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How to get a handle on Medicare bad debt

By Jonathan Wiik

Medicare bad debt is a significant source of revenue leakage for hospitals and often is not adequately addressed.

Revenue cycle technology Deciding whether to build or buy robotic process automation systems	3
Revenue cycle operations Patients, employees and technology lead revenue cycle transformation	5
Coding Q&A Know your denials challenges before developing prevention strategies	7
Figure at a glance Consumer-oriented services necessary for healthcare providers to maintain patient loyalty	8

How to get a handle on Medicare bad debt

Jonathan Wiik

Each year, hospitals claim more than \$3 billion dollars in Medicare bad debts on their cost reports, representing about 15% of Medicare recipients' out-of-pocket responsibility, CMS reports.

Healthcare is becoming increasingly unaffordable to many, and patient bad debt is an escalating issue. Although many people struggle to pay for healthcare, the issue is particularly prevalent among Medicare beneficiaries, who are often retired and on a fixed income.

Consider that patient financial responsibility represents more than 30% of a hospital's annual revenues, primarily because of expanded numbers of patients having high-deductible health plans. (*DARK Daily*, Sept. 22, 2017).

Each year, hospitals claim more than \$3 billion dollars in Medicare bad debts on their cost reports, representing about 15% of Medicare recipients' out-of-pocket responsibility (Cost Reports HCRIS data, CMS.gov). This is a significant source of revenue leakage for hospitals, one that is often inadequately addressed.

Medicare bad debt is defined as Medicare coinsurance and deductible amounts that are unpaid and uncollectable from the patient.

The Centers for Medicare and Medicaid Services (CMS) pays hospitals 65% of their gross Medicare bad debt if the documentation is in place to demonstrate appropriate collection efforts and the patient's inability to pay (*Acute Care hospital inpatient Prospective Payment System*, CMS.gov, February 2019).

The Notice of Program Reimbursement (NPR) is the finalization of the cost report and occurs after a Medicare Administrative Contractor (MAC) audits and/or reviews the cost report submission. Hospitals have three years from the date of the NPR to ask the MAC to re-open the cost report for further reimbursement or correction of errors. MACs can deny this re-opening

request at their discretion. The current trend is that many MACs are denying re-opening requests.

Challenges collecting Medicare bad debt

Recovery of Medicare bad debt is a significant revenue opportunity for many hospitals. However, CMS has stringent rules and reporting requirements to realize this revenue. To accurately and efficiently identify accounts and dollar amounts eligible for Medicare bad debt, large amounts of complex and disparate data sets need to be aggregated. Unfortunately, many hospitals lack the internal resources and technology to correctly determine eligible Medicare-bad-debt payment, or they rely on inaccurate internal reports. As such, hospitals spend a lot of time *manually* identifying accounts.

Recovery of Medicare bad debt is a significant revenue opportunity for many hospitals. However, CMS has stringent rules and reporting requirements to realize this revenue.

If hospitals are under-claiming relative to their peer groups, they are likely leaving money on the table. Internal reporting processes are highly dependent on accuracy of financial transaction data obtained from the patient accounting system. Although many hospitals struggle with inconsistent

Mary Mirabelli

Senior Vice President, Content Strategy and Delivery

Brad Dennison

Director of Content Strategy

Betty Hintch

Senior Editor/Content Project Manager

Deborah Filipek

Content Editor

Linda Chandler

Production Specialist

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Deciding whether to build or buy robotic process automation systems

Andrew Woughter

Consider a partner's automation expertise and its ability to learn organizational processes.

Robotic process automation (RPA) is expected to have a transformative impact on revenue cycle management in the next few years, automating much of the rudimentary tasks in healthcare while also improving efficiencies and reducing costs.

