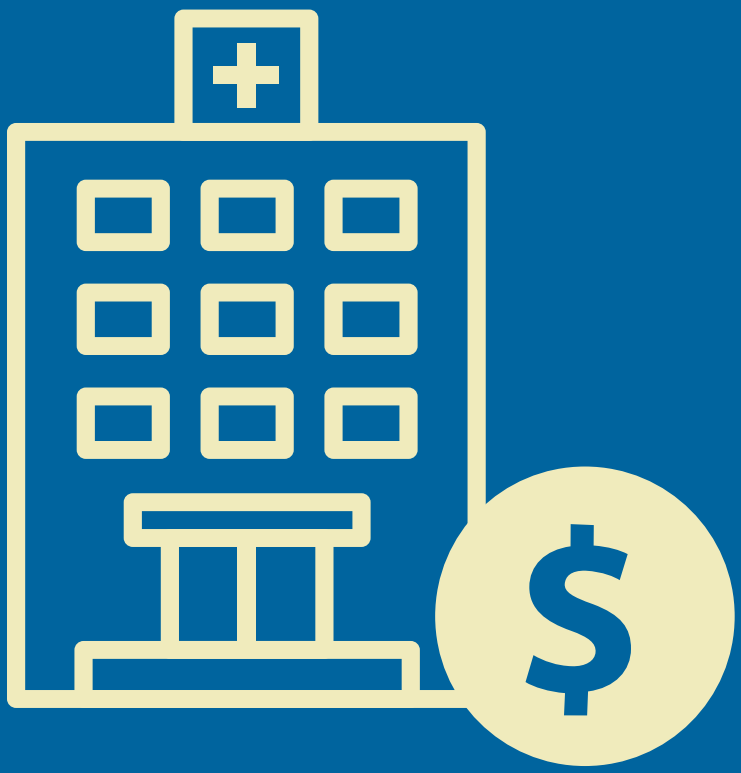
GOVERNANCE THOUGHT LEADERSHIP SERIES

Texas Healthcare Trustees

How Hospital Finance and Reimbursement Works in Five Steps



Providing education, resources, leadership development to inspire excellence in health care governance.

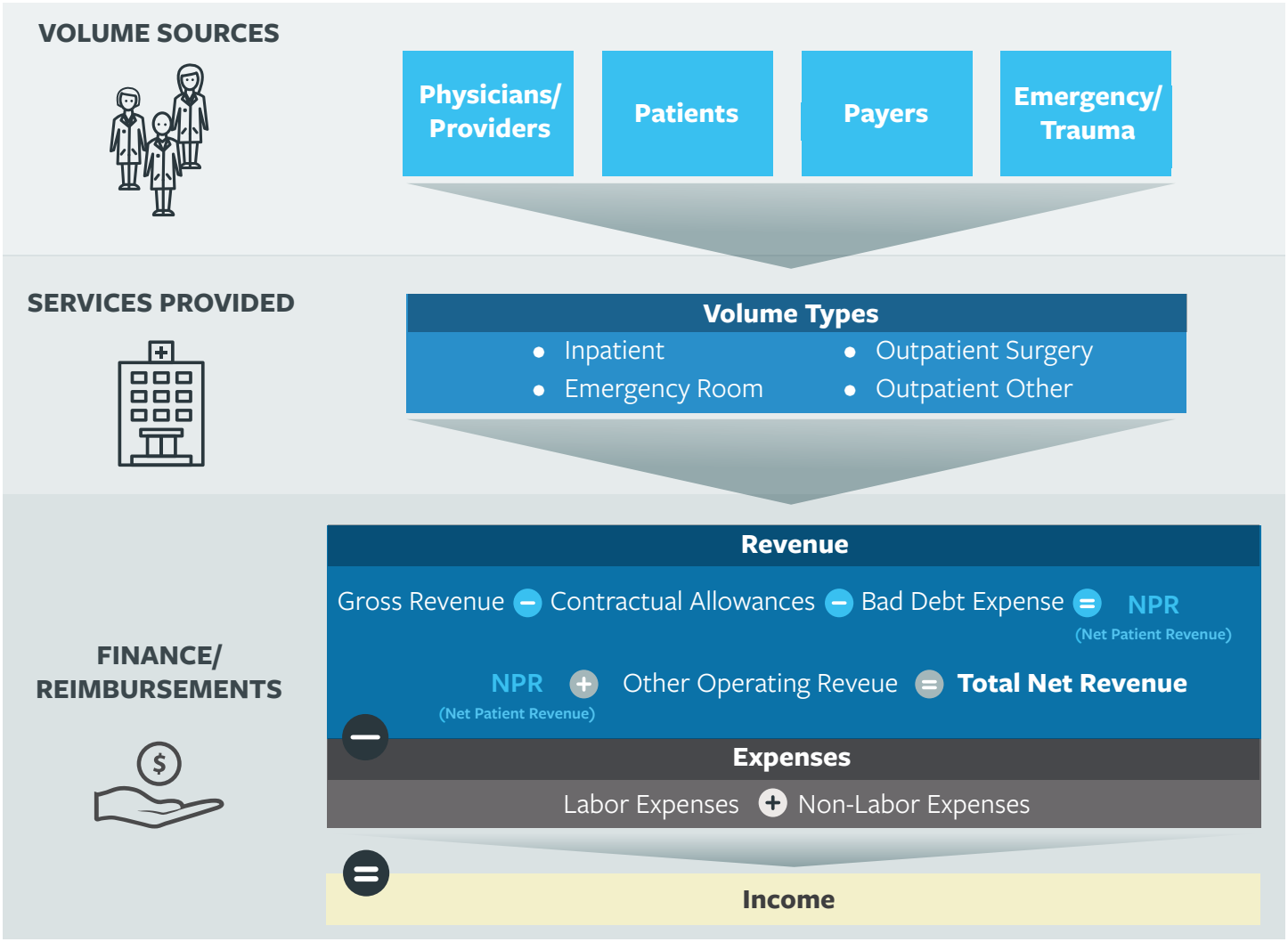
Like any industry, health care has its own vocabulary, acronyms, and processes that can at first be confusing. For a new hospital board member reading hospital financial reports and working to understand the financial health of their organization and how that fits with the strategies and organizational vision set forth by the entity's leadership, the labyrinth of terms can make this challenge particularly daunting.

