

Effective Revenue Cycle Management Begins at Access

Best practice solutions for the emerging front-end revenue cycle

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Traditionally, revenue cycle management consisted of many tasks performed in the business office, or back end, of the revenue cycle. Recent economic challenges and recognition of the inefficiency of prevailing revenue cycle management processes have led forward-thinking health care providers to shift their focus to front-end management of the revenue cycle, specifically in the area of patient access.

Faced with decreased revenues and rising costs, providers are finding that best practice technology solutions provide a way to improve their patient access processes.

External Challenges

Historically, the health care industry, in general, has been somewhat insulated from economic recessions, in particular for the pharmaceutical and biotechnology industries, due to relatively steady drug demand. Health care providers, however, are far more vulnerable to economic downturns.

One of the first effects of a recession is the decrease in elective procedures. This was evident after the dot-com bubble burst in 2000. The ensuing 2001–2002 recession resulted in the lowest demand for hospital services ever.¹ During that time period, unemployment rose from 4.2 percent to 5.6 percent. Compare those numbers to the current economic recession, during which unemployment has jumped from 4.6 percent in 2007 to 10.0 percent at the end of 2009.²

How does an increase in the unemployment rate translate into greater demand for government health care services? Every one percent increase in the unemployment rate equates to one million new Medicaid and State Children's Health Insurance Program (SCHIP) enrollees and 1.1 million newly uninsured.³

Even before the current economic downturn, hospitals were dealing with the challenges of rising uncompensated care for the estimated 46 million uninsured Americans. It is not just the uninsured, however, who pose a problem.

As health care costs continue to escalate, more of the financial burden is being shifted to the patient. The average out-of-pocket expense for the insured has increased four times in the last eight years, with the median preferred provider organization (PPO) deductible at \$1,000 in 2008. At the same time, the percentage of plans requiring deductibles also has increased significantly—81 percent of PPO plans required deductibles at the end of 2008.

The impact on providers is clear—patient balances represent a larger portion of outstanding receivables (*see* Exhibit 1). With more health plans requiring deductibles and out-of-pocket costs increasing, patient balances will continue to be a growing concern for health care providers.

Internal Challenges

In addition to external pressures, patient access staff members often are faced with significant internal challenges. Patients enter hospitals in a variety of ways: scheduled, walk-ins, referrals, emergency admissions, and as recurring patients. Each patient type may require a different process flow in

Exhibit 1. Out-of-Pocket Health Care Expenses: 2000–2008

	2000	2004	2008
Median PPO deductible	\$250	\$400	\$1,000
Percent of PPOs requiring deductible	52%	73%	81%

order to complete the appropriate tasks and ultimately provide care for the patient.

Patient access staff members often must use multiple disparate systems in order to complete the tasks, and that compounds the problem. The average patient access staff member uses six to ten different systems, and the process of registering and financially clearing a patient can take more than five hours.⁴ In brief, the process is often complex, time-consuming, and fragmented, resulting in inefficiency due to errors, bottlenecks, and duplicative efforts.

The Emerging Front-End Revenue Cycle

The traditional revenue cycle is typically a back-end-heavy process where core activities often occur only after the point of service. In many cases, significant amounts of time and resources are spent correcting errors, filling in missing information, and coordinating benefits—essentially serving as a safety net prior to bill submission. The process is inefficient and results in tremendous bottlenecks and black holes, ultimately resulting in missed opportunities, delayed cash, denials, and increased bad debt.

Often, this back-end-heavy process is more a result of technology constraints than simply process constraints. The problem is that front-end staff members are ill-equipped to perform the necessary tasks best accomplished earlier in the process.

The emerging front-end revenue cycle shifts many of these key tasks to the front end (*see* Exhibit 2). This concept is not new. Providers have long realized that more than half of the information on a bill is collected and entered into the facility's information system prior to or at the point of service, so it only makes sense to obtain as much information as possible and ensure the accuracy of the information on the front end.

Best Practice Technology

With a number of technology solutions that address front-end revenue cycle optimization on the market, it is important to understand the key components of a best practice patient access solution. Simply, the components require that patient access solutions be

fully integrated into core systems of the organization, and that solutions be comprehensive.

- First, the solution needs to be fully integrated into the core systems of the organization. Workflow needs to coincide with existing solutions to avoid duplication of efforts. A fully integrated system will reduce missed information and eliminate the need for manual workarounds.
- Second, the solution needs to be comprehensive, addressing all the major areas within patient access, from pre-service patient estimation to point-of-service insurance and demographic verification to financial counseling and collection workflow. Front-end revenue cycle optimization, however, is not just about shifting the burden of tasks from one area of the revenue cycle to the other. The real key is to shift these tasks and make them much more efficient, accurate, and automated, thereby empowering front-end staff to carry out appropriate tasks at key points in the process.

