



**Winning Under Reform:
Strategies to Optimize
the Revenue Cycle**

HFMA Lone Star Chapter
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Revenue Cycle – the Tip of the Iceberg


2-3% net revenue	
	<p>Balanced Budget Act/HIPAA Billing and Collections Improvement Pricing Transparency Compliance Audit Recovery (RAC/MIC/MAC)</p>
	<p>Payment Cuts & Cost Shifting P4P Provisions & Poor Performance Penalties Geographic Payment Adjustment Provisions Transparency Provisions Coverage Expansion Provisions Delivery System Provisions</p>
7-10% net revenue	



Current Healthcare Revenue Cycle Environment

Biggest issue in the healthcare payment is "administrative waste"

- Huge fragmentation
 - More than 2,000 payers
 - 30,000 contact points - or "channels" to deal with
- Cumbersome processes
- Unenforceable standards – HIPAA standardization
- Excessive reliance on paper or proprietary gateways
- Constantly changing payment protocols
- Physicians/Hospitals and Payers spend \$350 BILLION annually to submit and process claims



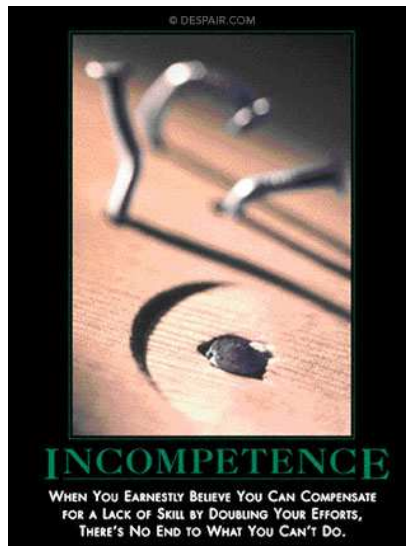
Top Five Reasons Revenue Cycle is Increasingly Challenging for Providers

1. Abnormally high and accelerating cost of billing and collections for healthcare encounters
2. Reimbursement and market pressures reducing share of resources available for overburdened and understaffed administrative functions
 - Too many encounters with avoidable issues
 - Too many encounters with unresolved or under-resolved issues
 - Too much reimbursement not collected
3. Significant Business Office operations cost reductions
 - Pressure to collect more—faster
 - Increasingly sophisticated and demanding third-party payers and patients
4. Increasingly granular adjudication due to accelerating HIPAA standards
5. Economies of Scale opportunities abound

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Why its not working...




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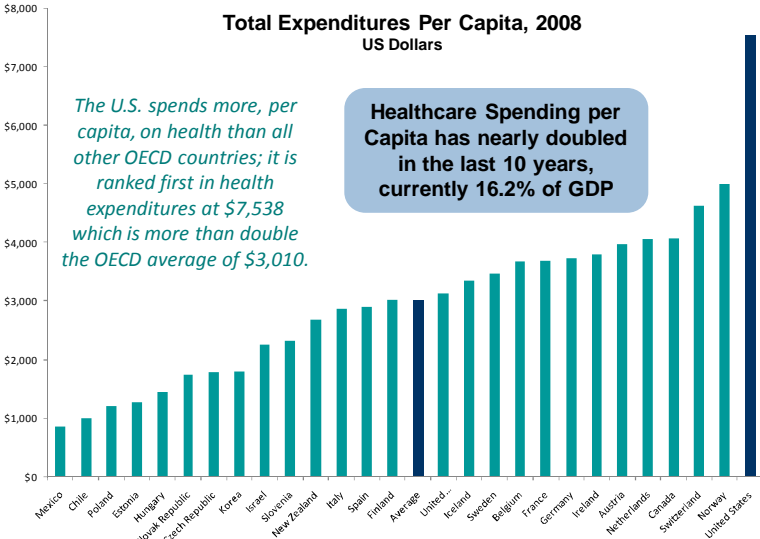
Economics of American Healthcare... ...National Perspective

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U.S. Leads in Health Expenditures Per Capita

Total Expenditures Per Capita, 2008
US Dollars




The U.S. spends more, per capita, on health than all other OECD countries; it is ranked first in health expenditures at \$7,538 which is more than double the OECD average of \$3,010.

Healthcare Spending per Capita has nearly doubled in the last 10 years, currently 16.2% of GDP

Country	Expenditure (US Dollars)
Mexico	~800
Chile	~1,000
Poland	~1,200
Estonia	~1,300
Hungary	~1,500
Slovak Republic	~1,800
Czech Republic	~1,800
Korea	~2,000
Israel	~2,300
Slovenia	~2,400
New Zealand	~2,700
Italy	~2,900
Spain	~2,900
Finland	~3,000
Average	3,010
United Kingdom	~3,100
Iceland	~3,300
Sweden	~3,400
Belgium	~3,600
France	~3,700
Germany	~3,800
Ireland	~3,900
Austria	~4,000
Netherlands	~4,100
Canada	~4,100
Switzerland	~4,500
Norway	~5,000
United States	7,538