What do hospital charges mean? What is a contractual allowance? How are prices established and why is there is such a shortfall between charges and collections? How does Medicare determine reimbursement for services? What determines how much United or Aetna pays for a service? What is a charity care policy? What is a "good payer mix" versus a "bad payer mix?" The questions can seem endless at first.

However, with time and experience, a board member can learn how to ask meaningful questions that enable the board to perform its duty in providing oversight and direction to the hospital's administrative leaders. The purpose of this article is to help jumpstart this learning process and provide insight into how hospital finance reimbursement works – in five steps. Within each step, we will highlight helpful questions a board member can ask to gain further insight into the organization's health and processes.

The Big Picture

Before jumping into finance and reimbursement details, it is helpful to first understand the basics – the sources of a hospital's volume, the services it provides, and how these combine to generate a hospital's Net Patient Revenue.



Volume

Acute care hospital volume (i.e., patients) is driven from a variety of sources:

- Physicians have a great influence on which hospital a patient chooses, since many patients simply go to whatever hospital their doctor recommends. This gives physicians power to drive hospital volume, and is one of the reasons hospitals spend so much time, effort, and resources in building positive physician relationships and alliances.
- Payers also influence a patient's hospital choice. Some patients are enrolled in health insurance plans that limit the level of benefits paid to certain facilities, encouraging patients to choose one facility over another (or risk paying higher out-of-pocket costs).
- Emergency services also draw patients to a hospital, often based on proximity. Many of these patients are treated and released on the same day, but others are admitted for observation, surgery, or longer term therapeutic care.

Ultimately, a hospital's volume comes from patients in need of care. Their decision on where to receive care is influenced by each of these factors, but patients make the final choice.

Services

Acute care hospitals provide care in a number of different settings:

- Inpatient care is rendered to patients who require an overnight stay in the hospital, occupying a patient room for more than 24 hours.
- Outpatient care encompasses a variety of services provided to patients when no overnight stay is required, including:
  - Outpatient surgery.
  - Emergency room services.
  - Physical therapy.
  - Lab testing.
  - Radiology services.
  - Other diagnostic services and treatment.

