

# Revenue Cycle Management Turnaround – A Case Study

*White Paper*



Business Advisors for the Healthcare Industry

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## INTRODUCTION

Revenue is the lifeblood of any business. Without revenue, regardless of the market segment or service line, an enterprise cannot thrive, let alone survive. Whether privately held or publicly financed (e.g., stocks/equity, bonds, etc.), the inflow of revenue and efficient operation precede the viability of any business.

Given the margins in healthcare, this is no less true in the operation of ambulatory outpatient physicians (or private practices) employed by health systems. Stunningly, some institutions continue to under-invest or place on the "back burner" the significance of revenue cycle management (RCM) and its accompanying component pieces. Healthcare margins are tighter than many service-oriented businesses outside of healthcare and, arguably, hampered by greater and more prolific regulation than for typical companies.

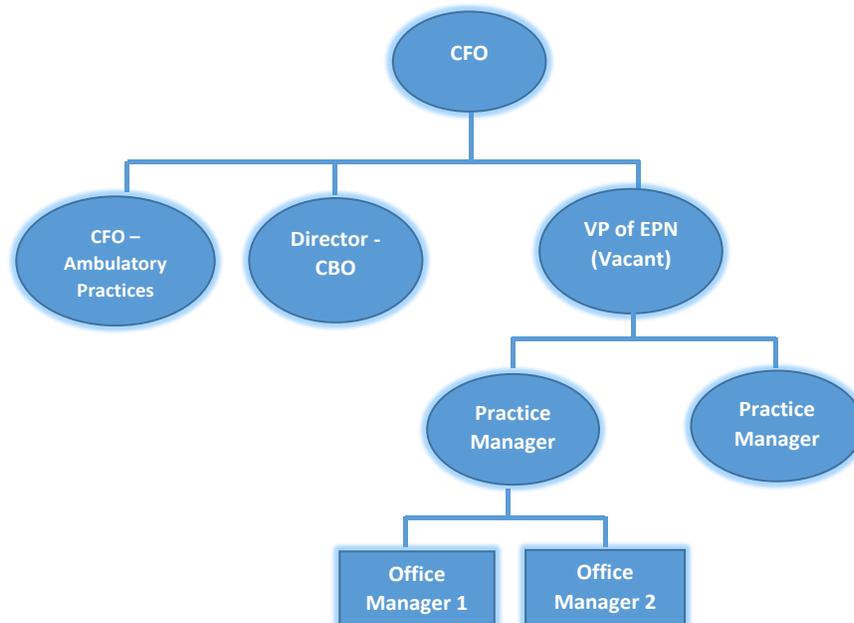
With that in mind, accurate billing and revenue management, from A to Z, is more crucial for a physician enterprise than for your local convenience store. Processes as delineated below are requisite.

In this case study, we explore the situation of a hospital system and Coker client that struggled with their RCM until the point that their financial foibles caught the C suite by the tail and threatened the fiber of the organization, forcing them to seek outside investment.

## THE SETTING – A BRIEF SNAPSHOT IN TIME

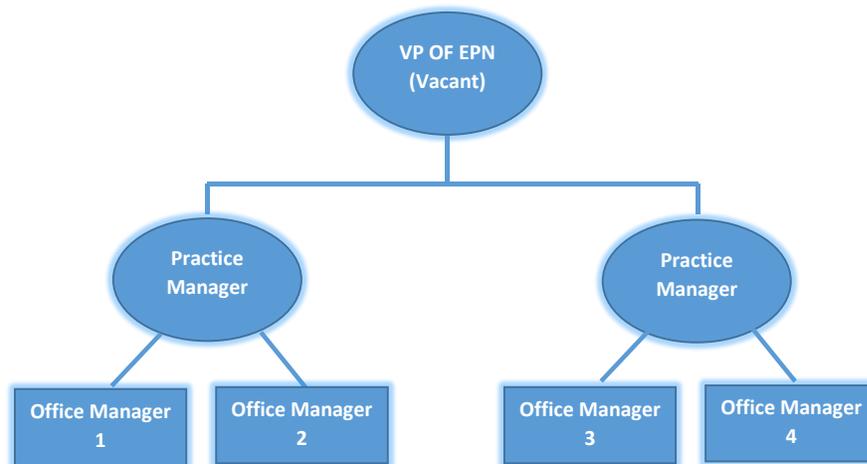
During late 2014 and into 2015, Coker was engaged by a community hospital with hundreds of employed physicians and extenders (nurse practitioners and physician assistants) encompassing multiple specialties to review their employed provider network's (EPN) RCM. The culture was open and "provider friendly," and physicians relished the benefits and protections that accrued from employment while joining the line of cohorts departing private practice. Coker would soon learn why physicians were so enamored with the system and senior management, to both parties' detriment.

