Healthcare Industry White Paper
Revenue Cycle Management

Cost reduction has been the focus of many healthcare providers for years. But in order to successfully fulfill core missions such as leading in medical technology, providing effective patient treatment and curing diseases, it is essential that emphasis be placed on revenue and gross margin performance by reducing claim denials through the implementation of a strong "***Revenue Cycle Management" (RCM)*** program.

The Problem:

Healthcare organizations are under pressure to cut costs, improve reimbursement and cash flow while improving efficiency. Today, running a healthcare organization is no longer as simple as it was in the 1970's and 1980's when resources were abundant. Margins are razor thin (< 2%) to non-existent, in part because capitated contracts leave no room for profits, government payments barely cover variable costs, and non-funded government mandates take resources away from patient care. Thus, PPO and Fee-For-Service-like arrangements, which make up approximately 35% of a provider's revenue base, are becoming the only profitable payers.

In the ***business office***, there is pressure to generate accurate billings in a timely fashion and to reduce the days in accounts receivable. Limiting factors to achieving this goal are the accuracy and access to proper patient, insurance and billing information. Typically the required information is stored in ADT, billing and Medical Records systems along with hardcopy documents that are contained in a patient specific folder. What makes the task of AR reduction even more complicated is that the information is maintained in a separate electronic and paper folder each time the patient receives services for clinical care.

To survive in today's marketplace, healthcare organizations must embrace a vision of achieving compliant and appropriate reimbursement with the first bill. Delays, mistakes, misunderstandings, and misplaced information each jeopardize healthcare organizations' cash flow and revenues. As surveys have shown in the past, hospitals don't collect between 4% and 12% of the money they are entitled to. Additionally, complicated billing and collection processes delay the average payment for services rendered by 75 days, compared to only 28 days for non-healthcare organizations. Examples of revenue source exposure that result in un-collectibles and delays in payment include:

- authorization process failures
- poor coding methodologies based on the specific health plan's requirements
- poor charge capture methodologies
- billing follow-up failures

Healthcare providers today need a system that can help them reliably increase their percentage of first time clean claims from an average of 55% in 2001 to 81% by 2004 (exhibit 1) Of course the HIPAA EDI regulation scheduled to go into effect in August of 2003 is designed to help the process. However, health plans still have clinical attachment and authorization requirements that will be not be part of the HIPAA regulations until sometime after 2005. By 2003, the HIPAA EDI rules will reduce coding errors by 60% and with the enhancement of web-based, real-time patient verification systems, errors in patient ID are expected to decrease by 61%.

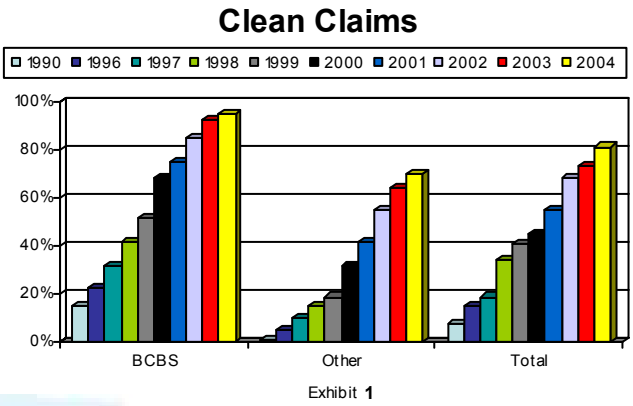

Exhibit 1

However, health plans will continue to delay payments because of improper Authorizations (45%) while they increase the requirements for more clinical documents in the form of attachments. This increase in attachments will account for 28% of delays in payment by 2004. The goal for every provider business office must be to develop a system for tracking required authorizations and attachments based on each individual health plan line of business. If the information is not tracked in a timely manner, the expected HIPAA EDI advancements will not help reduce AR days in the typical hospital.

