Winning Under Reform: Strategies to Optimize your Revenue Cycle in 2013

HFMA – Kentucky Chapter
March 15, 2013

PNC Healthcare Advisory Services
Today’s Presentation Goals

1. Provide some background on U.S. healthcare economics
2. Review the timeline, provisions, and impacts of healthcare reform
3. Explore revenue cycle strategies for improvement
4. Developing and reporting key performance indicators (KPIs)
5. Learn something new and have fun!!!
SOME ECONOMICS OF AMERICAN HEALTHCARE
The U.S. spends more, per capita, on health than all other OECD countries; it is ranked first in health expenditures at $8,233 which is more than double the OECD average of $3,268.

Source: Organization for Economic Co-operation and Development (OECD) Statistics
National Health Expenditures per Capita

National Health Expenditures per Capita and Their Share of Gross Domestic Product, 1960 – 2011

Breakdown of US Health Care Expenditures

National Health Expenditures as a Percentage of Gross Domestic Product and Breakdown of National Health Expenditures, 2011

Uninsured by State

Average Percent Uninsured by State, 2011
16% of the population is uninsured

Uncompensated Care Cost to Hospitals

Source: American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet, Jan 2013

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Hospitals Already Face Public Underfunding

Hospital Payment Shortfall Relative to Costs 1997 – 2010

Source: American Hospital Association Annual Survey data, 2010

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Public Funding Continues to Grow as a Source

**National Health Expenditures by Source of Payment ($Billions)**

- **1980**: $58, 23% Out of Pocket, 42% Public Funds, 35% Insurance Funds
- **2000**: $203, 15% Out of Pocket, 45% Public Funds, 40% Insurance Funds
- **2009**: $1,231, 12% Out of Pocket, 50% Public Funds, 38% Insurance Funds

Current Hospital Revenue Cycle Environment

2010 Profit Margins
(all hospitals)

- Over 12 billion major transactions
- Huge fragmentation
  - More than 2,000 payers
  - 30,000 contact points
- Cumbersome processes lead to revenue write-offs
- Unenforceable standards (HIPAA standardization)
- Excessive reliance on paper or proprietary gateways
- Disjointed IT systems
- Constantly changing payment protocols
- Abnormally high and accelerating costs of billing and collections
- Reimbursement and market pressures reducing resources available for overburdened and understaffed administrative functions

Source: Thomson Reuters Action OI database

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NOW ADD IMPACTS OF HEALTHCARE REFORM
A New World

- Patient Protection and Affordable Care Act (PPACA) signed into law March 23, 2010
- Aimed primarily at decreasing the number of uninsured Americans
- Sweeping changes to healthcare – possibly largest since the creation of Medicare and Medicaid program in 1965
- Implementation and effects to be seen over the period of 2010-2019
- Upheld by the Supreme Court on June 28, 2012
## Healthcare Reform Timeline

