

Revenue Cycle Turnaround: Rebuilding for an Advanced ROI – A Case Study

White Paper



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Abstract: Whether reviewing a hospital or employed physician network (EPN), the devil is in the details when examining the health of the Revenue Cycle (RC) ecosystem. Sometimes figures and reports don't tell the entire story. What may appear as a sound measurement of days in accounts receivable (AR) (e.g., 30 days) can actually mask systemic problems in processes and procedures. If data reported are inaccurate, miscalculated, or outright corrupt, leadership may not discover the issues until revenue wanes.

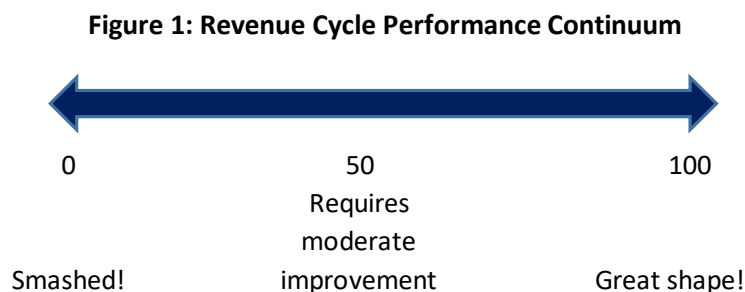
In this paper, we use a real-world case study to illustrate the signs of an in-danger RC that can be overlooked. Further, we explain how Coker helped one organization turn around its Patient Accounting System resulting in a 14 to 1 return on investment (ROI). We will review the health system's situation to show their struggle with their RC as a newly-hired Chief Operating Officer (COO) questioned why things were not moving ahead smoothly for the several-hundred provider organization.

Key Words: Revenue Cycle, days in accounts receivable, Healthcare Revenue Cycle

INTRODUCTION

Concerning the health of the Revenue Cycle (RC) ecosystem, the devil truly *is* in the details in that figures and reports don't always tell the entire story. More scrutiny may be necessary to determine an accurate picture. What may look like a sound days in accounts receivable (AR) measurement (e.g., 30 days) can actually mask systemic problems in processes and procedures. And, if data reported to the executive suite are inaccurate, miscalculated, or outright corrupt, the C-suite may not learn about the issues until revenue declines.

Each hospital, health system, or medical practice is fractured in some manner. As Figure 1 illustrates, on a continuum of 0–100, where “0” translates to “maximum problems” and “100” equals “smooth sailing,” every healthcare entity and business, falls somewhere on that line; something needs repair. The key to managing close to the “100” status is management introspection, humility, and the ability to stop and understand where you fall in your brokenness in order to remedy the issues.



Revenue is the lifeblood of every business. Without it, 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.

Healthcare margins are tighter than many other service-oriented businesses and, arguably, hampered by profligate regulation. Given the close margins in healthcare, the importance of the revenue cycle element is no less valid in the operation of hospitals, private medical practices, or health systems that employ physicians. Stunningly, some institutions continue to underinvest or underestimate the significance of diligence in RC management and its accompanying components. Through inertia or neglect, the RC can become a secondary cog in the operations of the business.

With this hindrance in mind, accurate billing and revenue integrity/management, from beginning to end, are more crucial for a healthcare entity than for your local convenience store. Processes examined and delineated below are requisite to the proper functioning of the RC.

In this case study, we explore the situation of a health system and Coker client that struggled with their RC as a new Chief Operating Officer (COO) questioned that affairs were not moving ahead smoothly for the several-hundred provider organization.

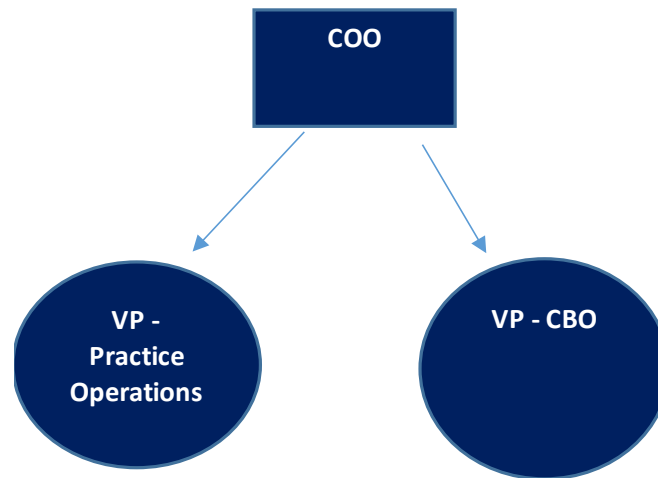
THE SETTING – A BRIEF SNAPSHOT IN TIME

At the beginning of 2016, a large multi-specialty health system with fee-for-service annual revenues in the hundreds of millions of dollars engaged Coker to review the operations of the Revenue Cycle. The system provided a considerable amount of managed care business and handled that revenue cycle component deftly. The organization employed several hundred physicians and advanced practice professionals (providers, nurse practitioners, and physician assistants).