Figure 1



As the system's employed model grew (see Figure 1), its problems grew in kind. Tangentially, the manager of the structure was weak, with the senior managers having few skills and little management experience. The position of vice president of the EPN had been vacant for some time foisting the practice operational duties and the RCM on to the CFO. Exacerbating the deficiencies were the front-line managers of the practices, the regular employees who managed the varying tasks of the smaller groups. These managers were ill-equipped to handle the complex tasks of practice management, even under the system's imprimatur, and there were few standard policies or procedures in place. Not all of the practice managers were sub-standard in their skills and experience, but they required training and leadership, which was lacking from the top down. A controller was brought in to assist with the RCM. The Director of the CBO was then asked to expand her job horizons outside of employment with the system. As Figure 2 illustrates, this leadership vacuum, on top of an already weakened system, fomented further chaos.

**Figure 2**



### THE LAY OF THE LAND

For several years, the system had buried the fact that their contractual adjustments were woefully understated, offering the peaceful fallacy that revenues were better than they were. The diagram below, Figure 3, provides an overly simplistic, but directionally appropriate, summary.

**Figure 3**

<b>As reported</b>	
Charges	\$ 100
(less contractuals)	\$ (50)
Net revenue	<u>\$ 50</u>

<b>Actual</b>	
Charges	\$ 100
(less contractuals)	\$ (80)
Net revenue	<u>\$ 20</u>

If the figures above were anywhere near the actual dollars involved, the system could've continued its ways. Instead, the system found itself nearly \$30MM in a hole, with cash on hand dwindling quickly.

One supposes that the CFO, for some time, inexplicably thought that the situation would eventually remedy itself. In other words, maybe fudging the numbers for one month would be ok. And then, when that proved easy, maybe it was simple to alter the numbers again for another month. And at some point, the die was cast, and the snowball began to roll, overtaking the then-CFO.

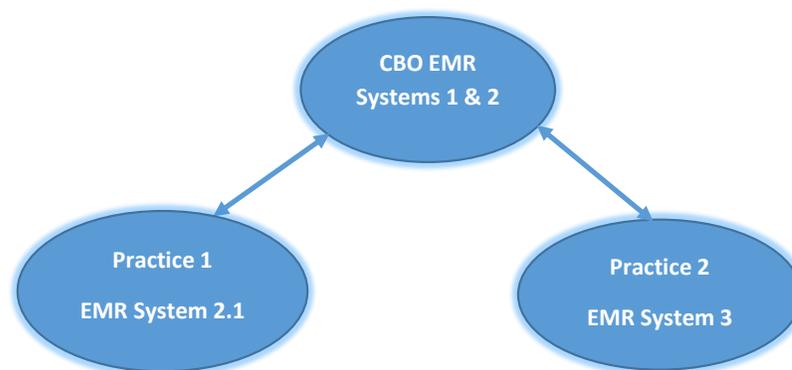
Whatever the case, that gamble was troubling and fraught with mathematical error. With the lack of structure, process, and policy in place for the RCM, there was little chance that the charade would last over the long-term, putting the system's finances and the CFO's job in jeopardy.

After two years of understated contractual adjustments, and overstated revenue expectations, cash flow winnowed away, board members started asking questions, and bondholders began to worry about longevity.

## THE ISSUE

The revenue cycle for the system's employed groups was an amalgamation of differing computer systems (practice management and electronic medical records systems [PM/EMR]). The main Central Billing Office (CBO) had two different computer systems deployed, System 1 and System 2. One of the recently acquired practices had its version of System 2; we'll call it 2.1. Another practice under the EPN umbrella had yet another system deployed, System 3. Figure 4 illustrates the PM and EMR computer systems model.

