The Contemporary Revenue Cycle - Measure, Apply, Perform!

Arkansas Chapter, HFMA
September 24, 2015

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Director, Healthcare Finance Practice
Revenue Cycle MAP

Today’s Conversation

• Setting the Stage – Financial Impact of Revenue Cycle Operations
• Detailed Best Practice Work Flow – And Why
• Metrics and Tools for Process Improvement
• Tips from High Performing Revenue Cycles
• Patient Friendly Billing
• Questions!
The Revenue Cycle Model Must Change

**Historical Model**
- Gather basic info before & at the time of service.
- Most billing processes are post-service, amounts due based on data gathered after service, calculated retrospectively.
- Patients notified of financial obligations after insurance is billed & paid.

**The Near Future**
- Pre-Service: Prospective Data Gathering and Processing
  - Gather info before & at time of service. Prospectively calculate expected out-of-pocket costs.
- At Service
  - Providers bill at or right after time of service. Many times, patients know in advance what they owe & agree on terms.
- Post-Service: Retrospective Data Gathering and Processing
  - Insurance bill verifies what the patient already expects.

And You Think Your Job is Tough? What Keeps the Revenue Cycle Leader Awake at Night …

- Changing reimbursement/ACA implementation
- Price transparency
- Patient satisfaction/patient experience
- ICD-10; Revenue integrity
- RACs, MICs, et. al.
- IT platforms – EHR, Integration, Bolt On’s
- Integration – Hospitals/Physicians/Payers
- Metrics/performance/cost to collect
- Patient financial communications/Medical debt best practices
Changing Reimbursement/ACA Implementation

ICD-10 and Revenue Integrity

- Are You Ready?
  - Patient Access
  - HIM
  - Patient Financial Services
  - Finance
  - Payers and Clearinghouses
  - Physicians
- Prove It!

Insurance exchanges – plans
Narrow networks
High deductibles
501(r) requirements
External Audits – RACs, MICs, et al.

- Suspension of ALJ appeals
- Provider success rates vs. contractor success rates on appeals
- Increased MICs activity
- Potential legislative relief

Information Technology
"Leadership has nothing to do with titles; it has everything to do with, “Do you inspire other people? Do they want to follow you? Do they want to be with you?”

**High Performance Award Winners 2013 - 2015**

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The HFMA Initiatives for Revenue Cycle High Performance

HEALTHCARE DOLLARS & SENSE

Price Transparency

Patient Financial Communications

Medical Account Resolution

hfma.org/transparency
hfma.org/communications
hfma.org/medicaldebt

Conceptual View of the Patient-Centered Revenue Cycle

Physician & patient identify need for service

Provider takes initiative to complete pre-arrival processes - clinical and financial

Post service – completion of activities required to successfully resolve the financial components for patient and provider

Time of service activities:
- Patient arrival
- Clinical services and documentation
- Revenue capture, Coding & Patient discharge

EHR
Background

Every day, healthcare professionals conduct sensitive financial discussions with patients. But there have been no accepted, consistent best practices to guide them in these discussions—until now.

- A message from Joe Fifer, CEO, FHFMA, HFMA
Eliminating Babel

Improving the Patient Experience

Best practices for healthcare providers:
- Emergency Department
- Time of Service (Outside the ED)
- In Advance of Service
- Patient Financial Communications – All Settings
- Measurement Criteria Framework
  - Training
  - Process compliance evaluation
  - Technology evaluation
  - Feedback and response evaluation
  - Executive level metrics reporting
When and Where to Have Patient Financial Discussions

Discussions at the time of service
  – In the ED
  – Outside the ED setting
Discussions in advance of service

Who Participates in Patient Financial Discussions

Routine scenarios
Non-routine or complex scenarios
**Topics Addressed in Patient Financial Discussions**

Provision of care
Registration, insurance verification, and financial counseling

---

**Topics Addressed in Patient Financial Discussions**

Patient Share
Prior balances (if applicable)
Balance resolution

Value = Quality Payment
Parameters for Patient Financial Discussions

Compassion
Patient advocacy
Education

Compliance Framework

Training program
Process compliance
Metrics reporting
**Staff Training - Strategies**

- Best Practices Training Recommendations
  - Annual program
  - Documented and shared with C-suite annually
  - Variety of methodologies may be used
  - May use internal or externally sourced program(s) and faculty, subject to review by designated quality officer
  - HFMA materials now available!

**Staff Training - Strategies**

- Best Practices Training Recommendations
  - Content
    - Match best practices to specific staff roles
    - Financial assistance policies
    - Available patient financing options
    - Alternative solutions for the uninsured
    - Standard language to be used in patient discussions
    - Laws and regulations specific to staff role (EMTLA, FDCPA, TCPA, etc.)
**Staff Training - Strategies**

- **Education**
  - Revenue cycle staff: change the vocabulary
  - Patient access staff: establish where, when and how to have what conversations with patients
  - Provider clinical staff: why financial conversations represent best practices; why financial care is a component of patient care
  - All other provider staff: how these best practices help our patients first

- **Education (continued)**
  - Physicians: non-interference with clinical care; why financial conversations represent best practices; why financial care is a component of patient care
  - Navigators or Certified Application Counselors (CACs): keep their conversations with patients in sync with provider’s philosophies and requirements
  - Volunteers: share why and how the best practices are helping patients understand the financial part of their care
  - Others
More Strategies

• Hire, train and motivate compassionate, service-oriented staff
• Equip staff with tools to succeed:
  - Charge estimation
  - Insurance verification
  - Prior balances
  - Financial assistance applications, process
  - Scripting
  - Ongoing refresher classes

Compliance Framework

Technology
Feedback process and response
Metrics

• What we measure, staff treat as important!
• Create the before and after picture
  - Patient satisfaction-HCACPS, etc.
  - Pre-registration
  - Insurance verification
  - Focus group results
  - % of patients participating in financial discussions
  - POS collections
  - Net A/R days

