

Today's Top Revenue Cycle Trends

Revenue cycle processes must be efficiently managed to ensure that a hospital receives the payment it is due—certainly no easy task, given the rapid pace of changes to legislation, payer rules, and technology. To prepare for what will come next in this demanding environment, it's key for today's leadership to stay on top of industry practices and trends. With this in mind, HFMA, with sponsorship from 3M Health Information Systems, recently brought together a group of healthcare financial executives to share their experiences and describe what's on their radar at the moment. The following is a highlight of the discussion.

What do you think are the most pressing long-term challenges facing the healthcare industry when it comes to the revenue cycle?

Washa: I think a big challenge is that there's a perception that hospitals are the problem and possible solution for the crisis of caring for the growing number of uninsured, so we're taking on the burden of charity care and bad debt. More and more is put onto hospitals' plates to fix the system, and I think that's caused a lot of misunderstanding from consumers and the various legislators who are looking to us for the solution.

Nelson: I think the other revenue cycle challenge we're seeing is getting payment that keeps pace with the costs associated with advancing technology. For example, hospitals routinely provide cardiac catheters, and now, 64-slice CTs are coming into play. The cost of those technologies is escalating, so how do you collect an adequate payment to cover the costs when rates are set 18 months in advance?

The *Federal Register* recently came out with the new Medicare DRG rates, and when you look at the relative weights, which define how we get paid, there are huge declines in certain DRGs. Think about what's going on in cardiac drug-eluting stent cases now: That's a 21 percent drop in the relative weight, which means my payment is

going to drop 21 percent on that particular DRG case. For me, almost 70 percent of my payer mix is governmental. I have no control over how I get paid, and so services are provided at less than cost. Faced with this, how does the healthcare provider continue to survive?

Stefo: For us, rising consumerism and the subsequent need for pricing transparency are huge issues. Most people outside of the healthcare industry, and even some of those in it, can't appreciate what the effects of these trends will mean. We've seen a big pick-up in health savings accounts with \$10,000 and \$12,000 deductibles, and that changes the game dramatically in terms of our front-end and back-end processes.

Also, with the insurance companies, there's a bit of a tilt to the table when it comes to making pricing information available. Insurers are starting to disclose a hospital's "pricing" on their websites, and this can be somewhat misleading since list prices are rarely what the consumer pays. Yet providers can't discuss the amount that is actually received from the insurance companies because of anti-trust regulations. So there's a big inequity in that process.

Groeper: Along with this, I think one of the biggest challenges that we're going to face—and we're already facing it to a certain extent now—is pay for performance.

Others of you nodded. What about pay for performance is so troubling?

Washa: Looking forward in terms of pay for performance, I just don't think we'll be seeing incentives. Instead, I think there is more concern that there will be penalties for underperformance—it will be a punitive system for those who don't meet the bar.

Ziegele: We have a contract or two that pay bonuses for quality, but essentially, we've given up some of the top side of negotiating an increase with that payer. Also, at this point, the quality information that those contracts pay on is just retrospective. We're making a large information system investment that theoretically, with a more

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Dennis Gooche, regional patient financial services director at Adventist Midwest Health.

William E. Groeper, CFO at Norwegian-American Hospital, a 200-bed acute care hospital in Chicago.

David A. Nelson, vice president of finance and CFO for St. Francis Hospital and Health Center in Blue Island, Ill., a 410-bed, Catholic, not-for-profit organization, and a member of SSM Health Care.

Andrew J. Stefo, CFO at Palos Community Hospital, a 436-bed, not-for-profit hospital in Palos Heights, Ill.

John F. Valles, senior vice president at Loretto Hospital, a not-for-profit community hospital located in Chicago.

Brian M. Washa, senior vice president, Evanston Northwestern Healthcare, an academic health system affiliated with Northwestern University, based in Evanston, Ill.

Paul Ziegele, CFO at Adventist LaGrange Memorial Hospital, a 274-bed facility in LaGrange, Ill., and a member of Adventist Midwest Health.

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robust clinical system, should be able to support care maps that include more of those quality indicators. However, while this investment might help us be better prepared than competitors for a performance-based payment system, again, it is mostly downside that we anticipate limiting. There's really not a lot of upside.

