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BECKER'S HOSPITAL REVIEW

4th Annual Health IT and Revenue Cycle Conference 2018

# Revenue Cycle 2025

## Transforming Reimbursements and Collections Cultures with Analytics and Automation

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**SEPTEMBER 20, 2018**

# Traditional Revenue Cycle

## Market Trends

## Deloitte healthcare sector outlook

"Public and private health systems have been facing revenue pressures and declining margins for years. The trend is expected to persist as increasing demand, infrastructure upgrades, and therapeutic and technology advancements strain the already limited financial resources. As a result, spending is expected to be driven by aging and growing populations, developing market expansion, clinical and technology advances, and rising labor costs. As health care costs increase though, affordability and insurance coverage remain problematic. Health care providers are also collaborating to gain competitive advantage."

Source: Deloitte - https://www2.deloitte.com/global/en/pages/life-sciences-and-healthcare/articles/global-health-care-sector-outlook.html#


 

# TOP TRENDS IN RCM

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## Mergers and Acquisitions -

Slow economic growth has stalled spending in healthcare sector, and costs continue to rise. Has led to exponential M & A activity, and also in non-traditional areas with retail, insurance, and others. Market size is shrinking, negotiating power is limited, and competition is fierce.

## Healthcare reform…

Quadruple Aim (Outcomes, Cost, Patient experience, Clinician Experience), ACA "reconciliation", CMS waivers, and state transparency laws are all gaining momentum. Well care through Value Based Outcome reimbursement.

## The good, the bad and the ugly – Big Data and Analytics

Everybody wants some, but WHERE is it and HOW do I use it effectively? Focus on Social Determinants of Health (SDOH) and preventative medicine to engage patients and curb utilization costs.

## Pay me now or pay me later, but please pay

Denials and underpayments are drivers to revenue leakage that cannot occur in a value-based care world. Provider patient facilitated financing and payer revenue protection are key areas of focus

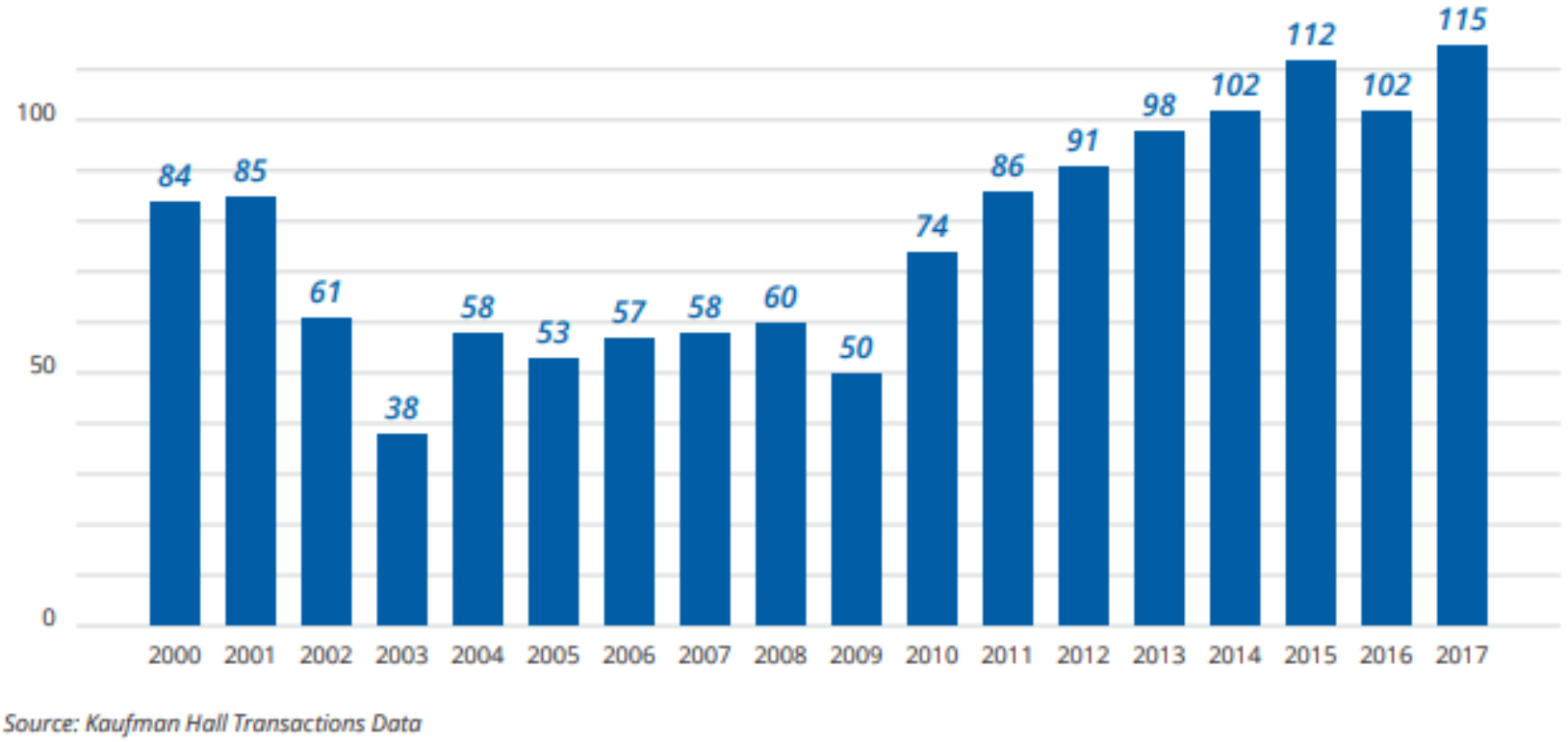
## Patient Financial Experience through RCM Transparency

Providers must create loyalty for the patient consumer "Amazonians". "Go mobile, or go home" is a focus as well as the impact of AI and voice. The clinical and payment experience must to be "frictionless".

# Hospital and Health System M&A Activity is largest it has been in recent history

Hospital and Health System M&A Activity, 2000-2017



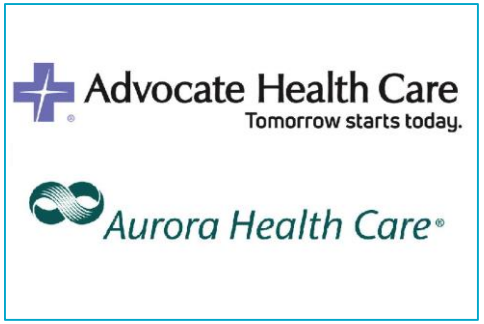

*Source: Kaufman Hall Transactions Data*

Source: KH: https://www.kaufmanhall.com/sites/default/files/2017-in-Review_The-Year-that-Shook-Healthcare.pdf

