



# Optimizing Revenue Cycle Performance In The Evolving Healthcare Landscape

**Healthcare Providers Face Unprecedented Challenges** 

The healthcare industry is facing some of its biggest challenges in recent history, creating a difficult environment for hospitals and physician practices. Providers are struggling to find survival strategies that can deliver long-term financial viability as they confront a host of costly, complex issues. Reduced reimbursements and financial pressures continue to plague the industry. Meanwhile, the regulatory environment grows more complicated every day, as providers are flooded with more rules and guidelines from federal and state levels related to ICD-10, drug pricing, Meaningful Use, and the Affordable Care Act, as well as privacy and security.

Providers must also adapt to the demands of consumer-driven healthcare to remain competitive, responding to patients wanting online access to their medical records and self-service tools to help them manage their own health. Consumers are also becoming more price/value conscious due to high-deductible health plans that have dramatically increased in number under the Affordable Care Act.

Other challenges also exist, including: A healthcare landscape littered with disparate systems, new EMR implementations, the ICD-10 transition, outdated technologies, and new evolving performance-based payment models. Given this endless list of formidable challenges, it is imperative that healthcare organizations maximize every revenue opportunity while controlling costs to help ensure their ongoing ability to respond to the changing environment.

#### **Today's RCM Tools Can't Meet Tomorrow's Demands**

While there are many uncertainties confronting healthcare organizations, one thing is certain: The revenue cycle systems that have been in place the past several decades cannot meet the demands of the future. Industry experts have sounded the alarm that current RCM tools are ill-suited to handle the payment reform that is on the horizon,<sup>2</sup> and revenue cycle management has become a hot topic in the industry.

According to some estimates, the IT systems that support revenue cycle operations in many organizations today were built in the '80s or '90s, and many even before then. Over the past several decades, they have been fine-tuned and modified to optimize performance for commercial and government accounts, with some new adjustments made for patient responsibility.<sup>3</sup> Obviously these systems are nearing the end of their life cycle. Additionally, they are not designed to effectively deal with the looming revenue cycle shifts that providers are

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facing. As accountable care organizations and value-based payment models come to the forefront, industry leaders are acknowledging that "most RCM systems aren't well-poised for a future where healthcare is rewarded for quality, not for volume."

High-deductible insurance plans are also driving changes in the RCM process that will require technology updates. A decade ago, hospitals only collected 5 to 10 percent of their revenue from patients, but recent estimates indicate the percentage has shifted upwards to 30 or 35 percent, due to more people choosing high-deductible health plans under Obamacare. This surge in self-pay has contributed significantly to

increases in bad debt write-offs<sup>6</sup> and is a cause for concern, as some analysts have predicted a 300 percent increase in uncompensated care over the next five years.<sup>7</sup>

These growing numbers illustrate the need to mitigate bad debt risk—especially that emanating from out-of-pocket insured patients—by shifting more revenue collection activity to the front-end of the revenue process, before or at the time of care, which in turn will necessitate upgrades in RCM systems in the near future.

A recent survey on revenue cycle management reported that "healthcare is being pushed to a 90 percent adoption rate of value-based reimbursements by the end of the decade" and that hospitals are "increasingly attuned to the need for forward-looking revenue cycle management technology."<sup>8</sup>

#### Revenue Cycle Optimization Requires An Integrated End-To-End Process

To achieve revenue cycle optimization, it is critical to understand the importance of a fully integrated front-to-backend approach, rather than a series of unconnected steps. A team approach should be implemented that embraces all operational areas that impact revenue. Effective financial management involves understanding each of these key areas and the role it plays in efficient revenue cycle management.

To optimize the entire spectrum of financial performance in the new value-based environment, four key performance areas should be addressed and integrated into a seamless flow:

#### √ Health Information Management (HIM)

The important role that Health Information Management plays in revenue optimization cannot be overstated, as HIM departments are the critical link between clinical documentation and revenue cycle. Since around 90 percent of all denials are preventable, <sup>9</sup> a detailed assessment and reengineering of HIM processes based on proven best practices, benchmarks and metrics can yield significant results. Providers should strive to improve all aspects of HIM performance, with a focus on the following critical areas:

#### Medical Coding Services

Timely, accurate coding is one of the most critical processes in the entire RCM operation, as quality coding decreases denials and maximizes revenue based on each service provided.



Unfortunately, doctors in the U.S. leave approximately \$125 billion on the table each year due to poor coding and billing practices. <sup>10</sup> It is essential to utilize highly skilled AHIMA and AAPC credentialed coders with RHIA, RHIT, CCS and/or CPC certifications to ensure coding competencies across all settings, including both hospitals and physician practices. Leaders of the coding team should be highly experienced and credential and include AHIMA-certified ICD-10 trainers to drive overall coding performance.

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For organizations considering outsourcing their coding operation, industry rankings provided by KLAS, an independent research firm, can be quite helpful in selecting a high-performing vendor. For best results, organizations should seek out vendors with a solid history of coding experience and strong resources to meet client demands in a timely manner.

