ROUNDTABLE

Revenue Cycle Rising to New Challenges

With the shift from volume to value in healthcare, efficiency gains and a widening scope of responsibility are transforming revenue cycle operations. Health system revenue cycle teams are deploying several strategies to maximize revenue in financially lean value-based business models, such as building strong financial relationships with patients to boost point-of-service and billing collections. Information technology is playing a key role in the transformation process.

PANELIST PROFILES

JANE BERKEBILE
System Vice President of Revenue Cycle, OhioHealth, Columbus, Ohio

DEREK ELLINGTON
National Treasury Solutions Manager, For-Profit Healthcare, Bank of America Merrill Lynch

JEFFERY HURST
Senior Vice President, Senior Finance Officer, Florida Hospital, Orlando, Florida

JOSEPH KESSLER
Chief Financial Officer, Community Health Network, Indianapolis

CHRISTOPHER CHENEY (MODERATOR)
Senior Finance Editor, HealthLeaders Media, Danvers, Massachusetts

Roundtable Highlights

HEALTHLEADERS: *Health systems and hospitals are overhauling their revenue cycle operations. How is the view of revenue cycle changing at your organization?*

JOSEPH KESSLER: We feel the revenue cycle is changing dramatically because there's basically a shift in the incentives for the organization. The revenue cycle, although it's critical to our success, is becoming more of an issue of how we are able to service the patient in a way that makes it a very good experience. ... Interjecting a patient experience officer into a revenue cycle process has been really successful.

JANE BERKEBILE: We're addressing the financial piece as well as the clinical piece when we're dealing with our patients. The revenue cycle is generally the first contact the patient has with the organization. We interact during the course of the stay or the service, then the last word is the bill that goes out to the patient and the collection attempts.

We have seen significant change in the perspective toward revenue cycle over the past several years. The organization, although very clinically focused, understands the importance of that financial communication and interaction with the patient.

JEFFERY HURST: Number one, we're changing the perception of the revenue cycle from a shared services overhead area to a strategic business unit. That is critical to the organization's success.

Often what happens with areas that aren't involved in direct patient care, when it comes time for budgeting, you're looking at how to minimize the cost in those areas. We have tried to change the conversation from one of cost to one of investment. Obviously, the expectation is that there's a return on that investment. ...

A second piece is how we engage with our peers in the organization. Historically, we've operated in silos—clinical and financial. If you're thinking in terms of catchphrases like *clinically driven revenue cycle* or *clinically aligned revenue cycle*, you understand that going forward, we won't be paid for the services we provide. We will be paid for the services we document that we provide in the integration between payment and clinical care. We are not in a situation where we can operate in silos. ...

The third area is how we engage with our patients. When I started in patient financial services years ago, the frame of reference was "collect." To a certain extent, we put the burden of responsibility on the patient: "You need to pay us, and if you can't pay us, that's your problem, not my problem." Clearly, it's becoming our problem with growth in patient responsibilities.

HEALTHLEADERS: *What are some of the major changes you are seeing in revenue cycle operations?*

DEREK ELLINGTON: We've seen a major shift in healthcare, with these deductible plans, to push the risk on the patient. We've got to be able to educate them at the same time so we can maximize our collections. That's a big part of the driving force in the change in the culture, and the change in the way the revenue cycle is going to look going forward.

From our perspective as a revenue cycle solution provider, the changes we've seen in the last seven years have been dramatic. Providers want to have multiple options for the patient to make their payments, whether that's through a Web portal [or some other option]. Web portals help providers create an opportunity on their website so that it can be a very easy and interactive experience. ...

From the "lockbox" side—all of this paper volume that comes in on a monthly basis—automating that and turning it into electronic images and a format where the information can upload directly into your patient accounting system is another big revolutionary move to speed up collections.

On the patient refund side, there's an enormous amount of volume and paper checks going out. Coming up with a card solution to make that really easy for folks to have another disbursement form that eliminates the check fraud is a big concern in the industry.

