EXECUTIVE INSIGHTS

RESILIENCY + RECOVERY

AUTOMATING AND STREAMLINING THE CLAIMS MANAGEMENT PROCESSES

Financial stability strategies amid workforce shortages and reimbursement roadblocks

American Hospital Association™

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Automating and streamlining the claims management processes

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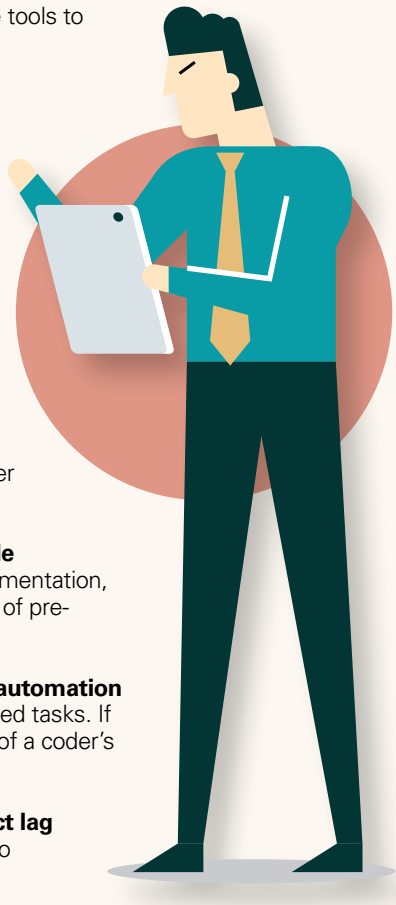
Claims denials, inefficient workflows and a changing payer landscape all contribute to delays in patient care and cash flow slowdowns. From overwhelmed staff to bottlenecks in claims processing, health care leaders are strategizing on how to improve organizational performance and increase patient satisfaction. The future of revenue cycle management relies on process optimization and technology to alleviate the impact of workforce shortages and additional payer requirements. Analytics and detailed performance data can pinpoint where processes are missing the mark and need to be adjusted. This executive dialogue explores how health care organizations are evaluating and refining current processes and creating an improvement plan to ensure the financial stability of their health system and access to care in their communities.

9 STEPS health leaders are taking to improve financial stability

1. **Engage and develop the revenue cycle team to be consumer-centric** as part of the patient experience and implement data-driven metrics so they understand the impact of their work.
2. **Track payer changes and reimbursement accuracy with smart dashboards** that send alerts for follow-up care and use these tools to make sense of the data and set work priorities.
3. **Meet with payers to review analytics** and challenge them on how quickly they pay based on billed charges and reimbursement, not on claim volume which may be as much as 20% of claims that are 80% of your dollars.
4. To decrease denied claims, **put more claim checks on the front end** and use claim scrubbers to verify that CPT codes are accurate.
5. **Look at first-pass denials** — know the reason for them and build edits — to impact your clean claim rate, improve accounts receivable and decrease work on the back end.
6. **Use denial analytics** to drill down into location, provider and service by CPT codes to see trends and patterns for better accounts receivable performance and patient experience.
7. **Optimize the electronic health record from a revenue cycle standpoint** and use integration tools for more accurate documentation, and capture costs in a more streamlined manner. Get in front of pre-authorizations and reschedule appointments if needed.
8. **Start using artificial intelligence (AI) and robotic process automation** for mundane tasks to free up staff time to do more complicated tasks. If working with an AI vendor, only pay for results at about 50% of a coder's time to do the work.
9. With revenue processes, **examine lead measures that affect lag measures** and develop a weekly and monthly plan of action to improve those numbers.



PARTICIPANTS

Carolyn Heithaus, MBA
/ EXECUTIVE VICE PRESIDENT OF FINANCE AND CHIEF FINANCIAL OFFICER
CALVERTHEALTH | PRINCE FREDERICK, MD.

Marina Houghton, CPA, CGMA, CVA, CFF, FHFMA
/ VICE PRESIDENT OF FINANCE
ASCENSION MICHIGAN | WARREN, MICH.

