

Optimizing the Revenue Cycle in Uncertain Financial Times – What Every Hospital Trustee Needs to Know

The economic downturn and efforts to reform healthcare continue to pose significant challenges for hospitals nationwide. These challenges are consuming intellect and resources above and beyond the daily challenge of delivering safe, effective, quality healthcare. They are forcing hospitals to navigate an environment plagued with shrinking reimbursement dollars; growing under- and un-insured patient populations; ever-tightening regulations; and increased public scrutiny.

Is your hospital optimizing its revenue cycle to improve its cash flow and, in turn, counteract the challenges brought on by both the economy and healthcare reform? If your hospital isn't considering how it can more effectively and efficiently improve functions like scheduling, utilization management and charge capture, you could be leaving money on the table.

HELPING HOSPITALS SURVIVE *and* THRIVESM

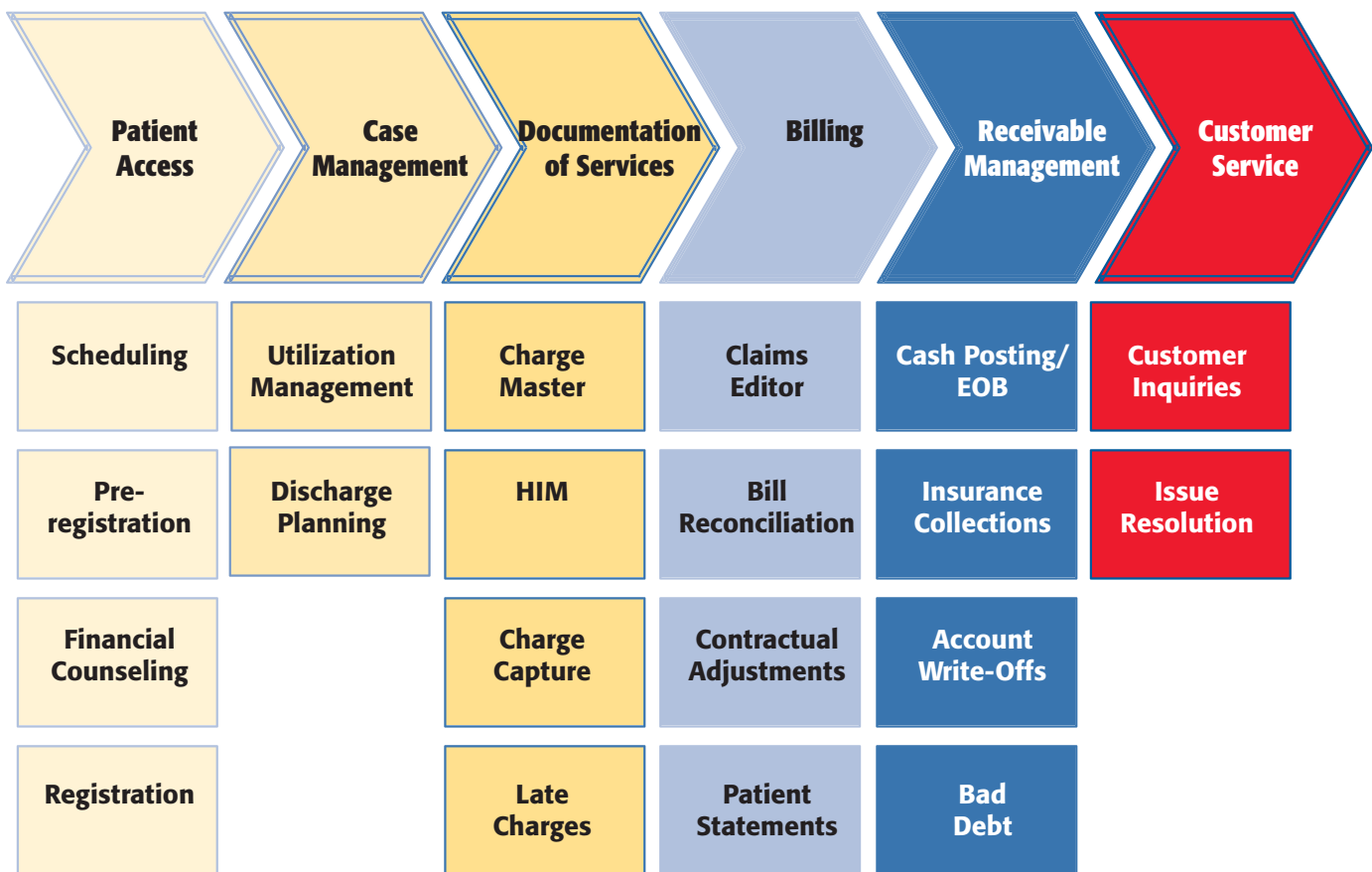
If your hospital is like most, it is responding to the challenges brought on by the economic downturn and efforts to reform healthcare in one (or more) of several ways. It's reducing its workforce. It's enacting expense reduction initiatives. It's eliminating services. Or, in extreme cases, it's considering bankruptcy or closing its doors altogether. In short, it's learning that hospitals are not recession proof.

