Metrics, Communication, Influence and Accountability: How actionable data can drive results in patient access

Julie Kay, VP Cerner Corporation

Contributors:

Lynne Gentry, Exec, PFS, Cerner / Adventist Health

Teri Meintel, Exec, Patient Access, Cerner / Adventist Health

August 30, 2016

Cerner

Recognized as the world's largest publicly traded health information technology company providing leading-edge solutions an services for healthcare organizations worldwide

Cerner Revenue Cycle Management offers complete, clinically integrated revenue cycle services, allowing for increased reimbursement, time savings, built-in efficiencies, increased provider and staff satisfaction and an improved patient experience.

Cerner experience

Manages over

$3.9 billion

clients in 42 STATES

Revenue Cycle Services leadership has an average of

22 YEARS OF EXPERIENCE

530+

REVENUE CYCLE MANAGEMENT ASSOCIATES

51 ACUTE CLIENTS

live or **under contract**

125 AMBULATORY CLIENTS

across **45 specialties**

11.4 million

ANNUAL EDI TRANSACTIONS

OVER FOUR DECADES OF REVENUE CYCLE MANAGEMENT EXPERIENCE

Objectives

- Build a data collection strategy that drives action and ultimately results
- Establish a plan to utilize to contribute to streamlined communication and accountability
- Create a culture of continuous improvement utilizing data as the foundation

Agenda

- Industry Overview
  - Changing Dynamics
- Key Revenue Cycle Data Leverage Points
  - Denials Prevention
  - Patient Responsibility
  - Bad Debt
- Examples
  - Using data to create a plan
  - Operational improvement
  - Cultural changes
  - Education
- Questions

Industry Overview

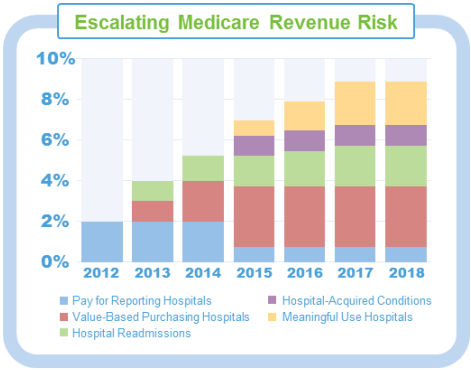
Changing Dynamics

- Value Based Reimbursement
- Denials Management and Prevention
- Patient Responsibility
- Staffing
- Metrics and Reporting

Shift to value

"And we [CMS] must execute in our role as a market catalyst and signaler– signaling that care delivery payments are changing, and reward people who provide the best care and we are pushing to a tipping point by 2018."

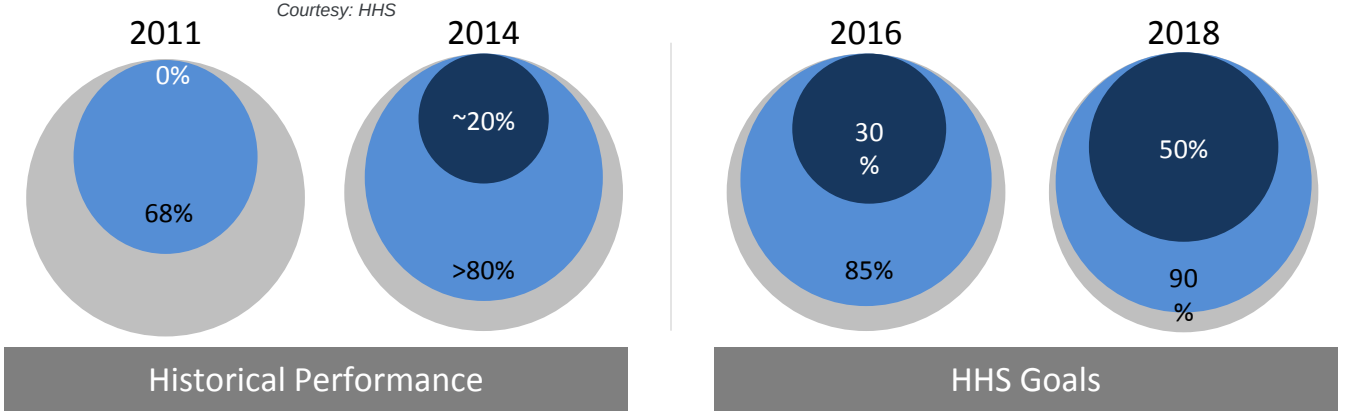
Andy Slavitt
CMS Acting Administrator
J.P. Morgan Annual Health Care Conference
January 11, 2016



Medicare Payments Linked to Quality

Alternative payment models · FFS linked to quality · All Medicare FFS

Courtesy: HHS



Value-Based Reimbursement

- A program designed by the U.S. Dept of Health and Human Services, administered by CMS which seeks to reward healthcare providers for improving the quality of care by redistributing Medicare payment among them so providers (both hospitals and physicians) with higher performance will receive a greater proportion of payment.

