The Data-Driven Revenue Cycle

Analyzing patient information to improve financial performance
The Data-Driven Revenue Cycle

Introduction

Shifting reimbursement, evolving payment models, increased provider risk and growing regulatory pressures are driving near-constant change in the healthcare revenue cycle. What began with passage of the Affordable Care Act (ACA) has and continues to transform an entire industry with a wholesale shift from fee-for-service to value-based reimbursement.

The reality is that healthcare is bought and sold differently than it was just five years ago. Healthcare organizations that used to be paid by the encounter are now also being measured and paid for how they perform during that encounter.

Although the ACA was just signed in 2010, the Centers for Medicare and Medicaid Services (CMS) reported that by the end of 2014 an estimated 20 percent of Medicare payments had shifted to alternative models that directly linked reimbursement to patient outcomes. The Department of Health and Human Services, which oversees CMS, has committed to investing in alternative payment models such as Accountable Care Organizations (ACOs), patient-centered medical homes, bundling payments for episodes of care, and more integrated care for beneficiaries. Its overall goal is to have 85 percent of Medicare fee-for-service payments in value-based purchasing models by 2016 and 90 percent by 2018.

This value versus volume movement has forced hospitals, physicians and other providers to look for ways to deliver high-quality care at a lower cost.

In the way payers use cost and quality data to measure providers’ performance and justify compensation, healthcare organizations must use patient data to shore up their own internal revenue cycle processes, evaluate and improve their own financial performance.

PROJECTED SHIFT IN MEDICARE PAYMENTS

![Chart showing projected shift in Medicare payments]

85%  30%
2016

90%  50%
2018

- = All payments
- = Payments linked to quality
- = Alternative payment models

Centers for Medicare and Medicaid Services
Big data is more than clinical
The concept of “big data” within healthcare has gained a lot of traction and attention in recent years as a tool for providers and health plans to achieve population health management, discover valuable trends, improve patient outcomes and more accurately measure quality of care. Lesser known – or perhaps not as often acknowledged – is its role in the revenue cycle.

Unlocking big data’s true potential includes financial data and analytics.
Driving revenue cycle processes with data and analytics not only empowers healthcare organizations to deliver more effective patient experiences, but also successfully adapt to payment reform and achieve the financial efficiency they need to continue supporting their overall mission of patient care.

Data from the American Hospital Association shows that more than 30 percent of U.S. hospitals continue to deliver care with negative operating margins, and one in four report negative total margins. There is ample room for improvement with little to no room for regression.

Healthcare organizations simply have more data available to them now than they have ever had, valuable data that can be used to validate important revenue cycle decisions. Consumer data that at one time may have been considered irrelevant to a healthcare encounter has become incredibly valuable and useful at every touch point, from patient access and registration through claims and collections.
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Wealth of patient financial data available
- employment status
- credit history and scoring
- life changes (marital status, dependents, etc.)
- recent loans
- healthcare payment history
- A/R data (collections, etc.)

Accessing data not the same as using data
Of course, big data is worth nothing if it sits dormant.

Hospitals, health systems, physician groups, medical specialty organizations and other types of healthcare providers have traditionally collected vast amounts of data related to clinical care and business operations but until recently did not use it to their full advantage, often because the necessary tools were not available.

Technology has changed that.

Data that once was relegated to paper files and manual charts can now be integrated and automated across the revenue cycle via electronic health records, automated financial management systems and other technology-enabled solutions.

Industry best practices applies smart analytics to convert existing data into actionable information that helps healthcare organizations increase accuracy and efficiency in the financial workflow and decision-making process.

Leveraging data has many benefits
- Correctly identify patients upon registration to prevent fraud and identity theft while simultaneously reducing the safety risks of patient misidentification.
- Move patient payment collections to the front end of the revenue cycle where the likelihood of collection is highest. Review contract terms, payment rules and benefits information to estimate the patient portion due prior to or at the time of service.
- Determine a patient’s propensity and ability to pay based on consumer data and, when necessary, pair the patient with charity care programs, financial assistance or payment plans that meet his or her unique financial needs.
- Segment patient accounts to determine which should be worked internally from those that should be referred to a collections agency.
Using data appropriately, healthcare organizations can optimize A/R classification, reduce debt, minimize risk and improve collections strategies.

