Rethinking Collections

How to Create a Payer Escalation Program as Part of the RCM Continuum

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- 10+ years of experience in healthcare industry
- Consulting for providers in the areas of revenue integrity, reimbursement compliance, technology, and revenue cycle process improvement
- Experience developing large-scale teams with both domestic and international resources, proprietary workflow and reimbursement calculation applications, and organizational reporting metrics

Experience

- Founding Partner, RemedyIQ
- Interim Director of Revenue Cycle, 50+ Facility Health System
- Vice President of Underpayment Recovery, Cloudmed
- Director of Underpayment Recovery, STAT Revenue (ParaRev)

Agenda

01 Situation

02 The Path Forward

03 Establishing Expected Reimbursement Accuracy

04 Operationalizing a Payor Escalation Program

05 Q&A

01

Situation

The payer environment is more challenging than ever before for healthcare providers

Administrative Challenges

- 2-4 hours hold times
- 90 days of backlogged claims to process
- Lost faxes to payer

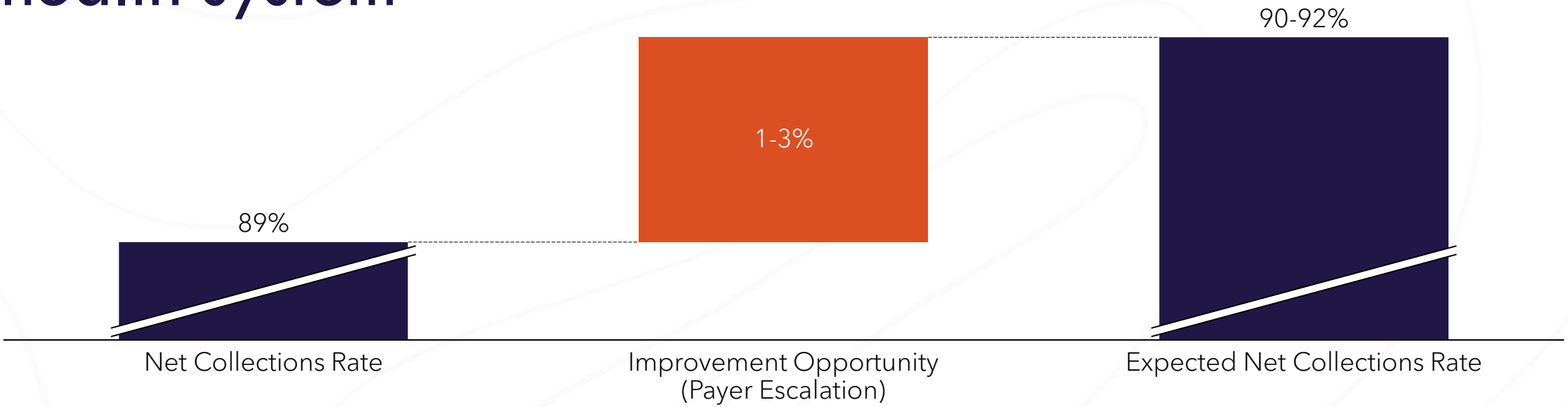
Technical Challenges

- Payer had incorrect fee scheduled loaded
- Multi-year phased rollout of claims processing system resulting in updates to member ID cards

Processing Challenges

- No longer accepts email processing for medical records and itemizations
- Incorrect denials for newborn claims

Difficult payer environment created annual missed recoveries of ~$15M-$45M for a large multi-state health system

