THE 2016 THESIS

Setting Your Revenue Cycle Course

Revenue Cycle Academy

The 2016 Thesis

MESSAGE FROM THE ACADEMY

Dear Members of the Revenue Cycle Academy,

Greetings from The Academy! We want to welcome you to *The 2016 Thesis: Setting Your Revenue Cycle Course*, developed with the intention of providing our membership community with insight into our research agenda for the months ahead. This report is intended to assist revenue cycle leaders in navigating and responding to the numerous shifts currently occurring within the healthcare industry, including but not limited to rises in patient out-of-pocket costs, continually strengthening payer and regulatory requirements, and a transition in reimbursement methodology, among others.

In structuring our research framework for this year, we wanted to not only consider these increasing pressures, but ensure items identified by the membership community itself as top concerns or priorities were accounted for as well. As such, our 2016 Thesis Survey asked leaders to rank, on a scale from 1 to 10, the importance of 12 specific revenue cycle initiatives/priorities within their chartered course for this year. A score of 1 indicated the topic was least important to the organization's strategic revenue cycle plan, and 10 signified it as one of the most prominent focuses ahead. The table on the following page represents the average ranking each initiative received among all survey respondents.

Many of the top-scoring topics will be explored within the framework of our 2016 research. As briefly summarized below, these topics include how organizations are reconsidering the traditional revenue cycle structure, how patients interact with the revenue cycle's touch points, and how leaders as well as their staff can work together to prevent recurring losses in reimbursement.

Governing an Enterprise-Wide Revenue Cycle

As the industry as a whole moves from a volume- to value-based structure—which inherently brings with it increased financial risk—the previously pronounced line between the clinical and financial aspects of operations is continuing to blur. Not only are hospitals and health systems looking to integrate physician practices into the core leadership structure and align further revenue-enhancing processes under the revenue cycle wheelhouse, but organizations are also working to nurture greater collaboration and understanding between typical revenue cycle departments, enhance recruitment and development of both frontline staff and leadership, and re-evaluate potential outsourcing opportunities in order to respond to growing patient volumes and compete with forward-thinking organizations despite declining third-party reimbursement.

Analyzing and Preventing Denials While Improving Payer Relations

Ranked the top priority for 2016 by Thesis Survey respondents, The Academy is sustaining a pulse on the continued efforts of healthcare organizations to identify denial root causes and prevent their future occurrence. Not only does this require advancements in the realm of data analytics, but with so many

touch points in the lifecycle of a claim, divided between a wide variety of staff groups, mitigating and preventing denials often necessitates a significant and collaborative cultural shift. In addition to internal efforts, such as developing staff workgroups around specific denial reasons, organizations are also looking to foster better relationships with their contracted payers in order to also influence unwarranted or payer-induced denials.

Evolving Patient Financial Literacy in an Increasingly Consumer-Driven Industry

Although providers continue to advance price transparency efforts given federal, and in some cases, state-based legislation, it appears many healthcare leaders are attempting to transition from increasing transparency alone to improving actual patient comprehension of their out-of-pocket costs, potential financial assistance options, and more. This is being attempted through mobile financial counseling, combined technical and professional price estimates, innovative metrics, and dedicated positions intended to measure and impact the patient financial experience, and even patient-managed payment plans.

As the year progresses, and as the impact of industry changes like 501(r) and ICD-10 unfolds, please stay in touch with The Academy for objective research regarding organizations' responses, innovations, and strategic plans amidst such a transformative era in healthcare.

Best regards,

Jerica Hopkins
Research Director

Members' Average Ranking: Importance of Initiatives for 2016

(1–10 Scale)

Tracking & Analyzing Denials	8.91
Patient Collections (POS, Estimation, Agency Partnership, etc.)	8.21
Centralized/Consolidated Pre-Service & Financial Clearance	7.82
Financial Assistance & Insurance Enrollment	7.50
Payer Performance & Contracting	7.16
Outpatient Clinical Documentation Improvement	7.12
Automating Staff Productivity Monitoring	7.08
Revenue Cycle Leadership Development & Staff Recruitment	6.77
Charge Capture Improvement via the EHR	6.62
Update Pricing Methodology	6.32
Operationalizing Bundled Payments	6.25
Insourcing Previously Outsourced Functions	4.24

The 2016 Thesis

GOVERNING AN ENTERPRISE-WIDE REVENUE CYCLE

Introduction

Most providers have centralized back-end and even mid-cycle functions, while pre-service functions remain the least consolidated among hospitals and physician departments.

As the dust settles from the implementation of the Affordable Care Act, ICD-10, and in anticipating a new reimbursement model—as well as a more patient-centered industry—providers are re-evaluating the way in which processes are conducted, patients treated, and costs managed. All of these are derived from the core operational structure, leading many health systems to develop a revenue cycle hierarchy in which all care settings and revenue-influencing functions participate in shared decision-making.

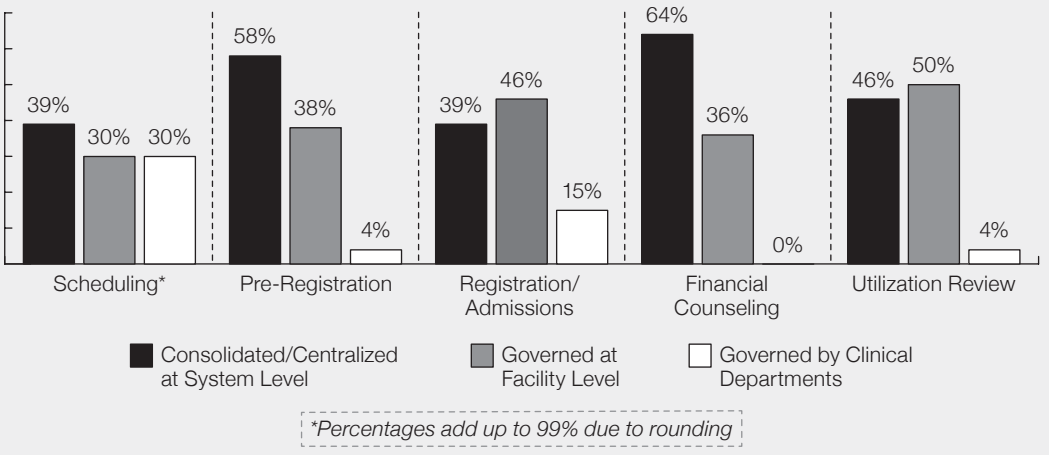
Promoting Integrated Operations

Quality-based and/or bundled reimbursement necessitate that physician offices have a more prominent place within the operational structure, right alongside hospital revenue cycle leaders, but consumerism is also calling hospital leaders to seek a greater hold over processes and initiatives in all care settings in order to promote a, consistent patient experience.

Re-Evaluating Core Revenue Cycle Functions

Given their impact on overall financial performance, functions being brought under revenue cycle purview include, but are not limited to, payer credentialing, clinical denials, utilization review, and managed care. Care settings including home health, skilled nursing, and others have also been put on revenue cycle leaders' radar given mergers and acquisitions and the prospect of bundled payments.

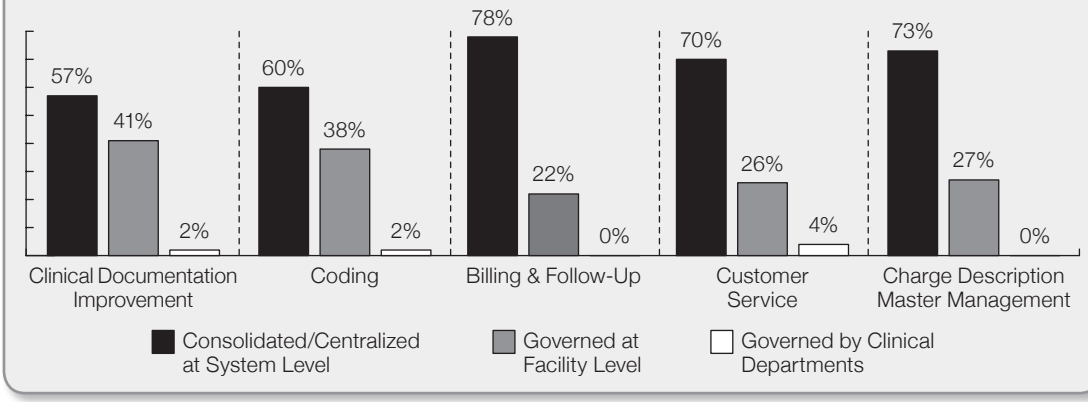
Current Governance Structure of Front-End and Clinical Functions
Source: Revenue Cycle Academy (2016)



**Percentages add up to 99% due to rounding*

Current Governance Structure of Mid-Cycle and Back-End Functions

Source: Revenue Cycle Academy (2016)



Recruiting Staff and Growing Leadership

With typical revenue cycle roles advancing in complexity and specialization, and others remaining relatively new to the industry, competition for qualified staff continues to swell. As such, leaders are looking to differentiate their organizations, grow frontline staff into future leaders, and build community partnerships that provide a conduit for recruitment and onboarding.

Some sources also show patient volume is climbing given new coverage options, further necessitating additional resources and infrastructure.

Trending Revenue Cycle Outsourcing

While some providers have realized significant cost-savings and operational proficiency by integrating clinical or other non-traditional functions into financial structures, others may be constrained by limited margins. Given this, organizations are increasingly turning to external partners—with more considering outsourcing portions of or the entire revenue cycle.

This section highlights still emerging trends and potential considerations with respect to:

- Cultivating an Integrated, Collaborative Revenue Cycle
- Broadening the Scope of the Revenue Cycle
- Recruiting and Developing Revenue Cycle Leaders
- Exploring Trends in End-to-End Revenue Cycle Outsourcing

Cultivating an Integrated, Collaborative Revenue Cycle

With the reimbursement model shifting from fee-for-service to a focus on the value or quality of service as a whole, including both clinical and revenue cycle touch points, hospitals and health systems are finding that the way in which their revenue cycle is organized may likewise need adjustment—instead of being structured according to cost centers, success in the future-state industry will require a more connected and collaborative organizational chart.

Promoting Further Hospital and Physician Integration

Academy research indicates many organizations have either completed a system conversion within the past few years or are bringing additional facilities on to the same electronic platform. With new-found commonalities in processes, this provides opportunity for a health system to operate as a single entity. If also recently undergoing a merger or acquisition, revenue cycle leaders are likely shifting their focus to consolidating resources and governance to create a more efficient care process.

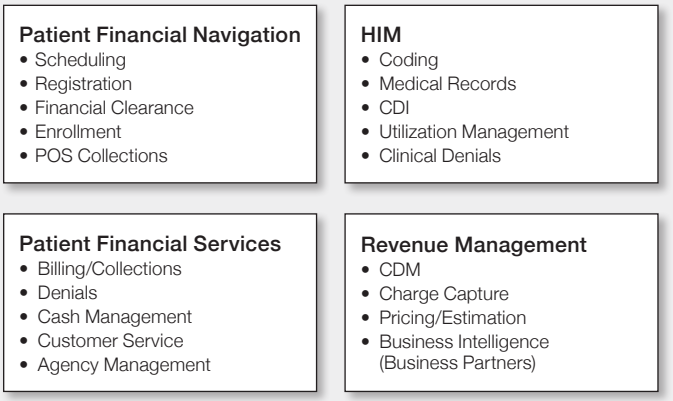
While many organizations appear largely consolidated from the hospital perspective, opportunity exists for creating an operational structure that promotes collaboration between technical and professional components of a health system. As the charts on the previous pages show, the majority of providers have either consolidated or centralized back-end functions across the system, more than half have corporatized mid-cycle functions like coding and CDI, yet that percentage noticeably decreases for pre-service functions like scheduling and registration.

