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*50 Years of Growth, Innovation and Leadership*

Creating the Foundation for Financial Health  
in 21st Century Healthcare Provision:  
Leveraging IT and Best Practices Via Business Process Outsourcing



A Frost & Sullivan  
White Paper

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Healthcare organizations must set a strong foundation of IT systems to support operations in order to be world-class providers in the 21st century. Much attention has been given to clinical IT systems, investments in EHR deployment, meeting Meaningful Use requirements, and collaborative care support via health information exchanges (HIEs) and accountable care organizations (ACOs). However, IT systems also play a core role in establishing a foundation of financial health, meeting quality and compliance requirements, and utilizing business intelligence to keep ahead of operational hurdles. Healthcare organizations must leverage IT systems to advance operational and financial efficiencies, improve processes, increase the velocity of cash flow, drive and monitor specific core and non-core financial activities, and allow the organization to maintain the high level of focus needed on quality, competition and improvement in the provision of care.

These functions are minimum requirements for healthcare providers to succeed in a more competitive world, expand and improve services, and pursue clinical research. In this paper, we discuss some of the most fundamental financial challenges faced by providers, how they impact financial health, and priorities for overcoming them.

## **CHALLENGES IMPACTING HEALTHCARE PROVIDERS**

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The financial health of healthcare providers is being severely challenged in an era where fundamental factors are clashing. The aging population is leading to increased demand for services, while skilled providers are in short supply, payers are becoming stricter about reimbursement, and many patients are losing insurance. Hospitals and physician practices are caught in the nexus of these conflicting forces, and to survive they are reacting as businesses must, by extracting economic efficiency wherever possible. Strategically this means becoming more competitive at enlarging their patient populations; recruiting and retaining the best physicians, nursing and technical staff; and improving their financial operations. Providers are demanding that basic processes, such as coding, health information management (HIM) and revenue cycle management (RCM), are cost-effective at improving cash flow. Providers also need to be very focused on reducing risks associated with inadequate compliance, because errors are costly. While these financial systems are largely IT-driven, they are becoming increasingly complex and reliant on expertise, which is in short supply.

### ***Declining Reimbursement and the Bottom Line***

Ask healthcare executives about the greatest financial challenges they face, and declining reimbursement will be at or near the top of the list. Providers are facing higher hurdles to receiving adequate reimbursement, as payers cut reimbursement rates and erect stricter criteria for the payment process. This challenge impacts both public and private providers, and is true across all payers. As a consequence, healthcare provider margins are declining, while patient co-pays are increasing, which leads, in turn, to further delays in collections and new cycles of eroding

margins. Compounding the problem is an increase in patients who lack insurance or are underinsured and cannot afford their charges, potentially tipping the organization into debt.

In response to the pressure of declining reimbursement and slower processing of payments, healthcare providers need to focus more than ever on improvements to basic healthcare information systems, such as accurate diagnosis and procedure coding, and squeezing efficiency out of the revenue cycle. The processes of accurate coding and capturing dollars with the highest efficiency are becoming top-of-mind in financial management, and a basic necessity to survive as a business. Business intelligence is becoming essential to constantly monitor losses from denials and failed collections, to identify and correct these “leaks” as soon as possible. Reimbursement systems had been cumbersome and costly, relying on a large and inadequately trained staff, but these systems are now largely driven by technology. Yet, due to changing and increasingly complex coding and payment systems, the best technology is still insufficient, unless the staff is fully trained and knowledgeable. Compounding the challenge is the impending adoption of ICD-10, a profound change that impacts numerous systems and requires intensive effort to learn and to enable.

### ***Higher Levels of Competition***

Declining margins and the need to increase scale are fueling consolidation, both in terms of hospital-physician alignment and consolidation of hospital systems. Their strategy is to extract efficiencies of scale by building integrated networks. One sign of consolidation is that more than 50 percent of physicians are now employees rather than independent practitioners, and the proportion is growing each year.

With mergers and acquisitions of practices and hospitals comes the challenge of integrating disparate systems and aligning processes. These integration issues are a hindrance, at least initially, to growth and efficiency in leveraging the value of consolidation. Hence, due diligence must include careful evaluation of the time and expenses of system integration. It is vital to assess the true cost of consolidating. For example, the cost of integrating a physician practice includes the risk of losing money due to outstanding claims that get lost in the transition. Physician practices are often inefficient at aggressively collecting reimbursement, presenting a liability in an acquisition.