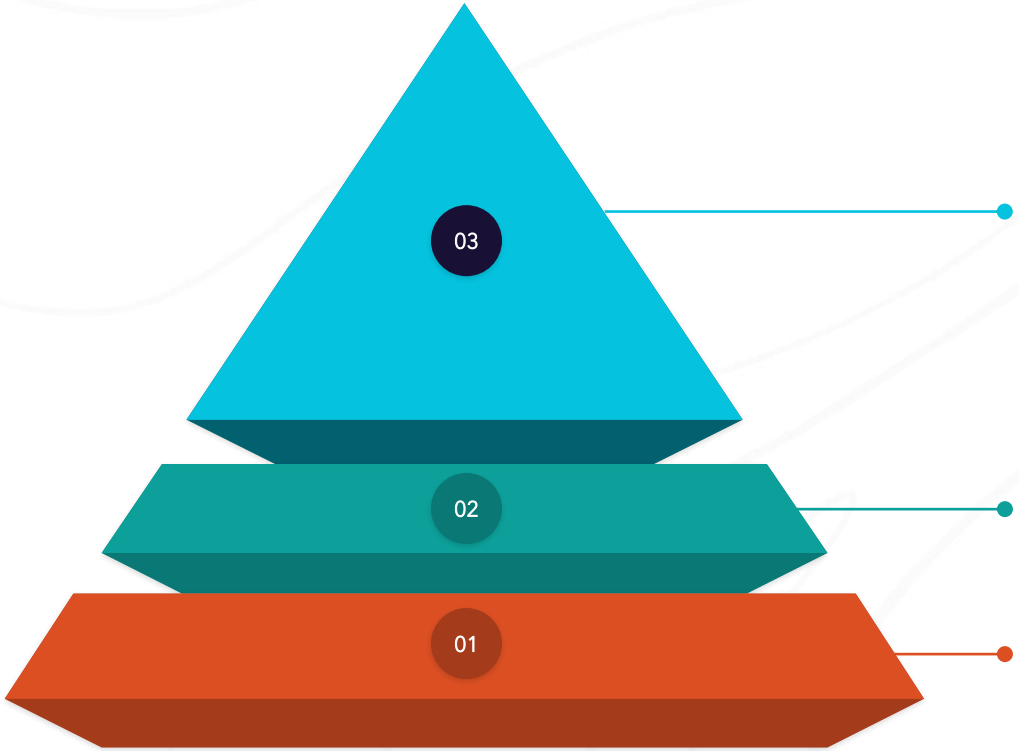


- Initial opportunity assessments of AR inventory determined uplift potential of 1-3%
  - This translated to $15M-$45M in potential recoveries
- Team determined opportunities existed where payers were not adhering to contracted terms and conditions for payment to provider