Given some service lines require more specialized knowledge of schedulers, and the ability to check-in at the site of service remains a patient satisfier, leaders are attempting to find innovative means to promote consolidation among revenue cycle functions while allowing for the nuances of various service lines or settings. Virtual centralization may be one solution, and this has been accomplished by having frontline staff remain site-specific for physician offices, but ensuring standardized training, tools, and procedures are facilitated through an integrated revenue cycle.

The Academy has also seen instances of a dual-reporting structure, in which individuals report to a site- or facility-leader in addition to a functional area or service division. This may mean a physician practice coder reports to a clinic leader while also reporting to the corporate director of coding or HIM. An health system in the Southwest instead created a unified outpatient department—headed by an ambulatory medical director and chief administrative officer of outpatient clinical integration—that reports directly to the system's CEO.

Example Re-Organized Revenue Cycle Structure

Source: Revenue Cycle Academy (2015)



This academic health system aligned all patient-facing teams into a single accountable department (Patient Financial Navigation), keeping access staff among physician offices site-specific but delivering standardized procedures, tools, and training through integrated governance.

As is the case with many similarly-titled leaders, a revenue cycle vice president at an Illinois-based health system had about 70 clinic locations brought under their purview. By adding intermediary positions, like a revenue operations coordinator—who was previously a hospital analyst—as well as designating initiative champions to help identify and drive opportunities for improvement, bringing key stakeholders (including vendors) to the table, as well as carrying over tools or solutions from the acute care side, significant financial and operational gains resulted among these facilities.

Fostering Interdepartmental Connectivity

Although current industry developments are causing hospitals to further integrate operations with facilities like physician offices—and perhaps skilled nursing and home health facilities as well—there still exists the need to cultivate a greater sense of fluidity between typical departmental areas.

Recognizing the vitality of a staff that views each other as partners, an academic health system in the Midwest underwent a three-year restructuring to establish a more interconnected revenue cycle. A director as well as managers from billing and collections were moved to patient access leadership, and certain mid-cycle staff were moved to back-end roles.

This organization also put in place a separate director-level resource over physician, facility, and specialty billing and collections, all reporting to a corporate patient financial services department. Revenue cycle directors previously placed at each of the system's smaller facilities were given more specialized roles within the integrated structure—for example, one became the cash posting director. The patient financial services department also went through a complete re-organization in which sub-teams were established per specialty or facility for physician-side staff and based on payer for the hospital side. This results in a model that The Academy has seen more providers turning to—having back-end staff hold responsibility for accounts from the initial bill through to resolution, sometimes even including the denials process. Those that do so have noted that this can reduce errors by promoting specialized knowledge and individual accountability.

Though, with reimbursement methodology also undergoing a transformation, a reasonable question that may arise in the coming year or so is whether billers, and perhaps other roles like coders, may become structured around procedure or perhaps payment type to better accommodate bundled services and payment.

Key Focuses of Academy Research in 2016

Numerous industry pressures are leading providers to re-evaluate revenue cycle organization and efficiency, including changes in health-care consumerism, declining reimbursement, and the value-based purchasing program.

- How are organizations adjusting their governance structures in order to better maintain costs, improve efficiency, and respond to current industry pressures?
- In what ways are health systems integrating their hospital and physician office operations, and perhaps other non-acute care settings, to promote greater standardization?
- Will frontline roles, like billing, also see adaptations related to changes in reimbursement methodology?

Broadening the Scope of the Revenue Cycle

As health systems grow and acquire additional care settings, revenue cycle leaders are beginning to re-evaluate the traditional revenue cycle structure in order to determine how to also create a singular culture and a consistently positive patient experience. Furthermore, with revenue opportunity on the rise in the outpatient setting, organizations are looking to expand revenue cycle services like CDI into those realms.

Realigning Core Functions to Improve Efficiency and Financial Impact

As the industry grows increasingly complex given mounting regulatory and consumer pressures, The Academy is seeing a number of areas that have traditionally been housed in other departments being brought under, or more closely aligned with, the core revenue cycle. For instance, with the ever-expansive capabilities now held by electronic health record, patient accounting, and other systems, having IT resources dedicated to electronic revenue cycle processes may be the key to achieving optimization. Some organizations are placing system developers or analysts within each revenue cycle area to help build rules, edits, or workflows. The aforementioned Midwest health system has a group of 50 IT support staff (separate from the central IT unit) under a director of IT revenue cycle who then dual reports to the chief information officer and system vice president of revenue cycle.

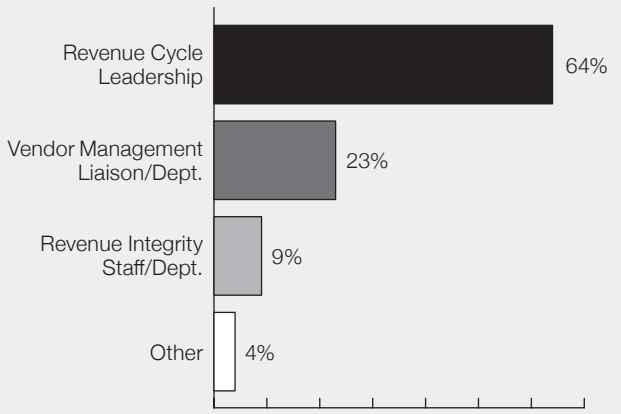
Advanced system capabilities have also made data more available than ever to healthcare leaders. To translate it into action, health systems are creating centralized data analytics teams. At a Texas-based organization, data analysts are primarily dedicated to an area such as patient financial services or patient access, and report through a manager to a director of analytics, who then reports to the vice president of revenue cycle. And, as quality-driven reimbursement and risk-based payment models become more prevalent, it appears chief revenue officers or even vice presidents of revenue cycle are taking on managed care contracting responsibilities.

Vendor and/or collection agency management is also finding a home within the system revenue cycle, as organizations are designating a single point of contact to regularly monitor and communicate business partner performance as well as adherence to contracted terms, 501(r), and other mandates. Similarly, compliance and legal teams are coming onboard to help leaders ensure processes and policies remain compliant.

Historically clinical functions, like utilization management, clinical denials, and even payer or physician credentialing, are likewise being repositioned given their significant financial impact. When under reorganization, the Midwest health system pulled utilization management from its care management team and placed it within its HIM department to allow this role to focus on patient status and continued authorizations while care management focused on discharge planning and other tasks. Its clinical denials team, made up of coders and nurses, was also then brought under

Staff Responsible for Managing Contracts and Revenue Cycle Vendor Performance

Source: Revenue Cycle Academy (2014)



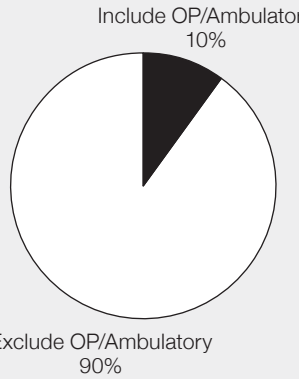
As part of this same survey, respondents noted that revenue cycle centralization had the most impact on vendor contracts and negotiations within the past couple of years—which is likely why most now have this function under revenue cycle leaders.

HIM to work medical necessity or authorization-related denials and respond to trends identified by UM.

Finally, by reallocating payer credentialing to a dedicated role under patient financial services, an Ohio-based provider reduced the frequency of write-offs related to credentialing issues by 46% within one year.

% of Organizations Including the Outpatient/Ambulatory Setting in CDI

Source: Revenue Cycle Academy (2015)



The Academy continues to hear interest in and pilot programs surrounding this initiative—likely given the significant revenue source this setting represents.

Extending Core Functions into New Service Settings

The linkage between quality and payment, as well as the rising stringency of payer requirements, are major driving factors for the expansion of hospital revenue cycle services into the outpatient or physician practice realm. For instance, revenue cycle leaders have been laying the groundwork to bring CDI to outpatient physicians. After examining denial volumes among outpatient service lines, a New Hampshire hospital hired two outpatient CDI specialists—one within the cancer center, and the second serving the pain clinic and cardiovascular department. In addition to identifying root causes of documentation errors (e.g., inconsistent or missing diagnosis codes), specialists also collaborate with departments to prevent denial root causes, make appeal decisions, and conduct chargemaster maintenance.

Not only do organizations need to be well-positioned to promote greater collaboration and communication among internal stakeholders, but pilot reimbursement programs foreshadow the necessity of doing so with external partners, like post-acute providers, as well. For instance, Centers for Medicare & Medicaid Services' Comprehensive Care for Joint Replacement Model provides a retrospective bundled payment for the collective cost of an inpatient stay and care extending 90 days post-discharge, even if that care was provided by home health, skilled nursing, hospice, or other providers. The Academy has seen a growing interest within the membership community regarding these care settings, suggesting that they may be beginning to move under revenue cycle leaders' purview as well.

Key Focuses of Academy Research in 2016

An emphasis on the patient experience, as well as the need to reduce costs in an era marked by declining and more at-risk reimbursement, is contributing to many organizations' efforts to provide a higher level of financial-based control over additional processes.

- What does the revenue cycle reorganization process look like among health systems in the current industry landscape?
- What roles or functions are hospitals and health systems integrating into their corporate revenue cycle?
- How are organizations creating synergies among other service settings, such as outpatient services or home health, as well?
- How is CDI evolving in the outpatient setting?

Recruiting and Developing Revenue Cycle Leaders

In nearly all aspects of the revenue cycle, recruitment remains a challenge—whether for entry-level or leadership positions, and among functions ranging from pre-service to coding to billing and collections. Not only are these roles continuing to grow in complexity as the industry necessitates increased regulatory, insurer, system, or other knowledge, but some roles are also becoming more specialized (e.g., with positions dedicated to insurance verification or price estimation, or based on specific payer, etc.). And, with 60% of organizations reporting an increase in staff turnover within 2015, this may mean heightened demand and competition between organizations for qualified/experienced staff and leaders.

Developing Front-Line Staff into Leadership Roles

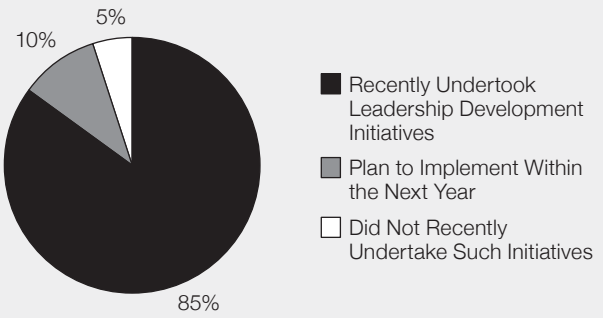
Through the course of The Academy's research and member interactions, many healthcare leaders have noted an overall concern regarding the lack of young professionals entering the healthcare administration or management field. As more tenured leaders take on new positions—whether internally or at another organization—or perhaps reach retirement, this concern only intensifies. While the most logical solution is to find ways to develop frontline staff into supervisory and management roles over time, leaders also report that staff recruitment has only grown more difficult as industry positions grow more complex and specialized.