Jane Berkebile
System Vice President
of Revenue Cycle
OhioHealth

BERKEBILE: Technology is the answer. We have been able to bring in a significant amount of business as we've added organizations and consolidated without adding any FTEs. And it's because of technology. ... But in addition to that, the data you can get out of these electronic transactions systems is just phenomenal in strategizing, collecting the receivable, the remittance advice process, and the denial management process. Electronic transactions give you a clear picture of where you stand and where you can go to resolve the receivable. So it's not just the automation helping with productivity and helping with the expenditures, it's also the data that you can get, so that you can strategically attack the receivable and keep it within an appropriate range.

KESSLER: What we have found is that technology has enabled us to shift to a more personal touch. We know now that we have folks—we'll say 5%–10% of the population—who have payment issues. With enhanced technology, we now have the capacity to have staff reach out to those folks. ... We spend a lot of time counseling. We have a lot more financial counselors today because that personal touch is needed.

ELLINGTON: The automation has helped from a risk management standpoint, putting more mechanisms in place to identify fraud. ... We had an example where there was a particular person who had been working in multiple roles in an organization, including as the executive assistant to the CEO of the company, then moving into a role working with patient refunds. When these refunds ended up in a personal account and when the company found it, there was over a million dollars that had just slid through the cracks. The more you begin to implement and manage and monitor, the better your chances are of eliminating those holes for fraud.

Derek Ellington
National Treasury Solutions Manager, For-Profit Healthcare
Bank of America Merrill Lynch

BERKEBILE: Now, you really need a higher level of staff who can analyze data and who can identify opportunities by way of the data that's coming through these automated systems.

KESSLER: You need to be an analyst, and that's one of the revenue cycle staffing fallouts from technology. We're actually talking about providing education for the staff in the form of licensure. We would create our own internal kind of certification through a training process. It would give the staff recognition that they've been through that process, and it would really elevate them.

HEALTHLEADERS: *Aside from the technology, how do you reach out to your patients?*

KESSLER: It goes back to customer perspective and patient experience. The people that we have on the phones talking to our patients, they have got to be scripted, they have got to be trained. There's a certain person who can deliver that service in a way that some people just aren't born to do.

BERKEBILE: We have financial advocates located in all of our facilities. We visit every inpatient and educate them on their own coverage. ... People don't understand their own healthcare coverage until they need it, so it can be stressful. Every patient who comes into the hospital is anxious about what's going on, and being able to have a financial conversation with the patient while they're in the hospital helps alleviate an amount of stress. We certainly check with the clinical areas to make sure the patient is up to having that conversation. We're very sensitive to that. It's mostly an educational conversation and an opportunity to leave our contact information.

After the course of a patient's treatment and when we're in the collection process, we rely on technology in our call center. The call center is open six days a week. We do all of our own patient contact. We don't outsource any of that until it becomes bad debt. We use technology to help us so my staff is not just making phone calls and talking to answering machines all day. We use our technology to send messages to our patients, and we contact all of our patients in the billing process, asking them to contact us. It makes my staff much more productive because, when they pick up the phone, they're talking to a live person, and then they can go into their scripting and work with the patient.

KESSLER: We take our population and split them. There is 20% who will pay up front, and we just need to ask them to pay. There is 20% who will never pay, and you have to isolate those folks and convert them to bad debt or charity care. Then you really spend your time on the 60% that's left, because usually you can use technology for the most part, with just friendly reminders. Those people will pay. They often just don't know what they need to pay. The technology is critical. But personal touch is still important, particularly with that 20% that you really have to touch every time because of collection challenges.

HURST: I'll break patient outreach into two separate topics. One is just simplification and education. ... To simplify the estimate process, the challenge I laid out for my team was inspired by my daughter, who at the time was in sixth grade. I wanted this to be simple enough that a sixth-grader could figure it out. Then we tried to wrap education into it—not just using the patient estimate letter as a tool to inform the patient of what they owe, but also using it as an educational tool. ...