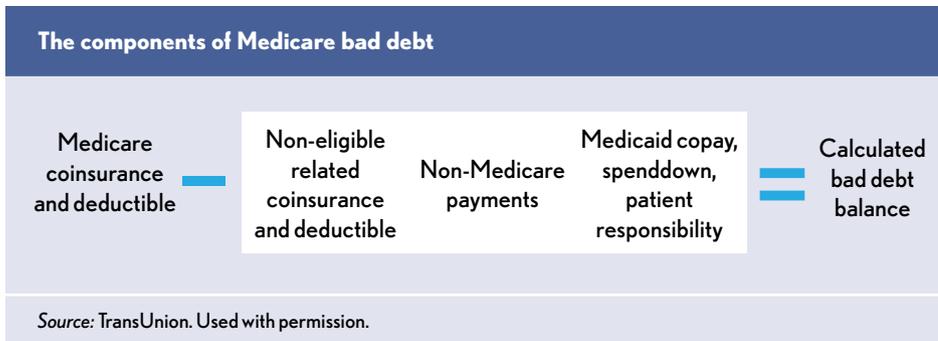
The trade-offs between a home-grown approach to RPA versus contracting with a supplier to deploy RPA is something every provider should consider. But first, healthcare organizations should define their automation needs and understand the critical impact of regular maintenance.

What can RPA do?

First, it's important to define what RPA can do so revenue cycle leaders can determine what processes will be automated. This is one of the most common questions regarding RPA. It is sometimes easier to explain what RPA can't do. Because RPA is a digital software, the most obvious limitations are any steps in a process that exist outside the digital world. If a physical object must be handled, then RPA isn't the right tool. Humans or physical robots are required.

However, many non-digital processes can be modified to enable automation. This includes processes that require printing documents or receipt of physical paper. Once items are scanned into the digital world, RPA can start having an impact.

Some specific ways to apply RPA within revenue cycle processes include the following:



and inaccurate data, adding a technology-driven process can help address this problem.

Take a holistic approach

When tackling uncompensated care, specifically as it relates to Medicare bad debt, it is important to address the problem holistically, to ensure all your earned revenue is realized. Sophisticated analysis of all the relevant data must validate the thousands of opportunities. This can be a burdensome process, detracting from the primary goal of the billers and follow-up team to ship out claims and audit reimbursement. It is critical to evaluate assistance from third parties in this process in order to help free time for revenue cycle management staff to focus on other important issues. Cost report filing time is stressful for reimbursement departments, but external software and consultation can off-load weeks or even months of work.

4 considerations before determining a solution

When evaluating a buy-versus-build approach in this area, here are some considerations:

1. Review internal efficiencies: Partners in this space can typically yield a ~20% increase in recoveries beyond a hospital's internal efforts. Closely evaluate whether the revenue cycle team has the bandwidth to take on another project to capitalize on missed revenue. Both fully outsourced service and software as a service (SaaS) options are available.

2. Analyze the data: Examining accounting and transaction codes should provide an in-depth analysis to find bad debts that are payable but may have been missed. Consider having an outside partner analyze the data, which may uncover missed or previously unknown opportunities.
3. Determine crossover bad debt: Ensure a sophisticated regressive analysis is used to match the information from Medicare claims against state Medicaid paid claims to determine which cross-over bad debts can be claimed as Medicare bad debt.
4. Secure defensible documentation: Medicare doesn't like giving money back, so reports need to be defensible on audit. Ensure the process delivers results with the full documentation required for submission to Medicare.

Hundreds of millions of dollars of unrealized Medicare bad debt revenue can be recovered at scale if reporting and analysis are performed efficiently with automation — whether via a fully outsourced consulting service or by using a SaaS solution. Recoveries can be close to a half a million dollars per provider (TransUnion Healthcare proprietary data).

To a hospital, every dollar of payment means a better opportunity to deliver excellent patient care. By finding the right partner and tools, hospitals can accurately and efficiently recover Medicare-bad-debt revenue. The money is waiting — go get it. •

Jonathan Wiik

is principal of Healthcare Strategy at TransUnion Healthcare, and is a member of HFMA's Colorado Chapter (jonathan.wiik@transunion.com).

What exactly is robotic process automation?