Given these challenges, one multi-hospital system in the South not only created career ladders for staff groups like registration, but also put in place a leadership career ladder that staff can transition into after becoming a shift lead within their department. Shift leads are expected to have working knowledge of each function within their department to be able to fill in during any shortages. The business office director at this organization notes that shift leads are ultimately considered leaders in training, begin to receive related education, and may have the opportunity to move on to the first rung on the leadership career ladder—a department-specific educator who oversees staff instruction and evaluations. The next level position is a team leader, which functions as a department manager. At the top of the leadership ladder then, is the department director position. Leaders from this organization emphasize that staff members' own interest, drive, and potential ability to lead are major determining factors in any promotion decision.

Taking a similar approach, one California health system put in place a three-level career progression plan. The first level requires all revenue cycle staff to pass an internally-designed core competency test made up of 200 questions spanning front- and back-end functions within 90 days of hire. Although staff continue to fulfill their original roles, passing this test comes with a standardized title and pay grade, as well as makes both staff groups eligible to fill temporary openings or take additional shifts in either department. Level two provides a 5% pay raise after completing a 28-course revenue cycle–wide curriculum, obtaining certification,

% of Organizations Undertaking Leadership Development Initiatives in the Past Two Years

Source: Revenue Cycle Academy (2016)

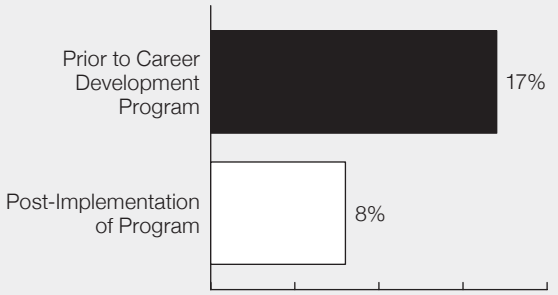


In addition to being a top-10 priority going into 2016, as identified by The Academy's survey preceding this report, 95% of providers reported during a recent Academy webinar that they have either implemented initiatives to improve leadership development within the past two years, or plan to do so in the coming year.

and presenting as well as taking on an improvement initiative or other project. Level three consists largely of leadership-related courses—including project management, conflict resolution, business ethnics, and more—but also requires staff to lead a Continuous Quality Improvement project. Not only does such an approach help identify potential leaders more quickly, but it later equips them with as well as tests their leadership skills. Furthermore, this organization experienced a more than 50% decrease in staff turnover and has also noticed enhanced recruitment.

Revenue Cycle Staff Turnover Rate at California Health System

Source: Revenue Cycle Academy (2016)



Through implementation of a career pathway, which includes leadership skills training, this organization was able to reduce turnover by more than 50%.

Evolving Staff Recruitment Strategies as Demands Increase

With heightened demand and competition for revenue cycle staff, many hospitals and health systems are looking beyond typical recruitment strategies like posting on field-specific job boards, and participating in job fairs and other industry events to effect more imminent results. For instance, some organizations offer recruitment incentives to staff who refer friends or acquaintances—perhaps by offering a prepaid gas card for a successful hire. Also, a Texas-based health system partnered with a local community college's medical office management program to recruit interns within its business office, allowing the organization to better evaluate an individual's work ethic and abilities before committing to long-term employment.

Such partnerships seem to be becoming more and more common, and are expanding to include not only local educational intuitions, but hospitality and retail companies as well. In at least one case, Goodwill has partnered with a healthcare organization to assist in vetting individuals with strong customer service backgrounds for patient service and access positions. This partner helps carry out initial training, provides new hires a mentor, and affords the healthcare organization a 90-day probationary timeframe in which leaders can assess whether each candidate is truly a good fit for the position.

Key Focuses of Academy Research in 2016

While organizations seem to be turning to external partners—often in the community but increasingly in other industries—to help recruit frontline staff, leaders are largely using internal strategies for nurturing their revenue cycle successors.

- Which tactics have healthcare organizations found successful in recruiting highly-qualified candidates for both frontline and leadership positions?
- How are current revenue cycle leaders working to develop and equip frontline staff to inherit supervisory, managerial, and even executive-level positions?
- What can organizations do to remain competitive and better retain top talent?

Exploring Trends in End-to-End Revenue Cycle Outsourcing

With the country's healthcare infrastructure in a rapid state of change, many leaders are finding that they lack the capital to fully invest in rebuilding their internal revenue cycles at the same pace or extent. This is leading them to look to more expansive, or end-to-end, offerings in which full processes, departments, or even entire revenue cycles are operated through an external business partner—though this market is still maturing.

Evaluating the Revenue Cycle Management Outsourcing Market

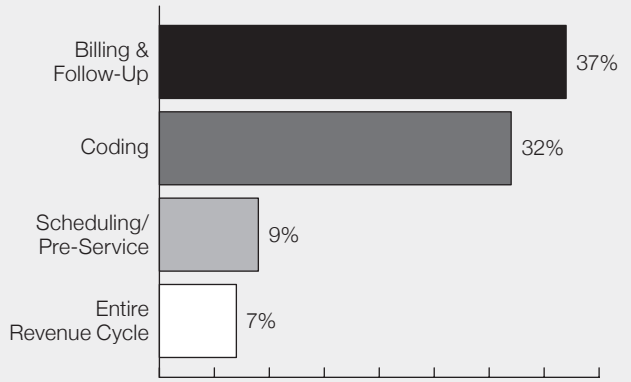
As headwinds within the healthcare industry come from a variety of directions—from accountable care organizations, value-based care and bundled payments, the ongoing decline in reimbursement rates combined with strengthening payer requirements, and the need for further data and information integrity—organizations have continued to seek increased expertise and cost-saving opportunities through partnerships with external organizations. Additionally, with changes in the insurance industry driving increasing numbers of patients to obtain care, facilities are also facing the need to increase staffing and other resources whether or not their margins allow for such added expenses.

As a result of these and other reasons, the revenue cycle management outsourcing market has grown at an expeditious pace over these past several years, and is expected to continue to do so. According to industry source MicroMarket Monitor, this market is expected to have an annual growth rate of 7.2% from 2014 to 2019. Moreover, Black Book Market Research LLC projected that the revenue cycle outsourcing market will increase from $7.7 billion to $9.9 billion by mid-2016 alone. However, within this market, there exists a variety of potential arrangements—from consulting on revenue redesign or enhancement, to outsourcing only a select few specific functions, or outsourcing the entire revenue cycle process. A previous Academy survey has indicated that only about 7% of organizations were planning to outsource their entire revenue cycle between 2014 and 2016, but this could also be indicative of the options currently available.

Many outsourcing agencies continue to emphasize extended business office services, offering claims processing, billing, balance recovery, and even cash posting and denial management resources, though these very same agencies exhibit a much more limited variety of front-end services aside from eligibility or financial screening. This could also be due in part to the current emphasis on the patient experience, which appears to be making providers hesitant to relinquish control over some of the more traditional patient-facing processes like scheduling and especially registration. Though appearing less common in the current market, vendors like Conifer Health Solutions do note being able to provide scheduling and financial clearance as part of their shared service–based model. And vendors like Optum360 also offer mid-cycle outsourcing services like coding, CDI, and charge capture.

Revenue Cycle Functions Considered for Outsourcing Between 2014 and 2016

Source: Revenue Cycle Academy (2014)



At the time of this survey, a small percentage of organizations were predicting the need to outsource the full revenue cycle—as opposed to certain functions.

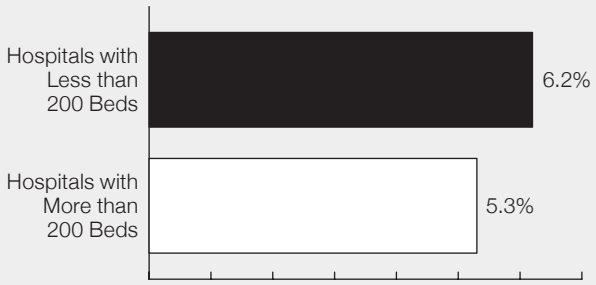
Ensuring True Partnership in Outsourcing Arrangements

While outsourcing certain or perhaps all revenue cycle functions can achieve true standardization, enhance compliance, and improve claims as well as collections efficiency, maintaining open lines of communication with such vendors and ensuring they adhere to the provider's mission and values could represent a wholly new challenge. This not only necessitates having a means with which to verify partners meet established goals, but that the provider also remains involved in setting those goals—both from the financial and customer service perspective. To emphasize patient-based results over financial outcomes, an Ohio health system set aside a certain dollar amount for each self-pay patient related vendors were able to convert to Medicaid as a performance bonus. This helped to emphasize the patient conversion rate over the resulting reimbursement amount.

In its transition to full outsourcing, a multi-state health system contracted with one of the large national firms to provide all back-end functions as well as a patient financial services director role that helps to oversee in-house patient access functions like scheduling, financial counseling, registration, and other activities. As part of the initial agreement, a certain percentage of existing provider staff were reserved at the vendor—for example, the patient financial services director role was filled by one of the provider's business office directors. The organization also decided to outsource revenue cycle functions among select pilot sites first, including hospitals of varying sizes and systems in order to project key impact. To ensure the vendor adhered to the performance standards and maintained the same level of quality customer service as before, the health system recorded patient-facing phone calls held by the vendors, monitored an executive dashboard that segments financial performance by group, hospital, individual accounts, and others, and conducted monthly reviews of both financial and customer service indicators with each hospital and Parallon.

Average Revenue Increases Among Providers Outsourcing Revenue Cycle Management

Source: Black Book Market Research (2014)



According to this industry survey, a large majority of hospitals attributed sizeable revenue enhancements to improvements made after outsourcing all or most of their revenue cycles.

Key Focuses of Academy Research in 2016

As trends in revenue cycle outsourcing unfold, The Academy will continue to keep a pulse on strategies for ensuring vendors act as an extension of the healthcare provider, and that leadership sustains transparency and influence on vendor-led operations.

- Are more organizations turning to process-based outsourcing solutions, and how are these solutions evolving within the healthcare industry?
- What criteria are used to identify best-fit vendors, and what steps are proving impactful in the selection process?
- How can healthcare providers maintain performance transparency and a certain level of governance over outsourced revenue cycle functions?

The 2016 Thesis

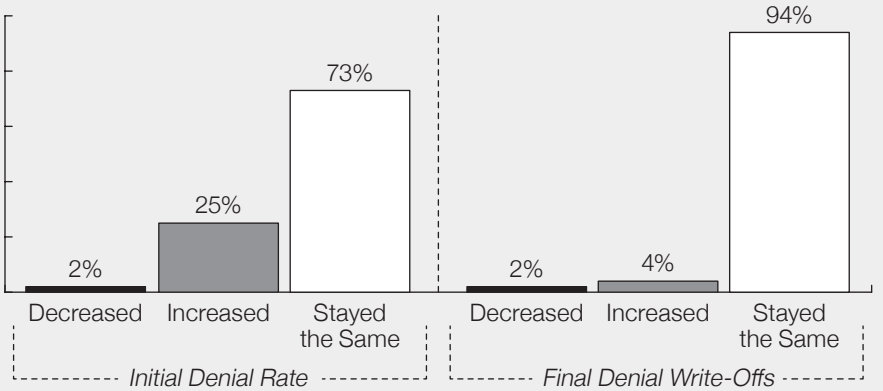
ANALYZING AND PREVENTING DENIALS WHILE IMPROVING PAYER RELATIONS

Introduction

Tracking and analyzing denials was the highest-rated priority among 12 initiatives listed within The Academy's 2016 Thesis Survey.