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</thead>
<tbody>
<tr>
<td><strong>PAYMENT CUTS &amp; COST SHIFT PROVISIONS</strong></td>
<td><strong>P4P &amp; PENALTIES FOR POOR PERFORMANCE PROVISIONS</strong></td>
<td><strong>GEOGRAPHIC PYMNT ADJ PROVISIONS</strong></td>
<td><strong>TRANSPARENCY PROVISIONS</strong></td>
<td><strong>COVERAGE EXPANSION PROVISIONS</strong></td>
<td><strong>DELIVERY SYSTEMS PROVISIONS</strong></td>
<td><strong>10 Yr Federal Revenue Estimates ($ billions)</strong></td>
</tr>
<tr>
<td>- PhRMA Tax (Ranging from $2.5B to $4.1B annually)</td>
<td>- Hospital Productivity Adjustments</td>
<td>- Hospital Productivity Adjustments</td>
<td>- Hospital Value-Based Purchasing Hospital Readmission Payment Reductions</td>
<td>- Hospital Acquired Conditions Penalties</td>
<td>- CMS Hospital Behavioral Offset relating to IPPS Hospital Market Basket Reductions</td>
<td><strong>$22.3</strong></td>
</tr>
<tr>
<td>- Medicare DSH Payment Reduction</td>
<td>- Hospital Productivity Adjustments</td>
<td>- Hospital Productivity Adjustments</td>
<td>- Hospital Value-Based Purchasing Hospital Readmission Payment Reductions</td>
<td>- Hospital Acquired Conditions Penalties</td>
<td>- CMS Hospital Behavioral Offset relating to IPPS Hospital Market Basket Reductions</td>
<td><strong>$262.7</strong></td>
</tr>
<tr>
<td>- Independent Payment Advisory Board (IPPS Hosp exempt until 2020)</td>
<td>- Hospital Productivity Adjustments</td>
<td>- Hospital Productivity Adjustments</td>
<td>- Hospital Value-Based Purchasing Hospital Readmission Payment Reductions</td>
<td>- Hospital Acquired Conditions Penalties</td>
<td>- CMS Hospital Behavioral Offset relating to IPPS Hospital Market Basket Reductions</td>
<td><strong>$393.4</strong></td>
</tr>
<tr>
<td>- Medical Device Tax</td>
<td>- Hospital Productivity Adjustments</td>
<td>- Hospital Productivity Adjustments</td>
<td>- Hospital Value-Based Purchasing Hospital Readmission Payment Reductions</td>
<td>- Hospital Acquired Conditions Penalties</td>
<td>- CMS Hospital Behavioral Offset relating to IPPS Hospital Market Basket Reductions</td>
<td><strong>$111.0</strong></td>
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<td>- Hospital Productivity Adjustments</td>
<td>- Hospital Value-Based Purchasing Hospital Readmission Payment Reductions</td>
<td>- Hospital Acquired Conditions Penalties</td>
<td>- CMS Hospital Behavioral Offset relating to IPPS Hospital Market Basket Reductions</td>
<td><strong>$835.9</strong></td>
</tr>
</tbody>
</table>

- **Cadillac tax – 40% tax on employer-sponsored health plans that offer policies with generous coverage levels.**
- **Medicaid DSH Payment Reduction**
- **Independent Payment Advisory Board (IPPS Hosp exempt until 2020)**
- **Medical Device Tax**
- **Medicare DSH Payment Reduction**
- **Hospital Productivity Adjustments**
- **Hospital Value-Based PurchasingHospital Readmission Payment Reductions**
- **Hospital Acquired Conditions Penalties**
- **Disclosure of Industry Payments to Physicians and Teaching Hospitals**
- **Comparative Effectiveness Research**
- **Disclosure of Standard Hosp Charges**
- **Comparative Effectiveness Research**
- **Disclosure of Industry Payments to Physicians and Teaching Hospitals**
- **Medicaid Expansion Insurance Reforms (Pre-existing conditions for adults, premium limits Individual Mandate and Employer “Pay or Play” State Exchanges**
- **Bundled Payments Pilot**
- **Accountable Care Organizations**
- **Center for Medicare and Medicaid Innovation**
- **Insurance Reforms (Pre-existing conditions for children, no annual lifetime limits, children on parents insurance until 26)**
- **“Doughnut hole” coverage gap in Medicare prescription benefit is entirely phased out. Seniors expected to pay 25% of drug costs until the threshold for Medicare catastrophic coverage is met.**

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Changes of Healthcare Reform

• CEOs report every year that their top concern is how their hospitals will continue shouldering the financial burden of caring for the uninsured.¹

• For the first time ever, a majority of the nearly 49 million uninsured in the U.S. will have access to health coverage.
  - More employers will provide health insurance to workers.
  - Medicaid eligibility will be expanded in participating states starting January 1, 2014.
  - Health insurance marketplaces (exchanges) will open in every state starting October 1, 2013 to enable uninsured Americans to enroll in health coverage.

• Consumer polling shows that 78 percent of uninsured Americans are unaware that coverage will be available to them.

YIKES!

