Dear Subscriber:

For the past 15 years, Health Data Management has been focusing its editorial eye on Revenue Cycle Management (RCM). The only thing we’ve seen year-in and year-out: change.

Health care providers and payers have been implementing claims processing, financial, electronic data interchange, billing, collections and analytical systems from a variety of health care information technology software vendors in an effort to keep up with health care industry demands—and ultimately to improve their bottom lines.

Once a trial and tribulation reserved for the back office, RCM now has become a challenge worthy of attention from all players—from C-level executives to clinicians to coding professionals. The information in this supplement addresses how this challenge has become an all-encompassing one and provides a glimpse at some real-world strategies and solutions.

We invite you to read on and learn all about how you can improve RCM at your organizations. And, we would like to take this opportunity to thank the industry-leading companies that participated by offering their keen insight into an array of RCM issues.

To learn even more about RCM, turn to our award-winning Web site, www.healthdatamanagement.com, where you’ll find the latest news on how innovative technologies are helping health care organizations succeed, plus an electronic version of this ad supplement with links to each sponsor.

Sincerely,

Greg Gillespie
Table of Contents

04 / The SSI Group, Inc.
Getting it Right the First Time

06 / Feature Article
Revenue Cycles: Managing Moving Targets

08 / CareMedic
eFR®—Tracking Patients Across Systems

09 / Quammen Group
A Holistic Approach to Revenue Cycle Success

11 / QuadraMed
Has Your Organization Solved the Revenue Cycle Puzzle?

13 / Eclipsys
Real Challenges, Real Solutions and Real Outcomes in Revenue Cycle Management

15 / Emdeon
Patient Financial Counseling that Benefits Patients and Providers

16 / MedAssets
Getting It Right the First Time

17 / Siemens
Siemens Helps Denver Health Point Revenue Cycle

18 / Passport
Passport—RCM Software with Service

More RCM Perspective available on the Health Data Management website.
Greg Gillespie, Publisher of Health Data Management, discusses revenue cycle management with industry leaders. Listen online or download at http://www.healthdatamanagement.com/podcasts/

Greg Veltri, CIO at Denver Health and Hospital Authority, believes that performance management is the key to controlling the revenue cycle. Access this podcast to learn how Denver Health is using an array of information technology, including a vast data warehouse, to improve clinical quality and its bottom line while dealing with challenges such as uncompensated care.

Listen to Martin Callahan, vice president of TransUnion Healthcare Solutions, discuss the RCM challenges that organizations face—including consumer-driven healthcare and pricing transparency—and the strategies emerging to face those challenges. Callahan also will discuss how the requirements of IRS 990 Schedule H will require change in current processes and policies to report community benefit data.
Getting it Right the First Time

What if your billing office staff had the right information for a project before they started it? Plus, they were confident knowing they had every fact necessary in possession, and that every piece of the information was correct. How much easier would it be to complete the project?

Now, take this scenario and convert it to your workflow. Many billing offices let much of the information acquired in patient access sit around, possibly incorrect, for days and even weeks, before deciding to correct it, right? How much of your billing office staff's time is dedicated to reworking the information that came from registration?

Everyone is human and we all make mistakes, but should an office continue to let the patient access team input incorrect data when there is technology available to alert that it is incorrect? It’s highly unlikely that anyone would elect to work in an office where incorrect data is entered on a routine basis and in turn staff members are reprimanded for poor performance. The technology is available to solve these problems now. Real-time information is the key to unlocking your facility’s financial success. Getting it right the first-time could be worth millions.

In fact, bi-directional feeds are now available for real-time edit checking and correction, enabling your staff to achieve the next level in the quest for real-time claim adjudication. Key factors, such as knowing patients’ co-pay and having real-time discovery, can increase patient satisfaction. So, stop surprising your customers with bills three months after they receive services. By utilizing this type of technology, the business office can receive payments quicker and can reduce costs for printing, billing, mailing and collecting on charges that eventually may become write-offs. Better fiscal management can be achieved by preventing errors and providing the most accurate data before submitting claims for payment.