Essentially, the organization's culture was open and provider-friendly. Physicians enjoyed the benefits and protections ensuing from employment while joining the line of cohorts departing private practice for employed models. (The group was the amalgamation of several disparate practices throughout the geographic area.) Management of the bulk of the RC process occurred in a central billing office (CBO). The CBO was severely fractured buckling under the weight of manual and inefficient processes.

Dispersed throughout the city were 60 clinics managed from a central location separate from the CBO. Given the housing of the components, and a bifurcation in the organizational structure at the senior management (vice president) level employees were enabled and empowered to function unscathed from the results of bad decisions and poor (or no) policies and procedures (P&P).

Figure 2. Organization Chart



New to the organization, the COO noticed that the managed care business worked reasonably well, but that the fee-for-service RC performance was lackluster. The monthly RC numbers presented to the COO looked fair, but the lower-than-expected revenue that was flowing into the coffers did not substantiate such good reporting. Something was amiss. (See Figure 2, Organization Chart.)

PART 1: THE ANALYSIS

Coker was engaged to perform an operational review of the RC to determine its current status: a baseline. This exercise was not meant to be critical of management nor undermine the current staff. Instead, it was to obtain an external and unbiased outsider's review of the mechanics of the CBO to diagnose and present remedies addressing shortcomings that flew in the face of best practices, both to nationally-accepted standards and proprietary data accumulated over time.

To commence, we requested specific data elements to obtain a picture of objectively-measured sticking points in the current process. (Clean data—a system dump—offers an unadulterated glimpse into the goings on in the system.) We also requested current internally-crafted reports to compare the raw data with presentation data.

Following a thorough review of the data, a small Coker team went onsite to begin the interview process and work with key team members, as identified by the client, and to review data anomalies identified in the previous offsite data review. The interviews provided a much-needed subjective component that enabled us to validate data outliers or provide insight into why the outliers were reasonable in the particular situation and marketplace. Coker's team also visited a sample of clinic locations to examine how the clinics impacted the RC on the front end of the process.

After the interviews, the team departed to work on the resulting report. We learned that the data pointed in one direction while the story was the polar opposite.

PART 2: THE REPORT

In an operation with such a robust revenue stream as our client had, hiding structural issues can be easy—at least temporarily. Eventually, these matters percolate to the surface.

The Vice President (VP) of the CBO was a knowledgeable leader with sound credentials. However, she was also a micromanager who occasionally let data noise cloud her analysis. Further, she chased staff around via email over-managing her small coterie of supervisors without offering them the proper tools or empowering them to perform the jobs each of them knew to do. Reports were voluminous (the monthly business report was 35+ pages—only three pages of which provided readily-actionable information/data), meetings were inconclusive, and deployed plans were seldom followed up.

OBJECTIVE MEASURES

We examined many standard objective measures to benchmark the organization and to provide a baseline from which to work. As we peeled back layers, we began to measure and monitor more nuanced figures because many day-to-day processes were creating a backlog and avoidable denials.

Figure 3, below, displays our broad data starting point.

Figure 3. Objective Measures

Category	Baseline	Goal
Days in AR*	48.6	35 - 45
Gross Collections	39%	50+%
Net Collections	68	95+%
Denials	27%	10%
Front End Revenue	>\$4M	>\$5M
Days >120	25%	15%
Lag Days	>50	12

After examining the data offered, it was determined that revenues to the organization could be enhanced, both via new revenue (e.g., capturing point-of-service collections) and cash acceleration (e.g., clean vs. denied claims, reducing days in AR).

As Figure 3 indicates, Days in Accounts Receivable (AR), as reported by the CBO, were nearing the desired goal of 35–45 days. However, the figure was misleading. The organization calculated AR, taking into account both millions of dollars in patient credit balances on the books *and* using date-of-entry (DOE) to begin the aging process rather than date-of-service (DOS), which artificially lowered the days in AR. We dove into the days in AR learning that the clinics' lag days (days from DOS to claim submission) ranged from 10–50. This fact *grossly* understated the days in AR.