Reporting Results

• Feedback and response protocols
• Escalation process for patient complaints
• Reporting to C-Suite on an annual basis
• Annual overall compliance report to C-suite team
From Compliance to Culture Change

Effective patient financial communications are critical
- For patient satisfaction
- For financial health of organizations
Integral part of their culture

Providers Benefit

- Opportunity to encourage patients to talk with financial counselor about any financial concerns
- Identify opportunities to locate additional or alternative insurance coverage
- Secure how accounts will be resolved through conversation
- Identify patients who fall under the 501r regulations
- Benefit from the PR value of a satisfied consumer vs. an unhappy consumer
**HFMA’s Programs**

Education Products – HFMA Suite available now*
Adopter Recognition – Available now
Compliance Recognition – Available now

*For more information, please contact Krys Hansen at k Hansen@hfms.org or 800-252-HFMA

**And Then …**

• Apply for HFMA Adopter recognition*
• Participate in HFMA’s compliance program for Patient Financial Communication Best Practices

*Revised Adopter Recognition Application has been released. Simplified, brief narratives, focus on “who, what, where, when, how” and related policies in the Patient Access operations
Are You Ready?

• Complete the checklist: Is your organization ready to apply for Adopter status?
• Remember, this is a journey not a sprint!
• Prepare to become an adopter
  – Why?
  – How?
• The challenge: become the first chapter to have 50% of your members achieve adopter status by December 31, 2015!

Early Recognized Adopters

The MetroHealth System
Duke Medicine
UAB Medicine
Price Transparency
Best Practices

“Somebody has to do something, and it’s going to be—and it has to be—you.”

Former Senator and Senate Majority Leader
Bill Frist, MD
Speaking at
ANI 2010
If we can do this…

…then why can’t we come up with a better system than THIS!
Key Principles For Transparency Efforts

1. Transparency should allow all stakeholders to make meaningful price comparisons prior to receiving care.
2. Any form of price transparency should be easy to use and easy to communicate to stakeholders.
3. Price information should be paired with other information that defines the value of services for the care purchaser.
4. Price transparency should ultimately provide patients with the information they need to understand the total price of their care and what is included in that price.
5. Price transparency will require the commitment and active participation of all stakeholders.
Moving toward price transparency

Price Transparency Task Force Members

• American College of Physician Executives
• American Hospital Association
• America’s Health Insurance Plans
• The Blackstone Group
• California Hospital Association
• Catalyst for Payment Reform
• Catholic Health Association
• Community Health Advisors
• Equity Healthcare
• Federal Trade Commission*

• Florida Blue (Blue Cross/Blue Shield)
• Geisinger Health System
• Healthcare Consumers
• Healthcare Incentives Improvement Institute
• HFMA
• The Leapfrog Group
• Maricopa Integrated Health System
• Medical Group Management Association
• National Rural Health Association
• Priority Health
• Sidley Austin LLP

*Advisory capacity
Key Points

We are committed to price transparency in health care. That means . . .

We work with uninsured patients or those seeking out-of-network care to give them price information.

Insured patients should view their health plans as a resource for price information.

We work with health plans to ensure that price information is accurate and reliable.

Transparency goals for consumers

Consumers will:

• Know how to get a price estimate
• Understand what the estimate includes (and excludes)
• Be able to comparison-shop among providers
• Improve their ability to make healthcare decisions based on value
• Have more interest and be more engaged
Transparency recommendations for referring clinicians

Physicians and other referring clinicians should:
- Help patients make informed decisions about treatment plans
- Recognize the needs of price-sensitive patients
- Help patients identify providers that offer the best value

Transparency recommendations for payers and providers

Payers and providers should:
- Collaborate!
  - Work together with the patient in mind.
- Embrace transparency
  - Don’t ignore it or fight it.
Price Information: Here’s How to Get It

Price Information: Here’s How to Get It

Key Points

This consumer guide is available on our website.

We understand that healthcare price information can be confusing.

This resource is available to guide consumers through the price estimate process—step by step.
Price Transparency Pledge

- I agree that price transparency should ultimately provide consumers with the information they need to understand the total price of their care and what is included in that price.
- I believe that price transparency should empower consumers to make meaningful price comparisons among providers.
- I recognize that price transparency should enable care purchasers and referring clinicians to identify providers that offer the desired level of value.
- I support pairing price transparency information with other information that defines the value of services for the care purchaser.
- I will encourage forms of price transparency that are easy to use and easy to communicate to stakeholders.
- I pledge to support efforts to improve price transparency.
Medical Debt: Key Points

We want to find solutions that are balanced, fair, and reasonable.

We keep patients informed about payment expectations and time frames.

The business practices that we—and our business affiliates use—have been approved at the Board level.

Medical Bill Collections

• In 2012, 32 million American adults were contacted by a collection agency for unpaid medical bills.

Medical Collections and Credit Reports

More than half (52%) of accounts in collection are medical bills.

More than one-third (36%) of medical collections had balances due, when reported, of $100 or less.
A Convergence of Issues…

**Consumer Trends:**
- Increased Use of HDHPs
- Tighter Lending Standards

**Environmental Ripe for Legislative/Regulatory Action**

**Provider Challenges:**
- Non-Standardized Account Resolution Processes
- Opaque Pricing
- Challenges Accessing Financial Assistance

CFPB to the Rescue!

Welcome to the ACA: 501(r)

- Final regulations released December 31, 2014
- Effective tax years beginning after December 29, 2015
- Details, details, details …
Medical Debt Task Force

- Coordinated HFMA & ACA Partnership
- Key Industry Stakeholders Involved:
- Goal to Develop Best Practices / Guidelines
- Proactive Approach to give CFPB / Congressional leaders steps to improve process.

