REVENUE CYCLE:
INSOURCING VS. OUTSOURCING

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INTRODUCTION TO NAVIGANT
NAVIGANT HEALTHCARE – WHO WE ARE

WHO WE ARE: 600+ CONSULTING PROFESSIONALS

2,500 BUSINESS PROCESS MANAGEMENT PROFESSIONALS

MULTIDISCIPLINARY

Physician Enterprise Solutions  Strategy Solutions
Specialized Solutions  Centralized Analytics  Revenue Cycle Solutions
Performance Excellence Solutions  Government Healthcare Solutions

WHAT WE DO:  • STRATEGY
  • OPERATIONAL IMPROVEMENT
  • BUSINESS PROCESS MANAGEMENT

DELIVERED TO:

HOSPITALS  MEDICAL GROUPS  PAYERS  AMCS

#5 ON MODERN HEALTHCARE’S LARGEST HEALTHCARE MANAGEMENT CONSULTING FIRMS

FORBES – AMERICA’S BEST MANAGEMENT CONSULTING FIRMS: HEALTHCARE 4 STARS
Employs more than 150 revenue cycle experts from leading healthcare systems, consulting firms, and technology service providers. Including trained, certified, and conversion experiences in all Epic revenue cycle applications (deep experience with Cerner, MEDITECH, GE, and McKesson):

**Services Include:**

- HIS System Selection
- Performance Assessment Solutions
- Revenue Cycle Optimization and Transformation
- HIS Technical Advisement
- HIS Conversion Project Management
- HIS Financial Risk Mitigation Services
- Interim Management
NAVIGANT DIFFERENTIATORS

• Proven Results
  - 85% of engagements results in additional work
  - 100% referenceable clients is our goal

• Dedicated Assessment Team with Standardized Approach
  - Multi-disciplinary background across operations and technology
  - Shared knowledge across over 50 assessments

• Epic and HIS Expertise
  - Driving ROI from your system, not adding additional cost
  - Market-leading content and thought leadership

• Partnership Model
  - Flexible implementation support options focused on long-term sustainability
  - Risk-sharing fee model
  - Specific initiative focused benefit calculations
CLIENT LIST

Pre-Live Conversion Support

Northwestern Memorial Hospital
Carolinas HealthCare System
UC Davis Health System
OhioHealth
MERCY Health
WELLSTAR
ProMedica
Hospital for Special Surgery
Edward Hospital & Health Services
Greenville Health System
StLuke‘s University Health Network

Post-Live Revenue Cycle Optimization

University of Michigan Health System
Benioff Children’s Hospital Oakland
UCSF Medical Center
Essentia Health
Kettering Health Network
North Memorial
Northwestern Memorial Physicians Group
Wake Forest Baptist Medical Center
INTRODUCTION TO TOPIC:
INSOURCING VS. OUTSOURCING
INSOURCING VS. OUTSOURCING

• Internal and external trends are driving organizations across the country to design more effective revenue cycle models. Health system yield volatility is stimulating 3-9% expense gaps that pressure organizations to change.

  - **Patient demands** increase competition and need for customer service experience excellence, pricing transparency, and high-deductible management
  - **Compliance and reimbursement changes** driving transition from fee-for-service to value-based care, cuts in reimbursement, healthcare reform, and compliance pressures
  - Transition from technology and processing requirements (requiring large scale system conversion) to **platform optimization and transformation**
  - **Cost to collect** pressures target either system and in-house optimization efforts vs. outsourced solutions:
    • Need to reduce the use of bolt-on technology, and embed content management that feeds the HIS
    • Workflow improvements that can effectively leverage system automation
    • Identify labor management solutions that sync with next generation HIS efficiency
ONE SIZE DOES NOT FIT ALL

• There are a number of unique factors that need to be considered when making a final decision on the strategic model for the revenue cycle.

• The decision must be combined with the cultural and mission drivers to ultimately define the best model for your organization.

