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from bottom to top
how one provider retooled its collections

How should a hospital go about increasing its upfront collections from self-pay patients? California's Sutter Health has found an effective way to accomplish this goal.

We all know the mantra, "no margin, no mission." One increasingly important strategy for optimizing margins in this time of high-deductible health plans and higher copayments is to collect more cash from patients, including self-pay patients.

Much has been made of the fact that nearly 47 million Americans are uninsured, but it's an erroneous assumption that none of these people can afford to pay for their health care. More than 80 percent of uninsured people come from working families, and many may have the resources to pay for some or all of their health care—if only someone would ask them to.

That "someone" is the patient financial services (PFS) staff member. To frame the question in a way that will elicit the most positive response, PFS staff need complete, accurate, and timely information and the appropriate skills—and the confidence to use them. These needs apply especially to registration staff because the best time to collect payment for services is before those services are provided.

Registration staff, however, typically are unaccustomed to asking for money. It is therefore important that the transfer of this responsibility from the back end—the central business office and collectors—to these front-end staff be managed thoughtfully and in a well-organized manner that takes into account the needs of all PFS staff.

The Sutter Health Approach

Sutter Health, one of Northern California's largest providers, is committed to giving its PFS staff on both the front and back ends the tools they need to improve patient collections and thus the system's bottom line. Having started in 2006 with the patient account representatives, collectors, and other members of the central business office of its Sacramento/Sierra region, the health system is working its way forward to the registration staff, ultimately aiming to transfer many of the back-end functions to the front end and make point-of-service collection the norm.

In the first three months of the project, Sutter reduced accounts receivable (A/R days) for the nine hospitals in the region from 65 to 59. Given that each one of those days equals $13 million,

AT A GLANCE

In its effort to increase point-of-service collections and improve the overall revenue cycle, Sutter Health took steps to:

- Measure performance using a handful of specific, primary benchmarks
- Empower PFS staff to assume responsibility for every individual account they handle
- Ensure each registration is analyzed using a rules engine to identify problems before patients leave the registration desk
- Ensure PFS staff receive appropriate comprehensive training to excel under the new system

that means the health system collected an additional $78 million.

Setting Benchmarks

In analyzing its revenue management cycle prior to implementing the new program, Sutter identified several problems.

First, PFS staff could not access real-time information on key financial and operational indicators such as A/R days and cash collections. As a result, managers and staff often had to wait until the end of the month to set benchmarks, track progress, or make important business decisions.

Second, the hospitals' accounting system did not allow managers to isolate and analyze select data or generate reports on demand to the level of detail required. Instead, the region relied on a specially trained programmer to develop these reports, often leading to costly delays in identifying and correcting problems.

Third, the central business office (CBO) staff also suffered from the lack of real-time information. With access to only a list of the outstanding accounts assigned to them, account representatives could not prioritize effectively or monitor their progress.

In turning this situation around, Sutter decided to focus on a handful of primary benchmarks:

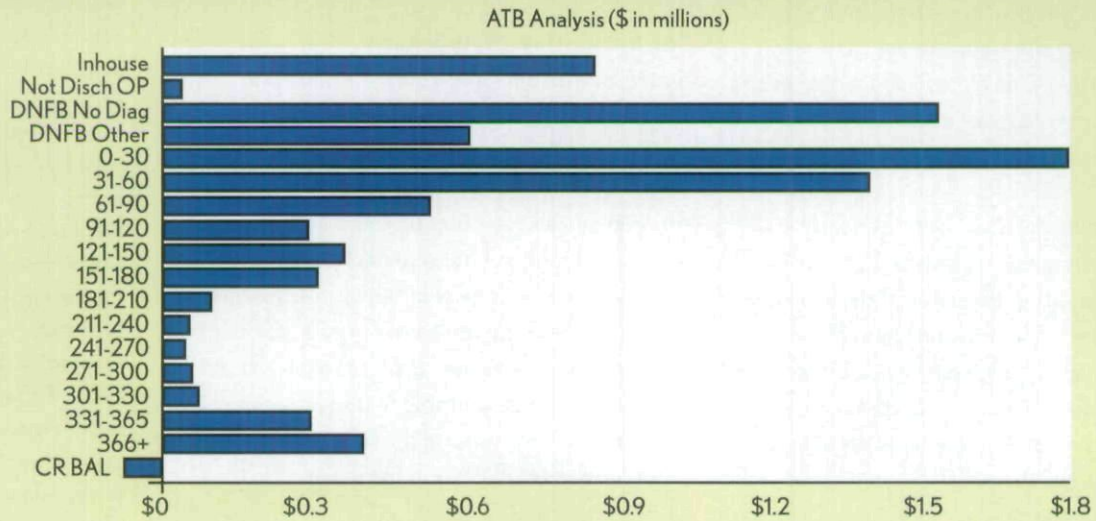
> Gross A/R days (less capitation and credit balance accounts)
> Cash collections
> Unbilled A/R days
> Billed A/R days
> Percentage of A/R over 90, 180, and 360 days
> Major payer A/R days

Empowering PFS Staff

Sutter's strategy for increasing collections and reducing A/R days focused on empowering individual PFS staff members to assume responsibility for each account they deal with. In effect, each person in the CBO owns his or her own business,

This aged trial balance analysis, which shows aging and status of a patient representative's personal assigned stewardship, is intended to assist the representative in his or her performance-improvement efforts.

