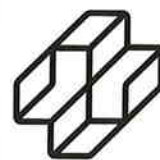


# Revenue Cycle Strategist



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## Healthcare System-Owned Collection Agencies

By Scott Godden

*Why would a hospital, with all its complexity, want to start its own collection agency?*

Many healthcare providers view collections as a task best left to the experts and employ an outside collection agency. But others see collections as a part of the revenue cycle that they want to oversee, influence, and control. In the end, these health systems see a huge benefit to having a system-owned agency.

Not paying an outside agency to do something that you can probably do better yourself is attractive from a practical perspective. Collection agencies can become so caught up in the collection process and getting their commission that they lose focus on the health system's vision and mission. Having a collection agency under the umbrella of the health system eliminates the "us-versus-them" mentality, so accounts flow to collection seamlessly. Patients get treated better, and all of the money stays within the system.

Collecting bad debt does require specific knowledge. Collection agencies must adhere to a great number of laws and regulations, and the state licensing requirements for collection agencies are complex. But because health systems have corporate compliance officers, human resource professionals, and legal staff, starting a system-owned collection agency is not a daunting task.

People are the key to every successful endeavor, and starting a collection agency requires good people. Staff to start up the agency likely can be found within the health system. Most hospital staff are not accustomed to the incentives and bonuses that are part of the collection world, and once they get a taste of an incentive-based pay plan, they are likely to take the ball and run with it—to the betterment of the health system.

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### COMING IN AUGUST

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Managing outside agencies can also be a full-time job, sometimes requiring more than one FTE. Many large health systems have multiple collection agencies working their accounts. They have complicated formulas for rewarding agencies that perform well and punishing those that fail to perform. But using multiple agencies and complicated formulas takes time away from patient accounts staff. Some health systems employ contract analysts, auditors, and others to police their outside collection agencies.

### A Successful Example

New York Presbyterian Healthcare System, New York, has its own agency, Network Recovery Services, Inc., which is owned by the system's member hospitals. The agency is the focal point for day-one self-pay (early-out) collections, Medicaid eligibility, charity care, Medicare 1011 program, collection agency referrals, contract compliance, and other related services.

Over the years, the agency has become an integral part of the overall strategy to reduce bad debt and collect balances due the member hospitals earlier in the process. In addition, the agency ensures that charity care policies are administered consistently throughout the network. They are responsible for reducing the self-pay inventories and reviewing the credit balances associated with them.

The results have been dramatic. For example, since the agency's inception, the inpatient self-pay inventories, including credit balances, were more than \$53 million. Today, those same inventories total \$18.3 million, almost two-thirds less. In addition, the patient account representatives at the hospitals now focus on collecting insurance revenue instead of talking to self-pay patients.

Collectors, trained and acting on behalf of the member hospitals, bring the expertise of "collecting" to the process. Having this process at the agency also allows New York Presbyterian Healthcare System to have more people available to serve all the members.

Facilities no longer need separate and smaller departments. In addition, business office hours have been expanded to reflect the current needs of today's working families: Monday through Thursday 8:00 a.m. to 9:00 p.m., Friday 8:00 a.m. to 5:00 p.m., and Saturday 9:00 a.m. to 1:00 p.m. The consolidated call center has 50 people available during regular business hours and approximately 40 people at night to handle inbound and outbound patient calls.

### Hospital-Owned Agencies Not New

Healthcare-owned collection agencies are nothing new. As early as the 1970s, health-care systems realized that the collection industry was ill-prepared to meet the mounting challenges facing them. Owned agencies were created to meet that challenge

and allowed health systems to diversify their own organizations.

Specializing in healthcare collections made these newly created agencies unique in the industry. The owner health systems quickly realized that they had greater control over how their accounts were handled and the resulting benefits to their bottom line and public relations. The drawback was that this new venture was not a part of the health systems' core business, and some systems struggled with how to manage these new businesses in terms of finance and compliance with federal and state laws. While some agencies failed, most survived and continue to operate today by marketing their services outside of health care or by serving exclusively healthcare clients, in addition to their parent corporation.

Most of these agencies compete with privately held agencies in a free and open marketplace. Even in today's complex healthcare environment, owned agencies continue to honor the vision that created them by giving hospitals more control over the use of protected health information (Health Insurance Portability and Accountability Act issues) and by allowing them more flexibility in charity care processes. Over the years, agencies have been adapted to serve smaller medical clients as well as nonmedical clients, making them a formidable competitor for collection business. According to Ken Smith, executive director of the National Healthcare Collectors Association (NHCA), the trade association for health system-owned collection agencies, these agencies drive some of the changes in the collection industry by making the collection of delinquent accounts a customer service event rather than a confrontation.

Smith has seen an upswing in inquiries about agency startups. "We don't get inquiries every day from hospitals looking to

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start up an agency," he said, "but we have noted a concern for patient privacy due to the negative impact that some privately held collection agencies have had on public relations. Both of these issues appear to be driving the interest in starting up an agency."