The ability to pay, co-pays and other out of pocket expenses address various issues such as verification, medical necessity, non-covered procedures, upfront eligibility and benefit verification, and identity fraud issues—all of which can be addressed immediately by your registrars when the patient is on-site. Real-time is key. Your patient access staff can have the correct information at their fingertips with detailed error trending and tracking accessible to managers for training and educational purposes. Everyone wants to be good at their job. Are you providing the right tools for your patient access team to succeed? *

EXAMPLE HOSPITAL

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In 20 short years, The SSI Group, Inc. has built itself from a small healthcare software company into an industry leader in the revenue cycle management arena. Our customers trust us as a single-source provider - from insurance eligibility data and real-time claims status reporting to document management and business office services. We provide an extensive suite of products, to help our customers develop right along with us. Let us create a customized revenue cycle recovery solution for you. Celebrating success, our customers and 20 years!
Although health care organizations have made revenue cycle management (RCM) advancements in double-time in recent years, the winner’s circle remains elusive.

New regulatory requirements, increasing numbers of self-pay patients, and the growth of high-deductible health plans are but a few moves in this game, keeping health care providers and payers on their toes. Additionally, the move toward pay-for-performance reimbursement models has prompted revenue cycle issues to emerge from the back office to take a seat in the waiting room.

Implementing the programs and technologies that lead to bottom-line success is imperative in an industry besieged by change. A look at the strides made in RCM, the current challenges facing health care organizations and emerging innovations sheds some light on just how important it is for health care organizations to continually fine-tune revenue cycle operations.

A promising start

The good news is that health care organizations have made significant progress in terms of improving revenue cycle operations by leveraging innovative technologies offered by information technology vendors. After many years of speculation, conversation and preparation, the health care industry is finally entering an era of true electronic data interchange.

A study released by America’s Health Insurance Plans, Washington, D.C., shows that about 75% of claims were submitted electronically in 2006, up from just 24% in 1995. Overall about 85% of all health care providers now process claims electronically, according to estimates from industry experts.

“There certainly has been quite a bit of progress in the area of sending out claims electronically. Many health care organizations have implemented technology that enables them to automate the claims process,” says Patrick Kennedy, president of PJ Consulting, Rockville, Md.
eFR®—Tracking Patients Across Systems

CareMedic offers an overarching technology called the electronic Financial Record™ (eFR), which stores information from disparate financial systems in a common data repository and can serve as a critical source for financial business intelligence at the patient level. The eFR creates an online, long-term record of each patient’s financial activity, storing information from both CareMedic applications and other hospital systems in a common patient folder. Once the patient folder is created, it is continuously updated as staff makes changes or additions in any of the systems that feed the eFR.

The solution, along with its complementary performance management dashboard, is geared to help the institution gain an affordable, easy-to-use, enterprise-wide business intelligence tool while simultaneously enhancing operational efficiencies to improve financial performance.

Each piece of data—insurance, eligibility, coverage information, referral information, physicians, department encounters—is associated directly to the patient account, tying “pockets” of information together. This aspect of the system becomes even more beneficial in an integrated delivery networks environment.

The eFR is an innovative breakthrough in addressing the deficiencies inherent in the traditional revenue cycle model, which requires a variety of people to access, monitor, update and correct information in a number of disparate systems that often cannot communicate with one another. The inability to track patient movement from one system to the next creates tremendously complex and inefficient workflows that require an extensive amount of time and labor to fully address breakdowns in payment recoveries.

Far too commonplace, failures in the registration process and/or interdepartmental communication breakdowns result in a patient receiving a bill for services that are either covered by their health plan, or reflect an inaccurate amount of self-pay dollars due. Most likely the culprit is insurance information data that wasn’t passed along at some point along the patient’s journey through the delivery system. While eligibility and verification systems may be in place, they lack the capability to enable the organization to track and flag where deficient data was passed from one department to another, thereby enabling the organization to avert patient billing issues. A mix of disparate systems also makes it challenging to produce reports that enable drill down to identify problematic areas of managing the patient’s financial aspects of care.