HCAHPS

- Hospital Consumer Assessment of Healthcare Providers and Systems
- HCAHPS (pronounced “H-caps”), also known as the CAHPS® Hospital Survey,
- National, standardized, publicly reported survey of patients' perspectives of hospital care.
  - 32- item survey instrument and data collection methodology for measuring patients’ perceptions of their hospital experience
  - Since 2008, HCAHPS has allowed valid comparisons to be made across hospitals locally, regionally and nationally.

AHA Monitors RAC

- 2,578 hospitals have participated in RACTRAC since data collection began in January of 2010.
- 60% of reviewed claims in Q1 2016 were found **to not** have an overpayment.
- 37% of hospitals indicated, for automated denials, that outpatient billing error had the largest financial impact.
- 79% of hospitals received a complex denial based on inpatient coding in Q1 2016.
- Hospitals report appealing 47% of all RAC denials.
- 37% of hospitals report having a denial reversed in the discussion period.
- 43% of all hospitals reported spending more than **$10,000** managing the RAC process during the 1st quarter of 2016, 26% spent more than **$25,000** and 8% spent over **$100,000**

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Total Corrections* - by Fiscal Year (FY**)

	FY 2010 (in Millions)	FY 2011 (in Millions)	FY 2012 (in Millions)	FY 2013 (in Millions)	FY 2014 (in Millions)	FY 2015+ (in Millions)	*National Program (in Billions)*
Overpayments Collected	$75.4	$797.4	$2,291.4	$3,650.9	$2,394.8	$359.7	*$9.5696*
Underpayments Returned	$16.9	$141.9	$109.4	$102.4	$173.1	$81.0	*$0.6247*
Total Corrections	$92.3	$939.3	$2,400.8	$3,753.3	$2,567.9	$440.7	*$10.2006*

* Amounts as reported in the Recovery Audit Program's Report To Congress for the respective Fiscal Year

**Fiscal Years run from October 1 of the previous calendar year, to September 30 of the next. For example, FY 2010 was from October 1, 2009 through September 30, 2010.

+ Amounts for FY2015 were reported in the FY2015 Agency Financial Report (AFR) released in November 2015

ICD-10 (AKA Y2K)

- Minimal impact on cash, denials, and days in A/R
- Initial loss on productivity and inflated DNFB
- California, Louisiana, Maryland and Montana did not transition- used cross-walk
- Concern regarding application of edits and lack of feedback
- Grace period ends 9/30
- Expect rejections and requests for additional information
- 5500 new codes 10/1

Patient experience

- Patient out-of-pocket increasing
- Patient satisfaction directly related to resolving patient balance
- 70% of hospitals rate the patient experience/satisfaction as a top-three priority
- Patient's satisfaction rates drop by more than 30% from post-discharge through the billing process
- Patients satisfied with the billing process are 5x more likely to recommend a hospital
- Lifetime Value of Patient (LVP) for a household influencer exceeds $1.5 million

New Era of RCM

Alphabet soup of new requirements

- VBP: Value Based Purchasing
- IQR: Inpatient Quality Reporting
- MMA: Medicare Modernization Act
- DRA: Deficit Reduction Act
- ACA: Affordable Care Act
- HCAHPS: Hospital Consumer Assessment of Healthcare Provider Systems
- AHRQ: Agency for Healthcare Research and Quality
- HAC: Hospital Acquired Conditions
- HRRP: Hospital Readmission Reduction Program

Education, establishing expectations and developing feedback is critical!

