Make Your Revenue Cycle Hum

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For many hospitals, an elusive portion of their financial processes just doesn't "hum." Whether it's 2 percent or as much as 15 percent of your revenues, the real impact on your bottom line of this elusive percentage can be the difference between surviving or not.

Today's economy, combined with the uncertain impact of Washington's reforms, makes finding the last dollar critical to your financial goals and to your core mission of patient care. That elusive last percentage needs your attention and presents the greatest challenge.

Some creative ideas and a step-by-step formula can help you tackle that elusive last percentage.

Step 1. Start with Your Star People

The right team can't be replaced by adding or cutting resources, or by implementing a "silver bullet" technology. You need to start with a team that is aligned around the following points.

Be accountable. A single area of the revenue cycle is rarely the sole problem. In this whole-system sequence, your team should be accountable to both personal and group goals. Finger-pointing or protecting departments from changes will only harm your work. Accountability is a soft skill that is just as important as the technical skills.

Measure up to the right goal. A goal that is measurable, achievable, and critical to your bottom line gives your team a "true north" point on its collective compass. Determine that necessary goal—for example, meeting the industry standard to financially clear 95 percent of all elective procedures five days before admission—and then measure your progress with a consistent scorecard of key metrics. Tracking the goal is a springboard to asking the right questions and better diagnosing issues.
Keep the goal fresh with cash and noncash incentives for any hospital employee tied to the goal. The exhibit illustrates a macro-level incentive program for all revenue cycle team members, including the patient access and patient accounting teams. The program uses an overall cash collection stretch goal of 102 percent of the budgeted quarterly cash collections (based on trailing two-month average collectible net revenues). Of course, checks and balances are needed between your accounting department and an external auditor to keep net revenue and the cash goal appropriate. If needed, solidify your goals with an internal contract that emphasizes each individual's commitment to improve the whole system—even if the explicit goal has to shift along the way.

Create the "tackle team." A task force—focused on key goals and made up of your star performers—will keep you on track. A task force should:

- Represent staff members from across the revenue cycle and from related hospital departments (for example, nurses involved in scheduling, discharge planning, emergency department discharges, and same-day surgery scheduling). Don't leave out key team members, such as IT staff.
- Be driven by a director-level steering committee, and use a working committee. Your business office director is a good team leader, seeing and understanding the entire revenue cycle. Meet regularly to review progress and goals—weekly or bimonthly as a whole team and more often in smaller groups.
- Obtain endorsement by a high-level executive to demonstrate organizational commitment.

Step 2. Disaggregate the Process

Next, separate your financial processes into key components. You'll need a scalpel, not an axe, and a perspective that sees the specifics and the big picture. Start at the front end, and break it down all the way to the end of the revenue cycle. Here's how.

Identify the tough pieces. The smaller you slice your revenue cycle pie, the greater the impact on your bottom line. Don't simply break down your financial processes into the core operational elements. Disaggregate them beyond component departments (patient access, health information management, and patient accounting) to a granular level, as shown in the exhibit. That's where the tough challenges exist that, if improved, will yield the greatest return.
Your financials may already painfully highlight your problem areas. Weaknesses that may yield significant ROI when corrected typically include registration errors, improper precertification methods, charge entry delays, chargemaster errors, and coding errors.

Analyze the data. With the tough pieces of your cycle identified, examine the data and ask the right questions. The more detailed the questions are, the more likely you are to target core issues. For example, if looking at precertification issues, ask whether someone is contacting the physicians' offices to obtain authorization or reschedule a procedure.

Step 3. Tackle Each Piece of the Pie Individually and Creatively

Now activate your task force and tackle away. Following are a few ideas for retrospective reviews—a method widely used in business—applied to patient access. This process works for any step in the revenue cycle.

Audit every account within two days of discharge. Patient access falls victim to the classic "garbage in, garbage out" scenario. A wrong keystroke by a registrar trickles throughout your process and leads to lost dollars. Disaggregating your processes quickly, and comprehensively correcting and documenting issues, can improve the quality of your entire revenue cycle, which means less follow-up work.

Determine areas to change. Cause-and-effect relationships are the most critical step in disaggregation. For example, don't waste time fixing the cashiering function when you should focus on how to determine patient liability.

"Score" your accounts. Every account has a set of core elements that must work perfectly to pay optimally. You can score each account and its elements using the following process: Elements within the account—valid addresses, good insurance information, full point-of-service collection efforts—receive X points if the element works perfectly and 0 points if there is even a single flaw. A perfect account should add up to 100, so the number of elements will dictate the point value of each element, and the elements will be weighted based on overall value in getting the claim paid. Tackle the flaws that prevent a perfect score, and look for similar errors in other accounts.

Rely on experts and creative labor solutions. Expertise is important, so if any members of your team are knowledgeable about process change, devote their time to the task. If not, consider hiring outside experts, and manage them as you do your own team: requiring accountability and commitment to specific goals.

Implement a new technology. Evaluate new, creative tools on the market, and integrate them into your team's efforts. For example, a number of "propensity to pay" tools may work for your team. Often, a vendor partner can help determine how to best use such tools at various times in the revenue process.

Step 4. Reaggregate and Make It "Hum"

Now seamlessly put the pieces back together so all parts act as a whole again for the good of your bottom line. A few issues to watch for:

Collateral issues. Changing one process can affect related processes. Be sure all teams are on board, because a lack of buy-in will derail any process improvement. For example, in preregistration quality

work, coordinate closely with physicians on the plan so their practice benefits also. Or if you're streamlining a scheduling process, include nursing, therapists, and diagnostic services.

Related policies within the department. While evaluating one process, take apart related processes, and make sure new processes work in lock-step with existing policies. For example, don't try to change a charity care policy without evaluating its impact on Medicaid advocacy, disability determination, or Medicare disproportionate share hospital numbers.

Measuring the results. Measure and document the process changes so you can forecast results daily, weekly, and monthly. Share the results graphically. If you need to make course corrections, base them on careful analysis so you don't fall victim to indecision.

How Memorial Medical Center Did It

At Memorial Medical Center, Las Cruces, N.M., the finance department knew it was missing out on collecting significant dollars. To tackle its "elusive 10," Memorial:

- Broke down its process into registration quality, charge integrity, managed care negotiations, and self-pay
- Analyzed data for root causes, including a lack of cohesive point-of-service collection policies; chargemaster files riddled with inconsistencies, errors in HCPCS coding, and pricing variances; clinicians who didn't understand their role in charge integrity; complex managed care agreements that could not be tracked; and fragmented self-pay account flows that clashed with other policies
- Created two teams: a Special Teams Patient Access Unit to tackle and monitor quality and collections and a Managed Care Team
- Purchased tools to monitor and control the chargemaster
- Rebuilt its self-pay processes

The result: Across the board, Memorial saw an overall 10 percent improvement in net cash collections from the base year to the second year of improvements. In addition, its process resulted in:
- Clean claims and reduced self-pay accounts receivable
- Better assessment of missing charges, effective pricing levels, correct coding, and charge integrity processes
- Clear scoring on each major payer contract to renegotiate fair, effective, and manageable fee structures
- Increased self-pay collections by 500 percent
- Improved ability to document and manage its charity care population

Resolving the Elusive 10 Percent

How long it will take to see results is different for every hospital and depends on the resources allocated. Too often, hospitals cut resources or chase small-dollar accounts in hopes that cost savings will follow. Instead, you should focus on the front-end root causes, break the process apart to fix it, and invest in creative solutions.
In the end, your new revenue cycle will make your organization more competitive among your peers and in today's unpredictable healthcare and economic environment.

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