The eFR’s patient-centric nature allows authorized users to access patient account information at any point in the revenue cycle process. The eFR interfaces with multiple systems used for or impacting the patient account, prompting user actions when data is needed, thereby automating interdepartmental workflow processes and maximizing productivity and operational efficiency.

CareMedic’s eFR (electronic Financial Record) solution, along with its complementary performance management dashboard, is geared to help healthcare organizations gain an affordable, easy-to-use, enterprise-wide business intelligence tool while simultaneously enhancing operational efficiencies to improve financial performance.

(800) 508-8494
www.caremedic.com
A Holistic Approach to Revenue Cycle Success

Revenue cycle success does more than simply enable health care organizations to keep the lights on. By optimizing revenue cycle processes, health care organizations can experience operational and financial improvements, enhance patient services and realize the financial gains that can help to sustain long-term strategic success.

Achieving revenue cycle success, however, requires going beyond taking a shot in the dark. Instead, health care leaders need to have a clear picture of where they are and where they want to go—and then develop a strategic plan to get there, says Robecca Quammen, CEO of Quammen Group, a health care information system and business consulting firm based in Winter Park, Fla.

To assist in the holistic revenue cycle management approach, Quammen Group uses its R4™ Framework Methodology Management. This project management blueprint facilitates the implementation of an IT program through the following stages: metric recognition, metric realization, metric realignment and metric resolution. The methodology identifies key clinical and business drivers and then develops best practice prototype metric models to guide improvements and implementation processes.

During this process, a variety of factors that could influence revenue cycle success are evaluated such as:

- Internal and external factors impacting cash collection
- Access management
- Core billing and receivables systems
- Bolt-on products to enhance current systems
- Manual workflow
- Integration
- Competing technology initiatives

External factors should also be considered. Regulatory conditions, managed care contracting, local market competition as well as the movement toward self pay populations and consumer driven health care can have an effect on an organization’s revenue cycle.

After thorough evaluation, leaders can then ask questions that shed light on the link between information technology and revenue cycle success such as:

- How well does your organization handle patient billing?
- Is the billing cycle patient friendly?
- How urgent is the need for new cash collection systems?
- How important is the purchase and selection of clinical systems on revenue cycle success?
- How important is the scheduling function/process on revenue cycle/cash production?

“With a strategic information technology plan in place, organizations don’t just buy technology. Instead, health care leaders can purchase and implement the systems that will support their overall vision for success,” Quammen says.
And, being plugged in is definitely paying off: The Centers for Medicare and Medicaid Services reports that the health care industry saved more than $25 million, as providers submitted only 80 million paper claims in 2006, compared to 114 million in 2005.

**Challenges abound**

Although health care organizations can point to this forward-motion as proof they are on the right track, their progress constantly threatens to be quickly overtaken by emerging demands.

Perhaps most notably, while health care payers and providers have worked laboriously for decades to automate claims processing, health care providers now are being required to collect a greater portion of their income directly from patients.

“We are an urban hospital, so our self-pay population is high and keeps growing. So, we are always trying to think of innovative ways to get people to pay their bills,” says Amy Konop, practice manager in the emergency department at UPMC Mercy Hospital, Pittsburgh.

The rising number of uninsured Americans is forcing health care providers to collect a greater percentage of payments directly from patients. Nearly 47 million Americans, or 16% of the population, were without health insurance in 2005, according to figures from the U.S. Census Bureau. In addition, the number of uninsured rose 2.2 million between 2005 and 2006 and has increased by almost 9 million people since 2000, according to a report from the Henry J. Kaiser Foundation.

The need to collect revenue directly from patients also is being driven by the break-neck growth in high-deductible or consumer directed health plans and insurance policies that have a higher annual deductible than traditional health plans, thereby placing a greater burden for payment directly on patients.

