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healthcare financial management

REVENUE CYCLE

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strengthening the revenue cycle

a 4-step method for optimizing payment

AT A GLANCE

Four steps for enhancing the revenue cycle to ensure optimal payment are:

- Establish key performance indicator dashboards in each department that compare current with targeted performance
- Create proper organizational structures for each department
- Ensure that high-performing leaders are hired in all management and supervisory positions
- Implement efficient processes in underperforming operations

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Improving the revenue cycle can be a daunting task due to the scope and complexity of the interdepartmental process. Because optimizing payment is so critical to optimizing a health system's margins, the entire revenue cycle must function at peak performance. Otherwise, like a rusty pipe, the revenue cycle can leak revenue at various stages of the process.

The revenue cycle links seven departments and functions to optimize cash collections. The cycle begins in patient access, where patient information is gathered, and ends in managed care, after the health system has been paid for services. The reason the cycle ends in managed care rather than patient accounts, where cash is collected, is that the amount collected must be analyzed to see whether payer contracts are profitable or need to be renegotiated. Case management (or utilization review), the chargemaster, and charge capture—which are sometimes combined to make up a revenue management department, health information management, and patient accounts—constitute everything in between.

Because of the interdepartmental process that combines these departments, it is often hard to know where to begin and where opportunities exist. The following is a simple, yet tactical four-step framework and methodology for improving the entire revenue cycle.

1. Establish Key Performance Indicator Dashboards

The first step to optimizing the revenue cycle is to establish and track the right key performance indicators (KPIs) for each department. A gap between current and targeted outcomes indicates an opportunity for improvement.

Only outcomes that fulfill the purpose and objective of the operation are measured. For instance, if the purpose of an operation is to accurately code all inpatient charts within four days of the discharge date, the KPIs should track only those outcomes—the quality, quantity, and speed—that are being coded. In this manner, KPIs drive accountability and productivity because the right performance is continually monitored and compared against a target. Over time, an operation will

Implementing efficient processes throughout each department is critical to achieving optimal payment.

naturally align and configure itself to produce the measured outcomes more efficiently.

KPIs should be summarized in a dashboard so that managers know at a glance which operations are on target and which are not. Dashboards should also be maintained and updated in a timely manner, such as weekly or monthly, to allow management to respond quickly to performance problems.

2. Create an Effective Organizational Structure

The second step is to implement the proper organizational structure for the overall revenue cycle as well as for each revenue cycle department. Ideally, all revenue cycle departments should report under a common executive, typically the CFO, to increase collaboration and ensure that accountability and performance expectations are consistent across departments. Case management is usually the only outlier to this structure, as it most commonly reports under nursing. However, in some hospitals, even case management reports to the CFO.

When all revenue cycle departments report to the same executive, the revenue cycle is managed as a process, allowing each department to work together in correcting delays and breakdowns. For instance, if patient access is not accurately and completely registering patients, patient accounts is adversely affected when it submits claims with incorrect patient information. When all parties are at the table, reporting to the CFO, the entire revenue cycle can be tracked and broken down into its component parts so that collaboration and accountability keep the process performing better.

In larger health systems, a revenue cycle or patient financial services vice president position may exist to provide leadership over large numbers of employees and reduce the number of direct reports to the CFO. Vice president positions within the revenue cycle should still report directly to the CFO with their peers from the other revenue cycle departments to discuss bottlenecks, systems, processes, procedures, and specific patient accounts.

The exhibit on page V illustrates a common revenue cycle organizational structure reporting directly to the CFO. Other departments that report to the CFO, such as accounting, finance, and decision support, are not included in the chart.

It is imperative that all functional areas within each revenue cycle department be properly aligned under specific directors, managers, and supervisors to ensure a specific focus on revenue cycle functions. This singular focus increases the expertise of the leadership, translating into improved efficiency, greater accountability, and better outcomes.

Functions should be aligned as much as possible under specific, subject-matter expert managers and supervisors. Ideally, front-line staff should be aligned under each leader according to their functional roles and responsibilities. Poor department organizational structures typically have a manager or supervisor overseeing too many different functions, eroding the manager's ability to effectively lead each area.

On the other hand, some functions are unnecessarily split up between two or more managers when just one manager would suffice. For instance, when a single function, such as financial counseling, is overseen by two managers, variability will occur in outcomes between the two groups because performance expectations, employee wages, processes, procedures, systems, efficiency, and accountability will differ between each manager. Over time, the two groups will become even more distinct, and one group will inevitably become more efficient than the other.