¹ ACHE Survey “Top issues Confronting Hospitals” survey,
Impacts of Healthcare Reform

- Hospitals stand to lose 10% of their reimbursement over the next 10 years.
- Getting the uninsured enrolled in health coverage is going to be a challenge.
- Don’t be fooled: There will still be self pay!

“More budget cuts. One gown per room. Who wants to wear it first?”
The Provider Challenge

- Providers need to work harder than ever to ensure they secure payment for service revenues rightfully due.

- Providers face rising demands to drive down costs as public funding declines and pressures on margins increase.

- Providers will need to take an active role in helping uninsured patients and their families enroll in coverage in the new reform environment in order to reduce uncompensated care costs.

- Providers must make serious efforts to address quality in their organizations, especially as P4P provisions and poor performance penalties go into place.

- Bottom Line: There’s no room for error or inefficiency in today’s healthcare marketplace!
Revenue Cycle – the Tip of the Iceberg

2-3% net revenue
Balanced Budget Act/HIPAA
Common Revenue Cycle Process Gaps
Pricing & Charge Capture Methodologies
Compliance Audit Recovery (RAC/MIC/MAC)

7-10% net revenue
Payment Cuts & Cost Shifting
P4P Provisions & Poor Performance Penalties
Geographic Payment Adjustment Provisions
Transparency Provisions
Coverage Expansion Provisions
Delivery System Provisions

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And now...a Demotivational Thought

PROBLEMS
No Matter how Great and Destructive your Problems May Seem Now, Remember, You’ve Probably only Seen the Tip of Them.

www.despair.com
REVENUE CYCLE STRATEGIES FOR IMPROVEMENT
### The “Pillars of Success” in the Era of Reform

**Optimizing Revenue Cycle Performance**

<table>
<thead>
<tr>
<th>Address the Value Equation</th>
<th>Align with Physicians</th>
<th>Transform the System of Care</th>
<th>Optimize Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Excellence</strong></td>
<td><strong>Clinical Integration</strong></td>
<td><strong>Care continuum – including pre- and post- hospital</strong></td>
<td><strong>Revenue cycle</strong></td>
</tr>
<tr>
<td><strong>Service Excellence</strong></td>
<td><strong>Medical Staff Education</strong></td>
<td><strong>Reduce readmissions &amp; HACs</strong></td>
<td><strong>Service portfolio &amp; market share improvement</strong></td>
</tr>
<tr>
<td><strong>Operational Effectiveness</strong></td>
<td><strong>Physician lead PI teams to address VBP</strong></td>
<td><strong>Lower LOS</strong></td>
<td><strong>Pricing strategy</strong></td>
</tr>
<tr>
<td><strong>At the lowest cost position</strong></td>
<td><strong>EMR Implementation</strong></td>
<td><strong>Reduce variability &amp; resource consumption</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Accountable Delivery Organization**

- Move from transaction-oriented to outcome-oriented
- Become “accountable” for outcomes and costs for a population
- Partner with providers to coordinate episodes of care

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Key Principles for Success

Measurement

Accountability

Discipline

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Measurement

• We’ve all heard it: you can’t manage what you don’t measure.
  – Measurement aids in identifying problem areas.
  – Sets the stage for setting goals/targets and working toward them.

• It is also a proven principle that:
  – When performance is measured, performance improves. When performance is measured and reported, the rate of improvement will accelerate beyond mere measurement alone.

• Other principles to keep in mind:
  – Ensure that what you are measuring is accurate and meaningful. Use a standard data source.
  – Use metrics instead of just data reporting – standardized and widely used metrics will facilitate comparison.
  – Determine the appropriate frequency of measurement.
  – Automate the measurement process as much as possible.
Accountability

- Accountability must start with leadership.
  - A waterfall without a source is just a cliff – the source of accountability must be with leadership, then it can flow to the rest of the organization.

- Establish accountability for every process of the revenue cycle.
  - Ensure that every revenue cycle process reports to the right person – the “right people in the right seats on the bus” principle.

