27th Annual Revenue Cycle and Finance Conference

Building Beyond: Leading the Future of Revenue & Finance

PATH TO EFFICACY – DATA STEWARDSHIP FOR COMPLIANCE

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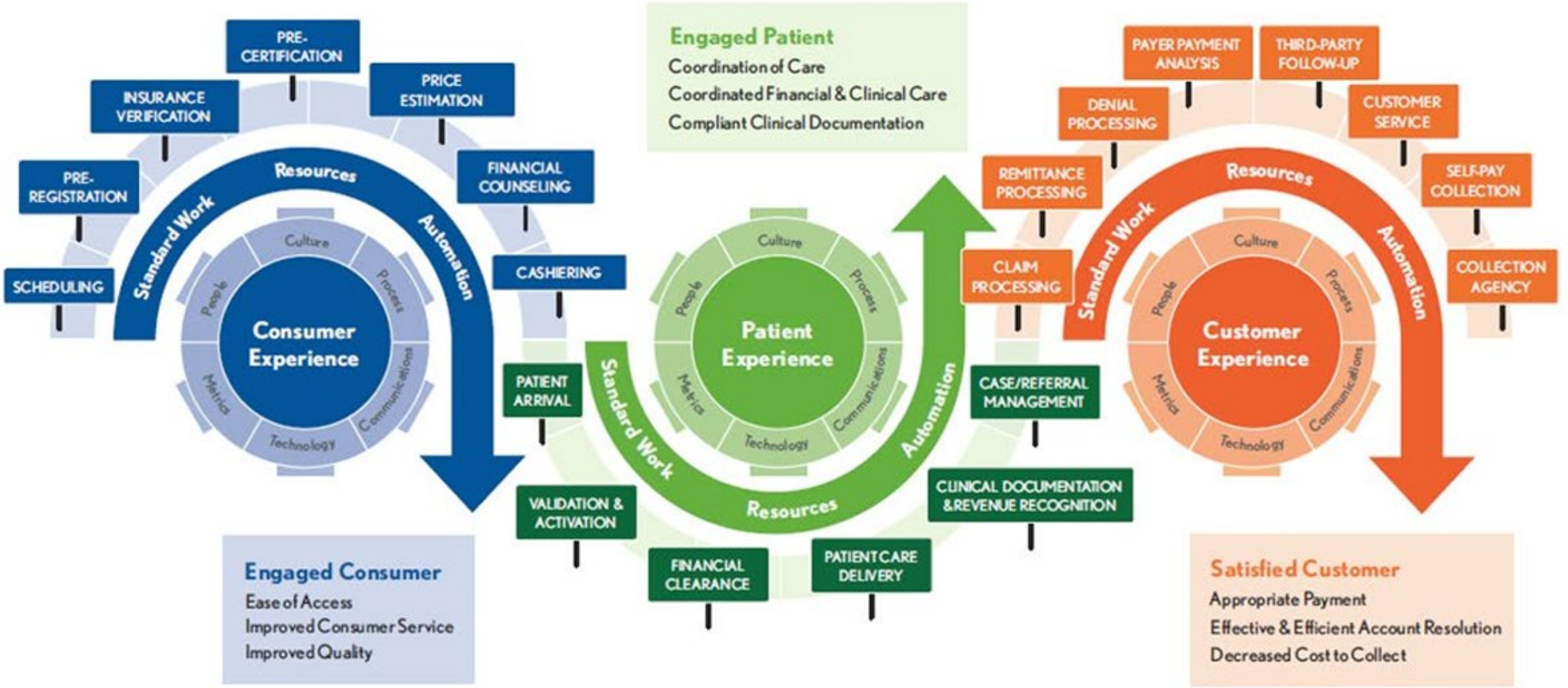
AGENDA

- Understanding Healthcare Data Sources
  - Internal vs. External Data and Their Strategic Value
- Principles of Effective Data Stewardship
  - Defining Goals, Scope, and Key Stakeholders
  - Aligning with Government Standards
- Case Studies and Actionable Insights
- Questions and Discussion

UNDERSTANDING HEALTHCARE DATA SOURCES

INTERNAL VS. EXTERNAL

INTERNAL DATA - REVENUE CYCLE MANAGEMENT



EXTERNAL DATA - PUBLICLY AVAILABLE DATA

CMS DATA SETS

- Medicare Cost Reports
- Medicare FFS Inpatient & Outpatient Claims Files
- Quality Data – HCAHPS, MIPS, etc.

