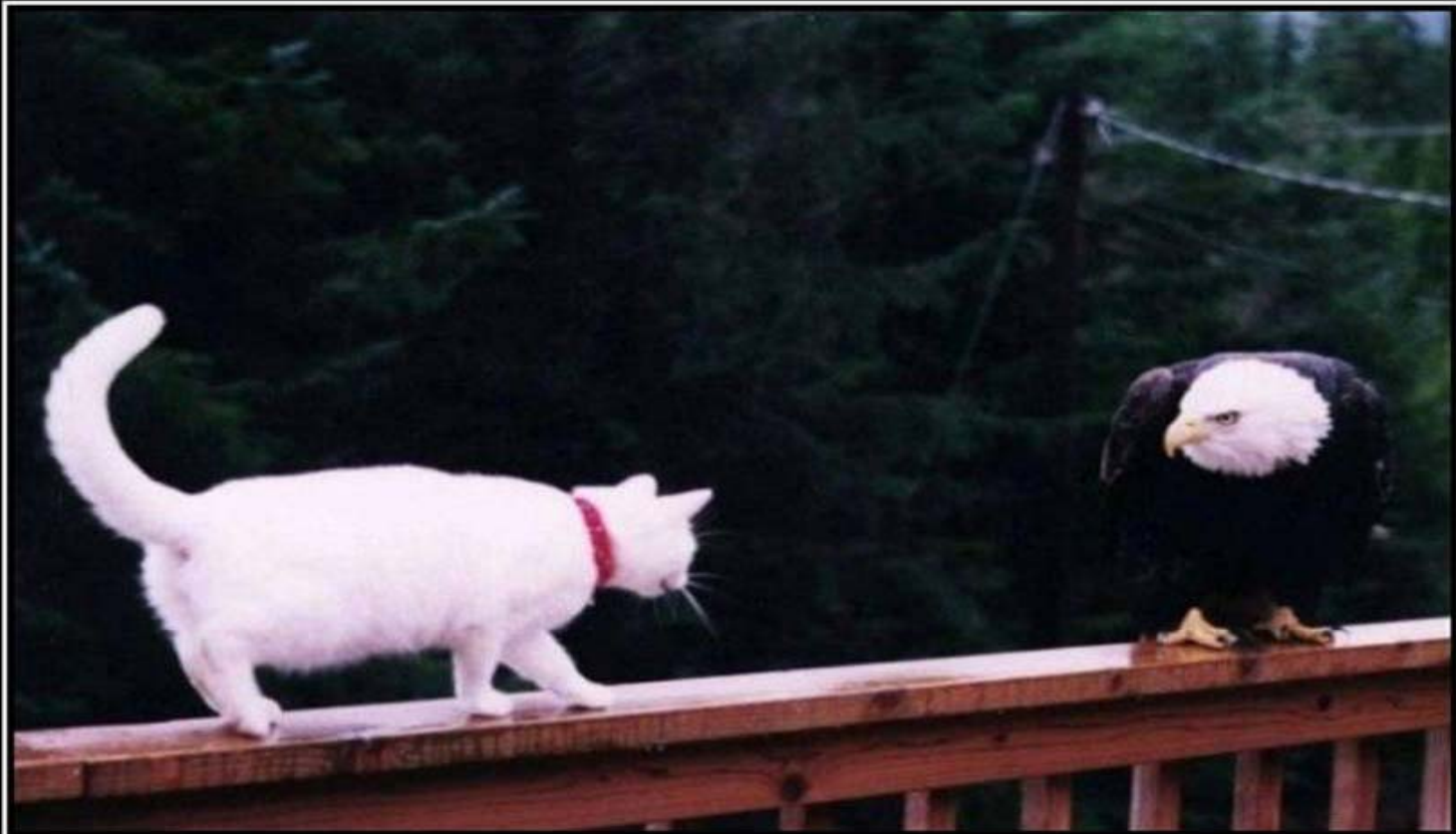


Current Trends in Revenue Cycle Performance Benchmarks, Outsourcing and Reform

Discussion Outline

- Discussion Objectives and Approach
- Process Definition
- Leading Practice Comparison
- Trends in Outsourcing
- Reform Update for Revenue Cycle Professionals



OVERCONFIDENCE

This is going to end in disaster, and you have no one to blame but yourself.