# Examples of Health System M&A Activity







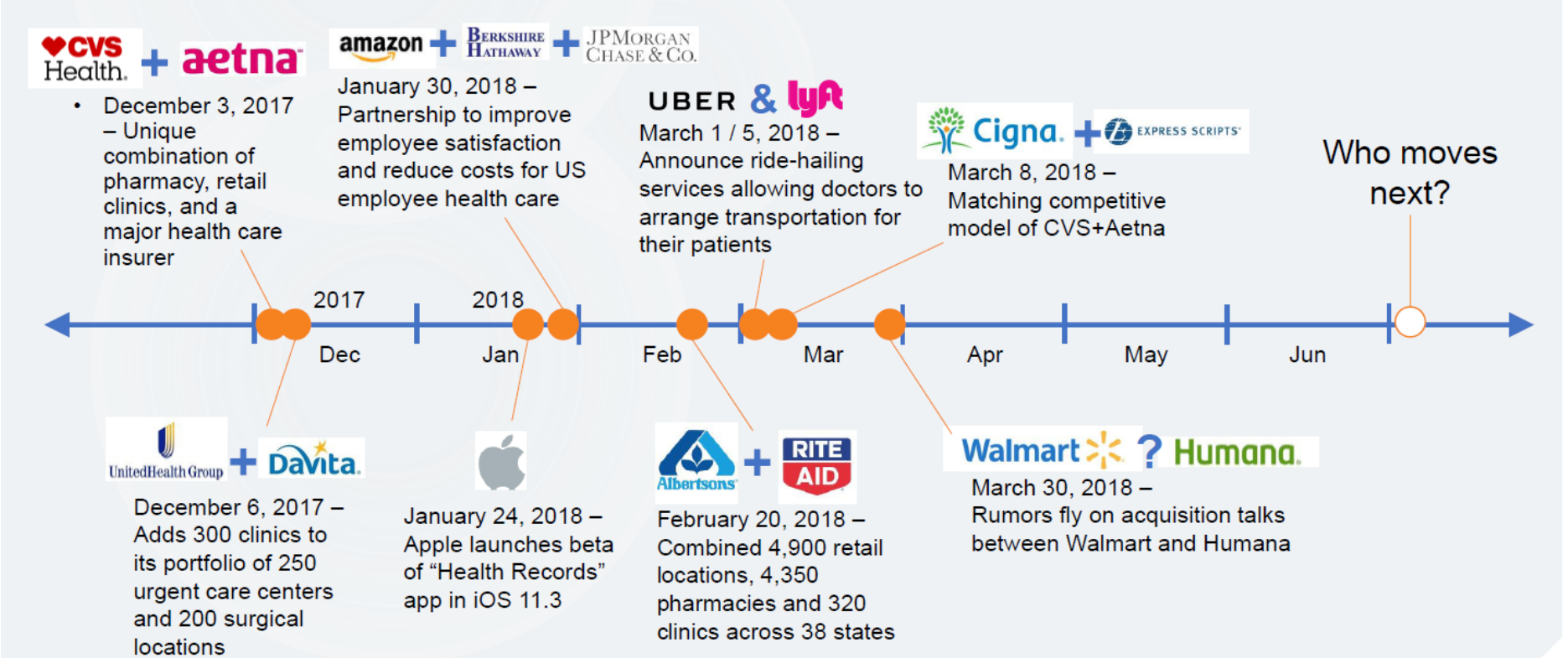






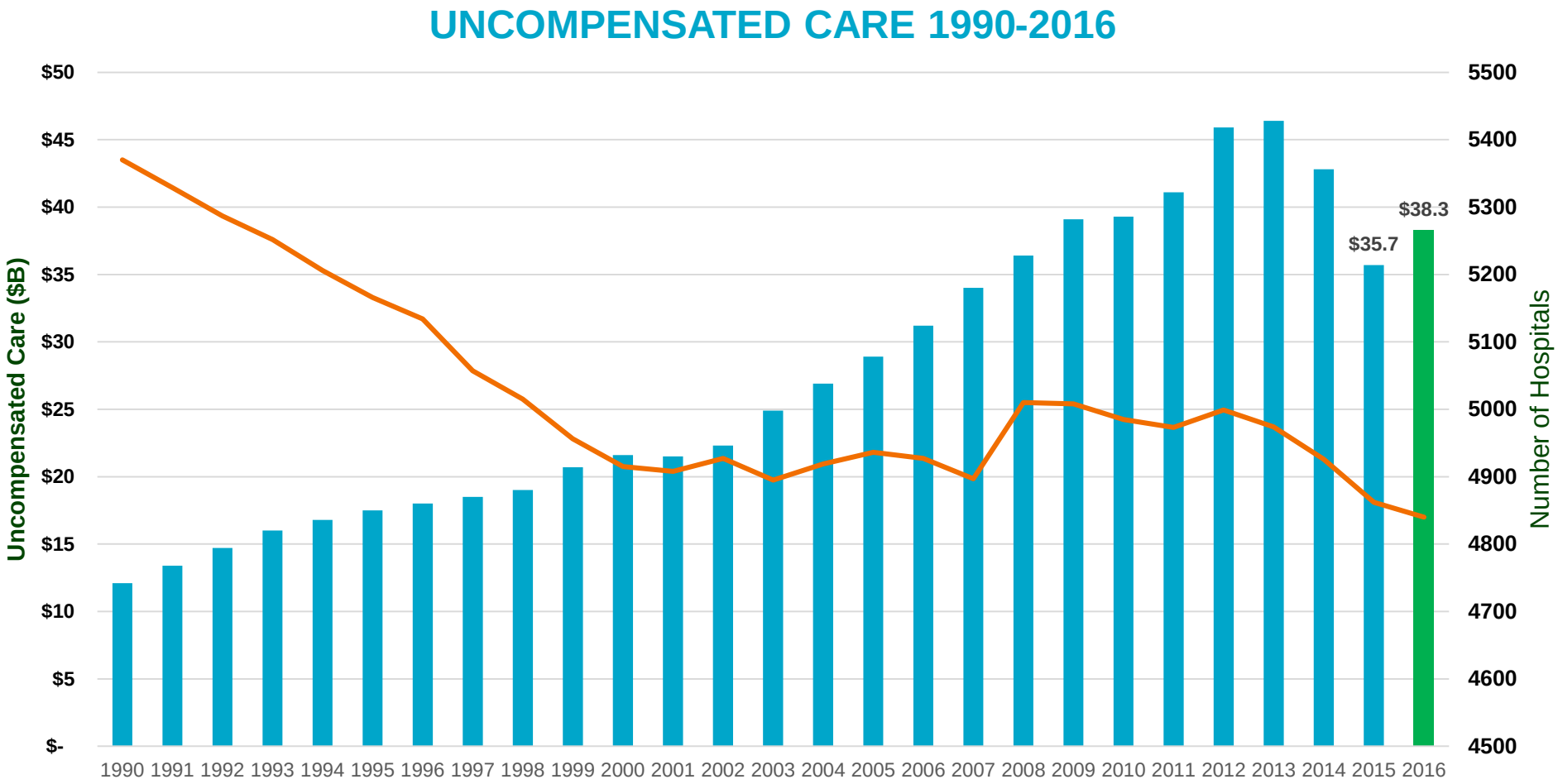
 

# Non traditional Merger and Acquisitions are disrupting hospital market




Source: HFMA Annual 2018: Jared Sorensen, 3M

# For the first time since 2013, uncompensated care *increased* by $2.6B in 2016




Source: AHA Dec 2017 Uncompensated Care Report

## Hospitals have three areas of focus to contain costs in 2018:

| 1 | CLINICAL VARIATION REDUCTION | 2 | LABOR MANAGEMENT | 3 | REVENUE CYCLE MANAGEMENT |
|---|---|---|---|---|---|

- In 2016, annual expense growth rate outpaced annual revenue growth rate for nonprofit and public healthcare organizations
- Declining reimbursement and payer steerage to less expensive, low acuity settings is prevalent
- Revenue cycle costs have remained flat in recent years despite increased consolidation in the industry, indicating health systems have not realized greater savings by pooling their revenue cycle functions…

***"Hospital leaders will need to focus more on 'blocking and tackling' and ongoing efforts to seek out efficiencies, reduce costs and find ways to grow their business."***

***"Technology will be a critical tool for cost containment efforts… analytics and EMRs should be considered as a tool to target savings."***

