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# Managing the Economic Impact: Using People, Processes and Technology to Improve Point-of-Service Collections

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# Today's Presenters

- **Julie Waddell**  
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# Overview

- **Assessing the climate**
  - Challenges we're facing today
- **Embracing change**
- **Tenet/Conifer**
  - A case study
  - Facing the challenge
  - Creating a solution
  - Recommendations
- **Mayo Clinic Arizona**
  - A case study
  - Facing the challenge
  - Creating a solution
  - Recommendations

# Industry Challenges

- According to *hfm*, health sector outlooks changed from stable to negative
  - Increasing bad debt exposure
  - Softening volumes
  - Restricted pricing growth opportunities
  - Increasing charity care



# Issues Impacting Operations and Reimbursement

- Payor delay payment tactics
- Lack of eligibility and benefit information
- Increased delays for medical necessity audits, reductions in reimbursement
- Increased administrative requirements to ensure timely and adequate reimbursement
- Complexity and rate of change has accelerated for compliance and regulatory requirements of government and managed care payors
- Limited timeframe to appeal on denials, respond to audits

# Industry Trends

- **Insurance fraud and identity theft**
  - Verification and validation in scheduling, pre-registration and registration
- **Managing new financial risks**
  - Financial securitization in pre-service
- **Transparency**
  - Pricing and quality
- **Staffing / Training**

# Embracing Change

- **Adopt HFMA Patient Friendly Billing® guiding principles**
- **Collect data: Know your employers, payors and physicians and prepare for change**
- **Focus on standardizing processes and leveraging technology**
- **Communicate**
  - Physicians
  - Community
  - Employers
  - Health Plans

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## Tenet / Conifer

**Managing the Economic Impact:**  
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# Tenet

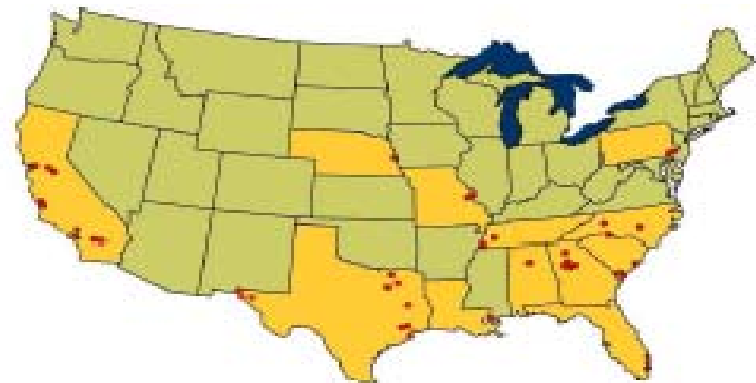


- **Company Overview**

- Tenet Healthcare Corporation, through its subsidiaries, owns and operates acute care hospitals and related ancillary health care businesses, which include ambulatory surgery centers and diagnostic imaging centers. Tenet’s hospitals and related healthcare facilities are committed to providing high quality care to patients in the communities they serve.

- **Company Snapshot**

- 51 acute care hospitals in 12 states
- 13,723 licensed beds
- 60,297 employees (CY08)
- 530,000 admissions (CY08)
- 4 million outpatient visits (CY08)



## Tenet (cont'd)



- **Quality**

- Our mission is to improve the quality of life of every patient who enters our doors. Quality is the reason our patients and physicians choose us, and we seek out relationships with those who place a high value on quality.