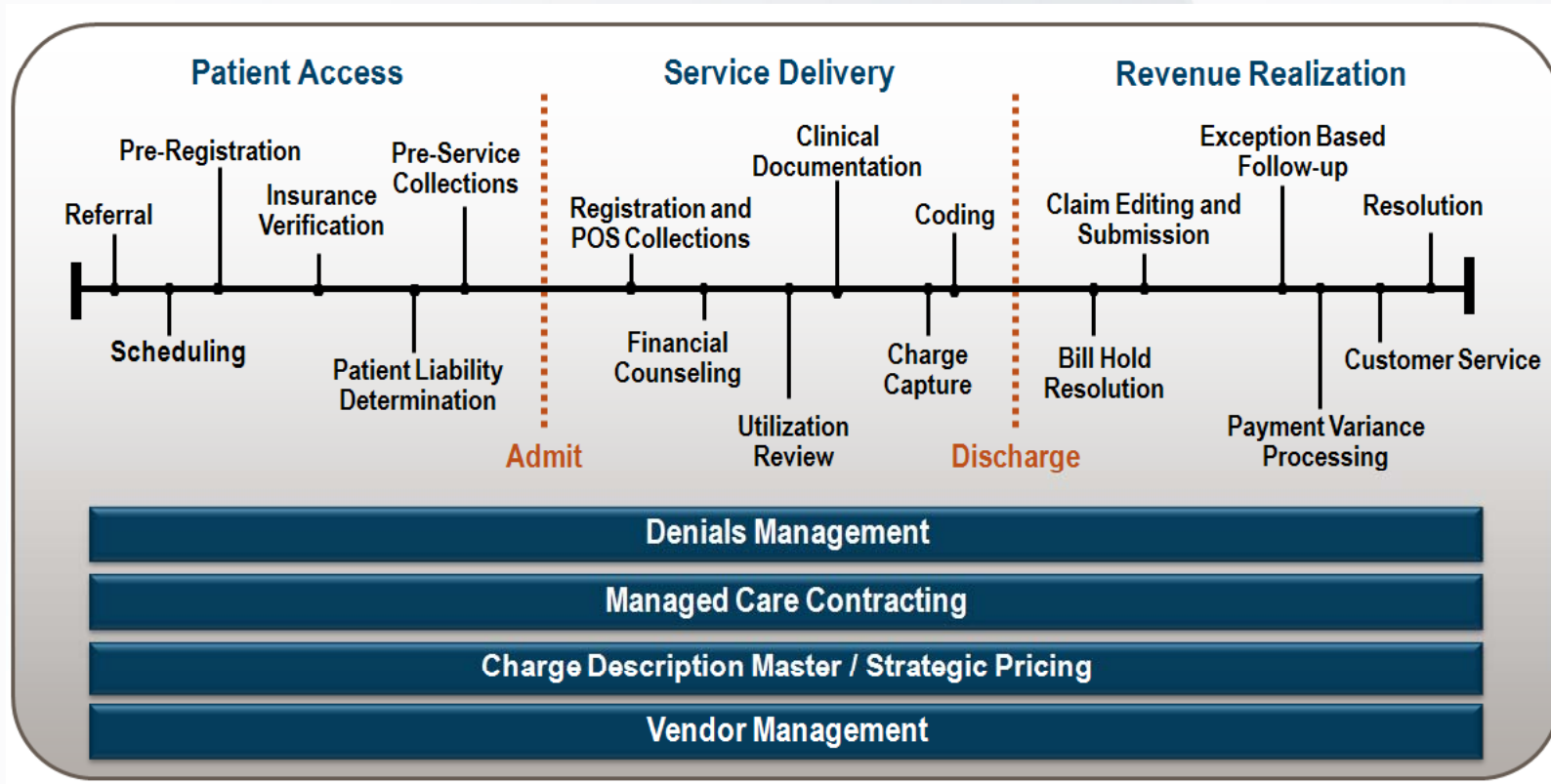
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What do you Consider the Revenue Cycle ?

Definition of Revenue Cycle

Almost all processes and inputs can have measurement tailored that targets opportunities across a hospital or professional fee revenue cycle.

Key Selection Factors: Accuracy, Relevance, Actionable



Benchmarks, performance standards,

- A performance standard something can be measured or judged
- A measure of performance of a process relative to another similar item in an impartial scientific manner
- Benchmarks can be # or other process performance indicators

What isn't a benchmark or performance standard

- Simple counting : How much is there? How many there are of something? That's **Measurement**
- Tracking outcomes or volumes across a set of similar processes / locations without ownership - **That's pointless comparison**

What destroys benchmark value

- Normalization of data
- Poor alignment - or does your team find value in the measure



ROLE MODELS

Choose Wisely


Critical Success Factors

- Measure to improve Not to promote
- Measurement should foster distributed accountabilitypersonal ownership
- Invest in automation of measurement and report production
 - Stability is as important as relevancy! If a performance report, data elements, format or distribution frequency changes it is viewed as less relevant
- Standards can be internal or external to your organization
 - Don't be a snob - e.g. UHC
- Don't normalize a national / regional / benchmark ...
- Can't find a relevant benchmark? Set relevant performance comparisons
 - Requires more frequent review for relevancy
- Align with performance standards – benchmarks - real \$
 - This is not an academic exercise .