Tammy Nadler, CPA
/ CHIEF FINANCIAL OFFICER
GOLDEN VALLEY MEMORIAL HEALTHCARE | CLINTON, MO.

Kaley Neal, MBA, FHFMA, CHFP
/ CHIEF FINANCIAL OFFICER
SHENANDOAH (IOWA) MEDICAL CENTER

Summer Owen, MBA, CPPS
/ CHIEF FINANCIAL OFFICER
GREAT PLAINS HEALTH | NORTH PLATTE, NEB.

Stan Salwei, MBA
/ DIRECTOR OF REVENUE CYCLE
ALTRU HEALTH SYSTEM | GRAND FORKS, N.D.

Danielle Willis, CPA, MPA
/ CHIEF FINANCIAL OFFICER / CHIEF ADMINISTRATIVE OFFICER
NEW ORLEANS EAST HOSPITAL-LCMC HEALTH | NEW ORLEANS

Lori Zindl
/ VICE PRESIDENT, BUSINESS DEVELOPMENT
INOVALON | PEWAUKEE, WIS.

MODERATOR Suzanna Hoppszallern
/ SENIOR EDITOR, CENTER FOR HEALTH INNOVATION
AMERICAN HOSPITAL ASSOCIATION | CHICAGO

FINANCIAL STABILITY STRATEGIES AMID WORKFORCE SHORTAGES AND REIMBURSEMENT ROADBLOCKS

MODERATOR *(Suzanna Hoppszallern, American Hospital Association):* **Where are your revenue processes missing the mark and what lagging key performance indicators are top of mind to address?**

STAN SALWEI *(Altru Health System):* The No. 1 metric that we are struggling with is accounts receivable (AR). We typically saw improvement on this metric over the years until COVID-19, but now globally we're seeing payers increasing denials for additional documentation or information that doesn't meet their medical necessity and/or prior authorization guidelines. Overall, we were seeing about a 9.54% increase in hospital AR and on the professional side, 7.22% from other years. Finance, accounting and bondholders focus on this key metric.

We have to use analytics to identify denial trends and patterns because the amount of rework going on in the back end is unsustainable — drilling into location, provider, service by Current Procedural Terminology (CPT®) code.

With revenue processes, we're trying to focus more on lead measures that affect lag measures and how we can incorporate more of a weekly and monthly plan of action to improve those numbers instead of seeing the results at month-end.

DANIELLE WILLIS *(New Orleans East Hospital):* Our immediate issues have been denial management, specifically related to authorizations.

TAMMY NADLER *(Golden Valley Memorial Healthcare):* Right now, we're struggling with denial management. We are using an outside consultant to help us look at our processes. Clearinghouse is showing our clean claims are approximately 95%, but on the back end our denials are about 22%, which is super high. We need to put more claim checks on the front end. In addition, we've been working with a vendor to start using artificial intelligence (AI), so robots do some of the mundane tasks to free up our staff for more complicated tasks.

MODERATOR: Tammy, what criteria did you use to select the AI technology vendor?

NADLER: We currently have two AI vendors, with one only getting paid for what they execute, and the other is a flat monthly rate, regardless of how many processes we have the bot perform. To calculate payment for executed tasks, we calculate the average hourly rate and benefits along with time staff spends to complete the task and then pay the vendor 50% of that amount. We do that on a monthly basis, and only pay on what's executed. So, if the bot has three tasks to complete the project or deplete the item and they get to No. 2 and run into a hiccup and can't complete it, we don't pay anything.

We've been doing this for about nine months. From personal experience, you don't want to pay a lot up front because it's a slow process. We're getting ready for a priority pack update on our electronic health record (EHR), and with every update you have to test the bots. There's a heavy up-front lift when you start a bot project. One AI project with our prior authorization team has reduced their time by 35%.

LORI ZINDL *(Inovalon):* I love your contract negotiation on the AI and only paying for results. We're starting to see lawsuits because some vendors didn't deliver what they promised.