The Approach

- Cross functional teams representing all aspects of the cycle:
  - Various healthcare providers: profit, non-profit across the country
  - Consumer advocacy and non profit healthcare association representatives
  - Credit Bureau
  - Debt Collection Agencies
  - Early Out providers/Data scoring provider
  - Representative from ACA International
  - HFMA staff leading and organizing the process
**Task Force: The Process**

- Discuss the issues that exist today
- Break into cross functional teams
- Brainstorm an ideal world
- Map out the process
- Present back each teams’ diagram
- Select the best processes from each
- Develop one plan incorporating feedback from outside sources
- Review and finalize with the team
- Publish for feedback
- Address any roadblocks identified

**Task Force: The Result**

- A high level outline of the process from the time of dropping a bill to resolution/write off to bad debt
- Incorporating the best practice in all the steps
- Keeping in mind the various laws not only in practice today but looking ahead in anticipation of future legislation
- Keeping the Patient Experience as the number one priority
- Incorporating technologies, laws, best practices and expertise to identify any roadblocks that need to be addressed
Pre-Service

Physician & patient identify need for service
Provider takes initiative to complete pre-arrival processes (clinical and financial), applying Patient Financial Communications Best Practices

Routine Revenue Cycle Activities:
- Production of a complete, legally executed order
- Determination of medical necessity
- Patient interaction with provider
  - Schedule service
  - Demographic and insurance data; data validation (address & insurance)
- Pre-authorization completed, if required
- Cost of service identified
- Determination of patient payment responsibility/financial assistance need
- Confirmation of arrival instructions and pre-testing clinical information
Physicians

- Physician determines the need for service
  - Completes comprehensive order
  - Confirms medical necessity for service*
  - Initiates or directs patient to initiate scheduling process
  - Responds to order clarification requests during hospital medical necessity processing

*Suggested process which includes ABN; in reality, screening and ABN process occurs at the hospital during pre-registration or at time of patient arrival

Scheduling

- Sets the stage for effective data collection
  - Schedule/coordinate appointments
  - Receives and files physician order via EMR, by phone, by fax or by e-mail
  - Screens for medical necessity
  - Collects basic patient demographic and insurance information
  - Screens for out-of-network insurance and site of service issues
  - Instructs patient regarding preparation and arrival
Medical Necessity Screening & Resolution

• Medicare and other payers
• Advanced Beneficiary Notification (Medicare)
  – Notice prior to service
  – Reason for non-coverage
  – Cost
  – Other requirements
• Other payers – do you know who they are?
• Price estimation
• Process to interface with physician when patient does not opt to continue with the service or testing

Pre-registration

• Foundation for the entire revenue cycle
  – Obtain or verify patient demographic and insurance information
  – Obtain complete physician order if not previously received (exception)
  – Complete ABN and Medicare Secondary Payer (MSP) screening
  – Prepare or queue up required paperwork or electronic transactions
  – Coordinate data flow and resolve edit failures
Insurance

- Price determination, as applicable
- Confirm all third party coverage and liabilities
  - Determine eligibility and benefits
  - Identify deductibles, co-pay and co-insurance due
  - Determine in-network vs. out of network status
  - Verify authorization requirements
  - Notify patient and physician of non-coverage issues

Pre-Authorization

- What does “pre” mean?
- Your organization’s policy?
- What “if” no pre-authorization?
- Opportunity to improve relationships with physicians and improve patient satisfaction
Conversion from Self Pay to Insured Status

- Insurance identified after initial registration
- Financial clearance still applies!
- In-house or vendor-based program

Medicare Secondary Payer Screening

- Medicare (traditional) is never liable for:
  - Worker’s compensation case
  - Veteran’s Affairs
  - Black Lung
  - Federal grants or public health services
  - Medicare Advantage Plan

- Medicare may be secondary:
  - Working aged
  - ESRD
  - Liability
  - Disability
How Well Do You Know The Rules?

• In order to be classified as “working aged”, the beneficiary must:
  a. Be diagnosed with end stage renal disease
  b. Be aged 65 or older
  c. Be covered by an Employer Group Health Plan
  d. Be at least partially disabled

• Susan Stricken, a disabled Medicare beneficiary, has elected coverage under her husband’s Large Group Health Plan. Does she forfeit the Medicare Secondary Payer benefit?
  a. Yes or No

How Well Do You Know The Rules?

• What type of insurance does a beneficiary have if the insurance is provided as a benefit of the spouse’s job?
  a. Medigap policy
  b. Employer group health plan
  c. Worker’s compensation
  d. Limited liability coverage

• Why is eligibility questioning an important part of the registration for a Medicare patient?
  a. Helps to identify communicable diseases of the elderly
  b. Provides emergency contact information
  c. Allows provider to determine if other medical insurance is available
Managed Care

- Comply with payer requirements
  - Contact insurance for pre-certification when required
  - Document number of days certified and/or approval number assigned
  - Coordinate with physician and case management
  - If not authorized, contact physician and patient for additional information and reschedule if necessary

Financial Counseling – Patient Financial Communications Best Practices

- Communicate insurance benefits and patient financial responsibility
  - Produce accurate estimate of charges, payer “discount” and apply patient’s benefit package to determine patient’s responsibility
  - Explain in-network or out of network status of provider
  - Reduce “fear of the financial unknowns”, a.k.a. “surprises”
  - Identify and pursue applications for Medicaid, public assistance, and/or financial assistance/charity
  - Comply with 501(r) if applicable to your organization
  - Reach agreement with the responsible party and secures payment
Price Transparency

- **Common Definitions**
  - **Charge:** the dollar amount a provider sets for the services rendered before negotiating any discounts. The charge can be different from the amount paid.
  - **Cost:** definition varies by the party incurring the expense
    - To the patient, cost is the amount payable out of pocket for healthcare services.
    - To the provider, cost is the expense incurred to deliver healthcare services to patients.
    - To the insurer, cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.
    - To the employer, cost is the expense related to providing health benefits.
  - **Price:** the amount a provider expects to be paid by payers and patients for healthcare services.

