ROUNDTABLE

# IT Systems and Effective Treasury Management

Healthcare is in a state of upheaval. Nowhere is this more evident than in treasury management, where the ability of a health system to be paid for its work can be jeopardized thanks to a number of initiatives that threaten to slow or halt payment—from ICD-10 to new commercial payment models to the need to effectively integrate hospital and physician practice billing and collection. At the same time, new points of revenue collection are opening up. Health systems are investing millions for better patient accounting systems. But integration between IT systems that bring money into the organization and those that catalog patient care is fraught with potential potholes. Further, consolidation in the industry means conversions of legacy systems, which provide further room for expensive delays and missteps. Mission-critical revenue and accounting systems require working capital, which can be obtained, but cost savings from all this change are expected as well. Senior financial leaders are quickly learning how to manage the transition of their health system's most critical systems without costly breakdowns.

## PANELIST PROFILES

**JEREMY EAVES**
Senior Vice President, Financial Operations
Baylor Scott & White Health
Dallas

**MARY ANN FREAS**
Chief Financial Officer
Southwest General Health Center
Middleburg Heights, Ohio

**JEFF PAULY**
Senior Product Manager
Healthcare Product Solutions
Bank of America Merrill Lynch
Charlotte, North Carolina

**LORI WOOTEN**
SVP and Chief Financial Officer, Hospital Operations
Capella Healthcare
Franklin, Tennessee

**PHILIP BETBEZE (MODERATOR)**
Senior Leadership Editor
HealthLeaders Media
Brentwood, Tennessee

# Roundtable Highlights

**HEALTHLEADERS:** *What are you dealing with that could disrupt your organization's revenues?*

**MARY ANN FREAS:** For starters, the 2-midnight rule has been a huge disruptor. It has the potential to reduce revenue, period, never mind cash flow. It's complicated and it's likely to be adopted by commercial payers. Regardless of bill status, we are expending the same resources on the patient. Another tough issue is trying to make sure that our physicians have documentation that will support the diagnosis and level of care. That's also true for [Recovery Audit Contractor] audits and ICD-10. One of the largest challenges is around clinical documentation. We've made considerable investment in systems, people, and time. We've spent a lot of time training our top admitters and our hospitalists, who have a huge impact on what we collect and how quickly we collect.

**JEREMY EAVES:** The source of most revenue disruptions in the industry is the widely held opinion that healthcare in the U.S. is too expensive. As a result, beginning four or five years ago, there has been steady pressure to cut reimbursement rates and an increased number of new entrants into the market particularly for outpatient services, leading to more competition. Generally, we've had more employers say they're not going to pay rates they paid previously. We've seen startups created that specialize in providing healthcare cost data to employers, so that has only increased the pressure on providers to lower costs. Meanwhile, Medicare has pushed to have less inpatient procedures and lower readmission rates. It's a challenge to compete effectively with so much change in the healthcare landscape.

**LORI WOOTEN:** To your point about the 2-midnight rule, we're seeing a large increase in others evaluating medical necessity after the fact—the last couple of years in particular. Our staff has to spend much more time working on those appeals than ever before. Just the cash flow impact of that—particularly with the RACs—can be significant. Right now you often have to go through three levels of appeals, and often it takes two years to get to the [third level] Administrative Law Judge.

**JEFF PAULY:** A lot of our emphasis is around streamlining and automating the revenue cycle processes associated with getting paid, collecting, balancing, and posting. A lot of these new requirements are driven by CMS. But our clients can't have a CMS way of treating patients and a commercial way of treating patients. As they implement these changes, it's got to be consistent across the board. That adds a lot of overheard, administratively and operationally, and at the same time they are trying to get more efficient and drive cost reduction.

**FREAS:** Revenue recognition is challenging, and not only because of the lag time on valuing denials. For example, right now, it's unclear to us how many of the uninsured actually paid their premium under the state exchange, and whether reimbursement for their care will be made. Many of our self-pay patients are pending Medicaid coverage. Hopefully that will all come through as we expect, but I don't want to overstate or understate my revenue in one quarter just to have to go back to the board and say, "Oh, missed it!"

**WOOTEN:** Revenue recognition is hard because there's not a lot of history on much of this. It's more complicated than I've ever seen. Annually, we do five-year projections for our hospitals which incorporate key industry and reimbursement changes. Over the past year, we probably needed to adjust these projections every three months because things change so rapidly.