By improving overall operational efficiency and accuracy, an organization can make significant progress in reducing costs and bad debt. Exhibit 3 shows some functionalities to consider in evaluating technology solutions to implement at patient access.

Challenges in Redesigning the Patient Access Process

In moving the collection process to the front end, staff members need to think differently about how they interact with the patient and always bear in mind the ultimate objective of patient satisfaction. Steps need to be taken to facilitate this change in management process. These steps include training and education, clearly defined processes, and monitoring and oversight.

- First, staff members need to be educated and convinced that a positive patient experience and financial outcome are interrelated. This requires a culture change to embrace a new process and model. By addressing this at the front end, the experience for patients is improved, their financial expectations addressed, and the organization's financial requirements are met, a win-win outcome for both patients and provider.
- Second, the organization must ensure that the right processes are well-defined and in place for all the complex steps of the patient access process, from the point of referral and collection of patient information to scheduling, registration, and the patient's arrival for service. If this is done

Exhibit 2. Emerging Shift to Front-End Revenue Cycle		
Core revenue cycle activities that once occurred after the point of service are shifting to patient access to more effectively and efficiently manage the revenue cycle. This shift in moving what once were traditional back-end responsibilities to the front end is revealed below in the growing list of functions now increasingly assigned to patient access.		
Pre-Service Functions	Point-of-Service Functions	Post-Service Functions
<ul style="list-style-type: none"> • Scheduling • Patient payment estimation • Charity screening • Demographic verification • Insurance eligibility verification • Medicaid screening • Authorization management 	<ul style="list-style-type: none"> • Registration • Charity screening • Bill edits 	<ul style="list-style-type: none"> • Billing • Collection • Denials follow-up

Exhibit 3. General and Special Functionalities	
General Functionalities	Specific Functionalities
Estimates patient obligation	Accounts for historical data to provide average patient charges by procedure and insurance plan
	Provides contract rules to determine expected net revenue by payer to estimate coinsurance baseline
	Includes payer eligibility data from third parties to determine benefit details and deductible status
	Identifies patients with previously unpaid bills at the time of service to maximize cash collections
	Identifies the probability of payment to determine optimal point-of-service collection strategy
Verifies insurance and demographic data	Automates the process for 100 percent of patients
	Verifies insurance and benefit details
	Screens for Medicaid coverage
	Provides alerts when there are demographic discrepancies and allows for correction without leaving the solution
Calculates and assesses propensity for payment	Automates the process for 100 percent of patients
	Separates ability vs. willingness for payment
	Uses predictive models that are customizable to the hospital

properly, there will be a clear end-to-end process from point of service to point of care.

- Last, there must be oversight of the process. This can be achieved by providing patient access staff and leadership with the necessary tools to manage the accountability and performance of patient access activities. Having consistent and accurate information to provide to the patient regarding upcoming services greatly improves the chance of up-front collections and reduces the ambiguity and uncertainty patients have and dislike about

receiving care. The tools should also provide specific information regarding the success of the front-end collection process from an operational perspective.

In Summary

Revenue cycle management traditionally has focused on the back-end revenue process. Focusing on front-end management of the revenue cycle, specifically in the area of patient access, can greatly increase bottom-line profitability as well as patient satisfaction.

Providers seeking to improve the front-end revenue cycle should look for the following functionalities in technology solutions:

- Produce patient estimates;
- Perform quality assurance audits on 100 percent of registrations;
- Screen all patients for charity eligibility;
- Verify demographic information;
- Verify insurance eligibility;
- Screen for Medicaid coverage;
- Identify payment propensity; and
- Manage authorizations. ■

Notes

1. Catherine Arnst, "Healthcare: not so recession proof," *Business Week*, Mar. 25, 2008.
2. Bureau of Labor Statistics, US Department of Labor, "Employment status of the civilian noninstitutional population 16 years and over, 1970 to date," <http://www.bls.gov/web/cpseee1.pdf>, accessed Mar. 16, 2010.
3. Dorn, Garrett, Holahan, and Williams, "Medicaid, SCHIP, and Economic Downturn: Policy Challenges and Policy Responses," Kaiser Family Foundation and Urban Institute, Apr. 2008.
4. MedeAnalytics market research, Oct. 2009.

Reader's Resource

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