• A number of factors may be unique to each case scenario. A successful model for one organization may not meet the needs for another.
TYPICAL SCENARIOS THAT TRIGGER GLOBAL OUTSOURCE EVALUATION

- Leadership and staff turnover
- MSO expansion with community providers
- Heavy technology and operational investments
- Mergers and acquisitions
- Surrounding labor market dynamic restricting available talent pool resources
DETERMINE WHERE YOUR ORGANIZATION IS

Non Standard
Decentralized
Functions

Standardization

Standardized P&Ps
Standardized Reporting
Standardized Workflow

Consolidation and Alignment

Consolidated HIS Platform
Consolidated Leadership
Consolidated Locations

Enhanced Delivery Models
Optimized Platforms
Optimized Staff Synergy

Leverage

Synergy
CONSIDER KEY FACTORS

- Cost to Collect, Financial ROI, and Capital Availability
- Culture and Mission Alignment
- HIS Platform Capacity, Staff, and Investments
- Staff Skill and Talent
- Surrounding Labor Market
- Pivot from Fee-For-Service to Value-Based Care
- Organizational Capacity for Change
- Risk Level
- Internal Leadership
EVALUATE YOUR OPTIONS

**Assess**
- Create short vs. long-term recommendation plan to account for:
  - Corporate, divisional, and regional structure
  - Definition of physical locations of work, including possible centralization
  - Definition of who will do the work (insourced vs outsourced)
  - Summary of necessary technology platforms to implement change
  - Potential consolidation of corporate or functional duties across physician/tech services
  - Summary of financial impact, ROI, and capital expense to implement operating model
  - Outline of implementation risks to cash flow, productivity, patient experience, etc.

**Model**
- Create detailed financial model comparison (along with people, process, technology) of fully insourced vs. outsourced model

**Recommend**
- Assess factors from previous slide (including for-profit, not-for-profit scan), and financial review to determine net revenue, cash flow, and cost implications
- Create detailed financial model comparison (along with people, process, technology) of fully insourced vs. outsourced model
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- Create detailed financial model comparison (along with people, process, technology) of fully insourced vs. outsourced model
MODULAR OUTSOURCING
UNIQUE FACTORS THAT DRIVE MODULAR OUTSOURCE NEEDS

- Put your staff in the best position to succeed and drive value on high-yield accounts.
- Evaluating cost to collect and ROI at a global level tends to mask pockets of poor performance due to the ease of visibility of low-hanging, high-yield, early-aged AR.
- All things equal, recent, non-specialty AR tend to provide the highest yield at the lowest effort. Specialized AR pockets in subsequent slides tend to require the most expertise and time.

Identify Your Core Competencies
Leverage Technology to Automate and Work by Exception
Evaluate Strategic Partner Needs Outside Your Expertise
PATIENT ACCESS: BASIC WORKFLOWS AND TECHNOLOGY

The following technology and operational recommendations should be reviewed (and can be obtained in-house) for basic patient access workflows:

**Operational**

- Centralized Pre-Service Centers
- Centralized Patient Access Leadership, Policy and Accountability Standardization

**Technical**

- Orders to Scheduling Worklists
- Real-Time / Batch Eligibility Checking to Drive Work by Exception
- 271 Eligibility Response Adaptable Views, Payer Web Scrubbing
- Authorization Automation and Work by Exception
- Staff Productivity and Error Reporting
- Patient Estimates (Standalone or Driven from Eligibility)
- Registration Error Edits to Prevent Claim Submission
# PATIENT ACCESS: COMMON SPECIALIZED FUNCTIONS TO EVALUATE FOR OUTSOURCING

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| **Back-End Eligibility Scrubs and Payer Search** | Low-cost and minimally-invasive way to identify eligibility or coverage missed at time of service  
**Factor:** Not necessary if strong batch eligibility technology and operations solution is in place |
| **MVA and TPL**                   | Requires heavy workflow integration, but typically cheaper to leverage a vendor vs. in-house legal council  
**Factor:** Organization must be willing to file liens |
| **Pending Medicaid**              | Typically beneficial to outsource on contingent fees (which free staff up for less difficult functions) |
The following technology and operational recommendations should be reviewed (and can be obtained in-house) for basic middle revenue cycle workflows:

**Operational**
- Revenue Management Programs (or Committees)
- Decentralized Charge Review Edits and Ownership
- Centralized Coding Leadership

**Technical**
- Charge Review Edits and Worklists
- Missed Charge Capture Review
- CDM Compliance Toolset
- Computer Assisted Coding
- Embedded HIM Coding Workflows and Worklists
# MIDDLE REVENUE CYCLE: COMMON SPECIALIZED FUNCTIONS TO EVALUATE FOR OUTSOURCING

