The New “Gold Standard” in PASC’s and Regional Service Centers RSC’s: Best Practices for Centralizing Operations that Improves Revenue Cycle
Today’s Learning Lab Panel

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Radius Global Solutions, Inc.

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Health First

Emily Jones, CPC
Director of Pre-Arrival Services
Health Management Associates
Best Practices for Centralizing Scheduling Operations

The New “Gold Standard” in PASC’s and RSC’s: Best Practices for Centralizing Operations that Improves Revenue Cycle and Creates a Legendary Patient Experience

Why?
- Healthcare moving from volume-based to a risk-based reimbursement
- Health system executives are looking for high-impact ways to drive outpatient volumes and improve margins

How?
- Implementing a centralized scheduling function to proactively schedule procedures and resources across the entirety of a provider network – regardless of size or locations.

Results?
- Many health systems are realizing that they can capture new outpatient revenue streams, while – AT THE SAME TIME - create a legendary patient experience.

LET’S FIND OUT HOW!!
At the end of today’s session, after hearing from our dubious panel of experts, we hope you will leave with practical ideas and tips on how you can implement these outcomes at your facility:

- Increase your health systems’ patient and physician satisfaction and efficiency with a ‘one call for all’ approach by scheduling appointments and resources across the entirety of your provider network.
- Improve point-of-service collections and decrease denials by enabling revenue cycle tools early in scheduling and pre-registration process.
- Create ‘gold standard’ patient-centric resource scheduling using embedded expert rules-engine to create ideal workflows.
- Develop an effective implementation and rollout strategy that empowers team members and creates excitement within your organization.
- Reduce gaps in care and prevent network leakage by implementing a system-wide centralized scheduling, call center, RSC or PASC.

Let’s get Started!!
Trends in Patient Access

• Revenue Cycle focus is shifting to the **Front End**
• Focus on Quality – **Accountability for Errors**
• Focus on Process Transformation to **reduce Denials**
• Increase **Point-of-Service Cash** collections
• Accountability for Discharged Not Final Billed
• Patient Access needs to understand their impact on the Revenue Cycle
• Cross Department **Communication/Blowing Up the Silos**
• **Partners** in the Revenue Cycle
Trends in Patient Access

- Shared Systems and Processes
- Shared Goals
  - a) Clean Claims
  - b) Reduced Denials
  - c) Cash Collections
  - d) AR Days
- Shared Training
- Shared Management
- Front End Key Performance Indicator monitoring
Why Now?

• **Economic Situations** - Tells us all hospitals must continue to improve operation margins
• **Growing Unemployment & Uninsured**
• **Growing Healthcare Costs**
• **Growth in High Deductible Plans**
• **Shrinking Reimbursement** from Medicare & Managed Care Payers
Health Care Reform – *The Patient Protection and Affordable Care Act (ACA)*

- **Pre-existing health conditions**
  - High Risk Pool established for persons with pre-existing conditions

- **Coverage under your parent’s plan**
  - Children under 26 can stay on or join parent’s plan (applies to both individual and group plans)

- **Limits on Services Eliminated**
  - Annual and Lifetime Limits - Policies with annual or lifetime limits on
  - “essential benefits” are being phased out

- **Preventive Health Services with No Share of Cost**
  - wide range of preventive care services—including immunizations and well women exams—must be covered without cost-sharing

**Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you aren't, you may be required to pay an assessment based on income.**
Some States Are Served by the Federal PCIP

- The U.S. Department of Health and Human Services runs the PCIP in some states, and is contracting with a national insurance plan to administer benefits in those states, i.e., UHC.