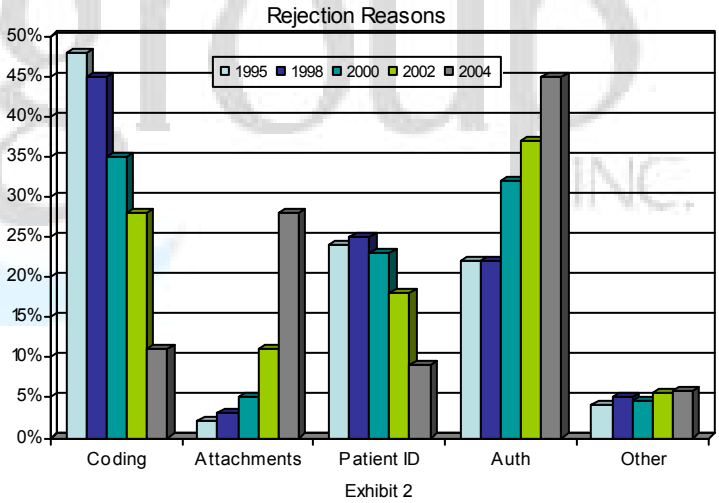

Exhibit 2

The Solution:

For efficiency, proper tracking, and AR reduction, the billing office needs more effective functionality that is not found in today's automated billing systems– they need a ***Revenue Cycle Management (RCM***) system. Today, the CFO has two alternatives – replace the current billing and AR collection system with a newer and more

automated system, or install an RCM system that will provide better performance through enhanced measurement and tracking of the claims process. The problem with the first alternative is that studies have found that conversion from one AR system to another increases AR days by an average of 32% for a period of 3 months (sample size of 365 hospital conversions). Within the sample, > 30% saw a 60% increase in AR days while < 30% only saw a minimal increase. Only 3 reported a decrease in AR days during the first month.

A more reliable approach is the development of an RCM solution. Typically, 95% of what healthcare providers call RCM is concentrated in the information management department and business office, and revolves around coding, bill presentation and bill correction. It is clear then that provider revenue is as least as much a function of clinical activities (68%) as it is administrative processes (32%), and more efficient management of human and automated activities through measurement and tracking of claims is needed.

A fundamental requirement in today's dynamic healthcare environment is to ensure that current and accurate patient billing and demographic information is available to caregivers and administrators. An RCM solution focuses on measuring and tracking processes that simplify, control, and consolidates healthcare computing environments to assure consistent access to data.

The RCM process spans the breadth of revenue cycle management – clinical, information technology, administrative and business processes:

- capture key patient, claim, denial and appeal data
- use historical and real time data to identify problem areas through management reports
- prioritize claim, denial and appeal activities and assign to team members through personalized task lists
- send automated alerts and reminders for milestone completion
- establish denial prevention rules to detect and avoid at risk clinical and administrative conditions such as eligibility, authorization and coding
- execute avoidance actions such as alerts, reminders, guidelines and data feeds

As a result, RCM prevents delays, mistakes, misunderstandings, and misplaced information that negatively affect collections and days in accounts receivable. The best part about RCM is that an organization is not required to overhaul existing systems or processes; rather, RCM is implemented through a thin electronic management layer that is wrapped around existing systems and processes. The basis of RCM is to implement a methodology that can oversee processes and produce meaning results quickly through incremental measuring and tracking steps. The organization is not exposed to the trauma of total reengineering and end to end workflow automation unless the organization is ready and it is the right response to the business situation. Experience has shown that healthcare financial outcome is dependent on the critical interplay of human and automated clinical and administrative activities addressed by RCM.

Benefits and ROI:

The proper installation of **RCM technology** can improve the timely access and tracking of billing and collection information within the business office. Healthcare organizations that have implemented (RCM) have seen a 28% decrease in the average days in Accounts Receivable (AR) and an increase in the average collection rate per case mix adjusted patient day of 4.8%. For the average 300-bed hospital, the implementation of RCM can improved first-year cash flow by $1.8M.

Vendor Solution:

A healthcare IT vendor that is attacking the “Revenue Cycle Management” challenge is Altary, Inc, based in Concord, Ca. Their service offering, STAR Denial Management, establishes measuring and tracking processes for patient, claim, denial and appeal information resulting in improved cash flow for an institution. It also introduces a continuous process improvement methodology and can be configured to measure and track any administrative, patient care, and financial process.

Bottom Line:

In summary, RCM is required to ensure the financial health of every healthcare organization by avoiding delays, mistakes, misunderstandings, and misplaced information, thereby improving costs, revenues, and quality of healthcare experiences that you deliver. It further enables those same organizations to incrementally improve their processes by introducing a continuous process improvement methodology into existing administrative, patient care, and financial processes.

