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PHASE 2 CONSULTING
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Reimbursement, Specialty Hospitals Weigh Heavy on Minds of CEOs

Declining reimbursement, the threat of specialty hospitals and quality initiatives were top of mind for CEOs at ACHE Congress in March. The concerns were expressed at a focus group hosted at Congress by Phase 2 Consulting.

The top concern of CEOs was continuing reimbursement pressures from various payors. The CEO of a Tennessee hospital reported that TennCare — Tennessee's Medicaid managed care plan — will have a $55 million negative annual impact on just 10 hospitals in one system. Blue Cross/Blue Shield was cited as an Alabama hospital's biggest concern, because it is currently reimbursing the hospital at rates below Medicaid. In California, all of this revenue pressure has led to 60% of hospitals there operating in the red, noted one CEO.

The threat of niche providers and specialty hospitals weighed particularly heavy on the minds of CEOs. Specialty hospitals are expected to become a major drain on both revenue and medical staff. One CEO expects to lose half of his neurosurgery volume as well as most of his neurosurgeons.

About 100 specialty hospitals are now operating in the U.S., with 20 to 30 others in some stage of development. Since most of them accept only insured patients, CEOs expect them to increase the proportion of uninsured and self-pay patients their hospitals must treat. "The rise in uncompensated care makes me a health care gatekeeper, and that's a role I'm not comfortable with," said one CEO. The moratorium on physician ownership of specialty hospitals imposed by Congress is set to expire in June, but a strong fight is expected. Last year, the American Surgical Hospital Association mounted a $1.5 million lobbying campaign to push for expiration of the moratorium.

Quality initiatives are also growing challenges for CEOs. The public availability of quality data is compelling many physicians, who don't want to risk taking on an "outlier" status, to get on board. But CEOs believe technology has become a double-edged sword. While it's indispensable in the collection and reporting of quality data, it's effectiveness is limited by the human factor. Some nurses are resistant to utilizing bedside documentation systems, and physicians failing to document key events mean hospitals don't get credit for some quality measures.

Dear Client,

We are pleased to introduce *The Phase 2 Advisor*, a free quarterly e-mail advisory. Written by the Directors and staff of Phase 2 Consulting, *The Advisor* is is a quick, easy-to-read synopsis of pertinent industry information, current trends, and lessons learned from our engagements. We monitor industry journals and compile knowledge gained from our consulting assignments to create a concise review of the trends, problems and potential solutions that we hope this will benefit your operations. We welcome your suggestions for ways to make *The Advisor* a more useful tool, as well as content recommendations. E-mail us at **lapeterson@phase2consulting.com, or call 1.800.995.0097.**

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Identifying Lost Revenue: A Data Driven Assessment of the Revenue Cycle

Marlowe J. Dazley, MBA/HSA, Sr. Managing Director, Phase 2 Consulting

A chronic and cumulative problem spanning several years has begun to surface in the revenue-producing functions of our nation's health care delivery systems. Some of it is self-generated and some results from tactics deployed by managed care companies to delay or deny a claim. Most hospitals/systems are leaving millions on the table every year because they lack the knowledge, experience, and discipline necessary to bill and collect correctly. Every hospital in the U.S. has or will experience problems in areas such as pre-registration, insurance verification, registration/admitting, co-pay collections, uncompensated care, charge entry, charge capture, coding, billing, denials, and collections. As the cost and demand for health care continues to rise, more pressure is placed on enhancing revenue as a solution for improving financial performance. Now more than ever, financial managers and administrators must rapidly identify revenue improvement opportunities that increase revenue, maximize reimbursement, and decrease write-offs to realize long-term profitability and improved results.

RECONCILING CASH COLLECTIONS TO ACCRUED NET REVENUE

The first step is to conduct a reconciliation of patient cash collected over the last 12-18 months to accrued net revenue for the same period. The reasonableness of a particular month's revenue recognition can be substantiated by subsequent month's cash collections on those receivables. While this seems like a simple and obvious process, the calculation of net revenue is usually based on historical reserve formulas that have not kept up with the complexities of managed care contracting. Usually, Accounts Receivable reserves are understated because managed care pricing generated deeper discounts than the reserve formulas acknowledged and/or a significant deterioration in billing and collection has surfaced, hence more revenue is being recognized monthly than the hospital/system is entitled to or capable of collecting. Frequently, this has been a cumulative problem spanning several years, which finally reaches such a magnitude that the hospital/system's cash position is seriously eroded, when according to the financial statements, the hospital/system has been profitable. Upon serious examination it becomes clear that the net income of the hospital/system has been and continues to be overstated significantly for both the current and most recent prior periods. Hence, while the hospital/system made resource allocation and capital spending decision based on a belief they were very profitable, in fact they were losing money each month and spending capital that didn't exist. Annual audits have not been very successful in identifying the magnitude of the problem because they rarely reconcile the existing A/R to actual cash collected on a month-to-month basis.