The gross collection rate was relatively low but was not a great indicator of financial performance, because it was predicated on the chargemaster, which can be overly inflated relative to reimbursements.

The net collection rate was a dismal 68% indicating that staff did not diligently chase outstanding collectible dollars due to the health system. Denials ran at 27% of claims submitted, which created additional work for the clinics and the CBO *if* they were addressed and/or appealed by the clinics.

Front-end (e.g., point-of-service) receipts were low, and treatment of the collection process at the clinic level varied throughout and amongst the 60 clinics in the area. AR over 120 days was well outside the norm, which also led to an appreciation of the oddly quasi-normal days in AR.

The capstone was the lag days, at least in a macro sense. There was no initiative in place to force providers to finish charting and close out charts expediently. Compensation was not predicated on timely submission of charges; ultimately, the approach was all carrot, no stick. So, with little oversight, time from DOS to DOE stretched for some clinics as long as one month or more.

As Coker pushed forward, we determined that the topline macro data was leading us down a complicated and complex tunnel system throughout the organization.

SUBJECTIVE MEASURES

The data analysis was sending us in one direction, but we needed to marry the objective measures with our subjective components.

Overall, staff expressed discontentment due to inefficiencies, managing multiple priorities (that shifted throughout the week), and a morass of manual processes. The inefficiencies led to gross overstaffing in the CBO. The frenetic environment and ability to hire vs. analyze human capital needs created significant inefficiencies and over management of the staff.

Payer fees and allowables were not loaded into the practice management (PM) system(s), and the practices ran three different PM and electronic medical records (EMR) systems (though they were migrating to one PM and one EMR).

Objective feedback from the CBO to the Operations staff (senior leadership) was sporadic and fragmented resulting from a management communications loop that mirrored the inefficiencies of the organization, top to bottom. The Operations team (reporting to the VP of Operations) was undereducated regarding the role they played in the overall RC and were seldom managed to a measurable outcome. Operations staff, from top to bottom, were not accountable for the errors they created [e.g., Advance Beneficiary Notice (ABN) collection and subsequent denials, incomplete patient demographics, no co-pays, etc.]

To the client's credit, some sound P&Ps were in place, but those were enforced haphazardly and without focus. For instance, front-desk staff lacked cohesive training, from office to office, on standard practice management issues and their obligations, such as collecting similar data elements during patient registration or collecting the Medicare Secondary Payer (MSP) form on Medicare patients.

Eligibility was problematic with processes in the CBO that hampered quick turnaround, and some physicians lagged in credentialing.

Given the three computer systems, data was an amalgamation reliant upon significant manual manipulation. This dependence allowed space for errors in reporting and data storage presented problems.

Some of the front-line management staff had little or no practical experience running a stand-alone clinic, and a dearth of feedback back to and from the CBO to the practices created expected inefficiencies and errors. These managers were ill-equipped to handle the complex tasks of practice management, even under the system's simprimatur. 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.

THE DEPLOYMENT

The initial assessment and resulting report was constructed and delivered in two months. The client agreed with our assessment and realized that, considering its staffing and structure and the urgency of the issue, it did not have appropriately positioned resources capable of righting process wrongs.

The client engaged Coker to assist in implementation. In doing so, a small Coker team was built to partner with the client's staff and work as a cohesive unit to begin rebuilding the CBO one policy at a time.

Over the next nine months, Coker teamed up with the client's staff and leadership to prioritize, craft policies, train, and deploy the new CBO policies.