The good news is that your hospital has revenue cycle opportunities – opportunities to improve its cash flow and, in turn, counteract the challenges brought on by both the economy and healthcare reform. Your hospital may believe it's already making the most of these

opportunities by focusing on the back end of the revenue cycle (i.e. billing and receivables management), but what about the front end? If your hospital isn't considering how it can more effectively and efficiently improve functions like scheduling, utilization management and charge capture, you could be leaving money on the table.

DEFINING THE REVENUE CYCLE

The revenue cycle includes several key areas of your hospital business, including Patient Access, Case Management, Documentation of Services, Billing, Receivables Management and Customer Services.



While most hospitals focus on Billing and Receivables Management, the majority of net revenue opportunity resides in Patient Access, Case Management and Documentation of Services. Think about it...most organizations are working a step behind! Follow-up staff cannot follow-up if their time is being spent re-billing. Billing staff cannot bill if their time is being spent gathering information (the preferred function of Patient Access). What if hospitals weren't functioning a step behind? Could they reduce outstanding days by 10, 15 or even 20? Would they be more likely to collect payment before the patient is discharged? Waiting until the patient leaves the hospital reduces the likelihood of collecting to less than 40 percent!

IMPROVING THE HEALTH OF YOUR REVENUE CYCLE, ONE STEP AT A TIME

Step 1

Begin by forming a Revenue Cycle Steering Committee, comprised of representatives from all revenue cycle departments (Patient Access, Case Management, HIM, Reimbursement/Charge Master and Patient Financial Services) and non-revenue cycle departments (Emergency Department, Outpatient Surgery, Nursing Leadership, Compliance, Finance and Information Technology).

Step 2

Next, define a successful revenue cycle. For example:

Patient Access – If 100 percent of your patients are “walk-ins” (you didn’t know they were coming.), then it is hard to do a compliant registration in a timely manner; either patient wait times or data accuracy suffers. The good news is that, for the majority of hospitals, a 100 percent “walk in” rate isn’t an issue. We do know scheduled patients in advance and we need to take advantage of that advanced notification. *The “best practice” target is to pre-register at least 90 percent of the non-emergent patients.*

Case Management – Although your hospital doesn’t want either of these, concurrent denials are easier to manage and have less impact on Accounts Receivable than retrospective denials – because they are known at the time of service. Tracking and managing concurrent denials can not only improve the hospital’s AR, but

provide useful information to the UR Committee and Senior Management. *Nonetheless, both categories should be kept to less than 2 percent.*

Health Information Management – In a “best practice” environment, accounts held in Discharge Not Billed (DNB) should total less than three (3) days gross revenue. Top performing HIM departments have been able to reduce this number to ½ day of gross revenue.

Patient Financial Services – Days Receivable Outstanding, Bad Debt and Charity targets are driven by your hospital’s payer mix. As Healthcare Reform evolves, you will see the impact on payer mix and, subsequently, the targets for these performance indicators. Take for example Medicare Advantage (MA): Medicare pays a clean claim in 14 days, but MA plans will most likely pay in 30 to 45 days. This can have a significant impact on your hospital’s A/R performance! What is your specific AR target? Challenge your hospital to go beyond industry benchmarks!