SAMPLE AGED TRIAL BALANCE ANALYSIS



Above is a graphical representation of your current receivables stewardship. We would hope to see the following trend in the bars: The longest bar would be the 0-30 day bar. From there we would hope to see a steep Mount Everest drop-off to nothing as quickly as possible. Every bar after that should be no greater than half the size of the one above it. You have five aging categories that do not follow the ideal pattern: 121-150, 271-300, 301-330, 331-365, and 366+.

complete with a customized dashboard to track progress in meeting individual and team targets.

To help PFS staff manage their businesses effectively, Sutter has provided them with a set of tools that allows them to:

> Prioritize and automate account work lists
> Sort accounts in various ways, such as by dollar amounts, oldest previous work date, and payer
> See at a glance their ranking within their work group and officewide, based on their performance as a percentage of the target achieved

The tools tell staff members not only how they are doing, but also where and how they could improve, pointing out which accounts, if worked successfully, will have the greatest impact on their A/R days and cash collection goals.

Managers have their own receivables dashboard and tools, enabling them to:

> Query all aspects of receivables for trending purposes and identify problem areas
> Drill down to the patient account level
> Monitor revenue, payments, adjustments, receivables, and days for periods from the previous day and week to the previous 18 months
> Calculate average daily revenue by day and 30-day period
> Assess their performance for the month to date, and estimate likely results at the month end
> View all receivables or select any segment for quick analysis
> Generate timely reports on demand, including aging analysis, A/R stratification, discharged not final billed (DNFB) analysis, credit balance analysis, and analysis of problem payers

A denials management component was implemented in late summer. When registration staff go online at the end of the year, the cycle will be complete, with all parts having access to all the data they need to produce clean claims.

Front-End Collecting

Half of the required billing elements on a UB-92/04 originate at the point of access. As a result, this point in the revenue cycle presents the greatest opportunity to reduce claims denials. To help ensure optimum performance at this crucial juncture, Sutter's new process requires that each registration be analyzed by a rules engine before the patient leaves the registration desk to identify potential problems.

Examples of problems or errors that can be identified at this stage include the following:

> Workers' compensation or liability financial class lacks accident information.
> Workers' compensation is filed with an occurrence code other than 04.
> The patient's guarantor is under 18 years old.
> The patient's marital status is widowed, but the relative is listed as husband, wife, or spouse.
> The patient type is not valid for hospital service.
> The patient is age 65 or older, but the Medicare insurance plan is missing.
> The patient had Medicare in any plan code, but the Medicare secondary payer questionnaire is missing.
> The health insurance claim number or policy ID number is missing.
> The patient address includes errors in format, punctuation, and/or abbreviations.
> The patient has duplicate medical record numbers.

This front-end claims editing enables PFS staff to quickly identify problem areas where corrective action and/or further training is needed.

In the same way, computer interfaces allow the system to flag accounts that require special handling. The admitting clerk receives an alert that may include a description of specific action he or she should take. Examples of such alerts include "Patient has other accounts with returned mail;

ABOUT SUTTER HEALTH

Sutter Health is a leading not-for-profit network of community-based healthcare providers that deliver care in more than 100 Northern California communities. The network consists of more than two dozen acute care hospitals, as well as physician organizations, medical research facilities, home health services, hospice and occupational health networks, and long-term care centers.

please check for valid address," and "Patient has other accounts in bad debt; please request payment."

Experience has shown that a simple prompt to the registrar to collect the amount preregistration has established with the patient can make all the difference. Sutter will be testing a tool to track how much money each staff person collects up front, hoping eventually to link that tool to estimating and contract management systems so that registrars can be evaluated as well on percentages of contracted rates and established targets collected.

Comprehensive Training

Sutter's system is designed to support the existing PFS and registration staff without the need to hire a more formally educated staff or to increase wages beyond the current average of $10 to $20 an hour. The system does, however, require that staff receive comprehensive training.

