

HFMA Roundtable

No-Nonsense Tactics for Revenue Cycle Improvement

With reimbursement pressures continuing to intensify, technologies changing, and hospitals and health systems going through tremendous organizational and operational change, how can healthcare finance leaders help their organizations move toward their strategic and financial goals? One key area that has increasingly become a focus is revenue cycle management, because of its centrality to hospital financial health, and because of its vast opportunities for process improvement.

Through individual interviews, we've culled some opinions and perspectives from those out in the trenches who are trying to improve revenue cycle management. We hope you will find these perspectives useful and thought-provoking as you help your organization make process improvements and move toward process optimization.

The members of this HFMA Roundtable are:

- > **Jeff Brownawell**, vice president of managed care and government reporting, Memorial Hermann Healthcare System, Houston. Memorial Hermann is an integrated health system that encompasses nine acute-care hospitals, two long-term acute-care hospitals, a physician network for primary and specialty care, retirement living and nursing homes, rehabilitation and home health programs, and an air ambulance service. The system has 3,171 licensed beds.
- > **Patrick Buckley**, president and founder of OSI Systems, a division of MedAssets, Atlanta. OSI Systems provides revenue solutions by offering strategic pricing, pre-billed charge capturing, and ongoing charge master management.
- > **Ryan J. Fischer**, managed care manager, Truman Medical Centers, Inc., Kansas City, Missouri. Truman Medical Centers, Inc. is a 551-bed integrated healthcare delivery system composed of three entities—Truman Medical Center Hospital Hill, Truman Medical Center Lakewood, and the Behavioral Health Network—in the Kansas City area.
- > **Roland Funsten**, assistant vice president of finance, St. Vincent Health, Indianapolis. St. Vincent Health is a 12-facility, 1,700-bed multi-hospital system.
- > **JoAnne Tucker**, vice president of business services, Hoag Hospital. Hoag Hospital is a 409-bed community hospital in the Southern California community of Newport Beach. It has seven additional health centers throughout Orange County.

ABOUT HFMA ROUNDTABLES

With this article, HFMA launches a series of "virtual" discussions to offer thought leadership and practical perspectives on healthcare financial issues straight from the experiences of leading industry professionals. This first HFMA Roundtable offers viewpoints and advice about improving the revenue cycle. This HFMA Roundtable is made possible through the support of MedAssets, Atlanta.

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If you only had one day to improve your revenue cycle, what would you focus on?

Jeff Brownawell: If all I had was one day to look at things and then a little extra time to get them sorted out, and if the majority of my managed care business was on a percent-of-charge basis, I'd do a charge master analysis, and then optimize my charge master for managed care business. And if the majority of my contracts were per diems, case rates, or DRGs, I would be going through my contracts to make sure I had carve-outs for high-cost drugs, implants, and prosthetics, and that I had stop-loss thresholds in all of those contracts.

Roland Funsten: For me, the key area would be patient access—scheduling, preregistration, and registration—and what needs to be done differently there to improve the revenue cycle, as far as getting quality data captured and improving data integrity for the billing system and billing purposes.

JoAnne Tucker: There are really two questions there. One, to improve the whole process, what would you do? And the other question is, going after the most money, what would you do? For the whole cycle, we need to focus on delays in the cycle, whether coding, charging, things that slow payment down. On the other side, where I am going to get the most bang for my buck is to get into contracts and identify where we're not being paid correctly.

Patrick Buckley: Often there is plenty of “low-hanging fruit” that can be solved pretty quickly. For instance, cleaning up your charge master may significantly improve billing rejections, ensure complete and accurate APC reimbursement, and help ensure that all appropriate services are being billed for. The total benefit of cleaning up the charge master is often not fully appreciated, and the financial benefits of doing this are substantial.

Ryan Fischer: I would focus on the follow-up, reviewing all information, making sure that every dollar that is due to your organization for rendering services in good faith is collected. Ideally, your patient accounting department would be reviewing remittance advice, kicking in the whole denial management part of the revenue cycle to effectively deal with those denials, and appeal them if necessary. Then you get into the whole tracking and trending of denials. You want to target those areas where you're not collecting the revenue, so that you can go out and improve the process.