Business Analytics

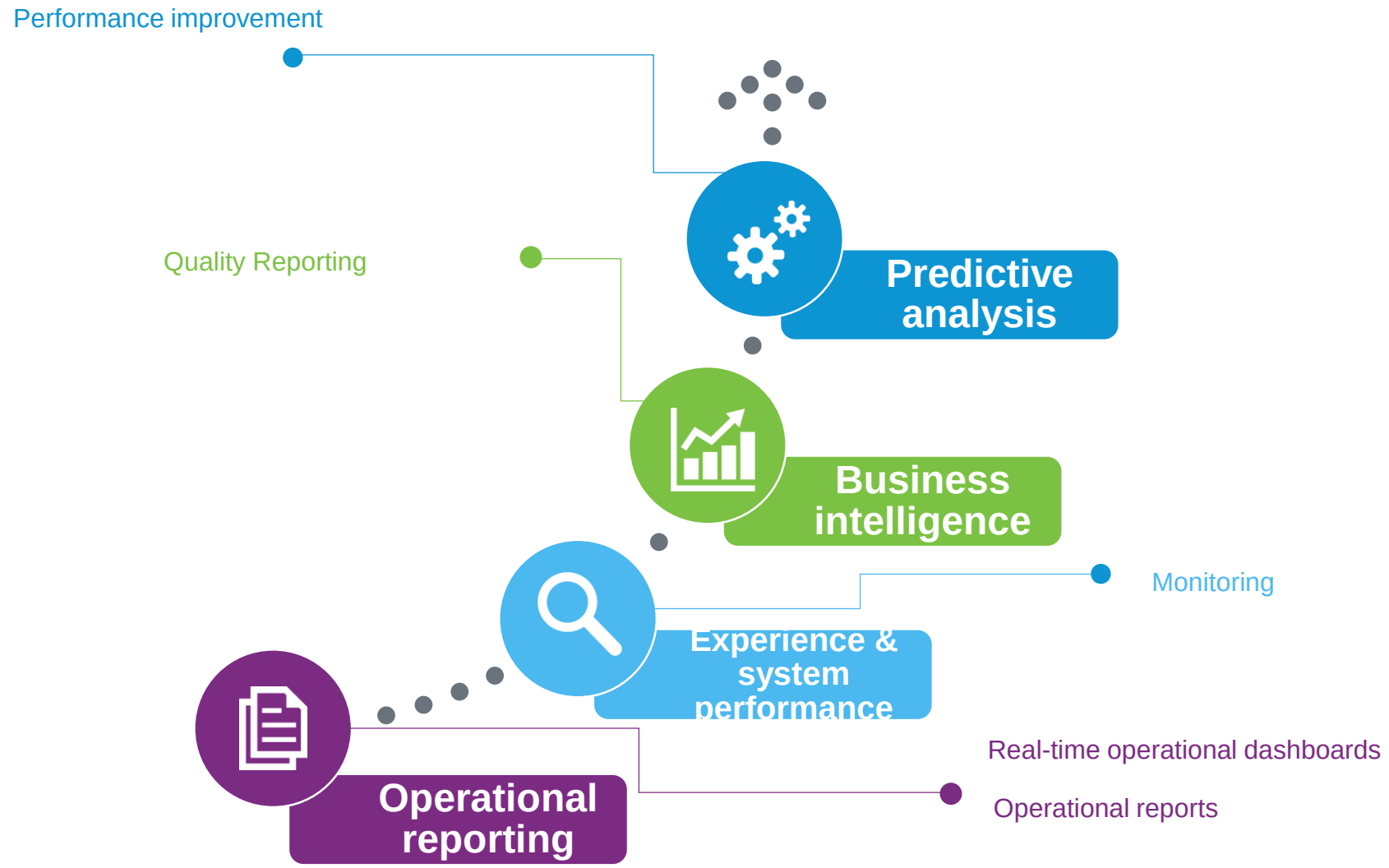
"We developed the concepts in this work from the data we gathered, building a framework from the ground up. We followed an iterative approach, generating ideas inspired by the data, testing those ideas against the evidence, replacing them with new ideas, revising, testing, revising yet again, until all the concepts squared the evidence."

From Great by Choice, Jim Collins, 2011

The revenue cycle presents unique opportunities for bottom-line improvement. As payment continues to decline, hospitals should take a renewed interest in improving their financial performance through the revenue cycle.