Clinical Services

- Data required for pre-authorization
- Data required per scheduling protocol from service department
- Patient safety data
- Clinically prepare patient for upcoming services
  - Communication among physicians, clinicians and patients
  - Confirm all required pre-admission testing completed
  - Plan staffing and resources needed
Patient Benefits with Financial Communications

- Understands Out-of-Pocket Liability
- Focus on clinical care at time of service
- Single point of contact for finances
- Reduces back end problems (denials, etc.)
- Knows how account will be resolved
- Engaged

Summary Pre-Service Workflow

<table>
<thead>
<tr>
<th>Service need identified; service scheduled; edits initiated</th>
<th>Pre-registration completed</th>
<th>Insurance verification completed</th>
<th>Managed care identified and completed</th>
<th>Patient charges and liability estimated; financial conversation completed; account resolved</th>
<th>Patient cleared for fast track arrival process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exception/Resolution</td>
<td>Exception/Resolution</td>
<td>Exception/Resolution</td>
<td>Exception/Resolution</td>
<td>Exception/Resolution</td>
<td>Exception/Resolution</td>
</tr>
</tbody>
</table>
### Challenges and Impacts!

<table>
<thead>
<tr>
<th>Activity</th>
<th>If Correct</th>
<th>If Incorrect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting incomplete demographic information for scheduled patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting incomplete demographic information for unscheduled patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to verify insurance eligibility and benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to complete state and federal screening for financial assistance eligible patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Challenges and Impacts

<table>
<thead>
<tr>
<th>Activity</th>
<th>If Correct</th>
<th>If Incorrect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to obtain pre-authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to discuss patient's financial responsibility</td>
<td></td>
<td></td>
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<tr>
<td>Failure to identify modality or site of service restrictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to determine price to patient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Metrics

- What metrics do you currently use and what are the new metrics you plan to implement to monitor pre-service processes.
- For each metric, identify the name, relevance, data elements, source, calculation and frequency
- Examples: pre-registration rate; insurance verification rate; service authorization rate; POS cash collection rate; conversion rate of uninsured patient to payer source
Time of Service

Physician & patient Identify need for service

Provider takes initiative to complete pre-arrival processes - clinical and financial

Patient arrival:
- Pre-registered track
- Sign and go
- EMTALA
- Medical necessity
- Demographic and insurance data
- Data validation
- Pre-authorization
- Cost of service
- Determination of patient payment responsibility/financial assistance

EHR

Time of service activities:
- Patient arrival
- Clinical services and documentation
- Revenue capture, Coding & Patient discharge
Conceptual View of the Patient-Centered Revenue Cycle

- Treatment provided
  - Documentation
  - CPOE
  - Automated charge generation
  - Care coordination
  - Discharge planning
  - Patient discharged/testing completed
- Comprehensive automated edits employed to ensure completion of pre-billing requirements
- Clinical record reviewed for completeness and coded for billing, data mining and quality review

Time of service activities:
- Patient arrival
- Clinical services and documentation
- Revenue capture, Coding & Patient discharge

Special Considerations:
3 Day and 1 Day Windows

- MS-DRG Window (3 calendar days prior to admission)
  - All diagnostic services
  - Non-diagnostic, non-related services excluded, including ambulance, maintenance renal dialysis, SNF Part A
- Other Providers/Other Payers 1 Day Window
  - Non-IPPS facilities
  - Commercial payers by contract terms
**Two Midnight Rule: Patient Care Meets Revenue Cycle**

- CMS rule (FY14 IPPS; updated in the latest IPPS Reg) – Medicare patients
  - Involves physicians, nurses, and revenue cycle
  - Driver is physician’s expectation of patient’s need for inpatient care, not traditional case management tools
  - Physician expects patient to stay beyond two midnights and admits patient on that basis = inpatient
  - Physician expects patient to stay only for a limited time and does not cross two midnights = Part B outpatient service
  - Unforeseen circumstances (death, transfer) – physician’s expectation and the interruption must be documented in the record
  - Exceptions = IP only cases may have one or no midnight

**Charges: Capture Methods and Importance**

**Importance:**
- Constant indicator – resource utilization
- Reimbursement

**Issues:**
- Missing charges
- Obsolete or invalid codes
- Missing required modifiers
Health Information Management

• Electronic medical records platforms
• Responsible for accurate identification and security of patient records, ensuring completion of records by all caregivers
  - Ensure health information is complete and accurate
  - Release treatment documentation to authorized parties
  - Ensure appropriate use of standard coding systems
    ▪ ICD-9-CM to ICD-10 October 1, 2015
    ▪ Common procedure terminology (CPT)
    ▪ Level II Healthcare Common Procedure Coding System (HCPCS)

• CAC, CDI initiatives

Summary Time of Service Workflow

<table>
<thead>
<tr>
<th>Scheduled patient arrival</th>
<th>Walk-in patient arrival</th>
<th>Services ordered and provided; charges generated and posted; EHR documentation updated</th>
<th>Patient discharged/service completed</th>
<th>HIM analysis and coding completed</th>
<th>Remaining edits resolved; account qualified for billing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exception/Resolution</td>
<td>Exception/Resolution</td>
<td>Exception/Resolution</td>
<td>Exception/Resolution</td>
<td>Exception/Resolution</td>
<td>Exception/Resolution</td>
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</tbody>
</table>
Metrics

- What metrics do you currently use and what are the new metrics you plan to implement to monitor the time of service processes.
- For each metric, identify the name, relevance, data elements, source, calculation and frequency.
- Examples: POS cash collections; insurance verification rate; service authorization rate; conversion from self pay to payer source; claim edit failures related to patient access activities; claim delays related to patient access activities.