- Accountability is enhanced when coupled with measurement.
  - Every metric being measured should be tied to an accountable leader.
  - All staff level employees should be accountable to at least one quality and one productivity metric.
Discipline

• Process discipline = a standardized approach:
  – Define each task within the revenue cycle very clearly, then stick to that definition each time the task is performed to improve overall revenue cycle performance.
• You don’t have to be a six sigma black belt to identify areas and ways in which a process can be improved and where process discipline can be implemented.
• If you talk to different employees who perform the same task and they give different answers on how the task is done, you know you have a problem.
• Develop tools such as workflows, scripts, and training sheets so staff can easily follow the standard approach.
• Identify or create a process champion – someone who performs the task (or is willing to) in the best manner and utilize him/her as an example/role model/trainer for others.
DEVELOPING & REPORTING KEY PERFORMANCE INDICATORS
Developing KPIs

• What to measure?
  – Develop indicators for each process at the department/functional level as well as overall RCM indicators

• Develop a baseline - where are you today?

• Where have you been?
  – Trending information is more valuable than one point in time
  – Calculate values for the previous 12 – 18 months
  – Track a 3 – 6 month rolling average

• Where do you want to be?
  – Use industry resources for best practice benchmarks
  – Try to find benchmarks more specific to your type of facility and geographic region
  – Look for opportunities and create your “own” target
# KPIs by Functional Area

<table>
<thead>
<tr>
<th>PATIENT ACCESS</th>
<th>REVENUE INTEGRITY</th>
<th>CLAIMS MANAGEMENT</th>
<th>REIMBURSEMENT</th>
<th>OTHER MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pre-Registration Rate</td>
<td>• Days Gross Revenue in Discharged-Not-Final-Billed (DNFB)</td>
<td>• Days Gross Revenue in Final-Billed-Not-Submitted (FBNS) to Payer</td>
<td>• Initial Denials as a % of Gross Revenue</td>
<td>• Cash Collections as % of Net Revenue</td>
</tr>
<tr>
<td>• Insurance Verification Rate</td>
<td>• Days Gross Revenue in Discharged-Not-Submitted to Payer (DNSP)</td>
<td>• Clean Claim Submission Rate</td>
<td>• Final Denials Write-offs as a % of Net Revenue</td>
<td>• Bad Debt Write-offs as % of Gross Revenue</td>
</tr>
<tr>
<td>• Insurance Authorization Rate</td>
<td>• Late Charges as % of Total Charges</td>
<td>• Net Days in A/R</td>
<td>• Overturned Denial Rate</td>
<td>• Charity Care Write-offs as % of Gross Revenue</td>
</tr>
<tr>
<td>• Uninsured Inpatient Conversion Rate</td>
<td>• 3rd Party Billed A/R &gt;90 Days</td>
<td></td>
<td></td>
<td>• Charity Care to Uncompensated Care</td>
</tr>
<tr>
<td>• Point-of-Service Collections Rate</td>
<td>• Days Gross Revenue Held in Credit Balances</td>
<td></td>
<td></td>
<td>• Cost-to-Collect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Days Cash on Hand</td>
</tr>
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# Patient Access KPIs

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Calculation</th>
<th>Things to Consider</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pre-Registration Rate</td>
<td>Number of patient encounters pre-registered</td>
<td>All scheduled encounters pre-registered prior to date of service. A scheduled encounter is considered prior to day of service.</td>
<td>≥98%</td>
</tr>
<tr>
<td></td>
<td>___________________________</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Number of scheduled patient encounters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Insurance Verification Rate</td>
<td>Total number of verified encounters</td>
<td>All scheduled patient encounters where eligibility/insurance is verified prior to date of service and non-scheduled encounters verified within one day of service/admission date.</td>
<td>≥98%</td>
</tr>
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<td>___________________________</td>
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</tr>
<tr>
<td></td>
<td>Total number of registered encounters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Insurance Authorization Rate</td>
<td>Number of encounters authorized</td>
<td>Authorization is defined as required approval from the 3rd party payer for the services ordered.</td>
<td>≥98%</td>
</tr>
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<td>___________________________</td>
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<tr>
<td></td>
<td>Number of encounters requiring authorization</td>
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## Patient Access KPIs