### ***Continuing Impact of Healthcare Reform***

An overall trend in healthcare reform is toward a model of shared risk. An accountable care organization (ACO) is one embodiment of this model. In this model, the transaction environment is one in which there is a single input and a single bill-out per patient. Hospitals and physicians in an ACO need to develop and agree on a transparent model for gain-sharing or else suffer from a lack of trust. Even in the current environments of fee-for-service and prospective payment, there is distrust between physicians and affiliated organizations regarding billing. Physicians expect earnings by procedures, but healthcare organizations model

earnings by percent of involvement, not by CPT codes or other segmented units of billing. The concept of payment for outcomes is gaining acceptance in principle, versus the model of payment for activity, but it is difficult to implement. The challenge is determining the various contributions, apportionment of who did what to justify revenues. In general the concept for revenue split is that of contribution margin, but the shared risk model blurs this concept. Hence, as the shared risk concept gains traction, there need to be new models of contribution of value.

One route to tempering the challenge of conflicting perspectives of contribution is by outsourcing billing to an independent third party. Outsourcing the division of revenues to an entity not tied to any of the ACO providers creates trust among the providers that revenues are being transparently divided per the agreement, as the third party has no stake in any one party receiving more than the agreed-upon share. The outsourcing provider is incentivized to maximize reimbursement and provide transparency in the division of revenues, as opposed to the case in which a dominant entity in the ACO administers billing internally and may be viewed (rightly or wrongly) as favoring one ACO partner over another. Hospitals and physician groups need to develop allocation models of how to split billing among different units of the healthcare process, and outsourcing RCM is a solution to equitability. These partners provide value to clients not only on collections, but on how to measure contributions and build trust among the provider parties.

### ***Increased Complexity of Clinical Documentation***

Standards of documentation in healthcare, from registration to diagnosis, treatment to billing, are increasingly complex. Near the top of the list of documentation challenges is implementation of ICD-10-CM and –PCS by October 2013 for all HIPAA-covered providers. This replacement of ICD-9 is considerably more detailed and is accompanied by a new and more complex billing standard, 5010. Adoption of these standards requires new investments in systems, processes, training, and compliance monitoring. With this transition comes the potential for denials, claims errors, and the likelihood of audits. As a result, there is increased pressure to track and document outcomes and compliance. The users of IT systems for billing cannot assume the outcome will be correct. There will always be a need for human expertise to monitor various points in the process and verify the accuracy and efficiency of billing systems.

Discussion of business processes for financial health should weigh the value of insourcing versus outsourcing. When RCM was easier to administer and execute, providers were focused on growth strategies. It was not imperative to find experienced staff because training was quick and errors were more tolerable. Now the priorities have switched, becoming focused more intently around billing and the cost of staff. There are costs of in-house billing, and one of the main issues is what the staff is learning, because the learning curve is steep and does not level off. Too often the in-house staff is not expert and is not billing correctly. Soft-dollar opportunities are lost to in-house billing. This is where outsourcing helps the

bottom line. Outsourcing business processes makes more sense when those processes are complex and changing, such as RCM. Outsourcing partners offer expertise, quality control and more efficient processes. Hence, providers should evaluate the return on investment for in-house versus outsourced business processes. They may find that outsourcing offers a higher return than trying to build and maintain capabilities internally.

### ***Increased Importance of Business Processes***

A shift is due in providers' strategy in prioritizing IT investments. Providers were initially deterred in implementing RCM because it was a distraction to make the investment; RCM had been overlooked, being viewed as having ancillary impact. But providers need to build a RCM framework into their systems now, as improved financial performance cannot wait.

Providers who formerly based value on software are realizing that software alone does not maximize dollars. Business processes such as RCM are too complicated to rely only on software and need to be overseen by experts who can review results and implement process changes that reduce denials. Successfully integrating all participants in the RCM process, from providers to external consultants who bring in analysis and expertise, is necessary to effectively implement processes that improve both the timeliness and value of reimbursement flow. Analysis of processes and process change requires the involvement of all stakeholders acting as partners; therefore, RCM is not a solution to be purchased out of a box.

## **SETTING A FOUNDATION THAT WILL ALLOW HEALTHCARE ORGANIZATIONS AND SYSTEMS TO FOCUS ON DELIVERY OF OPTIMAL PERFORMANCE**

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In the face of these many ongoing challenges, success comes from maintaining the focus of the organization on issues that will drive competitive advantage and deliver quality outcomes to patients. The foundation of financial health rests on consistently high performance in basic business processes such as RCM, HIM, compliance, business intelligence, and best practices.

### ***Revenue Cycle Management***

Healthcare organizations can improve performance in collecting payments on a number of fronts, including pursuing the causes of denials, assisting patients in identifying all potential payers, pursuing claims with these payers, and assisting patients in arranging their out-of-pocket payments. The investment required to achieve incremental improvement in collections should be evaluated, because there is a point of diminishing return. Revenue increases of a few percent per year are possible and could have a large impact on the bottom line. Reinforcing the RCM function entails reexamining processes and systems to ensure they are sufficiently integrated,

adopting new technologies if needed, improving communication with payers, and organizing management to align the parts toward the goal of decreasing lost revenue.

