In the current healthcare environment, no provider can afford to let any available payment dollars slip away. SSM Health Care–St. Louis was outsourcing 80 percent of its pending Medicaid account processing, relying almost entirely on its vendor to screen, monitor, and resolve self-pay accounts with potential linkage to Medicaid coverage. A review of the processes, performance data, and detailed accounts showed an opportunity for the organization to reduce costs and capture millions of additional dollars in revenue.

By bringing inpatient and observation pending Medicaid accounts back in-house and optimizing workflow and processes within the revenue cycle, SSM Health Care–St. Louis generated $12 million in new cash. The main drivers of this revenue inflow were an increase in Medicaid application approvals and an increase in correctly identifying insurance coverage on registered self-pay accounts. These efforts, combined with other targeted revenue cycle initiatives, contributed substantially to the network advancing from a −0.3 percent operating margin in 2008 to a +2.6 percent operating margin through mid-2010.

### Competitive Environment Creates Burning Platform for Change

Based in St. Louis, SSM Health Care is sponsored by the Franciscan Sisters of Mary and owns 14 acute care hospitals, one pediatric hospital, and two nursing homes in Wisconsin, Illinois, Missouri, and Oklahoma. The St. Louis region is its largest, with six acute care hospitals and one pediatric hospital that account for $1.5 billion in annual hospital net patient service revenue.

Already operating in a competitive geographic region that has 18 hospitals and three other health systems, SSM Health Care–St. Louis faced an even more challenging business environment as the economy slowed in 2009. As a result, regional leaders needed to find new ways to maintain and advance their mission—and realized they needed to move from “good” to “great” in revenue cycle performance. As part of their overall efforts to improve, they recognized an opportunity to optimize their Medicaid application approval process.

### Reassessing Outsourcing Strategy

Previously, SSM Health Care–St. Louis outsourced most of its pending Medicaid application process because it did not...
The team increased cash by $8 million through additional Medicaid approvals that would have otherwise gone to self-pay collections and $4 million through identifying accounts that had insurance.

However, the organization fell prey to a common pitfall of outsourcing: the inability to have the vendor operate as a fully accountable extension of internal operations. Working with a consultant, SSM Health Care—St. Louis leaders conducted a comprehensive performance study and cost-benefit analysis to see whether bringing management of these accounts in-house was feasible and would add sufficient value to justify change.

**Reviewing Medicaid Screening and Application Processes**

A focused review of the Medicaid eligibility screening, account processing workflow, and application process disclosed five areas where the organization-vendor relationship was not achieving the best available results—and was therefore driving an avoidable revenue loss:

- Vendor staffing shortfalls, performance inconsistency, and training deficiencies
- Inadequate tools to manage the screening and application process
- Limited management reports to track weekly and monthly performance
- Poor productivity and quality metrics
- Gaps in oversight to ensure that each part of the complex process was handled appropriately

As a result of the assessment, SSM Health Care—St. Louis elected to bring inpatient and observation accounts, representing about 80 percent of its overall outsourced Medicaid eligibility process, back in-house.

**A Re-Engineered Approach Through Insourcing**

SSM Health Care—St. Louis reengineered its approach to self-pay and potential pending Medicaid accounts in the following key ways.

- **Established appropriate staffing/portfolio ratios.** SSM Health Care—St. Louis analyzed and hired the right number of employees needed to manage the existing volume of in-house screenings and post-discharge follow-up. Over a four-week period, eight additional employees were hired in the Medicaid eligibility unit, bringing the unit’s total number of team members to 12.

- **Provided staff development and training.** Over eight weeks, training was provided to all staff, both new hires and existing employees, to ensure a solid understanding of the Medicaid screening and application process, standardize approaches to patients, and establish best practices and consistency in follow-up methods. Performance expectations were also introduced during this process, including quality and productivity measures to ensure all team members were working in a consistent and standardized way and to foster sustainability.

- **Restructured revenue cycle job functions.** Job functions were restructured and accounts organized by facility, rather than having team members across facilities share accounts. In the new structure, each account was “owned” by the team member who initiated the primary action on an account. This served to simplify and streamline key processes within and across job functions.

- **Installed tools to enable data-driven process flow.** Staff used tools to track the status of each task, measure quality and productivity, and ensure that all processing was proactive, timely, and effective. The tools allowed staff and supervisors to proactively manage their work, address exceptions, and prioritize work more effectively. From design and planning to implementation, the solution was activated in 10 weeks.

- **Established consistent performance metrics.** Staff also created metrics that measured effectiveness, continuously monitored results, and held process owners accountable for achieving goals.

**Benefits of Insourcing**

Using the strategies described above, the organization’s in-house Medicaid application process achieved substantial results.

By improving in-house screening processes, increasing productivity,
and ensuring proactive follow-up, the team was able to more effectively identify sponsorship—through insurance or Medicaid—on accounts that had previously been designated as self-pay. The team increased cash by $8 million through additional Medicaid approvals that would have otherwise gone to self-pay collections and $4 million through identifying accounts that had insurance, as shown in the exhibit below.

In addition, the team added eight new staff members and saved approximately $300,000 per year in vendor costs. The team gained a more thorough understanding and tighter control of its accounts receivable. Importantly, they were able to improve patient satisfaction by correctly identifying a payment source for care provided.

**Dramatic Process Changes Create Sustainable Gains**

Once SSM Health Care–St. Louis re-defined vendor scope, more effectively managed the in-house Medicaid screening and application process, and used tools and reporting to improve performance, it was able to significantly increase cash collections and improve patient service. These efforts positioned SSM Health Care–St. Louis to drive and maintain improved performance in its revenue cycle at a time when all opportunities for cash absolutely matter.

Due to the significant improvement gained through internalizing these functions, SSM Health Care–St. Louis will be duplicating the process throughout the system. SSM is also consolidating all scheduling, preregistration, registration, billing, and follow-up into a consolidated corporate department—Patient Business Services. This will allow SSM Health Care–St. Louis to streamline patient business service operations and implement best practices across the organization. 

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