Metrics Reporting Worksheet: TOS

<table>
<thead>
<tr>
<th>Name</th>
<th>Relevance</th>
<th>Data Elements</th>
<th>Source</th>
<th>Calculation</th>
<th>Frequency</th>
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</table>
Post Service

Conceptual View of the Patient-Centered Revenue Cycle

Physician & patient identify need for service

Provider takes initiative to complete pre-arrival processes - clinical and financial

Post service – completion of activities required to successfully resolve the financial components for patient and provider

Time of service activities - Patient arrival; Clinical services and documentation; Revenue capture, Coding & Patient discharge
**Conceptual View of the Patient-Centered Revenue Cycle**

**Routine Revenue Cycle Activities:**
- **Suspense Period**
  - Diagnosis and procedure codes sent to billing system and validated
  - Additional payer edits resolved
- **Final Billed A/R**
  - Claim produced and electronically transmitted
  - Electronic remit and payment
  - Exception(s) identified and resolved
  - 2nd insurance/patient balance billed
  - Electronic payment
  - Account fully resolved, charity or bad debt
  - Data archived for data mining

**Claim Delay Factors**
- Unbilled – suspense period only
- Incomplete clinical documentation
- HIM backlogs
- Missing or late charges
- Unresolved pre-bill edits
- Hold flags not released
Suspense

Established number of days claim is held to ensure all required information is present

What is the best practice suspense period?

Claim Processing

All payers require essential information such as:

- Patient and policy holder names
- Patient date of birth
- Date of service
- Subscriber identification number and group number

- The definition of clean may vary by payer
  - Special requirements
  - Specific attachments
Payers

Medicare
- Traditional Fee for Service
  - Part A; benefit period
  - Part B
  - Deductibles and co-insurance requirements
  - Limitation on Part A coverage
- Medicare Advantage Plans – Part C
  - HMO model
  - Plan deductibles and co-insurance rules apply
- Medicare Part D
  - Prescription drug benefit

Medicaid
- Traditional
- Medicaid Managed Care

Payers

Tricare (formerly known as Champus)
- Prime
- Standard and Extra
- Tricare for Life

Indian Health Service
- Native American tribes and Alaskan tribes
- IHS setting or Medicare-participating providers

Blue Cross
- Oldest plan
- Interplan bank claims processing

Managed Care
- HMO
- PPO
- POS
- EPO
## Payers

- **Commercial Indemnity**
  - Traditional coverage with Major Medical coverage
- **Self Insurance**
  - ERISA rules
  - COB options
  - Employer funded
  - TPA
  - Managed care component contracted separately
- **Liability**
  - Worker’s compensation
  - Auto
  - Premises

<table>
<thead>
<tr>
<th>Step Activity</th>
<th>Step Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>After applying the discount, the silent PPO states on the EOB that the health care provider has agreed to reduce your bill based on your contract with the PPO</td>
<td></td>
</tr>
<tr>
<td>After a successful hit, the claim is re-priced based on the PPO discounts found in the PPO database</td>
<td></td>
</tr>
<tr>
<td>The patient’s claim is sent to the listed primary insurance carrier</td>
<td></td>
</tr>
<tr>
<td>The medical provider accepts the insurer’s statement on the EOB and writes the discount off—never knowing the discount was invalid</td>
<td></td>
</tr>
<tr>
<td>The patient’s insurance company runs the healthcare provider’s tax ID number through a PPO discount database, or provides a re-pricing company a copy of the claim</td>
<td></td>
</tr>
</tbody>
</table>
Claim Processing: UB-04/837i

Summary of Data Sources: 81 field locators
- Patient Access – 40%
- Service Departments – 11%
- Health Information Management – 20%
- Billing or system generated – 20%
- Reserved for future use – 9%

CMS 1500/837-P

Summary of Data Sources: 33 items
- Patient Access – 90%
- Service Departments or Provider – 2.5%
- Health Information Management – 1%
- Billing or system generated – 4.5%
- Reserved for future use – 2%
Creating Clean Claims

- Clean claim = a claim that is sent to a payer that can be processed and paid correctly without asking for additional information from the provider
- Pre-bill claim edits applied using payer specific data requirements
  - Medical necessity coding
  - CCI coding issues
  - CPT/Revenue code conflicts
  - Authorization code requirements
  - Formatting of subscriber ID
  - Missing required information

Typical Claim Edits

<table>
<thead>
<tr>
<th>Claim Edit</th>
<th>Resolution Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical necessity (NCDs and LCDs)</td>
<td>Follow up with provider for additional or corrected ICD-9-CM diagnosis codes</td>
</tr>
<tr>
<td>Incomplete demographic or insurance information</td>
<td>Follow up with patient or insurance as necessary</td>
</tr>
<tr>
<td>Invalid revenue codes or HCPCS codes:</td>
<td>Review manuals for updated codes; follow up with HIM for correct coding and/or chart review</td>
</tr>
<tr>
<td>- Obsolete</td>
<td></td>
</tr>
<tr>
<td>- Incorrect for type of bill</td>
<td></td>
</tr>
<tr>
<td>- Missing modifiers</td>
<td></td>
</tr>
<tr>
<td>- Incorrect combination of codes and/or modifiers</td>
<td></td>
</tr>
<tr>
<td>based on Correct Coding Initiative (CCI)</td>
<td></td>
</tr>
<tr>
<td>Missing digits (fourth or fifth) of ICD-9 or ICD-10 codes</td>
<td>Follow up with HIM for appropriate coding</td>
</tr>
<tr>
<td>Missing physician NPI numbers</td>
<td>Contact physician for NPI numbers</td>
</tr>
<tr>
<td>Condition code required for one of following:</td>
<td>Obtain required condition code</td>
</tr>
<tr>
<td>- Work related</td>
<td></td>
</tr>
<tr>
<td>- MSP Issue</td>
<td></td>
</tr>
</tbody>
</table>
Typical Claim Edits