The most recent count, by America’s Health Insurance Plans, shows that almost 3.2 million people were covered by high-deductible health plans in January 2006. This is a growth of 2.7 million people since September 2004, or more than 600 percent.

“With the onset of high deductible health plans on the commercial side, hospitals and other health care providers are now at greater risk and have to find ways to successfully collect payment directly from patients,” says Dan Thiry, managing principal with Revenue Cycle Solutions, LLC, a health care consulting firm based in Pittsburgh.

**The regulatory wrench**

In addition to dealing with the rise of self-pay patients, health care organizations wrestle with a deluge of regulations that have emanated as a result of HIPAA. For example, in recent years, health care organizations have had to adjust revenue cycle systems to accommodate a number of standards including code sets, privacy, security and the National Employer Identifier.

Health care organizations have been coping with the National Provider Identifier (NPI) standards that will eliminate the need for health care providers to use different numbers to identify themselves when communicating with health plans. Many Medicare, Medicaid and private health plans were expected to use NPIs in standard transactions by May 24, 2007. Small health plans have until May 23, 2008.

**The clinical concern**

Although health care providers are accustomed to being paid for services rendered, the industry is now moving toward pay-for-performance models. With pay-for-performance, payment is based upon quality of care delivered or even upon actual outcomes. In essence, then, payment could be tied to clinical
Has Your Organization Solved the Revenue Cycle Puzzle?

As quality measurements become critical drivers of reimbursement, tracking performance requires tightly integrated clinical and financial systems.

By automating and seamlessly linking end-to-end processes for access and identity management, care management, health information management and patient revenue management, healthcare enterprises can both improve quality of care and increase financial strength.

_The new imperative: linking care records to revenue cycle management._

### Access and Identity Management

Quality care and lasting consumer loyalty are dependent upon accurate patient identification and ready access to clinical information. Effective patient access management solutions should improve cash flow and operating costs, reduce duplicative tasks, and enhance safety. In addition, access systems must comply with current regulations and standards.

_QuadraMed advances Access Management beyond traditional appointment booking by integrating scheduling, registration, and enterprise identity management solutions._

### Health Information Management

The ability to move health information seamlessly and securely is imperative to quality patient care, timely and accurate billing, improved cash flow, reduced denials and compliance with CMS regulations. Effective HIM solutions should improve access to patient information, streamline processes, deliver greater efficiency in record management and increase coding accuracy. Ultimately, comprehensive HIM offerings should provide a foundation for a paperless department.

_Designed with input from HIM professionals to address key success metrics, QuadraMed HIM solutions provide powerful links between access, care and patient revenue._

### Patient Revenue Management

Patient Revenue Management solutions must efficiently manage the business of transforming patient care into positive financial outcomes. Clinical records must be linked with billing data to ensure proper reimbursements. Rules and embedded certifiable HIPAA EDI transaction sets must drive workflow.

_QuadraMed Patient Revenue Management solutions use exception-driven workflow and rules-based logic to deliver timely, accurate and complete billing and collections._

### Putting it All Together

Healthcare enterprises increasingly desire to source as many of their health IT solutions as possible from a single vendor. Not only do they want the benefits of integrated systems and single-supplier accountability, but they also desire a partner that will continually help them keep ahead in an evolving market.

QuadraMed’s integrated revenue cycle solutions include identity management and HIM as core components. Healthcare executives can confidently partner with QuadraMed in their mission to leverage quality care into positive financial outcomes.

Visit QuadraMed at Booth 1444 at the HFMA ANI Conference to learn more.
outcomes measures, structural measures or even patient satisfaction measures.

As a result, to optimize reimbursement, health care organizations will need to increasingly focus on clinical quality and performance.