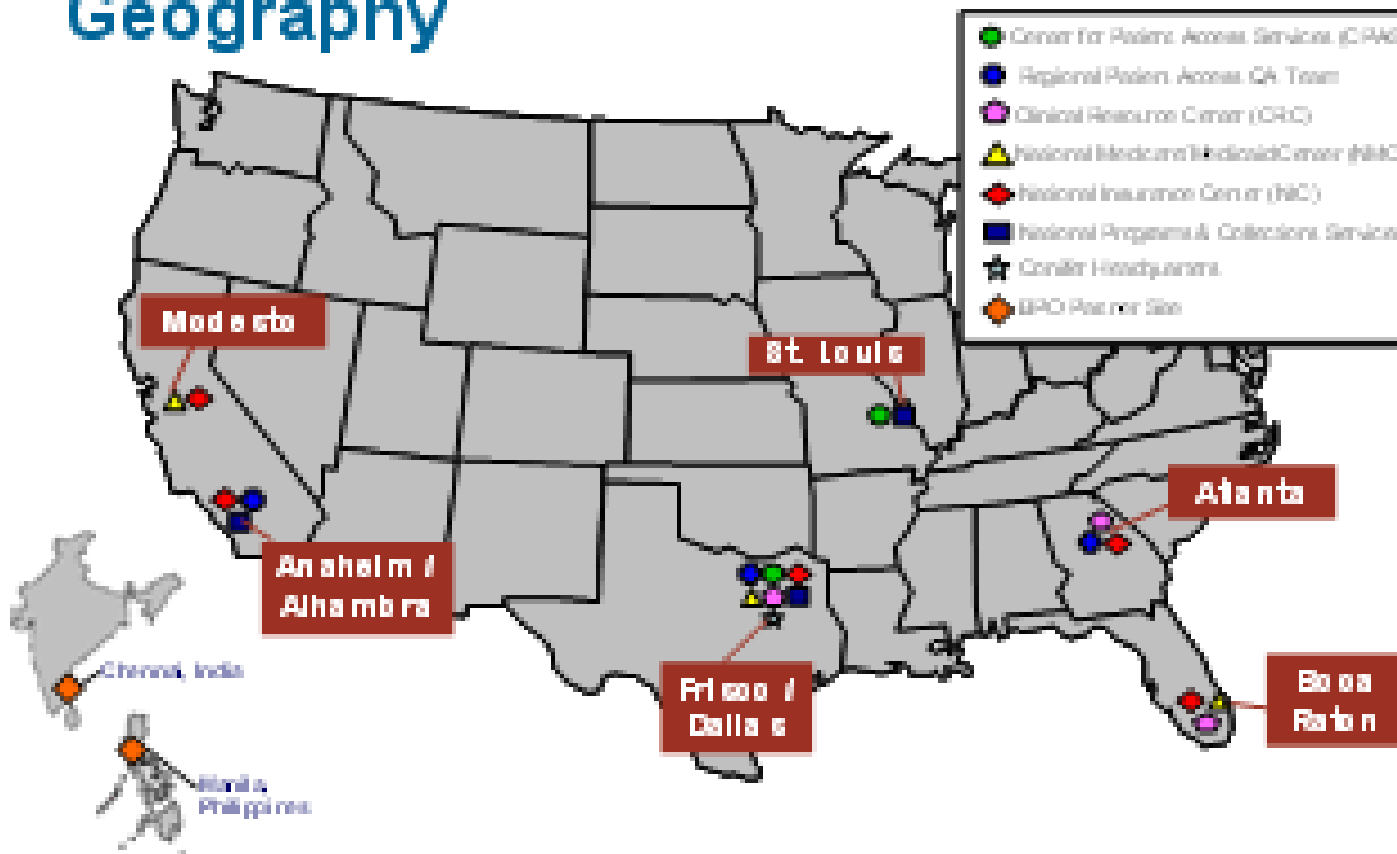
**“Quality is at the cornerstone of everything we do.**

**It is our passion to provide exceptional care  
to every we serve.”**

**- Tenet’s *Commitment to Quality* Pledge**

**Launched in November of 2008, Conifer Health Solutions** was created by bringing together MedContact and the Patient Financial Services division of Tenet Healthcare. Conifer has 7 centers of excellence throughout the United States. We serve over 100 hospitals nationwide.

## Geography



**CONIFER**  
HEALTH SOLUTIONS

MedAssets

# Tenet Mission/Vision



- **Tenet Mission**

- Tenet's name and logo reflect its core business philosophy - the importance of shared values between partners in providing a full spectrum of quality, cost-efficient health care.

- **Our Vision**

- Tenet will distinguish itself as a leader in redefining health care delivery and will be recognized for the passion of its people and partners in providing quality, innovative care to the patients it serves in each community.

- **Our Tenets**

- Successful partnerships require that the parties share certain beliefs; that they hold philosophies, expectations and standards in common. Tenet has articulated our beliefs in a list of [Our Tenets](#).

# Conifer Mission/Vision

- **Conifer Mission**

- At Conifer, we understand patient satisfaction is key to both your mission and your margin. Conifer delivers improved process accuracy and results through our personal understanding of the financial issues hospitals face.