KEY PERFORMANCE INDICATORS AND BEST-PRACTICE TARGETS, PATIENT ACCOUNTS

Patient Accounts Key Performance Indicator	Best Practice Target
Average days to bill from discharge	7 to10 days
Billing/claim errors	95% of processed claims should be error-free (<5% should fail claim scrubber)
Bad debt write-offs as a percentage of gross revenue	No more than 3%
Charity care write-offs as a percentage of gross revenue	No more than 2% (unless state required)
Cash collections to net revenue	98% of expected net revenue
Net A/R days	45 to 55 days
A/R greater than 90 days	No more than 20%
Cost-to-collect ratio	3.5% or 3.5 cents on the dollar
Collection agency netback	No more than 6% to 10%
Days revenue in credit balances	< 1.5 days
Suspense or bill hold days (inpatient/outpatient)	2 to 4 days
Unbilled amounts greater than bill hold days	2 days' revenue greater than suspense days
Customer service	Average hold time < 1 minute Average talk time < 2 minutes Average calls abandoned per day < 20
Repeat bad debt	Flag and identify repeat offenders
Denials	< 5% of net revenue or 5% error rate
Self-pay and patient-responsible balances	Collect at point of service (or at preregistration)
Biller productivity	100 to145 rep/day 2,250 to 3,000/month (much higher from electronic billing)
Follow-up productivity	45 to 55 rep/day (lower end for following up large-dollar accounts, higher end for low-dollar accounts) ≤ 1,000 accts for large-dollar reps ≤ 3,500 accts for small-dollar reps

Source: Marlowe Dazley, managing director, Phase 2 Consulting. Used with permission.

In addition, assistant director, assistant manager, and coordinator positions typically hinder the effectiveness of a department because they add unnecessary layers of management. Although in rare instances, these types of positions may be necessary, they generally and unnecessarily reduce the workload and dilute the accountability of the director, manager, and supervisor. When directors, managers, and supervisors can delegate too many of their responsibilities, they tend to get a little too comfortable, and performance suffers.

Once the right management structure has been created, the appropriate number of front-line staff can be determined according to productivity standards.

3. Hire Outstanding Leaders

All staff should be overseen by high-performing leaders. Low-performing leaders can cost organizations millions in lost revenue due to mistakes and low productivity. When the department head is a model of high performance, he or she insists on hiring supervisors with similar high-performance profiles.

Starting at the top is critical because the department leader establishes the culture and work ethic for the entire department. If a department is overseen by a mid- to low-performing director, that director's style, personality, and personal qualities will cascade downward so that over time, the entire department will display a fairly homogenous set of traits. This phenomenon occurs as high-performing employees begin to resent the department head and leave the department. It also occurs when replacements are hired who share the qualities of the low-performing leader. In today's competitive environment, it is not enough to hire a manager who is proficient in functional and technical duties; the performance attributes of outstanding leadership are equally important.

4. Enhance Workflow Processes

Implementing efficient processes throughout each department also is critical to achieving optimal payment. Underperforming areas that need improvement can be identified from the KPIs. Those showing the greatest opportunity for improvement should be redesigned or reengineered first.

When redesigning a process, it is important to benchmark with best practice health systems and learn what they are doing. This can save much of the needless and duplicative trial and error that all too many health systems engage in. Following are 10 revenue cycle process improvement recommendations that can help optimize cash collections.

Registration accuracy. Create a registration auditing/training team responsible for training registration clerks and performing quality control on the patient registration work they do. This team should provide training for new employees and existing employees, monitor payer denials, conduct paperless face sheet audits, shadow staff, and test staff knowledge. Also, develop a policy for registration accuracy to hold staff accountable to accuracy standards. New registrars should undergo a 40-hour training period and pass a test before registering patients on their own.

Outpatient clinic registrars. Where feasible, place outpatient clinic registration clerks under patient access to ensure consistent, accurate, and complete registrations across the health system. Registration clerks who register patients in the clinics usually report to nurse managers, and do not have the same knowledge base and performance expectations as registrars reporting to patient access. Registrars who cannot report to patient access should be held to the accuracy policy developed by patient access, which can result in restricting habitually poor performers' access to the registration system.