Once the reconciliation is complete, restate the income statements to reflect reality. This must be done for each business unit so that everyone understands the magnitude of the problem for each unit. This may include unbundling the accounting for various business units that have historically been reported as part of a larger operation. The process itself is simple, and is accomplished by comparing patient cash collections, preferably by payer, for a period 12-18 months ago to the amount of net patient revenue accrued for that time period. Historically, accurate collection formulas have existed for fee-for-service, Medicare and Medicaid. The problems lie in the formulas for managed care contracts and self-pay.

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In the table below, note the significant differences between revenue accrued and cash collected in the self-pay, commercial, and managed care categories. In this instance, the discrepancy amounted to over $16 million in one year. Unfortunately, significant resource commitments had been made based on monthly income statements that reflected operating gains. Once reporting was restated to reflect actual cash collections, the operating margin that had existed virtually disappeared. In addition, when corrected patient revenue was distributed to various product lines and ancillary businesses, several lines of business which were thought to have been profitable were now in the red.

Gross/Net Accounts Receivable ($000's)

	GROSS A/R BALANCE	RESERVES	RESERVE PERCENT	EXPECTED RECOVERY	NET A/R BALANCE	ACTUAL COLLECTION RATE	DIFFERENCE	REVISED NET A/R BALANCE
Medicare & Medicaid	27,042	(17,727)	66%	34%	9,315	34%	-	9,315
BlueCross	2,226	(1,183)	53%	47%	1,043	47%	-	1,043
Workers Comp	1,451	(1,016)	70%	30%	435	30%	-	435
Self-Pay	25,284	(9,535)	38%	62%	15,750	25%	(9,428)	6,321
Commercial	25,378	-	0%	100%	25,378	75%	(6,345)	19,034
Managed Care	12,982	(4,803)	37%	63%	8,179	55%	(1,039)	7,140
	$ 94,363	(34,264)	36%	64%	$ 60,099	46%	$ (16,812)	$ 43,288

UNPAID ACCOUNTS

This "reconciliation" provides no assurance that earned revenue has been collected or that collection efforts are as required. In recent years, the total percentage of gross revenue written off as uncollectible has steadily increased, thereby reducing revenue, cash collections, and increasing bad-debt expense. Most recent figures place combined bad-debt and charity care expense for better performing hospitals at 5.9% of gross charges (11-13% of net revenue) in addition to avoidable denials written off as contractual adjustments. This trend places added pressure on finding and collecting additional lost revenue.

A detailed analysis of accounts with no payment or partial payment identifies process breakdowns that cause "collectable" revenue to be left uncollected. Begin with twelve months of patient level charge and payment data. Allow at least six months to lapse from date-of-service to allow for the majority of accounts to be adjudicated. Identify accounts with no-payment or accounts that are partially paid, e.g., accounts where payments as a percent of charges is less than 10%. Array unpaid or underpaid accounts by payer and service location, and determine the number of cases that fall into each category. Next, quantify what the expected reimbursement should have been (lost revenue), then research a sample of these accounts to determine the root cause for no payment. Typical, and usually fixable problems include no authorization, timely billing denials, coverage not in effect, patient responsible balance, etc. Not all of the uncollected revenue issues can be resolved, as there will always be "uncollectible" accounts, however, quantifying opportunities and focusing efforts on the issues with the greatest economic benefit will result in increased revenue and decreased write-offs.

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KEYS TO SUCCESS

Once underpayment issues are resolved, ensure that every process in the revenue cycle is functioning with optimal performance. There are 10 steps to the successful processing of any health care claim. These steps must be followed for every health care service encounter to collect predictable cash. To ensure that each of these steps are successfully completed, a weekly monitoring process must be installed to measure each step.

One of the most important steps is the completion of an accurate patient encounter face sheet. There are 10 critical data points that must be captured at the patient point of service to have any realistic hope of actually collecting for the services rendered. Auditing each access point (emergency department, off-site clinics, inpatient admission, ancillary services, etc.) on a weekly basis ensures that registrars are accurately obtaining this information. If a site's completion and accuracy percentage drops below 90%, a training team is deployed to the site to remedy the problems.

An equally critical step includes accurate and timely coding of the claim, which requires prompt medical record and attending physician support. Medical records can become a literal quagmire in the billing and collection process if you let it. The cash impact of ensuring that 90% of all claims leave medical records within four days is substantial.

Similarly, the percentage of claims rejected for administrative and clinical reasons becomes the feedback mechanism for identifying existing process flaws in the billing and collection system. In order to reduce the percentage of rejections you must understand why they are being rejected in the first place. This usually involves several meeting with the various payers' claims processing shops to fully understand what they think you are doing wrong. These issues can be corrected fairly quickly once they are identified.