When deciding to build or buy robotic process automation (RPA), healthcare providers must first have a clear understanding of what it is, and what it can do. In simple terms, RPA software enables users to configure or train a robot to emulate the actions of a human being within a process by interacting with other digital systems through user interface and other application controls.

RPA is commonly used for repetitive, simple rule-based tasks however this is a very limited interpretation of it. The robots that can be built with today's technology can be governed by business logic and structured inputs, as well as artificial intelligence to manage complex processes with significant decision-making abilities.

Because terms and their definitions are not standardized within the RPA industry, it is helpful to describe what is meant by the term *robot* or *bot*. A robot is the collection of RPA software components that automate a single defined process. In other research, the term robot may be used to describe the machine that runs automations which could be multiple processes. Within revenue cycle management, a bot typically is used to complete a defined process.

- > Work claim denials
- > Preventing claim denials
- > Managing authorizations
- > Triggering inpatient notifications
- > Eligibility research
- > Working billing edits in claims' scrubbers
- > Managing most cash posting functions
- > Managing lockbox correspondence
- > Validating underpayment flags on paid claims
- > Managing initial claim attachment processes
- > Monitoring governmental eligibility changes
- > Identifying correct payer/plan code selection at registration
- > Loading large data files into systems when no direct interface exists

With such broad use cases for RPA, it is easy to see why significant ROI can be achieved with the deployment of bots. At nThrive we have experienced more than 900% ROI on labor cost savings by deploying a bot to automate and work certain claim denials. A rule of thumb is to deploy bots when the full payback period is less than 12 months. With such financial benefits and so many places to start, it is easy to get excited and just want to build bots right now. However, there are risks that need to be considered before jumping headlong into RPA deployment.

Don't overlook maintenance

The biggest factor organizations overlook with RPA initiatives is the fact that bots require maintenance. A bot works on existing systems and websites, and when the underlying systems change, the bot must be re-trained based on the changes.

Some use this as a reason to dismiss the use of RPA. This seems to be the equivalent of suggesting that people should not buy cars because cars require maintenance and can break down. Instead, people should just walk everywhere? If organizations fail to have a plan to address RPA maintenance requirements, they likely will find themselves with a broken-down bot eventually. However, there are several ways to mitigate the impact and cost of maintaining bots.

A much less talked about risk with RPA is complacency with the current process. Providers must not let themselves simply take a bad process and just do it faster. Processes should be evaluated and optimized for an automated environment without resource constraints. It is likely that an organization's current processes are not as efficient or effective as they could be because they were developed in an environment with constrained resources. These organizations only work the way they do now because that was the best they could do before automating processes.

Once the process is automated, it is also just as important to have a plan in place to

regularly determine and implement underlying process improvements.

Build or buy?

The most obvious benefits to the do-it-yourself (DIY) approach to RPA is a lower initial cost. However, if organizations are not careful with this approach to RPA, it can result in higher maintenance costs that may make it worth working with a partner.

Although any organization can license an RPA platform and train/hire a team of engineers to build bots, the idea that organizational leaders know their processes better than anyone often leads to the idea that they should directly manage the development of bots. Why? It allows organizations to emulate their processes, with access to their own data, systems and infrastructure. That sense of control and protecting access is a driving factor for many organizations who take a DIY approach to RPA. Ownership of the intellectual property for the deployed bots is another benefit of a DIY approach.

Deciding to work with an RPA partner has its benefits as well for healthcare organizations. When taking on a new initiative, especially a complicated one, it is necessary to honestly evaluate existing capacity and organizational capability.

Most partners have developed expertise in RPA and can provide lessons from both failure and success to make the RPA initiative as smooth as possible. However, providers must consider the partner's level of expertise and knowledge, not only of RPA but also the organization's processes. For example, do providers want to be explaining to their partner what an 837 transaction set is or an 835 electronic remittance advice is or the value of the code?

An ideal partner understands the details of the organization's processes to optimize them prior to automating. Any RPA partner can document the steps taken to appeal a denial, but the right partner can leverage RPA to prevent denials in the first place.

What else should providers know?

