Taking Action

Four Ways Hospitals Are Improving Revenue Cycle Performance

Revenue cycle challenges continue to mount in 2018, and hospital finance leaders are more stressed than ever. At the same time, the pressure is leading them to innovate like never before and score new wins.

Rick Lyman, vice president of revenue cycle management at Memorial Hermann Health System in Houston, is battling a multitude of revenue cycle hotspots. But in particular, he says the sheer volume of payer challenges impacting care quality, revenue, physician satisfaction, and the patient experience have become much more time-consuming.

"On any given week, there are dozens of changes to payer manuals that we have to somehow digest and operationalize. It is always the tail wagging the dog," he says.

Lyman and the organization's 700-strong revenue cycle team are counteracting with strategies to gain more leverage, including using analytics in new areas, expanding the scope of CDI, and investigating technologies that will automate manual processes.

"I don't want to run behind or just keep up. I want to be ahead," says Lyman.

Moreover, while consumers want patient care that's high-value and cost-effective, healthcare systems are challenged by increased administrative requirements to ensure coverage for that care, says Jenni Alvey, CFO at Indiana University Health (IU Health). "Authorization requirements and processes often impact patient access and revenue cycle processes, and cause stress to patients," she adds.

Other revenue cycle hurdles include the move to alternative payment models, the migration from inpatient to outpatient care, an increase in claims denials, and continued demands for pricing transparency.

Here are four ways high-performing revenue cycle teams are taking smart, actionable steps to address their top pain points.

HCTEC®

ASK AN EXPERT

HOW EFFECTIVE CODING AND CASE MANAGEMENT CAN BENEFIT YOUR BOTTOM LINE

When you seek advice on what your health system can do to benefit its bottom line, you look to the experts. We went straight to the source and sat down with **Barry Matthews, Vice President of Health Information Management for HCTec.** HCTec is a KLAS-rated leading provider of hospital IT and revenue cycle workforce optimization solutions, including specialized skills staffing, consulting and managed services.

How can a hospital improve patient care and maximize revenue without adding to its headcount?

Incorporate coding and case management under revenue cycle operations. Hospitals that are organized in this manner are continuing to see gains in revenue despite an ever-changing environment. When you have clinical documentation improvement (CDI) and case management working together, you are able to ensure proper code use, keep patients on track for recovery, and reduce or eliminate readmissions. In value-based care, these tasks are critical to ensure maximum reimbursements are paid quickly and accurately, costs per patient are effectively managed, and penalties are kept to a minimum.

What can a hospital do to maintain quality of care and manage costs during high capacity situations, while continuing to support their full-time staff?

One-third of hospitals across the country are hiring skilled, outsourced consultants and seeing huge benefits across their health systems. Get in on their secret sauce! Hospitals are able to meet demand when experiencing ebbs and flows in patient census with a flexible, highly-skilled workforce who can help maximize revenue, identify trends and educate providers. Be sure to choose a partner that only employs top quality, U.S.-based coders, CDI specialists, and case management experts who are fully immersed in the latest technology and industry trends.

What is the best way for a hospital to find inefficiencies within their HIM operations?

A good first step is to start with an audit. This helps identify major pain points and the types of coding or clinical documentation errors being made, as well as the opportunities presenting across all of your health system's departments. After an audit, work with your partner organization to develop a strategy to address the inefficiencies found, while staying within budget. Your partner should provide your physicians, staff, and management with education on how to identify routine coding missteps, communicate coding trends, and offer ongoing insights into coding best practices—all with complete transparency throughout the entire process.

HCTec employs highly skilled HIM specialists who positively impact financial performance, operations efficiency, and clinical quality while maintaining the highest level of care. We have a top-talent workforce at the ready. Let's work together to guide your hospital to the best solution for all your HIM needs.

Visit www.hctec.com for more information.