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<th>Indicator</th>
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<th>Things to Consider</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Uninsured Inpatient Conversion Rate</td>
<td>Number of uninsured patients converted to a payer source</td>
<td>Payer source can include COBRA, Medicaid, workers comp, other insurances such as motor vehicle, and other government programs.</td>
<td>≥10-20%</td>
</tr>
<tr>
<td></td>
<td>Total number of uninsured patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Point-of-Service (POS) Collections Rate</td>
<td>POS Payments</td>
<td>Defined as patient payments collected prior to or up to seven days after discharge/date of service for the current encounter only.</td>
<td>≥2-3%</td>
</tr>
<tr>
<td></td>
<td>Total Cash Collected</td>
<td></td>
<td></td>
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</tbody>
</table>
# Revenue Integrity KPIs

<table>
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<tr>
<th>Indicator</th>
<th>Calculation</th>
<th>Things to Consider</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Days Gross Revenue in Discharged-Not-Final-Billed (DNFB)</td>
<td>Gross dollars in A/R not final billed</td>
<td>Include inpatient and outpatient, and exclude in-house claims.</td>
<td>≤4–6 Days</td>
</tr>
<tr>
<td></td>
<td>Average daily gross patient service revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Days Gross Revenue in Discharged-Not-Submitted to Payer (DNSP)</td>
<td>Gross dollars in DNFB + gross dollars in FBNS</td>
<td></td>
<td>≤5–7 Days</td>
</tr>
<tr>
<td></td>
<td>Average daily gross patient service revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Late Charges as % of Total Charges</td>
<td>Charges with post date &gt;3 days from service date</td>
<td></td>
<td>≤2%</td>
</tr>
<tr>
<td></td>
<td>Total gross charges</td>
<td></td>
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## Claims Management KPIs

<table>
<thead>
<tr>
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<th>Calculation</th>
<th>Things to Consider</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Days Gross Revenue in Final-Billed-Not-Submitted (FBNS) to Payer</td>
<td>Gross dollars in FBNS</td>
<td>Average daily gross patient service revenue</td>
<td>≤1 Day</td>
</tr>
<tr>
<td>• Clean Claim Submission Rate</td>
<td>Number of claims that pass edits requiring no manual intervention</td>
<td>Total claims accepted in to billing scrubber for editing</td>
<td>≥85-90%</td>
</tr>
<tr>
<td>• Net Days in A/R</td>
<td>Net A/R</td>
<td>Should exclude credit balance accounts and any non-patient service A/R</td>
<td>≤45–55 Days</td>
</tr>
</tbody>
</table>
# Claims Management KPIs

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Calculation</th>
<th>Things to Consider</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>3rd Party Billed A/R &gt; 90 Days</td>
<td>$\frac{3^{\text{rd}} \text{ Party Billed A/R &gt; 90 days}}{\text{Total 3rd Party billed A/R}}$</td>
<td>Should only include debit balance of 3rd Party accounts aged from discharge date.</td>
<td>≤15–20%</td>
</tr>
<tr>
<td>Days Net Revenue Held in Credit Balances</td>
<td>$\frac{\text{Dollars in credit balance accounts}}{\text{Average daily net patient service revenue}}$</td>
<td>Should not include accounts in pre-admit or in-house status.</td>
<td>≤2 Days</td>
</tr>
</tbody>
</table>
## Reimbursement KPIs

