

# Performance Strategies



Reducing Bad Debt Using IT Tools and Services

Vol. 2, Issue 4, 2008

## Novant Health: Clear Patient Statements and Online Self-Pay Benefit Patients and Bottom Line



*By Lesa Klepper, FHFMA  
Central Business Office Director  
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Winston-Salem, N.C.*



### Providing a Better Billing Experience for Patients

Prompted by the [Patient Friendly Billing® Project](#), an industry-wide initiative led by the Healthcare Financial Management Association (HFMA), we realized that our patients were, indeed, having a hard time understanding our statements, delaying payments for their share of the bill. Although we couldn't change what patients were charged, we knew we could at least improve the patient billing experience at [Novant Health](#), a not-for-profit integrated healthcare system serving North Carolina and neighboring states.

Like many other healthcare organizations, our process was riddled with difficulties. Patients received hospital bills in the mail that they did not understand. They would call the business office, sometimes enduring long waits and engaging in prolonged discussions with a customer service representative. At the end, patients still might not understand the bill or how much they owed — and would become dissatisfied with the entire care experience.

We also came to the conclusion that the billing process was not doing our organization any favors either. Because the statements were acting as a barrier to payment, our organization endured high customer service costs, reduced cash flow and even increased levels of bad debt.

### Rethinking Billing Practices

We decided that we needed to start from scratch and develop a customer-centric billing process that would truly meet not only the needs, but also the wants, of our patients. Here's how did we did this.

- **Assigned a project team** that included representatives from finance, patient accounting, patient access, information technology and marketing. This team worked on assessing the problem and finding solutions.
- **Obtained patient input.** To get a better idea of what patients wanted, we conducted multiple patient focus groups. We discovered what patients wanted on their statements in terms of content, clarity and detail. We found that about 80% of patients wanted online billing functionality.
- **Selected a vendor.** Through a request for information and in-person interviews, we selected a vendor based on the following four key criteria: services provided and levels of automation; internal control processes; HIPAA compliance; and price.
- **Implemented an online billing option.** With this alternative, patients have around-the-clock access to updated account information, online payment and expanded communication capabilities.

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## Novant Health: Clear Patient Statements and Online Self-Pay Benefit Patients and Bottom Line (Cont.)

### Results of Our Patient-Friendly Intervention

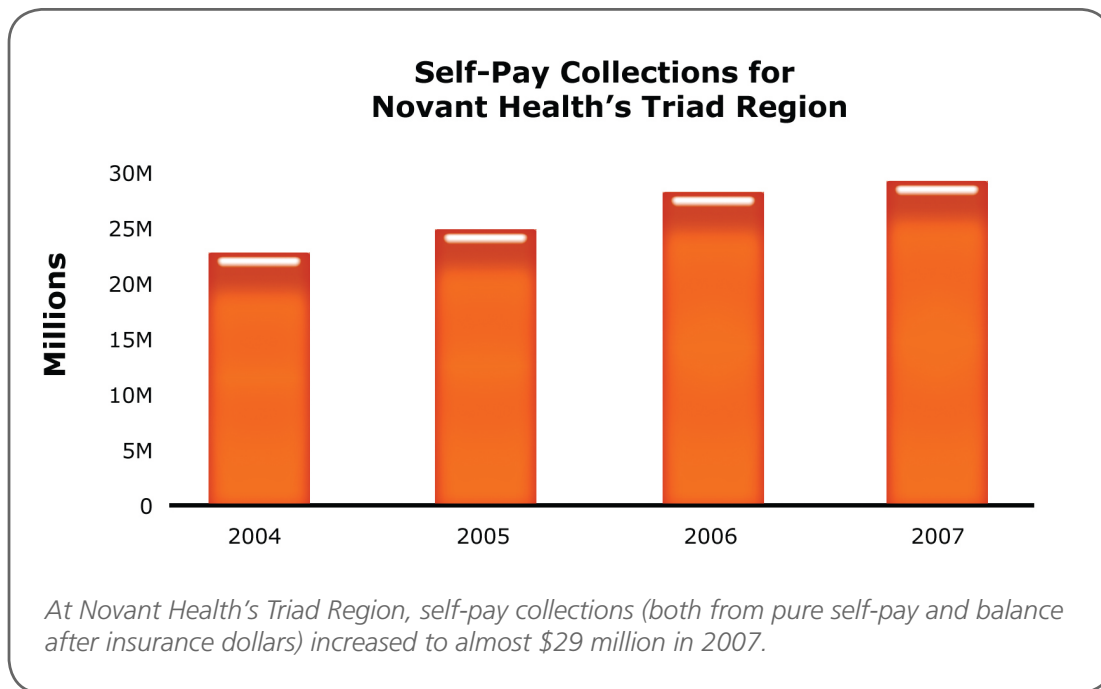
Through the revamping of our entire billing process, we have been able to achieve significant results at Novant Health's Triad Region, including:

- **Reduced bill processing costs.** Healthcare organizations can save up to \$1 per bill by converting a paper-based transaction to electronic. At Novant Health's Triad Region, self-pay payments have increased from \$23M in 2003 to almost \$29M in 2007. We are averaging about \$450K per month utilizing the online self-pay payments process — with 250 new households registering for the service each month.
- **Improved cash flow.** Because patients understand their bills and have access to an online option, they pay their bills more quickly — which improves cash management through reductions in days in A/R and bad debt. In addition, because the bills provide information about how to apply for assistance, patients who are eligible for charity care are more likely to pursue such assistance, reducing bad debt even more.
- **Enhanced patient satisfaction.** The online functionality offers our patients an increased level of customer service — they can access account information and pay their bills during non-business hours. After-hours access would be too difficult and expensive to provide through traditional phone and in-person communications.

The revised paper statements and the ability to pay online using [RelayHealth's Patient Compass™](#) solution are making it much easier for patients to understand and pay their bills. The redesigned statements clearly delineate what patients owe and what third-party payors have paid, making it easy for patients to settle their accounts. Our efforts to improve the billing experience have not only resulted in bottom line gains, but have also helped improve patient perception of the overall care experience at Novant Health.

*Lesa Klepper is the Director of the Central Business Office, Triad Region, for [Novant Health](#), located in Winston-Salem, N.C. She has held this position since 2000 and has A/R responsibilities for four acute-care facilities, an outpatient surgical center, and two long-term care facilities. Prior to joining Novant Health, she held positions at the University of Tennessee Medical Center, Williamson Medical Center, and Hawkins County Memorial Hospital over an 18-year period. She is active in HFMA, having served as President of the Tennessee Chapter, held a four-year term on the National Board of Examiners, and participated in HFMA Abroad's inaugural trips to China and Russia. She currently sits on the NC Hospital Association's Medicaid Technical Advisory Group.*

## Novant Health: Clear Patient Statements and Online Self-Pay Benefit Patients and Bottom Line (Cont.)



## Learn More

[Achieve a Consumer-Oriented Revenue Cycle](#)

[The Opportunity of Price Transparency](#)

[Patient Compass™ Gets HFMA Peer Review Status](#)

# Performance Strategies



Reducing Bad Debt Using IT Tools and Services

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## Wellmont: “Measure, Analyze, Intervene” to Reduce Bad Debt



By Becky Cooper Baker  
Vice President, Revenue Cycle  
Wellmont Health System, Kingsport, Tenn.



### Staying Alert for the Latest in Best Practices

*“Excellence is a journey, not a destination.”* It’s a philosophy that we have taken to heart when it comes to revenue cycle management at [Wellmont Health System](#), a nine-hospital organization based in Tennessee. That philosophy has helped us face the myriad challenges inherent in the business of delivering healthcare.

To continue our journey to excellence, we read industry publications, identify best practices, and then do what we can to bring our operations up to, and beyond, industry benchmarks. We implement a process change, staffing reorganization or technology enhancement at least once a month, if not more frequently.