Pros – Most are free, familiar formatting, contains your data
Cons – DUAs, storage, self-guided, requires refresh, training

"PAYWALL" DATA

- IQVIA
- Komodo
- Definitive Healthcare
- Kythera

Pros – Pre-aggregated, "clean", national, reportable
Cons – Pre-aggregated, cost, training, black box sources

TRANSPARENCY DATA

- Hospital Produced
- Payer Produced
- 3rd Party Vendors

Pros – Adoption rate, regulated, "click-and-download"
Cons – Training and time, storage, requires contracting experience

EFFECTIVE DATA STEWARDSHIP

DEFINING GOALS, SCOPE, AND KEY STAKEHOLDERS

PRINCIPLES OF EFFECTIVE DATA STEWARDSHIP

- **Goals – What Can Your Organization Achieve with Data?**
  - Drive efficiency and cost savings
  - Enhance compliance and mitigate legal + regulatory risk
  - Identify and address operational blind spots

- **Scope – Defining the Reach of Your Data Strategy**
  - Focus on specific services of revenue centers
  - Monitor internal performance against market trends
  - Determine the need for historical data analysis

- **Stakeholders – Identifying Your Audience**
  - Internal leadership or board-level
  - Prepare for potential government audits
  - Administrative reporting vs. clinical

ALIGNING WITH GOVERNMENT STANDARDS

- **Service-Specific Regulations**
  - False Claims Act (FCA), Qui Tam actions, Stark Law, Anti-Kickback Statute (AKS), and related compliance requirements
- **Prospective Monitoring**
  - Utilization of PEPPER reports and other predictive tools to identify risk areas
- **Reactive Monitoring**
  - Response to emerging industry trends, litigation, and enforcement actions

CASE STUDIES AND ACTIONABLE INSIGHTS

CASE STUDY 1 – FALSE CLAIMS ACT

Client A is a Hospice Care provider, with operations in multiple states. Government alleged Client A was overbilling Medicare for care, based on recertification guidelines that CMS has outlined in their policies. This is a False Claims Act case.

A false claim may be interpreted a few ways based on the matter, judge, state, etc:

1. Any claim that was falsely **paid** by Medicare; or
2. Any claim that was falsely **submitted for payment** to Medicare;

Regardless of interpretation, **there should be:**

- **Review of each alleged false claim -** determine whether each any every one of them was fraudulently submitted (internal billing and claims data)
- **Benchmarking for damages –** market rate of reimbursement for historical years, by county, state, etc. (public data)

CASE STUDY 1 – IMPORTANCE OF BILLING DATA

The following data was used to rebut claims of overbilling:

- **Client A's billing data -** sourced from several legacy systems and consolidated into one (1) centralized repository (***validation***)
  - Evaluation of each claim, whether it was submitted, the amount billed, and **write-offs**
- **Client A's patient medical records** – in "cold" storage in physical form, older records needed to be scanned in and evaluated, which was turned into a separate database to map patients to claims and assess proper documentation (***validation***)
- **Client A's Admin FTF Report –** once the claims and medical records were combined, it was then consolidated with admin reports (***validation***)
- **CMS Hospice Claims Data** (***Public Data***) – based on Client A's facilities, a repository of historical per diem rates based on care type was created (***repricing***)

CASE STUDY 1 – TAKEAWAYS

- **Data Integrity Matters**
  - Reports are only as accurate as the data feeding them
  - Quality input drives reliable output
- **Digitization is Worth the Investment**
  - Converting paper records, bills, and documentation ensures accessibility and accuracy
  - This is worth the upfront investment and burden
- **Prepare for Regulatory Requirements**
  - If there are data-driven requirements from CMS, it is in your best interest to programmatically set them up for audits and review
    - E.g., referral trackers in the PACE setting, timing for certification periods, claims data
    - Reactionary monitoring is more expensive to implement than proactive monitoring
  - Know your data and how to wrangle it before third parties get involved

CASE STUDY 2 – PAYER-PROVIDER DISPUTE

A lawsuit was filed by Hospital A against Payer B, alleging that Payer B systematically decreased reimbursement rates, in violation of their contractual agreement. Payer B countersued and alleged that Hospital A was increasing their chargemasters without notifying Payer B.