# Driving Forces and Customer Demands

- **Driving forces**
  - Economy
  - Complex contracts/patient liability calculation
- **Customer demands (Patient)**
  - Minimal wait
  - Clear communication
  - No surprises
- **Customer demands (Physician)**
  - No wait
  - No complaints from the patients
  - Clear communication
- **Customer demands (Billing and Collections Operations)**
  - Accurate information
  - No complaints from the patients
  - Clear communication

# Tenet/Conifer Challenges



- **Economy**

- Increased unemployment
- Increased uninsured and underinsured
- Higher deductibles/co-pays

- **Complex benefits**

- For patients
- For employers
- For hospital employees

## **THE PATIENT ACCESS CHALLENGE:**

We need to understand and communicate the benefits to and for everyone.

# A Five-Day Course is Offered for New Employees That Includes:

- Defining your role
- Personal responsibility
- Teamwork
- Customer Service
- Target 100
- Regulations
- JCAHO
- HIPAA
- Keys to Compliance
- EMTALA
- Medicare Compliance and LMRP
- Forms
- Patient Access Directives
- Financial Clearance
- Methods – Discussion Point
- Components of Verification
- Insurance Quick References
- Insurances – Government Payors
- HIC Number Suffixes
- Railroad Retirements Beneficiary – Number Prefixes
- TRICARE
- Other Federal, State and County Programs
- Commercial Insurance
- Required Information for Approvals
- Financial Counseling Timing
- Credit Checks
- **Financial Counseling – 6 hours**
- Scheduling
- Pre-Registration
- Walk-Ins Unscheduled Non-ED
- Quality Control
- System Overview
- Data Validation
- UB04 Activity

# Financial Clearance

- **Definition**

- **All patients must be financially cleared.** It is done prospectively, concurrently and retrospectively to ensure proper adjudication by the payor and patient understanding of financial obligations and requirements.

- **Key Components**

- Insurance eligibility/benefit verification
- Obtaining all necessary insurance approvals
- Calculating Patient Liability
- Financial counseling

# Financial Counseling

## Step #1: Determine payor and obtain benefits

- **Identifying the correct payor source**
  - Interviewing the patient
  - Information from doctor's office
  - Insurance verification
- **Results will determine appropriate calculation of patient liabilities**

# Financial Counseling

## Step #2: Calculation of Patient Liabilities

- **Calculation of liabilities**

- Obtain co-payment, co-insurance and deductible amounts
- Review contract rates
- Review open past due account balances

- **EXERCISES**

# Let's Compute!

**Patient A: Inpatient for 4 days**

**Outstanding balance: \$100 in same calendar year**

**Deductible: \$500 not met**

**Insurance pays: 90% of per diem rate \$900/day**

**OOP maximum: \$2,000 not met (not including ded.)**

---

**You will ask the patient for:**

**\$100 balance + \$310 coins + \$500 ded. = \$910 total**

# Let's Compute!

**Patient B: In house for 10 days**

**Outstanding balance: \$550 from same calendar year**

**Deductible: \$1,500, \$600 met**

**Insurance pays: 80% of \$1,000 per diem**

**OOP maximum: \$1,500 (not including ded.)**

---

**You will ask for:**

$\$550 \text{ balance} + \$900 \text{ ded.} + 1,820 \text{ coins} = \$3,270$

$\$3,270 > \$1,500 \text{ OOP}$ , so you collect  $\$1,500 + \$900 \text{ ded.}$  because  
OOP does not include ded. =  $\$2,400 \text{ total}$

# Financial Counseling

## Step #3: Collection of Patient Liabilities

- **Collection of liabilities**

- Review Total Liabilities
- Create Estimate
- If In-house, determine patient status

- **EXERCISES**

- Scripts
- Role Play
  - Agreeable
  - Challenging

# Extraordinary Patient Collectors

**Have the ability to:**

- **Verify Benefits**
- **Calculate Liability**
- **Collect Liability**

# Creating a Solution – Liability Calculation

## Define the Requirements:

- **Accurate, automated Patient Liability calculation using**
  - Benefits
  - Charges
  - Contract rates
- **Easy to use**
- **Clear patient communication**
- **Integration into current systems**