CAROLYN HEITHAUS *(CalvertHealth):* What concerns me most right now is our days in AR. It's driven by commercial payers and the medical documentation that they're asking of our teams and the repetitions payers require to work through what is considered a clean claim. We use our scrubbers to make sure that we have clean claims. We too have asked: 'Can we just send the itemized bill and claims with the packet? Do we just get away from electronic billing the way we know it?' But the payers don't want that. We get a quarterly delay in cash. We can add about three days within a quarter just because

payers slow down the process.

MARINA HOUGHTON *(Ascension Michigan):* We're trying to get in front of those pre-authorizations and make sure that we're rescheduling appointments if necessary. We're making sure that we tighten down the front-end processes.

SUMMER OWEN *(Great Plains Health):* Top of mind is optimizing our EHR for revenue cycle workflow and resetting to best practice. We are struggling from a key performance indicator (KPI) standpoint. We don't have a claims scrubber on the professional side, which we are slated to implement in 2024. That will help us across the board.

Everyone is struggling to staff their revenue cycle right now. I've spent the last year focused on recruiting talent. We're turning our attention now to developing our team and implementing some data-driven metrics, so they understand how their work is affecting the overall revenue cycle.

KALEY NEAL *(Shenandoah Medical Center):* Our biggest focus right now is on our revenue cycle. We've definitely seen an uptick in denials.

ZINDL: I heard the word clean claim about six or seven times, and it's one of the most frustrating KPIs to me because EHRs have it on their dashboards. All the clearinghouses talk about their clean claim rate. What providers say is that a clean claim doesn't really matter, does it? It's what the payer says is a clean claim. Payers have to pay a clean claim within 30 days, but what's their definition of clean? That's what they don't share.

With our customers, I don't focus on the clean claim; I focus on first-pass yield. That's the percentage of claims getting paid on first submission because that's the clean claim rate of the payer, what they're paying. Focus on first-pass yield, and then find out what the first-pass denials are. Our tool was peer-reviewed by the Healthcare Financial Management Association (HFMA) about three years ago, and right after that, HFMA added first-pass denials to their metrics. Looking at first-pass denials is important: knowing the reason for them and building those edits. By doing this, you end up impacting your clean claim rate. If you build edits into your system because of the denials and get it right the first time, cashflow is good, AR is good, timely payment is good and you don't have to pay people on the back end to follow up, especially with the staffing shortages.

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— Lori Zindl — Inovalon

MODERATOR: In the face of ongoing workforce shortages, what are some of the processes you're implementing that are helping with workforce frustrations and ultimately, drive patient satisfaction?

OWEN: To maximize nursing resources on the inpatient side, we're scrutinizing the administrative tasks that we ask nurses to do. We've bundled many of our chargeable supplies into the room charge. As a result, our nurses aren't spending time charging those out; they go into the supply room and get what they need to take care of patients. Charging an inclusive rate has helped us on the back end by reducing cumbersome payer audits and supply charge denials. We're also looking at moving to charging through documentation in some of our procedural areas to remove the burden of revenue cycle for our clinicians.

On the revenue cycle side, we are working on optimization of our EHR as well. The goal is to get highly transactional low-judgment tasks automated. For our experienced staff with deep revenue cycle

expertise, we're focused on having them manage denials and payer workflow issues. Through our EHR consultant, we've been able to obtain good data and trends out of the system and are excited about the progress we're making.

SALWEI: We're reviewing our top priorities because if you have too many, you can't accomplish them. We're looking at how to work differently and using bots, but we found that there's an opportunity to utilize our EHR system more efficiently by turning on capabilities or using them correctly. To improve the patient experience and be more consumer-centric, we educate our revenue cycle staff that they are part of the patient experience even though they're not caregivers. From beginning to end, they can make a positive difference in the patient experience.