Most recently, we took on the challenge of reducing our level of bad debt — a growing concern as private and government payors tighten their belts, and patients become responsible for a larger share of their healthcare bills. By combining the use of information technology with ongoing process change, we’ve been able to reduce our bad debt expense as a percentage of gross revenue 13.5% over the past two years.

### Using Continuous Improvement to Achieve Goals

To achieve such results, we employ a continuous performance improvement model where we measure current results, analyze them to find opportunities for improvement, and then intervene in the current process by implementing a change. Then we monitor the results to evaluate exactly what each process change is bringing to the table. We are always asking: Has the intervention helped us progress toward our goal? If necessary, we make modifications and measure the results again.

McKesson’s Web-based business analytics solution, which provides analysis, reporting and scorecarding, is the engine that drives this continuous performance improvement cycle. With this tool in place, revenue cycle leaders and employees gain secure access to timely information — a real boon to our performance improvement efforts.

For example, if the CFO calls and asks why accounts aged over 90 days have increased, I can simply go into the system, drill down to the patient account level and come up with an answer. I can analyze the accounts by patient responsibility or financial class, or by any one of a number of other criteria to determine the explanation for the problem. With this information in hand, I can then formulate a potential solution and take the action required to ensure that these accounts do not morph into bad debt.

### Results of our “Measure, Analyze, Intervene” Strategy

Our “measure, analyze, intervene” approach has helped us improve revenue cycle practices by:

- Implementing a process to verify insurance eligibility online at the point of service. Using the patient’s insurance information, we go to individual payor Web sites to determine a patient’s financial responsibility. With this process in place, we have increased our upfront cash intake 237%, from about \$81,000 per month in 2006 to more than \$273,000 per month in 2008.

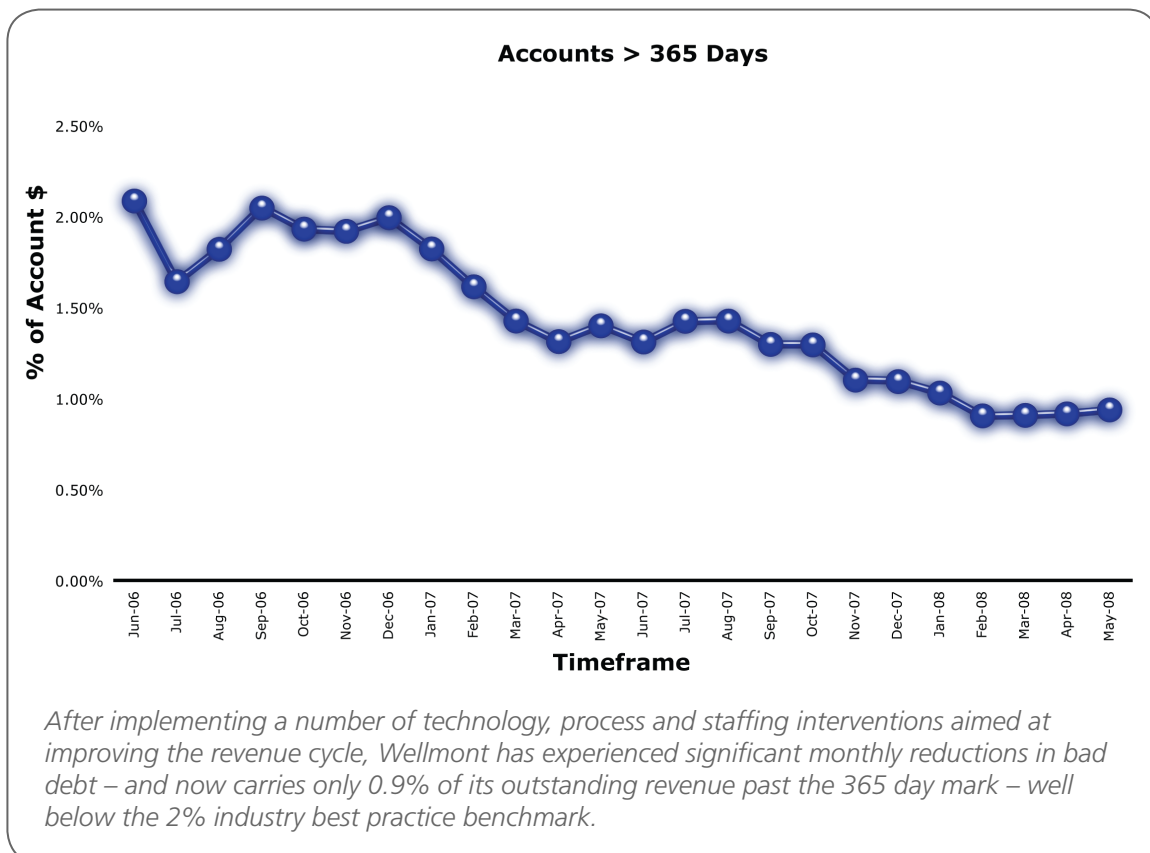
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## Wellmont: “Measure, Analyze, Intervene” to Reduce Bad Debt (Cont.)