**Figure 4**



In this EPN, practices were on-boarded, and commitments were made to providers that they could keep their EMR/PMs, staff, and processes, and the system would manage the RCM process as it existed. Logically, this was a no-brainer for physicians who were selling their practices or engaging in professional services agreements (PSAs) to the system so as not to disrupt current operations or create undue tension among staff.

In many instances, when health systems purchase practices, the goal is to minimize disruption quashing the prospect of dissension and/or politics that often attend the onboarding of new practices. In the near term, this peace offering keeps providers happy, keeps their staff relatively content, and in some ways goes toward closing the deal. It's a very palatable approach to a

tumultuous endeavor. The result, however, is a mix of systems and processes that require different inputs, work, and functionality and the vanishing of any prospect of efficiency. To add, now that the providers no longer needed to manage their RCM as a way to ensure their compensation, they were removed from the equation and had no dog in the fight (e.g., no concern of the proper billing/collecting for the practice).

Given critical and significant structural deficiencies, the system's RCM was already set up for painful, if not fatal, times.

## THE RESULTS?

Coker's engagement commenced with a phone call from the CEO the week of Thanksgiving. When Coker entered the picture, we were first told that the CBOs were in varying stages of disarray. This description may have been the understatement of understatements. On our initial call, the CEO conveyed to us his feelings, anecdotal though they were, that the RCM was broken.

We arrived on site in early 2015 and performed a broad macro review and assessment overview of the CBOs. In general, we found the CBOs to be a hodge-podge of policies, training, procedures, informational loops and lackluster follow-up. Components of the CBOs were housed in four different locations; two were recently acquired medical practices, and the other two were business offices.

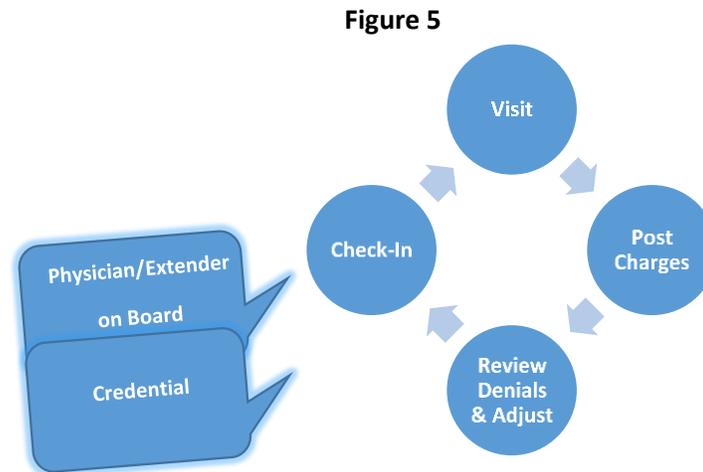
Just before Coker arrived on-site to begin work, the CFO was asked to seek employment elsewhere. During the project, which lasted several months, the CEO also resigned. The Controller, who in another life had been a CFO, was promoted to CFO and became our project touchstone. He also began managing both the RCM via the Directors and the operations of the practices (as noted in Figure 2).

This role was challenging, regardless of whether or not things moved smoothly and without issue.

When Coker arrived, we found a system with average days in AR hovering near 65, flat charges and collections, bloated "aged" buckets (e.g. >120 days), few standard policies and procedures, minimal upfront cash collections, a fractured credentialing process, and little educational feedback to staff.

## IT BEGINS LIKE THIS

Too often the RCM is viewed in pieces versus as a system with multiple inputs and variables.



For instance, systems often fail to coordinate new provider contracting with credentialing. As Figure 5 shows, in the current case, the system hired new physicians and added them to the EPN while involving credentialing was essentially an afterthought. (e.g., less than systematic.) Thus, the system had physicians who were on staff and had privileges in the hospital but were not credentialed with payers. In some instances, this lasted with some payers for more than one year.

Also, the system had converted many of their ambulatory physicians to Provider Based Billing (PBB). When properly deployed, PBB is a challenging proposition, at best. It is fraught with regulations and oversight and can get sideways quickly. Ill-advised deployment, in this case, left many with little oversight and management, with few in the senior level of the RCM fully apprised or understanding the impact of PBB and its billing and collections. In many instances, the process was manual. When things went badly, the inevitable finger-pointing soon followed. In this case, the blame casting occurred between the ambulatory CBOs and the hospital billers.

