Performance Improvement – The Rice Memorial Hospital Journey
Performance Improvement in Revenue Cycle MAP Award Winner

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Rice Memorial Hospital

Today’s Discussion

• Introduction to Rice Memorial Hospital
• Structure
• Denials Management
• DNFB – Pro’s and Con’s of External Resource Utilization to Reduce Backlogs
• Net Days in A/R and Reduce Days over 90 Days
• Clinical Documentation Improvement
• Point of Service Collections and the EHR implementation impact
• Other Revenue Cycle Improvements
• “How do you eat the elephant?”
• Future Revenue Cycle Projects
Meet Rice Memorial Hospital

- Rice Memorial Hospital is a Level 3 Trauma Center and the largest municipally-owned hospital in the state of Minnesota. Rice has been a proud member of the Willmar community since 1937 and strives to provide patients and visitors with Respect, Integrity, Compassion, and Excellence (R.I.C.E.) Rice Memorial is comprised of Willmar Regional Cancer Center, Rice Regional Dental Clinic, Suite Beginnings private birth suites, and Therapy Suites (short-stay rehabilitation facilities) at Rice Care Center.

- Staffed Beds: 110
- CMI
  - Medicare: 1.408
  - Overall: 1.026
- Annual Visits (last FY):
  - IP: 3,463
  - OP: 54,548
  - ED: 13,225

Notable Revenue Cycle Initiatives

- Revenue Cycle Restructuring
- Estimates and Point of Service Collections
- Patient Financial Communications Project
- Enhancing insurance and self-pay follow-up work queues
- No-interest financing program for self-pay balances
- Updated patient statements/smartphone app
- Clinical/Financial Integration
- Telecommuting for billing and coding staff
Revenue Cycle Restructuring

2016 Revenue Cycle Organizational Chart

Chief Financial Officer
Director of Revenue Cycle

- Patient Access
  - Patient Financial Services Coordinator
  - Manager
- Patient Access Registrar Coordinator
- Operating Room Coordinator
- Ancillary Services Coordinator
- AR/Billing Representation
- Documentation Specialist
- Underwriting Representative
- Reception

- Financial Auditors
- Billing Account Rep
- Audit & Contract Analyst
- Charge Capture
- Medical Coding

- Chief Financial Officer
- Director of Revenue Cycle
- Revenue Cycle Analysis/Integrity Director
- Compliance Analyst
- Health Data Specialist
- Coding Supervisor

- Payroll
- Bills
- Billing Supervisor
- Account Supervisor
- Accounts Receivable Specialist
- DS Coordinator
- CDR & Reporting Analyst
- Radiology Coding
- Pricing Analyst

Key Performance Indicators

- Top Performing:
  - AR Days – Gross hospital trends at 38, national average 50 (net 20 days)
    - AR over 90 days – 8.2% National average 29.3%
  - Denials as a % of Gross Revenue - .2%, national average .8%
  - Self pay AR over 90 days – 30%, national average 44%
  - Bad Debt and Charity Care are below average

- Areas for Improvement
  - Point of service collections - .3% (goal .5%-1%)
  - Late Charges
  - DNFB
Revenue Cycle Analysts

- Positions pay for themselves
- Auditing/compliance, regulatory monitoring and reporting, revenue review, claims analysis, audit specialists
- Underpayment review
  - External review found only 0.1% of total net revenue, 99.9% accuracy rate
  - Average range is typically 98.5%
  - For Rice, this was a difference of $2.1 million, or $630,000 saved in outsourced contingency fees

Denials Management

- Focus on opportunities for improvement
  - Medical necessity
    - In 6 months, decreased denials by 6% ($306,000)
  - Non covered
  - Medicare IP only
  - Late charges
  - No ABN
  - No Prior authorization
  - Credentialing
  - Restricted MA patients
Denials Management

Discharged Not Final Billed Strategy

- Transparency/Accountability
  - Change in reporting structure for coding
  - Productivity measures and workflow/list enhancement
  - Goal setting/accountability as a team and individually