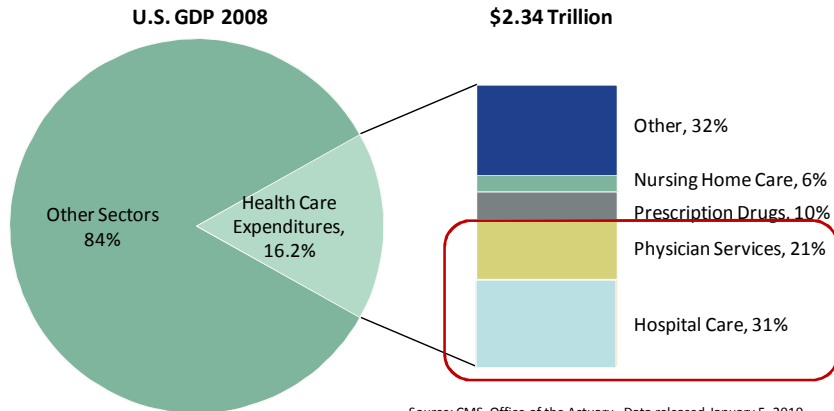
Source: Organization for Economic Co-operation and Development (OECD) Statistics

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Hospitals Account for Almost One-Third of Health Care Expenditures

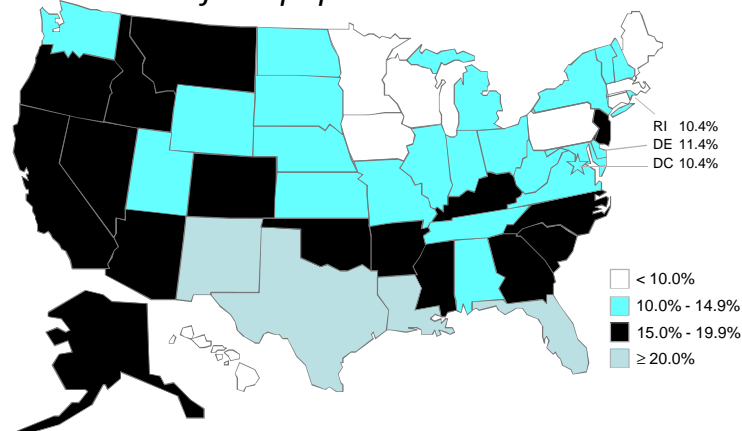
National Health Expenditures as a Percentage of GDP and Breakdown of National Health Expenditures in 2008



Source: CMS, Office of the Actuary. Data released January 5, 2010.

Uninsured by State – Florida, Texas, Louisiana and New Mexico Have the Highest Uninsured Rates

Average Percent Uninsured by State, 2006 – 2008
16% of the population is uninsured



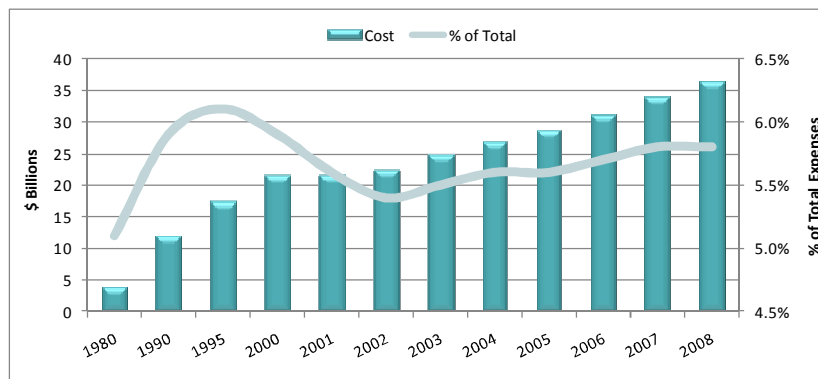
Source: US Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2008. Data released August 2009.

Economics of American Healthcare... ...Hospital Perspective

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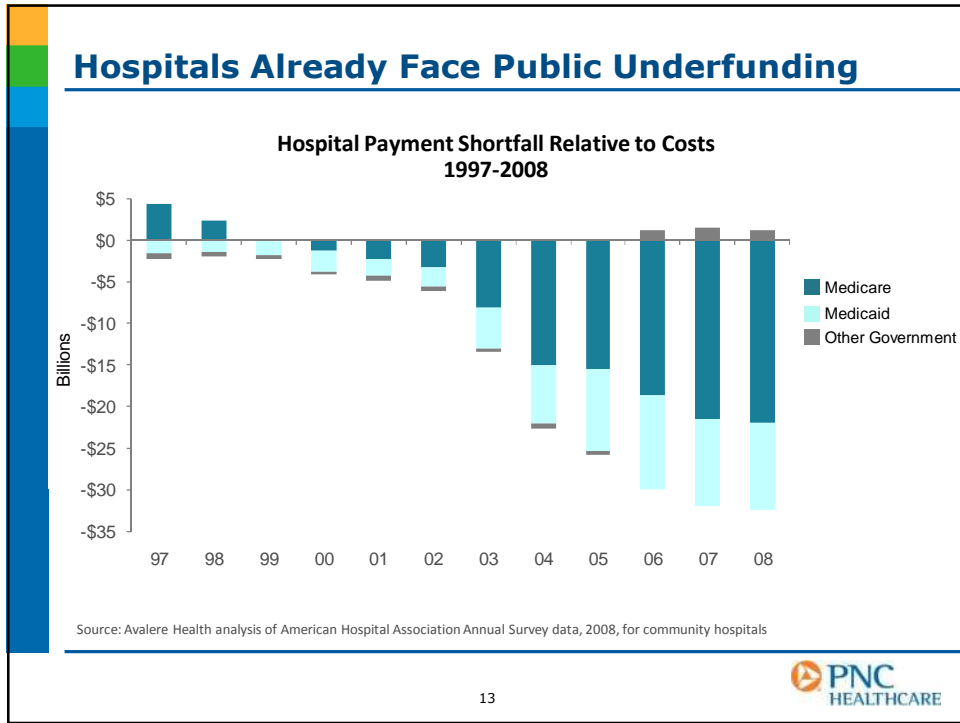
Uncompensated Care Cost to Hospitals



