Optum

Better financial health and improved operations

Your roadmap through 3 critical priorities

Current state challenges

Confronted by a range of financial and operational challenges, health systems across the country are struggling through the most difficult operating environment in history. With operating margins throughout health care organizations in a nearly universal deficit, burgeoning inflation, increased labor costs and staffing shortages further challenge opportunities to rebuild profitability.

Flat revenues and rising expenses have forced health system executives to look for new solutions. Fortunately, key industry investments in the areas of automation, data insights, information exchange and innovative partnerships present viable opportunities to address these factors.

Establishing positive operating margins is crucial to ensuring that health systems have the ability to serve patients and communities, attract and retain a skilled workforce, expand lines of service and preserve capital. By working with health system clients and conducting detailed research and review, we documented 3 specific areas where health systems should look to address these pain points. With strategies to address **cost optimization, revenue performance** and **clinical efficiency,** health systems can get back to what matters most – providing quality care in their local communities.

Our second volume offers a detailed review of the following strategies to improve revenue performance:

- Optimizing revenue recovery
- Achieving revenue integrity
- Succeeding in risk-based and quality-based programs

2.5%

Despite revenue increases, the median hospital operating margin heading into 2022 was slim at 2.5%, compared to pre-pandemic baselines.[1]

1. National Hospital Flash Report. Kaufman Hall. January 2022. Accessed October 2022.

Volume 2: Revenue performance

It's critical for health systems to implement changes to save on costs in the short term. But short-term solutions won't create lasting progress. To foster sustainability and mitigate vulnerabilities in the long term, health systems must also look for paths to establish appropriate levels of owed and new revenue. Faced with increasing financial strain and limited resources, health care leaders are again considering new ways to address familiar challenges, including achieving proper levels of reimbursement, writing off bad debt and successfully expanding into new service areas.

Let's take a closer look at how, and where, health systems can improve their revenue performance by **optimizing revenue recovery, achieving revenue integrity** and **succeeding in risk and quality-based programs** in new and increasingly complex operating environments.

Hospitals that cannot easily access concrete data about the scope and nature of revenue performance deficiencies are left in extremely vulnerable positions.

Optimizing revenue recovery

Every year, millions of dollars in expected provider reimbursement goes uncollected. On average, facilities lose nearly 3% of revenue due to denials, of which 90% are preventable.[2] Hospitals that cannot easily access concrete data about the scope and nature of revenue performance deficiencies are left in extremely vulnerable positions. Without a precise picture of expected and actual revenue, hospitals face avoidable financial losses under the administrative burden of identifying and remediating payment variances.

Health systems need to establish renewed priority on revenue loss and attain a better understanding of their existing revenue. To accomplish this, health care leaders should focus on:

- Denial recovery
- Accelerated cash collections
- Contract management

2. 2022 U.S. Healthcare Denial Management Market: Industry Outlook and Forecast 2022-2027 (page 43). Arizton Advisory & Intelligence. Accessed November 2022.

Denial recovery

Although the amount of final denial write-offs has decreased across the industry in the last few years, payers have become less lenient on appeals. Providers must be able to track and analyze the causes and consequences of claim denials, as well as underpayments, on revenue. Take a moment to ask, "Where are denials originating, and why are they occurring? Are the hot spots in patient access and registration, documentation, coding and billing, or utilization and case management?" By analyzing the exact causes of denials, providers can pinpoint denial contributors and address them directly.

No matter how successful an organization is at correcting the causes of denials, some will undoubtedly slip through. To minimize the impact of denials quickly and effectively, a well-tuned denial management and recovery approach should:

- Pursue every viable overturned denial
- Utilize clinical expertise
- Leverage peer-to-peer reviews
- Use technology to simplify and amplify efforts

Accelerated cash collections

High costs have consumers skipping payments or treatment, leading to increased bad debt, decreased patient volume and overall losses in revenue. To maintain a strong bottom line and accelerate cash collection, health systems must adjust their collection methods to meet the needs of health care consumers. With emphasis on open communication, accessible payment options and streamlined financial experiences, patient collections will improve while consumers will be better supported — and not left feeling confused and fed up with their health care provider.