1

Mounting a payer offensive

In recent years healthcare organizations have faced an increase in delayed payer authorizations, heightened scrutiny on clinical indicators and medical necessity, and a growing volume of denials and appeals. They're fighting back, however, as clinical appeals and denials are the bread and butter for maintaining and improving net revenue.

Memorial Hermann, for example, reengineered its CDI program to keep pace with payer changes and requirements, as well as new codes added last year. It even donned the new name "clinical documentation integrity" to reflect a new direction.

There are multiple reasons behind the overhaul, says Lyman. For one, CDI is no longer just about getting the clinical picture correct and driving the appropriate DRG, he says. "A broader CDI strategy needs to address PSIs, HACs, and everything else that drives your quality scores." To that end, Memorial Hermann is using new software that automatically queries for certain safety and quality issues. It also hired a full-time physician who works on CDI and coding and clinical appeals. The program is also expanding and refocusing its staff on specific payers. "As a result, we have driven CDI improvements and increased net revenue," says Lyman.

2

Performing smart analytics

With hospitals losing billions of dollars each year to denials, having a strong analytics strategy is essential for identifying root causes and predicting which accounts will be denied. Memorial Hermann is applying analytics in new ways to address denials. The health system recently began scoring denials based on historical recovery rates, segmenting denials into three categories: ones they work, ones they outsource, and ones they let go. "We have to use data that way," says Lyman. "We can't just go after every single one of them." For example, there are many denial codes and their definitions differ by payer, which makes proper response difficult. "We are working to get down to that granular level of detail on the denials we are recovering. Now when denials come back through, we know how to respond to specific payers," he says.

3

Leaping forward with new technologies

Automation, AI, and other technologies are also becoming top of mind for revenue cycle leaders. At Memorial Hermann, technology is crucial from a resource management perspective. "I have to do everything I can to use technology and process improvement before I go ask for an FTE," says Lyman, who is closely watching new technologies such as bots. "I am interested in increasing automation, and possibly including bots to automate workflow." He believes technology will be key to enabling the organization to take action on every account. "Redundant processes, and anything routine, such as a medical records request, should be automated," he notes.

4

Making financial health an organizational priority

Several years ago, alarms went off for IU Health senior leaders. "We began to see that our payer mix was shifting and that our operating margin was beginning to decline," says Alvey. "We projected an operating margin gap several years into the future that served as a call to action." As a result, Indianapolis-based IU Health, which includes an academic health center, multiple hospitals, and more than 1,500 physicians, set out to revamp its systemwide, long-range financial planning process. A major piece to this plan called for improving collaboration between doctors, nurses, operations teams, and regional executive teams.

The long-range planning process included working together to develop and update key assumptions in the organization's 10-year forecast. "Long-range financial planning has established a foundation and expectation supported by Lean process improvement techniques to eliminate waste from our operations," says Alvey.

Today, planning is continuous, and the process has created a discipline among teams to design improvement initiatives that are driven by data and aligned with the system's goals. "The long-range financial planning process has made the financial health of the organization a priority for all members of the organization, taking it out of the financial department solely and making it a systemwide initiative," says Alvey. By establishing collaborative teams focused on specific subject areas and made up of members from across the system, clinicians are more engaged in identifying opportunities for savings, driving success, and working to standardize system operations. "There's more engagement at every level of the system," she says. ■

Claim Denials: Avoiding the Avoidable

Chris Fowler
President
TruBridge

Hospitals lose an estimated $262 billion a year from insurance denials. One way to increase revenue is by implementing a comprehensive denial management strategy, which can eliminate the majority of preventable and avoidable denials. "Ultimately, this allows organizations to work a small number of denials more efficiently and intelligently, ensuring the best opportunity for payment," says Chris Fowler, president of TruBridge. Fowler discusses critical denial trends and how to create a corrective action plan.

Q: How big of a problem are claim denials, and what are the most common types?