Providers must understand their existing strengths, evaluate what they are willing to

invest and have a strategy to use RPA as an innovative tool to transform their revenue cycle processes. If any of those areas is not 100% clear, an RPA partner can help begin the RPA journey and get the provider moving more quickly. An RPA partner can also help the organization's technology team reach a stage where they can develop bots on their own. Ultimately, the key to successfully integrating bots into the revenue cycle could well be a hybrid approach.

One thing is certain, the robots *are* coming. Choosing to ignore them and continuing with labor-intensive processes that can be automated to improve efficiencies and reduce costs, could cause healthcare organizations to struggle in today's highly competitive healthcare market. •

Andrew Woughter

is senior vice president of product strategy, nThrive, and is a member of HFMA's Southern California Chapter (awoughter@nthrive.com).

Patients, employees and technology lead revenue cycle transformation

James Logsdon

Break away from antiquated workflows and processes and update your infrastructure to exceed expectations on all fronts.

Revenue cycle is an intricate balance of delivering an exceptional experience that patients demand, while preserving the financial integrity that drives success.

What better way to remain in a state of equilibrium than breaking away from antiquated workflows and processes and updating your infrastructure to ensure you exceed expectations on all fronts.

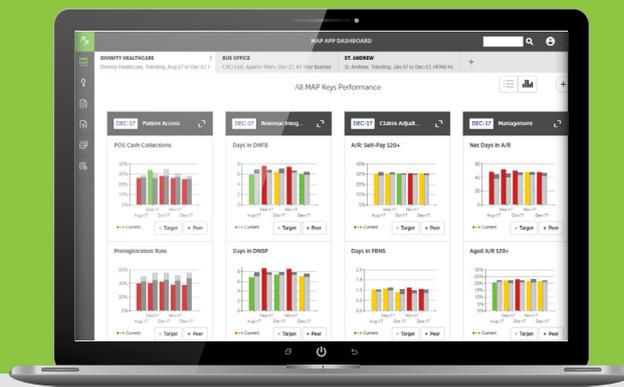
The modern patient expectation is convenient access, a seamless process and a patient-centric experience. And, if it's not, they take to social media and other public outlets to share their interactions.

A patient may have had an amazing experience throughout their entire stay, but if they have a frustrating experience with their bill post-service, they'll remember the hospital negatively because revenue cycle management does have a major impact on the overall patient experience.

We have to make ourselves easy to do business with — whether that is internally, with the processes we implement, down to the people we employ, and externally, from ease of information to how we treat patients. Because, at the end of the day, healthcare isn't just treating an illness or injury — it's about helping a patient



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navigate through maybe one of the hardest times of their life.

Putting people first

An organization's mission should be at the center of everything it does. You should remain true to your core while also making attempts to satisfy your patients and your employees.

Investing in your most important asset—your people. Investing in your employees is investing in the future of your company. Employees underperform or leave their jobs when they do not feel engaged, and that is at the expense of your patients. Use the following strategies to stay in touch with employees.

Frequently check-in to stay aligned. Providing your employees with real-time, constant feedback is key to open lines of communication and preventing misunderstandings. Invest in software that is a one-stop-shop for PTO requests, performance reviews, skills training and the ability to manage people up through publicly displayed compliments.

Offer up the ability to work remotely.

Allow your employees to work-from-home when it makes sense. The modern workforce is increasingly mobile, and it allows you to attract top talent outside of your geographical area. It frees up valuable real estate, improves productivity and most of all, it boosts employee retention.

Provide income stability through daily pay.

Financial stress can impact employees' performance. Employees experiencing unexpected financial hardship are trying to navigate taking out loans, tapping into their 401K or filing for bankruptcy. Give your employees the option to sign up for daily pay or cash advancements without administrative burden or making changes to payroll.

Give recognition through gamification. Do you know the feeling of closing all of your rings, receiving awards or winning competitions on your smart watch? What

if your employees could experience that throughout the day with their colleagues? Gamification dashboards recognize employee performance immediately with views of their performance targets and benchmarks. It also provides the opportunity for micro-learning when there are areas with room for growth.