## Creating a Solution (cont'd)

- **Define the problem with Sourcing Management**
- **Create Statement of Work**
- **Sourcing to identify potential vendors and send RFP**
- **Identify best candidates for on-site demos using statement of work and scripts**
- **Select best candidate**

# Definition

- **What is Sourcing Management?**
  - Sourcing management is those functions and business processes that are required for successful vendor management.
- **Sourcing Management is often referred to as:**
  - Supplier Governance
  - Relationship Management
  - Vendor Management
  - Contract Management
  - Supplier Management

# Statement of Work (SOW)

- **Purpose**
  - Clearly sets expectation of what you expect the product or service to deliver
  - Clarifies division of responsibility
- **Statements of Work describe “what” NOT “how”:**
  - “What” statements:
    - Specify the service to be performed
    - Specify the outputs that result from performing the service
    - Start with a verb
  - “How” statements specify the specific manner in which a service is to be performed (e.g., desk procedures)
    - The specific tools used
    - The work instructions to be performed
    - The location from which the work is to be done

# Draft Examples - SOW Draft

E2.N - BI -0	<b>1.1 Maintenance</b>		
E2.N - BI -1	1. Maintain claims data mapping for the Payor specific claims routing or distribution process		
E2.N - BI -2	2. Process claims electronically or via hard copy based upon: <ul style="list-style-type: none"> <li>• Demographic, Diagnostic, and/or Financial elements of the claim to allow for special handling needs based on Payor requirements</li> <li>• Tracking to ensure correct, consistent, and timely receipt of claims by the Payor</li> </ul>		
E2.N - BI -3	3. Implement changes to maximize acceptance rate as requested by client		
E2.N - BI -4	4. Maintain rejection log by Payor to identify claim format and content problems prior to submission		
E2.N - BI -5	5. Provide Web Based Claims Editor that includes:		
E2.N - BI -6	<ul style="list-style-type: none"> <li>• Secure access environment consistent with HIPAA security guidelines for data on the Internet</li> <li>• Claims editor to allow correction of claims</li> </ul>		

# Evaluation Criteria Summary

Category	Criteria	5	3	1
<b>Cultural Fit / Cultural Preparation</b>	Does the service provider have a good understanding of the Tenet culture, do they have a plan to train their team and what is the likelihood of a smooth integration into Tenet	Yes	Somewhat	No
<b>Good Understanding of Tenet</b>	Service Provider understands the Tenet environment	Understand the environment and special requirements	Somewhat confident	Not confident
<b>Innovation and Vision</b> Continuous improvement Total quality frameworks	Does the supplier show innovation and vision with a plan to continuously improve the solution and their environment	Yes	Somewhat	No
<b>Stability/Viability</b>	Is the service provider a stable and viable company	Yes	Somewhat	No
<b>Value Add</b>	Does the supplier provide any additional value compared to the original scope?	Yes	Somewhat	No
<b>Technical Solution</b>	Are they introducing new technology that could enhance the delivery of the services	Yes	Somewhat	No
<b>Viability of the Solution</b>	Will the solution deliver the desired results and have the ability to grow over time	Yes	Maybe	No

# Solution Results

## Define the Requirements:

- **Accurate, automated Patient Liability calculation using:**
  - Benefits ✓
  - Charges ✓
  - Contract rates ✓
- **Easy to use ✓**
- **Clear patient communication ✓**
- **Integration into current systems**

# Why Patient Access is Key in the Revenue Cycle

**Patient satisfaction is key to the mission and margin of our hospitals.**

- **Process accuracy and results will:**
  - Reduce denials
  - Increase point-of-service collections
  - Increase overall collections
  - Improve overall patient satisfaction

# Describe Any Barriers You've Encountered

## Barriers faced:

- **Financial clearance process implemented 2 years prior had not been adopted at all of the hospitals**
- **CarePricer<sup>®</sup> Trainer changes**
- **Hospital management organization**
- **Process changes**

# Performance Improvement Opportunities

- **Integration**

- Verification system to CarePricer
- CarePricer to ADT System patient liability screen

- **On-site follow-up**

# Emergency Room Use Key Factors

- **Administration Support**
  - Physician Support
  - Clinical Support
- **Clinical Communication**
  - Service Levels
  - Patient Status
  - Patient Discharge to Patient Access
- **Clear Discharge Process**
  - Discharge Desk
  - Lead Representative