While health systems must accommodate all patient preferences, like traditional bill pay methods, this alone is not enough. They also need to double down on digital solutions like text messaging, email and automation to make the biggest impact. It's critical that these tools are completely integrated across the patient pay experience. If each function independently, it can lead to a disjointed strategy and patient complaints. To help ease the stress around health care costs and effectively understand patient financial preferences, incorporate:

- Pre-care price estimates
- Financial counseling
- Customized payment plans

With these practices, health systems can empower patients who may not otherwise have the ability to pay.

90%

of claim denials are expected to be preventable, and two-thirds are recoverable.[2]

2. 2022 U.S. Healthcare Denial Management Market: Industry Outlook and Forecast 2022-2027 (page 43). Arizton Advisory & Intelligence. Accessed November 2022.

Contract management

Payer contracts are complex. They require considerable maintenance to ensure your reimbursement adheres to contract terms. They are also a prime area for improving performance. Regardless of whether your organization chooses to maintain its contract system and manage underpayments internally or in partnership with a vendor, there are certain capabilities that can significantly accelerate success.

Maintaining contract terms in your system requires continuous updates to complex information. An effective strategy for achieving revenue integrity incorporates contract management technology that quickly and accurately identifies payment variances based on contract terms. Without the right technology, many organizations fall behind on updates due to staff bandwidth. However, accurate contract data and automated variance detection will significantly increase collector efficiency and strengthen reimbursement accuracy.

Achieving revenue integrity

Achieving sound revenue integrity should be a cornerstone of any high-performing revenue cycle operation. However, reaching revenue integrity goals has become increasingly difficult as health systems face more challenging payer policies, reduced funding availability for revenue cycle innovation and rising complexity in value-based care.

A typical health system can risk up to 3.3% (around $4.9 million per hospital) of its net patient revenue due to claim denials.[2]

Forward-thinking health systems are creating new roles and departments dedicated to revenue integrity to bridge the gaps between clinical operations, coding teams and back-office departments. The integration of these areas can help reduce the risk of noncompliance, optimize payment and minimize administrative costs associated with resolving problems downstream.

To help achieve revenue integrity, health systems should focus on:

- Coding and clinical documentation modernization
- Government and payer policy compliance
- Utilization review accuracy

Coding and clinical documentation modernization

There are several barriers to accurate documentation — ever-changing payment models, regulatory requirements, incompatible technologies and inaccurate source data. But it's imperative to get it right upfront. Health systems rely on complete and accurate clinical documentation and coding to support revenue integrity, efficiency and quality reporting.

These complex documentation challenges require a 2-step approach. The first step lies with automated processes. Automation is vital to success so automated processes must be built on advanced, clinically aware artificial intelligence (AI) to successfully address the problem. As an example, combining clinical documentation improvement (CDI) tools with computer-assisted coding technology enables case review that identifies documentation deficiencies, gaps and potential quality events from a single platform. Second, automation must be combined with expert guidance and continuously updated clinical content, rules and guidelines. This approach drives optimal staff efficiency, prevents errors and promotes revenue integrity under changing payment models.

2. 2022 U.S. Healthcare Denial Management Market: Industry Outlook and Forecast 2022-2027 (page 46). Arizton Advisory & Intelligence. Accessed November 2022.

Government and payer policy compliance

The shifting regulatory environment creates a complex and difficult challenge for health systems. The Medicare inpatient only (IPO) list is just one example. This list identifies procedures that must be performed in the inpatient setting to qualify for coverage and payment, directly impacting revenue integrity. As a result, health systems must ensure their medical necessity and CDI processes not only accurately capture and relate clinical risk factors, but also account for conditions on this list. If IPO cases are miscategorized, health systems will experience negative revenue impact. Payer policies are equally complex. As policies continually shift, health care organizations can quickly fall out of the loop if they try to keep pace with payer requirements using manual systems alone.