Denials management and payer relations have consistently been—and continue to be—at the forefront of many providers' revenue cycle concerns. In fact, Academy survey results indicate that around 90% of providers ranked "tracking and analyzing denials" as their top priority in the forthcoming year. In order to better identify and mitigate denial root causes, providers have been exploring how to advance data-driven analysis of denials-related performance as well as payer relations through more consistent evaluation of their own denials-inducing practices and contracted terms, which will ultimately enable providers to pinpoint the specific processes and practices throughout an ever-expansive revenue cycle that need to change in order to bring about cleaner claims.

Impact of ICD-10 on Denial Rates as of January 2016
Source: Revenue Cycle Academy (2016)



Contrary to the predictions of many in the industry, as of early this year, most organizations had not seen a dramatic uptick in denials as a result of ICD-10, though it is possible that an upswing could be forthcoming once CMS lifts the one-year grace period currently in place with respect to code specificity.

Using a Data-Driven Approach to Pinpoint Denial Root Causes

As advancement of data analytics gains traction as an effective manner with which to chart revenue cycle performance, providers have been increasingly using its capabilities to assist in root cause analysis of denials. Given all the touch points that affect whether a claim will be accepted, taking a closer examination and more narrow categorization of denials data can help leaders isolate the specific practices that need to be addressed, or staff members to further train, in order to influence behavior and achieve sustainable performance improvement.

Modifying Practices and Structures to Improve Clean Claims

In order to capitalize upon the results procured through root cause analysis, organizations continue to re-examine staffing structures and denials-related processes in order to effect optimal improvement while conserving as many resources as possible. Exploring different and innovative methods of organizing denials teams—whether around denial type, payer, and other factors—may reveal significant opportunities for actionable change. Furthermore, by raising awareness of denials throughout all revenue cycle departments, leaders may be able to effectively create a culture of denials prevention in which all staff members realize the role they each play and begin to collectively act to bring about overall improvement.

Holding Payers Accountable for Performance

Given the integral role played by payers in terms of both initial denials and final write-offs, organizations are seeking methods of ensuring that payers are held accountable for the accuracy and efficiency of their own performance. Developing scorecards and placing an increased focus on effective contract negotiations may not only help revenue cycle leaders secure favorable and easily enforceable terms, but also ensure further denials outside of provider control are prevented and optimal reimbursement is secured.

Promoting Collaborative and Mutually Beneficial Payer Relations

As part of denial prevention efforts, providers are looking to improve contracted terms and payer relationships to help influence the performance of external as much as internal stakeholders.

In order to maintain positive relations with payers and gain greater efficiencies in the claims submission process, some organizations are finding it beneficial to enhance the level of collaboration and communication between the two parties. Not only can providers gain insight from the payer process—and vice versa—but working together to identify and resolve issues may help pave the way for more efficient and effective processes in the future.

Though by no means a new priority for healthcare providers, ever-increasing claims scrutiny among payers, still declining reimbursement, new payment models, and more, all bring denials tracking and management to the very forefront of leaders' minds. The Academy seeks to develop further research regarding how organizations are:

- Identifying Denial-Causing Behavior Through Data Analytics
- Integrating Denial Prevention into Staff Culture and Workflows
- Promoting Payer Accountability to Ensure Optimal Reimbursement
- Cultivating Mutually Beneficial Processes for Payer and Provider

Identifying Denial-Causing Behavior Through Data Analytics

In order to take effective steps toward minimizing denials, organizations must first gain an understanding as to the specific behaviors that may be causing denials to occur in the first place. This is no small task given the fact that denials can and do originate from many different departments and revenue cycle areas. With new technologies and techniques continuing to emerge that enable customized or strategic data collection, the practice of data analytics has grown in popularity and advancement.

Strategically Categorizing and Analyzing Denials

Developing a standardized set of internal denial reasons based on ANSI codes and payer-specific meanings can help providers better facilitate identification of true root causes and necessary adjustments. Academy survey results indicate that some variance exists in terms of the optimal number of denial reasons to employ, with 28% of respondents using 0–10 codes, 23% using 11–20, 19% using 21–30, and 20% using more than 30. Finding the appropriate balance in this respect allows leaders to gain the most meaningful information and effect actionable change without overwhelming them with too much data.

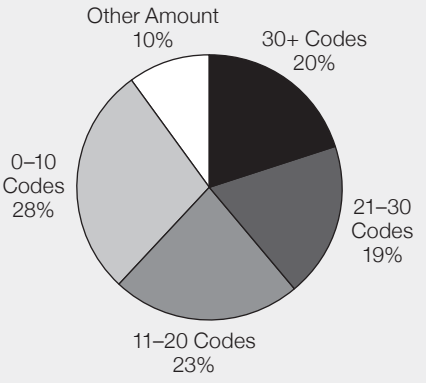
To further efforts in categorizing denials to facilitate meaningful analysis, some organizations are also differentiating initial denials from fatal denials—or those that are not expected to be recovered through appeal. In doing so, organizations may be able to gain more accurate insight into true, internal denials performance compared to those that are unpreventable or of payer error.

A Florida-based health system utilized the tracking and analysis capabilities of its analytical systems to compile denials data—more specifically, remark codes—by payer. This, in turn, allowed the denials team to develop a more deliberate prevention approach to payer-specific root causes, and also facilitated the sending of mass appeals to payers, since the denials could be grouped together as they came in. This organization was also on the market for a vendor that could further its efforts to sort through payer denial codes and translate them to internal remark codes to map, as an example, which denials are a result of unpaid exchange premiums.

At a Texas-based health system, leaders created a customized and interactive dashboard with the assistance of HBI's Member Driven Solutions team in which denials could be categorized at the click of a button by root cause, patient type, service area, revenue cycle department, individual physician, and other key categories as identified by the organization. This setup allowed staff members to more easily isolate potential denials-causing behavior in their specific department or their own workflows.

Number of Internal Denial Reason Codes Used by Organizations

Source: Revenue Cycle Academy (2015)



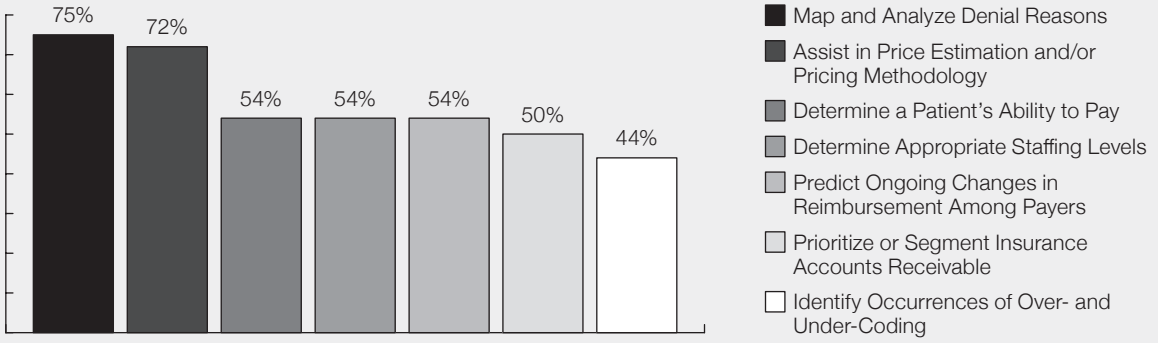
Academy research has found that around 20–30 internal reason codes has been successful among organizations that have standardized payer usage of ANSI codes.

Progressing from a Reactive to a Proactive Approach

While denials-related data has commonly been used to respond to already-established performance issues, The Academy has seen some indications of a potential shift toward a more

Organizations' Usage of Analytics Within the Revenue Cycle

Source: Revenue Cycle Academy (2016)



While data analytics furthers the aims of many different improvement initiatives, mapping and analyzing denial reasons topped the list as its most common usage for providers.

proactive analytics approach in which data is used to pinpoint an emerging trend and address it before it becomes an larger-scale issue. Rather than having to conduct a retroactive review to locate a root cause, staff would then be able to adjust practices before emerging issues result in a negative revenue impact.

In a similar vein, the use of predictive coding represents another forward-looking strategy that may help organizations minimize denials as the implications of the new code set's specificity continue to unravel in the forthcoming year—especially considering CMS' ICD-10 grace period, which is expected to end in October of this year. The Academy has seen one organization develop an internal predictive coding model by analyzing inpatient account history, including the specific characteristics of each case (e.g., length of stay) to note suggested codes and DRGs. These suggestions are planned to be included in EHR notes, providing coders with another source to consult when confirming their determinations. Taking a predictive approach in this way could potentially allow providers to function just as efficiently with fewer and/or less experienced coders during a time of high demand for qualified coding professionals.

Key Focuses of Academy Research in 2016

In order to gain more accurate insights about specific denials-causing behavior, organizations are increasingly leveraging data analytics to efficiently pinpoint and address root causes.

- How can organizations most effectively identify and collect denials-related data for root cause analysis and trending?
- Will ICD-10 have a more significant impact upon denials performance as payers become more stringent?
- What methods are organizations exploring in order to take a more proactive approach to the practice of data analytics and denials prevention?

Integrating Denial Prevention into Staff Culture and Workflows

Opportunities for improvement brought to light by data analytics or other methods of root cause analysis can help pinpoint the optimal course of action toward revenue optimization. However, for strategic adjustments to be effective in preventing denials, staff members must also understand how their roles affect one another and overall organizational performance, as well as learn to work together, instead of in silos, to elicit positive results.

Customizing EHR Technology to Mitigate Avoidable Denials

Since front-end functions remain a prominent source of denied claims for many organizations, taking measures to catch potential denial-causing errors upfront can not only improve clean claims performance, but reduce workloads for staff downstream. The Academy has seen one provider ask its patient access staff, specifically, to analyze denial reasons in order to identify those they could influence or prevent through EHR adjustments, while another facility in the Southeast developed EHR alerts for any services requiring pre-authorizations.

Similarly, The Academy has featured a provider that elected to develop rules within its EHR that recognize key words associated with potential denials. If one of the words is recognized, a biller is alerted and able to work to resolve the issue prior to the claim being submitted. Since the system handles the bulk of the effort, using EHR technology in denials prevention allows providers to expend a minimum amount of resources and/or staff time while efficiently preventing common revenue losses.

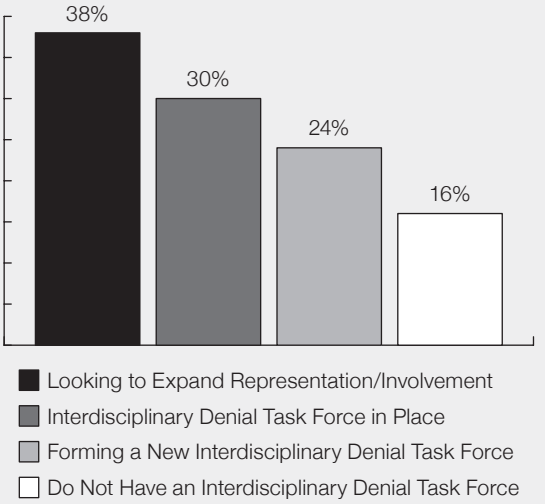
Structuring Teams by Denial Type

Whereas centralization of denials management teams has previously held sway as a popular approach to staff structure in this arena, organizations are increasingly looking to create committees or workgroups that are categorized, instead, by specific denial type or reason. Such a structure may be more easily aligned with data-driven objectives and can also help foster a more widespread culture of denials management in which staff members recognize their contribution to both an organization's financial loss and success.

