Improving Cash Flow

Whether it's focusing on faster payment, more efficient accounts receivable management, or improved billing processes, providers that examine revenue cycle operations often find opportunities to improve cash flow. HFMA, with sponsorship from MedAssets, convened a group of senior healthcare finance executives in New York to share their successful strategies—and future plans—for keeping their organizations' revenues protected.

Prompt payment is key to maintaining healthy cash flow. What advice would you offer to financial executives about where to focus their cash-flow improvement activities? What have you done at your organization?

Shapiro: We have rehauled our front-end processes. There's nothing more important than getting it right in the beginning. I'm talking about the nuts and bolts—verifying insurance and following up with patients while they're in-house. You could call it Revenue Cycle 101.

Langfelder: I agree with you that keeping an eye on the front end is critical. On the back end, we have had success with implementing automated work lists, which allow our billers to work smarter and more efficiently. These work lists are broken down by every category imaginable. They're terrific.

May: Besides front-end and back-end improvements, you also need to improve your business relationship with payer representatives if you want to minimize interruptions in payments.

Onifather: I'm looking at it from the electronics side, trying to do whatever I can to bring those processes in-house. The goal is to make it seamless—make sure that the patient is registered correctly and coded properly. You want to scoop up the payment electronically so you can start to work on the exceptions.

Shapiro: The patient's responsibility for payment is increasing, so many of our efforts have focused on collecting these amounts on the front end rather than chasing them down on the back end. We didn't try to collect copays up front until recently. There was a concern that asking patients for money up front would drive them away. We tried it on a pilot basis, however, and discovered that it hasn't affected patient satisfaction. I think patients expect it at this point.

Adams: Collecting copays up front has become commonplace in physician offices. And in hotels, it's assumed that you will need to present a credit card for incidental charges. This is a similar concept.

At Holy Name Hospital, here's how our process works: upon registration or prior to registration for elective services, our registrars input patient insurance information into the system. That system electronically verifies eligibility and provides specifics about the patient's coverage, including deductibles and coinsurance. Then we repopulate the internal system with that information. At that point, it's the registrar's responsibility to tell patients what their responsibility is and to collect it at the time of service.

How do you estimate patient financial responsibility for upfront copays and determine patient eligibility?

Langfelder: We use a system that verifies eligibility and determines copays electronically, which has helped a lot.

Skulnick: More than 90 percent of our admissions come from the emergency department. It's a little harder to collect any payment on the front end in an emergency situation. We do have an emergency department private practice that shares in the collections, and that has helped.

May: I observed a process that worked well in an ED at another hospital. They tell patients who are treated and released that 'a clerk will come in to wrap things up with you' before the nurse comes in to review discharge instructions. So patients know to expect a request for payment, and that seems to help.

How do you prioritize which areas will present the best opportunities for improving cash flow?

Adams: Let me start off on this topic. We're looking at our point-of-service collections in high-ticket areas like radiology. As patient responsibility increases, there is an opportunity to collect more dollars from fewer patients by implementing point-of-service collection practices for these high-cost services.

Shapiro: I analyze bad debts every six months. I don't worry too much about detail; I simply want to look at the largest bad debts and see if I can detect any patterns.

Langfelder: Medical records is a big source of DNFB (discharged not final billed). Coding issues may be a bit outside of the finance department's purview, but it's a critical piece.

PARTICIPANTS IN THIS HFMA ROUNDTABLE:

Gregory Adams, FHFMA, senior vice president and CFO of Holy Name Hospital in Teaneck, N.J.

Wael Fakhry, vice president of reimbursement for Continuum Health Partners, Inc., in New York.

Richard Langfelder, executive vice president and CFO, Lutheran Medical Center, Brooklyn, N.Y.

Stuart May, CFO for North Bronx Healthcare Network, Bronx, N.Y.

Jeffrey Onifather, executive vice president of finance at Cornerstone of Medical Arts Center Hospital in New York.

Robert Shapiro, CPA, FHFMA, senior vice president and CFO for North Shore LIJ Health System, Great Neck, N.Y.

Mark Skulnick, vice president for finance and CFO at Peninsula Hospital Center in Far Rockaway, N.Y.