Although it seems straightforward for an organization to consider routes of improving its RCM, it may not be easy to achieve the last few percent of uncollected revenue. In fact, many organizations lack sufficient personnel and infrastructure to efficiently manage the full spectrum of their collections in-house. And those organizations that are efficient at performing these functions internally may still lack the expertise to identify and resolve the remaining, more intractable inefficiencies. This is why organizations that are making an effort to raise the level of their RCM should consider outsourcing. RCM specialists offer a wealth of experience in working closely with payers and hold current detailed knowledge of policies to extract reimbursements that previously had been lost. Healthcare executives should consider whether it is more cost-effective to invest additionally in their internal RCM processes or to engage a provider of these services. The opportunity costs should also be considered. Organizations may find that outsourcing instead of further investment in internal RCM frees funds and staffing to activities that are more productively invested in the core business of healthcare delivery.

### ***Health Information Management***

The use of ICD-10 codes for diagnosis and procedures will be mandatory for HIPAA-covered providers starting Oct. 1, 2013. In parallel with this switch is the requirement to transition to a new transaction standard, version 5010. Many core operations will be affected, especially clinical and financial functions. The hope is that these new standards will lead to more precise matching of payments to diagnosis and treatment, and to more efficient documentation and claims processing. Additionally, the detail inherent in the new standard could provide better business intelligence with regards to clinical operations. On the other hand, during the transition period providers will experience disruptions in health information management and the revenue cycle.

By now all providers should be planning for ICD-10 adoption. Arrangements must be made for staff training, changes to HIM systems, analysis of clinical operations, and potential impacts on revenue. Nearly all clinically-related personnel must be trained, including coders, physicians and admitting/discharge staff. Coders must become fluent with the expanded code and how it relates to medical terminology. Physicians, too, must become familiar with the new details of clinical records they will need to keep. And clerical staff must know which new codes to use for diagnosis and procedures in the admission, order, and discharge processes.

The transition period from ICD-9 to ICD-10 will result in temporary disruptions and inefficiencies in operations. During this period, the productivity of staff will decline; CMS has estimated it will take three to six months for coders to become proficient. Hence, it is critical to train staff with sufficient lead time so that

operations do not experience a bottleneck during the transition. It is anticipated that there will be a shortage of highly qualified coding staff around this period, as highly knowledgeable and experienced coders will be in high demand. Hence, providers with their own coding staff may seek help by outsourcing. Those providers who already outsource coding must communicate with their vendor and ask tough questions about their readiness for the new standard. The financial benefits of outsourcing to experienced and prepared coding partners will be more important under ICD-10 than ever before. These benefits will be realized in the short term through uninterrupted services during the transition, as well as through long-term productivity, accuracy, and compliance under the new coding standard.

In meeting the highest standards of compliance to avoid financial and reputation risks, healthcare organizations should have a formal compliance plan that is reviewed annually by an attorney. This review should consider changes to the revenue cycle. There is the threat of treble damages for improper billing; additionally, there is a potential of lawsuits from patients. Therefore, providers must continually update their processes to avoid known and potential risks that could be financially devastating.

An approach to reducing risk is to outsource the coding and billing processes. First, outsourcing places responsibility in the hands of experts who have rigorous quality controls, lessening the chance of errors that bring oversight. Secondly, outsourcing places risk at arm's length, potentially reducing direct impact of compliance liability on the provider.

### ***Business Intelligence and Knowledge Management***

The adage “Data is useless; information is gold” applies more than ever to healthcare business practices. Providers need actionable information to monitor and correct critical processes that are operating inefficiently. An example is metrics of claims denials, which providers need to monitor to detect patterns that are symptomatic of incorrect billing.

For example, one provider's RCM partner meets regularly with physicians and staff to review the most frequently denied claims. An analysis of reimbursement metrics detected that one new treatment procedure was consistently being denied. The outsourcing partner (who combines RCM services with coding, audit and post-billing review services) investigated, working closely with physicians who performed the procedure, and discovered that the procedure was being incorrectly billed due to a seemingly minor aspect of the claim format. As a result, a new billing process was recommended and executed, in partnership with the provider, to make sure the change was understood by business staff and compliant with established processes. The provider recouped previously denied reimbursements and now earns the full eligible revenue from this procedure.