02

The Path Forward

The Path Forward



Operationalize Payor Escalation

Design Payor Escalation Workflow

Establish Expected Reimbursement Accuracy

03

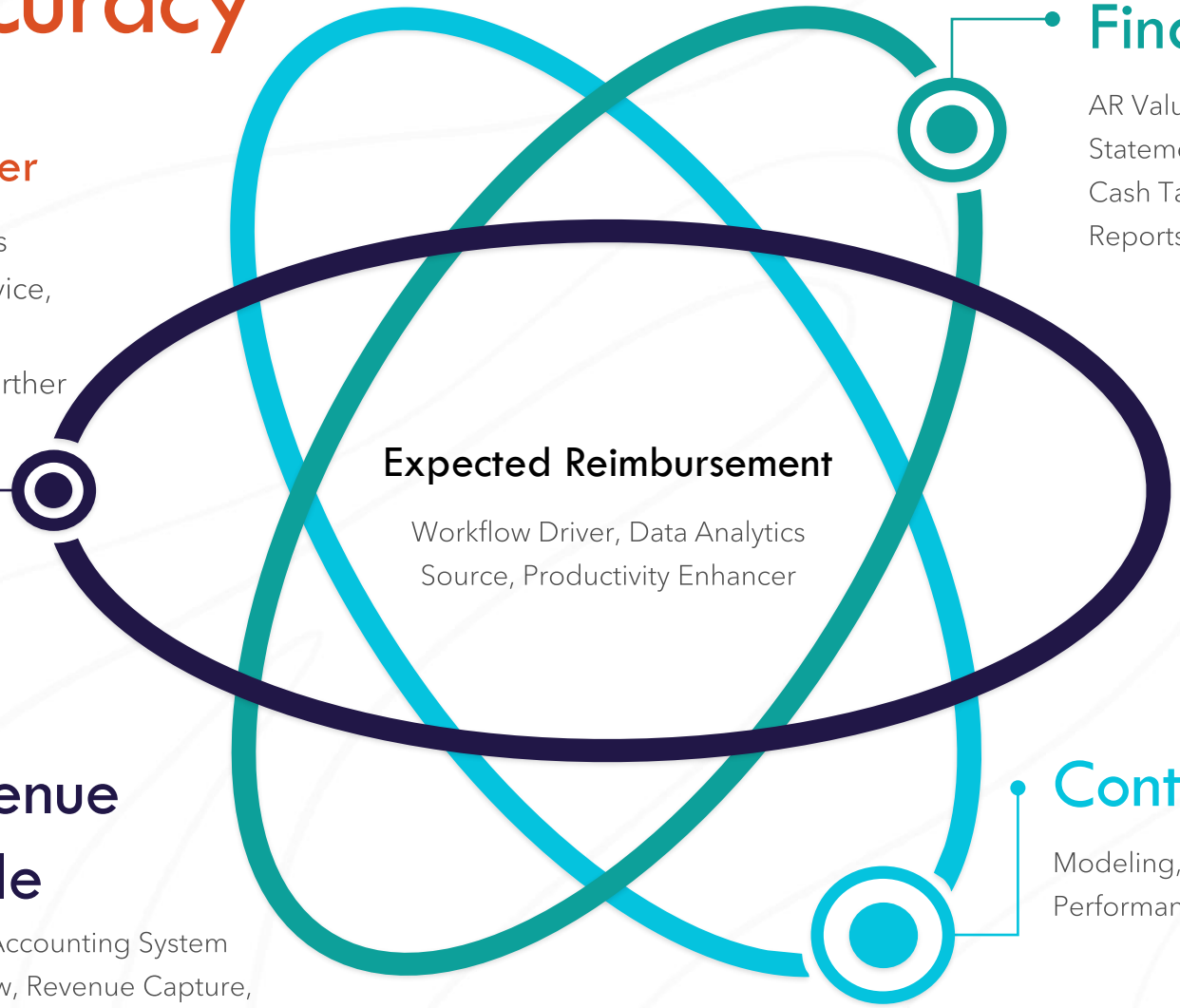
The Foundation Prerequisite:
Establishing Expected Reimbursement Accuracy

Expected Reimbursement
The Power of Accuracy

Why it Matters Now More Than Ever

We all know provider reimbursement from payors is complicated. In today's market we have fee for service, capitation, bundled/episode-based payments, in addition to payor reimbursement policies to add further complexity.

As provider reimbursement calculations drive workflow for so many stakeholders, it's a critical component to invest in for better outcomes for your organization.



Finance

AR Valuation – Feeds Income Statement Budgets, Balance Sheets, Cash Targets, Contribution Margin Reports

Contracting

Modeling, Negotiations, & Payor Performance Data

Revenue Cycle

Patient Accounting System Workflow, Revenue Capture, Meaningful Account Touches

Expected Reimbursement Drives Efficient Revenue Cycle Workflow

Source of Truth

With Expected Reimbursement calculations impacting Revenue Cycle, Contracting, and Finance, auditing Expected Reimbursement is a key area to focus on as a part of Revenue Cycle transformation and collection initiatives.

