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White Paper

Making the right choice: Evaluating outsourced revenue cycle services vendors

Managing resources at today's hospitals and health systems is an ongoing challenge, considering the numerous clinical and business functions that need to align for an organization to succeed. Despite their best efforts, many providers struggle with resource limitations or ineffective business processes that negatively impact performance. In these scenarios, it often makes sense for organizations to engage an outsourced services vendor partner to augment the business function, or handle it entirely. However, identifying the vendor that can improve efficiency and effectiveness as well as the bottom line can require a bit of homework on the part of the provider organization.

With the right partner, service arrangements can alleviate resource strains and increase an organization's performance. The revenue cycle is an area particularly suited for outsourcing, since it is labor intensive and requires specific expertise and technology to streamline ineffective processes and resolve bottlenecks that lengthen accounts receivable (A/R) cycles.

This white paper examines the components of outsourced revenue cycle management (RCM) arrangements and the key points organizations should consider as they evaluate vendors to collaborate with them in achieving their goals.

Deciding Where RCM Outsourcing Makes Sense

There are numerous components that contribute to revenue cycle effectiveness at hospitals and health systems. In many cases, some components function well, while others need improvement. The first step toward making improvements is identifying areas where performance enhancement or supplemental staffing can have the most impact, including coder productivity and qualifications, inefficiencies in denial management, challenges collecting patient payments, and more. Once an organization identifies the underperforming components, it needs to assess whether it is most cost effective to resolve the situation internally or engage a third party for help.

There are three key considerations when making this decision:

1. Does the organization possess the proper technology and expertise to resolve the situation?
2. Can the organization achieve its objectives in a timely manner without consuming resources needed in other areas?
3. Is it cost effective to handle the effort internally, or could savings be achieved by outsourcing the initiative?

A growing trend in the industry is for organizations to focus on their core competency— care delivery—and use outsourced services partners for areas where resources or expertise are lacking. RCM components that are particularly problematic and lend themselves to outsourcing arrangements include the following:

Medical Records Coding — The advent of ICD-10 is changing the medical records world as we know it. The transition to the new code set will significantly impact medical records coding—and revenue cycle efficiency—on multiple levels. The time needed for coders to train for ICD-10 will take them away from their daily work, decreasing the organization's overall coding productivity. Furthermore, coding productivity is expected to decrease in the months following the compliance deadline, as coders adjust to the significant code changes and resolve new coding issues. Beyond the ICD-10 transition, other factors impacting medical records coding include a general coder shortage, the intense competition for coders across the industry (both inside and outside each organization), and the anticipated attrition of coders who choose not to update their skills. Many organizations already compete for remote coders, hiring them from states where wages are lower, which in turn, creates coder shortages for the organizations in that location. In addition, consulting firms are now aggressively recruiting coders for use in clinical documentation improvement engagements. Even within organizations,

there is a competition for coding skills, since coders have the expertise to assist with electronic medical record (EMR) extractions, researching quality outcomes indicators, assisting with Recovery Audit Contractor (RAC) and other audits, and helping to compile core measures. When coders are used to assist in these efforts, they are removed from their core function, further diminishing productivity.

> **How vendor partners can help:** Health care organizations can maintain or even improve coding productivity through coding staff augmentation with a vendor partner that provides experienced resources for on-demand or longterm engagements. Staff augmentation helps organizations maintain workflow when coders are absent for paid time off or to attend ICD-10 training, when they experience coding backlogs, or when productivity decreases for any reason. Vendor partners can provide onshore coding resources, as well as offshore coders who are already familiar with ICD-10 because they have been using it for years to code medical records for other countries. In addition, some companies offer full outsourced coding programs so organizations can avoid staffing hassles while increasing productivity. Finally, vendor partners can further help improve productivity by providing computer-assisted coding solutions that can be used by internal staff, by remote coders, or by outsourced coders.

Self-Pay Balances — Since the largest percentage of revenue has conventionally come from payer reimbursement, collecting patient-owed balances at the time of care or after the encounter has traditionally been a medium to low priority for health care facilities. The industry's shift toward high-deductible health plans, however, is making patientowed balances a larger, and therefore, more important source of revenue. To maximize reimbursement, organizations need to focus on collecting patient payment as early as possible, as those aged accounts have a lower chance of being collected. Many hospitals and health systems either do not have the resources to collect patient-owed balances, or they do not pursue them aggressively to avoid alienating patients and negatively affecting their image in the community. The end result is that many patient-owed balances are written off as bad debt.