I tell everybody, 'We don't have financial systems; we have clinical financial systems.' You cannot separate the two.

Adams: Years ago, the financial systems were much further developed than the clinical systems. But in recent years, with the advent of CPOE (computerized provider order entry), priority has been given to developing clinical systems. Now, our clinical systems far outpace our financial system's capabilities.

One area that often presents opportunities for cash flow improvement is billing. Do you have any quick tips to help boost staff productivity in this area?

Langfelder: One thing that we've been doing recently is benchmarking our employees on their productivity. Supervisors can then counsel individuals who are less productive than others, and that has been very helpful.

Onifather: Our billers work from electronic collections lists, which facilitate productivity monitoring. With electronic systems, the quality of employees' notes and documentation is very important.

Skulnick: We have actually changed our billers' working hours so they can use the information system when it's less busy. That has enhanced productivity.

Use of management reports and key performance incentives also is commonly cited as contributing to improved cash flow. Which performance indicators do you track at your organization, and how does this process work?

Shapiro: We measure a dozen key items—the basic accounts receivable efficiency measures—and then build team unity around the results: bringing the business office and the front end together. It's amazing what can come of that process.

Langfelder: One of the performance indicators I didn't look at until recently is the number of medical records that never get off the nursing unit—that never get to the biller at all. By sitting down with nursing and medical records personnel and focusing on those, we have made inroads into our DNFB and A/R (accounts receivable).

Adams: We have bill holds for all patient types. In other words, we hold bills for a predetermined period of time to ensure all services are charged for. This is, in effect, a hidden DNFB. We're working on dropping those bill holds, because that amounts to an A/R that's not really tracked anywhere. We know that if we can reduce our bill-hold days, we'll increase our cash flow.

We also have implemented a work flow tool that prioritizes work for the billing staff. It tells us the number of EOBs (explanation of benefits) that need to be worked and the number of bills that are being processed, down to the biller level.

May: One dashboard indicator I like is the number of claims going out. This is a good barometer to ensure your systems are working. This is especially helpful after an upgrade, when things don't always crosswalk over appropriately.

Langfelder: If you're dealing with multiple facilities, then a P & L (profit and loss statement) for each off-site facility that shows cash collections can be useful. At my organization, communications in this area between the hospital and the off-site facilities were poor until we provided these reports. Then managers began looking at them and saying, 'Wait a minute. I know I collected more than this. I know there were more bills out there.' The P & Ls generated so much interest and brought attention to these types of situations that our cash collections almost doubled in a couple of sites. So I think getting people information that helps them do their jobs really does work.

May: I see the same sort of response when we give our clinical department heads a daily transaction report that shows them what actually got through the system. Often, they know what their volume was and they can spot problems upstream when they see those reports.

What steps have you taken to improve charging accuracy? What sort of monitoring processes do you have in place to support charging accuracy?

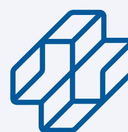
Langfelder: We have so many carve-outs now, that it's more important than ever to make sure we're capturing all the services we are delivering. We do a revenue and usage report, as my colleague was just describing, and send it to the clinical department heads. And we see similar results. The department head says, 'Wait, I did 100 of these, you only see 50.' And I say, 'Well, you only gave me 50.' Then they realize what they haven't reported to us, and it's worked out very well. But you have to keep on top of it all the time because they tend to stop reading the reports after a while. It's an ongoing battle.

Shapiro: Charging is primarily automated these days—except in procedure-based areas like the cardiac cath lab and interventional radiology. There are tremendous opportunities in these areas to make sure we have the charge capture and the documentation right.

How often do you provide clinical managers with financial information?

May: In an area like radiology, I like to give a daily charge report to the clinical manager. Another important report is the monthly denial management report that is provided to the service line administrator.

Skulnick: Most information systems have transaction error or rejection reports that go back to the clinical departments. I noticed early on that it takes some departments two to five months to correct those reports. So we have implemented a three-step process to address this problem. First, we keep a log to document when departments give us corrections so we know what is happening on a daily basis with the major ancillary departments.



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Second, we engaged a consultant to review the major ancillary departments and identify uncharged items that should be charged. Finally, we implemented a strategic pricing initiative to assess our charge structure for charge-paying patients. We've been pretty successful, even though the corporate culture in a community hospital is not oriented toward getting paperwork for finance or billing.

