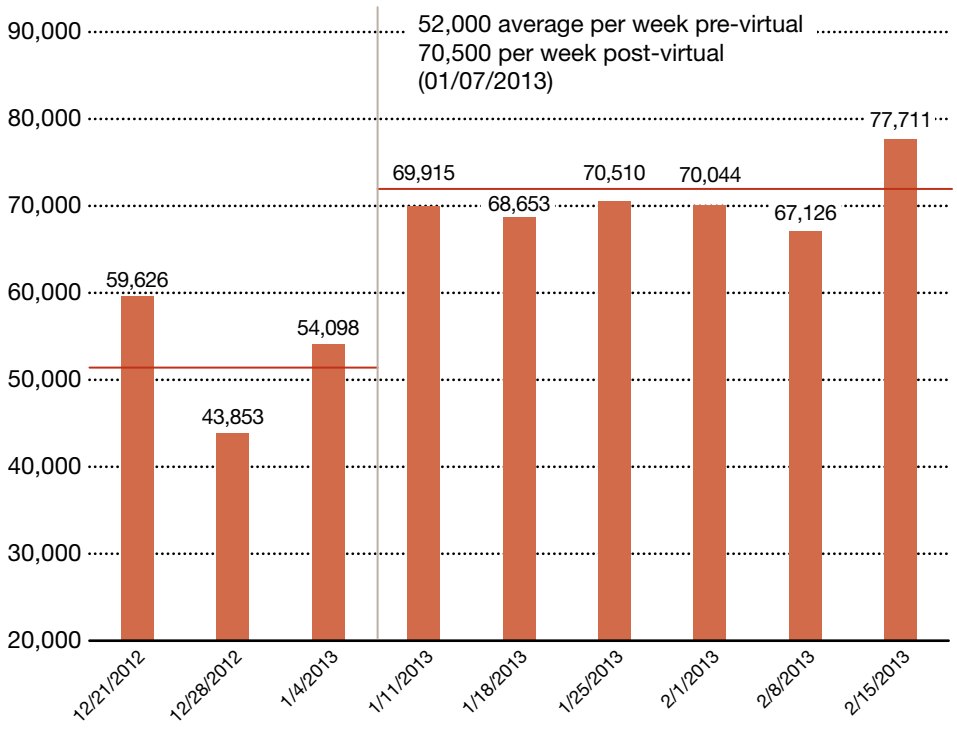
Logsdon said the transformation of his CBO into a virtual office has also promoted staff satisfaction. With most staff now working from home four days a week, both productivity and staff morale are higher than ever before. "We are in the 99th percentile nationwide in our Press Ganey CBO employee satisfaction scores," said Logsdon, adding that turnover has also decreased—from 9% before the transformation to below 6% now.

Having his employees work from home has also resulted in significantly increased productivity for Logsdon's office. Whereas his team averaged 52,000 accounts worked each week before transitioning to virtual offices, they now work an average of 70,500 accounts each week as a result of improved productivity. The reduction in Logsdon's real estate needs has had another bottom-line effect: THR's CBO is saving $760K annually by eliminating its need for office space.

Gronlund of UPMC says that his CBO has likewise adopted a partial virtual model in which staff have the option of working from home a couple of days a week. He said that staff have increased their productivity as a result of being less distracted and more focused. The CBO's collections system tracks employee productivity throughout the day: If an individual's system remains idle for 20 minutes, managers are alerted.

"Staff performance reports provide our management team with daily and weekly views of staff productivity," said Gronlund. "We are very big on providing staff real-time, meaningful feedback on their performance. We share with them their scores on their productivity, quality, and outcomes. They have a scale by which they are judged, and they know how far away they are from their targets. There should be no surprises when they meet with their supervisors."

Total number of accounts worked at Texas Health Resources before and after implementation of virtual CBO



Bennett of Hermann Memorial says that cash payments are the most reliable motivator in his CBO. "Monetary goals are publicized and updated daily to show employees where they stand," he explained. "The incentives are based on quarterly results, but they are paid out annually. We don't want one bad month to demotivate an employee for the rest of the year. And a $50 check doesn't have the same effect as a $500 check." Bennett's incentive bonuses range from $800 to $6,000, depending on the employee's level.

Conversely, Brannigan-Lowe of Western Connecticut Health Network said that the incentives offered by her office are not financial. Instead, the quality of employee performance is part of their annual evaluation, which determines any pay increases. Brannigan-Lowe says that her office rewards employee productivity throughout the year with parties that celebrate their mutual successes.