Health systems can address these shifting policies by applying technology that leverages content and rules based on how payers adjudicate claims. Clinical editing technology that monitors and tracks changing payment policies, pre-screens for errors and identifies certain-to-deny claims will help support accurate reimbursement. Also, by ensuring these tools work seamlessly with your electronic medical record (EMR) system and information is received in existing workflows, staff are more efficient without toggling between systems and interfaces.

Utilization review accuracy

Medical necessity now accounts for 29% of all denials and 53% of all denial write-offs.[3] At the same time, commercial payer appeal success has dropped to 50%.[4] This changing payer landscape has made effective utilization review (UR) more important than ever. Yet value-based reimbursement requires case managers to shift their attention toward quality improvement. Excelling in both traditional UR and quality improvement requires new processes and technologies.

While UR has been done for decades, outdated solutions no longer address current problems. Hospitals need to consider effective ways of using their talent, new technologies and innovative processes to share insights to ensure UR is generating value and supporting organizational objectives. Artificial intelligence (AI) can revolutionize UR by improving efficiency and accuracy and enabling case management and UR teams to refocus their efforts on more strategic objectives.

Some of the most impactful AI application strategies include:

- Implementing case stratification using customizable sorting thresholds
- Applying AI to reduce the occurrence of unintended self-denials or gray cases
- Arming physician advisors with the technology to help make their case reviews faster and more accurate

Artificial intelligence (AI) can revolutionize UR by improving efficiency and accuracy and enabling case management and UR teams to refocus their efforts on more strategic objectives.

3. Optum internal study, 2019.
4. Commercial self-denials in this context are unrelated to self-denial obligations under Medicare relating to Condition Code 44 use and medically unnecessary inpatient admissions.

Succeed in risk-based and quality-based revenue

Most provider organizations have experience with value-based contracts and managing population health through CMS-offered value-based programs or contracting with commercial payers. Some physicians also absorb risk under the Medicare Access and CHIP Reauthorization Act (MACRA) body of regulations. The COVID-19 pandemic changed the health care landscape and forced providers to adopt certain value-oriented practices to manage throughout the pandemic.

As the health care market adjusts to a post-pandemic future, organizations who aggressively pursued risk-based contracts prior to COVID-19 and were already incentivized to focus more on primary care can continue to ride the value-based care boom. That said, systems that relied on fee-for-service payments will need to accelerate their quality strategies while also addressing any drop in volume to safeguard their cashflow.

To help succeed in risk-based and quality-based revenue, health systems should focus on:

- Care coordination
- Strategic patient activation
- Ambulatory clinical documentation improvement

Care coordination

With more than half of the U.S. adult population having a chronic medical condition, and 4 of 10 with multiple chronic conditions, it's clear that a new approach to care is needed.[7] To achieve better clinical outcomes for high-risk patients — and those with chronic conditions — health systems should reevaluate their coordination efforts to remove any potential barriers, prioritize opportunities and provide better insights. But how do health systems accomplish this? With data. However, the right data requires the right patients.

Consider creating a registry of patients sharing common attributes and apply analytics to their longitudinal health history. This will help you determine risk factors to patient health — not only the most significant, but also those risks that would benefit most from intervention. Remember, prevention also plays a critical role in chronic disease management and delivering on quality contracts and agreements. By understanding the risk factors, care teams can develop and implement a care plan using the specific interventions best suited for success.

When armed with the best care plan, you have the opportunity to evaluate outcomes, determine the effectiveness of the intervention, and further improve care coordination going forward. Set a baseline for patient status and condition information, and compare post-intervention status with the documented baseline. Use the knowledge gained from these steps to improve the way you find patients, stratify risk factors, prioritize opportunities, develop care plans and intervene with the right treatment.

