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LEGACY REVENUE CYCLE MANAGEMENT SYSTEM RETIREMENT: EXPEDITING A/R LIQUIDATION AND CASH ACCELERATION

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ABSTRACT

A critical component of legacy system retirement is how outstanding Accounts Receivables (A/R) are handled. Hospitals and other healthcare organizations must weigh collection of outstanding A/R reconciliation when replacing legacy systems. Important components of success include: providing a cost-effective alternative to working post-sunset A/R with limited disruption to staff, users, and patients, ensuring cash collections remain at or exceed current performance, allowing revenue cycle leadership to focus on successful implementation and training of the new system, and expediting the legacy system retirement. Contrary to common perception, in most cases, an active archival system is unnecessary to achieve successful resolution of the outstanding A/R portfolio. Alternatives, such as maintaining the legacy system for a period while collecting outstanding balances or selling off debt to collection agencies can prove to be more cost effective.

REVENUE CYCLE MANAGEMENT & A/R BASELINES

- Claims clearinghouse InstaMed reported that 76% of providers surveyed said it takes more than a month to collect from a patient, with 56% citing patient pay-balances as their top revenue cycle concern
- For every 30 days an account languishes in A/R, the chances of collecting decrease by 30%
- The odds of a patient paying off his or her account fall to as little as 6% by the time you send the fourth statement
- For every dollar billed to a patient, nearly 50 cents will go uncollected
- Providers anticipate collecting only 50 - 70% of a patient balance after a clinical visit
- In 2016, 75 million patients had a high deductible health plan, with an average deductible of $1,478

THE INHERENT RISKS AND COSTS OF LEGACY SYSTEMS

Healthcare delivery organization (HDO) consolidation continues as mergers and acquisitions are driven by a desire to increase scale and spread out risk in the transition to value-based care. Rationalization and consolidation of the HDO portfolio is also prevalent, and has precipitated the need to transition from electronic medical record (EMR), patient accounting (PA), and revenue cycle management (RCM) systems to integrated enterprise systems. In these scenarios, maintaining the legacy system is necessary to preserve access to vital data for billing purposes and to comply with retention legislation. Federal and state regulations require the storage of patient health information for at least five years and often longer. Human Resource (HR) staff must keep records for at least a decade, and hospital accounting staff require access to long term accounts for A/R purposes.

However, with the maintenance of legacy systems comes inherent risk and additional cost. Compliance with record retention regulations requires HIPAA-compliant medical data storage ranging anywhere from 7 to 25 years based on medical specialty or state mandate. That is a long time to keep the replaced billing system or EMR running in tandem with the new system, and, in many cases, there are multiple legacy systems to consider. In addition to servers aging, software applications must be maintained with the latest upgrades. Users who know how to navigate the legacy system may leave the organization for a new job. Maintenance of the legacy system not only poses a technical risk for the organization, but it also extends the related costs and labor burden. Should release of information be required to fulfill a request from a patient, lawyer, employer, payer, or auditor, the patient clinical and financial history is legally required to be secure, accessible, discoverable, and easy to share in a HIPAA-compliant format.

A/R System Cost Components
System license / SMA costs
Minimal license
Upgrades
Hardware costs (if hosted on-premise)
Annual maintenance
Expected upgrades (such as OS migrations/new hardware iterations)
Infrastructure maintenance
Hosting costs (if vendor/3rd party hosted)
Staffing costs
Internal support
General IT/administration

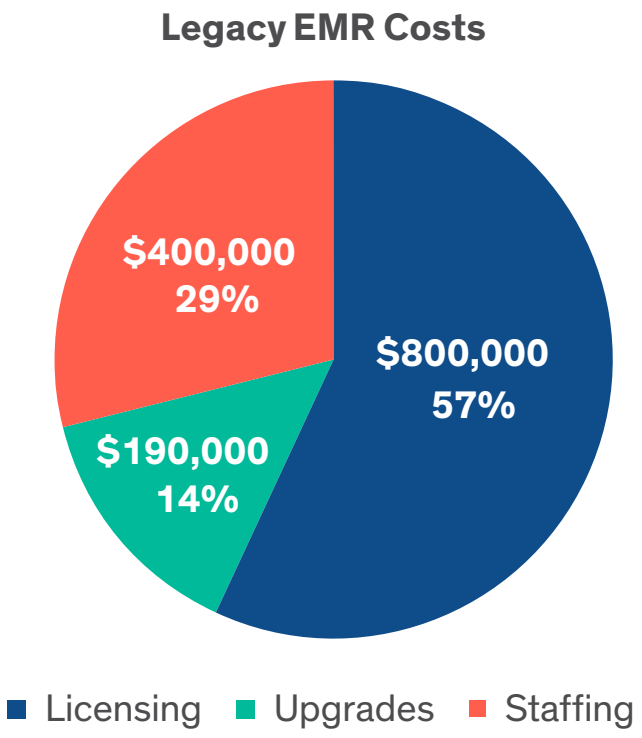
To avoid risk, ensure compliance with record retention mandates, and reduce costs, legacy system decommissioning and data archival are important components of any system replacement.