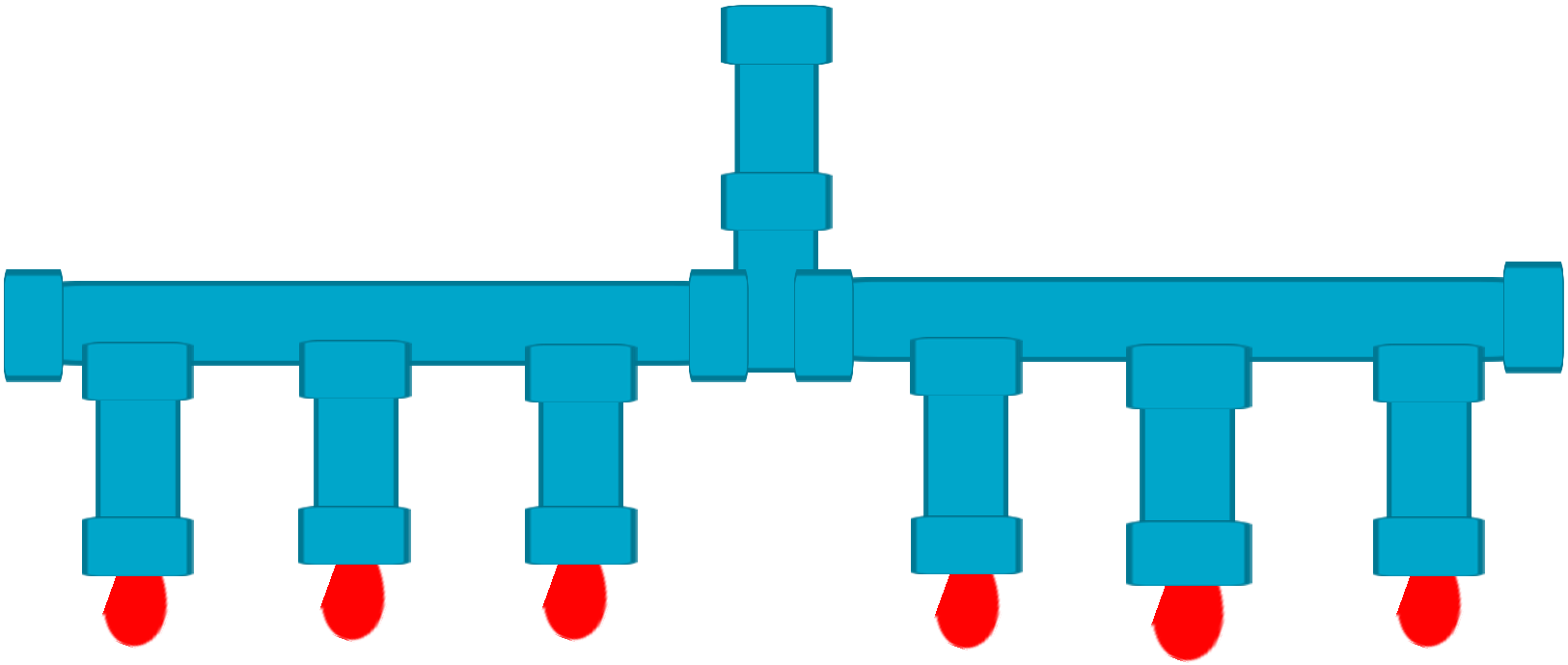
Deloitte, AHA, Healthcaredive:
https://www.healthcaredive.com/news/hospital-budgets-2018/512137/

# Revenue Leakage

$

Payer and Patient Revenue



**Underinsured**
Patient
Balance After
Insurance

**Uninsured**
Self Pay
Bad Debt

**Denials**
Medical
Necessity,
Eligibility,
Authorization,
out of
network,
OOTF etc.

Medicare
**Underpayments**
(TDRG,
IME/GME, etc.)

**Claims**
Management

Commercial
contractual
**Underpayments**

Revenue Leakage

# Underpayments

## Medicare

- Combined underpayments were **$68.8 billion** in 2016.
- This includes a shortfall of $48.8billion for Medicare and $20.0 billion for Medicaid.
- For every dollar spent by hospitals caring for patients in 2016, 87 and 88 cents for Medicaid respectively

## Commercial

- **$69 Billion** spent nationally by providers on payer rules
- Over half (58%) of commercial claims deny initially (4% increase in denied claims from 2015-2016)
- 5% of average hospital NPR is LOST in underpayments ~ $2.5M for a mid size hospital

Sources: 1)AHA: https://www.aha.org/system/files/2018-01/medicaremedicaidunderpmt%202017.pdf, 2)Advisory Board: https://static1.squarespace.com/static/554b97b8e4b01f8ee692d265/t/5a5947538165f53cdc4475d9/1515800410085/9.+Optimizing+AR+-+Beadle+Ryby.pdf, 3)MGMA https://www.mgma.com/MGMA/media/files/fellowship%20papers/Prior-Authorization-Denial-Challenges-for-an-Integrated-Health-System-fellowship-paper.pdf?ext=.pdf

# Revenue leakage and market impacts are staggering

| 77% | $25B | 3%-5% | 25% | 15.3% |
|---|---|---|---|---|
| **Percentage of providers** that still use paper-based patient billing methods | **Dollars in Medicare Spend** related to payment integrity and cost reporting | **Percentage of charges never posted.** This equates to $30-$50M additional revenue for a $1 billion organization | **Percentage of claims that are denied** according to a GAO study | **Average recovery rates** for hospitals, 21.8% for non-hospital providers |

Sources :Black Book ; accusttream; meddata, rev cycle intelligence
HFMA, HPS, TU proprietary TransUnion data

# Innovative Revenue Cycle

## What is working and why

# RCM INITIATIVES FOR 2020

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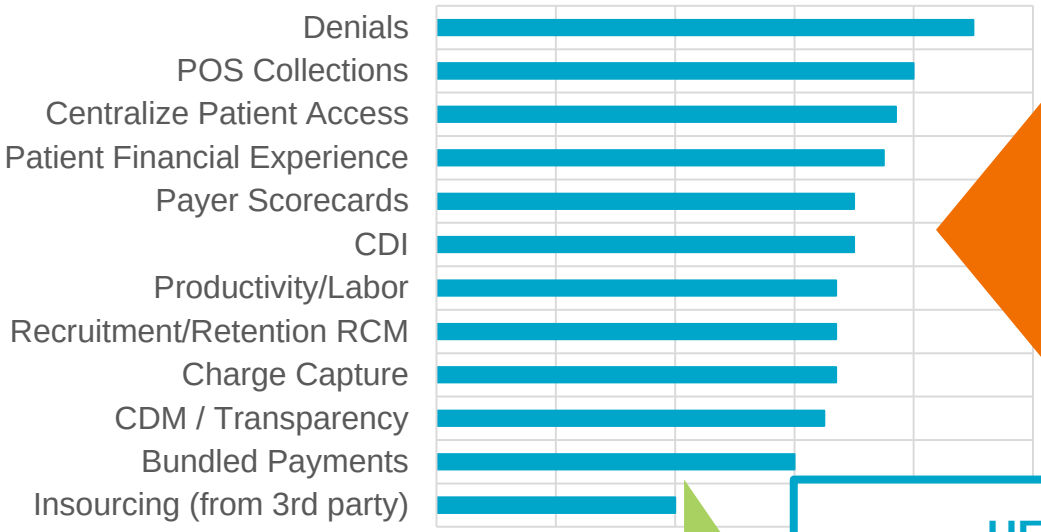
## HBI: Top Revenue Cycle Priority?