The other big area is how we segment our patients, then determining if and how we should continue to approach them differently, especially with respect to the uninsured and the insured. Historically, the approach with the uninsured population has been to try to screen them for Medicaid or some other form of financial assistance. The approach with the insured population has been payment in full at time of service. ... If you look at the central Florida market, the average individual income is about $14 an hour. The average household income is not much better. ... I don't care if

somebody has got insurance or if they are uninsured: if you make $10 an hour, you make $10 an hour. And with this growth in patient responsibilities, if you've got somebody who now owes $1,000 or $2,000, and they are making $10 an hour, you are talking about a month's pay. That's a lot of money for anybody's personal budget. So the debate we are having now is whether we should begin proactively screening people for financial assistance as the first step in the process even with the insured population.

BERKEBILE: We are focusing on those folks who really can meet their obligations. If there is an extraordinary circumstance, we certainly have a process within our policy to allow that to be appealed and even gain an additional discount as necessary. It's very important to not end up spinning your wheels on trying to collect from someone who's never going to be able to pay.

ELLINGTON: There's an opportunity in the healthcare industry to work with some of the collection agencies to protect the credit standing of patients. It's a domino effect. If we start creating an environment where patients have a bunch of unpaid collections on their credit, then their credit rating declines. Their ability to get other options starts to diminish. Some aggressive agencies put things on credit bureau reports as small as five bucks, and the deduction on your credit scores is the same for five bucks as it is for $500.

KESSLER: We apply the same write-off adjustments based on whether patients have insurance or don't have insurance. It doesn't really matter. It helps us focus our efforts where you know there's a payoff.

BERKEBILE: I want to base my entire follow-up process in reaching out to patients based on their history with OhioHealth. I don't care if they pay their electric bill or if they pay Macy's, I'm interested in knowing their history with OhioHealth. I haven't gotten there yet, but I am working on it because I want to be able to use our data.

ELLINGTON: It's overwhelming for patients. They go in for a certain procedure and the first two bills come in, and they pay those and they think that's it. Then they have to pay more outstanding bills for that procedure when they come for different services, and they're just overwhelmed.

KESSLER: For a long time, we have been trying to figure out how to do a combined bill. Wouldn't you love to have just one bill? I'm sure the patients would love it. The problem is our whole insurance system doesn't allow that to happen. I actually worked at a facility where all of our provider-based physicians were combined with the hospital bill, so there was one bill. The insurance companies didn't know how to handle that. They couldn't segregate it out, so we had to break it apart again. But as we start to take on full risk, that will change. It will be interesting to see how that affects the revenue cycle and how we bill for services.

BERKEBILE: I worked 20 years ago, when our CEO said, "Just send one line and get paid." I'd like to be able to do that, but that's not going to happen. If we could get there, that would help healthcare in general to really reduce costs.

KESSLER: Think about how much your operating budget for hospitals goes to billing. We have close to 220 people in our billing department. There's no value added for this cost to the actual delivery of care. ... When providers take on full risk, it's going to be interesting to see how this plays out for providers in the market. They are going to be the provider of care, and the biller, and take on the risk. That will create some standardization.

HURST: The next wave in healthcare is figuring out how to get the regulators, the providers, the payers, the employers, and the patients all engaged in a productive, collaborative conversation to fundamentally change how healthcare is delivered and how healthcare is paid for.

Jeffery Hurst
Senior Vice President,
Senior Finance Officer
Florida Hospital

ELLINGTON: As we go down this path of shifting risk away from the insurance companies onto provider networks and health systems, the hope is a lot of that will be fixed. Not all of it, but a lot of it will be fixed. But until we all come together, it's going to be this constant conflict over risk alignment.

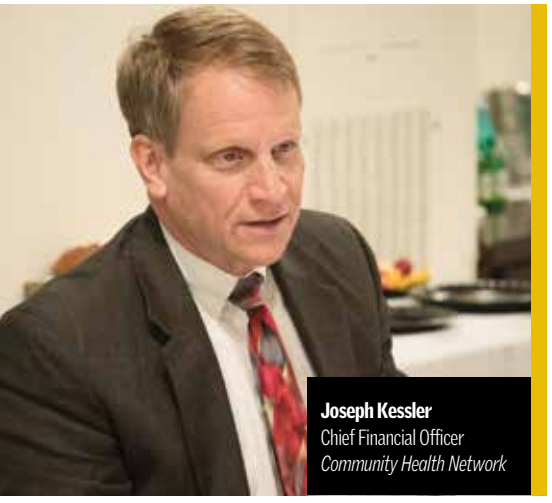
HEALTHLEADERS: *What are the essential healthcare IT capabilities to support revenue cycle operations?*