SAMPLE EXECUTIVE ANALYSIS

	General Memorial Inpatient	General Memorial Outpatient	General Memorial Total	Regional Medical Center Inpatient
Total A/R	**$62,401,511**	**$35,854,843**	**$98,256,354**	**$10,895,907**
Total A/R Days	**40.5**	**53.9**	**44.6**	**51.2**
Unbilled				
Preadmit				
Inhouse	$6,882,814	$21,076	$6,903,890	$1,080,159
Discharged not final billed	$14,153,379	$6,331,544	$20,484,923	$1,359,967
Total Unbilled	**$21,036,193**	**$6,352,619**	**$27,388,813**	**$2,440,126**
Unbilled Recurring	$81,460	$538,796	$620,256	$19,118
Billed				
0-90	$28,059,538	$16,828,778	$44,888,316	$4,685,794
91-180	$6,826,376	$7,335,094	$14,161,470	$51,163,563
181-365	$4,386,455	$2,873,829	$7,260,284	$677,426
366+	$2,789,969	$2,374,808	$5,164,778	$1,969,489
366+ BC/Medicare	$808,950	$846,676	$1,655,627	$433,435
Total Billed	**$42,062,339**	**$29,412,509**	**$71,474,848**	**$8,496,272**
Credits	−$778,481	−$449,081	−$1,227,562	−$59,610

The focus of the training differs with different staff areas. For example, registration staff, who are not accustomed to asking people for money, receive training that focuses largely on effective patient communications and includes role-playing and script rehearsal. By contrast, CBO staff are more used to asking people for money, but they are not used to taking stewardship of their assigned accounts. So in addition to time spent learning to use the tools and perform the functions, the first hour of the CBO staff's three-hour group training session focuses on the concepts and principles of effective receivables management—e.g., how to take ownership of problems and make autonomous decisions about how to solve them, how to identify trends and use that information to boost performance, and how to use performance feedback-based results rather than just activity.

Following the initial educational sessions, Sutter's staff use a technological alternative to

Regional Medical Center Outpatient	Regional Medical Center Total	Total Inpatient	Total Outpatient	Grand Total
$10,614,259	**$21,510,165**	**$73,297,418**	**$46,469,102**	**$119,766,520**
56.0	**53.4**	**41.8**	**54.5**	**45.9**
$1,914	$1,082,073	$7,962,973	$22,990	$7,985,983
$1,518,673	$2,878,640	$15,513,346	$7,850,216	$23,363,562
$1,520,587	**$3,960,713**	**$23,476,320**	**$7,873,206**	**$31,349,526**
$29,315	$48,432	$100,578	$568,110	$668,688
$5,677,245	$10,363,039	$32,745,333	$22,506,023	$55,251,356
$1,802,141	$2,965,704	$7,989,939	$9,137,235	$17,127,174
$886,650	$1,564,076	$5,063,882	$3,760,479	$8,824,361
$774,776	$2,744,264	$4,759,458	$3,149,584	$7,909,042
$146,544	$579,979	$1,242,385	$993,221	$2,235,606
$9,140,811	**$17,637,083**	**$50,558,611**	**$38,553,320**	**$89,111,931**
−$76,454	−$136,064	−$838,091	−$525,536	−$1,363,626

This report shows PFS managers the status of performance based upon hospital-defined targets.

GETTING PATIENTS ON BOARD

It's easy for hospitals and health systems to see the benefits of point-of-service (POS) collection. But what about the patients? Many healthcare leaders worry about raising their ire just as competition makes patient satisfaction more important than ever. A recent report of the HFMA-led **PATIENT FRIENDLY BILLING®** project, *Consumerism in Health Care*, suggests that, in combination with other patient-centric policies and practices such as pricing transparency, simplified charge structures, and quality information, POS collection actually will be accepted without problem by most consumers as part of an open and businesslike partnership with providers.

For one thing, patients with insurance coverage have become accustomed to paying copayments and deductibles up front at their physician's and dentist's offices before receiving services. It's no longer a new idea. For another, POS collection eliminates the infamous sticker shock patients get when they open a hospital bill four months after discharge—and long after their gratitude for getting better has faded.

The simple fact is that consumers want to know from the start what their financial obligation will be—that is, how much in total they will owe out-of-pocket, including copayments, deductibles, and coinsurances. And the earlier the better; one reason so many hospitals are moving to preservice charge estimating is to help patients be prepared to pay when they arrive at the hospital.

"My mechanic can tell me in advance how much I'm going to owe—why can't you?" had been a familiar refrain at Mayo Clinic in Jacksonville, Fla., before it started POS collection, according to Kelly White, section manager, PFS. "And the patients were right—we should be able to give them at least a ballpark estimate. We've found that the more details we can provide about their bill, and the sooner we can provide it, the more successful we are in collecting." Mayo Clinic is lucky, White acknowledges, in that the bulk of its admissions come from its clinic physicians and are scheduled well in advance, so that her staff can talk directly with patients, often more than once, before they arrive at the hospital.