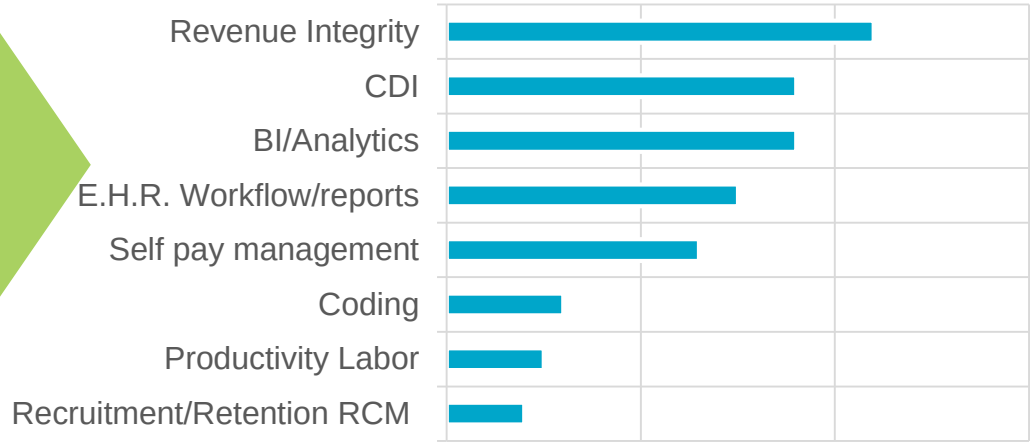

**7/10**

**OF THESE AREAS ARE ON BOTH LISTS**

**79%**

**OF THESE AREAS INVOLVE (OR ARE ENABLED BY) TECHNOLOGY**

## HFMA: Which RCM capability is your organization most focused on next year?




Sources: HBI, HFMA

# TOP 10 CHALLENGES ADDRESSED BY UNDERPAYMENT REVIEW

**10**

Identifying difficult, hard-to-find correct insurers & policy numbers

**09**

Managing timing delays & changes in payer eligibility databases

**08**

Identifying correct payer for a specific service

**07**

Unique Medicare billing challenges

**06**

Accounts with no “meaningful” activity due to information gaps

**05**

Unique, atypical billing requirements

**04**

Zero balance accounts – either “paid” or written off to free care/charity allowances

**03**

Bad debt accounts for deductibles and copays – no activity but have secondary payer

**02**

Determining correct OP primary payer when multiple coverage exists

**01**

Billing system setup issues – incorrectly or not billing claims

***And, with increasingly demanding timely filing limits***

# INSURANCE DISCOVERY CASE STUDY

***Physician-owned company in New York, focused on ED, Urgent Care, Hospitalists and Intensivists billing, and closely examined self pay patients with no apparent insurance coverage…***

## Recovered over $1,000,000

in insurance payments from found coverage

## Significantly lowered cost to collect

by re-billing missed eligibility that otherwise would have gone to bad debt

# Underpayment Review Case Study

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***"Ensure the solution finds the needle without going through the haystack."***

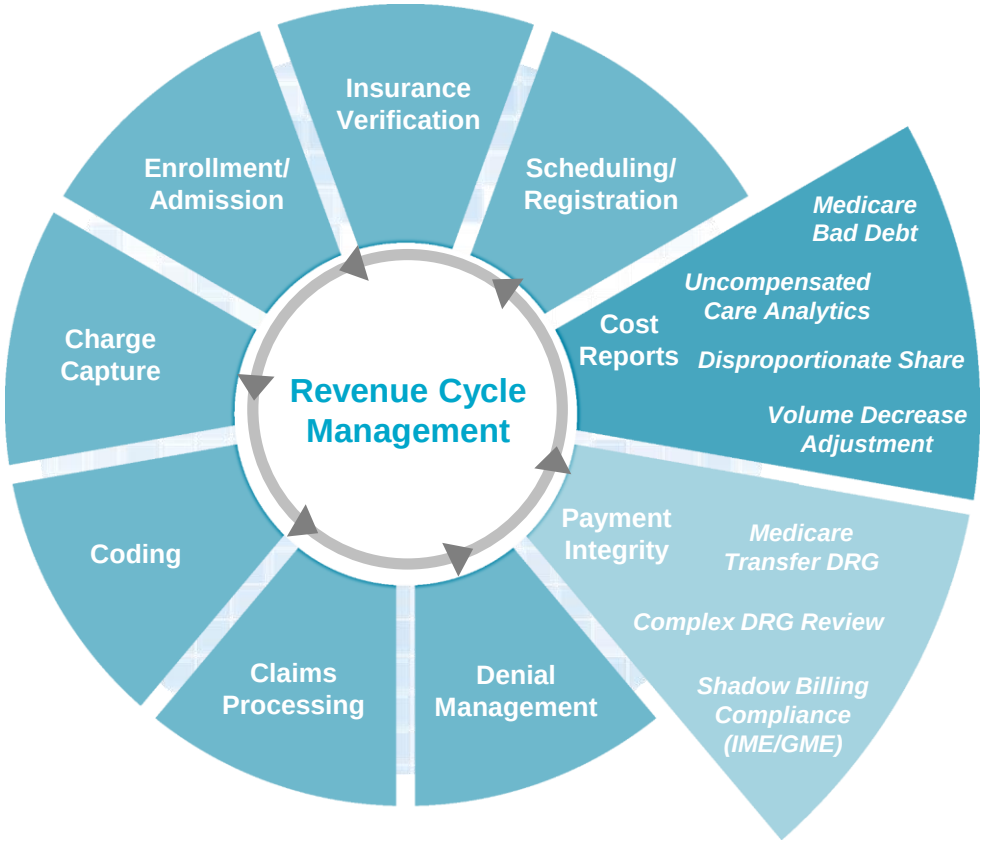
**VICE PRESIDENT, FINANCE, LARGE HEALTH SYSTEM IN GREATER NEW YORK AREA**

**Delivered over $10 Million in realized revenue to a large health system in the greater New York City area.**

| COMPREHENSIVE | CONSULTATIVE | ACCURATE |
|---|---|---|
| ▪ All payer class, all services<br>▪ Reviews all accounts, including zero-balance<br>▪ Targets timely filing, rapidly aging and complex accounts | ▪ Provides detailed guidance & knowledge sharing for continuous improvement<br>▪ 20+ years' experience serving academic medical centers | ▪ Results are 90%+ actionable, inpatient accounts are closer to 100%<br>▪ Technology-driven results are reviewed by experienced analysts |

# Medicare reimbursement optimization are an underserved segment of RCM




**These underpayments represent $25B Portion of Medicare Spend**

| | | |
|---|---|---|
| Ensure solution leverages one (1) data set | Look at all areas within PPS, LTAC, IRF, and CAH Hospitals | Closely evaluate Recurring and Retrospective Revenue Opportunities |

## Key Attributes of These Payment Issues

- Requires gathering, validating and integrating large and disparate data sets from multiple sources — hospital, Medicare, and Medicaid
- Requires expert knowledge of the complex regulations developed by CMS and the often inconsistent way in which these regulations are administered by the MACs
- Requires deep understanding of hospital information systems and business processes to identify how these areas impact the reimbursement available to the hospital

**Maximizing reimbursement in these issues requires leading edge technology, deep domain experience and proven analytics and reporting**

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# Medicare Underpayments Case Study

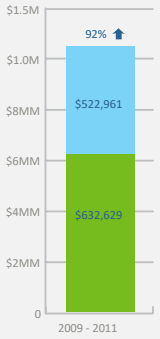
**Large Medical Center in Mountain States**

- 306-Bed Acute Care Facility
- Part of Large National Health network
- $1.8M Charity Care and $8.9M in Free Care 2017