Nelson: When you look at what Medicare has done in terms of pay for performance, one of the biggest concerns that we have is that things like mortality rate are being included in the criteria used for measuring quality. Mortality rate doesn't tell you anything about quality of care; it tells you about the population that might be in your area. If you've got an older population, it may trend to a higher mortality rate than if you were in a young, up-and-coming neighborhood. Such issues need to be understood, and sometimes I think even the government hasn't thought through all of the pieces. So it's going to be our job to try to educate them about having quality indicators that really mean something.

Pricing transparency also came up as a top concern. What are some of the biggest challenges that providers are likely to face in this regard?

Stefo: You could have 40 contracts and then add Medicare and Medicaid onto it, and the expectation is that ideally, you want your scheduler to be able to tell the patient, 'When this is repriced, it's going to cost X. Your plan is structured in such a fashion that you'll owe Y. You need to show up with Y? Well, to do that, the provider will have to be able to push not only the contract payment schedule but the plan structure through a mechanism that's understandable for them, and such systems don't exist today. On top of that, you will need to work with the patient to understand these structures.

Plunkett: How open have your third-party vendors been in providing "the black box" or any kind of detail as to what their true edits are?

Stefo: They don't have much at all really. What they've provided is very basic.

Nelson: That is exactly right. You can't always figure out the cost because of the system. The other problem that providers still have with the managed care industry is silent PPOs. You'll have a patient come in with an insurance card that may have six different logos on it. When the payer gets that bill, they are going to figure out which is the best price they are going to pay and the healthcare provider doesn't always know what that is. So giving patients an accurate estimate of their payment obligation upfront becomes a very difficult issue.

Gasbarra: Another complicating factor is that you can't be certain about the cost of services someone is going to receive. For example, you have the old type of stent at \$600 and you have the new drug-eluding stent at \$2,500. With the old stent, you used one; but with the drug-eluding stents, you may need to use two or three. So then the provider is in the difficult position of having to tell the patient, 'Well, you have to come in and have this service. It may cost you X, or it may cost Y, and we just don't know until it actually occurs.'

The growing number of uninsured and the dynamics associated with increases in self-pay were also mentioned as a concern. Experience shows pricing for this population can be a challenge. Do any of you have a way that you do repricing internally for your self-pay or uninsured populations, other than just doing a financial analysis?

Ziegele: We have been stuck with very simplistic pricing where, if you're in the emergency department, it's going to be X. If you're coming in for some sort of elective surgery, we're just going to have to give you the range. But let's be candid: With the uninsured patients, we're really not getting much of anything, so something is way better than what we have now.

Nelson: What we've done when uninsured patients come in is simple, and I think a lot of facilities have done the same thing: If you are uninsured and can't pay, we'll give you a standard percentage discount on the final bill. If you pay within a set period of time, then we will give you an additional percentage discount. That's about as simplistic as we can make it.

Valles: Just be careful how you collect.

Many organizations are using technology to enhance processes throughout the revenue cycle, particularly in relation to coding and obtaining necessary preauthorizations. Do you have any advice on how to generate buy-in from the clinical side of the business for these measures?

Stefo: Understand that obtaining clinical buy-in is a long-term process and isn't accomplished quickly. You have to approach these staff with the understanding that they're not working in clinical areas because they wanted to be accountants. That's the reality of it—most clinical staff like practicing in the clinical arena and prefer not to deal with business issues. So when it comes to obtaining buy-in, first you have to go through a long cycle of getting them to trust finance areas, and only then can you start building off of that.

Nelson: Discussions to generate buy-in should be framed around the importance of optimizing revenue. We're fortunate that our vice president of medical affairs has an MBA and understands the business issues. But when we have clinicians in the group at the table, we really stress the main issue of how we are going to generate revenue, because it comes right back to that. If I can't maintain a healthy bottom line, then I'm not going to be here doing things for the community at all.

Our facility, which has gone through some huge turmoil over the past five or six years, has made great strides in terms of cost-efficiency. We have set the benchmarks for the system for our costs per adjusted patient day and adjusted admissions. We are the lowest ones in the system



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for supplies. And we are running at the benchmark for all of our staffing levels. We had an \$8 million turnaround, but it's still not enough to get us over the hump. Clearly, the issue becomes revenue. And so, after living through all of those things, staff at our facility have recognized that, as efficient as we are, if we don't pay attention now to the revenue cycle and really put our arms around it, we're not going to be successful.

What other intersections with the clinical side do you anticipate being important to revenue cycle operations going into the future?