Enhance communication efforts. Offer up micro employee surveys quarterly to gauge the pulse of engagement throughout the year instead of one long annual survey. Provide routine communications such as podcasts, video messages and digital stop-light reports.

In addition to investing in your employees, you should focus on innovations that provide a frictionless, hassle-free, enhanced experience for your patients.

Humanize healthcare through concierge registration. Patient access is the front door to the hospital and the first impression on your patients. Investing in technology to make the check-in process simple and convenient sets the tone for the rest of the visit. Having a concierge greet your patients in the lobby with a tablet that can capture digital signatures, express check-in and offer a retail payment experience, demonstrates that you are prepared for their arrival and are there to walk them through the process.

Offer a robust payment portal and multiple payment plan options. Your online patient portal shouldn't just be driven by clinical need to meet meaningful use requirements. Going digital not only allows you to save millions of dollars on postage, you can enhance the patient experience by offering multiple payment plan options with a self-service approach. Also, provide visibility into all patient financial responsibilities by combining physician and hospital accounts in one location.

Survey patients after every phone call.

Surveying patients 100% of the time allows for real-time feedback to ensure they are satisfied with their experience and how their account was handled. The closer you

receive feedback in real-time, the faster you can resolve issues. Surveying software allows you to analyze data to see where areas for improvement are and if there are significant trends requiring course correction.

Workflows and technology

Lastly, incorporate analytics and process workflows into your operations for establishing KPIs and looking for areas for performance improvement.

Leverage data science for patient's likelihood of needing financial assistance. Instead of screening every patient, utilize artificial intelligence to score your patients to estimate their likelihood of qualifying for Medicaid and other assistance programs. Set targets and automate your processes to be as productive as possible.

Utilize automated dialing — within regulatory compliance. Manage multiple calls simultaneously, set rules around proper times to call and boost the productivity of your representatives with automated dialing technology. Ensure you are following Telephone Consumer Protection Act (TCPA) requirements appropriately, such as not calling cell phones without consent, especially wrong numbers, and honoring the do-not-call registry.

Analyze call performance through interaction speech analytics. Voice to text enabled analysis allows for 100% of calls to be recorded in order to spot trends, identify underlying reasons for calls, improve quality assurance programs, measure script adherence and determine training needs. The software can provide a word cloud feature to evaluate phrases and sentiment to track call trends.

Increasing revenue cycle efficiencies may seem like a major challenge, but by focusing on your employees, patients and workflows through automating and streamlining processes, you can improve patient relationships and your bottom line. •

James Logsdon

is the chief operating officer, Revenue Cycle Point Solutions Division, Parallon, and is a member of HFMA's Lone Star Chapter (James.Logsdon@Parallon.com).

Know your denials challenges before developing prevention strategies

Keith Olenik

A major challenge for revenue cycle leaders is ensuring staff are abreast of federal, state and industry regulatory changes.

Question: Our organization does not have a coordinated process to manage and prevent denials. With new regulatory demands and the steady increase in audits and denials, we're experiencing new staffing needs. What strategies can we implement to reduce denials and the detrimental impact on our revenue cycle?

Answer: Audits and denials impact revenue cycle, compliance, patient financial services, patient access, health information management (HIM), clinical documentation improvement (CDI) and physicians. Managing denials calls for a coordinated effort among all parties involved in responding to denials, particularly those responsible for documentation of medical necessity. Successful denial management and prevention strategies require the right mix of people capable of handling the process from beginning to end.

Before creating strategies to promote revenue integrity, healthcare organizations should know the core audit and denial management challenges they face.

Challenges

Denials process decentralization — when various areas within the organization receive denials and handle their own billing and coding — is a serious problem plaguing healthcare organizations today. Because decentralization is a core problem, there is a focus on the following related challenges:

- > Non-HIM staff lack the education and qualifications to understand denials and how to respond.
- > Ongoing changes to payer rules and regulations require education and

training as payers continually update coverage decisions based on their patient populations.

