

Smaller Margins, Clear Fundamentals

REVENUE CYCLE MANAGEMENT IN THE MEDICAL GROUP ENVIRONMENT
BY MARK HAGLAND

With their far smaller organizational size and generally smaller and more overburdened business and IT staffs, medical groups are often behind hospitals when it comes to applying the most advanced revenue cycle management (RCM) strategies to their financial situations. But at WellSpan Medical Group, the 480-provider multispecialty group affiliated with the two-hospital, York, Pa.-based WellSpan Health system, executives realized years ago that the potential return on investment in RCM solutions was very worthwhile.

In fact, as Jack Jensen, the medical group's vice president and COO, and Fred Graves, the group's administrator, medical group information systems and billing and collections, discovered, the potential greatly outstripped their initial expectations. "We had three years of continuous process improvement we had put in place, trying to refine what we were doing with revenue cycle management," Graves says. "And we had made assumptions that the federal plans were paying us the way we should be paid. But in testing it, we found that our Medicare intermediary was grossly underpaying us. That's an unusual experience," Graves adds. "I've been doing this for 35 years. We do get paid on 98 percent of our fields. But a number of our large payers were systematically underpaying us."



Further, Graves says, "Even as we had been running a manual process that was labor-intensive and cost-intensive, we realized we were seeing underpayment. So we were looking for a business intelligence tool that would help us do this more efficiently." As a result, the WellSpan folks turned to a vendor offering a contract management IT solution (the Austin, Texas-based MPV). "We



Fred Graves (left) and Jack Jensen say that revenue cycle management strategies are as relevant to medical practices as they are to large hospitals. Photo: WellSpan Medical Group

found a pretty exciting tool to pre-adjudicate our claims and let us know what we should be receiving in claims paid," Graves says.

NEW-FOUND REVENUE

Going live in early 2008, Graves and Jensen quickly began seeing results from using IT to pre-adjudicate claims. Indeed, Graves notes, "In the first 18 months, we saw a return on what we collected through this solution of over \$1 million," representing an additional 2 percent in total revenues. "That's very significant," says Jensen. "Having that kind of additional revenue definitely allows us to reinvest, to continue to grow our medical group and add additional products and services on the back end, including IT services, and thus to better serve our physicians. It's allowed us to continue down the path and look at other products and have the funding to do that, and also allows us to provide better staffing levels, etc., in the practice arena."

Putting all this into perspective, Jensen says, "We're having over a million visits a year, whereas a large hospital might have 40,000-50,000 inpatient stays a year. On the other hand, their charge per visit is 10 or 15 times what ours is. They're churning two-, three-, and four-thousand-dollar charges, while we're churning \$80 and \$100 charges."

Adds Graves, "Here's the difference between hospital-based thinking and medical group-based thinking" when it comes to RCM: "in the medical group setting, you have to be a true

believer in incrementalism; and an underpayment of \$2 for a procedure we do 200,000 times is significant. And when you're doing this manually, it's often difficult to see this; only by using a business intelligence tool such as we're using, can we see such incremental improvements."

The other element in all this is staffing, of course. "As we continue to grow the medical group, I can no longer continue to support deploying 0.25 central billing office staff per physician; we've gotten it down 0.23 per M.D.," Jensen says. "And our goal is 0.18. That's roughly about 10 employees out of about 120 business office employees overall." The bottom line? "We're doing better collections, more efficient collections, with fewer people."

And, importantly, Graves points out, "We didn't have to reduce staff; we retained staff while growing our business."

FUTURE PLANS

As for further steps, the next frontier for Jensen, Graves, and their colleagues will be the development of point-of-service capabilities. "We're working with MPV on eligibility and identifying what patients owe on the front end, and collecting at time of service," Graves reports, "because healthcare legislation is pushing more and more on the patient." They are implementing their vendor's patient financial responsibility module, which they believe will reap further advances. For example, he says, "We are live with the eligibility component of that module now. And that is already showing a good return. For example, 7.5 percent of our patients are registered as showing that they have no insurance, but in fact those patients are enrolled in Medicaid. "Usually," he notes, "you send out notices to patients, and by the time you find they had Medicaid coverage for a portion of their care, it's too late."

In the end, Jensen and Graves agree, medical group executives will find themselves more and more compelled to use IT solutions to help them optimize their RCM processes, given the emerging reimbursement environment. As Graves puts it, "It's about using technology to leverage your operational efficiency and [RCM] achieve results, while improving service to patients." ♦