- Sending statements to patients at opportune intervals via an automated billing scheduler. With this automation in place, patients are much more likely to comply with payment requests.
- Reducing claims processing time by three days because employees can more efficiently access needed information using an electronic medical records system.
- Using analytics to identify workflow problems — and then implementing the appropriate staffing changes to address them. For instance, we shifted all workers’ compensation claims to one employee who had developed relationships with these companies. This shift resulted in significant improvement in the time to process claims.
- Processing Medicare claims through a grouper twice a day, instead of just once, which has enabled us to reduce the time it takes to submit these claims from an average of about six days to just three days.

Implementing all of these improvements has enabled Wellmont to enhance revenue cycle processes and improve interactions with patients. In the final analysis, our results clearly illustrate how we are, in fact, “doing better” and optimizing performance: In June 2006, we carried \$2,271,045 or 2.1% of total revenue in bad debt, whereas in May 2008, we carried only \$1,876,916 or 0.9% of total revenue in bad debt.

*Becky Cooper Baker is the Vice President of Revenue Cycle at Wellmont Health System, Kingsport, Tenn. In this position, Ms. Cooper Baker has direct responsibility for patient financial services, reimbursement, and the charge master. Having worked for several multi-facility healthcare systems during the past 30 years, she has extensive experience in healthcare finance including patient accounting, general accounting, budgeting, contract management and reimbursement. Ms. Cooper Baker has served as an author for publications regarding Medicare reimbursement products, including Medicare and Medicaid Answers Now. Wellmont Health System is a nine-hospital network serving Northeast Tennessee and Southeast Virginia.*



## Learn More

[Adapting Customer Service to Consumer-Directed Healthcare](#)

[Performance Improvement: A “Left Brain Meets Right Brain” Approach](#)

[Reinventing How Health Systems Manage Revenue](#)

[Building a New Payment System](#)

# Performance Strategies



## A Strategic Approach to Reducing Bad Debt



By Keith Hearle and Shari Bailey  
Verité Healthcare Consulting, LLC

A new era of transparency and accountability has arrived for America's hospitals. The updated IRS Form 990, which all tax-exempt organizations must file beginning in 2009, requires disclosing a wider range of data about charity care policies and costs, community benefit activities, bad debt expense, and executive compensation.

While Form 990 will demand more time and resources for completion, it offers organizations the opportunity to ensure they are minimizing bad debt, appropriately identifying reportable community benefits, and maximizing cash flow. Achieving these objectives requires a strategic approach.

### Essential Elements of a Strategic Plan

Every healthcare organization wants to reduce bad debt by optimizing cash collections and reportable charity care. To be successful, healthcare providers must develop a strategic plan for revenue cycle management that includes these essential elements.