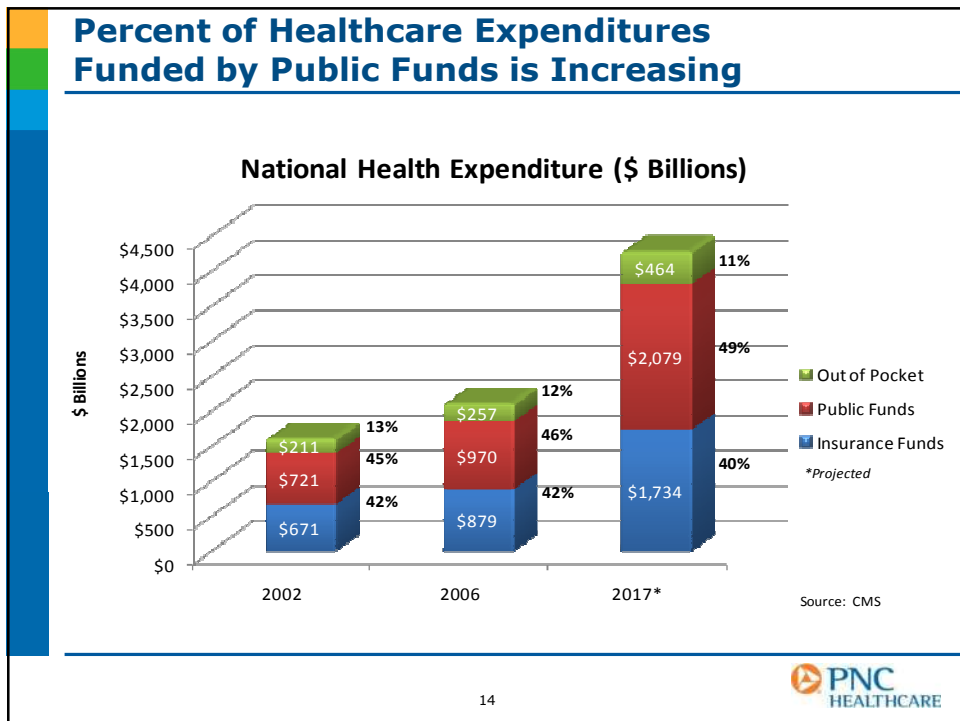
Source: American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet, (Nov 2009)

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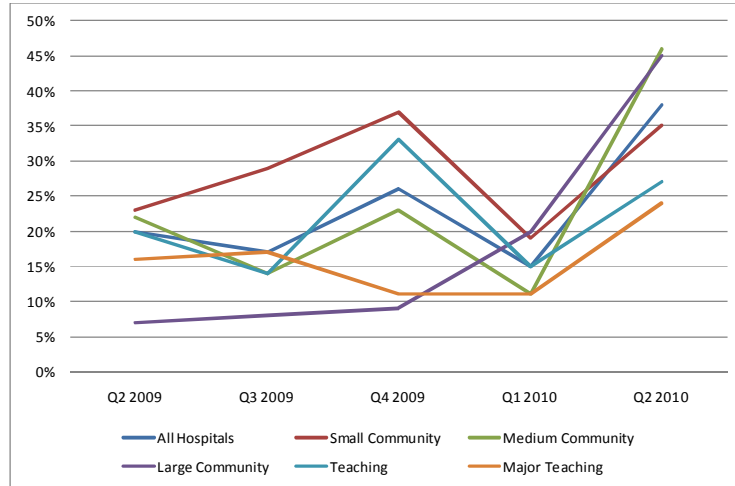


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Percentage of Hospitals with Negative Profit Margins



Source: HFMA Revenue Cycle Strategist/Thomson Reuters Action OI database

Top corporate priorities for 2010

Priority	Percent of Total Companies
Improve operational efficiency	90 %
Reduce costs	88 %
Grow top-line revenue	80 %
Improve cash optimization	73 %
Enhance IT systems	52 %
Optimize capital structure	47 %

Source: Perspectives on Working Capital, PNC White Paper, October 2010

Payer/Provider Efficiency

- 20 percent of all claims submitted in an average month are delayed or denied
- On average, providers must submit claims four times to get paid
- Two-thirds of providers need to resubmit a claim two or more times
- Nearly three-quarters of payers have to interact with providers at least three times to obtain all the necessary information to pay
- Remittances frequently still posted from paper EOBs, making consistent capture of denial data and use of reason codes highly variable and creating denial management challenges



