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Risk Management Strategies for the Outpatient Setting

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Financial Risks

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Introduction to Financial Risks

The financial strength of an organization is the cornerstone of its overall stability. Healthcare organizations are under pressure to maximize financial operating margins while maintaining quality patient care. Efforts to increase efficiency and lower costs should be monitored for any adverse downstream effect on patient care. Financial processes should be controlled to avoid operational disruptions, facilitate the achievement of strategic objectives and help to ensure the organization's future success.

Ongoing analysis of key financial metrics and well-established performance measures will identify the financial strength of the organization and provide opportunities to implement effective risk mitigation and operational improvement strategies. Analyzing key financial metrics, including their synergistic effects – both positive and negative – should enable leaders to address potential risks.

Financial Performance Metrics

- **Reimbursement and payor mix** – refers to the percentage of patients covered by public health insurance plans, such as Medicare and Medicaid, versus the percentage of patients covered by private health insurance plans. Understanding the amount paid for medical services by public and private third party payors, the timeframe within which they pay, the incentives to deliver quality of care, and accuracy of billing are important in managing the revenue stream within an organization.
- **Billing accuracy/compliance** – accurate and compliant medical billing and coding are critical to receiving the entire amount to which the organization is entitled for services rendered. Inaccurate or noncompliant billing and coding practices can create vulnerabilities to lost revenue, delay in reimbursement, denial of claims and the potential of governmental fines and penalties. The most common medical billing and coding errors include upcoding, downcoding, unbundling, and billing for services that were not rendered. These errors may lead to allegations of fraud and abuse resulting in serious consequences involving federal penalties, sanctions against an individual provider or healthcare organization from participation in federal healthcare programs, as well as monetary fines and potential criminal sanctions.
- **Revenue cycle management** – refers to the process of accurate medical billing and coding, timely submission of claims to the payor, managing incoming payments, claim adjustments and/or rebilling denials, and accurate collection of patient payments such as copayments and co-insurance.
- **Revenue enhancement** – is the process of measuring how well the revenue cycle is managed by setting specific goals at each point along the billing process. An important measure is days in accounts receivable (A/R), or the average number of days it takes to collect on outstanding payments. Other important measures include the length of time for a claim to be submitted, the percentage of payment denials and reasons, and the age of claims past 90 or 120 days from service.
- **Credit and collections** – credits can reflect overpayment by a payor which must be returned. Understanding the reason for overpayments is important in the understanding of billing accuracy. The number of delinquent accounts may reflect inaccurate billing, payor contract issues or failure to collect payments that are patient responsibilities. It is important to develop a process that requires providers to review all accounts identified for collection prior to submitting them for action. The review should consider and determine whether any care-related issues are evident that would influence the decision to proceed with collections.
- **Audits** – routine proactive audits of provider transactions, care coordination functions (referrals), billing and claims coding, and the effectiveness of the compliance program are often required and necessary to ensure efforts are established and implemented in order avoid fraud, waste and abuse allegations.
- **Access to capital** – access to capital, or additional financial support, may be required in the event of a sudden, unexpected large expense, or the intent to expand service capabilities. A financially healthy organization is in a stronger position to negotiate terms or rate of loans.
- **Budgeting** – successful management of an organization's finances requires the establishment of an annual budget reflecting income and expense. To establish an annual budget, all revenue and expenses should be categorized and tracked using the prior year's data to estimate the revenue and expenses for the subsequent year. Consideration should be given to operational changes that may affect revenue and/or expenses year-over-year such as expanding services, adding staff, investment in technology and rising costs of supplies, to name a few. Monitoring budget variances from month to month can enable organizational leaders to make adjustments, as needed, to keep the budget on track.

The following items should be considered when developing and monitoring the organization's budget:

- **Income**
  - Revenue from services rendered
  - Revenue generated from other sources (e.g. leasing space to another provider)
- **Expense**
  - Staff salaries
  - Provider salaries
  - Benefits
  - Supplies
  - Equipment
  - Contracts – cost of others under contract that support the organization and/or operations
  - Rent/mortgage
  - Insurances – professional liability, business interruption, general liability, errors and omissions, property, cyber

If necessary, consult and engage experienced financial and legal advisors to ensure implementation of required financial controls and compliance with applicable laws and regulations.

For more information, please call us at 215-509-5437 or visit www.nso.com or www.hpso.com.

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