# Results

**We piloted at 3 hospitals:**

- Three months post implementation:**

	<b>CarePricer</b>	<b>No CarePricer</b>
Accounts that were Paid in Full post insurance payment	90.6%	54.4%
% of payment amount received	88.8%	74.9%

# Recommendations

- **Review current process first (Don't assume processes are established.)**
- **Communicate time frames clearly**
- **Train management team first to ensure a good training fit**
- **On-site follow-up to ensure system use**

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# Mayo Clinic Arizona

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# Mayo Clinic Arizona



- **244 licensed/teaching beds**
- **Satellite locations through Arizona**
- **VHA Certificate of Recognition Performance Excellence in 2007**
- ***HealthGrades* 2008 America's 50 Best Hospitals Award**
- ***Newsweek* 100 Best Employers**

## Our Mission/Vision

- **Mayo will provide the best care to every patient every day through integrated clinical practice, education and research.**
- **Mayo Clinic will be the premier patient-centered academic medical organization.**



## Customer Demands: Patient Liability Estimates

- **Information about cost of healthcare services**
- **Key quality performance indicators and outcomes**
- **Cost comparisons availability via websites**
- **Anticipating out-of-pocket expenses**

# Mayo's Challenges



- **Multiple methodologies for calculating patient's out-of-pocket**
- **Multiple points of entry**
- **Dissatisfied customers**
- **Increasing shift to patient liability**
- **Increase in bad debt**
- **Uninsured and international patients**
- **Medicare requirements for non-par physicians**

# Creating a Solution

## Process: Upfront collection policies

- **Before:**

- Attempted to collect from self-pay and underinsured
- Collections efforts for insured patients after services rendered
- Co-payments collection prior to service

- **First things first:**

- Evaluating the key components that enable effective processes upfront

# Why Patient Access is Key in the Revenue Cycle

- **Registration**

- Verification of information
- Consents and authorizations
- Insurance benefits verification
- Estimate patient out-of-pocket
- Establish the ability to pay
- Identify other payor sources

# Barriers

- **Buy-in from our physician colleagues, concerned that volumes might decrease because of the implementation of an effective upfront collection model. (Cure them clinically and kill them financially!)**
- **Concerns about our culture supporting this process: “The needs of the patient come first.”**
- **Customer service concerns regarding the change in our process because “you’ve never done it this way”**
- **Putting finances before patient care**
- **Ability and skill of the front-end staff to do appropriate collection activity**
- **Ineffective tools**

# Example of an Inaccurate Estimate

- Patient presented to Financial Counseling for nominal estimate for Bone Marrow Aspiration
- Counselor accessed CDM and gave estimate of \$1,179
- Charges came in at \$10,789
- Huge out-of-pocket expense for a non-contracted patient

Bone marrow aspiration	FPI EFF DATE:	
PRIMARY CPT: 38220	MOD: <input type="text"/>	SECONDARY CPT:
<b><u>HOSPITAL PRICING</u></b>		
<b><u>NOMINAL:</u></b>		
MH NOM TOTAL FEE:	<input type="text" value="1179.00"/>	
MH NOM PRO FEE:	<input type="text" value="1179.00"/>	
MH NOM TECH FEE:	<input type="text" value="0.00"/>	
MH NOM EFF DATE:	<input type="text" value="1/1/2008"/>	
<b><u>MEDICARE Limiting Chg:</u></b>		
MH MED TOTAL FEE:	<input type="text" value="60.95"/>	
MH MED PRO FEE:	<input type="text" value="60.95"/>	
MH MED TECH FEE:	<input type="text" value="0.00"/>	
MH MED EFF DATE:	<input type="text" value="1/14/2008"/>	
<b><u>MEDICARE Assigned:</u></b>		
MH ASGN TOTAL FEE:	<input type="text" value="53.00"/>	
MH ASGN PRO FEE:	<input type="text" value="53.00"/>	
MH ASGN TECH FEE:	<input type="text" value="0.00"/>	
MH ASGN EFF DATE:	<input type="text" value="1/14/2008"/>	



5777 E MAYO BLVD  
PHOENIX, AZ 85054

# ESTIMATE

Printed On: 09-05-2008  
Creation Date: 09-05-2008  
Quotation valid until: 12-04-2008