She emphasizes that one of the principle ways her office ensures quality work is to hire the right employees to begin with: "We have put a lot of energy into making sure we are hiring the right people for the right job," she said. "Our interview process is extensive. We now require college degrees to ensure we have analytical thinkers. They are more likely to be able to maneuver the intricacies of today's reimbursement process. It's made a noticeable difference."

Training for success

Of course, once a hiring decision has been made, an employee must be well trained in revenue cycle processes and procedures in order to be effective. Participants agreed that this can be a critical process that can make or break new staff. Western Connecticut requires employees to attend a four-day training session, after which they are shadowed for a period of time. Continuing education is offered to help staff refresh their skills, and customer service classes take place on a regular basis.

"In our initial training, we emphasize the front end rather than the back end," said Brannigan-Lowe. "We start with scheduling, and we teach them how to determine medical necessity and how to decode insurance information. We make sure they understand very clearly what their responsibilities are."

Gronlund said that UPMC employs a team of five to train new hires and maintain continuing education efforts. New employees undergo orientation that includes a week-long course on insurance concepts, core patient accounting systems, and specialty areas. While the core classes take place in classrooms, ongoing training is Web-based.

Bennett says that he personally takes charge of training new hires on Memorial Hermann's systems. Part of the orientation is a two-day interactive competency class. Bennett said that while the class was initially held after candidates were hired, passing it is now a condition of employment. During the class, candidates take turns playing the patient during role-playing exercises. "I've included scripted dialogue in the exercises to try to trip them up," said Bennett. Other orientation classes include an entire class just on dealing with exchange patients. "We aim to have them ready for everything when they begin work."

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>
> *– Shawn Gronlund, UPMC*

Part IV
Case studies: AR management leading practices

UPMC: Home-grown AR solution paves way to collections success

PwC's collection of participants' revenue cycle metrics revealed that several of the health systems represented had achieved significant success in multiple collections areas. Shawn Gronlund of UPMC shared some remarkable metrics that illustrated the effectiveness of the improvements the UPMC CBO has instituted. During the past decade, UPMC has reduced its percentage of AR days over 90 from 31% to 6.2%, reduced its percentage of denials from 5.2% to 0.8%, and reduced its self-pay balance from $114 million to $77 million. At the same time, the health system reduced its number of CBO FTEs from 475 to 363.

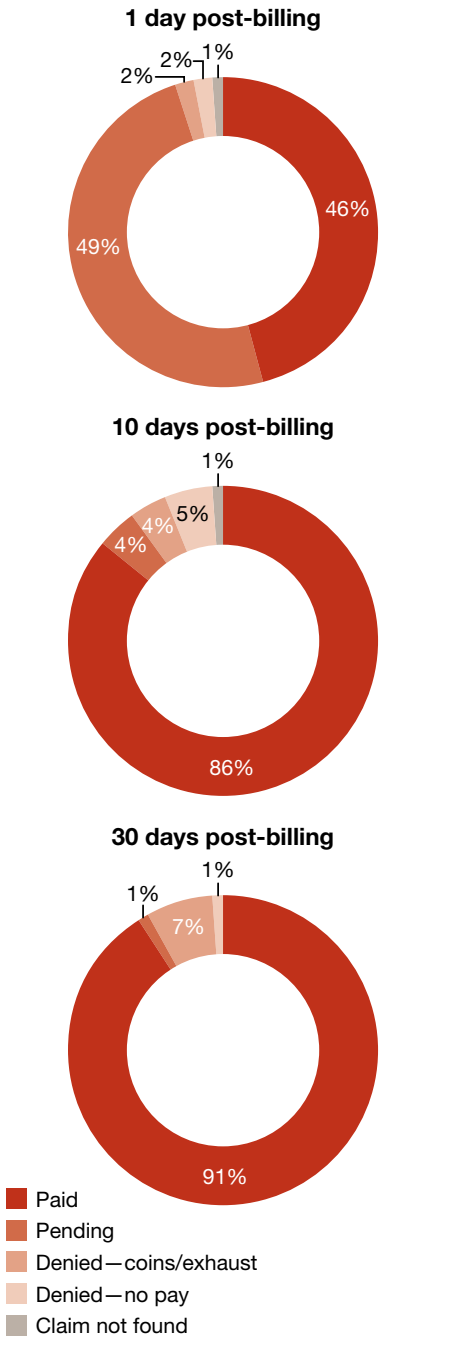
Gronlund said UPMC was spurred to make these changes by a period of significant expansion that left it with multiple inefficient systems. "We had acquired or converted 10 hospitals in the past 12 years," said Gronlund. "As a result, we had a lot of inefficient AR systems. We had to change fundamentally to be able to handle that influx."