LEGACY SYSTEM RETIREMENT ROI

As it stands today, HDOs have enormous sums of money invested in infrastructure, software licensing, and support costs for multiple clinical systems that are deemed "legacy." Unfortunately, retiring those legacy systems is not as simple as migrating users to a shiny new EMR and flipping the power switch. Those legacy systems have millions of dollars' worth of critical information in them, both from a continuity of care point of view and from a harrowing legal perspective. There are rules, some specific, some vague, about retaining this data. Indeed, the task at hand can be so confusing that many organizations shun the entire issue and keep those legacy systems on minimal life support. However, minimal life support rarely equates to minimal cost and risk.

Substantial return on investment (ROI) can be achieved by retiring legacy EMR systems and archiving. Recently, one of our clients, a 150 bed, 350 physician hospital, sunset legacy eClinicalWorks, Hyland OnBase and Allscripts Sunrise Clinical Manager applications, archiving the data with VitalCenter Online Archival. Their savings were staggering, with > 90% lifetime ROI.

Legacy EMR Costs	
Licensing	150 licenses: $800K/year (hosted system)
Upgrades	Smaller updates (regulatory) 2-3/year @ $20-$30K per; Major Version Updates 1/year @ $80-100K (this included vendor service costs)
Staffing Costs	4 FTEs (3 analysts, 1 manager) on the app side/ .5FTE on the infrastructure side (delivery through CITRIX).



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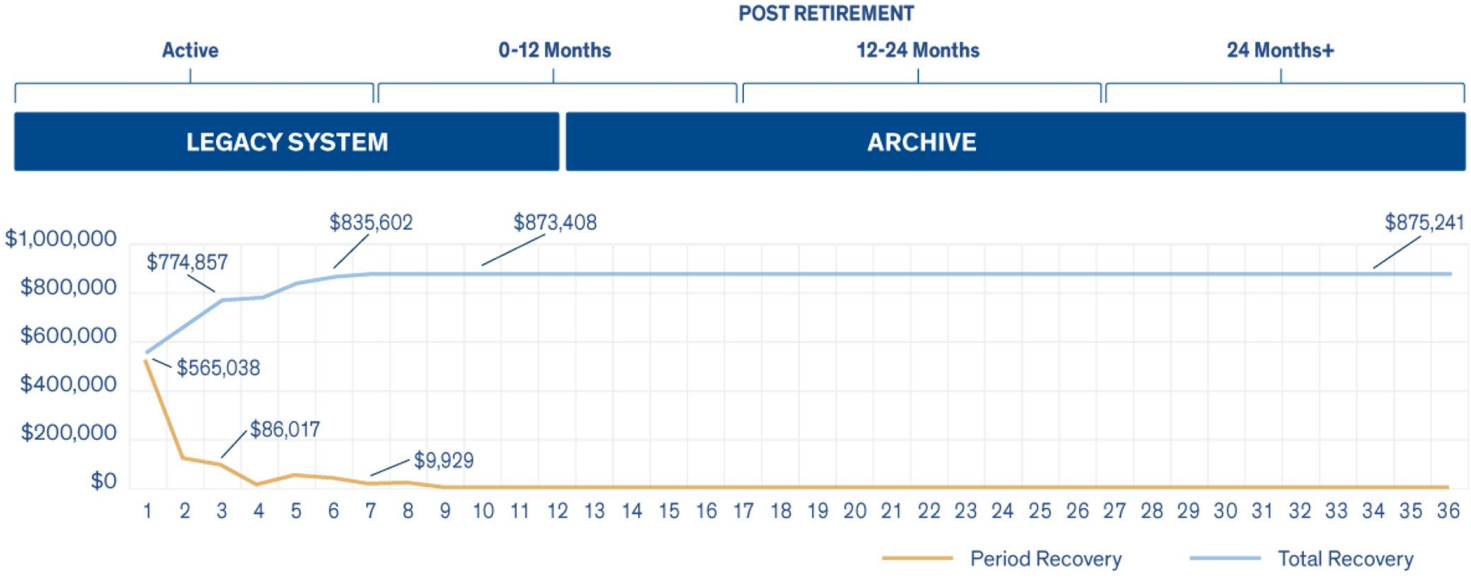
REVENUE CYCLE MANAGEMENT SYSTEM RETIREMENT

