Introduction

Hospitals today are faced with rapid industry changes and greater financial pressure. The ability to quickly and efficiently process claims for reimbursement is not only important, it’s critical to financial success. Hospitals need to understand issues impacting their payment velocity that greatly influence the hospital’s outstanding accounts receivable.

The Pulse Perspective is a macro view into the billing processes of hospitals and the speed or velocity of payer reimbursements. The report leverages RelayHealth’s unique data assets representing millions of claims processed each year across the U.S. Using claims processed in 2012, we calculated the 2012 Median Payment Velocity for each hospital within the report’s dataset. We analyzed common hospital billing processes from patient service to payer payment resolution and defined a set of key performance indicators highlighting the entire life cycle. The performance indicators are used in the report to show the median payment velocity across all hospitals, U.S. regions and hospital size. In addition, the report defines the median score for hospitals with the fastest and slowest payment velocity.

The median score across all hospitals was 42.5 days to receive payment from the point of patient discharge to payer payment resolution. Hospitals with the best scores or fastest velocity received payments in a median of 26.8 days. Hospitals with the worst scores received payments in a median of 106 days, representing payment delays of 79 days.
2012 U.S. Median Payment Velocity

The 2012 U.S. Median Payment Velocity was created by scoring each hospital in RelayHealth’s dataset, then calculating the median days across all hospitals for each phase of the billing cycle. The common phases analyzed within the report include Patient Services & Discharge, Claim Generation, Claim Transmission and Payer Payment Resolution. Patient Services & Discharge represents the clinical services rendered to patients and the point of discharge. Claim Generation includes activities for updating the patient’s medical record, charge capture and finalizing any information necessary for creating the claim. Edit, review and release of claims to payers are encompassed within the Claim Transmission phase. The remaining billing activities are payer processes within Payment Resolution. These activities include payer acknowledgement of claim receipt, verification of eligibility and benefits, payer edits, and final adjudication.

RelayHealth created a set of key performance indicators aligned with the hospital’s billing cycle to measure payment velocity. Service to Payment Days measures the number of days between patient services to payer payment resolution. Service to Release measures all hospital activity such as medical records, charge capture, claim edit & review and release. It is further defined by Service to Submission and Submission to Release. Release to Payment measures all payer activity to adjudicate the claim for payment.
2012 U.S. Median Payment Velocity

Based on 2012 claim data, the median days for hospitals to receive payer payments from the point of patient service was 42.5 days. Processes within the hospital for the generation and transmission of the claim required a median of 17.9 days, which represents 42% of the Service to Payment duration. The remaining 58% was time allocated to payers for claim receipt, adjudication and payment. The adjudication activities include patient verification of eligibility and benefits, payer edits and resolution of payment.

The amount of time hospitals needed to edit, review and release claims was only a median of 1.4 days. Most of the processing time was devoted to generation of the claim prior to submission.

U.S. Region

From a geographic perspective, the median payment velocity across U.S. regions does not vary widely in 2012. The total time for hospitals to receive payer payments (Service to Payment Days) ranged from 39 days in the Mountain region to 50 days in the Northeast and Southeast regions.
2012 U.S. Median Payment Velocity

Potentially, the size of a hospital inversely correlates to the speed of payment. As part of the analysis, we stratified hospitals based on size using licensed beds. Hospitals with beds less than 100 were grouped as small hospitals. Hospitals with licensed beds between 100 and 500 were considered medium size, and hospitals with more than 500 beds were identified as large hospitals. The results indicate small hospitals released claims 3 days faster and received payer payments nearly 8 days faster than large hospitals. The Service to Release Days performance indicator ranged from a median 17 days for small hospitals to 20 days for large hospitals. Once again, the Service to Release Days indicator encompasses all hospital activity for claim generation and transmission to payer from the point of patient services/discharge. After releasing claims to payers, small hospitals received payment in a median of 21.3 days. Medium hospitals required an additional 5.4 days. Large hospitals received payments in a median of 29.2 days, representing a 36% increase in delayed payment compared to small hospitals.

Interestingly, the percentage of payer claim rejections for each hospital grouping ranked in similar order to payment velocity. Small hospitals had the lowest percentage at 5%, followed by medium hospitals at 6% and large hospitals at 8%. This may indicate a relationship between claim rejections and delayed payments. However, the percentage of payer denials is not consistent with payment velocity by hospital size. Small hospitals had the largest denial rate at 18%.