Leading Practice Comparison

Current Performance Metrics and Practices

Revenue Cycle Function	Revenue Cycle Leading Practice Performance Indicator
Pre-Registration & Insurance Verification	On average, pre-registration and insurance verification activities are completed 7 days out for scheduled services
Pre-Registration & Insurance Verification	95%+ of patients are financially secure at admit/service for scheduled or elective cases
Financial Counseling	90%+ of uninsured and underinsured patients are financially screened by discharge
Charge Capture	OP Charge capture audits are performed for high dollar and high volume areas on a regular basis with a error rate of < 10%
Clinical Documentation	Comprehensive, concurrent clinical documentation improvement program driven by dedicated CDS associates. The Average CDS contributes > \$500K in MS DRG NR improvement

Below Average Performance/Not Measured =  / Average Performance =  / Strong Performance = 

Leading Practice Comparison

Current Performance Metrics and Practices (continued)

Revenue Cycle Function	Revenue Cycle Leading Practice Performance Indicator
Bill Hold Resolution	Comprehensive Billing Work-In-Process (WIP), post suspense, is within 2 days gross Average Daily Revenue (ADR)
HIM / Medical Records	Chart deficiencies and uncoded accounts are tracked, reported, and communicated
Account Follow-up	Average follow-up activity (productivity) is within leading practice range (45-55 accounts per day per staff member)
Revenue Cycle-wide	Total A/R (including unbilled) aged over 360 days from discharge is below 2%
Vendor Management	Vendors are strategically deployed throughout the Revenue Cycle. Vendor performance is tracked and monitored on a monthly basis. Regular vendor meetings are conducted to review performance.

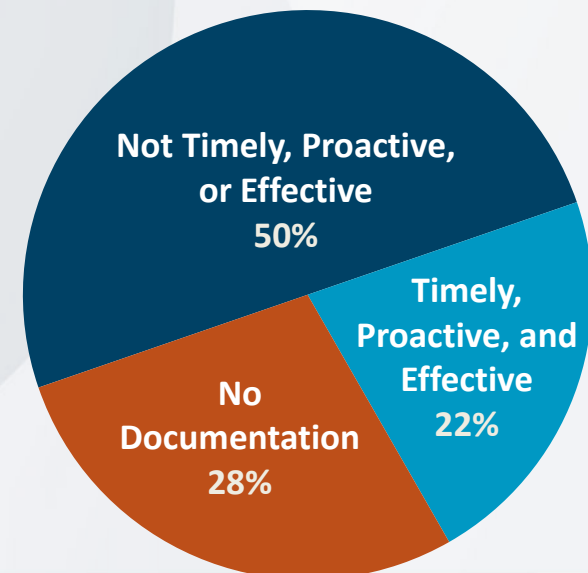
Other High Level Revenue Cycle Benchmarks

<u>Category</u>	<u>Berkeley Targets</u>
■ Accounts have timely, proactive, and effective processing	> 90%
■ Follow-up Quality	> 75%
■ Avoidable Administrative Codes	<1.5% of NR
■ Total AR Agings 360+	<5%
■ Total AR Agings 90+	<19%
■ Bad Debt Write-Off Codes	<3% of NR
■ Billing Work In Process	3 days ADR
■ Net AR Days	<40 days
■ POS Collections	1% of NPSR

Active A/R Account Reviews – Account Processing Activity

- **Performance Measure Objective:** Determine opportunity for cash flow / process improvement by reviewing the frequency, quality, and effectiveness of account processing activity (e.g., billing, follow-up, appeals)
- **Leading Practice: Every Supervisor needs to be able to explain the measure**
 - More than 90% of accounts have timely, proactive, and effective processing
 - Proactive processing occurs at least every 30 days for accounts over \$1,000 and more frequently for accounts over \$10,000
 - All processing activity (including vendor activity) is thoroughly documented
- **What are the main areas of process breakdown:**
 - Coding issues delaying billing
 - Large gaps in follow-up
 - Interdepartmental hand-offs including medical record requests
 - Coordination of benefits
 - Lack of escalation impacting account resolution