More Information about the Author:

Mr. Mark R. Anderson is one of the nation's premier IT research futurists dedicated to health care. He is one of the leading national speakers on healthcare and has spoken at > 280 conferences and meetings since 2000. He has spent the last 30+ years focusing on Healthcare – not just technology questions, but strategic, policy, and organizational considerations. He tracks industry trends, conducts member surveys and case studies, assesses best practices, and performs benchmarking studies. He also assists vendors in their Business Strategies, Market and Customer Strategies, Competitive Analysis, and Product Profiling.

Mr. Anderson is a highly accomplished healthcare executive with an impressive track record of success in managerial positions of progressive responsibility and bottom-line impact over the past twenty-eight years. He is a widely-versed individual whose line and consulting responsibilities in more than 200 hospitals and 50 healthcare payer organizations has resulted in a firm foundation from which to make difficult decisions and the ability to perform complex analyses. The health care institutions varied in size from 50 to 2,600 beds while corporate wide revenues exceeded one billion dollars per year. Mr. Anderson has extensive experience in health care redesign and organizational restructuring along with a comprehensive background in start-up and replacement of multi-facility health information platforms, including financial, clinical, managed care and decision support systems.

Prior to joining AC Group, Inc. in February of 2000, Mr. Anderson was the worldwide head and VP of healthcare for META Group, Inc., the Chief Information Officer (CIO) with West Tennessee Healthcare, the Corporate CIO for the Sisters of Charity of Nazareth Health System, the Corporate Internal Consultant with the Sisters of Providence (SOP) Hospitals, and the Executive Director for Management Services for Denver Health and Hospitals and Harris County Hospital District. His experience includes 17 years with multi-facility Health Care organizations, 15 years Administrative Executive Team experience, 6 years as a member of the Corporate Executive Team, and 9 years in healthcare turnaround consulting. Mr. Anderson received his BS in Business, is completing his MBA in Health Care Administration, and is a Fellow with HIMSS. Additionally, Mr. Anderson serves on numerous healthcare advisory positions including:

* Advisory Board and Content Chairman - Healthcare IT Outsourcing Summit, 2002, 2003
* Advisory Board and Content Chairman - Patient Safety and CPOE Summit, 2002, 2003
* Advisory Board and Content Chairman – Consumer Driven Healthcare Conference, 2003
* Advisory Board and CPOE Chairman - Reducing Medication Errors, 2003
* Advisory Board of TETHIC 2003
* Advisory Board of NMHCC 2000, 2001, 2002, 2003
* Advisory Board of TCBI Healthcare Conference 2000, 2001, 2002, 2003
* Advisory Board of TEPR and MRI, 2000, 2001, 2002, 2003
* Advisory Board of the World Healthcare Information & Technology Congress
* Board of Greater Midwest and Houston Chapters of HIMSS
* Developer of the Six-levels of Healthcare IT for the Physician Office
* Editorial Board of Healthcare Informatics 2001, 2002, 2003
* Judge, MSHUG ISA, 1999-2003
* Judge, TEPR Awards, 2001-2003
* National HIMSS Fellows Committee 2001, 2002
* National HIMSS Programs Workgroup Committee 2001, 2002, 2003
* Researcher and producer of the 2002 and 2003 EMR functionally report

More about AC Group:

AC Group, Inc. (ACG), formed in 1996, is an information technology advisory and research service designed to save healthcare industry participants' precious time and resources in IT decision-making. More than 500 healthcare organizations worldwide have approached their most critical IT challenges with the help of trusted advisors from ACG. Since 1972, ACG advisors have been helping IT professionals make better strategic and tactical decisions. ACG offers clients the advantage of the finest industry research available anywhere, as well as a resource equally valuable – the collective hindsight of hundreds of companies whose IT experiences it has monitored and analyzed in detail. This unmatched combination of market research and real-world IT assessment gives clients the tools they need to eliminate wasteful IT spending, avoid the inefficiency of trial and error, and discover a superior alternative to "guess" decisions. For our healthcare vendor clients, ACG provides independent advisory and consultative services designed to assist vendors in their Business Strategies, Market and Customer Strategies, Competitive Analysis and Product Profiling.