MGMA 2014 Health Systems Forum: Optimizing Ambulatory Revenue Cycle Management in a Health System Environment

Driving Efficiency and Improving Revenue Amidst Change

In the midst of industry-wide transformation, the ambulatory care sector is realizing unprecedented change. As part of the MGMA 2014 Health Systems Forum, sponsored by Navicure, approximately 50 revenue cycle executives and business office leaders participated in numerous round tables.* During these sessions, attendees discussed current revenue cycle management (RCM) challenges that arise when hospitals and health systems acquire physician practices, along with strategies and tactics for successfully addressing these.

These types of acquisitions and the alignment challenges they bring are consistent with overall industry trends. According to Deloitte's issue brief, “Physician-Hospital Employment: This Time It's Different,” physician practice acquisition grew by 32% from 2008 to 2012. Hospital-based acquisitions were at an all-time high in 2011, increasing by 139%.i Particularly at the onset of the Affordable Care Act (ACA), many practices realized the benefit of aligning themselves with a parent organization that could provide the technology infrastructure to achieve meaningful use and increase interoperability. In addition, physicians may often be tempted by better hours, more patient care time and fewer administrative hassles, along with the potential to rely on a parent organization to purchase technology to achieve meaningful use, when approached to align with health systems or hospitals.\(^ii\)

Throughout the round-table sessions, four key challenges emerged:
- Implementing the appropriate office billing structure – centralized or decentralized
- Ensuring best practices across workflows and processes
- Creating new, proactive payment strategies
- Optimizing payer collections

This white paper outlines these challenges in detail and provides accompanying strategies and solutions to handle them. All parties agreed that despite the fact that RCM initiatives are on a much larger scale when physician practices and health systems align, revenue cycle leaders must develop strategies for standardized, consistent best practices in patient collections and claims management as soon as the organizations align for optimal RCM results.
Challenge #1: Implementing the right strategy to manage RCM initiatives via the centralized business office vs. on site at practice locations

When a health system acquires practices – especially within a relatively short timeframe – centralized billing office (CBO) and physician practice RCM leaders can have differing ideas about who should manage certain functions. It’s important, however, to develop a strategy as early as possible during the acquisition phase. A good first step is to conduct an assessment of current technologies, employee skill sets, practice workflows and revenue cycle performance. This assessment will allow you to determine strengths and weaknesses among all practices and identify common themes. If many practices use a solution that doesn’t allow for electronic claims submission or remittance for high-volume payers in the region, it may be time to implement a new clearinghouse – unless, of course, the CBO already had a solution that meets the practice group’s needs. If many practices struggle with appeals or don’t have adequate follow-up processes, centralizing this function may optimize revenue in this area.

As they evaluate skills and technologies, revenue cycle leaders often realize that a hybrid approach is preferable over implementing a completely centralized or decentralized RCM model. This approach allows practice groups to leverage skill sets and expertise at each location while relying on the CBO to manage initiatives that require top-level oversight.

Bringing the CBO and physician business offices onto a standardized, single-technology platform can be the most daunting part of assimilating the physician group into the hospital brand. It becomes easier – or at least makes for an easier transition – if new technology makes a formerly tedious process much simpler. Even if claims management is decentralized, having a consistent, streamlined and automated process at each practice location can increase efficiency and cash flow. Technology that enables work lists to clearly delineate responsibility, along with transparency to determine where a claim is in the payment process, are two features that practice managers agree are particularly important. These two technology components can also enable the CBO to develop a hybrid model for shared responsibility, allowing leaders to make continuous process improvements by leveraging data.

At a minimum, if leadership decides to maintain a decentralized RCM model, the CBO should still leverage analytics at an organizational level. The physician practice group offers a valuable analytics opportunity; leaders can delve into organization-wide data, review single-location data or make comparisons among practices similar in size or patient demographics.
Challenge #2: Ensuring best practices across workflows and processes at all physician practice locations

While many revenue cycle leaders see the value of complete standardization across the enterprise, many realize that such an initiative is a difficult undertaking – at least as one initiative. Many health systems acquire as many as 50 or 100 practices, and these practices each retain their unique culture and serve a specific demographic. This is a new challenge for a health system CBO, which doesn’t generally manage revenue cycle functions for such a high number of disparate locations. Added to that, acute and ambulatory RCM processes have many inherent differences, such as necessary coding skills and the composition of patient statements.

While the CBO is the logical place to provide oversight and help all practices standardize and adhere to best practices, it is important to include revenue cycle managers from various practice locations when updating and standardizing new processes. Forming a committee that comprises various practice leaders and health system RCM leadership may extend the length of the project, but it will also ensure greater buy-in, along with the confidence that any workflows and policies established are optimized for physician practices rather than an acute care environment.

Building upon the hybrid approach mentioned in Challenge #1, consider a phased approach to integrating standardized processes. It is likely that organizations will identify functions that can stay in the practice locations rather than being centralized. Of these functions, it is important to prioritize them and determine where you can achieve the greatest effect from standardization. Start with patient collections, for example, and determine the optimal policies, processes and technology before moving to any other functions.