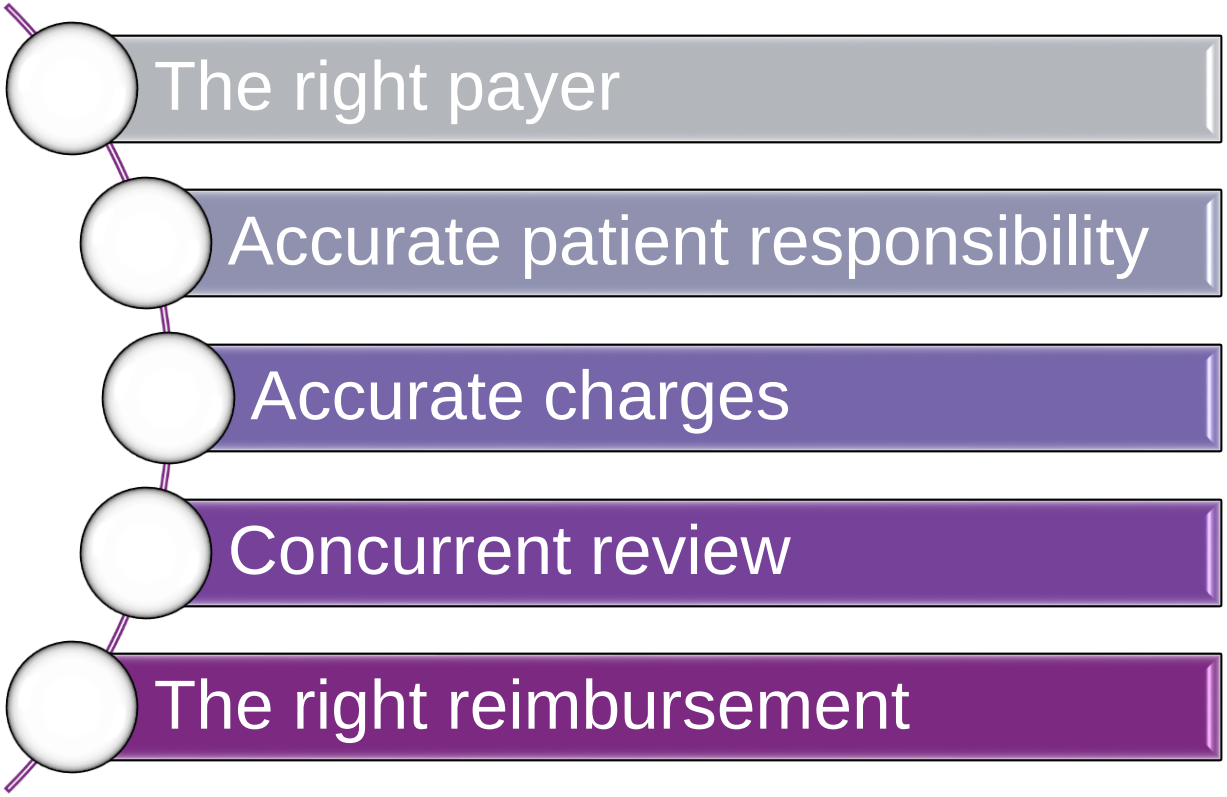
HFMA

Data Analytics



Leveraging Data for Improvements

- Get it right the first time



Evaluating the Health of an Organization

Typical back-end metrics:

1. Days in A/R
2. Cash
3. DNFB (Discharged Not Final Billed)
4. A/R > 90 days

Adventist West

- Goal: High performing, adaptable, “exception-based” processing units
- Objective:

  Strategic – Data Driven Decision Making

  Consistency and Standardization

  Achieve, Sustain, Improve Performance
- Mechanism (“how to…?”)

  Council Forums

  90 Day Action Plans

  Consistent Messaging with leadership and Stakeholders'

  Ownership

Establishing Metrics

Indicator
Point of service as % of total cash
Cash collections as a % of net revenue
POS/upfront cash as % of total cash collected
Bad Debt write-off as % of gross revenue
Pre-registration days out
Scheduled insurance verification days out
Insurance verification secure rate
Net days in AR
% of AR greater than 90 days
Registration accuracy
Denials as % of gross revenue
Late charges as % of total charges
Medicaid IP conversion rate
Medicaid OP conversion rate

Examples

Denial Prevention

Reason Code	Reason Code Description	Count
OA18	Exact duplicate claim/service	6314
CO29	The time limit for filing has expired.	5249
OA23	The impact of prior payer(s) adjudication including payments and/or adjustments.	5165
CO24	Charges are covered under a capitation agreement/managed care plan.	3600
CO97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	2901
CO45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication.	2636
OA109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	2080

Collecting / Presenting the Facts

Selecting the “Right Payer”