When the Centers for Medicare & Medicaid services launched the Hospital Quality Initiative in 2005, a demonstration project was established to evaluate rewarding hospitals for superior performance based on certain measures of quality as well as reducing payment for hospitals that fall below a clinical baseline threshold. This, along with other federal initiatives such as the Tax Relief and Health Care Act of 2006 and HIPAA claims attachment severity adjusted DRGs will further challenge providers as they strive to enhance patient care in an effort to improve revenue.

New strategies
With so many moving targets, health care organizations are coming up with new ways to play the revenue cycle game. Here are just a few of the strategies that health care organizations are using:

Putting first things first. To start, health care providers are increasingly realizing that they need to zero in on front-end transactions—and find ways to collect payments at the point of service.

“It’s a huge change from the way medicine has been practiced historically,” says Donna Gilley, director of revenue cycle & regulatory compliance at LBMC Healthcare Group, LLC, a consulting company based in Nashville. “Health care providers need to ask for the co-pay and deductible at the point of service. And, for many that is a cultural change. For many providers, the desire is to treat the individual without consideration for reimbursement. But providers need to come to the realization that they have to get reimbursed. They simply can not provide treatment for free.”

As a result, more attention is being paid to the front-side of the RCM process, Thiry, the consultant says.

“There is huge opportunity on the front side of the revenue cycle process,” he says. “More hospitals are getting serious about getting it right on the front side of the process, trying to get correct information during the scheduling and registration instead of trying to correct everything on the back-end. As a result, they know exactly how much of the payment the patient is responsible for.”

Thiry points out, too, that some hospitals are now registering and verifying the insurance of their patients three or four days ahead of their appointments. By
Real Challenges, Real Solutions and Real Outcomes in Revenue Cycle Management

As healthcare organizations work to prop up sagging bottom lines, the C-suite is continually evaluating strategies to improve financial performance. The revenue cycle sits at the heart of an enterprise’s financial success, and throughout that cycle, technology is creating efficiencies once thought impossible. Eclipsys delivers proven billing, access management and financial performance-improvement solutions that are helping clients automate and more-effectively manage the business of healthcare. These solutions are providing finance executives with the tools they need to analyze, measure and focus attention on financial performance like never before.

As The Outcomes Company®, we prefer to let Eclipsys clients’ achievements with our solutions speak for themselves. Here are but two: Kaleida Health (Buffalo, NY) and WellSpan Health (Adams & York Counties, PA).

Kaleida Health
The Challenge
To replace outdated legacy financial systems and streamline the revenue cycle across multiple facilities.

The Solution
Eclipsys Sunrise Patient Financials™ and Sunrise Access Manager™, a front-end, open relational database solution that manages the complete revenue lifecycle of today and provides a solid platform for tomorrow.

The Outcomes*
- Increased cash collections 9% (over $70m)
- Decreased A/R > 90 by 32%
- Increased point-of-service collections 36%

In use at all five of Kaleida Health’s acute care hospitals and an ambulatory surgery center, Eclipsys revenue cycle solutions help the organization process over 1 million claims annually in New York State’s complex regulatory environment, while seamlessly managing patients as they move from one facility to another.

Eclipsys solutions streamline Kaleida’s billing processes, maximizing reimbursements, improving cash flow and enhancing patient and staff satisfaction. By tying to its clinical systems, Kaleida has extended revenue management into the patient care cycle. This ensures the health system’s clinical and administrative actions generate accurate financial transactions and capture complete information throughout the continuum of care.

WellSpan Health
The Challenge
Complex managed care and compliance requirements coupled with staff-intensive back-end processes, leading to poor contract management, long A/R cycles, decreased cash flow and excessive clerical duties by Care Management nurses.

The Solution
Eclipsys revenue cycle solutions integrate registration and accounting workflows to boost employee productivity while ensuring compliance with payer and regulatory requirements.