Some States Run Their Own PCIP

- Some states and non-profits are running their own PCIP. In these states application procedures, costs and benefits may be different.
WHERE PATIENTS OBTAIN HEALTH INSURANCE

Health Coverage Status of Total Population

- Employer: 49%
- Uninsured: 16%
- Medicaid: 16%
- Medicare: 13%
- Individual: 5%
- Other Public: 1%

United States 307,891,500

Patient Access: The Root of Much Evil

- Percent of data needed for billing originates at registration: 70%
- National average registration error rate: 46%
- Percent of denials that could be prevented at registration: >50%

And you must do all of this accurately and quickly, and all with a SMILE 😊
Today’s Patient Access professional, in addition to the traditional role, must be the patient’s (and the hospital’s) advocate in securing funding for the encounter.
Optimize Resources to be Successful

- Use the resources you have in the most meaningful way to the organization
- Re-direct staff where appropriate to manage re-admissions
- Outsource functions that are routine and can be performed affordably by a third-party
- Focus on the 80/20 rule when assigning work to internal staff
If you haven’t already done so …..

- Centralize scheduling, pre-registration, authorization, and financial counseling functions

- Standardize policies governing financial responsibility, charity and screening for benefits
Tools You Need to Be Successful

- **Technology**
  - Monitor the utilization of the tools you have
  - Maintain & Update
  - Incorporate in standard processes
  - Terminate contracts that do not compliment your processes or payer populations

- **Vendor relationships**
  - Are they meaningful?

- **Job Aids**
  - Contract information
And do ALL of this Prior to Service

**QUALITY - Who is my patient?**
- Scheduling & Orders
- Accuracy/Guidance
- Demographic Verification
- Compliance (M/N)
- Physician Orders
- Diagnosis, ICD-9, CPT
- Imaging/Scanning
- Red Flag Rules

**CLEARANCE - Who Pays?**
- Real Time Insurance Eligibility / Referral Management
- ABN/Clearance
- Patient Payment Estimation
- Financial Counseling and Clearance Workflow

**GET PAID - Financial activities**
- Patient Friendly Payment Options
- Pre-Service Collections
- Payment Posting
- Patient Payment History
- Bad Debt Flags Workflow
- Capturing Payment of Outstanding Balances
Know Your Solutions & Tools

COBRA

Pure Self Pay
- Medicaid Screening
- Uncompensated Care (Charity) or internal programs
- Self Pay Discounts
- Prompt Pay Discounts “Good Faith Deposit”
- Payment Plans
- Loan Program (when available)

Patient Responsibility After Insurance with no Secondary Insurance:
- Co-Pays
- Deductibles
- Co-Insurance
- “Good Faith Deposit”
- Payment Plans – Loan Program (when available)
- Medicaid Screening
- Financial Assistance (Charity/Uncompensated Care) or other internal Discounts, if available

Previous Visits - Outstanding Balances
Collect ....
A Patient’s Rationale

• Studies show that a patient’s feeling of obligation to pay for hospital services drops significantly after they leave the facility
• Patient’s rationalize that because they did not plan to get sick/injured they shouldn’t have to pay immediately
• A good comparison is car problems or accident
• They are unplanned, but payment is expected at time of service
• Homeowner Insurance or Auto Insurance…?
• What bills do you pay first?
A Patient’s Priorities

- Mortgage/Rent, Cell Phone, Cable, Car Payment, Utilities
- Credit Cards, Tuition/Education, Loans
- Healthcare Bills
When a Patient’s Priorities Change

- Healthcare Bills (at the time of occurrence)
- Mortgage/Rent, Cell Phone, Cable, Car Payment, Utilities
- Credit Cards, Tuition/Education, Loans
Collections And The AR Timeline

Probability of Collecting

- 75% collected before discharge
- 2% collected after 90 days
## Significant Barriers To Collecting at Time of Service

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Difficulty estimating cost of charges</td>
<td>55%</td>
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<tr>
<td>Constraints related to current technologies</td>
<td>41%</td>
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<tr>
<td>Difficulty gaining internal buy-in to ask for payment at time of service</td>
<td>28%</td>
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<tr>
<td>Difficulty accessing data from payer(s)</td>
<td>26%</td>
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<tr>
<td>Constraints related to staff capabilities</td>
<td>22%</td>
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</tbody>
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More than half of respondents say difficulty estimating cost of charges is a significant barrier to collecting at time of service.