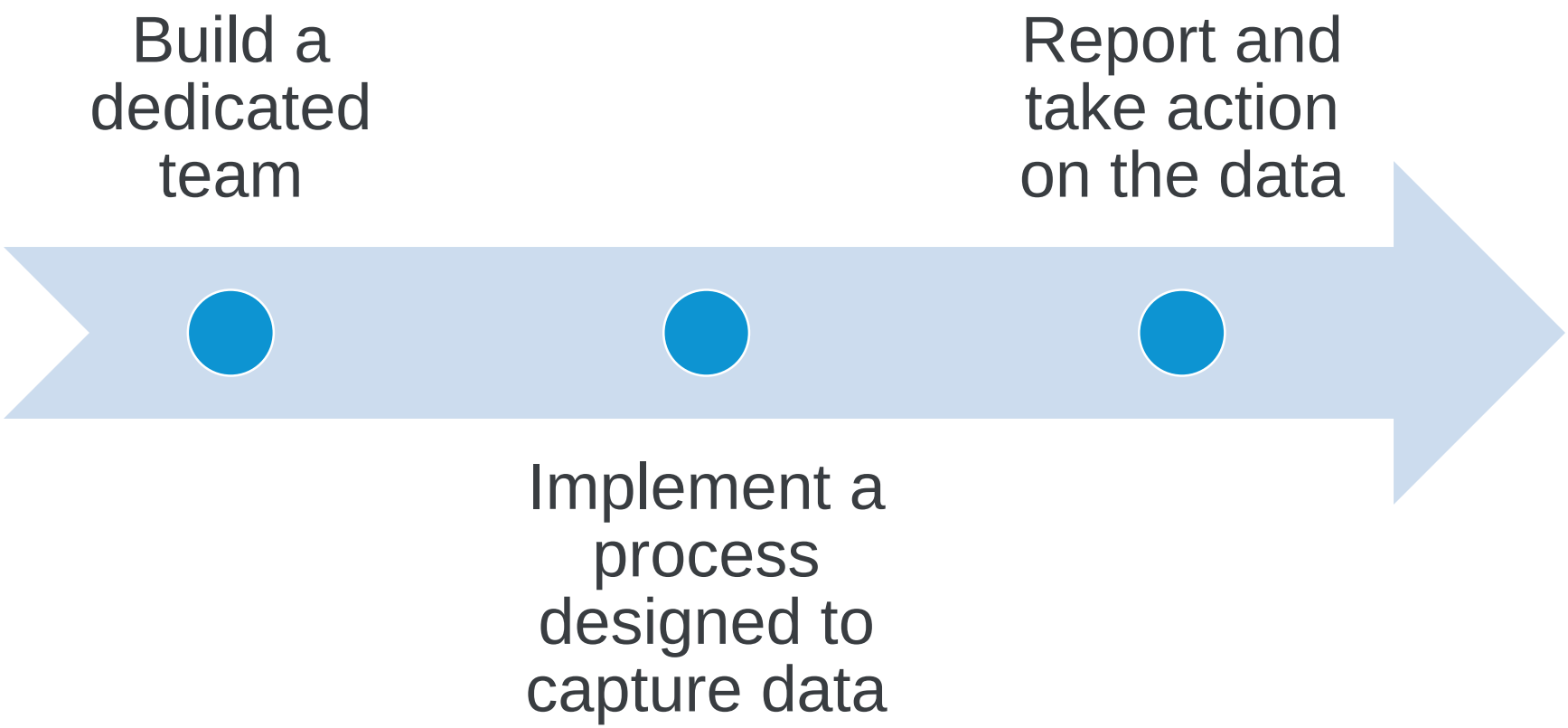
- Specifically define reason:
  - “Service not covered by this payer”
  - Potential causes:
    - Incorrect insurance plan selected
    - Plan mapped incorrectly
  - Potential actions
    - Education
    - Better description
    - Evaluate plan mapping
    - Measure / report
    - Provide specific feedback

Collecting / Presenting the Facts

Selecting the “Right Payer”