- Account Follow-Up
  - Previously, follow-up on accounts was automatically set at 30 days
  - Shortened the follow-up time by payer that was automatically populating the EHR
  - Implemented new policies with defined timeframes for billing and self-pay staff
Discharged Not Final Billed Opportunities

- Documentation
  - Physician Communication – is the record not complete, or do we have deficiencies?
  - Nurses entering education for acuity points
- Coding/billing/chargemaster huddles
  - Edit review
  - System enhancements/change requests
- Late charge holds

Net Days in A/R
A/R Aged Over 90 Days

- No-interest financing
  - In response to rising self-pay A/R, partnered with a financing entity to offer 0% interest loans to patients
    - Decreased self-pay AR by 2.4 days
  - Provides patients with more feasible payment options and also allows the facility to close accounts earlier
  - Partnered with a vendor to assist with patient and payer non-compliance issues—further expediting payments for difficult accounts

- Updated payment options
  - Updated patient statements to make them more clear, easier to understand, concise, and reflective the services provided
  - Patients can also download an app for their phone to make payments online and set up payment plans directly from their device
Trending A/R Dashboard

Clinical/Financial Integration

- CDI Program developed to bridge the gap between clinical documentation, coding guidelines, and regulatory requirements improving profitability and compliance.
  - Medicare case mix improvement of .120, or $1.1 million
- Team approach to payer audits
  - 857 Requests
  - 259 accounts to appeal totaling $641k
- Level of Service
  - Two-Midnight Rule
  - Medical Necessity/Denials Management

NOS Shift – Heart Failure

Pre-CDIP (n=691)  Post-CDIP (n=262)

Specific Code  NOS Code
Clinical/Financial Integration, cont.

CC/MCC Capture Rate – Pneumonia DRGs

PRE-CDIP

66.1%

POST-CDIP

68.3%

2.2% improvement

Net Change - $27,435!!

Case Mix Index Trend
Point of Service Collections

• Patient bill estimates
  – Following EHR implementation, reinstated bill estimate and POS collection practices
  – Prior to scheduled, non-emergency services, front-end staff contact patients to help them understand their liabilities
  – Once patients furnish insurance info, out-of-pocket estimates and/or financial advocate referrals are provided

Patient Financial Communications

• Changed Financial Counselors to Financial Advocates
• Updated policies to provide clearer guidance for follow-up requirements
• Updated website
  – Posted policies
  – Plain language summaries
  – FAQ section on the website
  – Grant applications
  – Patient Communications Video
• Financial Assistance Options brochure
Patient Financial Communications cont.

- Patient Communications Video
  - https://vimeo.com/122449582

Revenue cycle telecommuting

- Revenue cycle telecommuting
  - Members of Rice’s billing and coding staff transitioned to working from home in 2013—increasing both productivity and satisfaction
  - Staff’s quality of work has also improved, as measured by our days outstanding, amount of denials and write-offs, etc.
Employee Engagement

- Elephant Project
  - How do you eat an elephant?

  **How**
  Assumes there are solutions, and provides creativity and confidence

  **Might**
  Allows for ideas that might or might not work

  **We**
  Allows the team to work together and build on each other’s ideas

“Collected a $34,691.80 payment from a delinquent facility account”
“Sent first coder home to work remotely”
“RAC audit appeal Level I with NGS successful x2”
“Reached over $1.5 million in POS collections since Dec. 2010!”
“Coded first week of radiation therapy!”

Revenue Cycle 2016 Goals

- Expansion of POS
  - ER, direct admissions, recurring services
- Denials management
  - Appeal coordination (knowing what to appeal – fight vs. appeal)
- Increase accountability and transparency
  - Competency metrics
  - Registration accuracy
- CDI expansion
- Expanded audit and compliance tracking
- Continued revenue cycle consolidation
- Payer report cards
2015 “Theme”

- “There’s a Hole in the Sidewalk” by Portia Nelson
  - How to “safely” navigate life’s sidewalk

“Do not confuse motion and progress. A rocking horse keeps moving, but does not make any progress.” Alfred A. Montapert

Thank you!