> **How vendor partners can help:** There are several benefits to outsourcing patient payment collection. Of utmost importance is maintaining a positive relationship with the patient and providing estimates of the amount owed as early in the process as possible so that appropriate arrangements can be made. Vendors should offer a staff that specializes in patient payment collection and that practices appropriate communication to successfully collect without alienating the patients. The chosen vendor should also use technology that can streamline collection activities by segmenting claims by dollar amount and payment histories, and even by using third-party credit scoring services to determine which patients are most likely to pay. The desired end result is increased patient collections. Although the outsourced vendor receives a percentage of the amounts collected, these fees are typically offset by increased collections on accounts that wouldn't have been collected using in-house resources.

Insurance Follow Up — Determining the status of claims—whether they're lost, pended by the payer, or just slow to get paid—is a labor-intensive and time-consuming process. Additionally, most organizations pursue insurance follow up in an inefficient manner, e.g., contacting each payer on an issue-by-issue basis, rather than addressing multiple issues in a single call. Such inefficiency can result from working off of a static, host system ATB without intelligent automation that allows exception-based activity. This overwhelmingly inefficient process often means that many low-dollar claims are ignored and payment is never collected. However, those low-dollar claims can add up to a significant sum of money over the course of a year, representing a meaningful reimbursement opportunity.

> **How vendor partners can help:** Service companies with health care-specific

expertise will have a familiarity with the nuances of regional and national payers, such as claims handling policies and payment turnaround times. This experience helps their staff work more efficiently to resolve issues and accelerate payment. Additionally, they should use health care-specific technology to automate processes and allow staff to sort and view claims by code, dollar value, and payer to gain a better understanding of where bottlenecks exist and how to resolve them. The technology can improve overall efficiency by routing denied or pended claims to the appropriate resources for resolution, and should include functionality that will group claims by payer, enabling staff to efficiently resolve multiple issues each time they contact a payer. In general, technology-enabled services should result in accelerated payment, reduced A/R days, and fewer writeoffs. As a result, the service can pay for itself.

Denial Management — Similar to insurance follow up, denial management is labor intensive and time consuming. Furthermore, resolving claim denials requires a significant amount of experience and information management to track, correct and re-submit claims for appropriate payment. Losing denials in black holes or missing timely filing deadlines exacerbate the problem, and many organizations write off millions every year unnecessarily. Efficient denial management—and denial prevention—requires specific processes and methods, preferably driven by technology.

How vendor partners can help: Successful services vendors maintain a staff of denial management experts that are accustomed to researching and resolving claims-related issues to accelerate payment. Vital to efficiently resolving claims is the use of technology to sort claims by denial types, including eligibility, documentation, coding, duplicate claims, or medical necessity edits. Once sorted, the claims should be automatically routed to the appropriate resource for correction and resubmission, eliminating manual workflow. The technology should also provide robust reporting and analysis tools that will allow the vendor's staff to identify root causes and other trends by payer, provider, facility, and more. This information can be used to isolate issues that can be corrected to prevent future denials. In a best-case scenario, the vendor will act as a partner to help the provider identify the root causes and assist with implementing process improvements that will support denial prevention efforts.

Secondary Claims — With secondary claims often having a low dollar value, many organizations forego the extra effort required to prepare and submit them. This strategy is a mistake, as the incremental reimbursement earned from secondary claims over time can add up to a significant sum of revenue. Still, hospital staff members are often overwhelmed with the volume of higher dollar primary claims, and simply don't have the bandwidth to cover secondary claims.

How vendor partners can help: The secondary claim creation and submission processes can be completely outsourced, so hospitals and health systems no longer have to devote resources to this function. A dedicated staff of secondary claim specialists enables vendors to efficiently handle the process—even making low-dollar claims worth the effort. Payer follow-up and payment posting are commonly offered as part of the service to further alleviate the burdens on in-house resources. Some vendors offer technology as part of the engagement, including automation that can benefit the in-house staff working primary claims, as well. The end result is a collectively significant revenue stream that contributes to the bottom line.

Outsourcing Considerations

When looking to outsource components of their revenue cycles, hospitals and health systems should only consider service partners that are solely focused on the health care market. It's common for vendors with broad insurance experience (e.g., not health care-specific), or those with general outsourced staffing experience, to bid on hospital

and health system outsourcing contracts. Without specific health care revenue cycle experience, these outsourced services vendors are unlikely to grasp the intricacies of the function that they are hired to perform, which places the hospital or health system that hired them at risk for underperformance or even regulatory compliance violations. The health care industry's revenue cycle is exceedingly complex. Generalists are better left to focus on other industries.