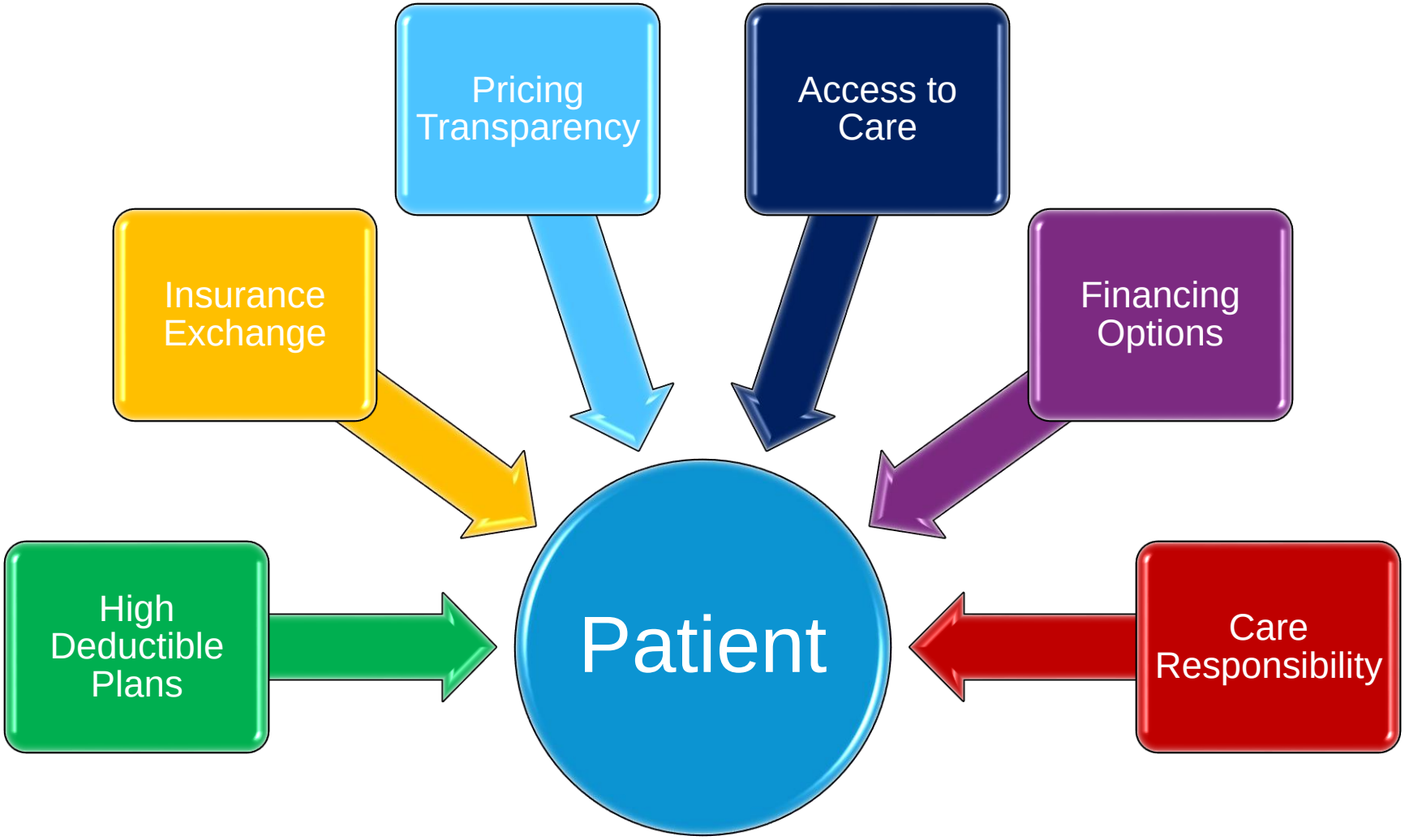
- Contributing Factors
  - Authorizations CPT ordered vs. performed
  - IPA
  - Misc. Insurance plans

Denials Prevention Requirements



26

Patient Responsibility



The Consumer has chosen

Plan Type	Covered Medical Expenses Paid by Plan	Covered Medical Expenses Paid by Consumer	Maximum Out-of-Pocket Costs	% of Plans Purchased by Consumers[7]
Bronze	60%	40%	$6,600 Individual, $13,200 Family	20%
Silver	70%	30%	$6,600 Individual, $13,200 Family	64%
Gold	80%	20%	$6,600 Individual, $13,200 Family	9%
Platinum	90%	10%	$6,600 Individual, $13,200 Family	5%
Catastrophic	>60%	>40%	$6,600 Individual, $13,200 Family	2%

National Health Expenditure Data; Centers for Medicare and Medicaid Services; Office of the Actuary

Patient Responsibility

Getting it right:

- Lessons learned POS
  - Ded / Co-pay vs. estimate
  - Benefit Advisors vs. Financial counselors
  - Deposit requirements
  - Measuring accuracy
- Establishing Expectations
- Education
- Validation
- Customer Service

Bad Debt Reporting

- Specific and detailed descriptions
- When items are retuned from bad debt, data should be collected to determine reason account was sent to bad debt
  - Insurance identified
  - Charity Care identified
  - Patient satisfaction adjustment
- This data should be included in a standard revenue cycle dashboard for revenue cycle teams

Using Bad Debt Data

- Analysis of Bad Debt can identify the following revenue cycle issues
  - Front-end
    - Registration
    - Authorization
    - Financial Counseling
  - Back-end
    - Self-pay follow-up process
    - Insurance Follow-up process
    - Balance after insurance follow up process