Net Patient Revenue

From a financial perspective, every service rendered to a patient generates a charge and is ultimately paid for by the patient, an insurance company, or a governmental entity – most likely a combination of all three. Additionally, a hospital writes off a significant portion of its charges due to:

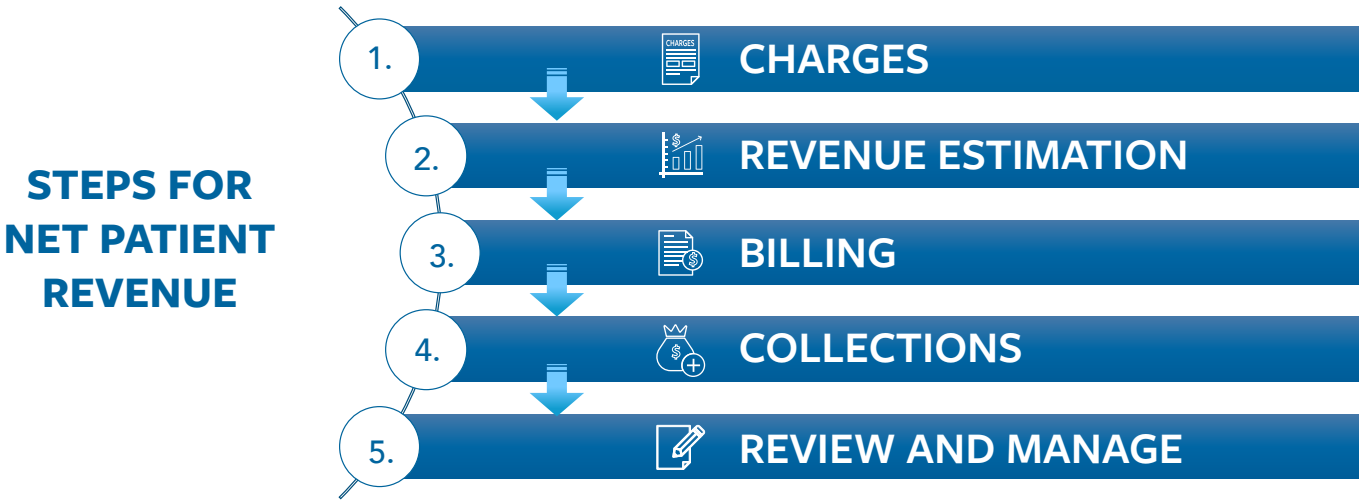
- Contractual allowances, which are negotiated discounts with third-party payers, or
- Bad debt, which encompasses amounts that cannot be collected because a patient cannot (or will not) pay or a third-party payer has denied payment for some reason.

After services have been rendered to a patient, the associated charges have been billed, and the applicable discounts and write-offs have been applied, the resulting balance is the net patient revenue reflected on a hospital's income statement.

Now that we have the big picture, the next five steps will examine in more detail the pieces of the puzzle that drive this net patient revenue amount.

Step 1: Charges

Charges describe the amounts a hospital bills for the services and resources (space, supplies, etc.) that are provided or utilized



during the rendering of care to patients. The specific amounts are contained on a hospital's master price list, or **chargemaster** as it is commonly referred to in the industry.

A hospital's chargemaster can be several thousand lines long, containing a per-unit price for every item that could be charged to a patient. This list should be reviewed and adjusted on a regular basis. Generally, charges for each item should be set at a level that maximizes the ability to receive the highest reimbursement from payers, considering specific contract terms. On a hospital's income statement, the **Gross Revenue** line item is the aggregation of all charges for all patient accounts billed during the period. The terms "charges" and "gross revenue" are often used interchangeably.

KEY QUESTIONS TO ASK:

1. Do we charge for all services and resources used to treat a patient? (Or, have we done a charge capture analysis?)
2. When is the last time the chargemaster was reviewed?
3. How are charge amounts and supply mark-up factors determined?

Step 2: Revenue Estimation

Gross revenue is only the first step in determining net patient revenue. The amount that will ultimately be collected is often much less than charges and is driven largely by who is paying the bill. The source of payment for services is referred to as the **payer**, and different payer types can pay vastly different amounts for the same service. Payers are broadly categorized as managed care, governmental, and self-pay/charity care. A hospital's **payer mix** refers to the percentage of patient volume, usually based on charges, that comes from each of these payer types.

Managed Care

Managed care payers are defined as any third-party payer that negotiates payment rates for services provided to member patients by the hospital. These payers include private insurance companies such as Aetna, Blue Cross Blue Shield, and United, and separate contracts between the hospital and each managed care payer govern how much the payer reimburses for services. For example, reimbursement for services rendered to a patient with Blue Cross PPO insurance will be determined by the contract between the hospital and Blue Cross Blue Shield. Services provided to a patient with Aetna health insurance will be paid under a different agreement between the hospital and Aetna. These contracts are negotiated separately by the hospital and each payer.