#### Coding Audit, Education and Compliance

Organizations need to be proactive to ensure ongoing coding quality, keeping a watchful eye on compliance, internal coding practices, coding accuracy of reimbursements and overall coding quality. A thorough assessment of current documentation should be done on a regular basis to pinpoint opportunities for queries and improved documentation specificity, as well as to ensure compliance. Coders should be regularly audited by credentialed audit staff to maintain a ≥95% quality standard at all times. A variety of audits can be used, including concurrent, pre-bill or focused on a particular area. The goal is to ensure the coding is accurate and supported by proper documentation. Analytics can be quite helpful in finding denial patterns and identifying areas for performance improvement in coding, documentation, billing, and reimbursement practices.

#### Clinical Documentation Improvement (CDI)

Accurately capturing clinical documentation leads to enhanced quality care, better cash flow and billing processes, as well as improved clinical and financial audit results. Unfortunately, research shows that about 45 percent of patient medical records contain poor quality documentation.<sup>11</sup>

A comprehensive CDI program can promote quality documentation, better outcomes and revenue integrity through assessments, implementation of improvements, best practices, and regular audits. A collaborative model should be utilized with a highly experienced team consisting of certified clinical documentation specialists with a strong clinical background. For optimal results, all team members should be ACDIS certified Clinical Documentation Specialists (CCDS). Analytics and query templates can be used to support and enhance the CDI process and provide reports on CDI productivity and key program metrics. Areas for improvement can be identified to drive educational opportunities. Educational tools are available in the marketplace that provide a platform for real-time physician feedback and collaboration among providers and the coding team, improving knowledge of key coding concepts and overall coding quality.

#### ICD-10 Services

Healthcare organizations need to ensure they have a successful path to an ICD-10 environment that supports regulatory compliance. Outside resources can be especially helpful in this arena, offering assessment, remediation and education services. Whether in-house staff or outside



vendors are used, it is imperative to utilize industry best practices and a structured assessment methodology to gauge ICD-10 competency and risk. Assessment results can drive specialized training to help providers achieve and maintain ICD-10 compliance.

#### √ Patient Financial Services

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Patient Financial Services (PFS) is another important performance area that has a major impact on the revenue cycle. Key revenue management functions fall within this domain, including activities such as Prior Authorization, Scheduling and Admissions, Registration, Billing, AR Management and Payer Follow-up. It is estimated that up to 80 percent of medical bills contain errors that can cause an insurance company to reject a claim, 12 so this is an area that needs close attention in most organizations.

Innovative IT solutions, advanced analytics and best practices can be brought to bear to maximize cash collections, automate PFS processes and enhance performance, providing important benefits such as:

- Improving accounting workflows
- Identifying performance issues and developing action plans for improvement
- Eliminating costly error-prone manual procedures
- Enhancing patient interactions
- Reducing bad debt write offs
- Cleaning up aged accounts receivables
- Uncovering low risk, high yield revenue
- Ensuring appropriate reimbursement for managed care contracts
- Increasing cash flow, and
- Driving faster reimbursements

In an effort to shift more revenue collection activity to the front-end of the revenue process, revenue cycle front-end personnel must begin to act as financial counselors to enable point of service collections. Real-time analytics modeling and scoring can be used to analyze and segment patients according to their ability to pay. Other tools, such as point of service payment estimators, can be implemented to enable increased collection earlier in the revenue cycle. In addition to employing these solutions, it is critical to encourage and support a collaborative relationship between the PFS and coding departments. These two key players have a major impact on the revenue cycle, and it is imperative that staff from these departments work together as a unified team to solve any coding and billing issues that may arise. Strengthening this relationship will take the organization one step closer to achieving a healthy revenue cycle.

#### √ Revenue Assessment and Analytics

Organizations striving for revenue optimization should not overlook the importance of employing analytics to assess all of the key RCM processes to identify strengths and weaknesses along the revenue stream from the time the patient arrives until the claim is paid. Powerful advanced analytics can be applied to the huge volumes of data collected during day-to-day operations, providing actionable information to drive fact-based decisions that can enhance performance. An end-to-end assessment of financial counseling, charge capture, denial management, working A/R and reporting can provide rapid



identification of current performance and integration gaps. Best practices and new technologies can then be implemented to support efficiency and effectiveness in the workflow, improving the revenue cycle process through an integrated approach, rather than a series of unconnected steps.

Analytics are especially useful in assessing AR management, as they can consolidate disparate financial and patient data from various financial systems, providing transparency and insight into the organization's accounts receivables and helping to identify revenue at risk. Dashboards and reporting capabilities can convert data into insight, providing real-time information that can identify bottlenecks, find the causes of bad debt and revenue leakage, and empower organizations to more effectively monitor and manage their accounts receivables.

Dashboards and reporting capabilities can convert data into insight

State-of-the-art analytics can also be used to build a strong foundation for an organization's Clinical Documentation Improvement (CDI) program. New innovative analytic products can empower real-time physician feedback for improved physician education and documentation, as well as provide insight into coding quality and compliance.

#### √ Cancer Registry

Cancer Registry Services represent another key performance area that deserves close scrutiny for those organizations that provide this service, as several activities within the program can affect revenue, as well as have ramifications for the future of cancer care.