- When it comes to Payer-Provider disputes related to reimbursement, denials, etc., the contract and policies typically take center stage
- Objectively:
  - Claims data will need to be reviewed (internal and external)
  - Policies will need to be reviewed (historical)
  - Contracts will need to be reviewed

CASE STUDY 2 – COMPONENTS OF CHARGEMASTER REVIEW

In providing an objective review of the allegations and damages of both sides, the following data was relied upon:

- **Hospital A Claims Data (internal) –** while not utilized due to the presence of payer data, this was used to validate services, volume, and charges. (***validation***)
- **Payer B Claims Data (internal) –** using several years of historical data, services (DRGs, CPT/HCPCS, Revenue codes), were able to be isolated and analyzed individually for charge increases. (***repricing***)
- **Medicare Cost Report Data (external) –** while the dispute was specific to a single hospital and payer, several other hospitals that were similar (based on bed size, location, type, ownership type, etc.) were identified for comparison. (***validation***)
- **Medicare FFS Inpatient and Outpatient Claims Data (external) –** using the list of similarly situated hospitals, charges were evaluated for overlapping services. ***(validation***)
- **Transparency Data (external) –** rates were pulled for similarly situated hospitals for all other plans and services reported, such that a comparison of whether a fair-market value was set for Hospital A's services by Payer B. ***(validation***)

CASE STUDY 2 – TAKEAWAYS

- **Know your Chargemaster, Inside and Out**
  - Hospital A's changes to their chargemaster values resulted in an excess of $140 million paid by Payer B. This was an exponential impact, due to years of Payer B not neutralizing charge increases, which is a common industry practice
  - Chargemaster increases, in the aggregate, correlated with Hospital A's notification letters to Payer B
- **Identify and Understand Outlier Services**
  - 90% of the overpayment in Case study 2 was due to services that were being billed at a rate that was outside of the contracted methodology with the Payor
  - It is vital to review what percentage of services are triggering the outlier payment methodology because insurers (both private and government) scrutinize these outliers
- **Benchmark Against the Market**
  - Hospital A's services that saw an aggregate increase outpaced benchmark hospitals for the same services
  - Benchmark and ensure there is a valid business reason that your services would be charged at a higher-than-market rate

CASE STUDY 3 – PROSPECTIVE MONITORING

Client A is an RCM company that works with numerous hospitals across the country. They sought a way to proactively monitor their book of clients using available data, such that they could react and flag any instances where hospitals were behaving as outliers compared to the rest of their book of business and the market within which each operated.

This initiative was kicked off by the internal compliance team and focused on risk mitigation and monitoring.

CASE STUDY 3 – FINDING THE RIGHT DATA

To protect their clients, no internal claims data was used to set up the framework. However, the following ***external*** data was leveraged:

- **Medicare Cost Report –** through careful evaluation of a variety of factors, such as bed size, % Medicare discharges/days, urban/rural status, teaching status, etc., Client A's providers were organized into cohorts with similarly situated hospitals (national-level)
- **Medicare Inpatient and Outpatient Claims Data –** once hospitals were segmented into cohorts, FFS claims data was aggregated for DRG codes, CPT/HCPCS codes, and revenue codes
  - This was limited to overlapping procedures and services between Client A's providers and benchmark hospitals
- **Price Transparency Data –** while not ultimately pulled into the dashboard, this data was used to evaluate the rates set by Client A's hospitals against the market

CASE STUDY 3 – TAKEAWAYS

- **Leverage Public Data for Strategic Compliance Purposes**
  - Proactive flagging allowed Client A to contact hospitals and work with them to mitigate identified "red flags" (e.g., longer-than-usual length of stays for a service, significantly more units being billed, etc.)
- **Create a Scalable and Repeatable Process**
  - CMS Cost Report Data and Claims Data Files are released every year and are available historically for trending and projections (formatting stays the same)
  - Transparency Data can be pulled as often as desired, since every reporting hospital may have different dates of publishing
  - Any new providers added to your portfolio can be systemically benchmarked and grouped accordingly

Questions?

Let’s Connect!