One Southeastern provider organized its team into three separate sections based on its most commonly received fatal denial types: medical necessity denials, authorization-related denials, and those associated with non-credentialed providers. This strategy can also be much more fluid, with relevant staff engaged around very specific root causes as they emerge or are identified. This may even represent an effective compromise between having a dedicated team maintain constant focus on denials issues and the practice of forwarding occurring denials back to responsible parties for resolution.

Organizations' Usage of Interdisciplinary Denial Task Forces

Source: Revenue Cycle Academy (2016)

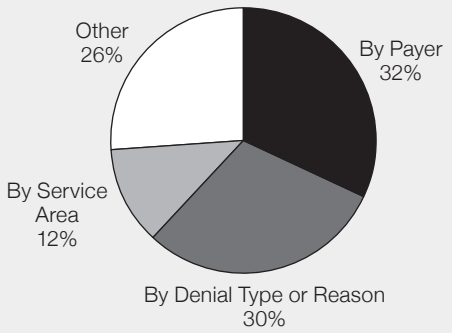


Interdisciplinary denial task forces—while recognized as an effective way to increase awareness of denials system-wide—have not yet been implemented or refined by many organizations, highlighting a significant opportunity to explore in 2016.

The Academy has also seen an organization structure its denials team by specific payer, finding that staff were better able to gain familiarity with each payer's specific requirements and develop effective communication strategies. For example, staff members were able to develop relationships with payer representatives who could serve as their central point of contact. Fostering this level of familiarity with payers may help staff members pinpoint the most successful approaches to take based on previous interactions with the payer (or representative) in question. This approach may also prove effective for organizations whose data analytics approach is also focused by payer.

Structures of Denials Management Teams/Workgroups

Source: Revenue Cycle Academy (2016)



There appears to be an emerging shift from having a dedicated and centralized denials team to developing workgroups around top denial reasons as they arise.

Fostering an Organization-Wide Culture of Denials Prevention

Establishing a denials committee or team can be a particularly effective way to gain buy-in from departmental staff and create a system-wide culture of denial prevention. For instance, certain organizations involve business office or patient accounting staff, patient access staff, coding, utilization review and/or case management, managed care, information systems, and other key representatives—including from ancillary areas—as needed. Involving certain clinical staff members in the committee may also be a beneficial endeavor, since doing so could help obtain not only their buy-in for denials-related initiatives, but also valuable insights they may have to share on any given subject.

Regardless of the precise staffing model in place, it also may be beneficial to place the organization's data analytics team or the department handling denials reporting, along with the denials team and auditing team (e.g., QA department, etc.) in close alignment under the same governance structure. Situating these three groups in close proximity enables them to more easily work together to identify trends and remediate them, as well as provide education to prevent similar issues in the future.

Key Focuses of Academy Research in 2016

To better promote clean claims and a system-wide culture of denials prevention, organizations are exploring several strategic adjustments to denials-related structures and processes, seeking to identify those most likely to drive desired improvement.

- How are organizations promoting awareness of denials among all revenue cycle staff?
- How are providers structuring denials teams?
- What process adjustments are being explored in the effort to enhance the rate of clean claims?
- How is the usage of interdisciplinary denials task committees continuing to evolve?

Promoting Payer Accountability to Ensure Optimal Reimbursement

Given the recent increases in Medicare Advantage Plans and managed care, as well as intensified payer scrutiny and requirements, many providers have been increasingly focused on how to effectively and consistently hold payers accountable for their performance—especially for denials of their own error. By developing methods and safeguards to better ensure that payers are following agreed-upon contract terms, organizations may be able to increase the likelihood that they receive the reimbursement they are owed in a timely, resource-effective manner.

Developing Effective Tactics for Successful Contract Negotiations

One of the principal manners in which providers may be able to set the stage for payer accountability is the contract negotiations process. Practicing an effective negotiations approach can help providers ensure contracts are favorable for their needs and also easily enforceable. One organization created a multidisciplinary managed care council—with representatives from patient financial services, reimbursement, registration, and more—to oversee payer-related issues, such as contract negotiations. As part of this council, several individuals with contracting experience were selected to form a smaller, specialized negotiations group to review prospective payer contracts and ensure the organization's expectations are being adequately met. As part of this process, the team solicits input from different departments to ensure all affected parties have an opportunity to voice their thoughts, suggestions, and/or concerns about the stipulations within the contract. After evaluating the contract and compiling a list of requirements/critiques, the team will go over the document with the payer until the two can reach an agreement about rates.

To limit the possibility of future contract adjustments after an agreement has been reached, some organizations recommend including standardized language in the contract itself to limit the possibility for retroactive changes on the part of the payer. Doing so can help prevent issues related to reimbursement and/or unfavorable terms. Similarly, certain organizations choose to include language in their payer contracts that place limitations or restrictions on the number or scope of audit requests, which helps the provider reduce the amount of time and/or effort spent on payer audits.

Example Metrics to Include on a Payer Scorecard

Source: Compilation of Revenue Cycle Academy Resources

- Differentiation between inpatient and outpatient cases
- Days in A/R
- Total A/R
- A/R over 90 (with or without a denial)
- % of claims accepted on first pass
- Payments posted
- Underpayments
- Denials posted
- Denials as % of payments
- Denials appealed successfully
- Actual vs. expected reimbursement
- Cost-to-collect
- % bad debt from payer's beneficiaries
- Average time to process claims (or % paid within 60 days)
- Provider inquiry calls

By regularly tracking a combination of valuable metrics, organizations may be able to use data to assist them in motivating payer performance improvements.

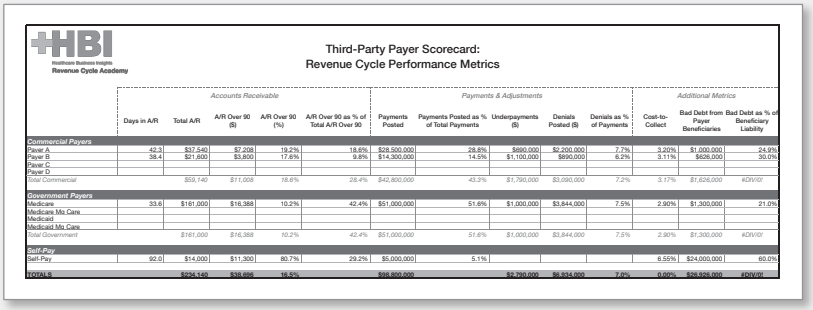
Proactively Monitoring Standardized Performance Metrics

Another method providers have been using to track payer performance is to develop scorecards or standardized evaluations specific to their payers and based on established payer-provider contracts. Not only can standardized scorecard templates enable providers to compare payer performance—and possibly drive performance by instilling a sense of competition among the involved parties—they can also be used to pinpoint areas that

may be in need of improvement, which can be incorporated into contract terms to ensure certain issues are avoided or minimized in the future.

Some examples of metrics that may be worth considering for such a scorecard include days in A/R, total A/R, A/R over 90, denials posted, payments posted, cost-to-collect, underpayments, how much of the organization's bad debt is among a certain payer's beneficiaries, and any other metrics that are easily measurable and indicative of a given payer's respective performance. Some organizations also chart the impact of payer performance upon their own processes, staff, and time by soliciting feedback from staff regarding the effort required to complete certain tasks for each payer (e.g., verification, eligibility, authorizations). Combined with the hard data discussed in the preceding sections, this type of feedback can provide a fuller picture of how a given payer is performing, providing organization leaders with ample data to support requests for improvement in low-scoring areas.

View The Academy's Example Payer Scorecards



Third-Party Payer Scorecard:
Revenue Cycle Performance Metrics

HBI Healthcare Business Insights
Revenue Cycle Academy

	Accounts Receivable					Payments & Adjustments					Additional Metrics		
	Days in A/R	Total A/R	A/R Over 90 ($)	A/R Over 90 (%)	A/R Over 90 as % of Total A/R Over 90	Payments Posted	Payments Posted as % of Total Payments	Underpayments ($)	Denials Posted ($)	Denials as % of Payments	Cost-to-Collect	Bad Debt from Payer Beneficiaries	Bad Debt as % of Beneficiary Liability
Commercial Payers													
Payer A	42.3	$37,540	$7,208	19.2%	18.6%	$28,500,000	28.8%	$690,000	$2,200,000	7.7%	3.20%	$1,000,000	24.9%
Payer B	38.4	$21,600	$3,800	17.6%	9.8%	$14,300,000	14.5%	$1,100,000	$890,000	6.2%	3.11%	$628,000	30.0%
Payer C													
Payer D													
Total Commercial		*$59,140*	*$11,008*	*18.6%*	*28.4%*	*$42,800,000*	*43.3%*	*$1,790,000*	*$3,090,000*	*7.2%*	*3.17%*	*$1,628,000*	*#DIV/0!*
Government Payers													
Medicare	33.6	$181,000	$16,388	10.2%	42.4%	$51,000,000	51.6%	$1,000,000	$3,844,000	7.5%	2.90%	$1,300,000	21.0%
Medicare Mix Care													
Medicaid													
Medicaid Mix Care													
Total Government		*$181,000*	*$16,388*	*10.2%*	*42.4%*	*$51,000,000*	*51.6%*	*$1,000,000*	*$3,844,000*	*7.5%*	*2.90%*	*$1,300,000*	*#DIV/0!*
Self-Pay													
Self-Pay	92.0	$14,000	$11,300	80.7%	29.2%	$5,000,000	5.1%				6.55%	$24,000,000	60.0%
TOTALS		**$234,140**	**$38,696**	**16.5%**		**$98,800,000**		**$2,790,000**	**$6,934,000**	**7.0%**	**0.00%**	**$26,928,000**	**#DIV/0!**

To review a sample of scorecards utilized by peer organizations, view The Academy's Payer Scorecards implementation portfolio at ***www.hbinsights.com/viewid/59154.***

Aside from the competition that could likely arise in light of such data transparency, providers can further promote accountability in how they convey this information to the payer. Some organizations have found success by holding regular face-to-face meetings to share scorecard results and clearly convey to the payer their strengths and weaknesses. Regular meetings of this nature can provide a forum to highlight desired improvements, discuss contract adjustments, and/or troubleshoot recurring issues—all of which can work to ensure payers are held accountable for their performance and adhere to agreed-upon contract terms. Letters or other standardized reports can also be an effective means of communicating performance results, though it may be important to follow up with the payer to ensure the desired message has been received and actions are being taken to realize change.

Key Focuses of Academy Research in 2016

With the current healthcare climate placing increased pressure on providers to proactively monitor payer performance, organizations are seeking strategies to better harness performance data to leverage improvements in reimbursement and contract compliance from their payers.

- What innovative strategies can organizations use to most effectively promote payer accountability for performance?
- How are organizations using data analytics to promote improvements in payer performance?
- What tactics are organizations using to ensure contract negotiations result in beneficial agreements and that agreed-upon contract terms are followed?