The Outcomes
- Reduced annual net A/R days by combined 28% (to 46 days at York Hospital; 37 at Gettysburg)
- Attained highest cash collections ever: 98% on net revenue
- Reduced managed care denials and writeoffs
- Improved registration quality to ~99% through bill edits
- Increased point-of-service collections 54%, to $1.2 million
- Raised clean-claim throughput to 99%
- Reduced staff and implemented Combined Business Office for both hospitals

Learn More
Join us at HFMA-ANI’08 in Booth 244 or see www.eclipsys.com/solutions to learn how Eclipsys solutions are integrating clinical and financial operations across the enterprise and leading to measurable, sustainable improved outcomes.
doing so, the provider can work with patients in advance of their appointments on payment issues, instead of after the fact.

Kennedy adds that health care payers also are trying to facilitate this front-end process by providing more information about eligibility and co-payments early on in the process.

In addition, some innovative health care organizations are implementing real time adjudication systems, which ensure that payment is made at the point of service. With real time adjudication in place, physicians will know what portion of a patient’s bill will be paid at the time of service, allowing providers to collect at the point of care.

For example, Unitedhealthcare Division of United Health Group, Minneapolis, is offering real time adjudication of claims submitted through its physician Web site. The service is designed to adjudicate a claim within 10 seconds. As a result, providers know what a patient owes before he or she walks out the door.

Finding a ringer. Some health care organizations are finding that it behooves them to hand off revenue cycle functions, or at least part of the revenue cycle operations to the experts. The simple thought of complying with the dizzying array of changes related to revenue, is enough to push some organizations to outsource revenue cycle functions.

Jan Hundley, COO of Arkansas Otolaryngology Center, Little Rock, says that government imposed regulatory challenges, the reduction in reimbursements and the increasing volume of insurance providers has prompted her practice to outsource revenue cycle functions to third-party specialists.

Making connections. To deal with pay-for-performance and other quality driven revenue cycle initiatives, many health care organizations are finding it necessary to link clinical information systems more closely to financial systems.

“We are really seeing a lot of attention related to clinical documentation and the importance of documentation in the patient chart,” Thiry says. “Some insurance companies are more aggressively auditing claims and are denying claims because of a lack of supporting documentation.”

Health care leaders, indeed, are seeing the importance of this clinical-financial link, according to the 2007 HIMSS Analytics Report: Care Based Revenue Cycle Management, sponsored by QuadraMed Corporation. About half of the respondents in the HIMSS study report that data flows between clinical and financial applications in their organizations as a result of using a single vendor solution. In addition, another 29 percent indicate that there is significant data exchange between the systems because the IT department has worked to create data sharing applications.

Most importantly, the respondents realize that this data sharing is imperative to future revenue cycle successes. On a scale of one to seven, an average score of 6.48 was recorded in response to the question: “How important is it to have key clinical elements support your revenue cycle management process in the future?”

Q: “How important is it to have key clinical elements support your revenue cycle management process in the future?”

A: On a scale of one to seven, an average score of 6.48

And, to more effectively deal with such requirements, health care organizations increasingly need to more effectively link financial information to care information. Perhaps the 2007 HIMSS Analytics Report sums it up best:

“Effective revenue cycle management strategies will depend on next generation clinical and financial information systems to address revenue cycle management from a care-based perspective in order for organizations to fully realize their revenue potential as the paradigm for reimbursement continues to shift toward payment based on quality and performance.”
Patient Financial Counseling that Benefits Patients and Providers

Over the past decade the changing healthcare landscape has left many patients in unfamiliar territory when it comes to paying for healthcare services and traditional commercial insurance coverage isn’t available. In many of these cases, the inability to identify alternative payment options leads to bad debt and write-offs that hurt both healthcare providers and patients. There is good news—it doesn’t always have to be that way. With thorough and intelligent investigation early in the patient encounter, providers can now identify often overlooked payment sources that save time, money and frustration for both providers and patients.

Consider these key points for your patient financial counseling procedures:

- **Be proactive by starting financial discussions early in the process.** It sounds simple, but it’s also the key to understanding patient needs and identifying potential problems. By doing this, providers can limit their financial liability and increase patient trust.

