



HFMA Executive Roundtable: Diagnosing Revenue Cycle Opportunities

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For any healthcare organization to maintain viability and serve its community, high performance is the key to success. Providing quality care and making the most of medical and technological breakthroughs go a long way in elevating market share. Yet any service line addition or operational modification affects the way an organization manages its revenue cycle. Today's industry leaders are identifying and implementing revenue cycle strategies that help ensure their positive outcomes are financial as well as clinical.

HFMA recently brought together a group of healthcare finance executives to share what improvements their organizations are implementing to overcome revenue cycle challenges and make the most of opportunities. The event was sponsored by MedAssets.

How Do Your Revenue Cycle Groups Interact?

The complexity of revenue cycle management was reflected in the roundtable participants' response to this question. Departmental representation varies, as does the frequency of meetings and their focus. One organization holds "issues meetings" every other week, which are attended by the vice president, chief financial officer, comptroller, IS director, HIM director, registration director, and others. Attendees analyze a list of fiscal and IS issues and try to come up with solutions. Another organization has what they call a New Age Revenue Cycle (NARC) committee composed of many revenue departments, which meets once a week. In addition to resolving issues, attendees make

sure all new services are covered. Participants agreed that it is important to focus on ROI, governmental, and coding issues, as well as to ensure the appropriate amount of information is shared with different levels of the organization.

One participant said, “We talk about planning for the future to make sure that we have a revenue cycle input into any new services coming on board, so that we can do an ROI and review how we’re going to set up the charging to make sure the system is going to work.”

Another participant added, “We actually have two separate meetings. We have one revenue cycle team; then once a month we bring in all the department heads from the ancillary areas, with the coders, with everybody else, and that group feeds back up into the big revenue cycle team. So we have two separate meetings going on monthly and that’s helped us a lot, because it’s brought the ancillary departments in. They work directly with the CDM coordinator, with their chagemaster, with their charges. They have to review their charges on a daily basis, and it has to be reported back to the VP of Finance.”

The NARC committee members invite different departments to their meetings. “We have them join us to explain things that they are doing. We have t-shirts for them that say ‘I survived NARC’ because we ask a lot of very pointed questions when they have issues. But it’s actually been very positively received by the clinical area.”

What Incentives Do You Have in Your Organization to Improve Key Performance Indicators?

Responses ranged from monetary incentives for cash collections and penalties for too much bad debt, to bonus systems for the entire hospital based on net profits. Departments are also rewarded based on their customer service and registration ratings. Some facilities use point systems that allow employees to “purchase” items from gift catalogs. Participants agreed that incentives should create a team atmosphere and be appropriate for each business unit. Further, they should periodically be modified and “mixed up” so that employees continue to be motivated rather than eventually viewing incentives as entitlements.

One participant explained, “We’re a union shop, so that was very difficult to implement when I arrived because they don’t allow them to treat a particular section of their members differently from other members. But we give a monetary incentive for cash collections, days in ER, aging over 90 days, but then if we write too much off to bad debt, there’s a penalty.”

Another participant offered, “We have something that’s unique. Ours is tied in directly to the bottom line and includes, of course, our cash collections, write-offs, gross revenue and so forth. Once the hospital reaches a certain percentage of net profits, we have a bonus system for the entire hospital, right up from the house-keeping staff to dietary, and including the president. And last year we were able to give out three bonuses. So that instills a real team atmosphere. Last year we gave one out in November that was based on the

October figures, and everybody thought it was going to be a Christmas bonus. Three weeks later we released the November figures, and they were just as good, so they gave out another bonus right before Christmas. The president hands the checks to all the employees and thanks them. He even comes in on the third shift to do it.”

One organization is making the most of technology in its incentive efforts. “Each facility or registration area within the facility, be it an ED business office or an admissions business office, has its own KPIs, and we incentivize them for upfront collections and customer service rating. We’re starting to incentivize them based on the quality ratings of their registrations. We have a product that allows us to do 100 percent automated QA every day. We used to do only 10 percent manually, but we’re now doing 100 percent with the product. And it keeps statistics on every registration for every person, so it’s all automated.