Patient Information	
Medical Record Number	000000000000000000
Patient Name	TEST, BONE MARROW ASPIRATION
Patient Address	
Patient Phone	
Patient Plan	Self Pay - SPY
Patient Type	Outpatient
Estimated Date of Service	09/05/2008

Services	
	Charges
38220 Bone Marrow Aspiration	
Estimated Clinical/Physician Charges	\$3,270.27
38220-Bone marrow; aspiration only	\$1,179.00
38221-Bone marrow; biopsy, needle or trocar	\$1,262.00
88305-LEVEL IV - Surgical pathology, gross and microscopic examination Abortion - Spontaneous/Missed Artery, Biopsy Bone Marrow, Biopsy Bone Exostosis Brain/Meninges, Other than for Tumor Resection Breast, Biopsy, Not requiring Microscopic Evaluation	\$118.80
88311-Decalcification procedure (List separately in addition to code for surgical pathology examination)	\$68.27
85060-Blood smear, peripheral, interpretation by physician with written report	\$137.00
85097-BONE MARROW INTERPRETATION	\$219.00
88312-Special stains (List separately in addition to code for primary service); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each	\$99.20
99232-Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical dec	\$187.00
Estimated Hospital Charges	\$7,308.62
0000-OTHER CHARGES	\$4,521.16
0250-PHARMACY	\$591.60
0258-IV SOLUTIONS	\$156.93
0272-STERILE SUPPLY	\$353.36
0310-PATHOLOGY LAB	\$214.22
0310-PATHOLOGY LAB	\$276.96
0310-PATHOLOGY LAB	\$37.35
0311-CYTOLOGY TESTS	\$674.39
0311-CYTOLOGY TESTS	\$114.96
0510-CLINIC	\$176.93
0510-CLINIC	\$31.75
0920-OTHER DX SVS	\$159.01
Combined Estimate Total Charges	\$10,578.89

# Performance Improvement Opportunities

- **Obtaining pertinent information**
  - Appointment office /Scheduling
  - Pre-registration
  - ED registration
  - Financial counseling screening
- **Providing the estimate and asking for payment**
  - Pre-registration
  - Registration appointment
  - Call center
  - Pre-certification appointment / Financial counseling appointment
  - International medicine

# Performance Improvement Opportunities

- **Process for handling in-house and ED patients**
  - Verification of benefits
  - Estimate of LOS
  - Estimate of emergency charge based on acuity
  - Calculate out-of-pocket
  - Request deposits
  - State AHCCCS to calculate spend downs

# Performance Improvement Opportunities

- **Shopper requests**
  - Call center
  - Financial counselors
  - Pre-certification
  - Admissions

# The Self-Pay Cycle

- **Managing**

- Expectations of customer
- Cash flow
- Cost to collect
- Bad debt expense
- Credit and collections