Increased

- Productive Revenue Cycle Account Touches
- Workflow Efficiency
- Trust in Expected Reimbursement for Revenue Cycle, Contracting, and Finance

Decreased

- Workqueue Volumes with False Variances
- Manual Contractual Adjustment Postings & Supervisor Approvals
- Vendor Spend for Underpayment Collections

Integrity Objectives

01

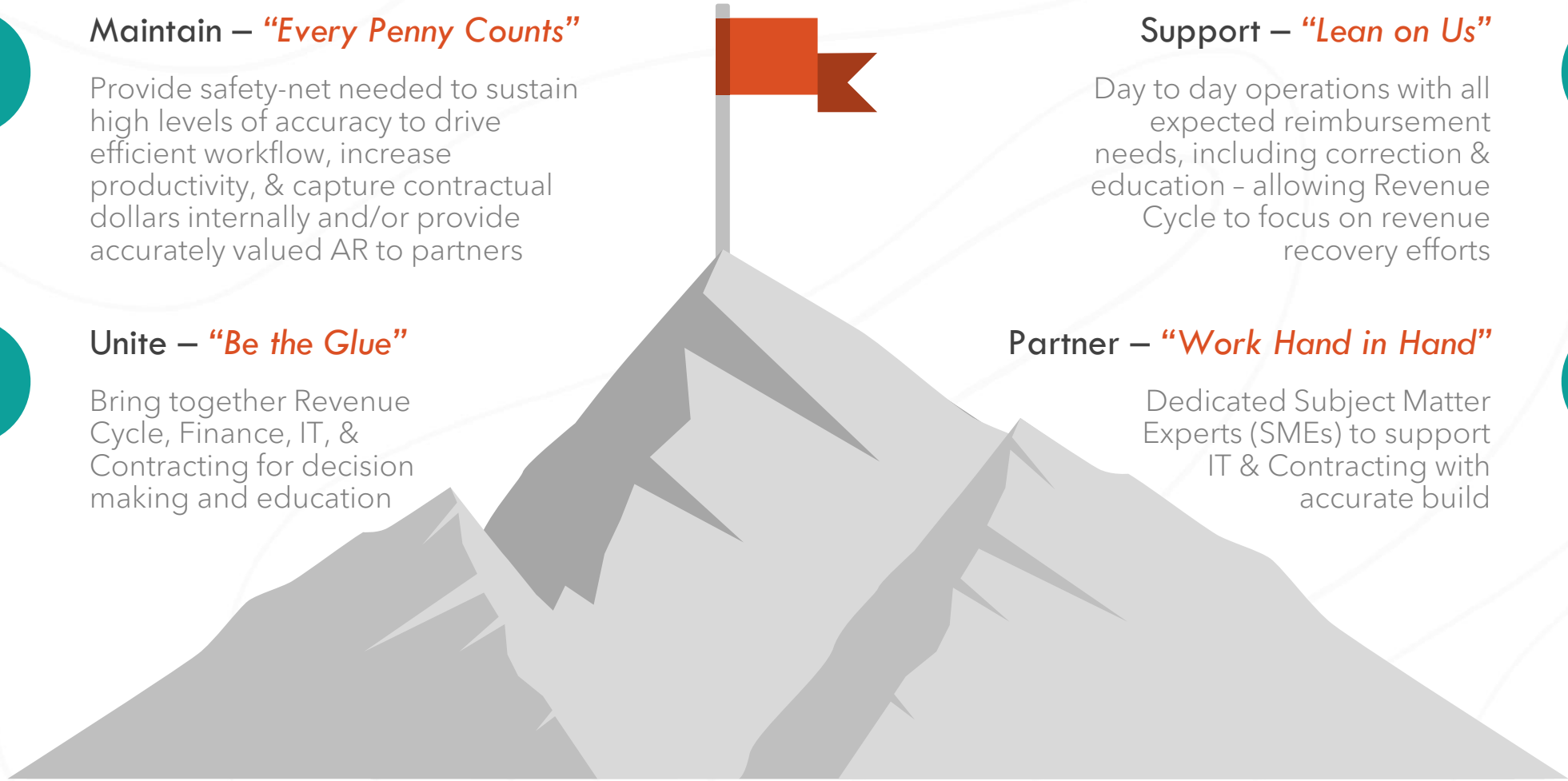
Maintain – *"Every Penny Counts"*

Provide safety-net needed to sustain high levels of accuracy to drive efficient workflow, increase productivity, & capture contractual dollars internally and/or provide accurately valued AR to partners

