LEAD WITH FTI

FTI HEALTHCARE

Understanding the Technical Side of the Revenue Cycle

National Federation Of Municipal Analysts

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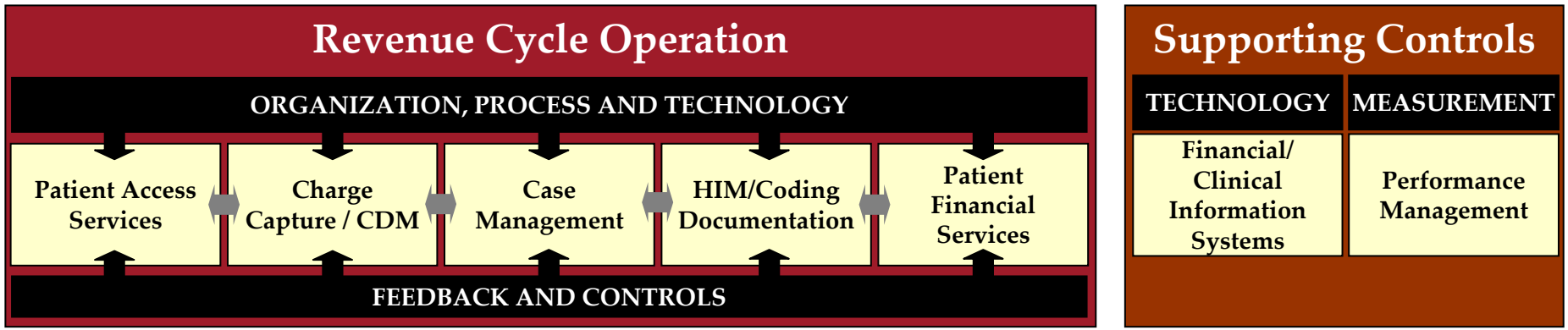
FTI