Cultivating Mutually Beneficial Processes for Payer and Provider

With the number of accountable care organizations on the rise, as well as the continued increase in regulatory and claims scrutiny, organizations may benefit from taking a more collaborative approach to the payer–provider relationship in order to proactively protect reimbursement. By setting the framework for an open and ongoing exchange between themselves and payers, organizations may be better able to glean insight from the payer perspective and work to develop mutually beneficial processes that will enhance the efficiency and accuracy of the claims processing cycle for all involved.

Customizing Payer-Facing Communication

One way in which providers have been working to enhance payer relations is by tailoring their payer-facing communication for optimal efficiency. For example, a health system in the Southeast created a customized coordination of benefits (COB) form to distribute to its payers upon receiving a COB-related denial—which were increasing in volume—instead of using disparate COB forms among each payer. This form, which asks the patient about primary and secondary health insurance coverage as well as their signature to verify accuracy, has been widely accepted by the organization's payers as it mimics their own forms' commonalities and enables staff members to more quickly locate and submit the appropriate COB form to the payer. Such an approach can help improve the efficiency of the process for both, and has helped the organization make significant improvements to its COB recovery rates.

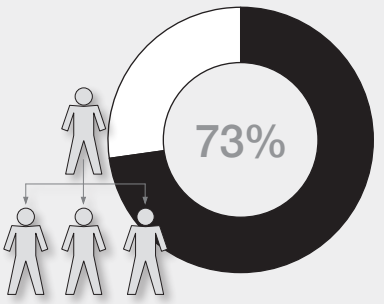
Involving the Payer in Troubleshooting to Collectively Resolve Issues

While communicating expectations to payers is an important strategy to motivate performance, including the payer in troubleshooting conversations regarding denied claims and/or audits can help both parties glean insight from one another and work together toward a mutually beneficial solution. Opening the avenues of communication in this way may not only help resolve recurring issues, but also establish a positive rapport between the provider's staff and the payer's representatives.

For example, a Florida-based health system opted to improve the efficiency and impact of payer audits by clearly outlining audit standards and requirements into its payer contracts and encouraging a collaborative exchange of ideas. Among the stipulations, the provider requires that payers requesting a mid-/large-scale audit must bring staff onsite to the facility, as well as send a list of the requested records in advance and hold an exit interview to discuss their findings—sometimes including coding, medical records, or other staff and/or leadership as needed. These meetings allow staff members to work through identified issues directly with the payer representatives over the course of a couple hours and attempt to resolve them that day. Such collaboration can lead to greater efficiencies for both parties, as it allows issues to be addressed quickly and efficiently and provides insight that can be employed in the prevention of similar issues in

Organizations with Clinical Denial Appeals Staff Reporting Through the Revenue Cycle

Source: Revenue Cycle Academy (2015)



As mentioned throughout this report, more and more organizations are moving staff related to clinical denials under the revenue cycle purview given these functions' impact on financial metrics and payer relations.

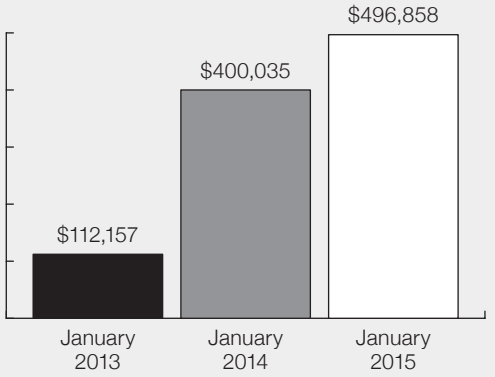
the future. Furthermore, this provider includes within its contracts that payers must submit any remaining denials in writing within 60 days of the onsite audit.

Fostering Concurrent Communication to Address Issues in Real-Time

Similarly, a New York-based provider utilizes its chief medical officers conduct conference calls either once per month or once per quarter—depending on payer—to appeal or dispute denials with the payer's medical director. Not only has this resulted in a more successful appeal rate, as well as reduced resolution costs for both the provider and payer, but the organization's revenue cycle director explains that "our physicians have loved it—they like being able to talk to a colleague directly about the case, the treatment, and necessity."

Southeastern Organization's Coordination of Benefits Recoveries

Source: Revenue Cycle Academy (2015)



Since developing a customized COB form for its major payers, this organization has seen significant increases in its COB recoveries.

As many other organizations have recently done or may be exploring, this provider also brought clinical denials, utilization review, and outpatient audit staff under the corporate revenue cycle, or more specifically, a revenue cycle clinical support director. Recognizing the tremendous opportunity the mid-cycle represents in preventing denials—as it is truly the only time a patient, provider, and payer are all engaged in a case—this organization is hoping that such a structural adjustment will allow more concurrent conversations to take root. For instance, UR staff may be able to review level of care or patients status and confirm acceptance by the payer all at the point of entry or while the patient still remains in a hospital bed. Leaders suspect this will create more influence with the payer, as hospital staff will be able to inform the patient directly when a payer deems inpatient status or their procedure non-covered. A leader at this organization also noted that it could also prove impactful to inform the payer that the healthcare provider will pass along the payer's contact information to the patient so they can address any questions or concerns. This may indeed be where the industry is going—a more concurrent as opposed to retrospective documentation, review, and approval process among both providers and payers.

Key Focuses of Academy Research in 2016

In order to promote an efficient claims submission process while maintaining positive payer relations, providers are seeking to enhance the amount of collaboration between the two parties—perhaps through more concurrent communication.

- What tactics are providers using to improve communication and collaboration with payers?
- What strategies are being employed to develop mutually beneficial and efficient payer–provider interactions?
- How are providers adjusting audit processes with payers in order to push back against increasing claim scrutiny?

The 2016 Thesis

EVOLVING PATIENT FINANCIAL LITERACY IN AN INCREASINGLY CONSUMER-DRIVEN INDUSTRY

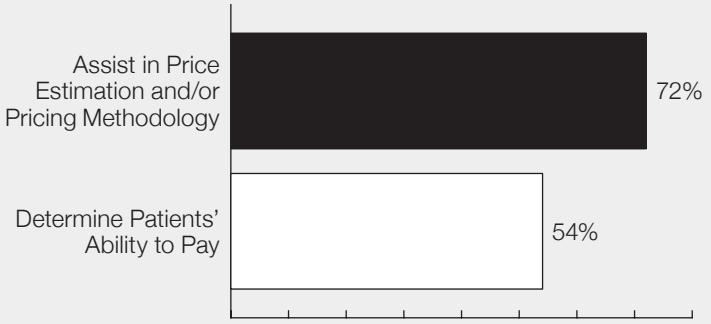
Introduction

As healthcare providers continue to acclimate to the changing needs of their patients, many are turning to other sectors like hospitality or retail to gain new ideas for service improvement.

Revenue cycle leaders have shown they understand the importance of treating patients as consumers in a progressively competitive market. While the phrase "patient financial experience" garnered much attention during the past year, many organizations are still exploring how best to solicit feedback and adapt processes in a manner that truly impacts customer loyalty. Resulting improvement initiatives are becoming inclusive of many different approaches, such as dedicated staff roles, new key performance indicators and monitoring mechanisms, as well as customer amenities familiar in other industries.

Organizations' Use of Analytics to Support the Patient Financial Experience

Source: Revenue Cycle Academy (2016)



By incorporating and advancing data analytics within the revenue cycle, healthcare providers are able to support a more positive patient financial experience, such as by offering enhanced estimates or calculating propensity-to-pay scores to tailor financial counseling or collection approaches.

Maturing 501(r) Compliance Efforts

While the 501(r) Final Rule is no longer a new development within the industry, many providers are still in the process of adapting processes to ensure compliance as well as educate and connect self-pay and underinsured patients with available financial assistance options. Calculations for amounts generally billed are now being applied to self-pay balances at the majority of surveyed organizations, and relations with vendors are being reassessed to ensure interactions with patients are compliant. Financial assistance education, especially, is evolving, as efforts are expanding beyond posting charge data online to include more expansive community outreach. Some organizations also are improving access to financial assistance options by instituting more flexible, and even retroactive, timeframes for applying charity care to outstanding balances.

Supporting the Patient Financial Experience

As the perception of patients as consumers becomes widespread throughout healthcare, providers are beginning to examine how best to monitor the effects their improvement initiatives have on actual satisfaction. However, because the industry currently lacks consensus on a core set of key performance indicators and resulting benchmarks specific to the patient financial experience, providers are taking the initiative to develop their own internal metrics and staff roles to evaluate and undertake related projects.

Incorporating Initiatives from Outside the Healthcare Industry

The increasing emphasis on consumerism in healthcare has created an opportunity to also incorporate best practices from outside the healthcare sector. For example, price transparency is maturing through multiple avenues, such as offering self-service or consolidated estimates, linking patients to online and mobile billing options, and exploring the appropriateness of refunds and other service recovery tactics. The Academy expects patient self-service features to only grow in functionality and popularity in 2016.

Adjusting Billing and Collections Processes

Patients are becoming more informed about their healthcare and related responsibilities, and this increased awareness has encouraged many to be more vocal about their concerns and opinions—especially during the billing and follow-up process. Providers are harnessing this feedback through surveys, patient membership on advisory committees, and other methods. Many organizations are proactively adjusting these processes to include improved vendor monitoring, dedicated staff who serve as billing liaisons, and tailored attention on self-pay and other specific patient populations.

Mobile bill pay, especially, remains an option many providers are exploring and working to implement in various forms, though it has yet been fully operationalized on a wide scale.

In light of these evolving priorities, many organizations are developing innovative strategies to promote a revenue cycle continuum that represents a seamless and positive patient financial experience. This section will explore trends that are defining current initiatives and indicate where providers are focusing their attention in the coming year:

- Improving Financial Assistance Accessibility and Patient Outreach
- Introducing Patient Financial Experience Metrics and Roles
- Integrating Consumer-Driven Strategies from Other Industries
- Crafting Patient-Centric Billing and Collections Practices

Improving Financial Assistance Accessibility and Patient Outreach

As healthcare providers grow more familiar and comfortable with the provisions of the 501(r) Final Rule, the industry is shifting from a period of learning how to comply toward developing best practices that strike a balance between organizations' financial needs and those of their patients. As part of this transition, formulas for amounts generally billed are maturing, and patient education efforts are becoming more robust.

Adjusting Self-Pay Balances and Write-Off Eligibility Practices

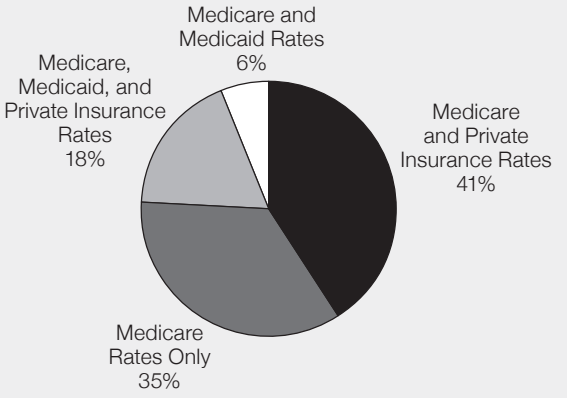
More than two-thirds of respondents to The Academy's 2016 Thesis Survey reported finalizing calculations for amounts generally billed (AGB), and more than half have also applied these AGBs to self-pay balances. About 24% of respondents using Medicaid data, in part to calculate these amounts, though it appears most common to rely on Medicare and private insurer rates—41% of organizations do so. Compliance strategies for 501(r), however, are extending beyond AGB calculations, such as by expanding presumptive charity processes. In this regard, front-end screenings—during registration, for instance—are growing in prominence, with some organizations instituting presumptive charity both pre-service and pre-billing to ensure no extraordinary collection actions will occur on accounts eligible for financial assistance.