Example – AR Process

- Data shows increase in patients with Blue Cross primary being returned from bad debt
- Review of data shows increase in line item denials from payer
- Improvement
  - Education to Patient Access and AR follow-up team
  - Data collected on payer report card to show unpublished denial

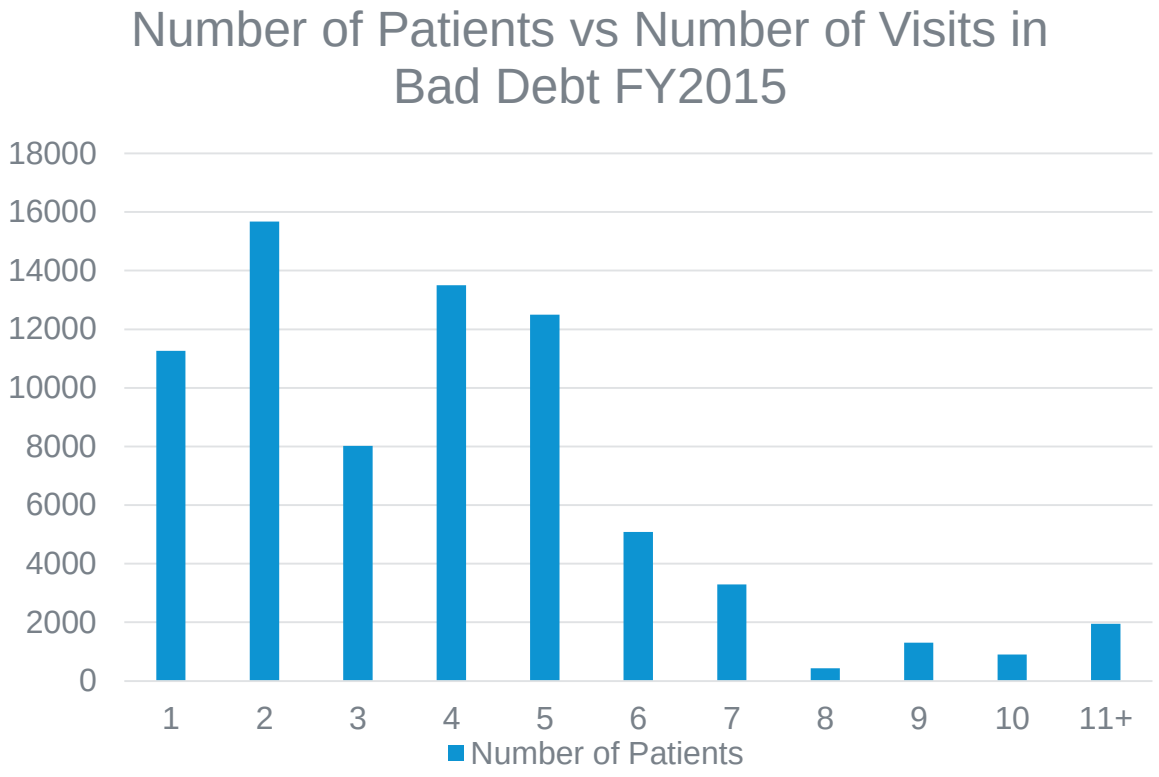
Data Collection and Analysis

- Frequent Fliers
  - Self-pay: Over a 12 month period, create a histogram of self-pay patients based on number of visits to the hospital
  - Balance after insurance: Over a 12 month period, create a histogram of BAI patients in bad debt based on number of accounts written off to bad debt
- Helps to determine where to start in managing your uninsured and underinsured frequent fliers

Example Reporting

Histogram

Number of Accounts	Number of Patients
1	11267
2	15673
3	8024
4	13503
5	12497
6	5082
7	3295
8	432
9	1304
10	902
11+	1952