Where are hospitals falling down the most?

Tucker: I think internal processes fall apart, and we don't understand how what we do impacts others.

What is the biggest misconception providers have about improving the revenue cycle?

Fischer: A lot of times, the biggest misconception has to do with follow-up processes and resources. You see a lot of literature that discusses the importance of entering patient information correctly during registration. Certainly that's a part of the first stages of the revenue cycle, and that gets focused on. Clearly, getting information in correctly is important, as insurance information will dictate the whole revenue cycle. But to some extent, people are looking at just one piece; you've got to step back and look at the whole cycle in order to see the results and to make sure that enough resources are being allowed to conduct appropriate follow up. In addition I would rec-



Jeff Brownawell

commend that the more traditional follow-up processes be coupled with a system for reviewing underpayments, as well. I go back to the question, at the end of the day, is every dollar accounted for, and have you collected all revenue to which you are entitled?

Funsten: One of the biggest misconceptions is that you can do it with limited staff, and that you don't need to touch all of your open accounts. Many providers fall down there in that they just don't have adequate staffing levels to effectively work 100 percent of their accounts; they try to use the 80/20 rule, as opposed to managing 100 percent of their business effectively. Some hospital people see the patient accounting operation as an expense area, not as a revenue area.



Patrick Buckley

Brownawell: I think there's a big misconception out there that there's no money left in your charge master to optimize your charge master for managed care business. I think there is. And there's money out there on underpayments and denials that we're not going after as aggressively as we should as a hospital industry.

Who is the one person who should be given overall responsibility for improving the revenue cycle?

Funsten: I think providers should establish a chief revenue officer (CRO), just as they now have a CEO, CFO, CIO, and COO. The CRO should report to the CFO, but should have full responsibility for patient access, revenue generation, charge description master management, health information services, and patient financial services.

Brownawell: It really depends on how your organization's set up. In Memorial Hermann's case, I'm responsible for all that. All those areas from the business office to appeals to underpayment, government reporting, charge master, decision

support, report to me, and I report to the senior vice-president for finance/CFO, who is the CFO for our entire system of nine acute-care and two long-term care hospitals. Organizations are all different; but the whole cycle has to report to one person above a senior level, so someone can be paying attention to it.

Fischer: I'm a firm believer that it has to come from the top. You have to have buy-in from the top. So I definitely begin with the CFO, and then, depending on the organization's structure, that's going to translate down into a corporate director of finance, which then sometimes translates into a corporate accounting person, and below them, all aspects of billing, both professional and facility, as well as behavioral health. But it starts from the top.

Buckley: The CFO. No question.

What revenue-cycle process improvement can achieve the highest return on investment?

Brownawell: I think one process right off the bat is your charge master optimization. The key improvement you get out of that is net revenue. If you have contracts based on a percent-of-charge basis and you optimize your charge master, you'll see significant improvement. It depends on the last time you did it, and it depends on how much managed care you have based on percent of charge or carve-outs, or stop-loss agreements. It varies.

Tucker: In Southern California, where most hospitals have a tremendous amount of business through managed care contracting, I would be looking at contracts to make sure they're paid correctly. You get big money in really quickly. We've found bringing in a revenue-recovery firm to be very helpful. Besides collecting the money due, the firm has trained our staff to run queries

so the staff can more readily identify incorrect payments.

Buckley: This will certainly vary greatly by facility. But most industry studies and our own results show that one of the greatest opportunities is the capture of all appropriate charges—charges for services performed but not captured and billed. Most hospitals can improve their charge capture by 1 to 3 percent with better daily monitoring tools.

What are the easiest, most immediate “fixes” that can improve the revenue cycle? What are the most difficult?

Brownawell: I think the easiest and most immediate fixes are in upfront cash collection. If you’re not asking for cash and deductibles and coinsurance upfront before you perform the service, you’re missing out on a lot of money. However, the mentality of the hospital industry to collect upfront is not there; you’ve got to retrain your people to collect from patients, but when they can do it successfully, it has a definite, immediate impact. The most difficult is changing your business office processes to make them more efficient and to reduce what it costs you to collect more dollars. Those improvements are hard and take a long time to accomplish, if you’ve got problems in the business office. I would say that most people are working to improve their processes, but it is not an overnight fix; it takes time.