## Identified $828K in Medicare Underpayments and Unrealized Revenue

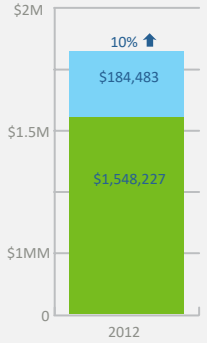
### Medicare Bad Debt

- Identified $522,961 in missed recovery for 2009–2011
- Average increase of 92% in recovery above hospital findings



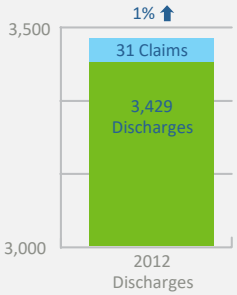

### Medicare DSH

- Identified $184,483 in missed recovery for 2012
- Located 6,000 Total Medicaid Days for 2012
- 10% increase in Medicaid days from years past



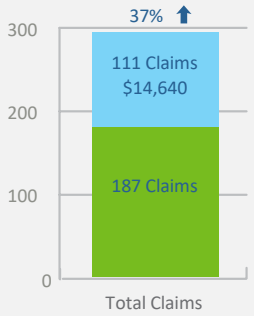

### Transfer DRG

- FY 2012 Recovery of $105,739
- Average amount per claim of $3,411




### Shadow Billing

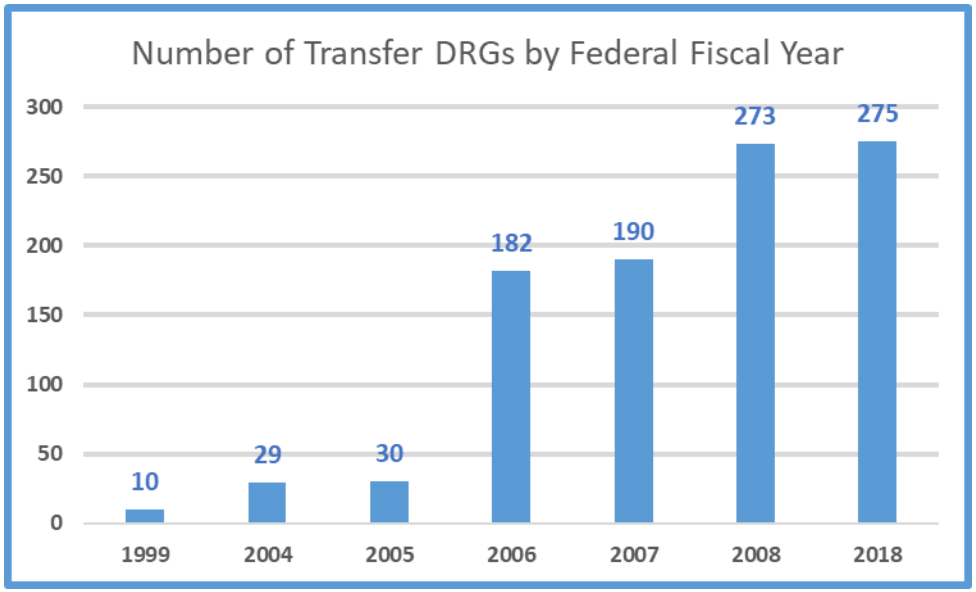
- Facility's internal review confirmed 111 claims
- Validated facility's findings to confirm an increase of 37% from past years
- FY 2012 Recovery of $14,640



# Transfer DRG Background and Case Study

- Post Acute Care Transfer (PACT) rule which changed the reimbursement for certain DRGs, and are growing
- Hospitals receive a reduced “transfer” payment for Transfer DRGs
- Opportunities earned revenue recoveries (as much as $70K per account) from Medicare underpayments





**Five hospital health system on west coast leveraged technology and tools to recover millions in Medicare underpayments**

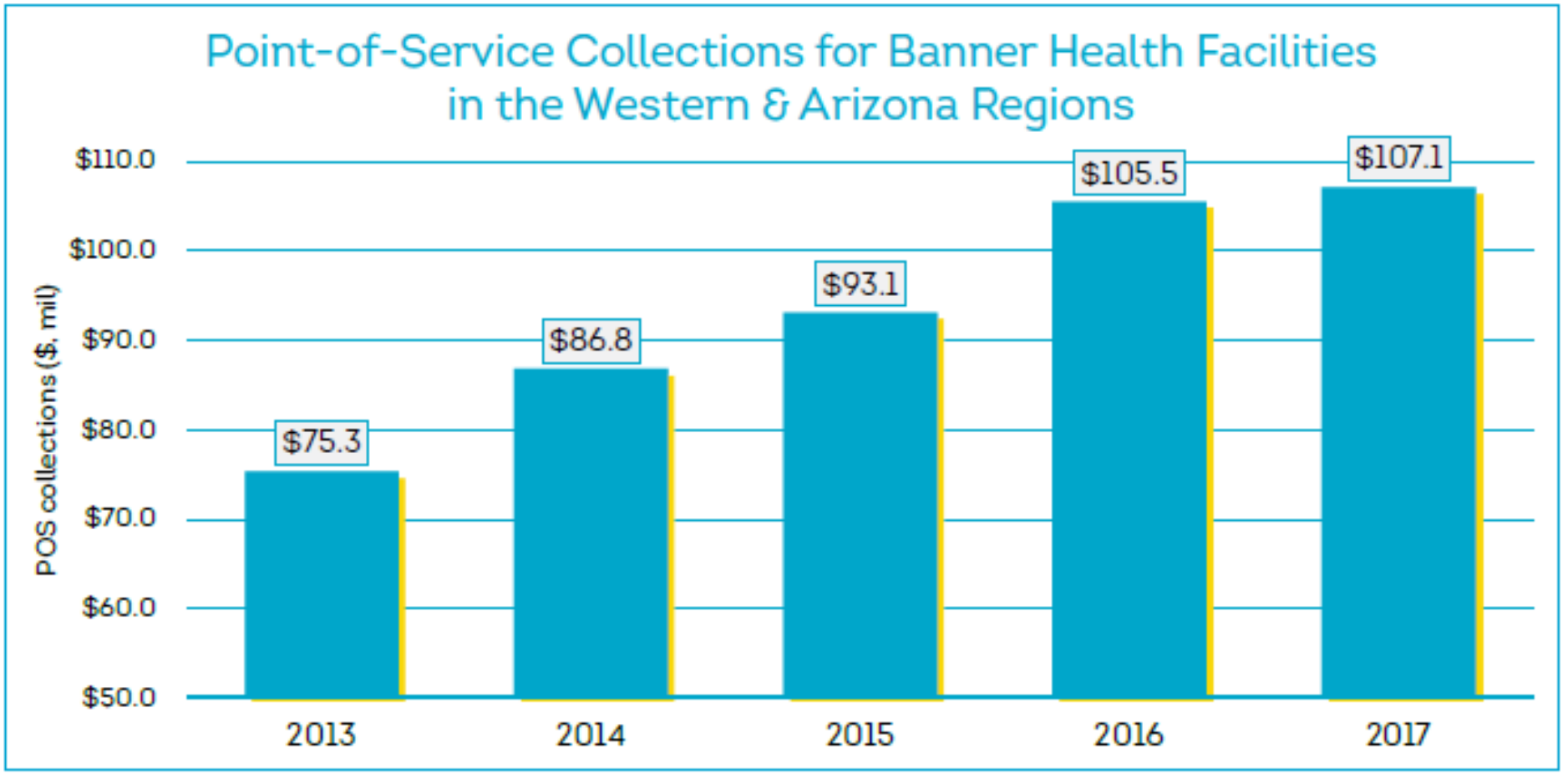
**$6 million** THE AMOUNT OF CASH RECOVERED FROM UNDERPAID MEDICARE CLAIMS