Many organizations focus solely on the design and setup of their new system, overlooking cash protection and the expense allocation associated with cash protection. It is vital that administration be proactive and not wait until after the system conversion to manage A/R.

Many organizations assume they can handle their receivables with the originating system internally right up to the point of conversion. Typically, around 60 days prior to the transition, they are struggling to maintain solid performance due to the mandated focus on training and the many challenges of successful implementation. Likewise, from a financial perspective, liquidating cash in A/R is paramount. After the conversion, administration must focus on allocating the same resources toward liquidating receivables completely from the legacy systems by any means necessary, including corrected billing of denied claims, claim submission to secondary payers, collections, and write-offs.

Legacy systems may have A/R records of unpaid debt that HDOs should not ignore. Maintenance of these legacy systems is required for debt reconciliation to occur prior to decommission. In cases of very large legacy systems, where the software maintenance costs can be exorbitant and the time it takes for A/R reduction is extremely long, it may make financial sense to utilize an archival solution in which billing may still occur. This approach would also apply in cases where a large portion of A/R may be outstanding in comparison to industry benchmarks. However, these are fringe scenarios and the more cost-effective approach for the majority of HDOs will be to choose to keep the legacy system intact while subsequently working the outstanding balances.

Revenue Cycle Archival Timeline



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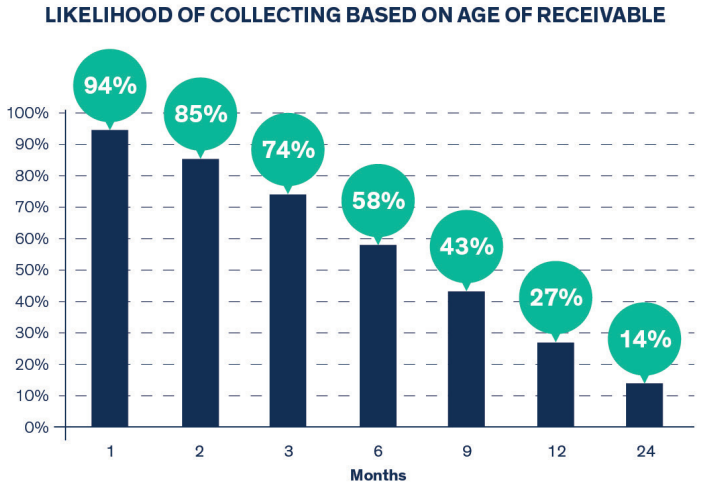
Break-even and ROI must be assessed when deciding on the timing and approach for legacy patient accounting (PA) retirement, which is not dissimilar to weighing the benefits of keeping a legacy clinical system running versus archiving with an on-premise solution (where the ROI is likely unjustified) or with a cloud-based solution (which can deliver significant ROI). There are several considerations in determining how long the PA system should be kept running, namely, the ability to collect, value of liquidating old A/R, as well as the cost of properly collecting all old A/R. Other factors include insurance take-backs, claim denials and reprocessing, and legal disputes.

Aging Category (days)	Performance Standard (%)
0 - 30	40 - 60
30 - 60	20 - 30
60 - 90	5 - 10
90 - 120	5 - 10
> 120	5 - 15

Table 1: A/R Benchmarking; Source: MGMA



A/R Retirement Lifecycle

0 - 6 Months

- High transaction volume
- High recovery

6 - 12 Months

- Medium/low transaction volume
- Limited recovery/organization dependent

12 - 24 Months

- Very low transaction volume
- Very limited recovery rate

IS ACTIVE ARCHIVAL NEEDED?

As previously mentioned, one of the most important considerations when retiring a PA system is to determine if an active archival system is needed. It is critical to formulate a strategy for working old receivables and PA system retirement based on phases. Consider the following scenario in which a hospital has $1MM in outstanding receivables. Using the aforementioned aging percentages and collection rate benchmarks, most of the outstanding receivables (83%) are collected within the first phase of system retirement (0-12 months post retirement), with diminishing returns for the next two phases (12-24 months and 24 months+ post-retirement).