### Pros and Cons of Setting Up an Agency

Setting up an agency is not as hard as it seems. The main requirements are a separate space off-site for the agency and a separate phone system. A collection agency license is required in most states, but the process for obtaining licensure is simple compared with the regulatory requirements that hospital compliance staff are used to seeing. Most states have online access to their regulations and requirements for collection agencies.

Health systems that have set up their own agencies have reaped not only financial rewards, but other major advantages as well.

By owning an agency, a health system can control what the collection agency does and how it operates, which is reassuring to the CFO and the hospital board.

Another benefit is the ability to use corporate resources to limit the organization's liability. Recent media attention has focused on lawsuits against some collection agencies for overly aggressive tactics and for violations of both the Fair Debt Collections Practices Act and the Fair Credit Reporting Act.

Health systems also should consider having their bill collectors become certified. Certification programs are available that are designed specifically for collectors who deal only with healthcare clients and healthcare consumers. Management certification for agency leaders also is available. Management certification involves not only possessing the collection knowledge necessary to achieve collector certification, but also possessing the required formal

education and healthcare experience. Using a formal certification program can limit a healthcare organization's exposure to lawsuits and consumer complaints.

System-owned agencies also have a downside, the first being expense. Starting an agency will require an initial investment for the space, the phone system, and the FTEs. This can likely be accomplished with an initial investment of \$100,000. Most agencies use auto-dialers, which cost between \$30,000 and \$50,000, although using them for scheduling or appointment reminder messages saves money and time. Also, health systems that have already set up the phone systems for all of the off-site clinics, surgery centers, and urgent care sites, probably have access to space and staff to set up a new phone system.

Another downside is that some health systems may not have internal resources to start the agency. General counsel, corporate compliance, and internal auditors are often akin to healthcare-specific compliance (e.g., Joint Commission) and are not willing or able to take on the additional requirements that a collection agency requires.

### Keeping Cash Flow In-House

Perhaps the biggest benefit of owning an agency is the ability to keep cash flow within the organization. The organization no longer needs to be concerned about whether it is getting a good commission fee from its collection agency. In addition, the organization can set the fee structure, eliminating the need to negotiate rates. Instead, it can focus on the revenue cycle.

Although starting a collection agency may not be for some health systems, for others, it may be a perfect course of action to improve their revenue cycle. ☞

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## U.S. Adults Engaging in Healthy Habits

- > More than 93 percent of adults are engaging in at least one of three recommended behaviors to prevent heart disease: not smoking, exercising regularly, and maintaining a healthy weight.
- > Almost 57 percent of the U.S. adult population said they engage in moderate to vigorous physical activity three times a week. More men (60.3 percent) than women (53.1 percent) reported engaging in moderate to vigorous physical activity at least three times a week.
- > Almost 79 percent of the U.S. adult population reported that they do not smoke. Of those who had ever been told by a physician that they had heart disease, more than 18 percent continued to smoke.
- > Almost 39 percent of the U.S. adult population reported maintaining a healthy weight by keeping their body mass index under 25 and thus are not considered overweight or obese, according to recommended guidelines. ☞

Source: Soni, A., *Personal Health Behaviors for Heart Disease Prevention Among the U.S. Adult Civilian Noninstitutionalized Population, 2004*, Statistical Brief #165, Rockville, Md.: Agency for Healthcare Research and Quality, March 2007.

## Improve Your Revenue Cycle

*In Revenue Cycle: Measuring, Managing, and Improving Your Processes*, an all new, revised collection of 11 articles from *hfm*, revenue cycle experts help you measure your revenue cycle performance and make the improvements you need so that, from scheduling to billing to collections, your revenue cycle is ready to face the latest challenges. To learn more, visit [www.hfma.org/hfm/hfmmagazinecollections.htm](http://www.hfma.org/hfm/hfmmagazinecollections.htm).

# Financial Intelligence Creates Financial Clearance

If a scientific system can accurately predict who is going to pay your bill a high percentage of the time, would this information be of use to you? If so, how would this ability affect time-of-service collections and financial clearance?

Scientific algorithms used to “model” patients for collection activity have been in widespread use in the healthcare industry for only the past two years or so. This process finally came to health care for three reasons:

- > Health plan design “tilted” the scale of self-pay out-of-pocket balances, leading to increased bad debt write-offs.
- > Healthcare providers lack the resources to adequately pursue collections.
- > Lawsuits forced healthcare organizations to revise their policies for processing patients for charity qualification.

The healthcare industry is changing its approach to collecting from patients. Healthcare organizations tend to outsource bad debt to collection agencies.

This approach often results in increased write-offs and poor patient public relations for healthcare providers. Waiting for agencies to collect bad debt is not the best approach, no matter how good a job the collection agencies might be doing. The focus needs to be moved from the back end to the front end.

Recent lawsuits against hospitals because of their billing practices have put hospitals on the defensive. Although uninsured collection policies have been a major focus, billing and collection practices in general receive considerable attention as well. Best-practice revenue cycle operations do not try to collect from people who lack the ability to pay.

Hospitals would benefit from implementing prediction-of-payment technology. They should take into account payment prediction when deciding what collection approach to use on an account. It makes sense to use different approaches for

patients who have a high probability of payment and those who have a low probability of payment. That’s what the commercial business world does.