Fischer: Probably the easiest would be the most basic blocking and tackling: verifying insurance information and eligibility for each patient, following the terms of the patient’s insurance. In theory, it’s not that hard to do, but it takes time on the part of the staff. To me, those are really the basics. I believe that going back to basics can provide for an immediate fix, as oftentimes

things can fall through the cracks and there can be room for improvement at the most basic level. I would say that the most difficult thing is being able to obtain usable and credible information about your revenue cycle so that you can make changes. That’s difficult for a number of reasons. For one thing, hospitals have different information systems that often are the products of different vendors. Also, information is running through the organization at such a fast pace that integrity can be lost along the way. As a result, it’s difficult to drill down to get the information you need to do some type of analysis on your revenue cycle. We’ve got a lot of data but we don’t have a lot of information; as everyone says about health care, we’re data-rich, but information-poor.

Buckley: The easiest? Eliminating charge description master coding errors—that offers an enormous, immediate financial impact. Next is strategic price setting—making sound pricing decisions with facts and tools. Effective price-setting requires an understanding of the local market, competitors, and financial sensitivity and impact of price changes by service line. What’s most difficult? Educating the right people about how to improve the revenue cycle by first understanding all aspects of the revenue cycle, from the front-end patient interaction and eligibility determination to ensuring that payers are truly paying according to the terms of the contracts.

What is the impact of the supply chain on a hospital’s revenue cycle?

Funsten: There’s a considerable level of lost revenue based not only on items, but on services provided by clinical areas, and some of these services go undocumented and not charged to the patient. So there’s a considerable impact there. It’s the classic dichotomy between the clinical and the financial side, where the clinical side is



Ryan J. Fischer

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focusing on the delivery of care and not always focusing on the financial aspects of what they do. The solution is bringing the parties together and trying to educate the clinical staff as to their impact; as I put it, connect their work to their paycheck. And once you achieve that, you'll win.

Fischer: I think that the supply chain has two effects. First, hospital departments have a real interest in the supply chain. For them, the correct capture of charges and how those charges go against their individual budgets is extremely important. I take it down to a simple level. For example, if the operating room ordered 20 boxes of a certain supply that they need, how does the operating room know that those 20 boxes made it off the truck and up to surgery? How do they know that they got 20 boxes and not 10, but were charged for 20? With the clinical areas being supplied with more information, they can effectively monitor their inventory and usage so they can prepare their specific budgets and be accountable. Supply chain management needs to work closely with nursing and other clinical areas, as they are often the largest internal customers. Second, finance needs to be heavily involved with supply chain management to ensure that codes and charges are established for all reimbursable supplies. Also, it is important for finance to stay current with what supplies are reimbursable and which ones are not. There are many regulatory and compliance requirements that can change frequently. Therefore, supply chain management

is both internal, in terms of the impact the department budgets have on revenue, and external, in that a code and charge need to be established so that the hospital will be reimbursed for all supplies from external sources.

Buckley: Today the supply chain is separate and disconnected to the revenue cycle. Yet supplies are the second largest expense after labor. The cost of supplies used in patient care is significant, but is unknown at the detailed patient-bill level. The supply chain and revenue cycle need to be connected. There is tremendous industry need to watch supplies as a part of the revenue cycle to ensure all associated reimbursement occurs. The supply chain represents one of the few areas of controllable costs left in the overall equation. Plus, once the connected picture is created, then other areas are addressable, like being better equipped to negotiate managed care contracts and getting carve-outs where needed, understanding gross margin by service line or patient case, focusing cost management efforts where needed most, and overall better cash flow management. This leads to better strategic financial management and performance for bond ratings, and enabling lower cost of capital.

Do you see this as a fairly big issue?

Fischer: Yes, most definitely. Because with the kinds of high dollar procedures being done, and the kinds of devices being ordered for these procedures, it has a big impact on the departments ordering those supplies; and it also impacts finance, as they are responsible for coding and charging those items. In addition, it affects managed care and the hospital's ability to negotiate adequate payment rates for carve-out types of procedures and devices.