1. Finding third-party sources of payment for self-pay patients, including Medicaid and other governmental sources.
2. Ensuring that policies governing charity care and collections incorporate best practices and are consistently implemented. Examples of these policies – and much more on meeting the requirements of Form 990 – can be found at the [990 Coalition for Hospitals](#) Web site.
3. Improving point-of-service and post-service collections from self-pay patients.
4. Building an operational revenue cycle structure that is well managed with competent and knowledgeable employees, efficient, “patient friendly,” and guided by effective policies and procedures for self-pay accounts receivable management.
5. Ensuring that the accounting process properly recognizes revenue, bad debt expense and charity care. Healthcare Financial Management Association (HFMA) [Statement 15](#) suggests that bad debt is overstated because “healthcare providers inappropriately classify some items as bad debts that were never revenue in the first place.” This occurs because they were never truly collectible.
6. Installing modern technology that supports processes and data analysis needed in today's environment.

### Role of Information Technology

While all of these elements are needed to achieve optimal outcomes, effective implementation is achieved with information technology. Technology enables providers to systematize financial assistance policies by incorporating best practices into their workflow and enabling patient access employees to apply them consistently — at the front end of the revenue cycle.

## A Strategic Approach to Reducing Bad Debt (Cont.)

- An emerging best practice is to grant charity care to patients who are “medically indigent” because their out-of-pocket healthcare expenses exceeded a specified amount of household income during the prior 12 months. Future technology will need to track patient spending, estimate upcoming patient out-of-pocket amounts, and flag patients who qualify for this form of assistance.
- Hospitals can use technology to support documentation requirements for charity eligibility — so long as the policies incorporate these procedures.
- Technology can help establish fair payment options by relying on scoring based on the patient’s credit history and record of paying medical bills.
- Technology supports operations by providing:
  - Real time and batch eligibility on all self-pay patients
  - Identifying patients who could be eligible for Medicaid
  - Automation of the financial assistance and Medicaid application process
  - Workflow management
  - Consistent application of policy
  - Integration of payment processing
- Technology can help ensure that revenue is recognized appropriately and bad debt is reduced. Technology systems can also provide the basis for reclassifying bad debt to charity care retroactively.

### Putting Policies into Action

From a strategic viewpoint, technology is not a quick fix. Instead it is a means by which carefully crafted policies and procedures are integrated into daily operations. Providers can create and implement a charity care policy that accurately identifies patients who truly have difficulty paying their bills. With ready access to patient data such as coverage information and ability-to-pay scoring, providers can use IT to make those kinds of determinations early in the process.

In summary, technology can:

- Find eligibility for coverage early in the process
- Support documentation requirements for granting financial assistance
- Provide metrics on charity care
- Automate the financial assistance and Medicaid-application processes
- Provide data for informed patient discussions regarding payment options
- Perform retroactive analysis to justify account reclassification from bad debt to charity care
- Support the accounting and revenue recognition process
- Help incorporate best practices into policies and operations

Implementing a strategic plan provides positive operational and financial benefits for everyone — patients and healthcare providers alike.

*Keith Hearle, president of [Verité Healthcare Consulting, LLC](#), has more than 20 years of consulting, management, and research experience in the healthcare field. He assisted the National Association of Children’s Hospitals, the Catholic Health Association (CHA), and the American Association of Medical Colleges (AAMC) in preparing comments on the draft IRS Form 990 for tax-exempt healthcare organizations, which is based on the CHA accounting framework for community benefit. Verité specializes in healthcare strategy development, financial analysis and decision support, self-pay accounts receivable management, and public policy analysis.*

## A Strategic Approach to Reducing Bad Debt (Cont.)

Shari L. Bailey, vice president of Verité Healthcare Consulting, previously served as senior director of Revenue Cycle for Mercy Health Partners of Southwest Ohio. While in that role, she was responsible for access management, self-pay accounts receivable management, centralized scheduling, and insurance verification. Shari has extensive clinical and financial operations management experience in urgent care, occupational medicine centers and a multi-specialty physician practice.

