The new revenue cycle imperative: A data-driven approach to minimizing risk and optimizing performance

An Experian Healthcare white paper
Shifting reimbursement, evolving payment models and growing regulatory pressures are driving near-constant change in the healthcare revenue cycle. For example, the Affordable Care Act (ACA), Value-Based Purchasing (VBP) and other regulatory programs are redefining traditional reimbursement in an effort to promote efficiencies throughout the industry, while placing a heavier focus on outcomes over services. With reimbursement transitioning to being tied to patient outcomes rather than the quantity of services provided, it is necessary for healthcare organizations to change how they define and evaluate financial performance.

Data and analytics play key roles in helping organizations navigate this change. That being said, within healthcare, the concept of “big data” is almost exclusively tied to the positive impact data and analytics have in clinical care, as it is becoming an integral force in shaping the way care is delivered and population health is managed. However, the healthcare industry must shift its perception of big data to realize the true potential, which centers on a marriage between clinical and financial data and analytics. This combined approach will propel and empower more effective patient experiences and outcomes with overall care while providing healthcare organizations with the financial margin they need to support their overall mission of patient care. In fact, financial data and analytics are greatly influencing the patient experience and becoming more critical to every part of the revenue cycle, including patient access, claims and contract management and collections.

By taking a data-driven approach to both the revenue cycle and clinical care, healthcare organizations can develop a cohesive clinical and financial strategy that enables success in the emerging healthcare landscape.

**Defining revenue cycle data**

Historically, hospitals, health systems, physician groups, medical specialty organizations and other types of care providers have collected vast amounts of data related to clinical care and business operations. Until recently, that data was relegated to paper files and manual charts and rarely integrated across the revenue cycle.

The increasing adoption of electronic health records, automated financial management systems and other technology-enabled solutions has given healthcare organizations greater access to more data that can shape the revenue cycle. For instance, organizations now have access to consumer data, which may include a patient’s credit history or information on his or her financial picture, including life changes, recent loans or employment status. Organizations also can look at payment data, including a patient’s financial record and healthcare payment history. In addition, organizations can review accounts receivable (A/R) data, which may include collections information that highlights trends for particular procedures or offers insight into the payment history for specific accounts.

Keep in mind that having access to data is not the same as using it. All too frequently, healthcare organizations underutilize the wealth of data available to them. They miss the opportunity to leverage information to evaluate current revenue cycle performance and pinpoint ways to make processes more efficient, effective and profitable.
Applying smart analytics allows existing data to become usable and actionable. Healthcare organizations can employ data to:

- Identify patients correctly upon registration to prevent fraud and identity theft while simultaneously reducing the safety risk of patient misidentification.
- Review contract terms, payment rules and benefits information to estimate the patient portion due at the time of service. While traditionally considered a “back end” process, data and analytics can shift patient payment collections to the “front end” whenever possible.
- Examine consumer data to determine a patient’s propensity and ability to pay and, when necessary, pair the patient with charity care programs or payment plans that meet the individual’s unique financial needs.
- Explore consumer and payment information to segment patient accounts for more streamlined collections processes. This allows an organization to decide whether accounts should be worked internally or through a collections agency. It can also identify accounts appropriate for financial assistance or a payment plan, not only optimizing payment strategies, but enhancing the accuracy of debt classification.

As seen in these examples, there are many potential benefits that come from effectively using data to drive the revenue cycle — increased accuracy, efficiency, risk mitigation and patient satisfaction, to name a few.

Roadblocks to a high-performing revenue cycle

In today’s typical revenue cycle environment, there are several obstacles standing in the way of efficiency. Siloed healthcare organizations with departmentalized systems and processes prevent collaborative efforts to identify ways to create an agile and productive revenue management process. Unless departments come together and embrace a data-enriched approach, they will leave opportunities on the table.

Another roadblock relates to overcoming resistance to a new revenue cycle management strategy. Unfortunately, as healthcare organizations face declining revenue growth rates, the favored strategy for promoting a positive bottom line oftentimes is to cut costs. While this legacy approach may guarantee a consistent margin, it will not position an organization to succeed as payment models and the reimbursement landscape continue to evolve.

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. As employers struggle with rising insurance costs, they are requiring employees to assume more financial responsibility for their healthcare by increasing co-pays and deductibles. This can create financial struggles for some patients, especially when they incur unexpected healthcare expenses. Increased patient responsibility is shaping patient behavior and motivating patients to select healthcare organizations that create a positive patient experience in both clinical care delivery and financial management.
By pairing reliable data with advanced analytics, organizations can use existing information to transform current processes and strengthen financial viability.

Three opportunities: patient access, claims and contract management, collections

When designed intentionally, a data-driven revenue cycle can overcome these roadblocks because it builds and sustains margins while improving performance, care quality and the patient experience. By pairing reliable data with advanced analytics, organizations can use existing information to transform current processes and strengthen financial viability. Instead of cutting costs, organizations can evaluate revenue cycle activities through a data-focused lens and identify possible improvements that could yield efficiencies. The following three areas are well-positioned for this approach:

**Patient access**

Patient access is the initial gateway to improved financial performance as well as enhanced patient safety and satisfaction. Correctly capturing and analyzing patient data at the initial point of care ensures downstream clinical and financial benefits.