Healthcare Reform....Timeline and Provisions

A New World

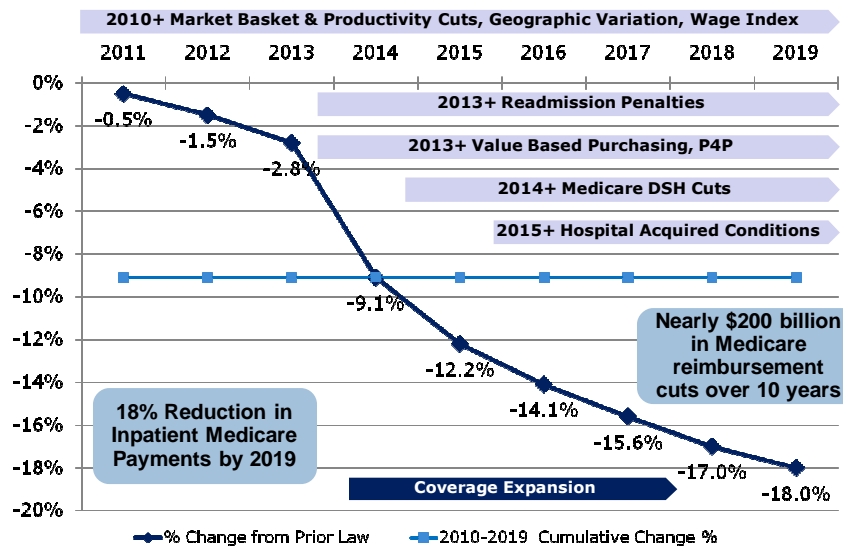
- Reform signed into law March 30, 2010
- Sweeping changes to healthcare
- Final bill NOT the final word...full or partial repeal? Revision?
- Implemented over the next five years in the following areas:
 - Expanded coverage
 - Medicare payment cuts
 - Payments tied to quality
 - Delivery system reforms



- National evidence-based quality strategy
- Attack fraud and abuse




Impact of Health Reform


(Sample 500 hospitals)



Source: CMS; Patient Protection and Affordable Care Act, Premier member hospitals

Aligning Payment with Outcomes in Reform


- 
 - **Value-based purchasing (VBP)** to tie 1% of Medicare reimbursement to performance on quality and outcomes measures (scales to 2% in 2017); heart attack, heart failure, pneumonia, SCIP (surgical care improvement project), patient satisfaction.
- 
 - **Readmissions** policy to cut up to 3% of all inpatient Medicare reimbursement based on excess readmissions (cuts payments by \$7.1 billion over 10 years). Initially heart attack, chronic heart failure, pneumonia; expands to chronic obstructive pulmonary disease, coronary artery bypass graph, and other vascular in 2015.
- 
 - Reduced Medicare payments by 1% for hospitals in the highest quartile of **hospital-acquired infections** starting in 2015 (cuts payments by \$1.5 billion over 10 years). Hospital acquired infections, central line bloodstream infections, resistant staph infections, ventilator-acquired pneumonia, surgical site infections.




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Delivery System Reforms

- **Accountable Care Organizations (ACOs)**
 - Establish shared savings program that promotes accountability and encourages high quality and efficient service delivery
 - Contracts awarded to programs starting Jan 2012
 - CMS may give preference to ACOs already contracting with the private market
- **Bundled Payments**
 - Acute care, physicians, post-acute
 - Voluntary Medicare pilot bundled no later than 2013
 - Episode of care: 3 days prior to admission and 30 days following patient discharge for 10 conditions






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Healthcare Reform....


.....What Does It Mean, And How To Prepare?



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Strategic Implications of Reform

- Downward pressure on reimbursement
- Link payment to quality (VBP, Readmissions, HACs):
 - Migrate payment models toward collaborative performance requirements
 - Expand transparency: track measures and benchmark against others
 - Adherence to evidenced-based care is focal point
 - Requires significant coordination
- Delivery system changes (Bundling, ACOs):
 - Move reimbursement from "transaction-oriented" to "outcome-oriented"
 - Hospitals must rethink the way care is delivered and move to bigger episodes of care coordinated across the continuum
 - Manage population outcomes
 - Coordinate care with physicians and post-acute care



Shared Accountability
Physicians and hospitals must coordinate and integrate responsibilities for care management in order to contain costs while improving quality.

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Projected Impact of Reform (ABC Hospital)

Detail of Impact

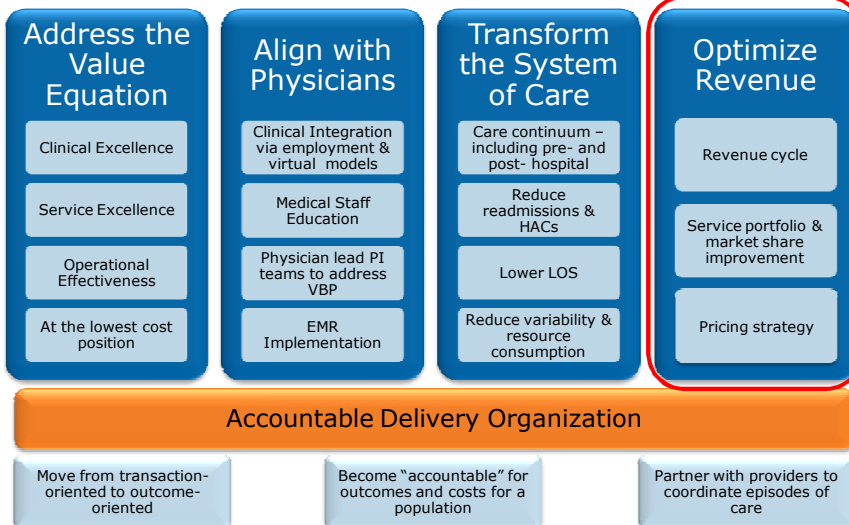
Category	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicare Inpatient Payment Reduction	\$ (9.5)	\$ (9.5)	\$ (9.5)	\$ (9.5)	\$ (9.5)	\$ (9.5)	\$ (9.5)	\$ (9.5)	\$ (9.5)	\$ (9.5)	\$ (95.0)
Medicare Outpatient Payment Reduction	-	(9.5)	(9.5)	(9.5)	(9.5)	(9.5)	(9.5)	(9.5)	(9.5)	(9.5)	(95.0)
Medicare Psychiatric Payment Reduction	-	-	-	-	(9.5)	(9.5)	(9.5)	(9.5)	(9.5)	(9.5)	(95.0)
Medicare Expansion of Coverage	-	-	-	-	-	(9.5)	(9.5)	(9.5)	(9.5)	(9.5)	(95.0)
Expansion of Inpatient Coverage	-	-	-	-	67.8	67.8	67.8	67.8	67.8	67.8	678.0
Total Estimated Impact	\$ (9.5)	\$ (9.5)	\$ (9.5)	\$ (9.5)	\$ (2.0)	\$ (2.0)	\$ (2.0)	\$ (2.0)	\$ (2.0)	\$ (2.0)	\$ (20.0)