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| Missed Charge Capture Audit Review    | Either built directly in the HIS (Epic Revenue Guardian) or as an ancillary, minimally invasive tools can be used to identify missed charge capture.  
**Factor:** As part of this process, ensure you have labor to work the edits.                                                                 |  |
| CDM Compliance and Management Tools   | Historically these tools can provide your revenue integrity team with an ancillary compliance/CDM management tool. These are now becoming more embedded with automated HIS integration.                               |  |
| Coding                                | Industry standard function to evaluate outsourcing needs as internal staff become limited (or not enough exist to manage backlog).                                                                         |  |
| Transfer DRG                          | Requires extensive in-house effort and review, although relatively cheap and minimally invasive way to evaluate optimal DRG transfer classification.  
**Factor:** Strongly recommended with high Medicare populations.                                                                                      |  |
The following technology and operational recommendations should be reviewed (and can be obtained in-house) for insurance billing workflows:

**Operational**
- Centralized Billing and Follow-Up Management
- DNFB, Denials, and Avoidable Write-Off Committees
- Insurance and AR Segmentation Follow-Up
- Account Worklist Prioritization and Timely Filing Review

**Technical**
- Paper EOB to 835 Conversion Program
- Automated Denial Workflows for Reason/Remark Codes
- Timely Filing/Appeal Account Escalation
- Expected Reimbursement Contract Evaluation and Follow-Up
- Denial and Write-Off Dashboard Trending
- Retro-Adjudication of Claims for Updated Insurance
# INSURANCE BILLING: COMMON SPECIALIZED FUNCTIONS TO EVALUATE FOR OUTSOURCING

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<td><strong>High-Aged and/or Low Dollar Insurance Balances</strong></td>
<td>If internal staff are focused on easier and higher yield volumes, a vendor can be utilized to focus on difficult to collect high-aged or low-dollar balances</td>
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<td><strong>Workers Comp and TPL</strong></td>
<td>Specialty accounts that require added expertise (and legal knowledge) can be contingently placed with vendor</td>
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<td><strong>Payment Variance</strong></td>
<td>If not currently in place, a common recommendation is to leverage a vendor for retro-active ZBA review, while building out HIS and internal operations for go-forward accounts (to work vendor out)</td>
</tr>
<tr>
<td><strong>Credit Balances</strong></td>
<td>Payers will often reimburse vendors who work provider insurance credit balances, which results in “free” engagements</td>
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<td><strong>Factor</strong>: Recommended if line level staff are not viable, but a competent manager must oversee</td>
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<tr>
<td><strong>HIS Conversion Legacy AR Balances</strong></td>
<td>If undergoing a system conversion, there are a number of strategies to leverage a third party vendor to effectively aid the rundown of legacy AR</td>
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The following technology and operational recommendations should be reviewed (and can be obtained in-house) for insurance billing workflows:

**Operational**
- Consolidated Follow-Up on Tech/Professional Balances
- Cross-Trained Staff for “One Stop Shop” Experience
- Targeted Account Segmentation to Drive Workflow and Value
- If Outsourcing, Follow “Once Early Out, Always Early Out”

**Technical**
- Patient Propensity to Pay Workflow and AR Value Driver
- Consolidated Statements (Ideally through HIS, if not Print Vendor)
- Consolidated Tech/Professional Balance Resolution Workflows
- Online Portal to View/Schedule Appointments, View/Pay Bills
Patient balance AR and propensity to pay segmentation should be leveraged in nearly all environments at any organization. Vendors can now scrub patient data to identify and segment populations based off:

- Likelihood to pay and estimated collection performance improvement
- Incorrect demographic/insurance information
- Missed insurance discovery, charity care identification, cost savings
- Perform a patient receivables valuation analysis and reserve requirement review
PATIENT BILLING: COMMON SPECIALIZED FUNCTIONS TO EVALUATE FOR OUTSOURCING