Chris Fowler: Denials are a growing challenge for healthcare organizations. A typical hospital puts about 10% of its revenue at risk due to denied claims. What's more, 65% of denials are never worked, resulting in significant loss of revenue. Overall, the vast majority of denials—around 90%—are preventable and avoidable. The two leading causes of denials are registration inaccuracies and missing information. Other common causes include insurance ineligibility, invalid medical codes, lack of medical necessity, and untimely filing. Hospitals find there is a significant return on investing in a comprehensive denial management program. With some work, 70% of denials can be overturned.

Q: What's the best way to understand the magnitude and root cause of a claim denial problem?

Fowler: Before a hospital can implement a corrective program, they need to clearly understand the various types and volumes of the denials. They can do this by tracking and analyzing claims data manually or electronically. Manual processes involve collecting the following: information on the payer that denied the claim, the reason for denial, appeal ability, date of denial, billing amount, amount denied, and the denial overturn percentage. A manual process takes 60 to 90 days and is ripe for errors. A more efficient way is to analyze 835 remittance data electronically and uncover the root cause of the claim denials. A claims denial partner can perform this analysis with virtually no effort from the hospital, looking both retrospectively and concurrently to uncover root causes. A claims denial partner should provide a report that categorizes and prioritizes the denials into key areas that include the number of claims and the corresponding revenue opportunity.

"Hospital administrators should have zero tolerance for preventable and avoidable claim denials."

Q: How can hospitals permanently reduce denials in the future?

Fowler: First and foremost, hospital administrators should have zero tolerance for preventable and avoidable claim denials. Without a zero-tolerance attitude, it's difficult to implement and stick to a correction plan. Focus first on the areas that are causing the highest percentage of the denials and assign specific responsibility to implement corrective actions. These could be registration errors, poor utilization management processes, insufficient claim editing and tool problems, as well as faulty processes for following up on submitted claims. The best denial management programs modify workflows across all departments, including financial and clinical areas, and according to industry best practices. Furthermore, in some cases, hospitals find they need better medical necessity and insurance eligibility tools, more comprehensive claim scrubbing and editing tools, and a simple but efficient way to automatically manage any remaining denials.

Q: What are key industry standard performance metrics?

Fowler: Hospitals should generally track three metrics, starting with the overall denial rate, which should be 4% or less. Once they permanently reduce the overall denial rate, it will become more manageable due to better processes and tools. Denial write-offs are also important. They should be 3% or less and calculated based on the percent of monthly net revenue. Finally, hospitals should aim for a clean claim submission rate of 95% or greater. ■

TruBridge

Breaking Through Revenue Cycle Problems to Exceed Industry Norms

Q&A with Mike Morris, President, Xtend Healthcare

Q: What services does Xtend Healthcare provide?

We're a Nashville-based revenue cycle management company with a nationwide clientele. We're 100% focused on the healthcare market, and we've got capabilities across the end-to-end revenue cycle. We manage every aspect of revenue cycle from patient intake on the front end through mid-cycle clinical encounters, as well as bill drop and follow-up, and payment posting. We have an array of services that address all of the points within the revenue cycle that occur in the life cycle of an account.

Mike Morris
President,
Xtend Healthcare

It is a very complicated process for a provider to get paid for the services that they render, so they will oftentimes reach out to us and ask if there is a way that we can help them improve their processes. A large part of our business includes going into facilities that have an A/R backlog. For whatever reason, their claims aren't getting paid as efficiently as they should, and they end up with an accumulation of A/R that they're struggling to keep up with. The A/R is aging out, and the provider needs our expertise to assist them in getting caught up and cleaned up. We will analyze the A/R, determine what resources are needed to get caught up within whatever time parameters our customers are looking for, and then we'll deploy a team to accomplish their strategic goals.

Q: What challenges do you hear about most when you meet with hospitals and health systems regarding their revenue cycle?