### Reducing Bad Debt – Helping the Uninsured Get Well and Stay Well

Hospital emergency rooms tell the story of how the uninsured get care. Uninsured patients with chronic diseases often cannot afford regular office visits, maintenance of prescription regimens and other care recommendations. A recent report documents that story. "[Eroding Access among Nonelderly U.S. Adults with Chronic Conditions: Ten Years of Change.](#)" was published online July 28, 2008, in *Health Affairs Journal*.

The study finds that access to care by nonelderly, uninsured adults with chronic conditions has declined over the past decade, and the reason is cost of care. By definition, chronic diseases require continuing care to manage symptoms and prevent complications — and to save health dollars.

- One-third of those with chronic conditions had difficulty getting the care they needed due to cost, and were twice as likely to either forgo or delay care.
- The uninsured with a newly diagnosed chronic condition are less likely to follow the recommendation for follow-up care due to cost, and they end up making more visits to the emergency department (ED).

Return visits are more costly than regular exams or drugs to treat the chronic condition, and often result in a bad debt burden for the hospital.

While bad debt can be reduced using IT tools to help qualify the uninsured and underinsured for charity care, it can also be reduced by helping these patients get well and stay well. Return visits can be reduced through strategies such as placement with a primary care physician in the community, care coordination, education and monitoring to assist patients in management of chronic diseases, and disease management for the high-risk, high-cost uninsured.

An innovative multi-pronged program from McKesson is designed to help these patients manage their disease and reduce readmissions or return visits to the hospital ED. McKesson's [Community Care Advantage](#) improves community wellness, chronic care management and patient satisfaction, and reduces the burden of uncompensated care with services that include:

- Analytics
- Individualized care coordination
- Establishment and reinforcement of a medical home or usual source of primary care
- Disease management of high-cost, high-risk patients
- 24x7 telephonic access to a nurse

Helping the uninsured and underinsured manage their chronic diseases can improve patient outcomes and overall hospital quality scores while reducing uncompensated expenses.

## IRS Updates to Form 990

### IRS Updates to Form 990

[News Release](#)

[Overview](#)

[Form 990](#)

[Instructions](#)

[Frequently Asked Questions](#)

## Feature Event

### Feature Event

See McKesson  
Revenue Cycle Solutions at:

**HFMA Executive Summit**  
**March 8-10**  
**Phoenix, Ariz.**

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Vol. 2, Issue 4, 2008

## Limiting Bad Debt with Enterprise Revenue Management



By David Hammer  
Vice President, Revenue Cycle Solutions  
McKesson Provider Technologies

### The Domino Effect of Fiscal Drivers

Average aggregate hospital margins could reach zero by 2013 if bad debt as a percentage of revenue grows at 10% per year — as some prognosticators predict and hospital leaders fear. But bad debt is just one of many symptoms of our struggling healthcare revenue management environment.

Shrinking margins, rising costs, inefficient processes — and a host of other challenges — are making it difficult for healthcare organizations to achieve financial success. The domino effect of all these factors is the growing difficulty of providing the care that patients need and deserve.

### What's the cure for these challenges?

As hospital finance professionals, we need to realize what clinicians have known for years: *You can't just treat the symptoms and get the results that you want.*

Simply trying to heal current revenue management processes may bring stop-gap improvements but never achieve transformative progress. For example, as an industry, we have made significant advances in electronic data interchange — providers submitted only 80 million paper claims in 2006, compared to 114 million in 2005 — a 30% reduction. But even with this success, providers still submit over 300,000 paper claims every business day. Our goal as an industry should be to eliminate paper claims entirely, and of course, submitting all those paper claims requires an army of billers.

### The Prescription — Enterprise Revenue Management

The prescription is a complete, holistic reinvention of the healthcare revenue management model. Designed to address the new revenue management environment, enterprise revenue management is aimed at improving the *economics* of care. It automates financial processes and connects key healthcare stakeholders: hospitals, payors, financial institutions, physicians and consumers. With enterprise revenue management, healthcare organizations use software, services and connectivity to completely reinvent the way they manage and collect revenue.

