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
The Solution

• The health of your “store” depends on a clear vision
  – Physician & staff engagement is vital

• 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

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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

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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**

<table>
<thead>
<tr>
<th>Health System 1</th>
<th>Midwest territory</th>
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<tbody>
<tr>
<td>More than 200 locations</td>
<td>Including hospitals, physician groups, clinics, primary care centers, specialty</td>
</tr>
<tr>
<td></td>
<td>institutes and home health agencies</td>
</tr>
<tr>
<td>One consolidated health group with 250 practices</td>
<td>Mix of primary care and specialty providers</td>
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The situation: Expansion and growing pains

<table>
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<tr>
<th>Expansion</th>
<th>Turnaround</th>
<th>Collaboration</th>
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</table>
| • 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 | • Health system started a revenue cycle turnaround project to reduce losses and allow for continued growth to care for patients | • 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 listed 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

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

- $3 million improvement in net patient service revenue
- $1.4 million time of service collection increase
- 30% improvement in AR days – reduced from 75 to less than 52 days
- $1.1 million from additional meaningful use from providers
- 15% reduction in AR and 30% increase in payments
- $20M impact on EBITDA
- $1.7 million from improved preventable denials with first-pass denials now 7%
- 45% reduction in pre-authorization denials in the first 8 months

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Thank you

John R. Thomas
Chief Executive Officer
MedSynergies, Inc.
972-791-1224
jthomas@medsynergies.com