Revenue Cycle Approach

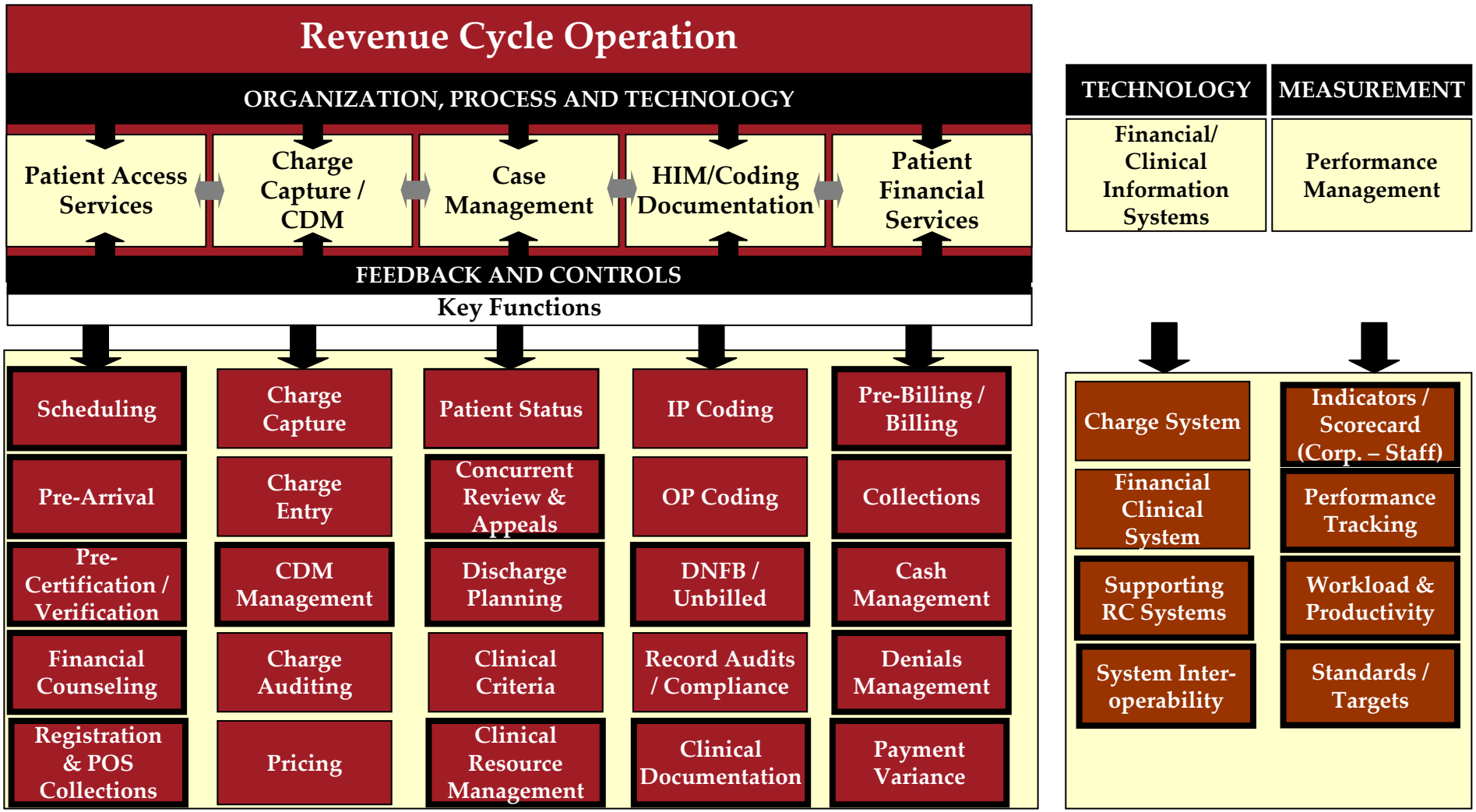


Managed care, third party reimbursement, case management……. Examined separately

Objectives:

- Collect and review Hospital data and compare to industry benchmarks
- Identify areas of net income and balance sheet opportunity
- Review processes and provide recommendations and define the overall strategy with prioritized areas for improvement
- Set targets and assist management with execution and achievement of goals if desired

Revenue Cycle Assessment Approach



Revenue Cycle Assessment - Project Approach

Assessment

Step 1: Data and Interviews

	Key Work Tasks
Task 1: Collect Key Revenue Cycle Operations Information	• **Submitted data request and interview list to Project sponsor** • **Collected Revenue Cycle information –** Organization charts, detailed and summary reports, staffing, policies and procedures, technology / system definitions, etc.
Task 2: Collect / Upload Revenue Cycle Transaction Data	• **Collected transaction data –** PA QA data elements, POS collections, first past yield, denials, charges, payment / 835 remittances, adjustments/write-offs, AR, and procedure files • **Validated and tested accuracy of information** • **Uploaded and map data into FTI proprietary analysis tools**
Task 3: Conduct Key Interviews	• **Completed interviews / process reviews with key managers and stakeholders (Typically 20-30 Interviews / Focus Groups) –** Patient Access (i.e. Scheduling, Pre-Arrival, OP Registration, Financial Counseling), Charge Capture/CDM, HIM/Coding, Denials Mgmt, Contracting, Case Management, Finance, PFS, etc. • **Documented current state issues/opportunities for improvement**

Revenue Cycle Assessment - Project Approach

Assessment

Step 2: Evaluation

Key Work Tasks

Task 1: Review / Evaluate Core Revenue Cycle Functions

- **Front-end Patient Access Functions –** Scheduling; Pre-Arrival Financial Counseling; Registration; Data Capture/ Quality; POS
- **Charging Functions/CDM –** Charge Capture/CDM Maintenance
- **Case Management Functions** – Status; Concurrent Review; LOS
- **Coding / Documentation Functions –** DNFB, HIM, IP & OP
- **Patient Financial Services Functions** – Bad Debt / Charity Care Management, AR Management
- **Managed Care** – Contract Review, Payment Variances
- **Denials Management Functions** – Technical and Clinical Denials; Appeals Overturn Rate; Write-offs

Task 2: Review / Evaluate Management Systems

- **Evaluated RC system functionality and inter-operability**
- **Analyzed Revenue Cycle performance management data**

Task 3: Complete Performance Analyses

• Scheduling	POS Cash	PA QA Review
• Insurance Verification/Payer Requirements		DNFB
• Medicaid Eligibility	Charity/Bad Debt	First Pass Yield
• Denials	Coding/CDM	Managed Care

Revenue Cycle Assessment - Project Approach

Assessment

Step 3: Outcomes

Key Work Tasks

Task 1: Aggregate Information, Analyses and Findings

- **Aggregated key findings:**
  - Net Income / Net Revenue Impact
  - Balance Sheet / Cash Flow Impact
  - Structure / Process Opportunities
  - Technology Opportunities

Task 2: Outcome Summary/Review

- **Summarized recommendations**
  - Quick Hits opportunities for immediate benefit
  - Revenue/Cash Enhancement opportunities (Recurring / One-time)
  - Infrastructure (Organization/Process/Technology) Improvement
- **Review report with project sponsor and key stakeholders**