02

Unite – *"Be the Glue"*

Bring together Revenue Cycle, Finance, IT, & Contracting for decision making and education



03

Support – *"Lean on Us"*

Day to day operations with all expected reimbursement needs, including correction & education – allowing Revenue Cycle to focus on revenue recovery efforts

04

Partner – *"Work Hand in Hand"*

Dedicated Subject Matter Experts (SMEs) to support IT & Contracting with accurate build

Integrity Responsibilities

01 Contract Audits

Monthly review of Top Payors by Market, in addition to regular spot-audits

02 New Build Validation

Provide quality assurance for all new build in test environment prior to promotion to production

03 Fee Schedules

Track and request all Commercial and Government fee schedules, in addition to regular Government factor updates

04 Vendor Optimization

Monthly review of vendor findings to identify any Expected Reimbursement calculation gaps

05 Revenue Cycle Support

Monitor Expected Reimbursement Workqueues in to answer Revenue Cycle inquiries

06 Finance Month-End Support

Perform review of high-dollar accounts for FP&A to provide confirmation of Expected Reimbursement

07 CMS Coding Updates

Review coding updates and recommend changes to contract build to accommodate

08 Reporting

Monthly Status Reports and Monthly Steering Committee to communicate progress and bring Expected Reimbursement stakeholders together for joint-decision making

Expected Reimbursement
Case Study: Assessment

01 **Situation**

11-Facility Health System with growing small-balance volumes & vendor performance concerns

Expected Reimbursement accuracy reports showed >90% for top payors

02 **Audit & Findings**

Targeted Contracts Selected by Health System with >90% Accuracy

~14K claims reviewed; 3.5K (26%) claims had errors impacting Expected Reimbursement calculation

OP Claims disproportionately affected, resulting in small balance issues

03 **Outcomes**

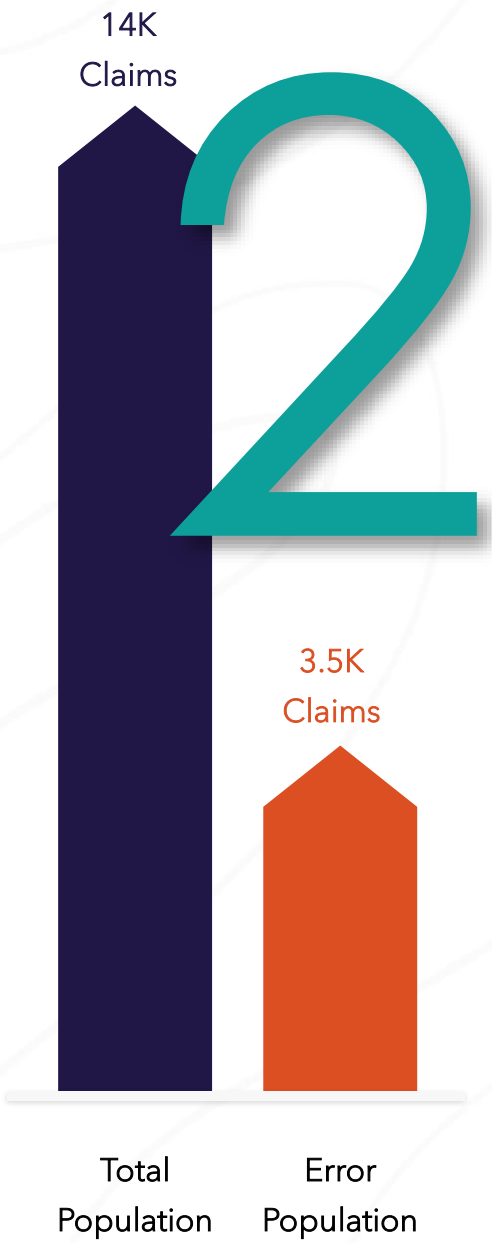
Annualized, correcting these issues for just these three contracts has the following impact:

- 14K Claim Balances Resolved
- $3.8M Absolute Variances Eliminated (~$300K Credit Balances)
- ~1 FTEs Saved (Calculated with Write-Off Thresholds & FTE Cost)

04 **Takeaways**

Lower dollar errors can greatly impact staff productivity

Accuracy reports do not paint the full picture



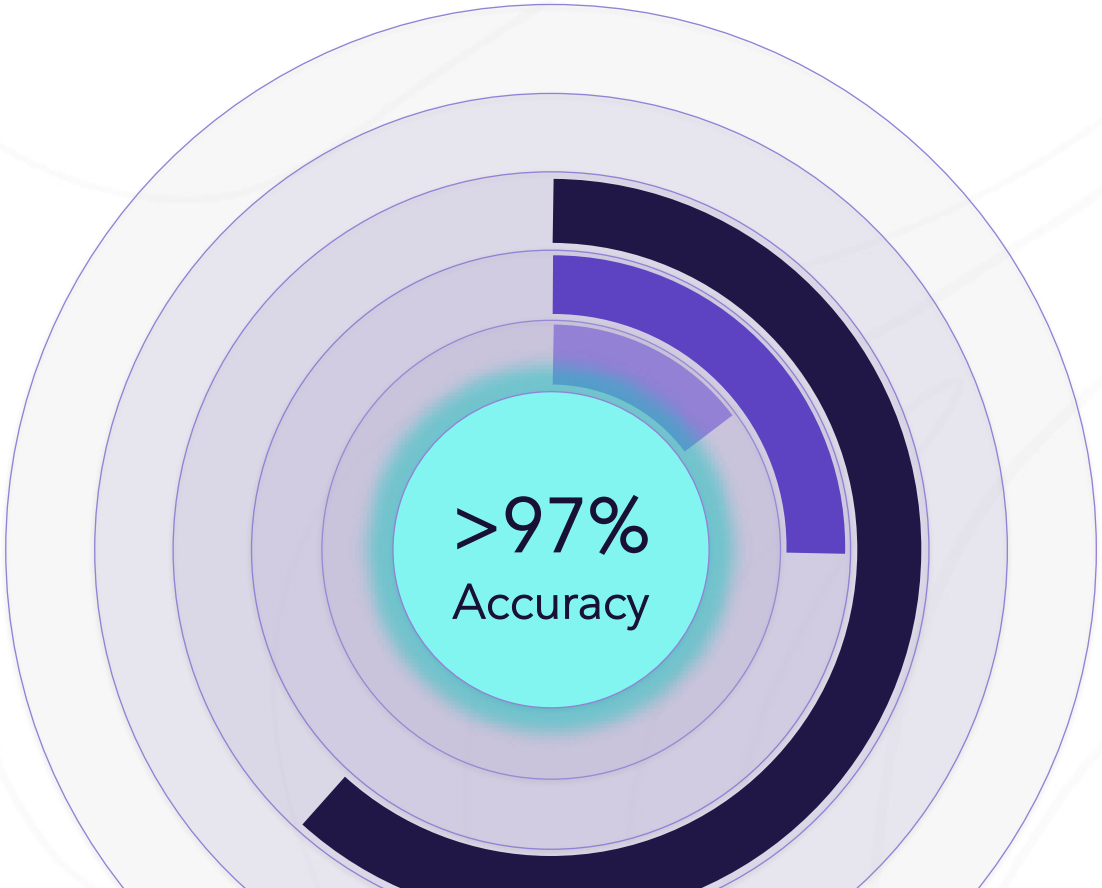
26%

claims

contained avoidable false variances

Expected Reimbursement
Case Study: Mature Program

Large 50+ facility multi-state health system with initiative to clean-up and maintain Expected Reimbursement to allow Finance to leverage calculations for AR Valuation, to improve Revenue Cycle productivity, to provide Contracting with reliable financial data for modeling and payer negotiation, and to lay the groundwork for a payor escalation program.