“If you’re in CBO, you’re incentivized depending on what we want to do. It could be the bottom line; it could be your collections unit performance. We try to juggle it so that people don’t become stale and just expect their incentive in the whole thing. But we always push the net revenue. And we constantly raise the bar. We raise the bar on customer service. And we don’t make huge increases to try to knock out the incentive. We just try to keep everyone motivated and not become stagnant. Our CBO is offsite. We had a banner year, and in September they blew away the goals, and that was our fiscal year-end, so they got the whole month of October in jeans. Now, they’re a

uniformed area. We have specific uniforms—there are business suits in the registration areas and there are more casual business uniforms in CBO. So it’s a huge motivator to wear jeans.”

Another organization rewards the CBO in a different way. “They select an employee of the month in the CBO, which has 240 people. We have a six-foot-tall trophy, and that trophy goes from person to person each month. It’s set in the individual’s cubicle, and you can see this massive trophy that comes out the top, because everyone can look across and see it. The trophy cost a couple hundred bucks, but we’ve been using it for three years now.”

Participants also suggested the following ideas:

- “Give a month’s free parking. The employees have to pay \$80 a month for parking, so we purchase an extra spot in the parking lot. I put that in my budget.”
- “I send a little card with a handwritten note to employees at their home address. Once a week I select somebody and send a note of appreciation.”
- “One person I spoke with takes his bonus money, breaks it down into \$10 bills, and keeps them in his pocket. He walks around the work areas, and if he sees somebody doing something special, he’ll give them a \$10 bill right on the spot.”
- “I give stars periodically—everybody wants a gold star, so I only give gold stars. But it’s interesting to then see staff members give other staff members gold stars for something they did. You know that you’ve actually affected someone, which makes me feel absolutely wonderful.”

- “We have a Gem Award for going the extra mile, which can be given by employees or managers. We do the presentation each week at a meeting. Those awards can be used toward purchases out of a gift catalog.”
- “We take play money and hand it out to employees in the Cancer Center who do something special. You can use those bucks in the cafeteria and the gift shops. And whoever takes them in then just charges it back to the cost center associated with it. So it’s a really inexpensive motivator. A lot of people don’t even spend the dollars. They just keep them and put them on the wall.”

To make sure employees stay motivated, one organization has “gotten creative with different games and we’ve gotten creative with different measures, and that’s helped because no one really knows at staff level what might be offered. I even got on the CBO’s overhead paging system and said, ‘You know what? If you guys set a new cash record this month, I’ll bring in a restaurant and we’ll have barbecue for 250 people.’ They blew the doors off, and I had the barbecue company come in.”

What Departments in Your Facilities Are Collecting Cash?

Participants agreed that in today’s complex healthcare environment, when it comes to collections, “cash is no longer king.” Credit cards and checks allow better tracking and accountability, especially with deductibles and copayments being collected in the ER, central registration, and the hospital’s physician practices. The right IT systems and the right scripts for employees requesting payments are vital to accurate tracking

and a high rate of collections. Systems throughout the organization should show outstanding balances, and employees need to be trained to look for these open accounts. In addition, the growing trend of high-deductible health plans is making upfront collections more complicated.

One participant explained, “We came up with all these scripts, and what works best is when the representative says, ‘The system is telling me that you have a \$50 copay. How will you be paying for that?’ By keeping the individual out of it, 9 times out of 10 the patient pays. But if the representative says, ‘I calculate that you owe \$50,’ then the patient tries to challenge it.”

Another participant added, “A similar case is to have a copy of the policy actually signed by the president of the hospital, encased in plastic right at the work area. The employee can then say, ‘Here’s the policy. If it were up to me, I wouldn’t be asking, but the president says we have to collect.’ And it works out okay.”

To reduce the potential for negative community perception, one organization “started all of our upfront collections simultaneously with all the physicians requiring their copays and things to be paid at the time of service. So our community is now totally in the mind-set that I have to pay something when I come through the door, whether it’s a physician practice or a hospital.”