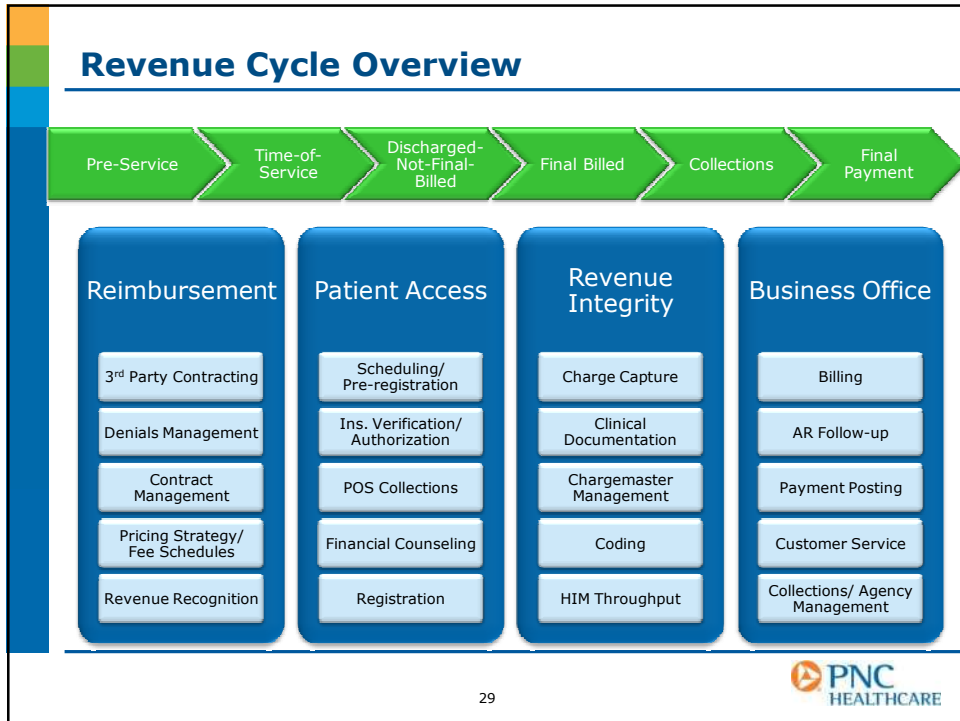
- With no interventions on behalf of leadership, the Patient Protection and Affordable Care Act (PPACA) is estimated to have a negative impact of \$25M over the ten year timeframe from now until 2019.
 - This equates to just over \$2.5M a year, although the timing is such that most of the impact occurs in the middle to end of the ten year timeframe.
 - The timing gives organizations opportunity to intervene so that the impact is not as projected below.

Summary of Impact

Impact of Medicare Inpatient Payments	\$ (79.4) Million
Impact of Medicare Outpatient Payments	(11.8) Million
Impact of Medicare Psychiatric Payments	(1.6) Million
Impact of Expansion of Coverage	67.8 Million
Total Projected Impact Over 10 Years	\$ (25.0) Million

The "Pillars of Success" in the Era of Reform Optimizing Revenue Cycle Performance





- ## Revenue Cycle Optimization
1. Model Reform Impact
 2. Optimize current process
 - Benchmark performance (Clinical Revenue Cycle Performance)
 - Rapidly diagnose performance
 - Ensure no leakage
 3. Pre-Service Model
 - Eligibility / Insurance Verification
 4. Integration of Technology
 - Use technology to improve efficiency
 - Reduce cost to collect (to < 2%)
 5. Strategic Pricing
 - Contracting
 - Defensible Pricing
 6. Revenue Integrity
 - Coding/Documentation
 - Charge Capture
- PNC HEALTHCARE

Revenue Cycle Optimization Model Reform Impact

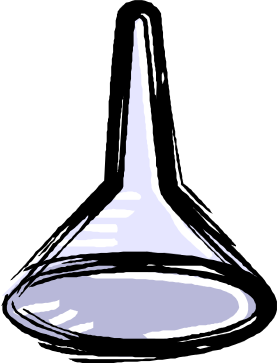
	2010-2019
ESTIMATED MEDICARE PAYMENTS UNDER PRIOR LAW	\$1,558,035,312
Market Basket Update Reduction	(\$89,154,825)
Reduction of DSH Operating Payments	(\$25,620,835)
Additional Payments for Uncompensated Care Costs	\$15,707,117
Readmissions Reduction Amount (AMI, HF, Pneumonia)	\$0
Readmissions Reduction Amount (COPD, CABG, PTCA, OVC)	#N/A
Reduction for High Cost of Hospital Acquired Infections	\$0
Value Based Purchasing Impact	(\$5,608,207)
ESTIMATED TOTAL IPPS IMPACT	(\$104,676,749)
Percent Change from Prior Law	-6.72%
ESTIMATED IPPS PAYMENTS UNDER PPACA	\$1,453,358,563
	2010-2019
Expansion of Insurance Coverage (Optional Provider Estimate)	\$45,492,000
Percent Change from Prior Law	2.92%
COMBINED IMPACT OF IPPS CHANGES AND EXPANSION	(\$59,184,749)
Percent Change from Prior Law	-3.80%
ESTIMATED TOTAL IPPS AND EXPANSION PAYMENTS	\$1,498,850,563