Buckley: Yes. By linking the master item file with the charge master, a more complete financial pic-

ture is created. On a tactical level, understanding the actual margin of patient cases where high cost physician-preferred supplies are used, such as orthopedic, cardiology, spinal, etc., will help focus efforts for cost control. Supplies that are reimbursable will be captured accurately by units and price for improved revenue. On a strategic basis, having full understanding of procedure cost, including supplies, and the resulting margin would better prepare the hospital staff for managed care contract negotiations to gain necessary carve-outs. Also, by linking supplies with revenue cycle—with actual costs, not averages being captured—greater accounting control and accuracy is achieved, which is very well received by bond underwriters and lenders.

What are the most important revenue cycle measurements to monitor?

Funsten: Cash collections as a percentage of net revenue. You want to achieve, on a month-to-month basis, 100 percent or better of that number in cash collections.

Tucker: Cost and reimbursement are important in a number of different categories. Everybody looks at days in accounts receivable, but there's no real standard in measuring gross or net. How much of your revenues go into collections? Look at delays; how long does it take to get a record coded? Some of those things have been around forever.

Fischer: Anything to do with the aging of your accounts, that's the number-one thing to be monitored. What I preach throughout my organization is, if you haven't received a payment or denial on your claim in 30 days, you need to contact the insurance company to find out what's happened. And by setting the 30-day thresholds, accounts can be worked timely before they become too old and nonpayment results. Second to that is monitoring your denials, and third is

that you need to be actively pursuing appeals.

Buckley: Days sales outstanding (DSO), expected receipts versus gross revenue, net to gross percent, and denial reduction.

What do you believe is the most effective way to motivate staff to improve their portion of the revenue cycle?

Brownawell: Incentivize them. I think that you need to have, as far as in your business office and cash collections side, set goals that are stretch goals but can be attained. If they are attained, your folks need to share in some of that cash you've collected, above and beyond their base salary. That gives people a goal, and then some reward, once they reach that goal. There are percentages that can be used throughout the revenue cycle that can be positive, and we're looking to put more incentives into our structure.

Funsten: You have to involve the staff and provide them daily feedback on their performance and how they're affecting the revenue cycle. It's the issue of connecting their day-to-day work to their paycheck and what it means to the organization.

Buckley: This may sound too simple, but help staff understand the larger revenue cycle and how their job fits and impacts downstream work. We work with many clients whose staff do not understand how doing their job correctly helps the process. These are often clerical and repetitive-task jobs. Track results and celebrate the successes. Get people excited about what they do. Second, give them software tools that help them do a better job and improve what they are responsible for.

Do you offer any kind of financial incentives?

Funsten: I am not doing so now, but I have in the past, with contests and awards on some sort of periodic basis.



Roland Funsten



JoAnne Tucker

Are there pluses and minuses to that?

Funsten: The pluses are that the employees are getting some sort of tangible recognition, whether monetary or not. The negative is, employees come to expect the award and don't truly appreciate it, and then you lose the impact of it.

Tucker: I think you train them well, you make them feel that they're a part of a larger organization, and you remove the rubs, the things that drive them crazy. Can I have coffee at my desk? Absolutely.

What do you think of financial incentives?

Tucker: I think they're hard to measure and get the right information. I think that it is not a healthy competition in the office, unless you make it one for all and all for one. Maybe group incentives would be better. And it's always hard to continually top what you did before.

Any final words?

Funsten: This area is going to be challenged more and more in the years to come, particularly the changing healthcare market nationally, so providers need to take a serious look at how to invest in their revenue cycle to achieve excellence.

Brownawell: I don't think there's any magic bullet out there. I wish there were. I think it's just a fact of focusing your attention on collecting as much cash that you're owed every day. This is kind of the blocking and tackling of the hospital business, but boy, you've gotta do it or you're in big trouble.

Buckley: Improving the revenue cycle is all about understanding the business processes, including linking those that are not linked today, such as the supplies item master with the charge master. But it's also all about using information technology tools that improve the process and eliminate the root causes of problems, so that staff can be much more productive and focused.

MedAssets improves healthcare providers' cash flow through revenue cycle and supply chain initiatives. MedAssets' OSI Revenue Solution, a proprietary tool suite, improves existing IT assets and revenue cycle performance.