Task 3: Final Report and Implementation 'MAP'

- **Final report to sponsorship / oversight group / 'MAP'**
  - Findings and Recommendations
  - Implementation Plan 'MAP'

Revenue Cycle Assessment
Performance Review – Indicators

Performance Indicator	Standard[1]	Hospital Actual	Favorable / Unfavorable
A/R > 90 Days as % of Total A/R	15% to 20%	14.2%	
Bad Debt & Charity as % of Gross Revenue	<6.0%	7.1%	
Total Unbilled	3.0 days	4.9 days	
Net Days in Accounts Receivable	55.0 days	48.6 days	
Cash Collections as a % of "Net" Net Revenue (Net Revenue net of allowance for doubtful accounts)	> 100%	101.4%	

Favorable
On Target
Unfavorable

Revenue Cycle Assessment
Performance Review – Indicators

Performance Indicator	Standard[1]	Hospital Actual	Favorable / Unfavorable
Clean Claim Rate	>80.0%	>90%	
Denial Rate – Medicare	2.0%	3.1%	
Denial Rate – Other Payers	4.0%	5.6%	
Cost to Collect: Registration/Admissions + Business Office	2%	2.3%	
Registration Accuracy	>95%	N/A	N/A

Favorable
On Target
Unfavorable

Revenue Cycle Assessment
Financial Opportunity – Income Statement (Denials)

Through comprehensive redesign of denials workflow, introduction of a management reporting system and enhanced communication with root cause departments, FTI estimates an opportunity of **$0.4M.**

Denials Analysis Assumptions	Statistic
Total Medicare Denials on 835 Remit File (12 mos.)	$ 2,354,780
Total Blue Cross Denials on 835 Remit File (12 mos.)	$ 2,236,143
Total Medicaid Denials on 835 Remit File (12 mos.)	$ 1,384,697
Total United Denials on 835 Remit File (12 mos.)	$ 1,379,285
Total Denials	**$ 7,354,905**
Estimated Medicare Denials Reduction Opportunity	$ 823,762
Estimated Blue Cross Denials Reduction Opportunity	$ 241,741
Estimated Medicaid Denials Reduction Opportunity	$ 444,257
Estimated United Denials Reduction Opportunity	$ 846,396
Estimated Denial Opportunity Gross	**$ 2,356,156**
Percentage Net to Gross	36.0%
Total Estimated Denials Opportunity Net	**$ 848,216**
Estimated Realization %	40%,50%,60%

Note: Estimated Realization % rates are based on benchmark data for overturn rates of 40-60%

Denials Opportunity	Calculation		
Estimated Denial Opportunity Gross	$ 2,356,156		
Collection Rate	*36.0%*		
Net Denials Reduction Opportunity	$ 848,216		
Estimated Realization % (Conservative, Midpoint, Aggressive)	*40%*	*50%*	*60%*
Total Denial Reduction Opportunity	***$ 339,286***	***$ 424,108***	***$ 508,930***

Revenue Cycle Assessment
Financial Opportunity – Income Statement (Uncollectibles)

Through improved front-end financial clearance processes and enhanced AR management, FTI believes Hospital has an opportunity to reduce uncollectibles of approximately **$0.4M**.

Uncollectible Analysis Assumptions	Statistic
Gross Revenue	$196,686,952
Uncollectible (Bad Debt and Charity)	$13,876,190
Uncollectible Percentage	7.1%
Benchmark Uncollectible Percentage (%)	6.0%
Average Collection Rate	36.3%
Estimated Realization	50.0%

Uncollectible Opportunity	Calculation
Uncollectible (Bad Debt and Charity)	$13,876,190
Conservative Uncollectible @ 6.5% Benchmark	*$ 12,784,652*
Gross Uncollectible Reduction opportunity	$1,091,538
Net Uncollectible Reduction Opportunity	***$ 198,114***
Mid Point Uncollectible @ 6% Benchmark	*$ 11,801,217*
Gross Uncollectible Reduction Opportunity	$ 2,074,973
Net Uncollectible Reduction Opportunity	***$ 376,608***
Aggressive Uncollectible @ 5.5% Benchmark	*$ 10,817,782*
Gross Uncollectible Reduction Opportunity	$ 3,058,408
Net Uncollectible Reduction Opportunity	***$ 555,101***

Revenue Cycle Assessment
Financial Opportunity – Income Statement (Cost To Collect)

Based on the information provided, FTI estimates **No Opportunity**. FTI recognizes that Hospital has areas of need such as Financial Clearance and a Pre-arrival Unit and resource should be obtained to address these areas.