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Calculation</th>
<th>Things to Consider</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Initial Denials as a % of Gross Revenue</td>
<td>Sum of denied claim amounts</td>
<td>Include denied claims received from 3rd party payers with denial codes on the remittance advice.</td>
<td>≤4%</td>
</tr>
<tr>
<td></td>
<td>_____________________________</td>
<td>Gross patient service revenue</td>
<td></td>
</tr>
<tr>
<td>• Final Denials Write-Offs as a % of Net Revenue</td>
<td>Sum of final denial write-off amounts</td>
<td>Include all net account balances written off within the month resulting from un-appealable denials. Do not include contractual allowances.</td>
<td>≤2%</td>
</tr>
<tr>
<td></td>
<td>_____________________________</td>
<td>Net patient service revenue</td>
<td></td>
</tr>
<tr>
<td>• Overturned Denial Rate</td>
<td>Number of appealed claims paid</td>
<td>Include all appealed claims (in response to a denial or take-back) that were closed/finalized within the month due to a receipt of payment.</td>
<td>40–60%</td>
</tr>
<tr>
<td></td>
<td>_____________________________</td>
<td>Number of claims appealed and finalized or closed</td>
<td></td>
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</tbody>
</table>
### Other Management KPIs

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Calculation</th>
<th>Things to Consider</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cash Collections as a % of Net Revenue</td>
<td>Total cash collected</td>
<td>Total cash collected from patient service accounts.</td>
<td>~100%</td>
</tr>
<tr>
<td></td>
<td>Average collectable net patient service revenue</td>
<td>Exclude any non-patient service cash.</td>
<td></td>
</tr>
<tr>
<td>• Bad Debt Write-offs as % of Gross Revenue</td>
<td>Bad debt write-offs</td>
<td></td>
<td>≤2-3%</td>
</tr>
<tr>
<td></td>
<td>Gross patient service revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Charity Care Write-offs as % of Gross Revenue</td>
<td>Charity care write-offs</td>
<td></td>
<td>≤3%</td>
</tr>
<tr>
<td></td>
<td>Gross patient service revenue</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Other Management KPIs

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<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Charity Care to Uncompensated Care</td>
<td>Charity care write-offs ──────────────────────────── Total uncompensated care (charity care + bad debt)</td>
<td>This should be monitored to track any significant trends or variations.</td>
<td>~50% But varies depending upon the mission of the organization and state regulations.</td>
</tr>
<tr>
<td>• Cost-to-Collect (HIM excluded)</td>
<td>Total revenue cycle cost (patient access, business office) ──────────── Total cash collected</td>
<td>Should include all Patient Access departments’ costs, including the functions of: scheduling, pre-registration, eligibility/insurance verification, admissions, registration, and financial counseling. Include all Business Office departments’ costs, including the following functions: billing, A/R follow up &amp; collections, cash posting, customer service, and denials/underpayments management. Include costs for any outsourced functions.</td>
<td>≤2–3%</td>
</tr>
<tr>
<td>• Days Cash on Hand</td>
<td>(Cash on hand + market securities) ──────────────────────────── [(Total operating expense - depreciation expense)/365]</td>
<td>Include all cash and other liquid assets as reported on the balance sheet.</td>
<td>&gt;150 Days</td>
</tr>
</tbody>
</table>
Your KPI Reporting Process

• Determine how you will display and track KPIs
  – Charts, graphs, dashboards, spreadsheets, etc.
• Decide which indicators will be tracked daily, weekly, monthly, quarterly
• Put someone in charge of collecting the data
  – Automate data collection where possible
• Hold regular meetings with the CFO and revenue cycle leadership team to review indicators
  – Give updates on current initiatives, identify new opportunities and create action plans
  – Results in common goals
• Hold individual department meetings that include director, managers, supervisors & leads
Examples of Measurement

KPIs, Dashboards, and Graphs, oh my!

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Putting it All Together

- Implement the principles of Measurement, Accountability, and Discipline and live them every day
- Identify which measurements relate to the area you desire to improve
- Utilize measurements to assess where you are now compared to where you want to be
  - Identify gaps and quantify opportunities
- Prioritize opportunities based on financial and operational impact
- Assign accountability to each measurement and process so that everything is tied to an accountable individual
- Develop and implement standardized, disciplined approaches for each process to be improved
- Continue to measure and report to monitor progress
- Celebrate successes
Our Message to Hospitals: Don’t Keep Doing The Same Old Thing!
Thank You!

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