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Enhancing Revenue and Reimbursement

Marti Klutho, Associate Director – Patient Financial Services

Liz DeGarmo, Manager – Patient Access

St. Luke’s Hospital, Chesterfield Missouri

St. Luke’s Hospital

Our specialty is you!
ST. LUKE’S HOSPITAL

• Not-for-profit located in Chesterfield, MO
• Serves the region from more than 20 locations, including 493-bed hospital, Urgent Care Centers, Diagnostic Imaging, Skilled Nursing & Rehab
• Only St. Louis hospital recognized as one of America’s 50 Best Hospitals™ by Healthgrades® (2007-2015)
• Member of Spirit of Women® Health Network
• MAP Award winner 2014, 2015 and 2016

Service Area map
ST. LUKE’S HOSPITAL

- Admissions & Observation – 18,000
- Outpatients – 308,000
- ED & Urgent Care visits – 126,000
- Annual Operating Revenue - $500 million
- Payer Mix
  - 52% Medicare/Managed Medicare
  - 42% Commercial/Managed Care
  - 6% Other
- Operating Margin – 4.3%
- 3,600 Employees

REVENUE CYCLE OPERATIONS
Front End Revenue Cycle

- Decentralized Registration and Scheduling
- Patient Access trains & supports registrars
- Eligibility and estimates automated
- Strong Quality Review Processes
- McKesson STAR ADT

Back End Revenue Cycle

Automated Processes
- Billing
- Cash Posting
- Receivables Workstation
- Propensity to Pay/Charity

McKesson STAR Financials
- PFS manages claims tables
- Assuming more responsibility for other IT support functions
SELF PAY CYCLE

1. Account balance is self pay ~ Day 30
2. Two statements sent ~ 60 days
3. Pre-collect Letter & Calls ~ 30 days
4. Bad Debt Pre-list ~ 30 days
5. Transfer to Bad Debt ~ Day 180

Key Strengths

- High performing Staff
  - Efficient
  - Motivated
  - Cost to collect is 1.6%

- Measuring & Monitoring
  - Productivity
  - Quality
  - Good process for bad debt vs. charity

- Strong Foundation
  - Solid front end revenue cycle process
  - Good report management
Focusing on these Objectives Leads to Optimal Revenue Cycle Performance….

Key Indicators

- Days in AR – low 40’s
- Cash as % of revenue – 100%
- POS Collections as % of total patient cash – 20%
- Bad debt expense - < .5%
- Aged AR as % of billed > 90 days – 20%
- Suspense days - 3
- Days in DNFB – 4
- Customer Service complaints due to wait time - 0
Multi-disciplinary Teams for Revenue Cycle Improvement

Revenue Cycle Improvements

Registration Accuracy

Pre-cert Denials

Co-pay Collections

Charge Capture CDM

The usual suspects…..

PFS
Revenue Integrity
HIM
Finance/Cost Accounting
Clinical Departments

REGISTRATION ACCURACY
Registration Accuracy

- Quality Review reports
  - SQL reports to identify common errors
    - Several reports recently consolidated into one
    - Payor information (Payor code/ID/MC replacement)
    - Incomplete fields
  - Real-time eligibility
  - Pre-bill editor reports
  - Duplicate registrations
  - Physician information
  - Financial Clearance Workstation
  - AHIQA

Keeping the focus on QUALITY

- Monthly report cards by registrar and department to reflect registration accuracy
- On-line classes for registrars to review current changes as well as common mistakes
- Focused and specialized training classes as needed
- Reflected in individual performance evaluation
Registration Accuracy