<table>
<thead>
<tr>
<th>Claim Edit</th>
<th>Resolution Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect formats (cannot use hyphens, punctuation, etc.)</td>
<td>Correct format (could program system to remove)</td>
</tr>
<tr>
<td>Payer-specific missing or invalid insurance information:</td>
<td>Follow up with patient or insurance to obtain required information</td>
</tr>
<tr>
<td>- Required prefixes/suffixes</td>
<td></td>
</tr>
<tr>
<td>- Authorization numbers</td>
<td></td>
</tr>
<tr>
<td>- Group name/numbers</td>
<td></td>
</tr>
<tr>
<td>Occurrence codes and dates required for one of the following:</td>
<td>Contact patient or service department for additional information</td>
</tr>
<tr>
<td>- Accident related</td>
<td></td>
</tr>
<tr>
<td>- Treatment dates for therapy</td>
<td></td>
</tr>
<tr>
<td>Negative charge amount on claim</td>
<td>Charge detail must be reviewed to identify why negative charge</td>
</tr>
<tr>
<td>New: ICD-9 vs ICD-10 code/date conflicts</td>
<td>Split claims based on DOS and use appropriate coding methodology</td>
</tr>
</tbody>
</table>

Strategy: Reducing Claim Edit Failures

- Homework: use claim scrubber daily edit failure reports to identify the volume and dollars involved
- Assemble the Team: bring the responsible parties to the table to explain the scope and value of the failures
- Brainstorm: ways to stop the failures rather than continue to fix the failures
- Develop: detailed solutions, identify resources, train, implement changes and continue to monitor & report results
Billing

- Accounts billed electronically
- Contractual adjustments calculated and applied
- Account status changed from DNFB to Final Billed
- Monitoring for required follow-up begins based on clean claim payment cycles
- Secondary billing-processed after EOB for primary claim processed

Calculating the Clean Claim Cycle By Payer

- Clean claim = a claim that is sent to a payer that can be processed and paid correctly without asking for additional information from the provider
- Data needed:
  - Payer
  - Clean claim status (if yes, include; if no, exclude)
  - Discharge date/service date
  - Claim submission date (primary payer)
  - Payment receipt date

<table>
<thead>
<tr>
<th>Payer</th>
<th>Discharge Date</th>
<th>Claim Submission Date</th>
<th>Payment Receipt Date</th>
<th>Total Elapsed Days: Discharge to Pay</th>
<th>Total Elapsed Days: Submission to Payment</th>
</tr>
</thead>
</table>
**Contractual Adjustments**

- Payer contract details adjustment methodology
  - Indemnity/FFS - % of charges
  - Per diem
  - Case rate/bundled charges
    - Specific services only
    - All-encompassing, i.e. MS-DRG’s, APC’s
  - Fixed contracting – fee schedules
  - Capitation
- Applied at time of billing or at time of payment posting

**Insurance Follow-Up**

- Clean claim payment cycles
- Subsequent follow-up based on results of initial activity
- Hospital-specific procedures
  - Unresolved insurance after 60 days
  - Segmentation approach
- Documentation requirements
  - Next follow-up date
  - Next activity
  - What was done, when, names of payer reps, etc.
**Tools to Reduce Payment Delays**

- Manage unbilled and final billed but not submitted claims
- Electronic claims processing
  - System record all bill submission dates
- Special handling:
  - Overnight mail or courier
  - Registered mail with required attachments
- Monitor payment cycles and backlogs

---

**Self Pay Follow-Up**

- Self pay defined: pure self pay or patient balance after insurance
- Underinsured and uninsured options
- Financial policy components, including 501(r) compliance for 501(c)3 organizations
- Bad debt vs. charity
- Charity policy components
- Bad debt placement
- Medicare bad debts
Denials Management

- Denials – zero pays
- Denials – partial pays
- Total number of denials overturned by appeal
- Denial write-offs as % of net patient service revenue

Denials Prevention

- Root cause analyses
- Team approach
- Assign ownership
- Track results
Definitions

• What is a payer denial or delay?
  – Payment was **expected** by the service provider but was not received from the payer. Additional **action** must be taken by the provider in order to receive payment from payer. Additional action does not always guarantee payment.

• Initial Denial:
  – Pre-action initial denial

• Final Denial:
  – Post action final write-off i.e. claim has been appealed and denial upheld by payer

• Payer Delay:
  – Request for information before payment can be received from payer

Denial Examples

• **Payer Denials:**
  – No authorization
  – No notification
  – No pre-cert
  – Not Medically Necessary
  – Pre-Existing Condition
  – Experimental
  – Non-Covered
  – Timely Filing
  – Benefits Exhausted
  – Out of Network
## Denials – Where They Occur

### Description of Denial

<table>
<thead>
<tr>
<th>Description of Denial</th>
<th>Revenue Cycle Segment: Pre-Service, Time of Service, Post Service</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplicate claim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate level of care</td>
<td></td>
<td></td>
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<tr>
<td>Unable to identify subscriber</td>
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<tr>
<td>OP diagnostic service provided 1 day prior to admission to IPPS hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient date of birth does not match information in subscriber record</td>
<td></td>
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<tr>
<td>Observation service considered part of routine procedure recovery time</td>
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<tr>
<td>Medicare billed; common working file indicates patient in first 30 months of ESRD coverage with EGHP benefit</td>
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<tr>
<td>Dates of service outside claim from and through dates</td>
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</tr>
</tbody>
</table>
Prevent Not Manage!

When it is less expensive and more productive to get something right the second, third or fourth time around?