Revenue Cycle Optimization Continuous Assessment of Current Processes

	Summary of Income Statement Opportunities	Financial Impact Range (\$000's)			Improvement Opportunity			Estimated Implementation (Time)	
		Low	Mid	High	People	Process	Tech	Range (months)	
Reimbursement	Managed Care Contracting	\$2,300	\$ 4,100	\$ 4,700	<input checked="" type="checkbox"/>			6	9
	Pricing Strategy	\$1,300	\$ 2,300	\$ 2,900	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	3	6
	Centralized Scheduling	\$ 400	\$ 900	\$ 1,100	<input checked="" type="checkbox"/>			4	8
	Verification/Eligibility	\$1,400	\$ 2,900	\$ 3,600		<input checked="" type="checkbox"/>		2	5
Pre-Service/ Time of Service	Point of Service Collections	\$ 800	\$ 2,100	\$ 2,800		<input checked="" type="checkbox"/>		2	6
	Uncompensated Care	\$ 500	\$ 1,200	\$ 1,600		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	5	8
	Charge Capture	\$ 700	\$ 1,100	\$ 1,800			<input checked="" type="checkbox"/>	6	9
	Coding/Documentation	\$ 200	\$ 400	\$ 1,100		<input checked="" type="checkbox"/>		2	3
Revenue Integrity	Chargemaster	\$ 500	\$ 400	\$ 2,000			<input checked="" type="checkbox"/>	4	5
	Cost to Collect/Overhead Reduction	\$ 350	\$ 625	\$ 900					
	AR Follow up workflow	\$ 900	\$ 200	\$ 2,500	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	4	6
	Outsourcing Strategy	\$ 300	\$ 700	\$ 1,000		<input checked="" type="checkbox"/>		3	6
	First Year Net P&L Impact:	\$9,650	\$18,425	\$26,000				8	10
Business Office	Summary of Balance Sheet Opportunities	Low	Mid	High	People	Process	Tech	Range (months)	
	Discharge Not Final Billed (DNFB)	\$3,250	\$ 4,500	\$ 5,600		<input checked="" type="checkbox"/>		2	5
	Unbilled Backlog	\$ 850	\$ 1,100	\$ 1,200		<input checked="" type="checkbox"/>		1	3
	AR > 90-days	\$ 800	\$ 1,250	\$ 1,500	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	2	6
	AR Reduction/Cash Acceleration	\$3,000	\$ 4,500	\$ 6,000	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	2	8
	One-time Balance Sheet Impact:	\$7,900	\$11,350	\$14,300				2	8

Revenue Cycle Optimization Focus on Patient Access Remodel and Performance


- Pre-Service Model and Financial Clearance
- Eligibility Screening and Future Medicaid Conversion




← Patient Access →

← Patient Care →

← Patient Accounts →



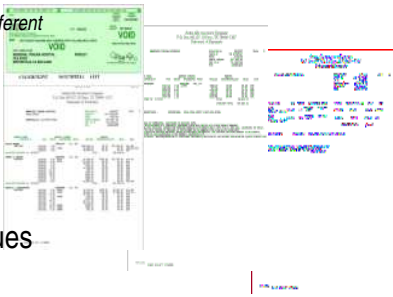



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Revenue Cycle Optimization Technology Integration: Payment Environment

Challenge—Processing Remittance Advices...> 200,000 different formats

- Inefficient layout for providers
- Complex patient communications
- Challenging PHI and security issues
- Complicated supplemental billing issues
- Translations and interpretations
- Trouble identifying and isolating payment issues
- High potential for posting and processing errors
- Original source is the “official” record

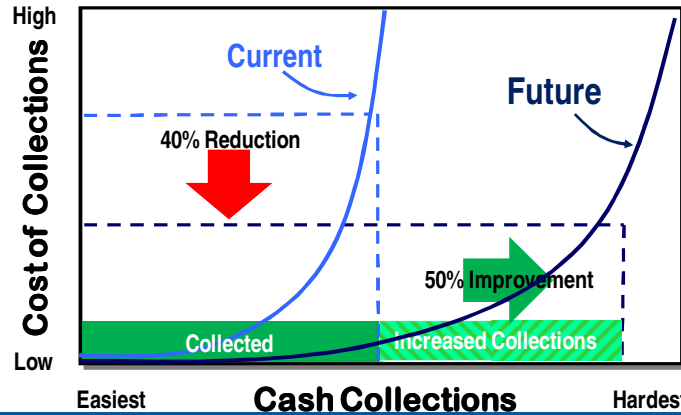




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Revenue Cycle Optimization Technology Integration: Bending the Cost Curve

- Use of technology to improve performance and efficiency
- Reduce Cost-to-Collect (to < 2%)
- Use technology for high volume transactions
- Improve process before automation



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Revenue Cycle Optimization Strategic Pricing