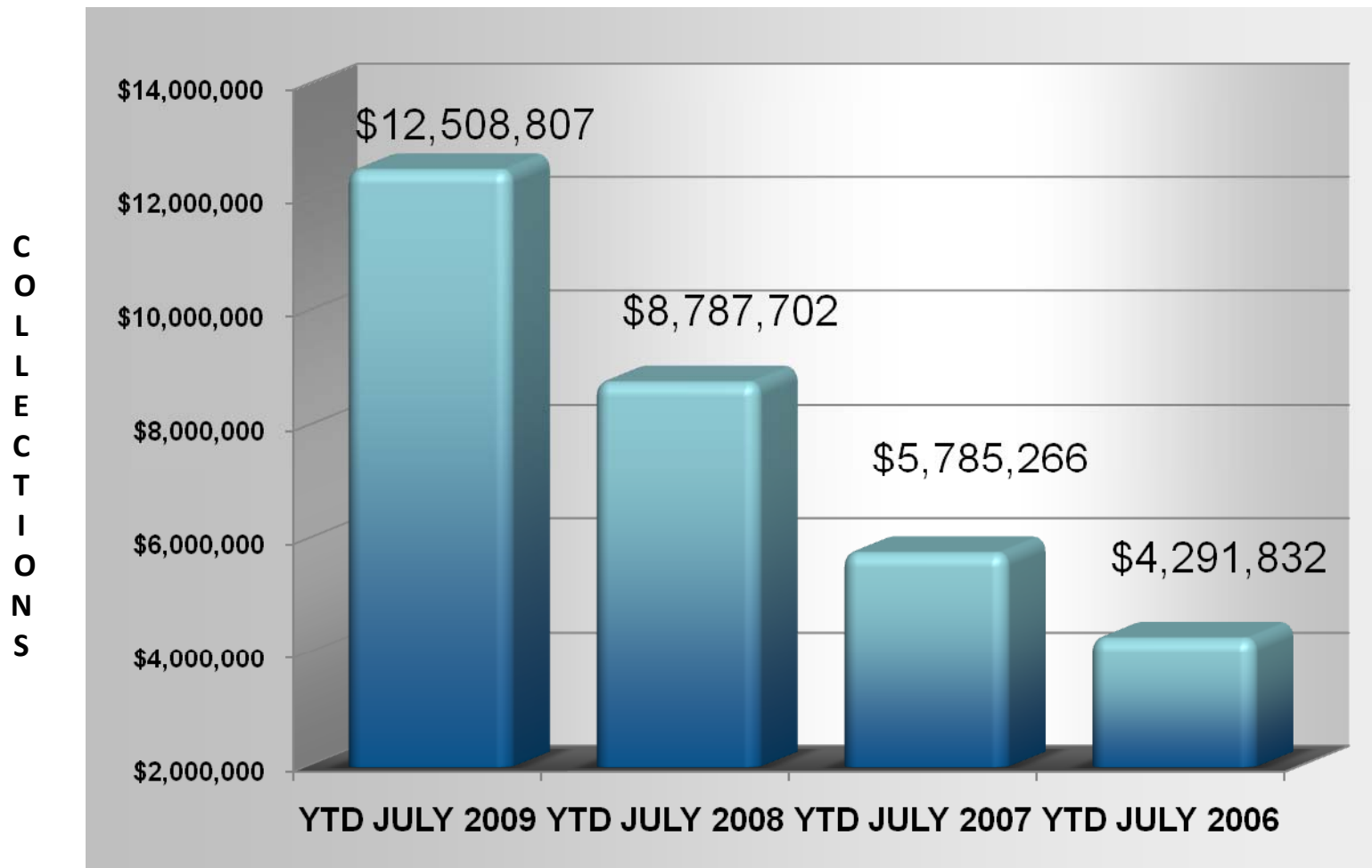


# Technology: Creating a Solution

- **After**
  - Pre-registration completed prior to service
  - Insurance verified and benefits calculated
  - Patient notified of out-of-pocket expenses
  - Collection/payment arrangements



# POS Collections Trend



# Recommendations

## Basic education requirements:

- **An understanding of the dataset – UB & 1500 claims data**
  - An understanding of what data elements are found on each type of claim
- **Basic coding and terminology and usage:**
  - Revenue codes
  - CPT®-4/HCPCS codes
  - ICD-9 codes
  - DRGs

# Policies, Procedures and Processes

- **Identify policies, processes and procedures that should be considered from an operational standpoint**
  - Narrow your scope initially: Start with co-pays and deductibles
  - Increase your scope by adding co-insurance using contract management system or other resources
  - Estimate non-contracted co-insurance based on historical payments



# Analyze Your Book of Business

- **A/R look back on “who contributed to bad debt?”  
(Insured vs. uninsured)**
  - True self-pay
  - Self-pay balances after insurance
  - High-deductible health plans
  - Conversion factors to Medicaid or other programs (Percentage before and after care)

# Creative Flexibility

- **Templates to be used for various types of estimates**
  - Implementation tips:
    - Compare internal volume procedure data
    - Build combined service categories (templates) for your most commonly performed procedures
    - Consider both physician and facility services
  - Multiple languages
  - Variable format insurance vs. uninsured
  - Consider larger font for aged population

# Engage Key Players for Buy-In

- **Administration**
- **Physician Leadership**
- **Division Chairs (This was a phased approach.)**
- **Public Relations**
- **Management**
- **Staff**



# Methodical Operational Implementations is Key!

- **Communicate across the organization**
- **Measure collections**
- **Monitor changes in the practice**
- **Track challenges**
- **Celebrate success**



# Measure Everything

- **QA to measure estimate against actual claim**
- **Build confidence in staff and improve accuracy**
  - Have staff build “test” estimates for live patients
  - Compare those “test” estimates to final bills
  - Establish super users in areas
  - Monitor system usage
  - Provide ad hoc training sessions and updates often

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