**Zero** THE AMOUNT OF HOURS SPENT BY BUSINESS OFFICE RESOURCES TO RECOVER THE UNDERPAYMENTS

# Banner Health

| | |
|---|---|
| **Organization** | ▪ Banner Health<br>▪ 50,000 employees |
| **Size** | ▪ 28 acute care facilities, from 22 to 744 beds, across 6 states<br>▪ Also provides Home health, Hospice, and Behavioral health services<br>▪ 2.1 million annual patient visits |
| **Adoption** | ▪ NOV YTD 2017 Bad Debt ~ $289M<br>▪ NOV YTD 2017 Charity Care ~ $389M<br>▪ Provided an estimate to every patient, every time |
| **Improvements over home grown estimation system** | ▪ Migrated from homegrown excel-based estimation to TU ClearIQ<br>▪ TU Loaded complex payer contracts<br>▪ Performs professional estimates as well as facility estimates<br>▪ Provides enhanced accuracy for estimation<br>▪ Estimate letter easy for staff to understand and explain to patients |

# Banner Health has had consistent YOY performance in POS Collections



**Banner Health processes and implementation of tool enhanced POS collections significantly…**

**42.2%** THE PERCENTAGE INCREASE IN POS COLLECTIONS FROM 2013 TO 2017 AFTER CLEARIQ IMPLEMENTATION

**$31.8M** THE DOLLAR INCREASE IN POS COLLECTIONS FROM 2013 TO 2017 AFTER CLEARIQ IMPLEMENTATION

# Preventing Revenue Leakage

## Strategies to protect your earned revenue

# Stratifying patient risk and payments

***Rapidly determine***

## Identity Verification

- Prevent fraud
- Verify identity and protect PHI
- Validate address and demographic information

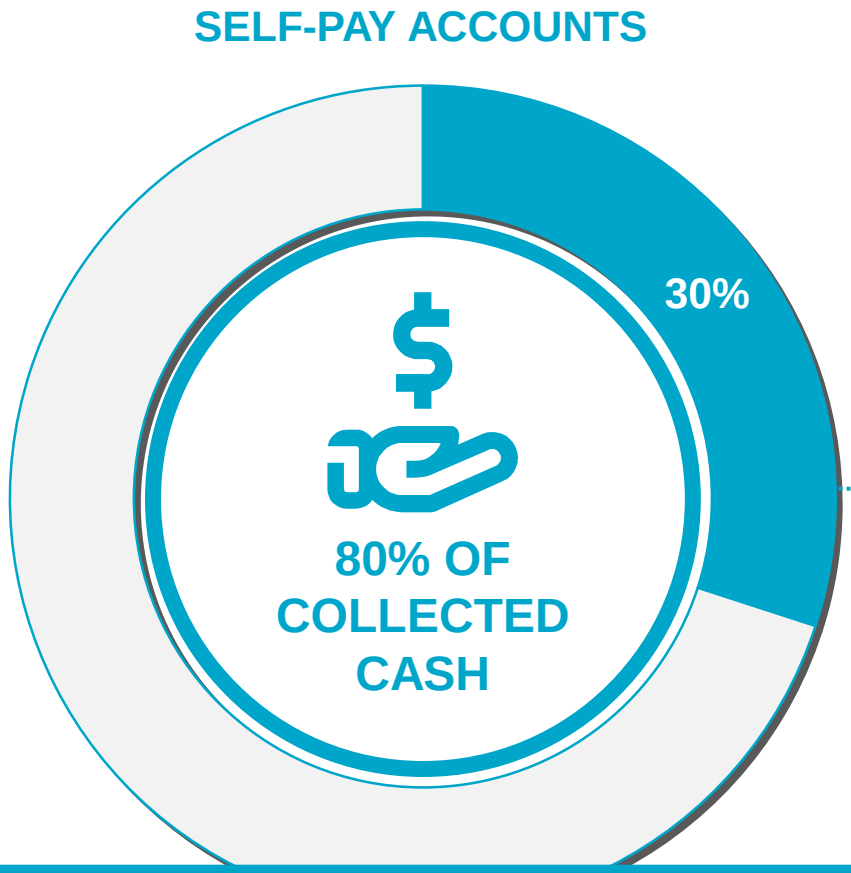
## Insurance Discovery / Presumptive Charity

- Establish Coverage
- Balance their bad debt portfolio
- Re-classify accounts as charity

## Propensity to Pay

- Prioritize high balance accounts
- Increase POS collections and cash flow
- Help patients truly in need and collect from those who can pay

# The Bottom Line




## 1-5% of self-pay accounts*

**written off to bad debt have billable insurance coverage unknown to the hospital or its vendors**

## 30% of self-pay accounts

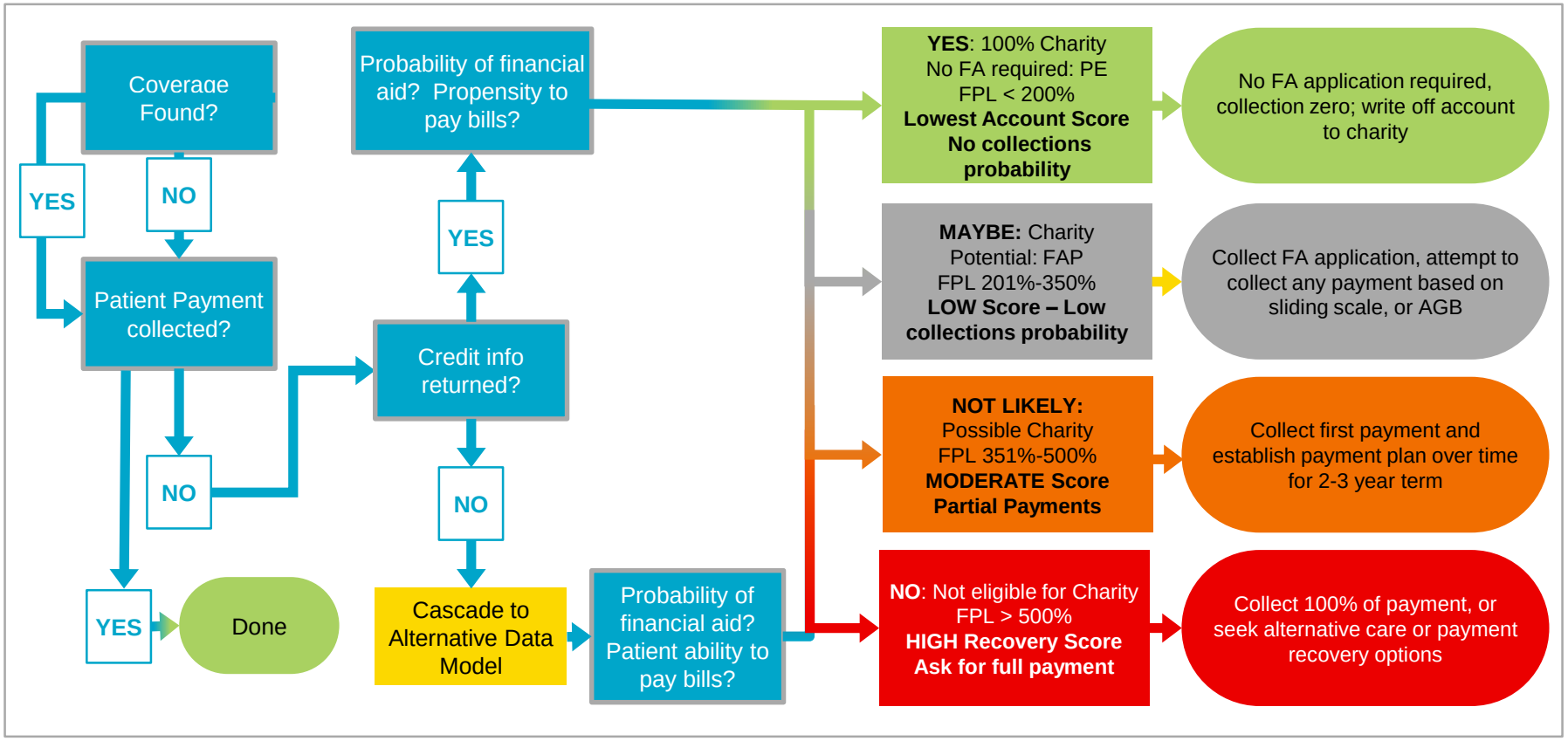
**will generate over 80% of cash collected***