Cost-to-Collect	Calculation
Patient Access(PA) Totals	
Salary Expense PA/ED	$403,037
Non-Salary Expense	$ -
Vendor Expense	$ -
Total	**$ 403,037**
Patient Financial Serivces(PFS)	
Salary Expense	$ 750,000
Non-Salary Expense	0
Vendor Expense	$ 750,000
Total	**$ 1,500,000**
Total Expense PA/PFS	**$1,903,037**
Cash Collections	**$ 81,949,348**
Cost-to-Collect	**2.3%**
Cost-to-Collect Benchmark	**2.5%**

Cost-to-Collect Opportunity	Calculation
Total Expenses PA/PFS	$ 1,903,037
Conservative Cost-to-Collect @ 3% Benchmark	*$2,458,480*
Conservative Cost-to-Collect Reduction Opportunity	***No Opportunity***
Mid Point Cost-to-Collect @ 2.5% Benchmark	*$ 2,048,734*
Mid Point Cost-to-Collect Reduction Opportunity	*No Opportunity*
Aggressive Uncollectible @ 2% Benchmark	*$ 1,638,987*
Aggressive Cost-to-Collect Reduction Opportunity	***$ 264,050***

Revenue Cycle Assessment
Financial Opportunity – Balance Sheet (Unbilled/DNFB)

With improved accountability and management of Unbilled AR across the entire organization, communication among departments and a focused reduction effort for current DNFB and other Unbilled backlogs, FTI estimates a **$0.3M** cash flow improvement opportunity.

Unbilled / DNFB Assumptions	Statistic
Current Total Unbilled	$ 2,628,041
1 Day Gross A/R	$ 538,868
Days in Unbilled	4.9
Benchmark Days in Unbilled	3.0
Average Collection Rate	36%

Unbilled / DNFB Opportunity	Calculation		
Current Total Unbilled	$ 2,628,041		
Days Reduction Opportunity	*1.9*		
Gross Reduction in A/R	$ 1,011,436		
Average Collections Rate	*36%*		
Net A/R Savings Opportunity	$ 364,117		
Estimated Realization %	*70%*	*80%*	*90%*
Total Unbilled Opportunity	***$ 254,882***	***$ 291,294***	***$ 327,705***

Revenue Cycle Assessment
Financial Opportunity – Balance Sheet (POS Collections)

With reimplementation of POS collection process in all applicable access points, FTI estimates an incremental and ongoing opportunity of **$0.6M** in cash flow.

POS Collection Assumptions	Statistic
Current POS Collections (ED)	$ 428,250
Conservative POS Collections Benchmark	1.00%
Mid Point POS Collection Benchmark	1.50%
Aggressive Collection Benchmark	2.00%
Net Revenue	$ 71,440,315

POS Collection Opportunity Summary	Calculation
Current POS Collections (ED)	$ 428,250
Conservative POS Collections @ 1.0% Benchmark	*$ 714,403*
Conservative Incremental Increase in Collections	**$ 286,153**
Mid Point POS Collections @ 1.5% Benchmark	*$ 1,071,605*
Mid Point Incremental Increase in Collections	**$ 643,355**
Aggressive POS Collections @ 2.0% Benchmark	*$ 1,428,806*
Aggressive Incremental Increase in Collections	**$ 1,000,556**

Revenue Cycle Opportunity Assessment

Income Statement – Net Revenue Opportunity	Low	High	*Midpoint*
Reduce Denial Write-Offs	$0.3 M	$0.5 M	$0.4 M
Reduce Uncollectibles (Bad Debt/Charity Care)	$0.2 M	$0.6 M	$0.4 M
Coding/Documentation	$1.0 M	$2.0 M	$1.5 M
Managed Care	$0.7 M	$1.1 M	$0.8 M
Income Statement Net Revenue Opportunity	**$2.2 M**	**$4.2 M**	**$3.1 M**

Income Statement – Cost Reduction Opportunity	Low	High	*Midpoint*
Cost To Collect	$0.0 M	$0.0 M	$0.0 M
Variable Cost Reduction	$0.3 M	$0.7 M	$0.5 M
Income Statement Expense Reduction	**$0.3 M**	**$0.7 M**	**$0.5 M**
Total Income Statement Opportunity	**$2.5 M**	**$4.9 M**	**$3.6 M**

Revenue Cycle Assessment
Financial Opportunity – Balance Sheet

Balance Sheet – Cash Flow Opportunity	Low	High	*Midpoint*
Reduce DNFB/Unbilled	**$0.2 M**	**$0.3 M**	**$0.3 M**
AR Management/Reduce AR (AR > 90 days)	**$0.0 M**	**$0.0 M**	**$0.0 M**
POS Collections	**$0.3 M**	**$1.0 M**	**$0.6 M**
Total Balance Sheet Opportunity	**$0.5 M**	**$1.3 M**	**$0.9 M**