PRE-CERTIFICATION DENIALS
A closer look…Pre-Cert Denials

Hospital Owned

Precertification Processes for Infusion Services

MD Practice
Collaborate and Listen

- Drug did not require auth until 1/1
- Patient services began 4 months earlier

Infusion services was not aware of auth requirement changes

- Infusion Dept re-trained
- Patient Access as 2nd level check

Large $ denial due

Process

Attention to Detail

Reduction of Denials

Focused meetings/efforts with individual departments

Monthly Reports to Department Managers reflecting denial reasons

Team Approach = Low Denial $s

Clinical areas assist with appeals

Support from Senior Management
### SAMPLE PRE-CERT REPORT

<table>
<thead>
<tr>
<th>Patient Identifiers</th>
<th>Physician</th>
<th>Payor Information</th>
<th>Services denied</th>
<th>Amount denied</th>
<th>Reason for denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Doe 12345678</td>
<td>Dr. Jones</td>
<td>Blue Cross</td>
<td>CT Scan</td>
<td>$XXX</td>
<td>CT of abdomen ordered but CT of abdomen/pelvis performed</td>
</tr>
<tr>
<td>5/1/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Doe 34567890</td>
<td>Dr. Smith</td>
<td>United Healthcare</td>
<td>Infusion Drug</td>
<td>$XXX</td>
<td>Drug authorized was not drug given</td>
</tr>
<tr>
<td>6/1/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jim Doe 45678901</td>
<td>Dr. Brown</td>
<td>Coventry</td>
<td>OP Surgery</td>
<td>$XXX</td>
<td>Additional procedure added during surgery that was not authorized</td>
</tr>
<tr>
<td>7/1/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PRE-CERT DENIALS

![Bar Chart](chart.png)

- Total $ ('000's omitted)
- FY10: $500
- FY11: $400
- FY12: $600
- FY13: $700
- FY14: $300
- FY15: $200
COPAY COLLECTIONS

• Estimation tool used for scheduled procedures – includes deductibles & coinsurance

• Goals based on actual claims for each department

• In-services on collection techniques that include scripting

• Observation of collection practices in departments
Asking for Payment Prior to Service

- Our Patient Accounts department contacted your insurance company and verified your eligibility and benefits for this procedure/test. According to the representative at your insurance company your responsibility will be ($ amount). This total represents (details of deductible, coinsurance, co-payment) set by your insurance company. How would you like to take care of that today? We accept cash, checks and all major credit cards for payment.

Scripts if Patient Objects to Paying at Time of Service

- **Patient:** I never had to pay at the time of service before.

- **Registrar:** I understand your concern, but insurance companies are changing the way that they pay and patients now have deductibles and copayments due which make up part of the insurance company’s payment to the providers. It is our responsibility to collect these from the patients and we prefer to do that at the time of service.

- **Patient:** Just send me a bill.

- **Registrar:** We prefer to collect your payment at the time of service. For your convenience you may pay by cash, check or credit card. If you cannot pay the entire balance today, we do ask that you pay a deposit toward your balance due.
COPAY COLLECTIONS

- Monthly reports distributed to department managers and Senior Staff

- Monthly audits of collection performance

- Focused meetings with departments
COPAY COLLECTIONS

changes

- Increased efforts in IP areas
- Signage in OP areas
- Contacting patients further in advance
- Improved documentation on account for no payments
- Including payment arrangements in collection totals

Your financial obligation (co-pay, co-insurance, deductible) is due at the time of service. If you have any questions or concerns, your Registration Representative will be able to assist you. Thank You.
Charge Capture Complexities

- Unidentified ownership
- Inadequate and unclear documentation
- Communication of department processes
- Competing priorities
- Understanding reimbursement
REPORTS TO VALIDATE CHARGE CAPTURE

• Zero charge
• Late charge
• Charge interface errors
• Device to procedure
• Monthly revenue
• Trend reports
• Billing edits

CHARGE CAPTURE – Our approach

• Regular CDM meetings to ensure:
  – All services/supplies are set up in charge master (as appropriate)
  – Codes and prices are accurate
  – Compliance issues are addressed
  – Clinical staff are educated in charge capture processes