Some providers continue to rely on manual presumptive charity screenings, such as an Idaho-based provider that has developed an interview form for registrars to work through. These staff members ask patients about their use of subsidized housing and/or food stamps, whether they are homeless, or if they know themselves to be eligible for other state or local assistance programs. If the patient answers "yes" to any of the questions or is deceased, estimated bills of less than $5,000 are automatically written off. Accounts estimated above that threshold are forwarded to a supervisor for review.

Technology in this realm is growing. By using a tool to search for credit histories, census data, and available assets, an Illinois-based provider is able to ensure various levels of charity care are applied appropriately and consistently among all patients before they are connected with financial counselors. Using this strategy, a healthcare provider could efficiently screen all patients to ensure financial assistance options are available to all who qualify, including those who remain unresponsive to requests for financial information, another major concern that was expressed by providers when 501(r) was proposed.

Approach Utilized by Organizations to Calculate Amounts Generally Billed

Source: Revenue Cycle Academy (2016)



The majority of organizations that reported finalizing AGB calculations are already applying the results to self-pay balances. However, the formulas used to arrive at AGBs vary significantly among organizations.

Improving Patient Literacy

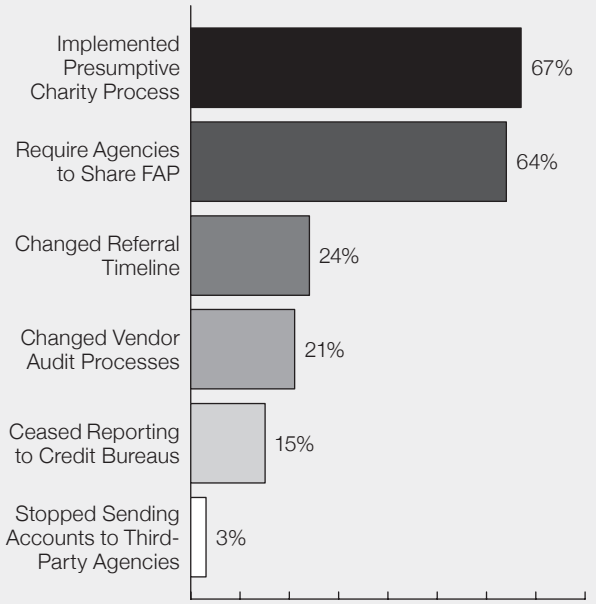
Patient literacy and outreach efforts are evolving beyond simply posting financial assistance policies on provider websites. One Ohio-based organization renovated an RV as a mobile office for certified application counselors. The CACs meet with patients at private workstations within the RV to explain financial

assistance options, possible external sources of assistance, and insurance exchange enrollment.

Healthcare providers are also becoming more creative in enlisting community partners or using internal resources to spread financial assistance information. One organization in Minnesota developed online videos to advertise the availability of financial counselors as well as overview front-end financial functions, such as price estimation. Other organizations rely on frontline staff to educate patients about their benefits and assistance options as part of their regular workflows. For example, an organization in Vermont conducts full benefit reviews for patients about to undergo extensive treatment, such as cancer care. These reviews involve a discussion of out-of-pocket maximums, assistance options, and other related topics to quickly inform patients about their financial responsibilities before encouraging them to focus on their treatment.

Organizations Adjusting Self-Pay Outsourcing Practices Given 501(r) Provisions

Source: Revenue Cycle Academy (2016)



Healthcare providers are adjusting their self-pay collections practices in a variety of ways as 501(r) compliance evolves, such as further developing presumptive charity care processes and monitoring external partners more closely.

Many healthcare providers also promote the accessibility of financial assistance options by allowing charity care to be applied to outstanding balances beyond those associated with the most recent episode of care. Roughly 74% of Thesis Survey respondents allow eligible patients to apply charity care to balances from past, present, and future care. Roughly half of respondents allow retroactive charity, however, to apply only to accounts aged 12 months or fewer. It also appears most common to limit future application to balances accrued within a maximum of 12 months, with a handful of providers indicating charity care applies only to the current calendar year, regardless of how many months remain.

Key Focuses of Academy Research in 2016

The focus on both compliant and patient-friendly self-pay collections will continue to increase due, in part, to growing enrollment in high-deductible health plans that yield large patient out-of-pocket responsibilities.

- At the advent of 501(r), are organizations changing the way in which they apply charity care and other financial assistance (whether presumptively, retrospectively, or another way)?
- In what ways are organizations attempting to reach and inform a greater number of patients who may be eligible for exchange plans or other financial assistance?
- How is 501(r) affecting relationships with external vendors, such as collections or bad debt agencies?

Introducing Patient Financial Experience Metrics and Roles

Healthcare providers are reconfiguring revenue cycle structures and processes as part of a broader effort to define and measure the patient financial experience in order to better pinpoint ways to improve it. This includes repurposing, renaming, or even implementing new staff roles to place focused attention on such tracking and enhancement efforts.

Creating Key Performance Indicators

While clinical interactions are being measured through HCAHPS, the healthcare industry does not yet have a standard survey specifically for revenue cycle touch points—even though these are often more numbered and influential than clinical touch points—nor key performance indicators tailored to the patient financial experience. Without existing data to draw from, it can be challenging to set benchmarks for performance. For example, while it may seem obvious that the accuracy of a patient's estimate would affect their overall experience, how should a provider determine that accuracy? Should a predetermined percentage of all estimates provided be within a certain dollar range of actual costs?

Due to these challenges, industry benchmarks might prove elusive for some time. As a result, providers are beginning to establish and track KPIs in this realm based on self-identified needs and abilities. A Texas-based organization developed a broad range of KPIs with which it plans to track the patient experience across multiple departments. The organization's vice president of revenue cycle and business office director will oversee performance in these areas, and individual staff members will be held accountable for the relevant metrics.

Example Patient Financial Experience KPIs Introduced by Texas-Based Organization

Source: Revenue Cycle Academy (2016)

- Pre-Service Collection %
- Patient Estimate Accuracy
- Billing Statement Accuracy
- Billing Statement Ease of Understanding
- Billing One-Call Resolution
- Medicaid Conversion %
- Charity Conversion %
- Collection % from Bad Debt
- Patient Credit Balance Turnaround Time
- Online Payment %
- Online Patient Inquiry Response Time

Organizations have a variety of options for KPIs they could measure to monitor the patient financial experience depending on their needs, but industry consensus on benchmark performance might take a while to form.

KPIs at this organization include accuracy of billing statements, determined both via patient surveys and an internal monthly audit of 50 billing statements, the percentage of out-of-pocket balances collected during pre-service, the percentage of self-pay collections from bad debt, and credit balance turnaround time, among many others. In monitoring these KPIs, the organization hopes to be able to better understand the link between patient satisfaction and collections. To select KPIs to measure, leadership at this organization tried to view the revenue cycle from a patient's perspective to identify interactions that could affect the overall experience, such as billing and collections processes. From there, they determined what they would be able to measure related to those interactions. Without industry benchmarks to draw from to set performance goals, this organization will first track and trend baseline achievement to determine reasonable expectations for improvement going forward.

Adjusting Staff Roles to Further Emphasize a Patient-Focused Approach

To ensure patient experience initiatives receive proper oversight, many healthcare providers are altering expectations for existing staff or creating positions dedicated to those efforts. According to Academy research,

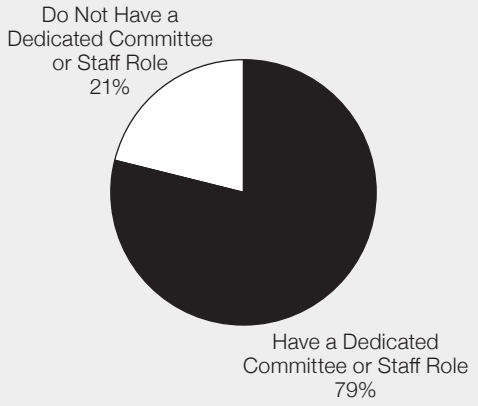
79% of organizations now have a dedicated committee or staff role specifically focused on identifying and carrying out initiatives to improve the patient experience.

The patient experience coordinator role created by a Midwestern provider, for example, reviews the results of billing surveys and helps relevant departments design and implement improvements to boost patient satisfaction among other duties. By requiring this position to have a nursing background, this specific organization has developed a liaison between clinical and financial roles, potentially fostering a more holistic view of the patient experience.

A southern organization that embraced this strategy created the position of a financial resource coordinator, a staff member who manages patient estimate calculations and screens patients for financial assistance needs. Estimation efforts are focused specifically on self-pay patients and on patients or guarantors with high deductibles or other out-of-pocket costs. The financial resource coordinator owns a work queue that front-end staff members, who verify insurance benefits, can route self-pay patients to automatically, while underinsured patients are routed based on identified need.

Organizations' Oversight of the Patient Experience

Source: Revenue Cycle Academy (2015)



The majority of surveyed healthcare organizations have formalized monitoring of the patient experience by creating a staff role or committee structure to oversee related initiatives.

Some organizations have chosen to repurpose or simply retitle traditional revenue cycle roles to represent their increased emphasis on the patient financial experience. A Northeastern provider renamed its registrars "patient benefit advisors" and its financial counselors "financial advocates" to communicate an enhanced focus on promoting patient literacy of coverage options for benefits, financial assistance policies or avenues, and payment options on the front end. These staff members educate patients about their out-of-pocket responsibilities and help them set up payment plans or apply for additional financial assistance. Through making this change, the organization has noticed patients are more receptive to pre-service calls, which could result in a greater chance of continuing patient engagement and correlated satisfaction.

Key Focuses of Academy Research in 2016

Remaining competitive in the future-state industry will likely require organizations to develop new benchmarks for performance in order to keep a finger on the pulse of their true patient financial experience.

- How will the industry begin to evaluate the patient financial experience in addition to the clinical experience?
- How can healthcare providers ensure optimal performance regarding such metrics (e.g., statement accuracy)?
- What type of roles or staff responsibilities are being introduced or repurposed in order to apply greater dedication to the patient experience?

Integrating Consumer-Driven Strategies from Other Industries

Increased attention to consumerism's role in healthcare consumption is driving healthcare providers to look elsewhere in order to swiftly adapt to shifting patient expectations. Advancement in this area includes new approaches to familiar initiatives, such as price transparency, and the incorporation of methods historically rare in healthcare but common in other trades (e.g., hospitality or retail), such as offering refunds.

Enhancing Transparency and Understanding

While many healthcare providers' price transparency efforts originated in response to the ACA, or perhaps other state legislation, related initiatives continue to evolve. For example, in order to publicize "standard" charges, some providers are reevaluating their chargemaster and/or self-pay charges. One organization recently conducted a cost evaluation by incorporating multiple sources of data, such as payer contracts, market pressures, and physician compensation models. Among other features, the analysis included an algorithm designed to measure resource consumption for all services and procedures to ensure its adjusted prices were both in line with its costs and with what patients could reasonably expect to pay.