**Critical to rapidly identify the accounts that will pay — from both the patient *and* the payer**

*Transunion Proprietary Data

# Sample Workflow* – Self-Pay / High BAI After Discharge

SELF-PAY / HIGH BAI




*Example provided for illustrative purposes and organizations should follow their unique Financial Assistance Policy(s)

# Identify and resolve underpayments – protect your earned revenue from leakage

Have a third party review your accounts to identify qualifying payments

Once underpayments are identified, undergo a strict documentation process to validate opportunity

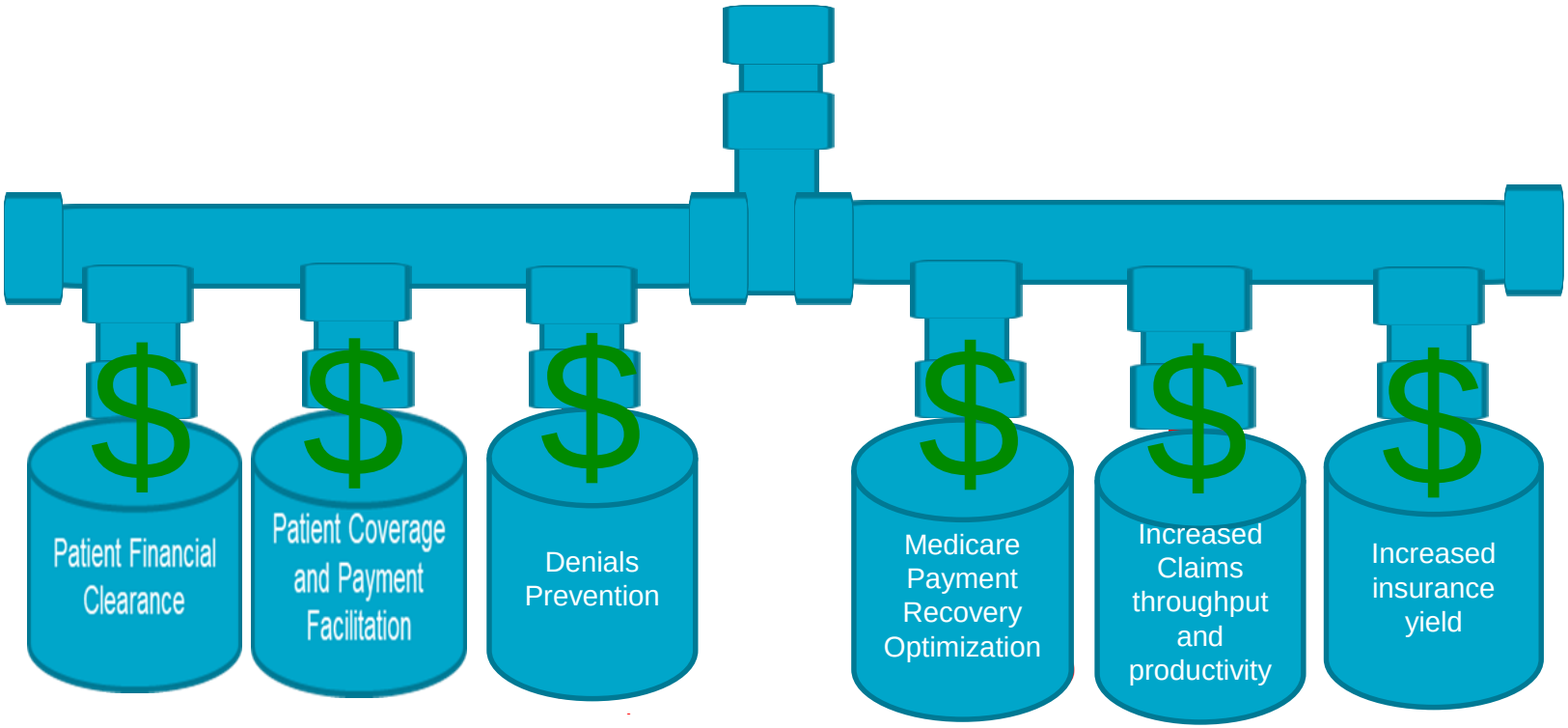
Ensure discovered underpayments are delivered for your review and approval in an automated and seamless fashion

Where necessary, deploy teams to complete all claim correction and appeal work to ensure payment

Monitor all underpaid accounts on a daily basis until you receive the incremental reimbursement

# Revenue Protection

Payer and Patient Revenue




- ✓ Eligibility
- ✓ Estimation
- ✓ Payment/Financing

- ✓ Insurance Discovery
- ✓ Charity Determination

- ✓ Authorization
- ✓ Medical Necessity
- ✓ Predictive Analytics

- ✓ Automated audits and retrospective payment reviews
- ✓ Resubmitted Claims
- ✓ Increased Medicare Payment Yield for TDRG, IME/GME, DSH and Medicare Beneficiary Bad Debt

- ✓ Claim Status Inquiry
- ✓ Resubmittal of assumed $0 claims
- ✓ Revenue Assurance