- Automation
- Process improvements
- Staff accountability

Remember the usual cast of characters: medical necessity, authorizations, service location, observation vs. admission

Cash

- Electronic funds transfer (EFT)
- Electronic Remittance Advice (ERA)
  - 835 electronic transactions set
  - Four levels
    - Level 1: received electronically, printed and processed same as a paper remittance advice
    - Level 2: electronic receipt and data entry, with significant matching of accounts and charges required manually
    - Level 3: electronic receipt, posting, reconciliation, and closing; manual only to resolve errors
    - Level 4: totally automated, including link to bank for reconciliation, plus produces Medicare logs and automated secondary billing
- Bank lock box processing
- Account reconciliation and silent PPOs
Credit Balances

- Account balance created by payments and contractual adjustments exceeding charges
- G/L impact
- Financial statement liability
- Medicare CMS-838 quarterly report
- State reporting requirements (unclaimed funds)

Guidelines for Reporting Bad Debts & Charity Care

- HFMA Principles and Practice Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers
  - Bad debts = deduction from patient service revenue
    - Functions the same as contractual adjustments in that when an account is classified as a bad debt, the receivable is reduced and the deduction from revenue is recorded
  - Charity = eliminated from both revenue and receivables
    - In effect, eliminates both the receivable and the revenue from the financial statements
  - Disclosure of charity care policy and amount provided required
    - Included in the community benefit information provided on the IRS 990 filing as well as any state filing requirements
    - Shown at cost as a footnote to the financial statements

Source: 2011 AICPA audit guide, Accounting Standards Codification 945-310 and ASC 954-605
Importance of Bad Debts vs. Charity Classifications

• Measurement of revenue cycle effectiveness, or ineffectiveness (bad debts)
• Consumption of resources for which no compensation is received (charity)
• Demonstration of fulfillment or organization’s charitable purpose (charity)
• Accurate statement of one portion of community benefits (charity)
• **Compliance**, discounting based on financial needs (charity and bad debts) + 501(r)


Components of Charity Care

• Financial assistance policy requirements, including 501(r) issues
• Formal policy approval
• Application form
• Eligibility criteria
• Restrictions on ECA during application period
• Publication and communication to patient population
• Communication in “plain language”
Bad Debt

- HFMA’s Best Practices for Resolution of Medical Accounts
  - Lay the groundwork by following the Patient Financial Communications Best Practices
  - Make bills clear, concise, correct and patient friendly
  - Establish board-approved policies for account resolution and ensure compliance
  - Handle key aspects of account resolution consistently
  - Coordinate account resolution activities with business affiliates to avoid duplicative patient contacts
  - Exercise sound business judgment about best ways to tailor policies and procedures to economic circumstances and needs of the community

Summary Post Service Workflow

<table>
<thead>
<tr>
<th>Primary claim produced and edited in claim scrubber</th>
<th>Claim submitted to payer</th>
<th>Contractual adjustment posted to account</th>
<th>Account paid without intervention – payment received and posted</th>
<th>Account paid after follow-up intervention – payment received and posted</th>
<th>Secondary bill or patient bill produced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exception/Resolution</td>
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<td>Exception/Resolution</td>
</tr>
</tbody>
</table>
Summary Post Service Workflow

<table>
<thead>
<tr>
<th>Patient follow-up cycle/medical debt resolution process followed – account resolved</th>
<th>Secondary payer follow-up/payment cycle followed – account paid in full or balance to patient</th>
<th>Zero balance achieved</th>
</tr>
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Metrics

- What metrics do you currently use and what are the new metrics you plan to implement to monitor post-service processes.
- For each metric, identify the name, relevance, data elements, source, calculation and frequency.
- Examples: Net days in A/R; Aged A/R >90 days; Denials; Days in Credit Balances; Cash as % of net patient service revenue, etc.
From Metrics to Process

It’s Results That Count!

- Key Performance Indicators (KPI’s)
  - Measuring performance
  - Using results to drive change
- Financial management issues
Learning from High Performers

• How frequently do you review metrics?
• Which metrics?
• How important is communication with your staff; how frequently?
• How often do you meet with insurance company provider representatives?
• What is the focus of your organization’s culture?
• Denials – weekly cross-functional team meetings; track progress; demand accountability for results

Lean concepts that work:
– Data walls
– Daily huddles
– Idea board
– Transparency
• Patient advisory councils
• Patient focus groups
• Portal application that allows patients to set up their own payment plans
Learning from High Performers

- Centralized call center-patient rapid response center
  - Technology based
  - Immediate feedback-patient survey after each call; share results
  - Record all calls
- Patient navigators/patient advocates
- Incentive programs – all system-based; no individual goals
- Improving patient satisfaction scores—it’s a BIG project! (Hint: accountability; projects; ok to fail; not ok to not try!)

Highly Effective Habits

Research Has Shown that High-Performing Revenue Cycles Focus on Six Key Areas

<table>
<thead>
<tr>
<th>People</th>
<th>Processes</th>
<th>Technology</th>
<th>Metrics</th>
<th>Communication</th>
<th>Culture</th>
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</table>
### Patient Friendly Billing® Strategies

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</tr>
</thead>
<tbody>
<tr>
<td>C-Suite</td>
<td>Set high expectations for revenue cycle positions</td>
<td>Develop &amp; participate in forming teams around revenue cycle</td>
<td>Appreciate community dynamics and those with greatest impact to the organization when prioritizing tech needs</td>
<td>Support organizational alignment around clear, correct and patient-friendly messaging</td>
<td>Demonstrate value for the revenue cycle through significant commitment of time and resources</td>
</tr>
<tr>
<td></td>
<td>Devote organizational resources to improved training and compensation</td>
<td>Use patient experience as cornerstone for setting revenue cycle strategy</td>
<td>Encourage improved monitoring of revenue cycle processes through use of traditional and non-traditional metrics</td>
<td>Set clear and transparent financial assistance policies &amp; procedures</td>
<td>Establish systems to reward high revenue cycle performance</td>
</tr>
<tr>
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<td>C-Suite</td>
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### Designing Operational Metrics