**Overcoming roadblocks to performance**

Despite the wealth of valuable data and technology solutions available, some healthcare organizations for various reasons cannot keep pace with industry best practices. One of the most common obstacles to achieving optimal performance is departmental silos. Disparate systems and processes obstruct collaboration, slow agility and stifle productivity.

**Data alone cannot and will not break down internal silos. Departments must come together and embrace a data-enriched approach or they will leave opportunities on the table.**

The importance of internal culture also cannot be overstated. Organizations that battle resistance to change often struggle implementing new revenue cycle strategies or solutions. Clearly communicating with staff about why an initiative supports the department’s and organization’s overall mission and how it will affect their work helps earn the necessary buy in.

Unfortunately, as healthcare organizations face squeezed reimbursements, increasingly cumbersome regulatory burdens and a host of other financial pressures, a natural response is often to cut costs. Sometimes it means reducing FTE count. For others, it may delay much-needed technology investments until the next budget cycle. While this legacy approach may positively impact margin in the short term, it does not position an organization to thrive under new, value-based payment models. Hospitals and health systems must make continual investments in their people, tools and processes.
An emerging cultural shift that is further disrupting the traditional revenue cycle is the need for healthcare organizations to be consumer-focused and patient-friendly across the enterprise. Employers continue to struggle with rising insurance costs and each year are passing more financial responsibility to employees (patients) in the form of higher co-pays and deductibles. The average employee contribution now approaches $5,000 per year, according to the Kaiser Family Foundation. Even under the ACA exchange, which was touted as a plan to help middle class and lower-income families afford health coverage, the maximum out-of-pocket expenses for a Marketplace plan can be up to $6,600 for an individual plan and $13,200 for a family plan.

This shift has caused patients to become more engaged in their own care and because they are now also purchasers, they view the financial interaction as a big piece of their overall experience and a factor in where they choose to receive care.

CMS designed and regulates the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey program, which since 2006 has measured patients’ perspectives of their overall hospital care. All acute care facilities throughout the U.S. must participate, and scores are readily available for patients to access online. One negative financial encounter could overshadow an otherwise positive patient experience and adversely affect the hospital’s overall score as well as their opportunity to earn bonus reimbursement.
Three opportunities for data-driven success

When designed intentionally and used appropriately, a data-driven revenue cycle can overcome common roadblocks to performance, build and sustain margins, improve performance, enhance care quality and the deliver a better overall patient experience.

Consider this: All healthcare organizations essentially have the same access to the same type of data. The organizations that apply advanced analytics to their data are able to transform current processes, gain operational efficiencies and strengthen financial viability.

Instead of cutting costs, organizations can – and should – evaluate three particular areas of the revenue cycle through a data-focused lens.

- **Patient access** is a broad term involving many different revenue cycle activities, including orders and scheduling, patient identification, insurance verification, financial planning and up-front patient payments and collections. Data can bolster each of these functions and increase the odds of a clean financial encounter at every patient touch point.
  - Consistently and correctly identifying patients at the outset of the patient encounter reduces the risk of misidentification, and elevates patient safety, both clinically and by thwarting fraud and identity theft. Patients are rightfully concerned about healthcare fraud. A study sponsored by the Medical Identity Fraud Alliance found that the incidence of medical identity theft continues to rise, nearly doubling in a five-year period. In 2014, there were nearly half a million more victims than in the previous year, according to the study, and 65% of victims paid an average of $13,500 to resolve the crime.
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- Verifying insurance benefits and coverage prior to or at the point of service reduces claim issues on the back end, such as denials due to lack of insurance or incorrect information or missed preauthorizations.

- Providing accurate estimates of the patient’s responsibility for co-payment, co-insurance and deductible amounts and determining a patient’s ability to pay at the beginning of the encounter support more proactive collections efforts, enhancing revenue and reducing bad debt. Patients also welcome – maybe even now expect – the pricing transparency and appreciate compassionate approaches to collections that involve payment plans or other assistance programs, where applicable.