Patient access incorporates many different activities, including patient identification, insurance verification, financial planning and up-front patient payment collections. Some specific ways data can help bolster the revenue cycle during patient access events include the following:

- By consistently and correctly identifying patients at the outset of the patient encounter and thereby reducing the risk of misidentification, an organization can elevate patient safety. The risks of potential fraud and identity theft also go down.
- Verifying insurance benefits and coverage before the patient arrives or at the point of service can reduce claims issues on the back end, such as denials due to lack of insurance or incorrect information.
- 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. At the same time, patient satisfaction grows because of the more compassionate approach to collections. Consider the organization that achieved an 85 percent collections rate for pre-service collections by providing printed patient estimates in English or Spanish. This in turn increased its financial counseling collections by $5 million annually and trimmed patient bad debt to just 1.1 percent of total charges.
- 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. Using data and analytics, one organization identified more than 4,000 accounts that qualified for financial assistance across 10 months, representing $2.7 million. By transitioning these accounts to financial assistance programs, the organization saw fewer A/R days, improved reimbursement from previously unidentified sources and reduced bad debt.
- 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

The number and complexity of payer contracts continue to grow, which not only increases the amount of time required to file claims, but also creates a challenge for healthcare staff when negotiating contracts. Analytics tools can be used to scrutinize payer proposed contract terms against an organization's actual mix of services and can help identify new service line opportunities for enhanced financial performance. The resulting information provides a clear picture of the effect of proposed contract terms and provides leverage during contract negotiations.

Analytics tools can also work with an organization's existing data to automatically review claims before submission and compare them with payer requirements, kicking out claims that have errors or need further information and allowing an organization to make corrections. Sometimes referred to as claims scrubbing, this process can help an organization avoid costly delays in processing and payment receipt.

Evaluating existing data can also allow an organization to manage denials and underpayments more effectively, examining patterns and identifying opportunities for improvement. Better denials management means increased efficiency in collecting funds. For instance, one healthcare organization improved the recovery rate on denials from 47 percent to 97.7 percent by using data and analytics that automatically compared the amount received for the claim with a contracted amount.

Collections

One of the dangers of the cost-cutting legacy management strategy discussed earlier occurs when staff reductions are not counterbalanced with process improvements that increase efficiencies and enable remaining staff to work smarter. An organization pursuing this kind of strategy may need to rely on external collections agencies to handle overflow work, which can oftentimes be more costly than a well-organized and sufficiently staffed internal collections process.

To improve internal collections efficiency and profitability, organizations can engage in several efforts. For example, they can 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.

Moreover, an organization can use data and analytics to segment accounts that share demographic and financial profiles, rather than simply looking at balance amounts and number of days open. Organizations can define a segment’s likelihood of payment by scoring payment and consumer data and stratifying the likelihood to pay. Armed with this information, organizations can develop tailored, patient-focused collections strategies and prioritize workflow, optimizing staff time.

Consider one health system that for years sent letters, called patients and assigned accounts to an external collections agency at the same point in time for all accounts. Today, the ability to segment more accurately results in different strategies for each group.
For example, hospital accounts in the segment most likely to pay and with a smaller balance do not receive a telephone call until day 75, and they are not referred to outside collections until day 210. Accounts in the segment with the lowest probability of payment and the highest balances, however, receive automated telephone calls beginning on day 21 and are assigned to outside collections agencies on day 79.

On average, collections in high-scoring segments exceed 70 percent and collections in low-scoring segments average 1.5 percent to 2 percent. By focusing on high-scoring accounts, an organization can reap the greatest return on investment.

Segmentation also provides clarity around the decision to route accounts to designated internal staff or collections agencies. In addition, robust data can highlight collections agency performance and provide insight into which agencies are delivering the most return on which accounts. It can also reveal where agency consolidation or internal support could yield stronger collections results. Take one organization that leveraged data to segment accounts and examine collections agency performance. As a result of its efforts, the organization now handles 99 percent of all accounts internally — reducing agency fees by $80,000 to $100,000 per month.

Data can also focus communication strategies to improve collections. Based on an account’s segmentation, different communication timing, tools and frequency may be employed. In addition to improving collections, this targeted communication approach enhances the patient experience. One health system saw an 88 percent decrease in customer complaints per month simply by learning more about patients’ financial situations earlier in the cycle.

Embracing the data
Capitalizing on the wide expanse of data already available to transform the revenue cycle requires an organization-wide shift in mindset. Healthcare organizations must commit to using data and analytics to identify opportunities to create efficiencies and ensure profitability. Just as the clinical side of healthcare has become heavily reliant on data, analytics and outcomes, so too must the business side move to this data-driven approach to minimizing risk and boosting performance.

The trends toward more stringent reimbursement rates and greater patient payment responsibility are sure to continue. Healthcare organizations that view the revenue cycle through a data-enriched lens can weather these trends while streamlining patient access, claims and contract management and collections processes. As new payment models evolve, a data-empowered revenue cycle can lay the groundwork for success, not only elevating revenue, but also enhancing the patient experience and fostering consumer loyalty long into the future.
financial performance redefined

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