To find out more about the 10 ten steps to ensure accurate payments, please contact Marlowe Dazley at mdazley@phase2consulting.com, or 801-363-3046.

Charity Care Will Continue to Receive Tight Scrutiny at Not-For-Profits

Dan Bergantz and Jacob Steed, Phase 2 Consulting

Over the past few months nearly 40 lawsuits have been filed against roughly 340 not-for-profit hospitals in 20 states. These lawsuits and the subsequent attention from the federal government have increased concern and sparked a renewed debate regarding the ethical and legal obligation of not-for-profit hospitals to provide charity care as part of their tax-exempt status. (continued)

The issues cited in a majority of the lawsuits focus around three main topics, charging not-for-profit hospitals of:

- charging uninsured patients a premium over the amount that is billed to insurers for the same care,
- engaging in aggressive collections tactics for self-pay patients that include lawsuits and liens on homes, and
- benefiting from profit-making businesses such as pharmacies and cafeterias that are housed within the hospital.

In June 2004, the U.S. House Ways & Means Committee called on a number of hospital CEOs to testify and defend the challenge that not-for-profit hospitals have been operating just like their for-profit counterparts. This is a complicated and sensitive issue, due in part to the fact that many hospitals define charity care in different ways. Enforcing charitable obligations is also difficult because the granting of tax-exempt status by the IRS is not tied to any defined amounts of charity care that the organization must provide.

The major concern surrounding these lawsuits is the financial effect they could have not only on the targeted hospitals but on all not-for-profit hospitals, which represent roughly 85% of the hospital industry. The American Hospital Association has also raised concerns about whether these lawsuits will divert attention away from the real issue of providing care for the uninsured.

As a result of the increased scrutiny, some hospitals are making changes in their billing and collections strategies and have begun to take a closer look at their charity care policies and procedures. Several steps are being taken by some of the involved health care systems, including publication of their pricing throughout hospitals, developing guidelines to better ensure that individuals who need financial assistance are directed toward appropriate resources, and curtailing overly aggressive collections practices.

While these changes are significant, we at Phase 2 Consulting suggest a proactive approach in implementing charity care and billing/collections best practices. We have a great deal of experience in helping hospitals improve not only their billing and collections practices, but also meeting charity care policy and procedure best practices. Some of Phase 2 Consulting's common recommendations include:

- Provide financial counselors to help educate and assist patients.
- Emphasize confidentiality and that charity care is available for all health care services.
- Develop monthly cash collections targets that are in line with management's cash flow expectations and monitor collections efforts against these targets.
- Have uniformity in policy and procedures in all additional service locations.
- Follow the best practice guideline of patient income of 200% or less of current poverty guidelines.
  - those exceeding poverty guidelines may be eligible for discounts on a wage-adjusted sliding scale

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- Extend charity care for one year once approved, unless there is a change in financial condition.
- Implement sliding-fee schedules, prompt pay discounts and payment plans.
- Post information and provide all patients with written and oral notice of charity care assistance.
- Consider keeping claims in-house for at least 45 days to reduce collection fees. Utilize a pre-collection program prior to placement to bad debt collections.

To learn more about our approach and best practices in charity care and billings/collections, please contact Marlowe Dazley at mdazley@phase2consulting.com, or 801-363-3046.

Are You Still Losing Money on Employed Physicians?

Strategies for Reducing Hospital-Employed Physician Losses

Rick Carter, Sr. Managing Director, Phase 2 Consulting

In a new budget year, some hospitals are still faced with reducing employed physician practice losses. We have seen these losses stabilize over the past five years at around $-70,000 per physician, a significant improvement over the past 15 years, down from $-125,000 per physician.

The reduction of loss has occurred for four reasons:

1. hospitals have stopped buying practices at high values,
2. hospitals have transitioned practices back to private status,
3. hospitals have converted physician compensation to break-even contracts, and
4. hospitals have learned how to improve practice operations.

If your hospital continues to lose more than $-70,000 per physician:

- consider transitioning all or some practices back to private status
  - remember, the transitioned practices will have to be capitalized, which will be less than the loss you are incurring
- consider converting compensation agreements to break-even contracts
  - do this with advanced notice and allow two to three years to full implementation