Current regulatory changes can impact the organization's cancer registry program, negatively affecting associated revenue and data reporting. One area of concern is the transition to ICD-10. Updates and modifications must be made to the structure of the program's registry fields for diagnosis codes to accommodate ICD-10's alpha-numeric codes and increased specificity. Additionally, cancer registry staff must be well versed in ICD-10 to abstract patient data and assess the correctness of diagnosis codes to ensure they are collecting accurate information.

Another area of concern is data interoperability, as oftentimes cancer centers are free-standing facilities that use a different EHR system than the hospital. As a result, some cancer registrars find it necessary to manually extract patient records from the cancer centers' EHRs and enter the data into their registries, a time-consuming costly procedure. These interoperability challenges can directly impact workflow efficiency and revenue, however, they can be solved with innovative technology platforms that are available today that enable providers and other clinicians to share information across the entire healthcare enterprise.

To ensure the organization's Cancer Registry Services meet Commission on Cancer (CoC) standards for compliance, survey readiness and other criteria, comprehensive assessments by professionals with expertise in this specialized field should be done on a regular basis. Deficiencies can be identified and an action plan for improvement can be developed that includes a prioritized list of processes that are the most likely candidates for re-engineering, as well as high-level designs for streamlining workflows. Technology and procedures can also be employed to minimize any backlogs.

Cancer registry services should be provided by fully credentialed staff to ensure compliance with state regulations as well as meeting Commission on Cancer standards. For optimal performance, staff should have earned Certified Tumor Registrar (CTR) credentials from the National Cancer Registrar's Association and ideally should possess one or more of the following additional certifications: RHIA, RHIT, CCS, CCS-P, CPC and/or CPC-H.



Implementation of best practices, ongoing performance assessments and retention of highly skilled, credentialed staff can ensure sustained and reliable performance in this critical service area.

#### **Outsourcing: A Viable Option That Provides Many Benefits**

Outsourcing complex RCM services can provide many benefits to healthcare organizations

Trying to optimize the organization's revenue cycle in today's evolving healthcare landscape is not an easy task. Managing the revenue cycle effectively requires a focus on claims data accuracy, proper use of technology, knowledge of everchanging payer/coding stipulations, efficient follow-up and key performance indicator monitoring, as well as other important activities too numerous to mention.

The burden of managing this on top of reform initiatives and new payment models, as well as increased patient volumes, can overwhelm understaffed and already taxed revenue cycle departments. Consequently, more and more healthcare organizations are partnering with revenue cycle vendors—especially those who offer end-to-end services— as

they deal with the shift to value-based care and the realization that their own legacy systems and staff are inadequate for the job. According to Black Book, a leading healthcare research firm, over the past several years, hundreds of healthcare organizations have contracted with vendors that handle the full range of RCM services. It is worth noting that a major reason these organizations sought out an end-to-end RCM vendor was the vendor's ability to deliver advanced analytics that could respond to the requirements of the new value-based reimbursement models.<sup>13</sup>

Outsourcing complex RCM services can provide many benefits to healthcare organizations. First and foremost, it enables them to concentrate their time, attention and resources on their core activity, allowing them to refocus on providing quality patient care. Additionally, RCM vendors that provide end-to-end services can offer organizations significant cost savings through potentially lower transaction costs. According to Black Book, processing costs for claims reimbursement can range from \$30 to \$90 per transaction without end-to-end RCM, but outsourced RCM reduces the cost. Vendors can leverage economies of scale because of the high volume of encounters they handle, which may provide additional savings.<sup>14</sup>

As a result of cost savings and efficiencies, RCM end-to-end outsourcing may improve providers' bottom lines. Black Book found that more than 80 percent of hospitals with greater than 200 beds had revenue gains of roughly 5 percent related to end-to-end RCM, while 78 percent of hospitals with less than 200 beds experienced a revenue increase of nearly 7 percent.<sup>15</sup>

Outsourcing also gives healthcare organizations more time to evaluate new financial software geared for the shift to performance-based payment models. Since the details of value-based care are still evolving, many hospital leaders are postponing making substantial capital investments in new RCM solutions until they know more about the ramifications of the new payment model.

Consequently, roughly 80 percent of hospital CFOs view outsourcing as the best course of action at the present time. <sup>16</sup>

Many physician groups are also realizing significant benefits from outsourcing their entire revenue cycle operation, from billing to collections, gaining benefits by eliminating overhead and management of an area few physicians have the desire or understanding to oversee.

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As healthcare providers struggle with increasing pressure to optimize revenue cycle management, "outsourcing has emerged as a powerful solution to the challenges of a rapidly changing healthcare model."<sup>17</sup>

#### Conclusion:

Revenue cycle optimization in today's dynamic healthcare environment requires an integrated end-to-end process, as each operational area can impact the other. Assessing the entire revenue cycle stream with advanced analytics, identifying gaps and developing a strong plan of action for improvement and ongoing quality control will be required to optimize cash flow in the future and successfully transition into the new value-based healthcare landscape. Revenue cycle outsourcing will be a key strategy for healthcare organizations as they deal with the major changes coming in the years ahead.

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