Gronlund said the organizational goal was to manage all of UPMC's AR on a single platform. But after looking at the middleware vendors on the market, UPMC did not find a good fit for its institution. "So we decided to build our own," said Gronlund. Today, UPMC's self-made system can connect to any underlying patient accounting system. It works so well, in fact, that UPMC now sells its Ovation Revenue Cycle Solutions to other organizations looking for their own middleware systems.

Gronlund credits UPMC's home-grown solution with much of the CBO's collections success. Rather than relying on the industry's traditional denial management process, UPMC's Web-based system automatically queries individual account status as early as one day post-billing, giving staff a significant jump on denial management. This allows the CBO to aim for account resolution within 30 days, rather than the industry's 90-day standard. UMPC subsequently enjoys a much lower number of aged AR than other providers.

By using its proprietary middleware to automate its claim status workflow, Gronlund says that the UPMC CBO now only needs to touch approximately 9% of all accounts, compared with the 25%-30% touch rate that existed before UPMC created its own automated account follow-up system. The workflow automation enables UPMC to retain a reduced number of CBO staff to work claims. "The Web-based system automates many tasks and saves staff a tremendous amount of time," said Gronlund. "We have consequently been able to significantly reduce our number of FTEs."

Claim status of UPMC's top four payers after implementation of workflow automation



Western Connecticut Health Network: Centralized scheduling leads to improved collections

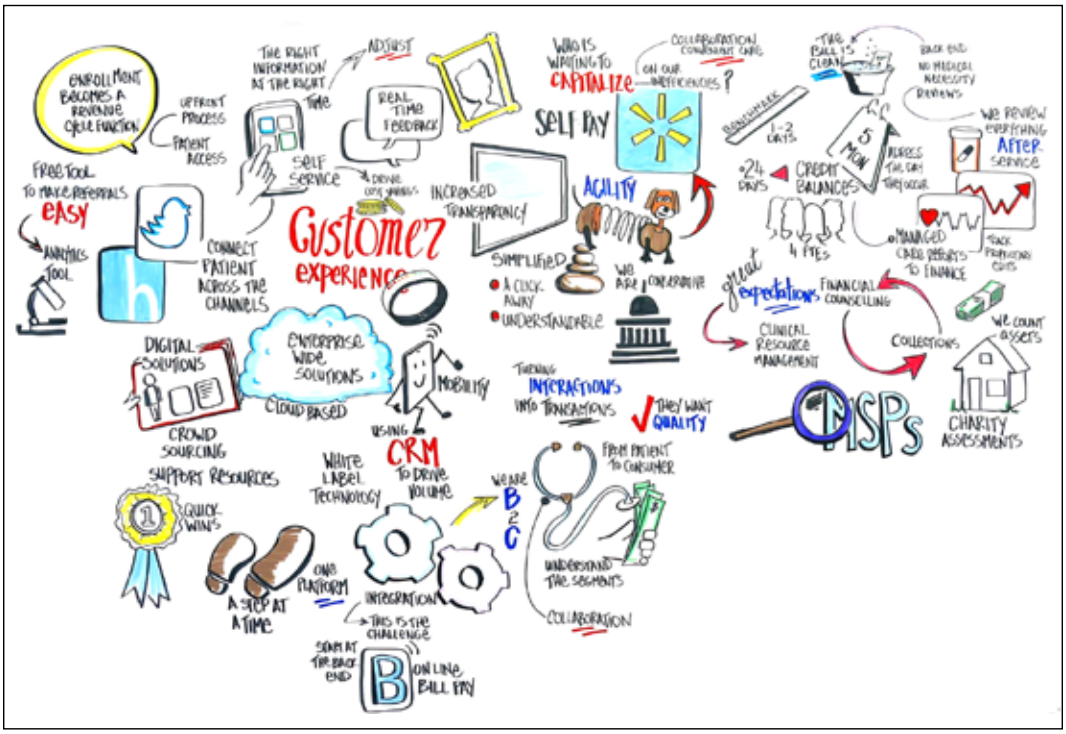
Western Connecticut Health Network was also distinguished among its peers for its low number of aged AR. (Only 1.4% of its Medicare, Medicaid, and Medicaid Managed Care accounts are aged more than 90 days.) Western Connecticut also ranked low in the credit balance days metric (0.3 days). Brannigan-Lowe illustrated the results of those metrics when she revealed that Western Connecticut was able to reduce its AR aged more than 90 days in its Danbury hospital from 26% to 14.3% within seven years. The health system was also able to reduce its AR aged more than 90 days in its New Milford hospital from 29% to 14.3% within three years.