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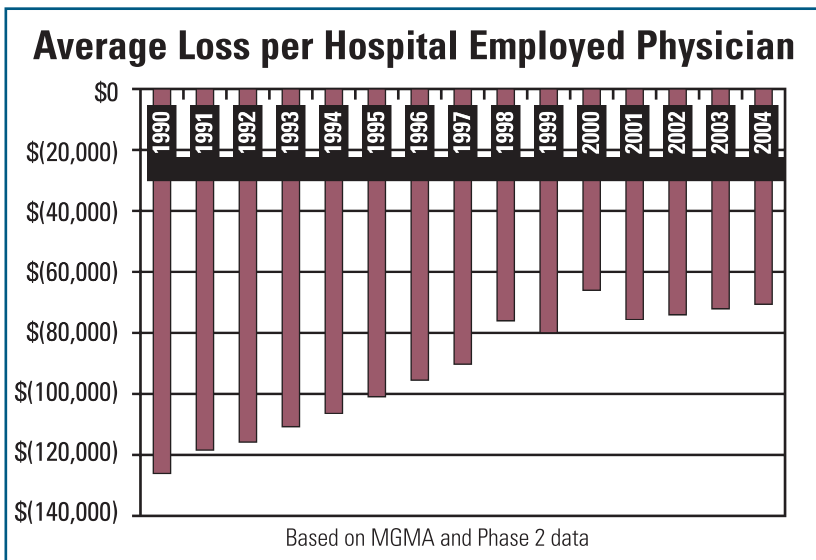
If your hospital continues to lose less than $-70,000 per physician, you can find operational opportunities to improve the bottom line in the following 10 areas:

1. Productivity: are scheduling templates restricting volume?
2. Charge master: are fees and codes affecting reimbursement?
3. Rates: are new contracts being renegotiated with 3-5% increases?
4. Payer mix: are patients with low-paying contracts consuming more than their share of schedules?
5. Coding: are physicians down-coding for fear of audits?
6. Revenue cycle: are collections maximized with days at less than 45?
7. Staffing: are staff productive relative to visit volumes and across all sites?
8. Rent: are there any underutilized offices or facilities?
9. Other overhead: are there any extraordinary expenses?
10. Compensation: are compensation levels equal to productivity?



Bilbrey, Gee Join Phase 2 Consulting

Carley E. (Mickey) Bilbrey III, formerly President and Chief Executive Officer of University of Tennessee Medical Center and **E. Preston Gee**, noted health industry thought leader and author, have joined the staff of Phase 2 Consulting.

Bilbrey, Senior Mangaging Director has over 30 years experience in health care administration, clinical development, managed care physician relations and marketing. He will head up the firm's new product development program, primarily focusing on health care organization restructuring, hospital/physician collaborations and care management processes.

At University of Tennessee Medical Center, Bilbrey orchestrated major initiatives in re-engineering and reorganization that resulted in significant quality improvement, solid financial performance and several prominent marks of recognition. Under his leadership, the University of Tennessee was named a Solucient Top 100 Hospital in 1999, a Solucient Top 100 Cardiovascular Hospital in 2004, and it received the National Research Corporation's Consumer Choice Award for Knoxville's Most Preferred Hospital in Overall Quality and Image for nine consecutive years.

Gee, who is joining Phase 2 as Managing Director, is recognized in the health care industry for his advocacy and expertise on consumer-driven market models. He has written seven books on health care trends and strategies, including his most recent book, *Service Line Success: Eight Essential Rules*. Published by Health Administration Press, *Service Line Success* presents rules for implementing a service line management model to meet new market demands, including the rise of specialty hospitals and physician centers.

Most recently, Gee was senior vice president for strategic planning for St. David's Healthcare Partnership in Austin, Texas — a position he held for 11 years. He also has held various marketing and business development positions in the health care and consumer goods industries. At Phase 2, Gee will apply his 20+ years of health care industry experience to help hospitals and health systems develop and implement market-driven models with strategic reinvention.

Phase 2 Consulting Management Team

Brent Hardaway, *Chief Operating Officer*

Mickey Bilbrey, *Senior Managing Director*

Rick Carter, *Senior Managing Director*

Howard Salmon, *Senior Managing Director*

Peter Singer, *Senior Managing Director*

Mary Wilkes, *Senior Managing Director*

Marlowe Dazley, *Managing Director*

Preston Gee, *Managing Director*

Upcoming Events Featuring Phase 2 Consulting

- Rick Carter will present a one-day program called "Practice-Based Solutions to Achieve Your Revenue Cycle Targets" in locations around the country: April 22 - Dallas, TX; June 10 - Atlanta, GA; and June 20 - Chicago, IL.
- Marlowe Dazley will be presenting "Creative and Innovative Pre-Registration, Verification and Financial Counseling Solutions" at the HFMA's Annual National Institute in Las Vegas on June 27.
- Phase 2 Consulting will sponsor the American College of Healthcare Executive's Santa Fe Cluster, June 13-16.
- Preston Gee will present "Optimizing New Product Opportunities" at the SHSMD Fall Conference September 16.
- Look for Preston Gee's article "Hospital Sales Force/Service Lines" in the May issue of *Strategic Healthcare Marketing*.