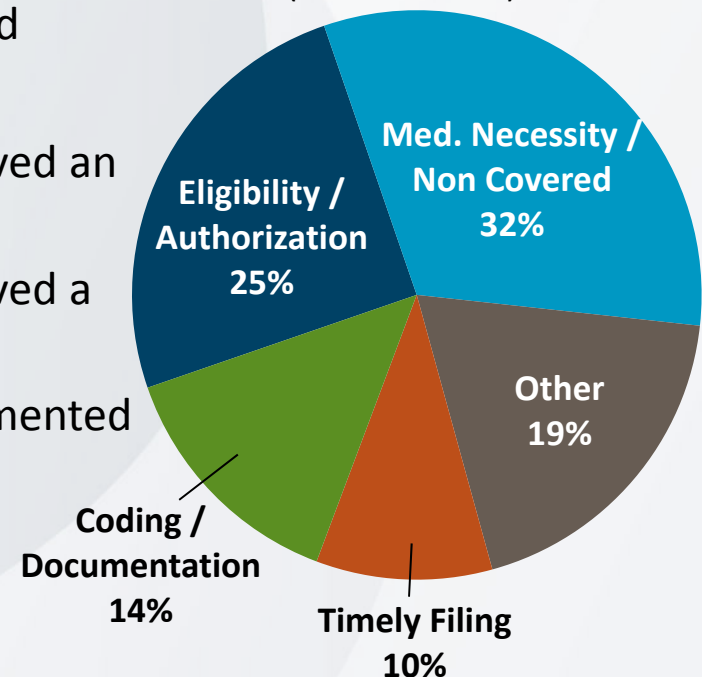
Account Processing Activity
(% of accounts)



Active A/R Account Reviews – Denials Management

- **Measurement Objective:** Determine opportunity for cash flow improvement by reviewing the frequency and impactability of denials (e.g., authorization, timely filing, missing documentation)
- **Leading Practice:** Supervisor presents
 - <5% of accounts receive impactable denials
 - Appeal steps and status are thoroughly documented
- **Denial Trends Observed in Reviews:**
 - Approximately 13% of the accounts reviewed received an impactable denial
 - Approximately 22% of the accounts reviewed received a potentially impactable denial
 - Appeal steps and status were not thoroughly documented

Summary of Impactable and Potentially Impactable Denials
(% of accounts)



Outsourcing Trends

Knowledge
Transfer

Flexible
Contract
Terms with
Shared Risk

Accelerated
Cash &
Reduction
of A/R

People | Best Practice Process | Technology

Patient
Centric

Qualitative &
Quantitative
Reporting

Utilizing &
Optimizing
Tools to
enhance
Performance

Example: Some vendor programs are designed to audit and correct 100% of patient registrations, specifically evaluating data completeness and accuracy of patient demographic and insurance information. The program blend of automation and people power to make corrections prior to the time of service or bill drop.

Reform Update

Its 1993 Again!



- Capitation
- Hospital Employed Physicians
- Government having an increased role in decision making

Three common elements of healthcare reimbursement over the next 20 years

- Quality and Accountability for Quality
- Payment Transformation
- Delivery Model Redesign

Maryland is leading the way.....

- Quality and Accountability for Quality - HSCRC Quality Indicators
- Payment Transformation – Total Patient Revenue Hospitals
- Delivery Model Redesign – Downtown Medical Home Model

Maryland Hospital Acquired Conditions (MHAC)

- 49 patient conditions tracked and reported
- Complications are measured against CMI – Adjusted ‘expected’ number of complications
 - Hospitals with less complications than expected , will receive additional reimbursement
 - Hospitals with more complications than expected , will receive less reimbursement

Readmissions

- Admission Readmission Revenue (ARR)
- The bundling of 30 day inpatient episodes of care
- Currently a voluntary program that offers revenue protection for hospitals that reduce readmissions for a 3 year period

Maryland Patient Transformation Examples

Total Patient Revenue: TPR

- A 3-year demonstration project has begun where some Maryland hospitals will not be paid on a volume-based model (charge per case). They are now paid under a total patient revenue model.
- Under TPR, our annual amount of total revenue is fixed for all services, care, treatment and procedures provided in the hospital.
- The focus is now the appropriateness of the admission rather than the number of admissions.
- TPR focuses on wellness and the cost effectiveness of the care delivered; it is preparing us for health care reform on a national level.

Calvert Memorial Hospital
Carroll Hospital Center
Chester River Hospital Center
Garrett County Memorial Hospital
McCready
Meritus Medical Center
Shore Health System
Union Hospital
Western Maryland Health System

- Medical Home models aim to provide accessible, continuous, coordinated and comprehensive patient centered care
- Regional structure that covers all care delivered in an area to a given population
- Managed centrally by a primary care physician
- Physician practices and hospitals are encouraged or required to improve practice infrastructure and meet certain qualifications.

The Goal

- Medical Homes are intended to encourage a population-based, proactive and planned approach to care, whereby care is coordinated across various providers.
- Targeting improved service, access, reduced unnecessary care and engaging patients in the community better .

East and West Baltimore medical home models are under design. We expect them to be rolled out in the next 1-2 years



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