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<td>AR Segmentation</td>
<td>Prior to evaluating early-out strategy, AR segmentation analysis should be prioritized to value AR and determine patient population propensity to pay</td>
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<td><strong>Factors:</strong> Vendors can now integrate this into HIS to drive workflow, or purely value AR to provide analysis for third party management</td>
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<td>Early-Out (Extended Business Office)</td>
<td>Based on the results of your AR segmentation, leverage this analysis to prioritize high-yield likely to pay patients in-house, while leveraging vendor (if needed) for more difficult segments</td>
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<td><strong>Factors:</strong> ALWAYS split your business between two vendors so they have to compete with one another</td>
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<td>Bad Debt</td>
<td>In the current marketplace, it is rare to not be leveraging a contingent vendor to collect on bad debt accounts, which are the most difficult to recover, with the lowest yield</td>
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EXAMPLE MODULAR CASE STUDY
BENEFIT RESULTS
A large multi-facility university hospital in the Midwest underwent an Epic conversion and subsequently saw negative operating margins year over year, decreased net collections, and poor internal performance.

The following breaks out strategic benefits derived from targeted internal efforts vs. outsourced solutions.
• Internal leadership and management provided $217M+ in cash acceleration benefit from reduction in **DNFB days starting at 20+ to under 6**

• The combination of a retro-active third party ZBA underpayment review vendor with the development of a go-forward internal payment variance team (partnered with expected reimbursement contract build workflows directly within Epic) created **$1.76M** in first-year net benefit with the development of a go-forward long-term internal solution

• A hybrid early-out self-pay optimization strategy (leveraging internal efforts for high-yield easy to collect accounts and a vendor for difficult segments) created:
  - Net benefit of over **$12.5M** in the first year by increasing overall global self-pay yield
  - Reduced customer service call abandonment rates from a metric high **76.6% to best practice <4%**
  - Reduction in patient correspondence backlog from a high of **3,300 to a low of 23**
A small scale safety net hospital facility located in the West with an antiquated HIS system underwent significant leadership turnover, driving the need for change.

Targeted vendor implementations were selected to derive benefit dollars that otherwise current internal staff could not perform.

The following breaks out strategic benefits derived from targeted internal efforts vs. outsourced solutions.
SAFETY NET HOSPITAL –
YEAR ONE MODULAR INSOURCING VS. OUTSOURCING

• Realized net benefits in year one included:
  - $444k+ related to back-end eligibility/payer search identification
  - $98k+ benefit derived from the implementation of a Transfer DRG vendor
  - $348k+ resulted from the implementation of both an MVA and TPL vendor
  - $278k+ additional net collections driven from patient account follow-up outsourcing

• Internal efforts were assigned based on the availability of existing leadership’s capacity to drive improvements of larger net revenue dollars
  - A targeted Point of Service Collections campaign (including technology enhancement, policy enforcement, and reporting packages) resulted in over $2.5M in additional collections
  - The implementation of a comprehensive avoidable write-off reduction task force resulted in over $3.2 net benefit of reduction in adjustments

• Total year-one annualized net benefit amounted to just over $6.9M in collections
A large scale multi-facility hospital system has been on its Epic platform for several years, and recently decided to perform an evaluation of all functions to target opportunity areas.

Targeted vendor implementations were selected to derive benefit dollars that otherwise current internal staff could not perform.
MULTI-FACILITY SYSTEM – YEAR ONE MODULAR INSOURCING VS. OUTSOURCING

• Realized net benefits in year one included:
  - $3.22M+ related to back-end eligibility/payer search identification
  - $265k+ benefit derived from the implementation of a Transfer DRG vendor

• Internal efforts were assigned based on the availability of existing leadership’s capacity to drive improvements of larger net revenue dollars
  - A targeted point of service collections campaign (including technology enhancement, policy enforcement, and reporting packages) resulted in over $2.3M in additional collections
  - The implementation of a comprehensive avoidable write-off reduction task force resulted in over $5.8 net benefit of reduction in adjustments
  - The implementation of a comprehensive 500+ Revenue Guardian edit set to identify and collect on missed charge capture opportunities resulted in $477K+ in benefit
  - The combination of a retro-active third party ZBA underpayment review vendor with the development of a go-forward internal payment variance team (partnered with expected reimbursement contract build workflows directly within Epic) created $540K in first-year net benefit with the development of a go-forward long-term internal solution

• Total year-one annualized net benefit amounted to just over $12.5M in collections
CONTACT

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