- Contracting Performance
- Defensible and Transparent Pricing

Considers Payer Mix by IP/OP and Reimbursement

CDM-Desc	CDM	Price	YTD Total Revenue	Inpatient Utilization	Outpatient Utilization	Reimbursement	Price Change	New Price
INTENSIVE CARE UNIT	1301000	\$ 2,750.00	\$ 10,628,750	100%	0%	26.1%	90%	\$ 2,475.00
M8 STANDARD ROOM (SP)	1371001	\$ 1,200.00	\$ 6,114,000	100%	0%	26.2%	90%	\$ 1,080.00
T6 STANDARD ROOM (SP)	1001001	\$ 850.00	\$ 4,936,800	100%	0%	26.1%	90%	\$ 765.00
COMPREHENSIVE METABOLIC PANEL	3011033	\$ 271.00	\$ 4,836,917	55%	45%	26.2%	90%	\$ 243.90
MISCELLANEOUS IMPLANT CHARGE	3809063	\$ 2,976.51	\$ 4,155,203	91%	9%	26.5%	90%	\$ 2,678.66
TELEMETRY/PER DAY	1002005	\$ 614.00	\$ 4,103,362	99%	1%	26.2%	90%	\$ 552.60
IMPLANT/TOTAL JOINT	3606392	\$ 6,761.25	\$ 3,962,096	100%	0%	26.9%	90%	\$ 6,085.13
OXYGEN LOW FLOW, PER HOUR	1006002	\$ 23.00	\$ 2,160,000	100%	0%	27.1%	90%	\$ 2,069.28
NEONATAL INTENSIVE CARE UNIT	1001000	\$ 43.62	\$ 1,650,000	100%	0%	27.1%	90%	\$ 2,469.28
I7 SEMI-PRIVATE ROOM	1061001	\$ 75.00	\$ 1,650,000	100%	0%	26.2%	90%	\$ 675.00
COMPLETE BLOOD COUNT	1001028	\$ 7.00	\$ 1,396,000	95%	5%	26.1%	90%	\$ 87.30
BASIC METABOLIC PANEL	1001038	\$ 12.00	\$ 1,216,000	26%	79%	26.3%	90%	\$ 198.00
CT-PELVIC W/CONTRAST	3212021	\$ 1,752.00	\$ 1,875,204	46%	54%	45.2%	110%	\$ 1,936.00
CT-SINUSES/LIMITED SCREENING	3212029	\$ 975.00	\$ 2,516,448	28%	72%	45.7%	110%	\$ 739.00
UNIVERSAL DRAINAGE W/NIT 8 FR	3418007	\$ 2,177.00	\$ 1,214,500	15%	25%	45.9%	110%	\$ 2,387.00
CT-TEMP BONE/ORBIT/SELLA/EAR	3212005	\$ 1,352.00	\$ 96,784	4%	56%	47.8%	110%	\$ 1,487.20
CT-PERC DRAIN ABS-PERITONRAD	3212044	\$ 1,449.00	\$ 55,787	82%	18%	46.7%	110%	\$ 1,593.90
CT LIMITED/FOLLOW-UP STUDY	3212004	\$ 1,240.00	\$ 39,060	0%	100%	47.1%	110%	\$ 1,364.00
CT-PELVIC COMPLETE	3212022	\$ 2,164.00	\$ 37,870	60%	40%	47.0%	110%	\$ 2,380.40
CT SINUSES W/CONTRAST	3212042	\$ 1,174.00	\$ 24,854	100%	0%	45.2%	110%	\$ 1,291.40
DEVICE PERU-STAY FASTENING	3216006	\$ 323.00	\$ 22,610	70%	30%	45.7%	110%	\$ 355.30

Description	Price
ACETAMINOPHEN 325 MG TABLET	\$ -
ACETAMINOPHEN 120 MG SUPP	\$ -
ACETAMINOPHEN 650MG SUPPOS	\$ -
ACETAMINOPHEN 100 MG/5ML 100ML	\$ -
ACETAMINOPHEN 500MG TAB ET	\$ -

Zero Pricing "patient visible items" and cost shifting elective and price sensitive procedures.

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Revenue Cycle Optimization

Revenue Integrity - CDM *(THE ROSETA STONE OF HEALTHCARE)*

- Coding and Documentation (Completeness and Accuracy)
- Charge Capture (No Leakage)

Audit charges at key access points to ensure all charges are captured, specifically ancillary departments where reimbursement is negotiated at a percent of charge.

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Revenue Cycle Index Questionnaire

Required Statistic	
1. Average Daily Net Patient Service Revenue (3-month DAILY Average)	
2. NET Accounts Receivable Balance	Required Statistic
3. Total Billed Accounts Receivable Balance	11. Average Monthly Bad Debt Expense (3-month average)
4. Billed Accounts Receivable Balance over 90 days old	12. Average Monthly Charity Care Expense (3-month average)
5. Point of Service Patient Payments (Current Month Only)	13. Discharge Not Financed (DNFB) Accounts Receivable Balance
6. Total Claims Collected (Current Month Only)	14. Claims Submitted to 3rd Party Payers without error
7. Total Revenue, less Cost (Current Month Only)	15. Total Claims Submitted
8. Net Revenue less Bad Debt Expense (3-month average)	16. Total Liquid Cash
9. Avg Daily Gross Patient Service Revenue (3-month DAILY average)	17. Average Daily Operating Expenses
10. Gross Patient Service Revenue (Current Month Only)	18. Percent of 3rd Party Payers Submitting electronic remittances
	19. Do you match (reassociate) electronic or paper remittances with electronic payments? (1=No, 2=Yes)

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Revenue Cycle Index Questionnaire