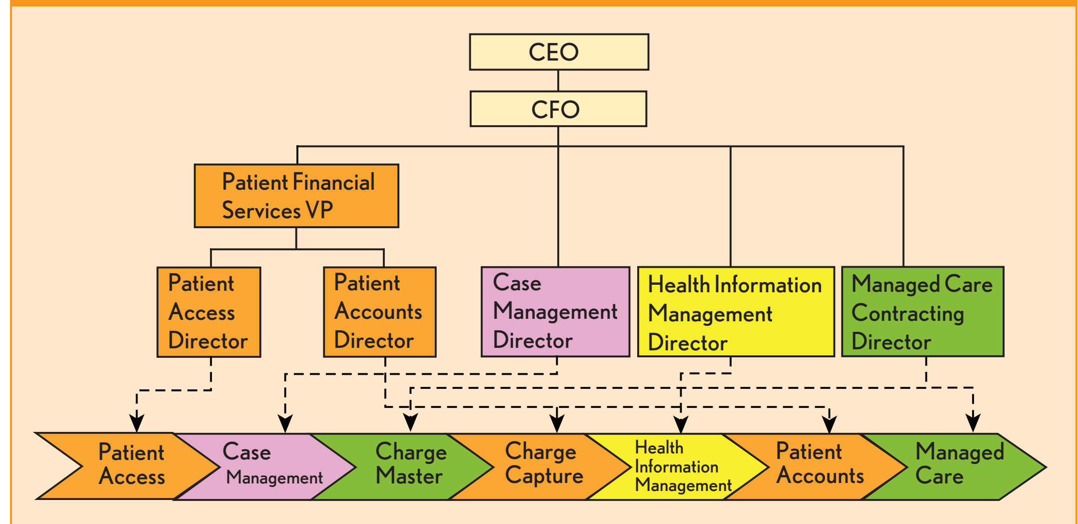
Denials management. Generate weekly payer denial reports that categorize denials into three categories: registration, clinical, and billing denials. Once denials are categorized in this manner, the mistakes can be forwarded to the appropriate department for review and follow-up. Although it often makes more sense for patient accounts to quickly fix many of the denial problems that occur in registration or case management, it is still important to track their errors to ensure proper training and accountability. In addition, case management can appeal appropriate clinical denials.

Emergency department (ED) registration. Register lower-acuity patients up front, rather than at bedside, because up-front registration typically requires fewer staff and results in higher numbers of accurate and complete registrations. In many hospitals, after triage, nurse practitioners perform the medical exam and stabilize patients before they can be registered, in accordance with Emergency Medical Treatment and Active Labor Act requirements. Lower-acuity patients are then given the option of paying an expensive deposit to see an ED physician or making a clinic appointment to see a physician at a lesser cost.

ED collections. For hospitals with high ED volumes and high percentages of self-pay cases, place a discharge desk in the ED to review and complete patient registrations at the time of discharge and collect deposits and copayments. Because patients can be missed in the registration process due to bedside registration, a discharge desk helps ensure patients are adequately registered before they are discharged.

Transfer center. Place the transfer center under case management to manage the appropriateness of direct admits and inter-facility transfers, particularly

COMMON REVENUE CYCLE ORGANIZATIONAL CHART SHOWING DIRECT REPORTS TO THE CFO



Revenue cycle job functions should be aligned as much as possible under specific, subject-matter experts and supervisors.

self-pay cases. Having a nurse in the transfer center also significantly helps in the proper bed placement of new patients.

Financial counseling. Review registration information on all newly admitted patients on the floors and units, particularly those being admitted from the ED. Do not outsource Medicaid conversions on the labor and delivery floor. Since these patient cases typically convert easily to Medicaid when financial requirements are met, it is usually more cost-effective to insource this function rather than outsource it.

Point-of-service collections. Create a policy for upfront copay and self-pay collections and monitor collections at each point of service. Typical self-pay collections policies state that 50 percent of charges should be collected in advance of the scheduled procedure, unless a form of medical necessity has been signed by the physician and hospital medical director authorizing the procedure.

Preregistration. Register patients and collect copayments at the time of scheduling. Implement adequate insurance verification and prior authorization processes for high-dollar scheduled and unscheduled cases. A matrix showing which payers require authorizations for certain procedures is helpful to have at the point of service so registrars can act as gatekeepers to ensure that procedures will be covered.

Charge capture. Run reports that identify, in descending order, what drugs, procedures, implants, and other supply items generate the greatest charges. Then, beginning with those items at the top of the list, determine if they are being properly charted, charged, billed, and reimbursed. Ensure that charges are being entered on correct account numbers and that daily reconciliations between what has been charted and charged are being performed daily. One area that is often overlooked is the incorrect unit of measure conversion for high-dollar drugs, often resulting in underpayments.

A Strategy for Enhanced Collections

These four steps to successful optimization of revenue cycle payment create a permanent infrastructure geared toward enhanced collections. The steps not only set the stage for ideal processes, but also help to ensure that these processes are sustained over the long run. ●

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