Brannigan-Lowe credits Western Connecticut's centralized scheduling and insurance verification services with consistently ensuring that patient data is accurate and medical necessity is documented. She says centralized scheduling has been a significant reason the health system has been able to achieve some of its more impressive benchmarks.

"Once we established centralized scheduling, we closed the loop between our financial counseling department and our collections department," said Brannigan-Lowe. "Our supervisor of financial counseling works with collections on a weekly basis. Our financial counselors see 99% of our in-house self-pay patients and interview each one of them or their families. They also fully support our physician groups. We focus on getting it right the first time by talking to the patient at the beginning." She adds that Western Connecticut links accountability for AR aging to employees' annual performance, thereby aligning staff goals with organizational initiatives.

Regarding Western Connecticut's dramatic drop in commercial credits, Brannigan-Lowe says that the health system takes the same approach to credits as it does to debits. "Credits are as important to us as debits," she said. "We take them very seriously. We created a payment review team that meets monthly to discuss payer issues and overpayments. It includes representatives from patient financial services, finance, and managed care departments. Our contract management system identifies payment errors and discrepancies, and all credit balances are worked as they are created."

> ***"Credits are as important to us as debits. We take them very seriously."***
>
> *– Mary Brannigan-Lowe, Western Connecticut Health Network*



Memorial Hermann: Proprietary estimation tool increases cash payments

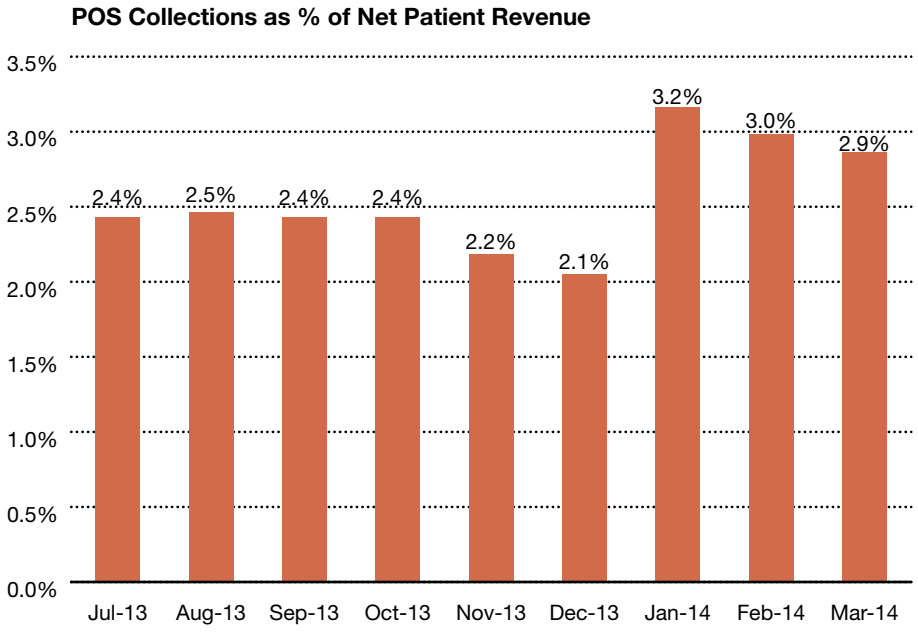
Asked how Memorial Hermann manages to collect nearly 3% of its net revenue in point-of-service cash payments, Bennett credits the extent to which his institution concentrates on its patient access operations. "We put a lot of emphasis on service line outpatient copays," he explained. "We are now able to better estimate how much patients will owe for the services they come in for. We want to touch every account before it reaches the business office."

Bennett said Memorial Hermann's in-house, self-built estimation tool is a big reason his department has had significant success in its front-end collections. "It works as well as the information that is put into it," said Bennett. "It is 100% accurate if the information the staff inputs is 100% accurate." To enhance the accuracy of the information employees have to work with, Bennett is looking into implementing another system that will better incorporate information about deductibles and copays from a wider array of insurance companies. "That's better than each clerk trying to wade through insurance small print to determine what each patient owes," he said.

Bennett also credits his POS collections success to effective employee training. A two-day interactive class dedicated to upfront collections incorporates role-playing exercises in which new employees have the opportunity to put themselves in the shoes of the patients they will be serving. Potential employees must demonstrate competency in this class's concepts to be officially hired and gain access to Memorial Hermann's patient accounting system. Bennett said that monthly monetary performance incentives maintain employee performance throughout the year.