When factoring in licensing and staff costs to support the legacy PA system, it may be advantageous to keep the legacy system active for one year while outstanding receivables are reconciled, and transition to a static archival solution thereafter. An alternative approach would be to transition immediately to an active archival solution and resolve outstanding A/R within that system. However, the costs of active archival systems are often several times the cost of static archival. Most active archival solutions include only basic functionality (add notes, edit demographics, payment and adjustment posting) as part of licensing costs. Additional features, such as interfacing to systems like general ledger, HR, and payroll, come at an additional cost. And, along with additional training that is required to learn a temporary system, the negligible benefit may preclude an organization from pursuing such an approach.

Example A/R Profile

TYPE	%	0-30	30-60	60-90	90-120	120-150	150+
Patient	16.00%	24.3%	7.2%	15.7%	17.4%	9.3%	26.6%
Insurance	84.00%	64.6%	14.2%	8.7%	1.1%	5.4%	6.0%
		58.2%	**13.1%**	**9.8%**	**3.7%**	**6.0%**	**9.3%**

78 days
Average Patient A/R Age

23%
Remaining Value of Patient Receivables Older than 90 Days

26 days
Average Insurance A/R Age

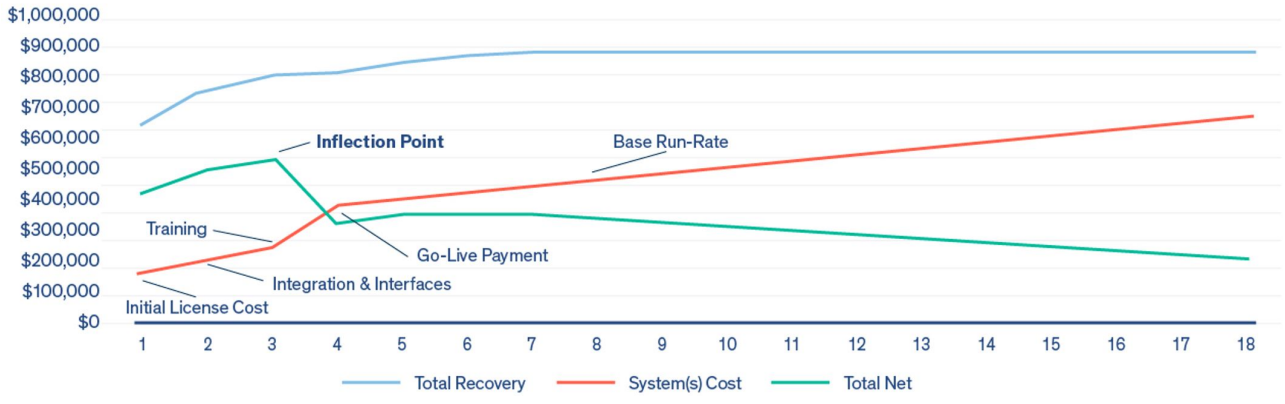
87.5%
Expected Insurance Receivables Within 90 Days

81.1%
Expected Total Receivables Within 90 Days

Active archival systems used for the purposes of A/R reconciliation of PA systems are typically rendered of limited utility after a year, as the likelihood of collecting outstanding A/R is low, and the costs of the active archival system, which can be several times the cost of static archival, often exceed additional revenue captured.

Cost	Legacy Application	Active Archive	Static Archive
Licensing & SMA	$800,000	$350,000	$60,000
Infrastructure Support	$400,000		
Hardware Maintenance & Upgrades	$50,000		
Application Support	$240,000		
Data Center Costs	$100,000		
Implementation		$150,000	$50,000
Training		$50,000	
Interfaces		$70,000	
1 Year Total		$620,000	$110,000
7 Year Total	$11,130,000	$2,720,000	$470,000

Inflection Point: Legacy RCM Migration/Active Archiving Solution



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The Reality of Patient Payments

30%

Decrease in Chances of Collecting

For every 30 days an account languishes in A/R

6%

The odds of a patient paying off his or her account

By the time the fourth statement is sent

11%

The odds of a patient paying a balance over $500

With patients now representing the 3rd largest payer

Patient Payment Plans

Unlike general outstanding A/R, patients that are participating in a payment plan have a much higher likelihood of repayment. On average, patients with at least two payments will fully repay the outstanding debt upwards of 95% of the time. This represents a significant opportunity for the HDO. Indeed, third-party organizations offer lump sum payments for this debt that will often exceed 80 cents on the dollar versus closer to 10 cents on the dollar for general A/R. The value of receiving 80% of outstanding payments is non-trivial on its own, and when combined with the savings that can be realized through static archival and faster retirement of existing revenue cycle systems and resources, it is rarely the case that active archival makes sense.