- Consolidating financial information from across the organization to generate a complete financial snapshot of the patient’s current and past open balances allows more productive financial discussions with patients at the point of service.

- Proactively and reliably identifying patients who qualify for financial assistance eliminates the burden of an unaffordable bill for the patient and bad debt for the provider.

- Identifying a patient who may not qualify for financial assistance but could benefit from an extended payment period provides data insight to help guide patient access staff in discussions about payment options, including credit cards, e-payments and personalized payment plans.

Claims and contract management

As the number and complexity of health plans’ products continues to grow, so too does the amount of time required to file claims and the challenge for healthcare staff in negotiating payer contracts.

HHS reported that nearly 11.7 million consumers were enrolled in 2015 Health Insurance Marketplace coverage, many in plans that did not even exist when the exchange launched just two years earlier. It’s increasingly difficult for many providers to keep pace as government and commercial payers continually adjust rates, narrow networks and develop new products.

The U.S. Census Bureau reported that 10.4 percent of Americans (or 33 million) were uninsured for the entire calendar year in 2014, the lowest number in several years. The Bureau also reported that two-thirds of consumers carried private health insurance. This means that for the average healthcare organization, the vast majority of its patients outside of the Emergency Department are going to have some type of coverage tied to a network contract.
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Analytics tools can be used to scrutinize contract terms proposed by a payer against an organization’s actual mix of services to identify new service line opportunities, anticipate how proposed contract terms will affect revenue and negotiate contracts with some leverage.

When it comes to billing for services, analytics tools can work with an organization’s existing data to automatically review claims before submission, compare them with payer requirements and kick out claims that have errors or need further information. Commonly referred to as claims scrubbing, this process can help an organization make corrections quickly to avoid costly delays in processing and payment receipt.

Drilling down into an organization’s existing claims data is the best way to manage denials and underpayments. It uncovers patterns that otherwise go undetected. It shines light on opportunities for process improvement. It exposes funds for collecting.

Collections

Work smarter, not harder. The age-old business proverb is easier said than done in the ever-changing healthcare sector, especially when staff sizes shrink and organizations are tasked with finding ways to accomplish more with fewer resources. Collections agencies continue to make hay from organizations that fail to use the data and tools at their disposal and on “overflow work” from organizations that are not sufficiently equipped to manage their collections in house.

Here’s where the combination of data and technology can make a marked difference.

Standard industry practice for years was to send letters, call patients and assign accounts to an external collections agency at the same point in time for all accounts. Many organizations unfortunately still do it this way.

An organization that uses technology to strategically segment and work patient accounts will typically achieve better results with the same or fewer FTEs, and less dependence on third party collections agencies.

Following are some proven efforts organizations have used to improve internal collections efficiency and profitability.

• Reconcile inventory to identify bad debt accounts. One organization that implemented this approach was able to identify 40,000 accounts — equaling about $11 million in outstanding bad debt — that were never identified properly.
• Segment accounts that share demographic and financial profiles, rather than simply looking at balance amounts and number of days open. Organizations can score payment and consumer data to pinpoint a patient’s likelihood to pay and prioritize workflow for optimal staff productivity, and better overall results.

• Robust data can also help organizations evaluate collections agency performance and determine which agencies are delivering the most return (and on which accounts) from areas where agency consolidation or internal support could yield stronger collections results.

Patient communication strategies should not be overlooked in the collections cycle. Data analytics gives an organization valuable insight that, based on an account’s segmentation, may call for different communication messages, timing and vehicles. This targeted communication approach improves internal staff’s rate of collections; it also enhances the patient experience.
Embracing the data

The information and technology exists to allow healthcare organizations to sophisticate their financial operations, minimize risk, generate real revenue and deliver a better overall patient experience. High performers are already seeing the benefits of a data-driven approach and the maturing value-based payment system may encourage – or even force – late adopters to see what they’ve been missing.

Sources

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