This is just one example of how periodic review of business intelligence metrics is increasingly essential in an era of deteriorating margins. It illustrates that, just as

reviewing business metrics is essential, so is following up on evidence of problems. There is a cost of not investigating, and this is where outsourced expertise pays off. RCM partners are incentivized to track down and recover lost revenue, and they have the knowledge and processes to do so cost-effectively.

BI partners who can trend productivity, trend payer activity (overpayment and underpayment), and trend denials and the reasons for denials can provide actionable results and support process changes that will reduce coding errors and claims denials now and in the future.

## **LEVERAGING BEST PRACTICES TO MEET THESE GOALS COST-EFFECTIVELY VIA BUSINESS PROCESS OUTSOURCING**

To remain solvent and competitive in today's economically challenging and rapidly evolving environment, providers must focus on their core strengths and consider outsourcing non-core operations to more economically efficient solutions: external vendors. Among the most rapidly advancing internal operations are business processes such as HIM and billing. Unless a provider considers these to be its core strengths in caring for patients, it often makes more economic sense to outsource these operations to specialists.

### ***Opportunities for Best Practices via BPO***

Vendors offer two primary potential advantages over internal support. First, they have efficiencies of scale that are inherently more efficient. Second, they are experts and can more quickly solve less common challenges. An overarching factor favoring outsourcing is opportunity cost: the savings earned by efficient outsourcing can be invested back into profitable internal operations. Additionally, the vendor will have access to data from other healthcare organizations and can offer benchmarking services to drive internal efficiency. For example, a RCM vendor may compare the coding efficiency of a client to comparable facilities to see if errors are leading to suboptimal billing. Finally, outsourcing can lighten the burden of liability on the provider by distancing the provider from the effects of errors or malfeasance that may occur in the operations of a vendor.

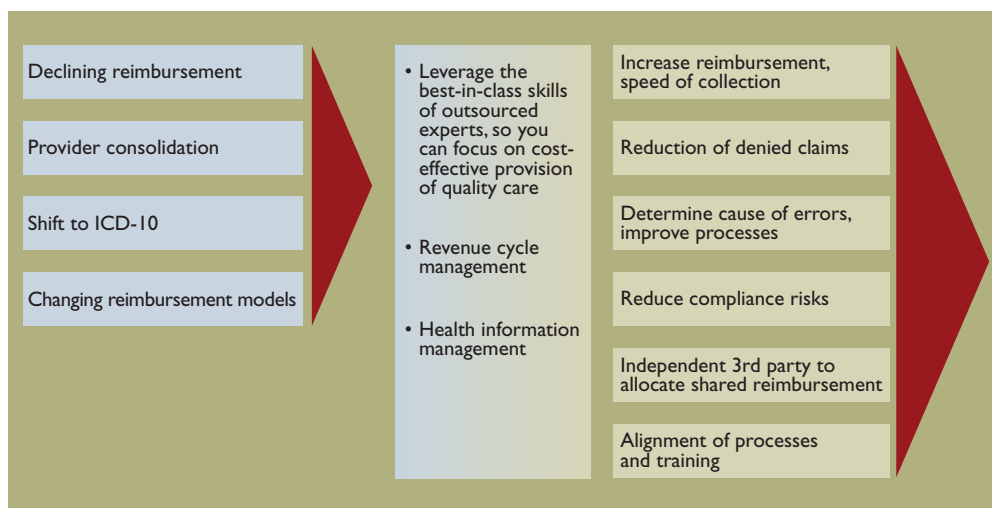
The traditional benefits of outsourcing business processes apply as well to outsourcing RCM and HIM:

- Cost savings
- Improved process quality
- Access to expertise
- Rapid innovation to adopt process best practices
- Increased process capacity in periods of high volume
- Permit focus on the healthcare provider's core strengths

### Choosing a BPO Vendor

Physicians and executives must exercise care in selecting outsourcing providers, since there needs to be a close match between the vendor’s services and the practice’s needs. Critically important is the experience and specialty of the vendor, which should match the specialty of the practice. Clearly an orthopedic practice would not be well served by a vendor that has most of its RCM experience in oncology. Other factors to consider in choosing a BPO vendor include its certifications and licenses. These must be considered at least from the liability standpoint, but also provide evidence of the level of expertise, and that the vendor is current in the latest practices and technologies.

Additional consideration must be taken into how the relationship will be managed. BPO vendors may be off site, but that just means that oversight is even more important. Questions to ask are who in the hospital or practice will manage the vendor and how? What metrics will be used to measure vendor performance?



While outsourcing has long been utilized in other industries to a much larger extent than in healthcare, in today’s competitive and changing environment, with providers challenged to maintain thin margins while focusing on improvements in the provision of quality care, outsourcing will be leveraged more as a key part of providers’ business strategy.

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