HURST: I'm looking for much more sophistication: real-time access to data and business analytics. Number one, the healthcare industry has become much more complex. Number two, our organization has grown. We've seen 200% growth in a matter of 10 years. Our ability to access sophisticated data to effectively manage our revenue cycle has become increasingly more difficult. ...

Our second priority around data, which is part of the reason more and more health systems are looking for an integrated solution provider for revenue and clinical operations, is finding

out how you can cross-reference data to make more informed decisions, not just from a financial standpoint but from a clinical standpoint. ... I would suggest if you take clinical data and then cross-reference that with financial data in terms of socioeconomic demographics, it would probably give you more insights. ...

A third big IT issue is just automating as many as transactional-type processes as possible, so that we can drive inefficiency and cost out of the organization.



Joseph Kessler
Chief Financial Officer
Community Health Network

BERKEBILE: In terms of reimbursement, tying clinical care to clinical documentation is critical to whether or not we get paid. ... Payer contract language is critical to enable payment for medically necessary services.

Providing the business office with access to all of the clinical documentation in the patient record helps with communications with patients. When you have a patient on the phone and they have a question, you can see the record.

Fighting denials requires gathering clinical data. It helps tremendously to have access to the physician office record and the emergency department record and the surgical record. You're able to pull that data together to support the care you've provided the patient.

HEALTHLEADERS: *Derek, what are Bank of America's healthcare revenue cycle clients coming to you and saying? What healthcare IT capabilities are they seeking to build up?*

ELLINGTON: The largest IT commitment consistently is a major systems change, which about 70% of the time is an EMR install. It is a tremendous financial investment as well as a commitment of resources because you need a tremendous amount of staff involved in the design and implementation. It is very disruptive from a lot of angles. Just from the personnel side, as a new system is installed, there are cash flow implications.

In every case, there's the need for customization based on the needs of the health system and how they're set up to get the best out of it. Then you have to pick the right modules that are needed as part of the new system to really make it work.

In the financial component of an IT system install, there's a personnel drain from having many staff members involved in the project. Everybody also is trying to be ready for ICD-10, so there's that added pressure. Then there's all the training: Everybody who's going through the install has to be trained on how the new system is going to work. All of this can be daunting for organizations.

"We apply the same write-off adjustments based on whether patients have insurance or don't have insurance."

HEALTHLEADERS: *What are the revenue cycle challenges associated with health systems acquiring hospitals and physician practices?*

BERKEBILE: Our greatest challenge as we have had organizations join OhioHealth has been dealing with the various IT platforms upon which they operate. When you're not on the same platform, pulling and analyzing the data is very difficult. ... Eventually, I had to take my IT team and send them out into these disparate systems and said, "Learn those systems and get me the data because I can't wait any longer to do that."

ELLINGTON: In physician practice integration, one of the biggest cultural challenges we hear is trying to get consistency. The challenge is getting people onboard quickly with a new culture and shifting away from "me, me, me" to "me and the organization doing extremely well."

KESSLER: Culture is probably the most challenging issue in mergers and acquisitions because it's not data driven. It's sitting down with a guy who used to be your competitor and trying to figure out how to work together. ...

When a hospital is acquired, right away you need to make sure that there is an appearance that the new facility is part of the health system. So our challenge is creating standard policies around charity care policies and bill formats and charge rates. Do I charge the same thing for services at the new hospital? We have had situations where we'll have a patient that shows up in one hospital, then goes to another one and gets a whole different charge.

HURST: There is a whole onboarding process to how you bring physicians who have been historically independent into a larger integrated organization. Oftentimes, that either fails completely or goes poorly because we've not done a good job articulating expectations to the physicians up front. You've got to be very clear on the objectives and get everybody in agreement behind those objectives, and that requires a little bit of give and take.

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