Source: HFMA’s Healthcare Financial Pulse (www.hfma.org/pulse)
Key Performance Indicators (KPI’s) and Targets to Review with Management

• **NEW** - * Patient Estimated Financial Liability $ vs Amount Actually Collected should start out to be at least 75% (attainable) to start then increasing to 90-95%

• Overall pre-registration rate of scheduled patients: 98%

• Overall insurance verification rate of pre-registered patients: 98%

• Deposit request rate for copayments and deductibles: 98%

• Deposit request rate for elective admissions/procedures: 100%

• Payment request rate for prior unpaid balances: 98%

• Insurance verification rate of unscheduled inpatients within one business day: 98%

• Average patient wait time: <10 min

• Maximum patient wait time: 15min
Key Performance Indicators (KPIs) and Targets to Review with Management

• Average registration interview duration for new patient: <15 min
• Average registration interview duration for repeat patient: <5 min
• Average IP registrations per registration per shift: 25
• Average OP registrations per registrar per shift: 35
• Average ED registrations per shift: 25%
• ABN’s obtained when required: 100%
• MPI duplicates created daily as a % of total registrations: <2
• Screening of uninsured IP and high dollar OPS patients for financial assistance: 98%
Key Performance Indicators (KPIs) and Targets to Review with Management

- Collection rate of elective services deposits prior to service: 95%
- Collection rate of co-pays and deductibles prior to patient discharge/departure: 65%
- % MSP’s completed when required: 98%
- % Returned Mail: <1%
- Point of Service Collection % of Total Payments Collected: >2% of monthly cash
- AR Days for Accts holding to be billed waiting for more info from Patient Access: <1.5
Panelists to Share Gold-Standard Experience in ACTION

- Michelle Fox, MBA,MHA,CHAM  
  Director Revenue Operations/Patient Access  
  Health First, Rockledge, FL

- Emily Jones, CPC  
  Director of Pre-Arrival Services  
  Health Management Associates (HMA), Fort Smith, AR
About Health First

- Four Not-for-Profit Hospitals
  - Cape Canaveral Hospital – 150-bed full service hospital
  - Holmes Regional Medical Center – 540-bed full service/Trauma Center/Heart
  - Palm Bay Hospital – 150-bed med surg/ICU/ED
  - Viera Hospital - 150-bed med surg/ICU/ED
- Multiple Outpatient Facilities
- 150+ employed physician group
- Central Business Office
- McKesson Star ADT ver. 18
- SCI Solutions Scheduling, Revenue and Order Management Solutions
- Allscripts Clinical Applications ver 5.5
- Centricity EMR and Allscripts
- Horizon Business/Patient Folder
About Health Management Associates

- Number of hospitals: 14 entities (33 locations) in RSC 1
- Total Bed Size
  - RSC 1 – 2,061
- Annual outpatient volume
  - Est. yearly OP volume – 460,000.
- SCI Solutions Scheduling, Revenue and Order Management Solutions
- Central Business Office
  - Health Management Associates (HMA, headquartered in Naples, Florida)—live with four out of five Regional Service Centers (RSC’s)
  - RSC 1—Fort Smith, Arkansas
  - RSC 2 – Mississippi
  - RSC 3 – Naples, Florida
  - RSC 5 - Pennsylvania
Panelist Questions

- Describe your organization:
  - Number of locations
  - Annual outpatient volumes per location
- Describe your call center:
  - How many FTE’s?
- Describe scheduling and financial clearance workflow:
- What departments are you scheduling within your call center?
  - Question and Rule Examples
Panelist Questions

- Describe your use of the worklist?
  - Authorization Management
  - Medical Necessity
  - Insurance Verification
  - Bad Debt
- Describe your use of self-service tools
- How long does it take to train a new user?
- What results have you experienced?
Panelist Questions

• What are some highlights and tips for success that you would share with others?
• What pitfalls and barriers to success that you feel challenged your team or your organization at different phases of rollout?
• How do you see a project like this scaling for the future?

Questions from our audience!