**HEALTHLEADERS:** *Does integration between IT systems focused on revenue and patient care solve or exacerbate this problem?*

**Jeremy Eaves**
Senior Vice President
*Baylor Scott & White Health*

**FREAS:** Clinical documentation is at the core of so many issues. Our patient accounting system is different than our health record. We're evaluating whether or not we need to change, and we'll have a decision later this year. But integrating the two provides an opportunity in discharge disposition—putting it in the hands of the discharging nurse. That has an impact on revenue, particularly with Medicare and the transfer rule. You have to rely on what the front-line caregiver is entering into the system. So, it's both an opportunity and a challenge to make sure it's correct. Technology around prompting the physician is gaining ground among our medical staff. It provides the opportunity for the documentation quality review to occur at the same time, and many physicians would prefer that to retrospective queries that we do as part of our current documentation improvement programs.

**PAULY:** I've heard other providers speak about ICD-10 preparations and the notion of leveraging computer-assisted coding, but it's entirely dependent on full EHR implementation. ICD-10, now delayed again, is where you see the clinical and financial interface really becoming a necessity. Have any of you had success with computer-assisted coding?

**FREAS:** We have implemented CAC and it's been very worthwhile.

**EAVES:** Our CAC implementation has been excellent, particularly as it relates to productivity. We projected with the implementation of ICD-10 that we were going to initially lose 30% or 40% of our coding productivity. Our goal was to at least get 20% of that lost productivity back. From that standpoint, CAC has been phenomenal for us so far. Further, almost all of the charging for one of our divisions is based on documentation that is largely automated. We talk about trying to get to a cost structure that's viable in the new, more challenging environment, including taking out a lot of the manual work, but in this case that means the quality of the documentation becomes very important.

**FREAS:** Often overlooked is the impact of clinical documentation on quality measures. That's often helpful when trying to get physicians on board.

**PAULY:** With any kind of risk-sharing or any kind of gainsharing, you need the metrics to go along with it, and that determines whether you get paid or not.

**WOOTEN:** We went through a system conversion in most of our hospitals last year in order to be able to meet meaningful use guidelines. Much of the stress came from making sure the interactions between the clinical and financial worked properly. If the documentation isn't there, the charges aren't going to come across, and it's going to impact you financially.

**Mary Ann Freas**
Chief Financial Officer
*Southwest General Health Center*

**HEALTHLEADERS:** *Does ROI become secondary on these conversions?*

**PAULY:** I've talked recently with a few providers who have done Epic installs, and they did it in large part because of meaningful use and integrated hospital-physician billing, but it's difficult from an ROI justification standpoint. It's not that you can't do it, it's just not quite obvious.

**FREAS:** Our EHR, initially, actually caused us to increase our labor cost. The biggest area we should be able to expect return on investment is in utilization, but if physicians don't have tolerance for the prompts and the alerts, that eliminates ROI from utilization. So I think that's a longer-term goal. Secondly, you would hope that it would have saved time for the caregiver to redirect efforts to hands-on patient care. But now, the nurse's time is spent on tasks related to the electronic health record.

**EAVES:** It's a difficult question. A number of initiatives are undertaken because they are vital to our mission and delivering the best patient care possible. On the patient accounting question or other purely financial systems, the decision becomes much easier to approach from a financial standpoint. In that regard, for one of our divisions, we have explored doing an upgrade, but we found it really made more sense to implement a handful of targeted bolt-on tools that provided the automation and the functionality we needed at a lower cost than the full implementation of a new patient accounting system.

**PAULY:** Anecdotally, what we are hearing from our clients is that if you were doing it just on a financial justification basis, that's not enough to clear the hurdle. There have to be other reasons.

**WOOTEN:** From our recent system conversions, we're not seeing as much of an impact on the revenue cycle side, but more on the clinical. As far as staffing, we haven't really seen any significant staffing improvements through these conversions. I think it's likely the new systems require more time.

**HEALTHLEADERS:** What pressures are you all seeing to upgrade your capabilities in these areas?

**FREAS:** The state of Ohio is expected to implement, on a limited basis, a bundled payment methodology. It looks just like the value-based purchasing model where the calculation is done retrospectively and the provider receives a bonus or penalty. So it's unclear to me how the patient accounting system will be affected. We're not seeing a lot of pressure from other payers, but conversations are expected to start.