The issue of tax identification numbers (TINs) was another problem that surfaced. TINs were not transitioned timely for newly acquired practices. In some instances, monies flowed into the "old" TIN of the medical practice that created cash flow anomalies, inefficiency, and extra work for the CBO.

The system would acquire new practices and establish a new system TIN, which created multiple different TINs for the different practices. Given the lag in credentialing, a decision was made by the former CFO to bill the claims under the each practice's old TIN that was already active in the health plans' systems.

To compound matters, generally speaking, the coding and charge entry were performed at the clinic sites. Charges were billed from the CBO. Payments would process and would be posted by the payment posters. Denials and outliers would be sent back to the "main" CBO where the account representatives would review and work the accounts (this was mostly a manual endeavor until Coker amended this process). These claims would then be resubmitted by the billers.

Owing to the massive aging issue, we worked along with the client to focus on the 90-120 day buckets. Patient payments were worked by the customer representatives who called patients for payments. Historically, attention had not been given to patients who did not pay after three to four months; few accounts were ever turned over to collections and managers; from the CBO on down to the office managers, the CBO offered almost no feedback regarding coding errors, diagnostic code errors, etc. As might be expected, similar errors continued to arise. All charges were entered at the CBO level that took on the accountability. At the practice level, claims were submitted from some of the medical practices and then follow-up performed at the CBO location, an entirely different place. Feedback and errors were handled haphazardly with little education or corrective action taken. No policies or procedures were in place to both manage the educational flow of information, training, or criteria for staff remediation apropos of their annual evaluations.

To compound "bad," some AR improvement was realized by staff writing off, at their leisure, collectible amounts versus working the accounts. Coker ended that process.

As noted, physicians who joined the system were indeed delighted because they received protection from the "pain" of running a private practice. They joined what they assumed was a financially sound system, were essentially offered *carte blanche* regarding running their practices, which included the "logic" of creating the multiple "CBOs" that billed on behalf of the physicians and the multiple EMRs that were deployed.

## THE NET/NET

Twelve months on, the system is struggling, but improving. They have an external suitor who will bring needed stability and capital to the partnership. An interim CEO is helping to right the ship, and the CFO continues to manage both the EPN and the RCM. (He is, though, taking our counsel to hire a VP of the EPN and a Director of the RCM to ensure both are managed appropriately.)

- During our tenure, Coker
- Designed, developed, and implemented Policies and Procedures for the CBO(s).
- Began plans to consolidate the CBO and its employees in one location.
- Established reporting structures and consistent lines of communication.

- Placed an interim seasoned healthcare executive to serve as the interim Director of the CBO (after the previous Director resigned).
- Consolidated, where possible, disparate processes that occurred throughout the organization.
- Oversaw realignment and streamlining of staff; instituted better-defined positions.
- Improved feedback to the practices so that errors created at the practice level were now "fixed" at the practice level, placing some of the onus for repairs on those who'd submitted erroneous work.
- Improved front office (e.g., at check in) collections of co-pays and deductibles.
- Suggested long-term strategy of migrating to a single platform IT solution.
- Automated processes, where applicable, for efficiencies (e.g., payment posting)
- The Numbers (see Figure 6)

**Figure 6**

	Past	Current*	Future
Cash Collections:	hap hazard	↑ budget by 20%	↑ 22% > <i>budget!</i> 7 figures of revenue growth
Days in AR:	65	47.9	Moving forward
Charges:	n/a	↑6%	
Collections:	n/a	↑23%	
>120 Buckets:	n/a	↓4%	Well under the MGMA median

\* 2015 vs. 2014

## SUMMARY

Diseases do not occur overnight, nor are they remedied overnight. To complicate matters the full details of our client's foibles were concealed from view until we were able to dig deeper and perform a micro-level review.

Metaphorically, in this case, the patient's "body" was riddled with comorbidities providing varying levels of difficulty, complexity, and fracture. The patient was on life support with vitals that neared flatline status. But as the months passed, care and management began to give the patient strength; a strength that should lead toward full recovery.