But the principle is the same regardless of the organization. Accurate, timely information on the front and back end of the revenue cycle is essential to this process. Yet technology can go only so far in preparing patients and providers for the new age of consumerism in health care. There are three things hospitals must accomplish beyond implementing new technology:

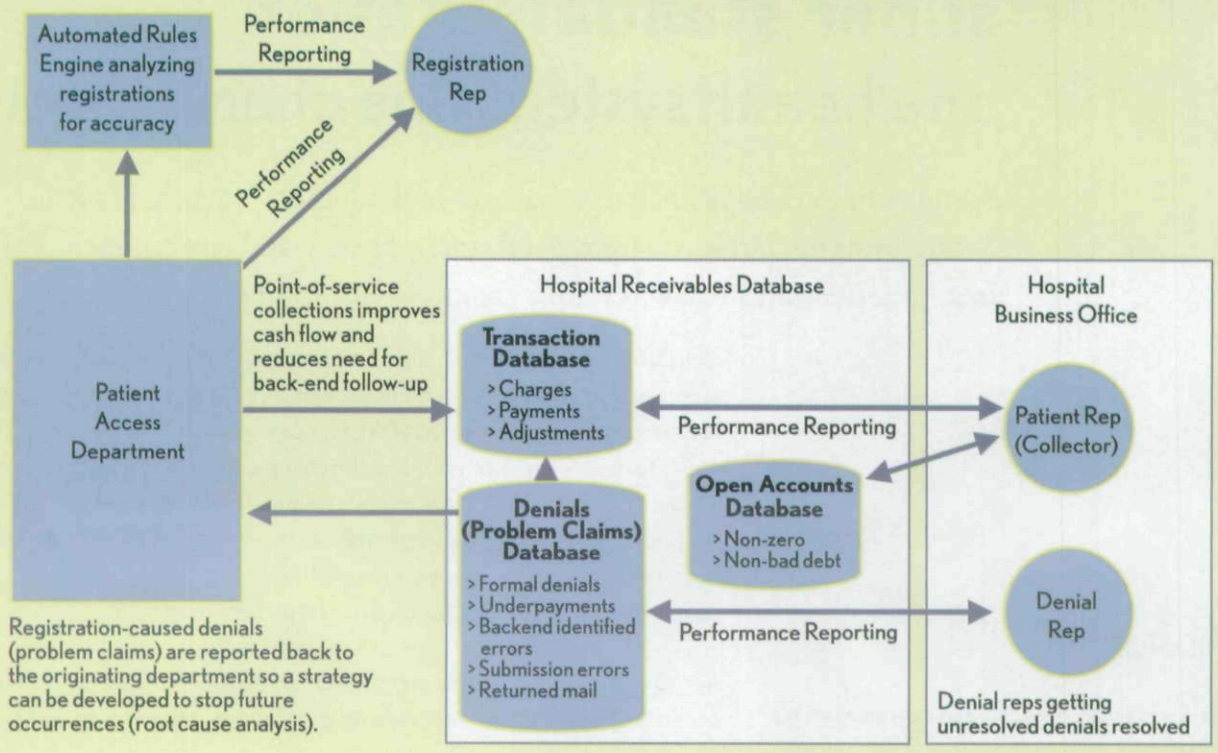
- They must be able to justify charges in a way that ordinary people will accept as reasonable, which means, of course, that the charges themselves must be reasonable. And that means, among other things, the end of cost-shifting.
- They must offer on-the-spot, skilled, and comprehensive financial counseling, discounts, and flexible payment options to self-pay patients who are unable to pay their bills.
- They must educate patients thoroughly, in more than one way and at more than one time, about provider billing practices—including who, what, where, when, why, and how.

With effective programs in place and the technological tools and training to help PFS staff deliver top-notch customer service, healthcare organizations in the vanguard of POS collection are finding patients to be not resentful but grateful.

personal tutors to practice in test system mode on their own for at least 30 minutes a day for a full week. The highly intuitive system allows them to work independently with minimal assistance. Each person must complete and pass the online competency test before receiving a production user ID. Staff also can refer to an online user manual at any time.

Where other health systems have used tangible rewards and formal recognition as incentives, Sutter has so far found that staff regard the boost

IMPROVING FRONT-END EFFICIENCY REDUCES BACK-END PROBLEMS



in autonomy and effectiveness as reward enough to embrace the system wholeheartedly. In fact, every respondent in a recent survey of Sutter's CBO staff commented positively about having gained a renewed sense of ownership and competitive spirit, and many staff members have sent unsolicited e-mails expressing their enthusiasm for the new system. And in 2006, the CBO received Sutter's Business Processes Excellence Award for outstanding achievement.

Object: No More Denials

There are 600 valid reasons to deny a healthcare claim. But by integrating all data elements in revenue cycle management, making PFS staff accountable for their own results, and concentrating on obtaining accurate and complete information, as well as cash upfront, Sutter Health is whittling away at the list. Almost $80 million in additional collections in three months says they are on the right track. ●

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