**EAVES:** The payment estimation piece is difficult because most organizations base their estimated payment amount on the financial elements that are found on patient claims. Particularly with some of the shared savings arrangements associated with the implementation of ACOs, clinical values and outcomes are now being introduced into the payment estimation process, and most contract management systems are not set up to adjudicate based on those data elements. Some vendors have popped up that appear to provide systems with that functionality. We're certainly not at a point where we need to invest in those systems, but it's likely something in the future that we will have to implement. In the long run, you'd like to have that functionality in your patient accounting system.

**WOOTEN:** We're not seeing any of the new commercial payment models at this point, so we really haven't thought about it in our financial systems. We outsource our revenue cycle function. I feel comfortable that, when we get to that point, we will have the systems in place.

**EAVES:** If you look at some of the demonstration projects from a few years ago, several health systems had to use third-party administrators because their

internal information systems couldn't handle all of the claims processing. It was a similar model to what many self-insured organizations do to process their own claims.

**PAULY:** You see a lot of commercial payers structuring their gainsharing programs along those lines: Go ahead and submit your claim just the way you do today, but let's share data, let's track it, and retrospectively, let's calculate an incentive payment after the fact. Some are even putting money on the table and saying you can earn this out through demonstrated cost reductions.

**HEALTHLEADERS:** *Regarding ICD-10, the latest delay is until at least October 1, 2015. Was that news good or bad for your organization?*

**FREAS:** We're certainly taking advantage of the delay. We're now able to test many more scenarios more thoroughly. We weren't going to be able to do that, even though we feel we would have been ready. On the other hand, we were gaining momentum with the medical staff—it really is coming this time, we really need you to go through these training modules—and then it didn't happen. So I think credibility was damaged and sense of urgency has been lost.

**WOOTEN:** For the organization, I'm glad they moved it back, but one negative is cost because we've invested a lot of money in this. For example, we trained our coders and a lot of other key people, and we're going to have to retrain people before we get to the implementation date. One positive is that we've implemented a clinical documentation improvement program at every hospital over the last year, and the delay gives us more time to improve the documentation so that when we get there, we'll be well prepared.

**PAULY:** Some folks I've spoken with feel like they were being punished by being ready too soon. You've spent the energy and effort training coders on ICD-10 only to see somebody who was late to the game come in and offer to pay them more and steal them away from you. That could be the penalty for early movers in ICD-10 preparedness.

**FREAS:** We've been fortunate. We haven't lost any coding staff, and we were expecting some turnover.

**EAVES:** It's probably going to cost us more in the long run because there's going to have to be some re-work. But, personally, the delay is probably a positive thing because it gives payers more time; it gives information systems vendors more time. You heard about some vendors that were saying their new software would be ready by August, and then we'd have to test it. That was pushing it under the old deadline. Fortunately, many organizations are able to test with some payers already.

**HEALTHLEADERS:** *In terms of getting paid appropriately for what you do, is the ICD-10 regime better for that or worse? Or a wash?*

**PAULY:** Initially it's got to be negative. It's just very disruptive in terms of how you're coding and getting paid. Denials are going to go up.

**FREAS:** The impact of denials should be temporary, and we should be able to go back and get that money. However, ICD-10 seems to be a mixed bag from the case-mix index perspective. That's one of the reasons it's important for us to test with our payers, so we can work out the arrangements around budget neutrality, so we're not hit from a real revenue perspective.

**HEALTHLEADERS:** *Today, where do you need assistance on the transactional side?*

**EAVES:** Whether it's computer-assisted coding or automation of transcription, automating the core transactional components of our functions within the revenue cycle becomes much more important, given all of the revenue disruptions we discussed. Giving patients the ability to go online, pre-register, pre-pay, as well as automating insurance verification, price estimation, all the way to the charging pieces and how

**Jeff Pauly**
Senior Product Manager
*Bank of America Merrill Lynch*

we do claim follow-up—there are just all sorts of transactions where we need to become more efficient. When we are able to automate routine transactions, significant reductions in cost typically follow. While we have had to increase staff in certain areas, like our denial resource center, which handles our appeals for RACs, the automation has significantly helped offset that investment.