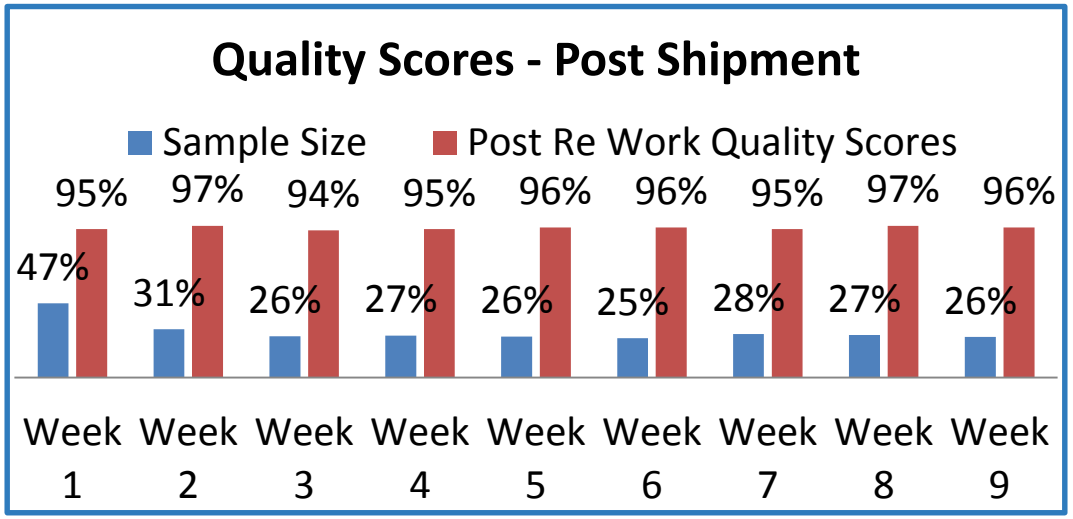
Example – Frequent Fliers

Number of Accounts	Number of Patients
1	11267
2	15673
3	8024
4	13503
5	12497
6	5082
7	3295
8	432
9	1304
10	902
11+	1952

Benefit Advisors

- Proactive Program to contact these patients
- Engage in multitude of strategies
  - Identify patients next appt
  - Field representatives
  - Identify alternative coverage options or payment plans
- Results
  - 26% of these patients provided secondary coverage, payment and balance alternatives

Using Data to Create a Plan



Top errors identified

- Incomplete documentation
- Billing screen not checked
- Registration screen not checked

Action Plan

- 100% Audits of the Quality Outliers for 5 consecutive days
- Documented Feedback & Coaching Sessions.

- DOU (Document of Understanding) created to include steps on working specific AR steps required for speedy resolution and updates received
- Certification of new agents on Analysis and Actions before they move into production
- FACT (Feedback and Coaching Terminal) to provide daily feedback on the errors identified
- Monthly Certification for agents in production on Analysis
- Regular Fresher training on the TOP 5 error reasons
- PKD (Process Knowledge Tests) conducted to gauge the understanding as per instructions provided

All plans are NOT created equal

- Measure / establish scorecard
- Develop plan
- Execute
- Culture

Sabotage

Leadership adoption and buy-in

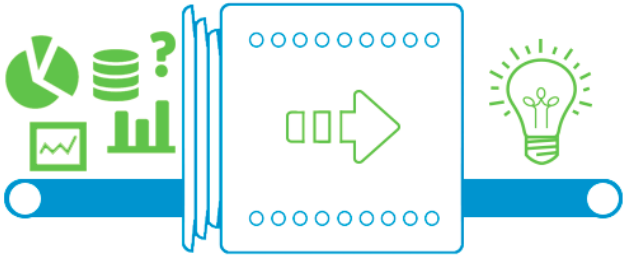
Metrics and Reporting

Measurement & Metrics

- New data collection and analysis focuses on improving and “tweaking” processes for incremental improvement
- Moves beyond the MAP or Access keys and looks at key control points or “switches” in the process
- Can be overwhelming when mapping out all of the places to measure and track data and the key to success in improvement is focus and consistency of reporting

Driving Results in Patient Access

- Efficient low-cost workflows
  - Automation through EDI
  - Patient self-service options
- Accuracy
  - Insurance plan selection
  - Authorization
  - Patient liability at POS
  - Real-time concurrent review
- Payment efficacy
  - Patient and payer
- New KPIs



Transform data into knowledge and action

The New Revenue Cycle

Success at Predicting the Future

Our vision is a fully transparent financial experience for the patient

Dr. John Showalter

Chief Health Information Officer

University of Mississippi Health Center

Managing Change

- From production worker to knowledge worker
  - Education
  - Recruitment
  - Retention
- Challenges
  - Data analytics tools
  - Feedback and resolution
  - Knowledge transfer
- Strong Leadership is critical

Objectives

- Build a data collection strategy that drives action and ultimately results
- Establish a plan to utilize to contribute to streamlined communication and accountability
- Create a culture of continuous improvement utilizing data as the foundation

“

The best way to predict the future is to create it.

”

Peter Drucker

Author and Professor

Claremont Graduate University

Questions?

Julie Kay
Vice President, Cerner Corporation
816-398-5079
Julie.Kay@cerner.com