Hospitals typically have relatively low margins on the services they perform, and it's a very capital-intensive industry. Cash flows tend to come in the door slower, which leads to revenue leakage. Even the best-run health systems tend to have 2%–3% leakage of revenue—lost dollars that they were entitled to, but with the complexities of trying to get the claim adjudicated, they are unable to collect. And we often see health systems that are leaking 5% or more of their revenue despite their best efforts to manage the process.

Q: How do you identify revenue leakage and opportunities for revenue cycle improvement?

We'll go in and look at aged trial balances, break them down by payer, aging bucket, and conduct an analysis around how that A/R is liquidating compared to industry benchmarks. The entire revenue cycle process is very difficult for providers to manage in a high-throughput environment, and hence the reason why Xtend exists. We can help customers and health systems solve those types of problems.

Q: Is it safe to say that the greater number of codes in ICD-10 is also a part of the challenges of revenue cycle these days?

When there's more choices to pick from in order to get it right, the more difficult it is to accurately get claims coded. Anytime you have that kind of industrywide adoption where coders are required to learn new things, the learning curve creates more uncertainty around the revenue cycle.

Q: How can Xtend help?

We can put together a comprehensive revenue cycle outsourcing engagement, where we assume full responsibility

of the patient financial services or business office at a health system. We also can include key revenue cycle functions in patient access and HIM within our scope of services. Our services provide health systems with cost certainty around their cost-to-collect, as well as key performance indicators and service levels that allow them to better manage their end-to-end revenue cycle performance.

If a health system is looking for a more targeted solution around a particular function or need, Xtend can help. A good example is a computer conversion. A health system that is moving from one patient accounting platform to another may want to carve out A/R on the legacy system. The business office team may not have time to sufficiently focus on the legacy A/R because they're learning a new system. That would obviously be a point solution, not a full end-to-end solution. We would have responsibility for a subset of the revenue cycle work events that need to take place within that hospital as they move through the computer conversion.

Q: What happens to the traditional role of the hospital's business office?

It is driven off of the specific needs and preferences of our customer, so when we encounter a situation where the preference of our customer would be a comprehensive solution, we will essentially become the business office. That's a growing industry trend.

If a customer has an organizational philosophy where they want to keep certain business office functions in-house, then during the design phase of our delivery, we outline the scope and responsibility Xtend is taking on versus what will be retained by our customer. Getting that right prevents us from having any confusion with our customer in terms of who is working what types of claims.

Q: How is the move to value-based reimbursement changing what you do or what customers ask of you?

The claims process, the actual transactions, still must be processed in value-based models. It goes back to the point of ICD-10, where as a country we have a collective interest in being able to keep statistics around the types of medical procedures that are being performed. Claim submittal is still required, even in a value-based reimbursement model where a provider may be receiving a capitated payment. There will still be the need to document to make sure you receive every dollar you're entitled to.

Q: Obviously you deal with almost every payer imaginable, including Medicare and Medicaid.

That's part of what makes it difficult. The vast variety of payers and rules under which the payers adjudicate claims gives rise to this need that we help fulfill. There's real insight to be gained from seeing payer behavior across multiple customers. Much of what we learn, if Customer A gets treated in a particular way by a payer, gives us great insight into how to interact with that payer on future engagements with other customers.

> "Even the best-run health systems tend to have 2%–3% leakage of revenue—lost dollars that they were entitled to, but with the complexities of trying to get the claim adjudicated, they are unable to collect."

Q: What is Xtend Healthcare's company history?

Xtend Healthcare has deep roots. In fact, the founders of Xtend are some of the initial pioneers of the A/R project delivery model going back to the late 1980s. Xtend in particular has been around since 2009. We are now a subsidiary of Navient. Navient's roots are not in the healthcare space, but they efficiently service payments on a $300 billion loan portfolio. Much of the workflows that they perfected in verticals outside of healthcare have applicability for Xtend's customers too, so one of the things that we are doing is trying to be an innovator and a market leader by applying best practices from other vertical markets to healthcare providers.

Xtend Healthcare
A Navient Company