- **Multiple levels from macro (Map Keys) to detailed to vendors**

First level Keys:
- Cash by major payer category daily and month-end
- Cash to Net %
- Discharged not final billed – Days in A/R (include failed claims)
- Accounts receivable aging
- Self pay A/R (include % of total A/R)
- Gross A/R days and Net AR days
- Bad debt write-offs as % of GPR
- Charity write-offs as % of GPR
- Denial write-offs as % of GPR
- Denial A/R
- Payment Variance A/R

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Source: Strategies for a High-Performing Revenue Cycle, HFMA, 2009, p4

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Source: Strategies for a High-Performing Revenue Cycle, HFMA, 2009, p4
Designing Operational Metrics

Level 2: Departmental Performance – Example – Patient Access
  – POS Collections
  – Customer service scores
  – Registration error rate
  – Pre-registration of scheduled procedures and services
  – Conversion of self pay to insurance
  – Central Scheduling – Call abandonment rate

Designing Operational Metrics

• Level 2: Department Performance – Example – HIM
  • $ delayed in HIM
  • DNFB days >3 days
  • Transcription turnaround time
  • Clinical chart turnaround time
Applying the MAP Strategies: Measure

- Payer Performance Scorecards:
  - Anonymous comparative data by payer
  - Denial rates as a % of visits/admissions
  - Types of denials
  - Overturn rates
  - Appeal turn around time
  - Average days to pay
  - A/R Aging
  - # and $ Outstanding appeals over X days old
  - # and $ Outstanding overturn denials over X days old

MAP Strategy: Apply

- Sharing performance with payers
- Comparing denial rates among payers
- Driving improvement in appeals resolution days
- Comparing average days to pay
- Using scorecard data to change managed care contract terms
MAP Strategy: Perform

- Use data to reduce days in A/R
- Use data to improve denial resolution rates and times
- Lower denial rates equates to $X increase in cash collections
- Reduce bad debts

Finding Your Opportunities …

Identify segments of the revenue cycle where performance is lagging
Prepare a Gap Analysis to confirm specific target areas
Use the ideal revenue cycle steps from the Gap Analysis and best practices from industry sources to redesign for the future
Finding Your Opportunities …

- Set performance expectations over a reasonable period of time
- Train staff
- Implement and continue to track the relevant KPIs to demonstrate progress on a routine basis

Gap Analysis…Sample

<table>
<thead>
<tr>
<th>Best Practice Activity: Pre-service</th>
<th>Facility - Current Activity</th>
<th>Gap Narrative</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally integrated electronic scheduling system used for all scheduled services; single database used to allow scheduling to view all system resources and enterprise-wide MPI</td>
<td></td>
<td></td>
<td>100% of services which should be scheduled are electronically scheduled</td>
</tr>
<tr>
<td>Electronic scheduling option available to physician offices through secure network</td>
<td></td>
<td></td>
<td>100% of services which should be scheduled are electronically initiated by the physician offices</td>
</tr>
<tr>
<td>ABN process integrated into scheduling and completed at earliest opportunity based on written order and coded diagnosis</td>
<td></td>
<td></td>
<td>100% screened prior to provision of service</td>
</tr>
<tr>
<td>Rules-based work distribution and delinquency monitoring tool used to route accounts for processing and to identify processing requirements for scheduling and pre-service work</td>
<td></td>
<td></td>
<td>100% of scheduled and pre-registered cases monitored to identify processing requirements for scheduling and pre-service work</td>
</tr>
</tbody>
</table>
In Closing

- Talk is cheap!
- Action takes effort!! And a TEAM!
- Key = Measure, Apply, Perform
- Think of the revenue cycle “secret sauce” as metrics leading to a never-ending set of opportunities …
- Aim for the moon!

<table>
<thead>
<tr>
<th>Net Days in A/R</th>
<th>Aged A/R &gt;90 days</th>
<th>DNFB</th>
<th>FNBS</th>
<th>Bad Debt</th>
<th>Cash as % of Net PSR</th>
<th>POS Cash</th>
<th>Charity</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.2 days</td>
<td>10.7%</td>
<td>2.8 days</td>
<td>0.0 days</td>
<td>0.5%</td>
<td>104.8%</td>
<td>38.5%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

The Revenue Cycle Model HAS Changed

<table>
<thead>
<tr>
<th>Historical Model</th>
<th>Contemporary Model</th>
</tr>
</thead>
</table>
| Gather basic info before & at the time of service. | Gather info before & at time of service. Prospectively calculate expected out-of-pocket costs. Communicate with patients.
| Most billing processes are post-service, amounts due based on data gathered after service, calculated retrospectively. | Providers bill at or right after time of service. Patients know in advance what they owe & agree on terms.
| Pre-Service: Prospective Data Gathering and Processing | Post-service: Retrospective Data Gathering and Processing
| At Service | Insurance bill verifies what the patient already expects.
| Post-Service |
Alternative Viewpoints!

Questions?
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Director, Healthcare Finance Policy, Revenue Cycle MAP  
HFMA

Ms. Wolfskill is responsible for revenue cycle and MAP initiatives at HFMA. Her extensive experience in revenue cycle management includes leading engagements with clients engaged in process mapping and analysis, project management, staffing analyses, using contemporary metrics to identify improvement opportunities, staff education, interim management and system implementation testing and training. Prior to joining HFMA, she worked closely with HFMA in supporting the task force work which lead to the CRCR study guide and certification process.

Background and Affiliations

Ms. Wolfskill received a B.A. summa cum laude from Wittenberg University and a Master of Arts degree from The University of Delaware. Prior to founding her consulting firm, Sandra had extensive revenue cycle experience and provider management experience in a variety of positions, including serving as the chief financial officer for a small community hospital.

When not engaged in revenue cycle opportunities, Sandra, along with her best friend Donna, can be found breeding and showing their Dandie Dinmont Terriers and judging dog shows in the United States, Europe, Canada, China and Russia.

Contact Information

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