Patients can have a great experience with their provider, but if their bill is wrong, then their experience can go south on them and us. Health care is like an assembly line much like the auto industry where the complete package of services ends up being that product. It's the same for the revenue cycle — scheduling, registration, admitting, seeing the provider, having surgery, follow-up care and processing the bill until the claim is paid in full.

ZINDL: Let's go back to the patient experience and denials. If AR is too high, it's because payers are denying, delaying or asking for more information on claims. Denial analytics is important to AR performance, but it's also important to the patient experience. If a patient gets a denial on a medical necessity, the explanation of benefits (EOB) goes to the patient. When the patient sees medical necessity on the EOB, it may not reflect well on the provider if the patient thinks these services are not medically necessary.

NEAL: Being in rural Iowa, we invest a lot of time training staff from the ground up. We use macros and automation on the back end, especially with newer staff coming in.

NADLER: We're from a rural area as well. To attract nurses, we've started a stipend program. We talk with high school students who are interested in nursing and offer a monthly stipend to continue their education in exchange for a work commitment. If they have a family, and there are a lot of single moms in our community, they're able to go to school and still put food on the table. Each year of school increases their work commitment. We've rolled the program out to imaging, ultrasound, respiratory therapy, physical therapy and occupational therapy. We've been doing this now for three years and, at this point, it's competitive. We have allotted stipend

slots, and we're letting the directors advocate for them. Overall, it's been successful, and we use that in lieu of our sign-on bonuses for those positions.

MODERATOR: How effectively is your organization ensuring compliance with changing regulations and reimbursement policies while maintaining operational efficiency such as with price transparency?

HEITHAUS: It's a challenge. We are more comfortable with our awareness and our reaction to compliance with Centers for Medicare & Medicaid Services (CMS) regulations than with other payers, whose notifications of changes are not always distributed consistently into the organization.

CMS contacted one of our hospitals about pricing transparency because it could not find the information on our website. After a review, CMS made some recommendations, and we made updates to our data and passed. Pricing transparency in Maryland is different, partly because we are rate regulated. All hospitals in Maryland accept the same percentage charges from each respective payer, so putting in contracted rates is challenging.

ZINDL: The payer regulations are changing daily. I've seen denials jump on a dashboard because a payer changed a rule. From the reimbursement perspective, you need analytics and smart dashboards to track payer reimbursement accuracy on claims and to send alerts for follow-up. Tools can help us make sense of data and prioritize what we need to work on.

MODERATOR: What strategies and steps are you employing to optimize the revenue cycle and improve financial performance?

SALWEI: Analytics is the key to prioritizing and making risk-informed decisions versus assumptions. When you have the numbers in front of you, discussions with the chief financial officer (CFO) and the executive team can drive an initiative.

NADLER: I'm trying to get a billing statement for all generations that is easy to understand and consumer friendly for payment. Our current statements are hard to understand, so we're using an external vendor to improve the process. You will be able to get our new statements by email, text or regular mail.

"Think about how many people want to use Apple Pay, Venmo and Zelle. Our EHRs and other systems are challenged by all of these tools. Many of my CFO colleagues are worried about accepting these and what it may open up from a cyberrisk standpoint."

— Carolyn Heithaus — CalvertHealth

HEITHAUS: Think about how many people want to use Apple Pay, Venmo and Zelle. Our EHRs and other systems are challenged by all of these tools. Many of my CFO colleagues are worried about accepting these and what it may open up from a cyberrisk standpoint.

SALWEI: First, the revenue cycle must be consumer-centric because we are part of the patient experience. Second, we need to become more insightful on the clinical side of operations to know if orders are causing denials. Third, focus on rework. It requires collaborating and communicating with front-end areas on the trends and patterns we're seeing on the back end that are fixed account by account. From a lean perspective, go to the origin of the problem when there's a pattern, and talk and work through it together. Fourth, use external data to help make informed decisions, not just what's in your own EHR. Lastly, roles and responsibilities are going to change and integrate where we're working together. I still see a lot of silos and that can't be moving forward.

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