Challenge #3: Creating a new, proactive patient payment strategy

When it comes to getting paid, practices face more complex challenges than ever, whether they’re dealing with payers or patients. While the CBO can facilitate certain initiatives, others require a “grassroots” change that must begin at the practice location. Patient collections is a prime example of a grassroots change that each practice location must address. Under health reform, the average deductible for a bronze individual insurance plan is more than $5,000 – an amount that both the newly and long-time insured alike are unaccustomed to paying. In the past, practices simply wrote off many of their patient balances as bad debt. Unfortunately, with the increase in patient responsibility resulting from the increase in high-deductible health plans, this is no longer a viable financial option. Instead, practices must employ new processes, policies and technology to meet new patient needs.
Patient collections should begin before the visit even occurs, with staff setting the expectation that patients will pay or make arrangements via a recurring payment plan before leaving an office visit. This policy change requires an update to internal processes and workflows. Fortunately, there are technology solutions that can automate many aspects of the patient collections process, including generating estimates and collecting outstanding balances, including copayments, co-insurance and unmet deductibles at the time of service. More advanced solutions also enable practices to securely store patients’ credit/debit cards and charge them once the patient responsibility is known or create automated payment plans for the outstanding patient responsibility.

Of course, implementing such new and different processes requires buy-in from all team members, including clinical, back office and front office staff. Practice administrators often have differing opinions regarding whether to involve physicians in patient financial policy changes. Optimizing the patient payment process requires change in many areas, including technology, processes and policies. It also requires training and new behaviors and habits from both staff and patients. To that end, having physician support for this critical initiative can be advantageous.

Lastly, as improving patient satisfaction and experience remain priorities for both hospitals and physician practices, technology providing online bill payment, account management and automated payment plans can offer patients the convenience and consumer-friendly options they want while also keeping them engaged and informed until their balances are paid. While physician practices traditionally take a more passive approach to up-front collections, their patients will likely perceive a technology-driven, proactive approach as a positive change that aligns with their bill payment behavior in other industries.

**Challenge #4: Optimizing payer collections in an increasingly challenging environment**

While patients are responsible for a growing portion of provider revenue, claims are still providers’ primary payment source. Providers face an increasingly challenging payer reimbursement climate. The American Medical Association estimates that more than $43 billion could have been saved from 2010 through 2013 if insurers had consistently paid claims correctly. While addressing a reimbursement system that seems like a labyrinth, providers must also keep abreast of new value-based care models that will ultimately change the way they’ll be paid.

Within claims management, addressing denials and appeals are two particularly critical functions. During the round-table discussions, leaders of hospital-owned physician practices discussed whether the two should be aligned under the CBO or maintained by staff in each practice location. Those in favor of the CBO managing denials said the CBO can bring value through its enterprise view. It can foster insights regarding the most common denial types and who is affecting them. The CBO is also in an ideal position to act upon this information via process improvements or training because it oversees each component of the billing process. Regarding the appeals process, leaders said they often centralize this function due to its time-consuming nature. If one group manages appeals, it can better monitor its time and potentially determine ways to streamline workflow.
On the other hand, several participants pointed out that staff at individual practices often have customized or adapted skill sets based on the common diagnoses treated at that location. This knowledge can enable them to tackle denial management work lists quickly and effectively. Also, their close proximity to on-site back office staff can facilitate a strong working relationship that can contribute to better revenue cycle outcomes.

Several of the hospital-owned physician groups have opted for a hybrid approach that blends the best of the CBO and physician-based denials and appeals management. While revenue cycle staff may report into the CBO, they work out of specific practice locations. Through this structure, CBO leadership has an organization-wide view of metrics, sets organization and per-practice objectives, and manages staff. Because staff work in a dedicated practice location, they can achieve greater efficiency with the necessary diagnosis codes and common denials.

The right work queues backed by the right technology are another necessary component of claims management optimization. This fact holds true regardless of whether the revenue cycle staff works in a CBO or decentralized locations. Implementing an effective model that encompasses prioritization, assignments and workflow can significantly affect revenue cycle performance. This model can enable greater returns depending on its level of automation and sophistication. For instance, routing complex claims to staff with a higher level of expertise is a simple workflow that can influence cash flow.

**Conclusion: Preparing for What’s Next and What’s Happening Now**

Value-based models have moved from “what’s next” to “what's happening now.” Even though payers currently make the bulk of payments via a fee-for-service model, most have already transitioned to value-based reimbursement for a small subset of payments. So far, this transition has been small and gradual, which makes it easy to overlook when surveying the landscape. It does exist though, and will soon gain momentum.

As value-based reimbursement becomes more prevalent, physician practices must optimize their technology and processes to support this payment model. This will require collaboration with technology vendors and payers. Practices must determine what new data they’ll need to collect, and how they can deploy the best workflow to support both value-based and fee-for-service models. Beginning these conversations now can facilitate a more seamless transition and ensure that the right technology is in place to support this new information exchange and workflow.

While the revenue cycle has no shortage of critical projects, it’s important to step back, review the challenges ahead and do some out-of-the-box thinking. Many revenue cycle leaders are gifted in analyzing numbers. Take the time to review your data, develop benchmarks and determine what changes you can make to affect improvements. After all, the healthcare environment is always evolving, and revenue cycle leaders have the experiences and capabilities needed to help organizations effectively meet the challenges ahead.


iii Source: HealthPocket, 2014, accessible online at http://www.healthpocket.com/individual-health-insurance/bronze-health-plans#VIC354v9Gg


* Portions of the white paper are based on roundtable discussions held at the MGMA 2014 Health Systems Forum, Sept. 9, 2014. Those participating included:

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