Some organizations are using technology to simplify the collection process. “We implemented an online solution, said one participant. “You just buy a kiosk and run the credit card right online. And if the patient writes a check, they just put the check through and it scans it and sends it right to the bank.”

One participant's organization is using a software application to focus on deductibles and copayments. "We don't collect coinsurance because it's too much of a headache on the back end. For a long time, we never collected from our Medicare population that didn't have a supplemental, because under APCs you never knew exactly what was going to be paid. But then we found a software application that we just linked on everyone's desktops in registration and you just pop in the CPT codes of the diagnostics and it will tell you exactly what the patient's copay is. So we've begun collecting all that; it's really a cheap little product. Boom, you're up and running. It's your wage index. It's your information."

Another participant said, "I've worked with medical center leaders that built their own web-based cashiering system because they own a couple hundred physician practices and a lot of outpatient facilities. They didn't find anything in the market that really did what they wanted it to do, so they built one. They put their credit card payments into it. They do remote check captures, and then they put their cash in. And then alerts go around to all the different areas that they're out of balance. It feeds back into a reconciliation system at the end of the day."

As to the effect of high-deductible plans on the process, participants voiced concern. Asked one, "When you identify a high-deductible health plan, do you treat that patient's entrance into the organization differently from somebody who has a lower deductible health plan? The reason I'm asking that is, we just put a process in place where...anyone who has over a \$2,000 deductible, once the patient's been scheduled, if they cannot come up with that deductible, we will remove them

from the schedule. And that's something we've never done before on an insured patient. So we're essentially treating a high-deductible health plan patient like a self-payor uninsured patient, because that's the same process we go through if they can't come up with their deposit. And if it's not life-threatening according to the physician, then we will reschedule that patient until they have the opportunity to come up with the funds necessary to meet the payment guidelines of the organization. So we're now taking an insured population and treating them in that same fashion because of that big front-end deductible."

Another participant added, "One of the national restaurant chains offers two health plans for its non-management staff. One of them has a maximum coverage of \$1,000 a year and the other one \$2,000 a year. That's all the healthcare coverage that the employees can buy. Management is on a traditional health plan with full coverage. But we're seeing it more and more where a lot of these large employers, especially in the service industry, are just pushing out things called a health plan, but they're just such limited benefits. And it's a difficult discussion sometimes with the patients, because they think they've been paying for health insurance and they don't understand."

Process and Outcome

Participants spoke about some of the challenges involved in maintaining the fiscal health of their organizations and the physical health of the communities they serve. As the cost of healthcare continues to escalate, consumers are having more out-of-pocket expenses and payments to hospitals are such that hospitals have difficulty maintaining an adequate margin. More than

ever, the field is looking to healthcare financial experts for solutions. The common thread in the responses from this group is the need for a systematic process that links all aspects of the revenue cycle, from scheduling to collections—a process that ensures appropriate communication takes place, that necessary data are captured, that data are transformed into actionable information, and that improvement actions are taken, and that improvements are achieved and celebrated. The importance of technology to enable this approach was highlighted repeatedly. Ultimately, all participants recognized that the goal of the revenue cycle function, like all functions in a hospital, is to serve patients. That service includes making sure the hospital remains in sound financial condition so it can continue to provide high-quality care, and it includes effectively communicating with patients about all things related to payment—a special challenge with the advent of high-deductible health plans. An effective revenue cycle means not just that a hospital receives appropriate payment; it means that patients receive needed care.

Roundtable Participants

Jeff Brownawell, vice president, Memorial Hermann Healthcare System, Houston

Lesla Klepper, CBO director, Novant Health, Winston Salem, N.C.

Linda Kline, senior director of patient financial services, Johns Hopkins Health System, Baltimore

April Langford, director of revenue cycle, University of Pittsburgh Medical Center

The moderator for the discussion was **Sydney Rountree**, senior financial officer, MedCentral Health System, Mansfield, Ohio.



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