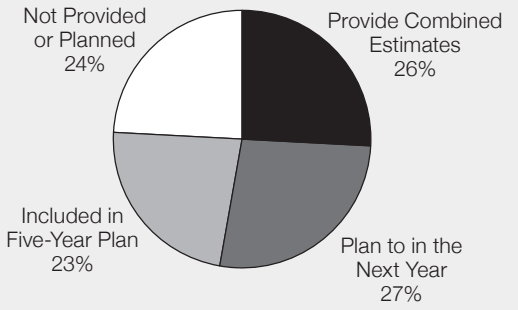
Price transparency also is evolving due to patients' increasing desire for personalized cost estimates. Many organizations' websites serve as conduits for estimation requests, and some include self-service generators that will provide patients an immediate estimate upon submitting key pieces of information, such as procedure codes, deductible amounts, and out-of-pocket maximums. Consolidated estimates, which provide potential costs for both hospital and professional billing, are becoming more popular, though many providers continue to perform these calculations manually while awaiting more robust vendor products.

Providers also are increasing transparency by making patient statements more comprehensive. Beyond now-standard statement redesigns that emphasize clarity, some organizations include Quick Response codes on their statements to drive patients toward online bill pay options. Another organization calculates potential monthly payments for patients without payment plans as an advertisement of the options available to them.

Furthermore, in an effort to improve responses to patient complaints and feedback after billing, some healthcare providers are borrowing a ubiquitous and entrenched strategy from retail: the refund. While payer contracts and third-party reimbursement can often complicate such efforts, some organizations are identifying innovative ways to compliantly test these initiatives. A healthcare provider located on the East Coast, for example, is piloting a third-party smartphone app that solicits patient feedback after care among members of its own integrated health plan. Using the app, a patient can report on both their financial and clinical experience, such as dissatisfaction if a physician promised but failed to check on the patient during rounding. The app also allows the patient to request a refund they believe to be fair per their displeasure—either a full or partial reimbursement of their co-pay.

Organizations Providing Hospital–Physician Charge Estimates

Source: Revenue Cycle Academy (2015)



Out-of-pocket cost estimation remains a popular strategy for improving patient financial literacy even as market products continue to evolve to better match organization and patient needs.

Expanding Patient Self-Service Options

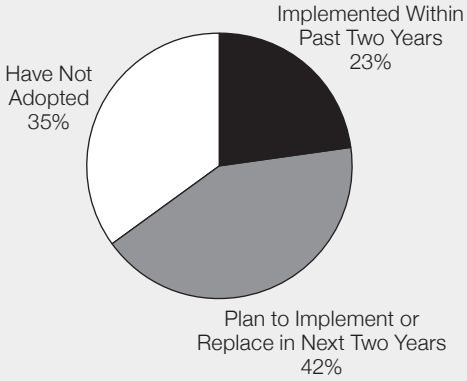
Many providers are beginning to embrace smartphone apps to offer other self-service options as well. While Academy research has shown only about 10% of organizations have had a mobile bill pay option, providers are continuing to explore and evaluate vendors in this space. However, building a smartphone app can be a time-intensive and expensive process, so some providers have chosen to incorporate industry-developed options instead. Some EHRs and even payers offer apps linked to their products that also allow patients to pay their medical bills. These apps can be robust, including options to manage bills at the guarantor-level and receive notifications when payment has been processed.

A variety of self-service options have also been adapted to allow patients to set up their own payment plans. A Wisconsin-based organization enlisted the assistance of a vendor to develop an online platform based on the provider's policy for acceptable risk. Payment plans can be created or adjusted on the platform, such as to alter the expected monthly payment or add new balances. Patients are alerted if terms they request fall beyond the organization's acceptable risk parameters (e.g., if a patient wishes to pay $50 per month but owes $10,000), and instructed to contact the provider for assistance. Offering this option has tripled the number of patients with payment plans, significantly increased the percentage of payments made online, and resulted in a 73% patient satisfaction rating.

Patients familiar with online shopping or automatic bill-pay in other industries also might see increasing options to leave a credit card on file with healthcare providers to streamline the billing and collections process. These arrangements could include pre-determined minimum and maximum amounts that can later be charged to a card the patient agrees to leave on file.

Adoption of Patient Self-Service Technology in the Revenue Cycle

Source: Revenue Cycle Academy (2016)



The majority of organizations responding to The Academy's 2016 Thesis Survey either already have implemented patient self-service technology (e.g., kiosks, portals, mobile applications) or plan to do so within the next two years.

Key Focuses of Academy Research in 2016

Adopting customer service strategies from other markets will continue to be a focus of revenue cycle leaders hoping to improve the overall patient experience and their competitive edge.

- How will price transparency efforts evolve in the coming year?
- What self-service options are organizations, and perhaps vendors, implementing and innovating to promote patient engagement?
- Are there compliant ways to offer patients service recovery options on a wider scale?
- How are revenue cycle leaders implementing mobile bill pay, and what can be done to encourage patient utilization of related smartphone apps?

Crafting Patient-Centric Billing and Collections Practices

Due to the significant role that billing and collections processes have in shaping patients' satisfaction with their care and overall experience, many providers are focusing improvement within these back-end functions more specifically. These efforts include ensuring both internally and externally focused processes are designed to not only secure payment, but account for patients' feedback and connect them with potentially needed resources.

Reconfiguring Internal Processes and Structures

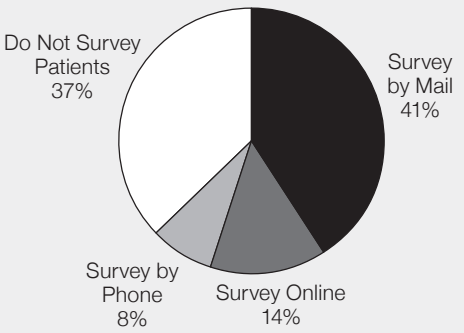
As providers emphasize to revenue cycle staff the importance of promoting and supporting a positive patient financial experience, it can be worthwhile to regularly solicit patient feedback to ensure initiatives are having the desired effects. The Academy expects the recent trend of surveying patients about billing and collections practices to continue, though these conversations can occur in multiple ways—whether sending questionnaires through the mail, requesting feedback at the end of customer service phone calls, or hosting a survey on the provider's website. Taking this concept further, one provider has at least two patients on every committee or advisory group, and its patient engagement council includes 20 patients who meet bimonthly with the organization's CEO. Other providers use their EHR portals to solicit patient feedback, such as by allowing patients to submit billing questions electronically and requiring staff follow up as necessary by email or phone.

In addition to dedicating roles to monitor the overall patient experience, as already mentioned, some providers are redesigning their back-end staff structures to promote positive billing interactions with patients, more specifically. These revised structures often include new or specialization within existing roles, such as financial counselors dedicated to self-pay patients with high estimated costs. At one organization, such a staff member reviews balances of at least $5,000 and helps determine whether patients will be able to meet their responsibilities. That screening is the first step toward connecting patients with financial assistance or payment options, such as a zero-interest payment plan.

Another organization also dedicated a patient advocate to conducting bedside visits for self-pay inpatients and insured patients with high deductibles to discuss financial assistance options, such as Medicaid enrollment. Another organization created the role of patient billing advocate, whose contact information is listed on all patient statements and who is available to answer questions and provide financial assistance information.

How Organizations Solicit Patient Feedback on Registration and/or Billing

Source: Revenue Cycle Academy (2015)



Paper surveys sent by mail appear to remain the most popular method for surveying patients about satisfaction with front-end and back-end revenue cycle functions, though online surveys may grow in popularity as patient portals continue to increase in functionality and use.

Redesigning External Partnerships

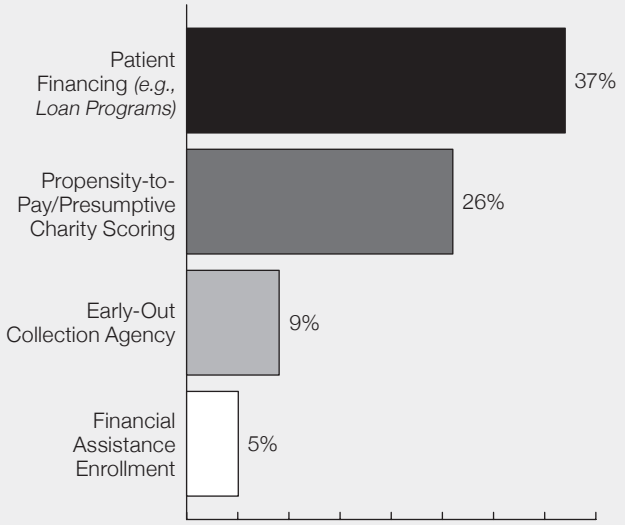
As mentioned previously, many healthcare organizations have altered their relationships with vendors in light of the 501(r) Final Rule, such as by changing their quality monitoring procedures. However, providers also are modifying these partnerships with the goal of creating

patient-centered billing and collections practices. For example, some vendors offer clients logs of patient complaints and access to accounting systems to view account assignments and actions in real-time. Healthcare organizations also are beginning to undertake more proactive initiatives, such as one provider that is developing a monitoring dashboard for its external collections partners. This tool is expected to include information about all accounts assigned to a particular vendor and to alert the provider if an account is assigned to a vendor not licensed to operate in the patient's home state, potentially helping to avoid regulatory concerns.

The trend of developing new staff roles extends to this area of the revenue cycle, too, such as through the patient experience coordinator role created by the Midwestern provider described previously. This staff member additionally audits collections calls and tracks trends in patient complaints. As more providers are enlisting the aid of early-out collections technology and/or vendor partnerships, this type of staff role could provide crucial oversight to identify and address any issues before they negatively affect the patient experience.

Organizations' Planned Patient Financial Experience Partnerships in the Next Two Years

Source: Revenue Cycle Academy (2016)



Healthcare providers intend to replace or implement solutions or business partner relationships within the next two years in a variety of areas that could support patient-friendly billing and collections practices when done strategically.

Finally, some organizations are looking to enhance or develop a variety of vendor partnerships to support billing and collections practices. External loan programs appear to be a popular initiative planned and/or revisited for 2016, as are propensity-to-pay and/or presumptive charity scoring programs. Others are likely to develop, as well, which The Academy intends to maintain a pulse on through the course of its 2016 research.

Key Focuses of Academy Research in 2016

Providers will continue to seek an appropriate balance among competing priorities with respect to billing and collections, including compliance, the patient experience, and cash flow.

- In what ways are organizations restructuring processes and structures to help simplify the billing and collections process, especially from a self-pay perspective?
- What surveying methods and questions yield the most comprehensive understanding of the patient financial experience?
- How are vendor offerings and partnerships expanding, and how can organizations monitor and influence their compliance and overall performance?

Healthcare Business Insights

ACADEMY COMMUNITIES

HBI
Healthcare Business Insights

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HBI's Information Technology Academy membership community serves Chief Information Officers and departmental leadership responsible for IT and clinical informatics governance, infrastructure management, support networks, and application deployment, security, and optimization.

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HBI's Supply Chain Academy membership community serves Chief Financial Officers, Chief Purchasing Officers, and their management teams in planning & forecasting, purchasing & sourcing, contracting, and materials management & logistics processes.

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HBI's Physician Network Academy membership community serves leaders focused on physician engagement, alignment, and cohesion—from Chief Medical Officers and Chief Transformation/Integration Officers to vice presidents, directors, and managers over the physician network or medical group.

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