Nearly

65 million

people in the U.S. will be covered under value-based health insurance plans by 2025 (McKinsey & Company).[5]

In 2020, 40.9% of health care payments in the U.S. stemmed from this model. (Health Care Payment Learning & Action Network (LAN) APM Measurement Report).[6]

5. The next frontier of care delivery in healthcare. McKinsey & Company. March 24, 2022. Accessed November 2022. mckinsey.com/industries/healthcare/our-insights/the-next-frontier-of-care-delivery-in-healthcare#value.
6. Health Care Payment Learning & Action Network (LAN) 2020-2021 APM Measurement Report. hcp-lan.org/apm-measurement-effort/2020-2021-apm/2021-infographic/.
7. Chronic Diseases in America. National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). Centers for Disease Control and Prevention. December 13, 2022. Accessed December 2022.

Ambulatory clinical documentation improvement

As procedures continue to be moved out of acute care environments and into outpatient surgical centers and clinics, health care organizations need to increase their ambulatory footprint and prioritize their documentation standards and practices.

The record of a patient encounter can look quite different depending on how efficiently clinical documentation and coding functions are performed. These 2 processes help capture the true health of patients — a vital step in properly reporting quality measures to succeed under value-based models. A simple omission or discrepancy can significantly affect the true depiction of patient severity, and possibly create discrepancies in quality measures and reimbursement.

Organizations should invest in natural-language processing (NLP) technology to identify potential documentation deficiencies at the point of care and concurrently review all cases for all payers. If each piece of documentation is reviewed holistically as it's added to a medical record — and paired with clinically relevant findings, gaps in documentation and potential quality events — hospitals get accurate documentation sooner, which removes the risk of disparity in clinical documentation.

Strategic patient activation

Value-based care works best when patients are motivated to proactively manage their health. In a post-pandemic world, every health care organization will benefit from better engagement with patients. The trend of consumerism in health care — favoring consumer convenience and giving patients and their families tools to make better decisions — is a concept whose time has come.

Specifically, investment should be made in understanding what works with high-risk and polychronic patients. Providers can successfully manage risk and drive toward predictable improvements by efficiently and cost effectively directing these patients to optimal sites-of-service for intervention and the most appropriate care at the right time with digital tools, personalized care navigation and timely notifications.

Final thoughts

From uncollected reimbursement and tedious clinical documentation, to changing payment models and the shifting regulatory environment, health systems are struggling to save on costs and drive revenue up. And while these challenges are familiar, historical solutions no longer make the necessary and needed impact. With strategies deployed in right areas — revenue recovery, revenue integrity, and risk-based and quality-based programs — health systems will be able to better navigate the ups and downs of the health care market and look beyond today to the future.

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Doug Clovis serves as a senior director and partner with the Optum Advisory Services Revenue Cycle team. Mr. Clovis brings more than 30 years of experience in the health care industry with a focus on revenue cycle management, improving customer operations, and maximizing effectiveness and efficiency of people, processes and technology.

With Optum since 2012, Mr. Clovis has served as a solution leader responsible for the development and delivery of revenue cycle consulting services to acute and ambulatory health care organizations. He has a proven track record in organizational transformation and redesign, root cause analysis and process improvement. He is a strong facilitator for revenue cycle design sessions and decision days, and has supported several high-profile clients in systemization and standardization of their revenue cycles. Mr. Clovis is a high-energy consulting and management professional with exceptional interpersonal and communication skills and a much sought-after speaker and presenter for many Optum and revenue cycle associations.

Prior to joining Optum, Mr. Clovis served in executive roles in global IT and health care vendor organizations. He has led successful system selections, multi-entity process redesign and implementation of health care IT systems including Epic, Siemens, Cerner, MEDITECH and IDX. He has managed teams of more than 20 professional consultants throughout the U.S. and oversaw system selection of a new revenue cycle system for a 9-hospital integrated delivery network (IDN).

Mr. Clovis received his Bachelor of Arts in Economics from the University of Missouri in Columbia, Missouri. He is a member of the Healthcare Information and Management Systems Society (HIMSS) and Healthcare Financial Management Association (HFMA).

Next up

For additional strategies on how to address other current state issues, see volume 1 of this series:

Volume 1: Cost optimization – Strategies to improve cost optimization by controlling fixed costs, delivering new levels of efficiency and enabling organizational flexibility and agility

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