NOTE: To help hospitals opportunistically identify adjudication efficiencies and process improvements, RelayHealth includes partial rejections in its calculation of payer rejections and denials. While that inclusion results in higher rates than some industry sources, this deliberate approach provides a more comprehensive view of the adjudication cycle. Payer rejections represent claims failing payer pre-adjudication edits and requiring updates from hospitals to process payment. Denials reflect claims that payers decline payment during final adjudication processing.
2012 U.S. Median Payment Velocity

Profile of Best and Worst Hospitals

So far, we have taken a macro view of payment velocity by analyzing all hospitals in our dataset processing claims in 2012. Now let’s take a micro view and focus on a sampling of hospitals with the best and worst Service to Payment Days from our 2012 Median Payment Velocity ranking. Top hospitals were small-to-medium sized based on licensed beds, and the claim distribution across payers was uniform. They also had fewer inpatient visits in comparison to hospitals with the highest Service to Payment Days. Bottom hospitals were medium-to-large size, and the claim distribution across payers was not uniform. In fact, 74% of all 2012 claims were processed to commercial health plans.

There were stark differences with payment velocity between the top- and bottom-performing hospitals. The median Service to Payment Days for top hospitals was 26.8 days. The median Service to Release Days, which represents hospital processing, was 10.5 days. In other words, top-performing hospitals on average completed all claim generation (i.e., charge capture) and transmission activities in around 10 days. The remaining 16.2 days (Release to Payment) focused on payer activity such as eligibility verification, edits and final adjudication. Bottom hospitals had significantly longer processing delays. The median Service to Payment Days was 106, which includes 31.4 days for hospitals to process claims and 74.6 days for payers to resolve payment. This represents an overall 79-day delay in receiving payments in comparison to top hospitals.

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<th>Payer and Encounter Mix of Analyzed Hospitals</th>
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2012 U.S. Median Payment Velocity

Profile of Best and Worst Hospitals

Payer Denial and Rejection* rates may provide some insight into the disparity between top and bottom performing hospitals. Top hospitals were able to process claims with significantly fewer payer denials and rejections. The percentage of denials for top hospitals was 12% in 2012 in comparison to 28% for the bottom hospitals and 16% for the national average. The percentage of rejections was 4% for top hospitals, which is 5% lower than the national average and 8% lower than bottom-performing hospitals. Potentially, the payer mix between hospital groups may influence denial and rejection rates along with overall payment velocity. As mentioned, top hospitals had a more uniform payer mix in 2012 compared to bottom hospitals. Our data sampling of hospitals with best and worst Service to Payment Days indicate these bottom hospitals processed 74% of all claims to commercial health plans.

* Payer rejections represent claims failing payer pre-adjudication edits and requiring updates from hospitals in order to process payment. Denials reflect claims that payers decline payment during final adjudication processing.
**Conclusion**

The financial pressures impacting hospitals in 2012 are expected to continue and expand in 2013. Economic challenges and industry change will continue to influence the payment velocity of hospitals across the U.S. Understanding revenue cycle issues and having access to information to pinpoint problems is critically important.

One of the biggest challenges for hospitals is having information to compare financial performance. In this report, we ranked U.S. hospitals based on 2012 payment velocity and discovered hospitals with the highest ranking received payer payments in a median of 26.8 days. At the other end of the spectrum, hospitals with the lowest ranking received payments in a median of 106 days, representing a difference of 79 days. This difference substantially impacts a hospital’s cash flow and potentially highlights poor processes resulting in payer denial and rejection rates being higher than the national average.

In future reports, we will explore deeper into issues impacting a hospital’s revenue cycle. Topics will include the impact of economic situations, changes to industry regulations or new insight into payment trends.

Other critically important performance indicators are available in RelayAnalytics Pulse™, a comparative analytics solution that provides visibility into strategic financial trends, inside and outside of a hospital’s facility. It improves upon traditional benchmarking by automatically providing consistent calculations across peer groups. RelayAnalytics Pulse provides insights that help hospitals analyze productivity, align and motivate staff, compare revenue and cash flow, and justify future investments with the data to support decisions.