By reinventing processes, relationships and organizational structures, this new methodology more effectively deals with the new realities of the healthcare business environment — such as the increasing need to go directly to consumers to get paid. Consider the following: According to the Advisory Board Company, 80% of patient self-pay net revenue is never collected. And the percent of patients without any insurance whatsoever continues to increase — forcing providers to collect the entire cost for care from a greater percentage of patients.

Enterprise revenue management helps by completely reinventing how healthcare organizations interact with consumers. Under the traditional revenue cycle process, consumers adopted passive roles. With enterprise revenue management, consumers actively participate in all facets of their care. Patients can go online and compare prices or procedures, request services online and even conduct some basic pre-registration activities online. Further, after they receive their services, they can track the progress of their accounts and pay their bills online.

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## Limiting Bad Debt with Enterprise Revenue Management (Cont.)

### Ensuring Expected Outcomes

To support this increased collaboration between healthcare organizations and consumers, healthcare providers need to implement technologies that offer the following:

- Self-scheduling and self-regulation
- Pricing and quality transparency
- Out-of-pocket expense estimation
- Self-service direction-finding, check-in, signature capture and payment
- Point-of-service claim adjudication
- Electronic funds transfer from health savings accounts
- Online insurance updates and bill payment

With such functionality in place, healthcare providers can create a completely new billing experience for patients. As a result, healthcare organizations will not just implement temporary fixes to problems. Instead, they can move forward with an entirely new approach that radically improves the interaction between providers, payors and patients. Consequently, the healthcare industry can sustain financial success by creating a new reality that mitigates many financial problems – such as bad debt – that currently plague our ailing healthcare system.

*David Hammer, FHFMA, is Vice President of Revenue Cycle Solutions for McKesson Provider Technologies. David has been extensively published in healthcare magazines and featured as a speaker at healthcare conferences related to best practices for improving revenue cycle operations. He is a member of HFMA's Florida chapter and has written numerous articles for HFMA's peer-reviewed journal, hfm. He is also a member of the Healthcare Information and Management Systems Society (HIMSS) Financial Systems Steering Committee.*

### Seven Key Attributes of an Advanced Revenue Cycle Solution

How will you recognize an advanced revenue cycle solution for enterprise revenue management? Here's the list of the top seven attributes you'll want to check for.

1. **Built-in capabilities** that eliminate the need for bolt-on applications. The system will provide an integrated, seamless flow of financial information throughout the enterprise, including clinical solutions. True integration leads to better efficiency, improved cash flow and lower cost of ownership.
2. **Adaptability and flexibility** to meet regulatory changes by giving providers tools to configure screen display fields, data elements, screen flows, security levels and other system components.
3. **Workflow rules-driven capabilities** that transform revenue cycle operations from an inspection-based process to exception-based quality control.
4. **Powerful analytics** that are built into the system and not data extraction machines. These built-in analytics should combine adaptable and flexible designs with clinical/financial shared database structures. The dashboards can be Web-deployed to desktops for review or drill-down.
5. **Consumer-focused features** that address the move to consumer-directed healthcare. Web-deployable solutions empower the consumer with self-service capabilities such as scheduling appointments, reviewing estimates of their share of the cost of care, and providing access to an online business office to review and make payments. For the provider, offer upfront financial clearance services versus the more traditional financial clearance activities after care is delivered.
6. **Single-database structures** for clinical and financial applications so that charges and clinical data from the care delivery process flow seamlessly to the claim for accurate, complete billing.
7. **Lower total cost of ownership** through increased efficiency, a lower "cost to collect," reduced software maintenance fees (from eliminating bolt-ons), and quality control that is exception-based.

While the thought of replacing a current set of financial solutions with an advanced solution is daunting, the efficiencies and reduction in costs will outweigh the implementation effort with improved business performance.

## Related Solutions

[Enterprise Revenue Management](#)

[Access Management](#)

[Revenue Cycle Management](#)

[Performance Management](#)

[RelayHealth Financial Services](#)

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with Total Savings/Recovery  
Of \$1.3 Billion+ using  
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