Healthcare providers are implementing state-of-the-art prediction of payment technology at the front end of revenue cycle operations. Of course, providers never use this technology to decide who gets treatment. They use it in a variety of ways at point of registration or in financial counseling to:

- > Determine the best method to collect at point of service (POS) based on probability of payment—adjusting collection efforts based on the patient financial situation
- > Achieve 100 percent financial clearance at POS (Some patients are financially cleared based on their financial circumstances; others require personalized collection efforts.)
- > Offer financial assistance at the front end to patients who qualify, which prevents unnecessary collection activity (For everyone’s benefit, patients who qualify for charity discount programs are slotted into them right away, saving time and money for everyone.)
- > Obtain payment at POS based on credit card outstanding balance availability

Interestingly, sophisticated financial information often is best used to assist patients and help them understand how they can pay their hospital bills.

Best-practice revenue cycle operations are routinely using technology to predict payment, verify address information, and automate the charity process. This new technology has produced incredible results for healthcare providers: lower bad debts, better reporting of charity, and improved patient public relations—beginning at the front end. ☞

## Determining Eligibility for Health Insurance Subsidies

Linking an individual’s or family’s income to the federal poverty level to determine eligibility for health insurance coverage subsidies may not provide a consistent level of financial protection over time as health insurance costs increase at a faster rate than poverty levels, according to a Kaiser Family Foundation report.

Between 1996 and 2004, family health insurance premiums more than doubled and premiums for individual coverage rose 86 percent while the federal poverty level rose about 20 percent, according to the foundation’s report *Effect of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level*. As long as health insurance premiums continue to rise faster than the costs of other products and services, eligibility thresholds tied to the federal poverty level won’t maintain a consistent level of financial protection against rising health insurance costs.

To read more, visit [www.kff.org/insurance](http://www.kff.org/insurance) and click on the report title.

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# Changes Are Coming to the IPPS

## *Is your organization ready?*

Efforts by the Centers for Medicare and Medicaid Services (CMS) to reform the inpatient prospective payment system (IPPS) have been under way for some time. The final rule is expected to be published in August. How should healthcare organizations—and more specifically, staff involved with the revenue cycle—prepare for the changes that will be required to receive reimbursement and collect every dollar owed to you?

For FY07, the first step in the reform effort includes phasing in the use of hospital costs rather than charges to set diagnosis-related group (DRG) payment rates. The transition schedule is at 67 percent cost basis in 2008 to a full cost basis by 2009.

### **DRG Reform**

Proposed FY08 changes to IPPS include adoption of Medicare Severity DRGs (MS-DRGs). These 745 proposed DRGs should be thought of as a complete replacement of the 538 existing DRGs.

Two aspects of the DRG reform stand out as having the greatest impact. First, coding could take up to 20 percent longer because it will be necessary to capture all of the complications and co-morbidities that add to the cost of patient's care. Hospitals must ensure that documentation practices fully account for conditions that are present on admission for a patient. In turn, hospitals must include coding for conditions present on admission. Education and training on this new coding methodology will incur costs and lower productivity by as much as 20 percent to 25 percent, according to estimates from pilot programs.

CMS also estimates payments will go up per case because more accurate and detailed documentation of admission assessments—and histories and physicals for conditions present on admission and more accurate coding of these conditions—will result in increases in severity documented per case. Conversely, CMS also plans to adjust payments downward by 4.5 percent in 2008-09 to compensate for increased severity per case.

The second major category of impact to the organization is systems modification—specifically, IT solutions that drive or support all aspects of the revenue cycle. In addition to acquiring and implementing new grouper software, hospitals will need to integrate the software with their revenue cycle information systems.

### **What Hospitals Can Do**

Although some of the decisions faced by organizations cannot be made until after the comment period has taken place and the final rule is published in August 2007, the following initiatives will be important to ensure smooth transition and trigger critical transformation efforts.

*Revenue cycle operations reviews.* Hospitals will need to make specific changes to systems and processes, including implementing updates to current CMS DRG groupers to meet requirements for severity-adjusted DRGs by Oct. 1, 2007. In addition, organizations will have to update contract management systems to reflect estimated reimbursement models. This work will likely require updates to interfaces from contract management systems to the patient accounting system to share present upon admission information.

*Education and training.* Training your staff in an efficient and effective manner will be crucial to operations. If your coding staff is not accurately using the new coding methodology, overall payment could decrease because CMS is expected to lower payments downward to compensate for higher overall severity per case.

*Documentation improvement.* Documentation will have to be specific about what conditions are present for a patient upon admission. CMS will provide more guidance on clinical documentation in August 2007.

Make sure your organization and technology systems are ready for these coming changes. Failure to comply will have financial repercussions. ☞

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## Learn More About IPPS for FY08

To view HFMA's comprehensive collection of online tools and resources about the proposed IPPS rule, visit [www.hfma.org/ippsrule](http://www.hfma.org/ippsrule).

To view a comprehensive collection of online resources related to Medicare DRGs, visit [www.hfma.org/library/reimbursement/medicare/medicareinpatientrule.htm](http://www.hfma.org/library/reimbursement/medicare/medicareinpatientrule.htm).