- **Determine a Patient’s likelihood of payment.** Traditional credit report information, healthcare specific credit scores and credit balance information is now available to enable providers to accurately predict a patient’s likelihood of payment. By having a clear snapshot of a patient’s financial health during the financial counseling process, providers are able decide the best way to proceed and can avoid costly collection activity whenever possible.

- **Identify situations where Medicaid may apply.** Medicaid may offer valuable relief to many patients who are unable to pay for their own healthcare needs. To better understand if this is an available option, providers can implement automated Medicaid screening processes to quickly pre-determine patients who most likely meet state requirements. This will maximize staff efficiency by eliminating the need to fill out time-consuming applications for those who are not likely to be eligible.

- **Leverage Charity Care programs.** When no other sources are available for payment, Charity Care discounts may be an appropriate solution to help patients. By using automated, non-discriminatory screening to properly classify patients for charity programs, providers are able to reduce the amount written off to bad-debt while also easing the burden on patients who can not afford to pay the full price for healthcare services. Additionally, many facilities budget for charity care, with some receiving special funding or tax benefits for using these programs.

**Emdeon Business Services Can Help**

Emdeon Financial Counseling Solutions enable providers to reduce revenue lost from the self-pay and underinsured populations. By using our family of solutions focused on payment prediction, Medicaid eligibility prediction and Charity Care screening, financial counseling staff can cover the most difficult and sensitive processes painlessly.

Delivering financial counseling solutions that help both patients and providers is just one of the ways our Revenue Cycle Management solutions are **Simplifying the Business of Healthcare**. To learn more, call us today at 877.EMDEON.6 (877.363.3666) or visit online at www.emdeon.com/solutions.
Getting It Right the First Time

JPS Health Network increases cash, improves revenue integrity with greater claim accuracy, faster resolution of denials

With constant changes in payer rules and regulations and time-sensitive processes, providers are challenged to ensure that every patient claim is billed correctly, on time and is paid accurately. Managing claims and denials with technology can significantly improve processes and workflow to help achieve a better first-pass payment rate, reducing denials, which leads to greater cash flow.

John Peter Smith Health Network (JPS) knew they had an opportunity to improve cash flow by addressing systemic issues that were creating a breakdown in the processing of healthcare claims and causing denials to go unresolved. The claims processing approach they had in place demanded significant manual effort by staff, and their accounts receivable (A/R) performance was trailing industry benchmarks.

Therefore, JPS began a search for a revenue cycle provider that could drive more effective results. Specifically, they were seeking to not only improve financial performance and staff efficiency, but also to find a more responsive partner to meet their needs. After a comprehensive evaluation process, JPS selected XactiMed, the #1 ranked solution provider in the KLAS market category of Claims Management.* XactiMed's solutions are now part of MedAssets' revenue management solutions and marketed as MedAssets Claims and Denials Management solutions.

“We chose XactiMed because they have the most dynamic revenue cycle management system available,” said Dee Chaisson, vice president of finance for JPS Health Network. “They have produced a comprehensive and extremely scalable system that has proven to produce positive financial impacts on the billing cycle.”

JPS implemented MedAssets’ Claims Management, Remittance Management and Denials Management offerings, as well as its automated secondary billing, and Reports Management for ad-hoc reporting and trending. These integrated solutions help JPS improve net collections by:

- Increasing billing accuracy and reducing denials through increased automation, editing and workflow
- Resolving billing issues, payer rejects and denials in a timely manner with improved workflow
- Driving accountability for errors and lost revenue across the health system

JPS has realized continued improvements in financial results since implementation of the claims management system. Upon implementation, JPS’ clean claims rate jumped to an all-time high of more than 95 percent. Also, A/R day performance improved from 87 days to 50 days within the first 12 months.

“XactiMed has a reputation for superior customer service, which is something JPS requires of its vendors. JPS is utilizing these revenue integrity solutions in a fashion that is assisting us in reaching our revenue cycle goals,” Chaisson said.