- ✓ Insurance Discovery
- ✓ Corrected Claims
- ✓ TPL/SUBRO Resolution

REVENUE PROTECTION

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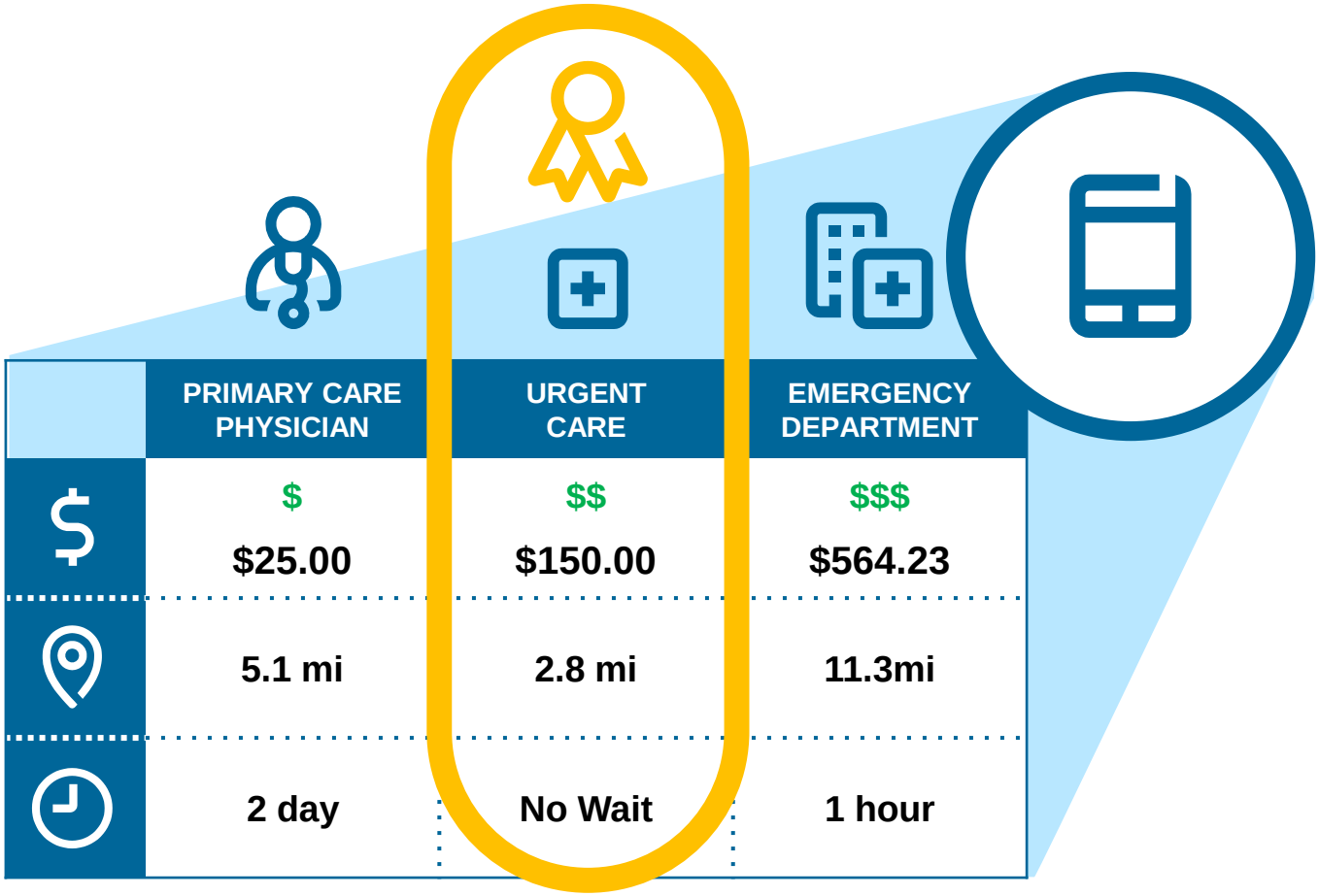
# Revenue Cycle 2025

## What to expect in a data and consumer-driven collections culture

# HiMSS Patient Financial Experience of the Future



| | PRIMARY CARE PHYSICIAN | URGENT CARE | EMERGENCY DEPARTMENT |
|---|---|---|---|
| $ | $ | $$ | $$$ |
| $ | $25.00 | $150.00 | $564.23 |
| | 5.1 mi | 2.8 mi | 11.3mi |
| | 2 day | No Wait | 1 hour |

# Robotic Process Automation applications to revenue cycle

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## Claims / Denials Management

Robotic programming can be prepared in accordance with COB/ Eligibility rules to replicate the human resolution process

## Financial Clearance

Robots can be positioned to verify / flag the necessary financial clearance-related tasks for a patient and then access a variety of websites or applications to complete them

## Credit Balances

Credit balance reversal through automated transaction posting can eliminate thousands of transactions over time, helping to reduce costs and reallocate staff to higher value activities

## Accounts Payable

RPA affords automation and streamlined workflows by managing the receipt, accrual and payment according to contract terms

Source: HFMA https://www.hfma.org/Content.aspx?id=55353

 

# BI Maturity Curve

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| | STAGE 1 | STAGE 2 | STAGE 3 | STAGE 4 | STAGE 5 | STAGE 6 |
|---|---|---|---|---|---|---|
| | **DATA ANALYSIS** | **INVESTIGATIVE ANALYTICS** | **BUSINESS INTELLIGENCE** | **PREDICTIVE ANALYTICS** | **PRESCRIPTIVE ANALYTICS** | **CONTINUOUS LEARNING ACTION** |
| | What happened yesterday? | Why did it happen yesterday? | What is happening now? | What will happen tomorrow? | How do we influence tomorrow? | Action-step optimization |
| **PATIENT ACCESS** | I can see that yesterday's First Pass Denial Rate was 30% of claims. | I can see that the majority of denials are related to authorization & eligibility issues. | Today we have X% of pre-authorizations obtained prior to service. | Because we are currently running a low percentage of pre-authorizations prior to service, we can expect X% higher rates of first pass denials related to authorizations in the next 90 days. | I get work queues of accounts that have been identified as high opportunity & are missing pre-auth so that they can be addressed before services are performed. | Patient Access staff gets visibility into the downstream impact of low authorization percentages along with daily reporting of Patient Access KPIs to help mitigate this issue in the long run. |
| **REVENUE INTEGRITY** | I can see that the prior period's discharges had an Actual LOS to Expected LOS ratio of 1.1. | I can see that 15% of discharges associated with 3 DRG codes are being delayed primarily due to patient status & DME waitlist issues. | Expected LOS projections for currently in-house patients with those same diagnosis codes match the projections for those that had a 15% discharge rate from the prior period. | Projections show that we will continue to run at a ratio of 1.1 or higher for the current & future periods. | Automated forensics produces worklists of accounts to investigate where there has been a recent change in the typical mix of procedure codes associated with these DRGs.<br>– I get reports & alerts on DME usage, status & wait-times. | Clinical staff provided with daily visibility into downstream impact of clinical procedure changes.<br>– System recommends an audit of the DME inventory & recommends reviewing /revising the expected LOS for these DRGs. |
| **PFS/BUSINESS OFFICE** | A/R turnover rate is declining. | I can see that my collector team's daily average for number of closed accounts has fallen by 6%. | # of Touches Per Account Until Conclusion is higher than the rolling 90-day average.<br>– % of Touches Within Follow up Guidelines is greater than the 90-day average. | A\R Days projected to increase by 2-3 days within 45 days.<br>– Cost to Collect projected to increase 4% by end of current month | Automated forensic analysis looks for statistically meaningful commonalities on accounts with higher than average number of touches (DRG, Assignee, CARC/RARC. Etc.), findings reported to stakeholders with recommended actions. | Collections staff is provided visibility into key performance metrics & alerted to declining performance trends.<br>– System provides organizational transparency (how much is coming vs how much is going out) so that every department can see if they are ahead or falling behind. |

Source: HFMA Central PA: Visiquate – Waller and Briner

 

# Where is RCM going?

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## Patient Access and acceleration of patient pay[1]

Transparency and personalized engagement plans will drive the patient to be more likely to pay, and they will have a better experience with higher levels of satisfaction and loyalty to the provider

## Mobile and voice[2]

The fastest growing technology will enable patients to check wait times, pay bills, book appointments and arrangement for transport. For staff, theit entire workflow could come from asking a question. Think for patients - “Alexa…I hurt my arm” or for staff - “Hey Siri…what are the unpaid claims for today? ”.

## Banking hits the healthcare beachfront[3]

Banking capabilities will help hospitals and providers automate tasks for patient financing, denial management workflows, paper and electronic receivables, primarily claim payments from insurers, and identifying root causes and accelerating revenue recoupment.

## Healthcare catches up to technology[1]

AI, RPA, MLE will afford automation and streamlined workflows to repetitive tasks of payment review, invoicing, payment, billing, and collections. A new competency around intelligently extracting data, analyzing that data with context, and delivering actionable intelligence into the workflows to the providers’ staff will become norm. Analysts will replace Billers and hospitals and payers may finally be on level ground.

SOURCES: 1) HFMA https://www.triple-tree.com/strategic-insights/2018/june/hfma-highlighting-rcms-next-round-of-innovation/ | 2) https://www.mdconnectinc.com/medical-marketing-insights/voice-search-improve-healthcare-patients-providers 3) HFN https://www.healthcarefinancenews.com/news/us-bank-optum360-partner-solution-streamline-boost-revenue-cycle-management

 

# *QUESTIONS*

# *THANK YOU!*

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