If a hospital has a negotiated contract with a payer, it is referred to as being in-network; otherwise, it is considered out-of-network. In-network reimbursement levels are much lower than out-of-network, but is usually still advantageous since payers discourage their members from utilizing out-of-network facilities.

Governmental

The largest governmental payer is Medicare, the federal health insurance program available to individuals 65 years old or older. This is followed closely by Medicaid, a state/federal government program available to lower income individuals and families. Tricare/Champus is the governmental health insurance program for active military personnel and their families.

Reimbursement for hospital services paid under a governmental arrangement is established by the payers themselves. For example, Medicare pays for hospital services based on complex inpatient and outpatient pricing formulas known as prospective payment systems. These payment systems are intended to incentivize hospitals to control costs because the payment rates are set in advance. States employ similar fixed fee schedules for Medicaid patients, though the rates are generally lower than Medicare.

Self-Pay / Charity Care

Self-pay refers to patients who are not covered by insurance, with much of this care being rendered as charity care, meaning the hospital receives no reimbursement for the services rendered. When the hospital does not receive payment for its services, such amounts are written off to **bad debt**.

A **contractual allowance** is the amount of discount from standard charges that is allowed by a particular payer for that service. For example, a hospital may charge $5,000 for an appendectomy, but based on terms of its negotiated United managed care contract, the amount United will pay is $3,000. The $2,000 negotiated discount for this service is recorded as a contractual allowance in the hospital's accounting system. Payer contracting and revenue estimation is a complex process that must be monitored closely to ensure accuracy.

KEY QUESTIONS TO ASK:

1. What is the hospital's payer mix? (Since managed care generally produces the highest reimbursement rates, a payer mix with a low managed care ratio might signify financial challenges.)
2. When was the largest managed care contract last negotiated?
3. What is the hospital's charity care policy and how much charity care does the hospital provide annually?

Step 3: Billing

The next step in this process is billing. Like any business, a hospital will not get paid for something that it does not bill. However, unlike other businesses, billing for hospital services requires a symphony of people, systems, and departments working efficiently together in order to send accurate and timely bills to payers.

Coding

The Health Information Management department (or HIM) is responsible for converting the medical record of services rendered into codes that are recognized by payers and drive how services are reimbursed. Inpatient services are categorized into hundreds of different codes, while outpatient services have thousands of codes. Once a patient account has been "coded" and all of the charges have been recorded, a bill is ready to be sent, or "dropped." These bills are submitted on standard forms or transmitted using standard protocols.

Patient Billing vs. Payer Billing

While bills for patients who have private or governmental insurance are sent to their respective payers, the patient is still responsible for a portion of the allowable reimbursement amount (or "allowable"). These **patient portions** are billed to the patient and fall into the following categories:

- **Deductible** – This is an amount that a patient (or the financially responsible party) must pay before any amount is paid by the insurance company.
- **Co-Insurance/Co-Payment** – This is a percentage of the allowable that a patient owes after the insurance company or government payor pays its amount.

Deductibles and co-insurance amounts have increased dramatically in recent years in an effort to control costs of health care coverage. This additional burden on patients has in turn placed a burden on hospitals who now bill greater amounts to patients, increasing exposure to bad debt.

Timely Billing

It is important that a hospital get its bills out on time, as most managed care contracts stipulate that payment can be denied if a bill is not submitted within a specified time, often as little as three to six months from the date of service. While this may sound like a long time, complex cases can take time to code accurately, and problems in the billing department can result in bottlenecks and backlogs that can increase the time it takes to bill for services.

KEY QUESTIONS TO ASK:

1. How long does it take from the time a patient is discharged until a bill is sent to the payer?
2. How much revenue has the hospital been unable to collect due to untimely billing? (Or, what is the rate of denials for claims that did not meet timely billing requirements?)
3. How robust is the HIM department?

Step 4: Collections

Once a bill is submitted, the hospital must collect for the services rendered. Collections come from two sources – payers and patients. Each source of payment presents unique challenges to the hospital.

Insurance Collections

After an insurance company receives a bill for a member patient, the bill is adjudicated and an **explanation of benefits,** or EOB, is issued. The EOB will show the charges, any reduction from charges based on the contract terms between the payer and the hospital, and any other denial codes, explaining reasons for denial of payment for certain services.