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Step 3

Once your hospital has clearly defined revenue cycle success, focus your efforts by identifying high priority/high impact opportunities. While opportunities vary by hospital, the chart below offers an example of how many hospitals prioritize.

	High	Med	Low
High	<ul style="list-style-type: none"> • DNB • AR Days • Late Charges 	<ul style="list-style-type: none"> • Registration QA • First Pass 	
Med	<ul style="list-style-type: none"> • Pre-registration • Bill Holds 	<ul style="list-style-type: none"> • Point of Service • Bad Debt % 	<ul style="list-style-type: none"> • Charity Write Offs • Cash as % Net
Low		<ul style="list-style-type: none"> • Write Offs 	

Step 4

Now that you know where to focus your efforts, consider these ideas for process improvement.

PATIENT ACCESS: PRE-REGISTRATION AND FINANCIAL COUNSELING

The Issue: Growing number of under-insured and uninsured patients. Patients faced with increased co-pays, co-insurance and high deductibles; more are self-paying out of pocket.

The Challenge: Collecting payments. Did you know that the likelihood of collecting decreases as a patient moves through the hospital and is ultimately discharged?

- ◆ Pre-access – 100%
- ◆ Admission – 75-80%
- ◆ In-house – 65-75%
- ◆ Upon Discharge – 60-70%
- ◆ After Discharge - <40%

Yet more than 75 percent of hospitals make limited or no collections efforts prior to or at time of service.

The Solution: Pre-registration and Financial Counseling Best Practices

For scheduled patients: Patients should be pre-registered 2-5 days prior to service. Pre-registration should include:

- ◆ Eligibility, insurance verification and pre-certification
- ◆ Calculation and communication of financial responsibility
- ◆ Financial counseling, including explanation of payment plans, healthcare loan options, and self-pay and prompt-pay discounts
- ◆ Collection of patient portion of payment via credit card or other form of payment
- ◆ Elective procedures should have 100% secured financing in advance of the procedure; otherwise, it should be postponed.

CLINICAL DEPARTMENTS: CHARGE ENTRY AND LATE CHARGES

The Issue: *On average, 4 to 5% of gross revenue is “lost” on charge errors and late charges.*

The Challenge: Engaging the clinical department to support a clean Chargemaster and appropriate billing

The Solution: Charge Entry and Late Charges Best Practices

- ◆ Track late charges monthly and calculate against the department’s monthly gross revenue
- ◆ Implement a Nurse Audit function that focuses primarily on outpatient claims auditing
- ◆ Review (monthly) clinical departments on late charges data and lost charge audits
- ◆ Identify and implement process improvements
- ◆ Remember that late charges have a double whammy! They could be lost revenue and they cause claim “re-work”.

PATIENT FINANCIAL SERVICES: BILL HOLD DAYS AND FIRST PASS RATE

The Issue: Growing number of edits based upon payer rules or provider established rules. In fact, approximately 75% of your business office staff is likely dedicated to rework. *Rework of claims can result in:*

- ◆ *Incorrect payments*
- ◆ *Inaccurate units*
- ◆ *Compliance concerns*
- ◆ *Delays in cash (time value of money)*

The Challenge: Focusing on tracking, trending and reporting (TTR) errors – rather than just correcting them and moving on.

The Solution: Bill Hold Days and First Pass Rate Best Practices

- ◆ Categorize claims scrubber edits by “responsible department” (e.g., address errors assigned to Patient Access)
- ◆ Track data by error by department each week, and then hold weekly team meetings to identify top bill hold (by dollars) edits
- ◆ Develop, implement and track process improvement projects

- ♦ Move team members, as improvements are made and sustained to have less resources assigned to claim production and more to claim follow-up.

WHAT THIS MEANS FOR YOUR HOSPITAL

In summary, gone are the days when a hospital's "Community Benefit" meant having no barriers to the front door and uncertain financial loss at the back door. Today's

hospitals – and the trustees who guide them – must learn to not only provide Community Benefit through discount and charity programs, as appropriate, but also support "front-end" best practices that help ensure the hospital's long-term viability. It's in everyone's best interest.

To learn more about how QHR can help your hospital optimize its revenue cycle, visit www.qhr.com.