Ziegele: The next thing that we're going to need their help with is this: When somebody presents at your registration desk, how much cash are they supposed to leave with you before they go any further? When somebody calls, they are going to want transparency regarding cost. They don't want to know what your charges are. What they want to know is, 'If I need to have cataract surgery with a lens implant, what will you expect me to pay?' And they will want to have your frontline registration folks be able to quote this figure at the drop of a hat. And you can bet that they are going to share this information with the physician. And is the physician going to hear the same answer from three different patients that he may have sent to you? It gets very complex. Clearly, you're going to have to get clinical folks to understand the complexity.

That said, I do think those on the clinical side are starting to recognize the importance of working with finance. They see how we have had a run up on the revenue half of the equation, and they don't want to be stuck on the expense half. So if that means having all emergency department patients cycle back through a financial counselor prior to discharge, they are probably going to be more supportive of that now than at any point in the past 10 years.

Nelson: I think getting their support in terms of documentation is another area that's key. What the physician accurately documents in the chart can make the difference in moving a DRG from getting paid just your hospital base rate to getting paid your hospital base rate plus an

additional percentage. It's just about thoroughness of documentation.

To this end, we have had a physician group out of California come in over the past two years and review medical charts. Based on their observations, they meet with specific groups of medical staff, such as the orthopedic surgeons and the cardiologists, and show them how adding just a few simple words in the chart to properly document a case can ensure a claim is comprehensive and what the effect will be on the hospital's payment and physician billing. This has helped bring the physicians' attention to the issue and has been very successful for us. When you coach physicians on charting in this way, you have to tie it into how the physicians are going to increase their income, because they have also had their payments cut dramatically during this process. If you make it only about the hospital, they don't want to hear about it.

Stefo: Gaining physician buy-in to improving documentation and other revenue cycle-related initiatives is going to become more difficult now that physicians are losing income levels. They're branching out into ambulatory services and paying less attention to what goes on inside the hospital. It's very much an uphill battle.

On a positive note, it may mean the demise of the old reticent medical staff since hospitals are going to have to get physicians willing to play ball, understand the economics, and make the kind of adjustments that are necessary. The way hospitals are all structured today is that the physician applies for privileges and then gets privileges. Sometimes you get people who cooperate, but lots of times you don't. Looking forward, however, we're not going to be able to afford people who won't cooperate all the time anymore. That's how we'll get the clinical buy-in.

How big of a priority is setting long-term strategy to examine revenue cycle issues?

Stefo: I don't think we CFOs traditionally look forward a whole lot, because we end up spending more time solving immediate problems. There are far too many changes, frequently introduced by payers of some sort, that really play havoc with your organization in terms of what you have to accomplish in order to be successful.

Washa: In terms of planning and prioritization, our preference is to set a plan for the year, decide which systems we want to implement, and then stay the course. Otherwise, if you followed every lead, every phone call, every new technology, that would be a formula for failure. I've been looking for new technology to move us toward more automation. That's really the vision for revenue cycle in the future: less manual forms, more systems.

How does your organization conduct planning to stay on top of revenue cycle challenges?

Gasbarra: My organization includes a corporate office and six hospital ministries. So what we have is a revenue cycle committee that's directed through the corporate office but has representatives from all the hospital ministries, the PFS area, managed care contracting, reimbursement, patient advocacy, and so forth. We try to pick up as many different views on issues that we're facing in the entire revenue cycle area, from front-end and patient access issues to coding and documentation issues to CDM issues, which seem to be constantly changing and migrating at every turn, to the 170-plus transfer DRGs that Medicare launched this past year. That committee meets regularly, at least once a month, and it works top-down as well as bottom-up from the individual organizations bringing to the table the specific issues that each of them is dealing with at the time.

Gooche: In my organization, patient financial services meets about twice a month with the CFOs of our three hospitals. We discuss things such as denials or problems we're having with upfront data we're collecting. From that forum, we've spun off other type of meetings or committees.

For example, if we are seeing denials in radiation/oncology relating to the Medicare side, we've been able to identify the issues and take this information to those departments involved in the process, calling in case management, if that's what it takes, or the radiology director, or any of the other players that feed into it. We try to reduce the denials and figure out where the failure occurred. Was it registration? Was it HIM? Did a case manager fail to obtain pre-certification for extra days on the inpatient side?

Nelson: For the past six months or so, we've had a group get together every month to look at revenue cycle performance-based criteria and measure how well we're meeting them. It's a multidisciplinary group that includes the care management team, medical records, patient financial services, the vice president of medical affairs, and myself. We also include our director of quality performance improvement, because a lot of this has to do with trends in this area and benchmarking quality data.



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