Chaisson attributes these results to the implementation of XactiMed’s revenue management solutions.

“Cash collections have increased from $93 million in Fiscal Year 2003 to $180 million in Fiscal Year 2007 due to an improved clean claims rate, improved management of denials, and improved billing and collecting processes, which are all centered around XactiMed products,” she said. “All of this occurred at the same time our charity care and bad debt were growing due to the challenges we have serving the county’s needs.”


Fortunately, working collaboratively with Malvern, Penn.-based Siemens Medical Solutions, Denver Health implemented a three-phased program that ensured nothing but forward momentum. With this approach, Denver Health leaders continually measured results—and only moved on to the next stage of the process when return on investment (ROI) was verified. Most importantly, this design enabled the team to turn the project into a self-funding proposition as ROI and unused budget were rolled into each successive phase.

The first phase of the project focused on establishing the existing technology. Phase two centered on process improvement and technical refinement. And, the final phase addressed continued process improvement and education and training of Denver Health’s staff. Most importantly, though, because results were measured at each stage of the game, the quality improvement program never stalled—but kept moving forward at a quick clip.

Much of this progress can be attributed to the results-centric vision of Denver Health’s CIO, according to Michael Long, senior vice president, Global Services, Siemens Medical Solutions Health Services division.

“Gregg Veltri has both the strategic vision for taking his enterprise to the next level and the financial acumen to implement strategic metrics and deliver on those metrics,” Long says.

The success of the project also can be tied to strong collaboration between information technology, the business office and Siemens. Working closely with Siemens, as a matter of fact, actually helped Denver Health leaders realize that they could make substantial revenue cycle improvements by learning how to most effectively use the systems that were in place, instead of investing in new technologies.

“Before we began this project, our business office director wanted to de-install our patient accounting systems. When we were finished, he agreed we should continue to leverage the systems for many more years,” Veltri says.

Certainly, the Siemens-Denver Health partnership has resulted in significant results such as:

- Reduced cycle times resulting in a $5 million reduction in commercial accounts receivable
- FTE savings of approximately $100,000 per year, emanating from redesigned workflow and increased automation
- A benefit of $900,000 gained through increased cash collection, reduced bad debt, reduced collection agency fees and FTE savings
- FTE position savings of 15% due to automated inpatient write off of late charges
- 25% FTE position savings due to automated process for submitting bad debt to collection agencies
- Reduction of error reports from 30 pages to 1 page per day via optimization of existing Siemens systems to increase data integrity

And, while these results are impressive, Denver Health does not plan on standing still.

“We meet with Siemens senior leadership at least twice a year and make course corrections as necessary. It is in both our interests to ensure the partnership remains strong for years to come,” Veltri says.
Passport—RCM Software with Service

In 1996, Passport was a start-up company near Nashville, Tenn., with few clients but many big ideas. Today, Passport is a national leader in health care technology. More than 4,300 hospitals, physician practices and other health care providers use one of Passport’s three products—OneSource®, BatchSource™ and IntelliSource™—to increase the speed and accuracy of the revenue cycle. The Company’s services include but are not limited to patient insurance eligibility verification, address verification, credit card processing, and medical necessity validation. But its customer support services are what really distinguish Passport.

- **Account Management**
  Each client is assigned one primary point of contact who is responsible for ensuring ongoing satisfaction throughout the relationship.

- **Implementation**
  Passport’s implementation team works directly with each client to see that the technology is installed properly and functioning according to the client’s specifications. Passport’s integrated solutions are especially configurable, and up front quality assurance sets the tone for ongoing reliability.

- **Training**
  Passport trains approximately 15,000 users annually from initial implementation to new user and refresher training. Online training is available to clients at any time, but the vast majority of training is performed on site, where Passport trainers interact with client users in a live environment.

- **Customer support**
  Passport’s customer support representatives respond to more than 6,000 questions and issues per month. Clients have access to a live person 24 hours a day, seven days a week. Further, all of Passport’s support is handled within the U.S.

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