Additionally, it's important to consider the cost of outsourced services from two different perspectives. First, organizations often fear that they can't afford to outsource, since the vendor partner is paid a percentage of collected balances. In most cases, the increased efficiency of the vendor's efforts results in higher gross collections, which essentially covers the cost of the service, or even more. Second, the lowest-priced vendor won't necessarily meet expectations, and a low fee structure may be indicative that the bidder doesn't understand the scope of job. For example, old accounts are much more difficult to collect, which warrants a higher fee structure. Vendors that offer a flat rate for all collections are more likely to focus on accounts that are easy to collect, essentially ignoring old accounts that can be an important source of revenue.

The experience of the vendor's staff needs to be thoroughly evaluated prior to engagement. Staff members should possess the necessary accreditations and certifications for the functions that they perform. Additionally, the vendor's employment structure should be evaluated. Does the company simply hire contractors to service customer accounts, or are the individuals employed by the vendor? Are staff members dedicated to a specific account, or are they split between accounts? Addressing these questions before engagement can identify potential problems that may occur, and help set service level expectations.

Finally, hospitals and health systems need to evaluate the vendor partner's goals. Is the vendor looking to gain a customer that will outsource its revenue cycle functions in perpetuity? Or, is the vendor looking to collaborate with the client to help resolve revenue cycle issues so that it can once again handle the function in house? A vendor that is focused on a client only as a revenue source is unlikely to help the client overcome obstacles and improve long-term performance. In contrast, a vendor that that acts as a partner by educating its clients sets its clients on a path to become self sufficient.

Technology Considerations

Vendors that are exclusively focused on the health care revenue cycle market place often possess proprietary technology that helps them more efficiently resolve claim issues and accelerate payment. These technologies include solutions for denial management, claims management, and computer-assisted coding (CAC), as well as reporting and dashboard solutions to increase visibility and accountability. In addition, some vendors provide monthly reports of their progress, while others use their technology to enable their clients to monitor productivity of the outsourced staff at any time. Providers should consider which reporting options will best meet their needs.

Some vendors sell technology solutions to hospitals and health systems in addition to the cost of their outsourced services offerings. Others provide the use of the solutions only while the client is engaged in an outsourcing arrangement, so once the vendor goes, so does the technology.

Using an innovative "leave behind" approach, some service vendors enable their clients to own the technology at the end of the outsourced engagement. Under this scenario, the technology is deployed at the start of the engagement, and the vendor's team helps train users on the solutions. At the end of the engagement, the client owns the technology and its staff is fully trained in the use of the solutions. This approach is an effective way for organizations to finance their technology purchases without the traditional upfront expenditures.

To assess the performance of the technology and the vendor's staff, powerful reporting and dashboard capabilities are needed to increase accountability and to add transparency to revenue cycle processes. Reporting and dashboard options should enable the hospital or health system to quickly get the status of claims, view backlogs and pended claims, and gain insights into A/R balances by payer type, facility, etc.

Finally, hospitals and health systems should evaluate the underlying infrastructure of the technology. Web-based solutions, also known as software-as-a-service (SaaS) solutions, are easily deployed and are maintained by the vendor. SaaS solutions eliminate the need for organizations to purchase, install, maintain and upgrade the solutions, which consumes vital resources. An important benefit of SaaS solutions is that they are highly scalable. This enables the vendor to quickly expand the solution and the number of users to accommodate unexpected claim or coding backlogs and other issues, and even rapidly add staff working in remote locations.

Managing Resources Wisely

With today's health care organizations focusing more on care quality and improving outcomes, fewer resources are available to handle vital business functions. For organizations to succeed in the changing health care market place, they will need to manage their resources wisely and carefully choose when it makes sense to handle a function in house, or outsource it to an experienced vendor partner. Evaluating the considerations outlined in this white paper will assist organizations in the selection of a services vendor that can fulfill a broad range of needs beyond a simple staffing agreement.

About Optum360™

Optum360 is a leading provider of patient-centered and client-focused revenue cycle services. With a comprehensive suite of technology, content and services, Optum360 is helping modernize health care financial transactions to make navigating the health system and understanding medical costs simpler and more transparent and intuitive for everyone.

For more information about Optum360, contact your Optum360 sales executive at 866-223-4730 or email optum360@optum.com

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