- > New payment methods change the denial management process and documentation requirements.
- > New staffing needs arise along with the volume of audits. Flexibility is needed to handle the influx of audit requests.
- > Release-of-information staff must understand expectations and guidelines related to protected health information.

3 abilities every coder should possess

The onus is on coders to be prepared to deal with the challenges that impact reimbursement and to provide insight beyond that required for basic coding.

Coders need to understand billing expectations, how the billing process works and how the revenue cycle is affected. Many are learning on the job through payer websites, coding guidelines and queries to the American Hospital Association (AHA) Coding Clinic.

The three abilities every coder should possess to do the job are:

1. Respond to denials based on payer regulations and documentation that supports the services being denied.
2. Make adjustments in the coding and address issues to mitigate or overturn a denial.
3. Review patterns and identify issues to determine how to move from denial management to prevention.

Furthermore, audits can involve thousands of patient records on a quarterly basis, requiring prompt response to each request, along with submitting documentation and ensuring staff availability upon receipt of the results. These burdensome tasks extend well beyond the daily responsibilities of HIM.

As healthcare organizations begin to understand what audit and denial issues they are dealing with on a regular basis, they can implement strategies to help decrease and prevent both audits and denials.

8 strategies to promote denial management and revenue integrity

As organizations make the shift to value-based payment, the following eight strategies will help create a coordinated process to manage and prevent denials as well as help promote denial management and revenue integrity:

1. Centralize the management of audits and denials under HIM to ensure consistent and timely responses.
2. Implement a rigorous tracking system to collect data and manage audits and denials.
3. Educate coding staff on the skills and competencies needed to manage the audit and denial process.
4. Establish a multidisciplinary team to participate in the response to audits and denials that require specific expertise beyond HIM.
5. Provide education regarding the payer stipulations that require preparation in advance of any audit request.
6. Develop solutions to issues that have been identified based on patterns of denials.
7. Document policies and procedures on the entire audit and denials process.
8. Consider partnering with a vendor that offers coding expertise to supplement staff and streamline coding and billing workflows throughout the revenue cycle.

Keith Olenik, MA, RHIA, CHP,

is a HIM consultant, Pivot Point Consulting (kolenik@pivotpointconsulting.com).

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• figure at a glance •

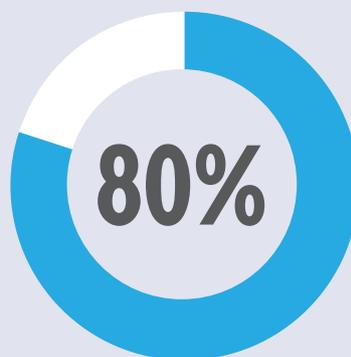
Consumer-oriented services necessary for healthcare providers to maintain patient loyalty

The healthcare industry is not immune to consumer demands for convenience. When consumers have bad experiences paying their bills, it may damage their loyalty to a provider organization. Eight out of ten patients said that lack of convenience factors would be enough to make them seek a new healthcare provider, according to InstaMed's *Trends in Healthcare Payments Ninth Annual Report: 2018*.

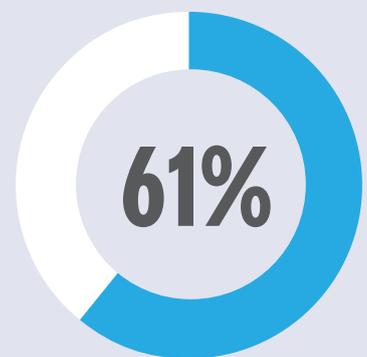
When asked specifically about payment options, six out of ten patients said they would consider switching providers for an improved payment experience.

The report is based on quantitative data, processed between 2015 and 2018, from more than \$396 billion in healthcare payments volume on the InstaMed Network. Data compiled for the survey represents more than 100,000 healthcare providers nationwide. •

Consumer loyalty hangs on convenience



Eighty percent of patients reported that convenience factors would be enough to make them switch providers.



Sixty-one percent of consumers would consider switching providers for a better healthcare payment experience.

Source: InstaMed. Used with permission.