> ***"We are now able to better estimate how much patients will owe for the services they come in for. We want to touch every account before it reaches the business office."***
>
> *– Michael Bennett, Memorial Hermann Health System*

Memorial Hermann's point-of-service cash payments to net revenue



Final thoughts

Today's revenue cycle executives are seeing their industry undergo tremendous change. The age of healthcare reform, high-deductible health plans, and patient engagement has ushered in a demand for price transparency, customer service, and a previously unseen consumer activism. Patients who had unquestionably accepted their healthcare charges—which were paid nearly in full by plans that charged nominal copays—are a phenomenon of the past. In their place are patients who bear a significant amount of their healthcare charges, and they want to know what they are paying for. Revenue cycle offices that cannot meet patient expectations risk losing them to new market entrants that have a proven history of maintaining customer satisfaction.

But, depending on how you react to it, that news is far from bad. Healthcare organizations that have answered the demand for enhanced customer service and increased transparency have emerged as industry leaders. Consortium participants that distinguished themselves with excellent metrics in areas such as cash collections and days in AR shared with the group innovative processes that have allowed them to thrive despite challenging economic times. Through a combination of excellent customer relations, effective staff motivation, and efficient charity care policies, these organizations have managed to both increase collections and decrease expenses.

The annual Revenue Cycle Consortium gives participants the opportunity to learn from industry pioneers and share leading practices to the benefit of everyone assembled. "I believe the consortium is one of the most valuable conferences I attend," said Betsy Sullivan, vice president of revenue cycle at Banner Health. "Being able to sit with my peers from around the country and learn what their teams are doing to improve the revenue cycle process is extremely helpful. Meeting folks who I can contact with questions and to ask for ideas is also a plus." As the consortium enters its tenth year in 2015, there is no doubt that the ideas will continue to flow.

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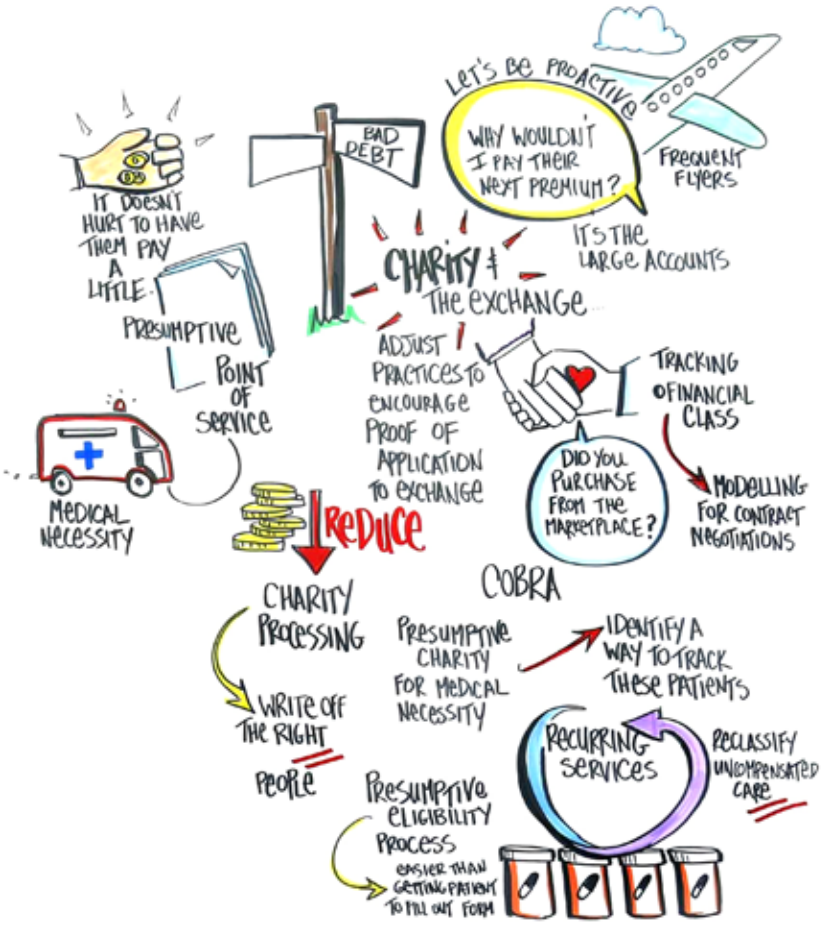

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