Some **denials** are considered manageable, which means the denials can be limited if the proper systems and processes are in place in the billing department. Examples of manageable denials include timely filing denials and denials for lack of pre-authorization. Unman-

ageable denials are those that may be out of a hospital's control, such as a denial for medical necessity.

Patient Collections

Patient deductibles and co-insurance amounts can leave insured patients with a significant financial responsibility for care received at the hospital. To collect these amounts, hospitals dedicate significant time and effort to help patients understand what they owe and to give them many options for paying. Most hospitals estimate patient amounts at registration and collect up-front payments, and have extended processes to collect from and counsel patients who owe amounts after they have been discharged and their insurance company billed.

Bad Debt

Billed amounts that cannot be collected are written off to bad debt and ultimately show up on a hospital's income statement as a bad debt expense. As patient portions have increased over the years, hospitals have seen increases in their bad debt expense levels.

KEY QUESTIONS TO ASK:

1. What is the single biggest reason for insurance denials and how has this trended over the past three years?
2. What is the bad debt trend over the last three years?
3. What is the up-front process for collecting patient portions?
4. What is the policy for sending accounts to collection agencies?

Step 5: Review and Manage

The final step is to review and manage all of the preceding steps. It is the responsibility of the hospital's CFO, CEO, and ultimately the board to ensure that the hospital has an efficient, well run revenue cycle process where each player in the symphony is hitting their note. This process starts with reviewing how charges are established and captured, how reimbursement levels are determined and calculated, and how effectively bills are dropped and collections are received.

Review and management activities include the following:

1. Determine whether managed care contracts are being reviewed and effectively negotiated as often as necessary to achieve market reimbursement levels.
2. Determine if managed care payers are paying in accordance with the terms of the negotiated contracts.
3. Understand whether contractual allowances reflected on the income statement are accurate.
4. Track and manage bad debt and denial trends.
5. Track and manage time to bill and time to collect trends.

Like any complex machine with multiple moving parts, consistent proactive maintenance is a requirement for the machine to continue to operate efficiently and effectively.

KEY QUESTIONS TO ASK:

1. How often do we review managed care contract performance?
2. Do we have a dedicated staff member (or department) dedicated to revenue cycle?
3. What reports and dashboards exist to help understand how the revenue cycle process is working (i.e., stats and trends)?

Conclusion

Although the complexity of health care finance and reimbursement continues to evolve, we hope the steps outlined herein will increase understanding of the revenue process. It is precisely because of the complexity that the process should be managed carefully and with intention. Asking the right questions can enable board members to obtain the information needed to understand specific challenges facing the entity and provide direction to hospital leadership regarding areas for increased focus to maximize revenue potential.

Glossary of Terms

Bad Debt – Billed amounts that are not able to be collected.

Charges – The amount charged for services rendered to a patient in a hospital. Patient charges are derived from the hospital's Charge-master.

Chargemaster – Detailed price list containing the per unit charge amounts for all services, space, and supplies that can be charged on a patient account.

Contractual Allowance – The difference between the amount charged for a service and the amount that is contractually allowed for the service.

Co-Insurance/Co-Payment – This is a percentage of the allowable that a patient owes after the insurance company pays its required amount.

Deductible – The amount that the patient must pay before the insurance company will pay.

Denial – Billed amounts that are denied payment by a third-party payer.

Explanation of Benefits – An explanation from a third-party payer detailing how payment was calculated.

Gross Revenue – The total amount charged for hospital services during a specified period.

Net Patient Revenue – The estimated amount of patient revenue that remains after contractual allowances and bad debt are subtract-ed from Charges (or Gross Revenue).

Patient Portion – See Co-Insurance/Co-Payment .

Payer – Refers to an insurance company, governmental health insur-ance program, or other financially responsible party.

Payer Mix – Refers to the percentage of patient volume, usually based on charges, that comes from each of the different payer types (e.g., Managed Care, Medicare, Self-Pay).

There is a lot to keep up with in health care. Texas Healthcare Trustees is here to help our members, trustees of hospitals and health care systems throughout Texas, with resources that will help to stay up-to-date on important information that can impact how they lead their organization. THT's Governance Thought Leadership Series is one of many resources THT has available for health care board members. To learn more about this series and to view other tools and resources available, visit **www.tht.org**.

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