- **Far higher long term value**
- **Revenue extending out to 72+ months**
- **Excellent early out candidate**

80%

Typical Early Out Recovery Percentage

92%

Value of PPP Receivables After at Least 2 Payments

3 Years

Most Common PPP Term Length

LEGACY RCM SYSTEM ARCHIVAL USE CASES

There may be interfaces established with the legacy RCM system. For instance, patient access systems (system used for patient registration, patient visit, etc.) may interface with patient accounting systems (systems used for posting charges and billing). The patient accounting system may also interface with the system used by a third-party vendor (e.g., for claim review, or collection agency) as well as general ledger, materials management, HR, and payroll systems. Further, billing rules and logic may exist in the legacy revenue cycle system. Leveraging an active archive will necessitate replication and re-establishment of interfaces and billing rules to match current revenue cycle management, and must be considered in the cost of ownership.

Other scenarios to consider include patient payment plans and Medicare Recovery Audit Contractors (RACs) adjustments. In these cases, functionality may need to exist in the archival system to accept payment, resubmit claims, and forward balances. However, an active archival system may not be required in this case. Instead, a static archival system can be used for payment plans by generating a report from the legacy system with balances and notes, importing into the target system, and populating a token to contextually link to the report. In the case of adjustments resulting from audits, annotations can be enabled in the static archive solution to reflect the change.

LEGACY SYSTEM RETIREMENT PREPARATION

Streamlining current workflows and processes prior to go-live helps to smooth the transition to the new system. All end-users must be prepared for the transition and managers must have a good understanding of how the new functionality can be used to run their departments. A high performing revenue cycle is less vulnerable to disruption during the transition than a low performing revenue cycle. Areas to consider include:

- Resolution of legacy system A/R and strategy development, including data archival, for sunsetting of the system prior to the cut-over to the new system.
- A denials management plan for resolution of the legacy system A/R, as well as post go-live workflows. This might include refinement and/or development of a line item denials workflow for improved tasking, tracking, and reporting.
- Establish baseline Key Performance Indicators (KPIs) for the most critical revenue cycle functions several months before go-live, and ensure the capability exists to capture these metrics before, during, and after the transition.
- Develop clear patient communications regarding the upcoming statement change and potential receipt of redundant statements.

PAYMENT RECONCILIATION BEST PRACTICES

As HDOs transition to a new system, it is essential to reconcile payments as thoroughly as possible. HDOs must determine criteria for posting to the legacy system as well as the new system. A strong internal business team with clearly organized, well managed accounts should be able to pursue this process independently.

Outside resources with experience in managing payment posting and reconciliation across both systems may be pursued. With proper process and guidance, internal and external staffs can complement each other to record all payments and adjustments rapidly and accurately in both systems.

The transition may also offer excellent opportunities to make other improvements in existing processes. Procedural areas, such as self-pay collection, insurance payer interaction and processing, and payment and posting practices could be made more productive.

For instance, payments are co-mingled in a single 835 file for accounts from each system. Uploading the entirety of the file to the legacy system renders the reconciliation process cumbersome to the payment posters and to both Patient Financial Services (PFS) and finance departments. The result is multiple error reports to review, and manual management of interface feeds from multiple systems.

Most HDOs create one or more placeholder accounts. It makes much more sense to post these legacy payments to the provisional placeholder account as one line item in the production system, as processes are cleaner, staff time is saved, and there is much less room for error. In professional billing settings, collection accounts are written off; so if payments come through, it's "found money." In the institutional setting, payments are kept on the books due to volume, but it's still "found money."

CONCLUSION

More often than not, early out and/or short term reconciliation using the legacy system provides the most cost-effective solution to legacy patient accounting system retirement, followed by long term archival. Preparing A/R for conversion with the right acceleration/liquidation strategy up front will help protect cash flow and avoid financial catastrophe. Hospital executives are turning to experienced partners to provide an A/R reconciliation and data archival solution to save costs and ensure record retention and compliance.