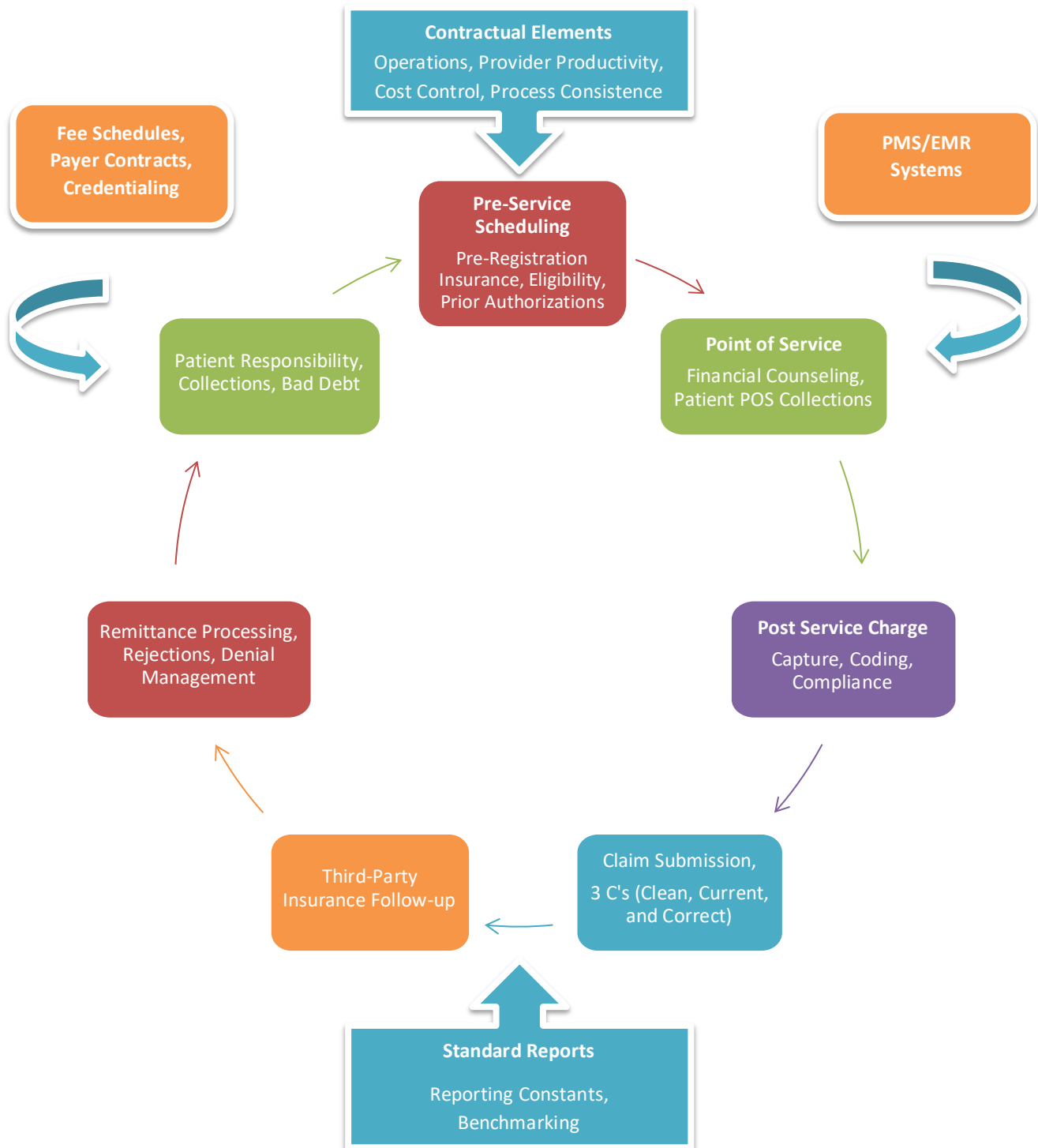
THE FIX

The COO determined that the system did not have the human capital bandwidth to implement timely the recommendations Coker offered. Coker delineated a plan and presented a proposal to the COO, and we were engaged on a nine-month project to raze and rebuild the operations of the CBO.

We began by identifying key members of teams that were needed, both on the practice side (operations) and the CBO side to ensure key thought leaders were at the table and all constituencies had a voice. To measure the result, using client-supplied data, we broke down the baseline so that we could monitor and manage the outcome of the project. (This information was useful for both Coker and the client as it showed areas of gain and possible areas where plans were not impactful, enabling us to remediate quickly.) We provided the client a range of potential revenue gains. The span ran from conservative to aggressive knowing that hitting the higher figure would be challenging as it would require all variables to function pristinely, an ideal that seldom takes solid root.

Too often the process of RC management is viewed in pieces versus as a system with multiple inputs and variables. However, the RC begins as far back as provider credentialing and continues until the last payment is posted to a patient's account.

Figure 4: Revenue Cycle Management Lifecycle



Repairing the damaged components required a multi-faceted approach. That is, multiple systems needed simultaneous rebuilding.

We focused on each detail in the RC lifecycle as Figure 4, above, illustrates. First and foremost, additional P&Ps needed to be developed, deployed, and managed. Working with the CBO and Operations leadership, policies were crafted that fit the organization's culture and style but also enabled the business to address its issues.

Data were cleaned and a rigorous reporting dashboard was built to convey the baseline of deployment, goals, and an updated deliverable of where the CBO was relative to both its baseline and goals. The system elected to add several more targeted goals to their measurement criteria, and we were happy to accommodate. While the client chose to keep their current days in AR calculation, we ensured that a lag goal/measure displayed on the dashboard. The purpose was to show that, while the days in AR were not how we would calculate them, their reasonable appearance should be balanced against the lag days to get a complete picture of the aging of claims from the date of service.