Revenue Cycle Assessment
Performance Review – Core Processes (Exqample)

Leading Practice	Hospital Doesn't Meet	Hospital Meets	Hospital Exceeds	Comments
Demographic and insurance information is collected completely and accurately for scheduled services				Pre-registration exists for only scheduled services; however heavy reliance on "copy forward" of data and physician information
Insurance and benefits are verified and auths obtained before service and are appropriately documented in system for scheduled services				Verification of patient coverage and benefits with payers does occur (completed by Physician Offices and not by PA staff). PA staff does confirm insurance information during the registration process versus insurance in Siemens
Current Revenue Cycle system(s) are optimized and 'Bolt-on' applications are in place to enhance operations				Current systems are not optimized and few 'Bolt-on' applications are in place. Therefore, manual process remain throughout leading to inefficiencies and process breakdowns
Point-of-Service (POS) payments from patient liabilities consistently collected at or before Date-of-Service (DOS)				POS collections does not occur consistently prior to DOS and no Financial Clearance function in place
Procedures in place to complete any missing patient information at check-in				Walk-ins meet with PA specialist on DOS prior to services to complete registration
ER Registration completes EMTALA "Quick Reg" and completes Registration post MSE (medical screen exam) thus minimizing walk-outs				EMTALA compliant Registrations are occurring in the ER per conversations with the ED Management

Revenue Cycle Management
Key Performance Indicators (KPI's)

- **Scheduling – 5 indicators**
  - **Pre-registration rate >98%**
- **Preauthorization – 10 indicators**
  - **Insurance verification >98%**
- **Patient Registration – 7 indicators**
  - **Average registrations pre shift – 35-40**
- **Financial Counseling – 7 indicators**
  - **Payment arrangements established for non charity eligible inpatients – 98%**
- **Health Information Management – 15 indicators**
  - **Inpatient charts coded per coder per day – 23-26**
  - **OP / ED charts coded per coder per day – 150-230**
- **Charge Entry – 13 indicators**
  - **Late charges as % of total - <2%**
- **Billing / Claims Submission - 5 indicators**
  - **Medicare return to provider denials rate - <2%**

Source: hfm July 2007

Revenue Cycle Management
Key Performance Indicators (KPI's)

- **Third Party / Guarantor Follow Up – 12 indicators**
  - **Bad debt + charity write-offs - <6%**
  - **DNFB A\R days - <4-6 days**
- **Cashiering – 5 indicators**
  - **Credit balance A/R - <2 A/R days**
- **Customer service – 8 indicators**
  - **Correspondence backlog - <1 business day**
- **Collection / Outsourcing Vendors – 6 indicators**
  - **Legal collection fee % - 20-30%**
- **Physician Practice Management – 15 indicators**
  - **Appointment no show rate - <2-3%**
  - **Copay collections as % of office visits - >95%**
- **Managed care Contracting – 8 indicators**
  - **Outlier $ fraction of total revenue - +/-5%**

- **TOTAL – 117 INDICATORS TO MONITOR**

Source: hfm July 2007

Upcoming Challenges

Not to mention dealing with an "informed" patient, increased uninsured / underinsured population, declining volumes and downward pressure on reimbursement…….the Chief Revenue Officer must prepare for

- **The Future is ICD-10**
  - **From 17,000 ICD-9 codes to 155,000 codes**
  - **Information about care process, co-morbidity, disease management, prior treatment, post-discharge outcome……**

    …….more information to delay and/or deny payment
- **Demands of Pay For Performance**
  - **Medicare's move to value based purchasing – withholds of 2% - 5%**
  - **Ditto Medicaid and commercial insurance**
- **Other Experiments in Payment**
  - **Bundling payments to physicians, hospitals and other providers**
  - **Prometheus Project: financial incentives to use evidence-based clinical protocols**
  - **"Never Events" will never pay**

What Does All This Mean

- **Pay extreme care to revenue recognition and A/R**
- **Tremendous pressure on all hospitals to keep up with current and future demands**
  - **IT systems, staff training, management oversight**
  - **The “have-nots” likely to be late adopters – without the human resources and capital necessary to make the changes**
- **Continued pressure to cut costs (especially “overhead”) will place even greater demands**
  - **Some poorly conceived changes can jeopardize cashflow**
- **A good season for consultants!**