



Engaging Physicians & Practice Staff in Revenue Cycle Management A Case Study

All comments are based on the personal experience of John R. Thomas and do not represent Optum, UHC, UHG or its subsidiaries.

Challenges abound in a rapidly-changing healthcare environment



A multitude of factors compromise revenue cycle management

Health care changes are bringing both new pressures and new partners to respond the shifting landscape.

INTERNAL

- Fragmentation of processes
- Misalignment between front-end clinic and back-end RCM
- Growing importance of patient preference



EXTERNAL

- Declining reimbursement
- Care organization accountability
- Increased patient responsibility

Implication

Holistically addressing patients, physicians and practices together is the key to unlocking growth

Why revenue cycle management as a topic?



High cost portion of the health care cycle



Multiple payment sources, amounts and timing



Hard to define the total cost of the RCM



Becomes more complex annually



“Thousand Points of Failure”



Historically a focus on the back-office function



Growing gaps in yield, revenue recognition, bad debt accruals and effective RCM metrics



A way to avoid bad debt accrual is to write everything off

20 years of experience has taught us best practices

Waiting for A SOLUTION is not going to work

- Complexities of RCM will continue to increase in terms of payments, technology and patient dissatisfaction
- To know what you are supposed to be paid is a lifelong exercise
- Back office functions do not create data....they only respond to front end data at a very high cost
- New technology allows bad processes to make errors more rapidly



KEY OBJECTIVE: NO A/R FOLLOW-UP IS NECESSARY

Effective revenue cycle management is a front office function

Inadequate planning and preparation can lead to poor performance in physician billing

PREVENTION



.....
An ounce of prevention is worth a pound of cure

FOCUS



.....
Focus should be on improving front-end processes:

- Maximize first-pass “clean claims” rate and minimize the amount of denials

GOALS



.....
The goal is to avoid A/R altogether

Become a retail health care delivery champion

The Solution



- The health of your “store” depends on a clear vision
 - Physician & staff engagement is vital
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- Become best-in-class
 - Training, benchmarks and processes to improve RCM
-



- Look at patients as consumers
 - Technology is driving *consumer* habits

The health of your store depends on a clear vision

Take care of your store



Define a clear vision for what you are doing

- A clear vision identifies direction and purpose
- A clear vision inspires enthusiasm and encourages commitment

Reduce turnover by engaging your staff

- Compensation
- Involve them in the financial conversations
- Improve processes and workflows
 - Make their lives easier
- Schedule templating is the most important



Provide knowledge of capabilities and tools to be successful

Become best-in-class



1

**DOS :
DOCE**
2 days
or less

*Reduce
entry time*

2

**Un-
reconciled
visits**
.5% or less

*Reconcile
all visits*

3

**Pre-bill
reject rates**
4% or less

*Decrease
pre-bill
rejections*

4

**First pass
denial rate**
10% or less

*Minimize
denial rates*

5

**Pass
through
rates**
3% or less

*Pre-
determine
payment
responsibility*

RCM is a front-end process. Period.



✓ Invest in training the team at the “store”

- Time of service collections
- Life cycle of a claim
- Financial reconciliation



✓ Establish and measure benchmarks

- Five Key Metrics™
- Set daily expectations of key metrics for the “store” manager
- Award financial incentives quarterly

Treating patients as consumers is a growing strategy

Look at patients as consumers



Patient Engagement

- Drive personalized strategy
- Communication touchpoints that promote positive patient behavior
- Targeted outreach



Patient Experience

- Communication preferences
- Satisfaction: interactions, observations and opinions



Patient Access

- Predictive and advanced access modeling
- Patient expectations
- Online scheduling

Case study research in revenue cycle management

Health System 1



Midwest territory



More than 200 locations

including hospitals, physician groups, clinics, primary care centers, specialty institutes and home health agencies



One consolidated health group with 250 practices



Mix of primary care and specialty providers

The situation: Expansion and growing pains



Expansion

- State program started in response to ACA provided coverage to over 500,000 residents
- The state's largest health system rapidly expanded to meet these growing needs especially in underserved areas
- Rapid health system growth challenged the employed providers to align differently



Turnaround

- Health system started a revenue cycle turnaround project to reduce losses and allow for continued growth to care for patients



Collaboration

- Health system leadership worked with internal and external partners to accelerate growth
- Leadership worked with our practice support team to find solutions

The solution: Collaboration and implementation of practice support tools



Change Agents

Side-by-side evaluation and streamlining

- Members of the practice support teams met routinely with the different practices to review data and streamline processes
- Our staff listened to the region's uniqueness and helped change the way employees worked for sustained improvements



Best Practices

Clinic best practices adopted

- Health system adopted the best practice to schedule referral appointments so that benefits can be verified and pre-authorizations were obtained
- Patients also followed through with care and knew insurance would cover their services



Global Support

24x7x365 support

- Our global support allowed health system to handle increased patient call volumes and the global model allowed for routine revenue cycle tasks to be seamlessly so health system experts could handle more complex issues















Do It Right Committee

Driving accountability and collaboration

- Do It Right Committee established between market leadership and external partners for collaborative best practice development and implementation

Tools to manage every facet of your organization's revenue cycle

Tools and Initiatives Structure

Leadership	Front Office	Reporting	Assessment & Communication
 Governance Structures	 Daily tracker-amount collected	 TOS/VOB readiness checklist	 Financial and Operational Practice Assessments
 Dyad Leadership	 Time of service	 Piloted patient estimator tool	 Surveys
 Do It Right Committee	 Contractual rates updated <i>(potential pick-up of \$1.1 million)</i>	 Monthly coding denial report provided to leaders to identify trends and impact	 Communication Plan

Results

\$3M

\$3 million improvement in net patient service revenue

\$1.4M

\$1.4 million time of service collection increase

30%

30% improvement in AR days – reduced from 75 to less than 52 days

\$1.1M

\$1.1 million from additional meaningful use from providers

15%

15% reduction in AR and 30% increase in payments

\$20M

\$20M impact on EBITDA

\$1.7M

\$1.7 million from improved preventable denials with first-pass denials now 7%

45%

45% reduction in pre-authorization denials in the first 8 months



Thank you

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