Payer contracts were reviewed (on the aggregate, this market-dominant payer was at approximately 105% of Medicare), and allowables were then keyed into the system to empower the posting team to ensure all revenues had been received.

Regularly scheduled meetings between the CBO VP and the Operations VP were structured and agenda-driven where concerns regarding the prior month's data and output were discussed.

We streamlined the eligibility process deploying different tools to ensure accuracy, timeliness, and schedule management of the team.

Working with the human resources team, we built objective measures for staff members on the operations side who impacted the RC process. For instance, we measured and monitored co-pay collections, denials, and integrity of data captured on each patient during check-in.

After some gnashing of teeth, co-pay collection goals were derived and deployed to each office. The offices, on the whole, saw a budgeted 15% increase in their goals of collecting point-of-service (POS) payments.

THE NET/NET

During our implementation tenure, Coker:

- Designed, developed, and implemented P&Ps for the front office (operations) component of the CBO

- Held operations (practice) staff accountable for measurable outcomes such as collection of co-pays, obtaining appropriate notices (ABNs), and holding front-line managers accountable
- Established reporting structures and consistent lines of communication.
- Placed an interim seasoned healthcare executive to serve as the acting Director of the CBO.
- Consolidated, where possible, disparate processes that occurred throughout the organization.
- Oversaw realignment and streamlining of staff; instituted better-defined positions.
- Improved feedback to the clinics so that errors created at the clinic level were now fixed at the clinic level, placing some of the onus for repairs on those who had submitted erroneous work.
- Improved front-office (e.g., at check-in) collections of co-pays and deductibles netting seven-figures of new revenue.
- Automated processes, where applicable, for efficiencies (e.g., payment posting)
- The performance results numbers (see Figure 5):

Figure 5: Performance Results

Category	Baseline	Goal	6 months, post implementation
Days in AR*	48.6	35 - 45	37
Gross Collections	39%	50+%	>50%
Net Collections	68	95+%	88%
Denials	27%	10%	15%
Front End Revenue	>\$4M	>\$5M	>\$5M
Days >120	25%	15%	16%
Lag Days	>50	12	16
ROI	14	to	1

As noted in Figure 5, above, key measures (with clean data) were monitored from baseline to present day. After six months of structural deployment, the days in AR had improved significantly. All measures were trending in the right direction. When establishing the baseline measures, we worked with the client to delineate, based on their data and with their concurrence, how each measure (and their subordinate) would impact revenue to the client, either via new revenue flowing into the bank or via accelerated cash flow.

The client obtained a 14 to 1 return-on-investment (ROI) for the implementation work performed by Coker.

SUMMARY

Of course, all that glitters is not gold. The client's CBO took some time to devolve into its state of disrepair and would take some time to emerge. However, all hands were now pulling the oars in the same direction.

Our client was an excellent partner—an honest broker in the process of teaming to make a difference. The success of our partnership delivered consistent structure and a sound ROI.

In the nine months Coker assisted in implementation, we, broadly:

- Assisted in the delivery of superior financial results
- Rebuilt the CBO and empowered managers
- Assisted in the hiring of a CBO director
- Improved communications and responsibility between the CBO and the practices
- Deployed objective, measurable goals for practices to use to ensure front-desk teammates understood their duties and were held accountable.

Implementation was a marathon, not a sprint. Work continues. After deployment, some operational items still required attention (i.e., individual measurements, accountability, tools and training, etc.).

Coker remained engaged with the client through this and other projects over an 18-month period. For instance, after the Assessment and Implementation work on the RC, the client asked Coker to provide interim director-level management assistance in the CBO to assist the VP in working within the new structure (this engagement continued into 2017 as noted in “Interim Director 2,” below). They also began the acquisition process of more providers engaging Coker to work during the diligence process.

Figure 6: Project Timeline

Project	Timeline
Assessment	1/1 - 2/28/2016
Implementation	4/1 - 12/31/2016
Interim Director 1	10/1 - 12/31/2016
Interim Director 2	1/1/2017 - 3/31/2017
Due Diligence	1/1/2017 - 4/30/2017
Post Due Diligence	4/30/2017 - 6/1/2017
Interim CBO Director	4/30 - 8/31/2017

As with any project, a team approach and an invested client are key components to obtaining optimal results.

While this case study is just one example, Coker Group has completed a number of revenue cycle reviews and is prepared to assist with future analyses. Call 678-832-2021 to speak with one of our experienced advisors and discuss your specific situation.