**PAULY:** The areas where we help organizations tend to be more transactional. In dealing with things surrounding RAC audits, for example, our clients' concerns are around the procedural, technical components of it—meaning, are we responding in time? Are we getting back with the proper documentation? Does our internal process support the turnaround time that we have to hit to make sure that we just don't automatically lose the reimbursement?

**FREAS:** Regarding automation, one place we struggle is around the charity care application. We had made nice progress transitioning from bad debt into charity care. We could find out right away if patients qualified for our financial assistance. So then comes this year, and we have to help patients connect with the people who can get them signed up with the insurance exchange, and lo and behold, they don't want to do it. Now they're going through the collection cycle and they're going to end up in bad debt. That was a reaction we didn't expect.


**EAVES:** Like a lot of organizations, we have historically had a large number of patients who need care and don't have insurance that end up in bad debt, when they might qualify for charity if they completed our application for financial assistance. To address this issue, we have implemented an automated presumptive charity process based on independently verified household income and size, greatly reducing the number of patients that end up categorized as bad debt. Additionally, we have recently automated the actual charity care application for many of our patients, providing them real-time feedback on their eligibility.

**FREAS:** It seems to me that the next window of opportunity is helping people get signed up for the exchanges. I am interested in what others have done to encourage enrollment.

**PAULY:** We are seeing some of the larger health systems offering their own health plan on the exchange. You're not just referring them to a third-party health plan through the exchange; you're actually putting them into a health plan that you control and is on your network.

**FREAS:** My personal speculation is you're going to have to visually be on these exchanges, because you have to drive volumes and you're going to have to agree to some narrow networks. But in the short run, some entities have not wanted to be there because the payment rates were worse. So that's the tradeoff right now. How do you get your cost structure to be able to accept those narrow network rates?

**WOOTEN:** We budgeted for coverage expansion. We're seeing more convert to Medicaid than we thought would have in the states that expanded as well as moderate volumes in the exchange programs.

**HEALTHLEADERS:** *Given the increase in high-deductible health plans and increasing levels of coinsurance, how are you making it easier for patients to pay their share?*

**FREAS:** We have an online portal available through a bolt-on solution. Eventually, the payment portal will be available through the personal electronic health record portal so the patient only has one place to go, and since the meaningful use criteria is tied to the patient accepting the invitation and getting onto the portal, it will help to serve both needs. Maybe 2% of what we currently collect comes through that process.

**HEALTHLEADERS:** *What other ways do you plan to push patients to self-service models?*

**EAVES:** We've done some things to try to simplify online payment, which actually has helped push more people there, but it's pretty basic. We're trying to make the functionality significantly better. We need to marry it to the clinical piece of our portal. Our online patient portals have some impressive clinical functionality. In terms of the revenue cycle functionality, we need to build it out—we'd like patients to be able to preregister and even schedule services online. Further, we would like for a patient to have the option to print an itemized statement, check the status of their claim, apply for charity, and receive an online estimate.

**PAULY:** Working with some clients directly, I was surprised at how often I hear the comment providers make that they're forced to give patients access to more self-service tools on their website because that's what patients want. I think the reluctance or ambivalence about it was, well, patients aren't going to want to do that. It's taken a while to see that's not the case.

**WOOTEN:** We have online bill-pay portals on each of our hospital websites, and we are launching our clinical patient portals. We also have kiosks in some of the hospitals. This is definitely an area that we're looking to improve because in reality, if you don't get payment up front or you don't get it through online tools, much of the time it goes to collections, and once it's there the returns are minimal.

**PAULY:** Is it true that the total value of the benefits on the exchange-based plans tends to be lower than what you typically see through a group coverage plan, or do you just not have enough experience under your belt yet to know?

**FREAS:** The coverage is less and the payment rates are lower. So it's up to the hospital to negotiate that payment rate. The big impact is going to be what employers next year or the year after are going to do. Do they keep employees on their group plan? Do they give them a dollar amount, take the penalty, and put them on the exchanges? Then we'll really see some cannibalization. I think there's another shoe to drop.

**WOOTEN:** You're right; it's too early to tell because really, we've seen relatively limited shifts from the commercial payers to exchanges.

**EAVES:** Unfortunately, there are still a large number of questions. In particular, how will each organization's payer mix shift now that the exchanges are in place, and at what rates will providers be paid under the plans? The feeling as an industry is that we're going to have to cut costs to be competitive. We're going to have to get to a point where we reach some new normal in terms of dealing with potentially lower reimbursement.

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