Adams: We discovered that information about outpatient denials was not getting back to the clinical department heads. So we started forwarding all denials to department managers electronically. Even though that's retrospective, it gives the department heads the data they need to research the denial and identify trends, and to make operational changes accordingly.

Shapiro: We know that a decision support system is one of the most important tools we have but at the same time, we recognize that too much information can be overwhelming. So we continually encourage everyone to utilize the system.

Adams: We need to get all the clinical managers who are running the operations much more involved in the process. It's critical to get the information out of the finance area and to the users who really know what's going on in their departments. For example, we have the managers review their chargemasters periodically because we have found on some occasions that new procedures are introduced but nobody ever sets up charge codes for them, so they're not being billed or are billed incorrectly.

May: That's a great example of why it's vital, when you're building product line or service line reporting, to bring in the clinical folks and say, 'How are we going to define your area?' Involve them early on and get that buy-in.

Are payment denials as much of a problem as they have been in the past? What strategies have you used to address this challenge?

Onifather: Denials are more of a problem than ever. The key is good documentation and it all comes back to basic training. Good documentation of all interactions between billers and payers is essential.

May: As denials increase, it is important to move toward concurrent reviews and eliminate some denial issues.

Langfelder: We make sure that billers have all the specifics on denials so they can follow up quickly. That's essential. We also address problems with denials when we're renegotiating managed care contracts.

Shapiro: At the end of the day, managed care contracts are the key. We are not afraid to litigate when payers try to introduce a new method that is not consistent with our contract. It helps level the playing field a bit when the payers see that we're not just going to ignore that kind of situation.

Langfelder: We're not shy about reporting to the Department of Health when managed care companies don't do what they're supposed to do. And that strategy is very effective.

Adams: When we're analyzing contract renewals, we do a net payment calculation. That enables us to document the real increase in rates and the impact of the denials—it's reflected in the payments.

Langfelder: Downgrades are a bigger problem for us than denials. We negotiate only an acute rate. The following year when we renegotiate, we make downgrades a central issue in the negotiating process.

As we move toward consumer-directed health care, self-pay responsibility is increasing. What sort of structures are you putting in place to respond to this trend?

Fakhry: We track point-of-service collections. A bureau registers elective patients beforehand and ensures that the necessary authorizations are in place when they come in.

Shapiro: I agree that in the next three to six years we will be grappling with the impact of payers shifting costs to patients. But that's a short-term solution. In the long term, access and healthcare costs have to be addressed on a public policy level.

Langfelder: I agree, but I don't think we'll see that happen in our lifetimes. It's just not realistic to expect anything more than an incremental approach to healthcare reform, and that doesn't seem to be solving the problems.

But going back from the visionary to the pragmatic level, if I may, my organization is working on initiatives such as implementing electronic posting of cash throughout the facility and keeping patient accounts in-house and away from the collection agencies a little longer. We also are working toward adopting electronic medical records.

What are your most important strategies for improving cash flow?

Langfelder: With our large Medicaid population, we have focused on improving our Medicaid application process and communicating our charity care policy to patients. As a result, we have increased our Medicaid submissions and applications dramatically. Many patients don't realize that Medicaid coverage will take the financial burden off of them. We work very hard at that for ED patients as well as elective admissions.

Adams: Some payers are selling their managed care rates without providing the level of protocols and utilization management we expect from managed care. That equation doesn't add up for us. It results in lower rates and payments than what we would have negotiated given the type of managed care product. It's an ongoing issue with some payers.

Shapiro: I think one of the most important things for us is a weekly high-risk account review, where case management goes through the high-balance, long-stay accounts. It's amazing how quickly these accounts can be resolved when they are identified early.

May: The care managers are the ones who can identify the long-stay patients early on. And they are the ones who can handle the social issues that might delay discharges.

Adams: It seems like much of what we are saying today is that improving cash flow has to be a coordinated effort. In the past, hospital operations were compartmentalized. Now, financial executives must look beyond the business office into the clinical departments for assistance with maximizing cash collections. It takes a group effort to identify cash flow improvement opportunities.

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