	Required Statistic
20.	ICD-10 training programs have been developed for your organization? (1=No, 2=Partial, 3=Yes)
21.	Internal development and testing of HIPPA Version 5010 standards will be completed by 12/31/2010? (1=No, 2=Partial, 3=Yes)
22.	Workplans and guidelines have been developed to complete external testing of HIPPA version 5010 by 12/31/2011 with payers, partners and providers? (1=No, 2=Partially developed, 3=Yes)
23.	The organization will begin submitting HIPPA version 5010 claims sometime in CY 2011? (1=No, 2=Yes)
24.	Number of zero paid claims denied
25.	Number of patient encounters pre-registered
26.	Number of scheduled patient encounters
27.	Total number of registered inpatient and outpatient encounters
28.	Total number of verified inpatient and outpatient encounters
29.	Total number of uninsured discharges
30.	Total number of uninsured discharges approved for payer source

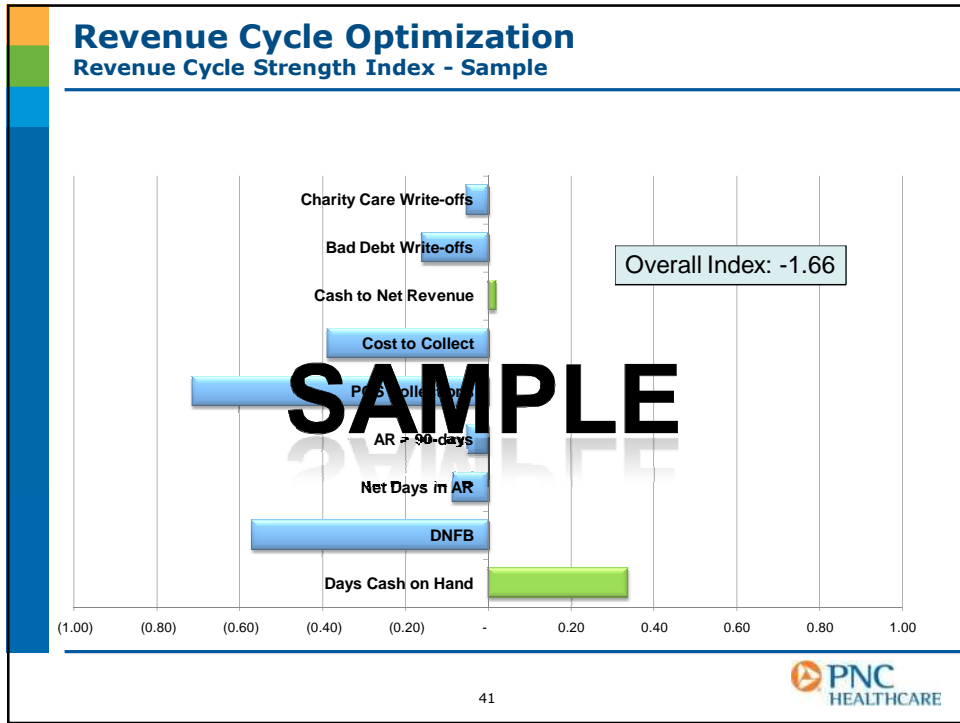


Revenue Cycle Optimization

Continuous Assessment of Clinical Payment Reform Benchmarks

- 1-day Length of Stay Admissions
- 3-day Length of Stay Admissions
- Hospital-Acquired Conditions (CMS hospital acquired conditions/HAC defined)/Payment Quality Indicators (PQI)
 - Defined by specific CC/MCC ICD codes including; foreign object retained after surgery, air embolism, blood incompatibility, pressure ulcers, falls & trauma, catheter-associated urinary tract infection, perforated appendix, diabetes, dehydration, hypertension, COPD, congestive heart failure, angina, bacterial pneumonia, etc.
- 30-day Readmission Rate
 - heart attack
 - heart failure
 - pneumonia
- Avoidable Admissions
 - Patients admitted but due to their diagnosis, may be more effectively managed outside the acute care environment





Select Revenue Cycle Benchmarks

	Key Performance Indicator	Target
Patient Access	Overall pre-registration rate of scheduled patients	>98%
	Overall insurance verification rate of scheduled/pre-registered patients	>98%
	Registration accuracy rate	>98%
	Successful attempts for collection of elective services deposits prior to service	100%
	Successful attempts for collection of inpatient self-pay deposits prior to discharge	>65%
HIM	Successful attempts for collection of ED self-pay deposits prior to departure	>50%
	Days of gross revenue held in Discharged-not-Final-Billed status	<4-6 days
Patient Accounts	Physician documentation completion delinquency greater than 30 days	<5%
	Final-Billed-Claim-not-Submitted backlog	<1 A/R day
	Billed insurance A/R >90 days from service/discharge	<15-20%
	Bad debt write-offs as a % of gross revenue	<3%
	Charity care write-offs as a % of gross revenue	<3%
	Total cash to net-collectible revenue (60 day average lag)	-100%
	Cost to collect (HIM excluded)	<2-3%
	Net A/R days	<45-55 days
	Point-of-service collections as a % of total cash collections	>2-3%
	Outsourced bad debt netback ((collections-fees)/placements)	>7-11%
Denials	Overall initial denials rate (% of net revenue)	<4%
	Clinical initial denials rate (% of net revenue)	<5%
	Appealed denials overturned rate	40-60%

Source: PNC Healthcare Advisory Services

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Don't Keep Doing The Same Old Thing!



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Questions?

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www.pnc.com/healthcare