• Regular audits to ensure:
  – Adequate documentation to support charges
  – All services rendered are charged
  – Clinical Revenue Auditor reports to Revenue Integrity/PFS
OPPORTUNITY .......... DEPARTMENT OF NURSING

- Clarification of documentation in chart
- Supplies – proper coding and ensuring new supplies are added to charge master
- Chargemaster descriptions are reviewed for clarity and consistency
- Inactivation of items no longer used
- Charging improved 24% in focal areas…supplies, procedures & 02 use... (an average increase of $137,000/month in gross revenue)

CDM Committee Members

- Patient Financial Services
- Revenue Integrity
- Health Information Mgmt
- Clinical Depts
- Finance Cost Accounting

St. Luke's Hospital
Our specialty is you.
Keeping the momentum going…..

- Monthly revenue reports tailored for end users track trends in revenue at charge or department levels
- Ongoing support of CDM maintenance
- Year-end support of CPT code changes
- Outside vendor review/support as appropriate
- Clinical audits ensure proper charge integrity

CHARGE CAPTURE REVIEW

- Engaged national firm to review charge capture processes at St. Luke’s
  - Reviewed one year’s worth of claims
  - Found 99.99% charge accuracy!!
  - Only two opportunities identified…blood transfusion & hemodialysis billing
CHARGE CAPTURE REVIEW

• Hospital efforts continue…..
  – Nursery level charges
  – Drug and Blood Administration
  – Oxygen use
  – Billable supplies
  – Devices
  – High cost drugs

PARTNERSHIPS WITH VENDORS
A LITTLE HELP FROM OUR VENDORS.....

<table>
<thead>
<tr>
<th>PATIENT ESTIMATES</th>
<th>SELF PAY COLLECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSFER DRG REVIEW</td>
<td>CHARGE CAPTURE REVIEW</td>
</tr>
<tr>
<td>MEDICAID ELIGIBILITY</td>
<td>MVA COLLECTIONS</td>
</tr>
<tr>
<td>ZERO BALANCE REVIEW</td>
<td>OBSERVATION REVIEW</td>
</tr>
</tbody>
</table>

ARE THEY LONG-TERM ENGAGEMENTS?

- **Not always....**
  - Our partnership includes learning from our vendors as well as St. Luke’s sharing knowledge to further develop their product/service
  - Vendors are held accountable for their goals/promise
  - Relationships are amicably ended when there is no value in continuing for either party
TIP!!!!

When possible, “test” vendor’s product before entering into long-term engagement

Shorter term engagements…..

The following services were moved in-house after a short-term engagement with the vendor….

- Medicaid Eligibility
- MVA Collections
- Patient estimates
- Transfer DRG review
- Charge capture
- Observation review
Longest term engagement....

- **Self pay collections**
  - Pre-collect letters
  - Full service agencies

- **Agency performance determines length of engagement**
  - 2-3 agencies
  - Monitor collection percentage and customer service

- **Looked at moving in-house but wasn’t cost effective**
Keeping payors engaged…..

• Continue to build relationships with provider relations....
  – Monthly meetings
  – Open communication
  – Follow payor protocol to resolve issues more timely
  – Reports are sorted by issue for more focused review by payor

• Payor scorecards to track aging, denials & appeals and payment timeliness

• Sound internal processes to monitor payment accuracy

TOP FIVE APPEALS BY PLAN

- Rev code 636
- Not medically nec
- Not paid per UM agreement
- Outlier not paid correctly
- OP Auth/Referral denial
PAYOR TIMELINESS

Days to Primary Payment

0 5 10 15 20 25 30 35 40
Payor A Payor B Payor C Payor D Payor E Payor F

PATIENT/COMMUNITY ENGAGEMENT
FINANCIAL COUNSELING

- In-house counseling supporting IP & OBS
- Medicaid eligibility
- Certified Application Counselors for Healthcare Marketplace
  - Serving St. Luke’s patients and other members of the community
- Financial Assistance