Integrity Program | 2023 Statistics

>3,900

Contracts Managed across Hospital Billing

>2,100

Fee Schedules Managed across Hospital Billing

>950

Errors Identified through variance reviews

>750

New Build/Rates Validated prior to promotion to production

>600

Revenue Cycle Calculation Inquiries researched and actioned

>$11.5M

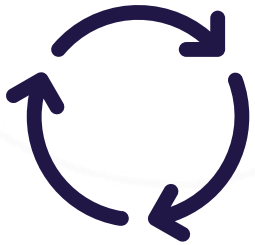
Revenue Opportunities identified and escalated to Revenue Cycle

04

Operationalizing a Payor Escalation Program:

Principles, Design, & Results

We set up a payer escalations team to deliver on a few principles



Standardization

Streamline Inventory Intake & Escalation Process to Payors

Accelerated Escalations

Trending AR

Predictive Technology

Payer Liaison

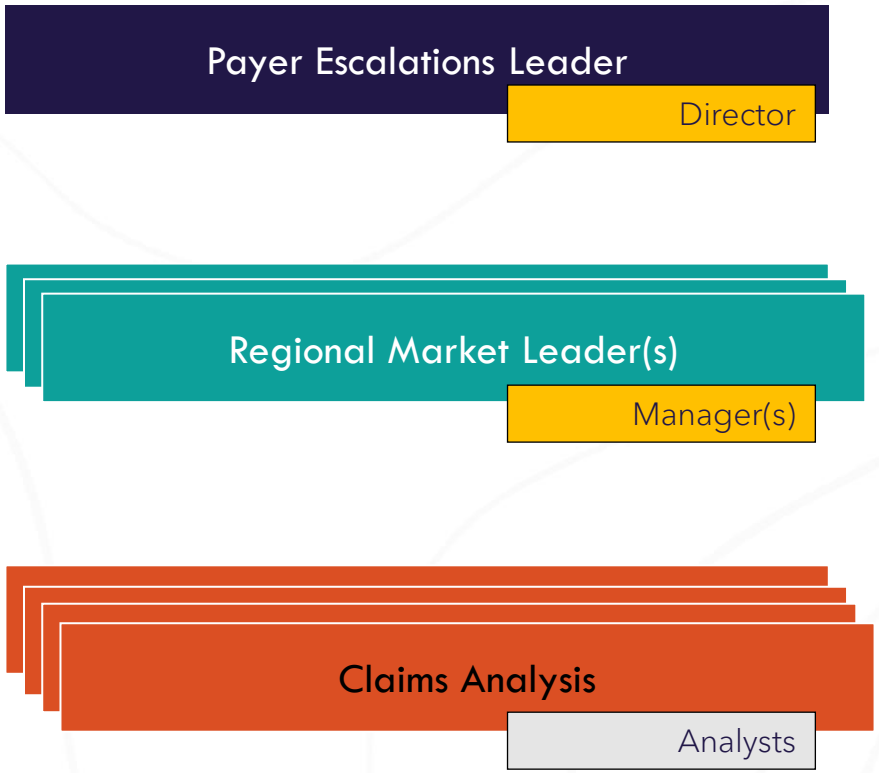
Relationships to Drive Resolution, Engaging Contracting as Contract Interpretation SMEs

Reporting

Insight into Inventory

Dashboards (stage & status & impact to revenue)

The team is split into regions to specialize for regional payers



- Key relationship owner with client
- Responsible for the success of client engagement
- Serves as knowledge expert

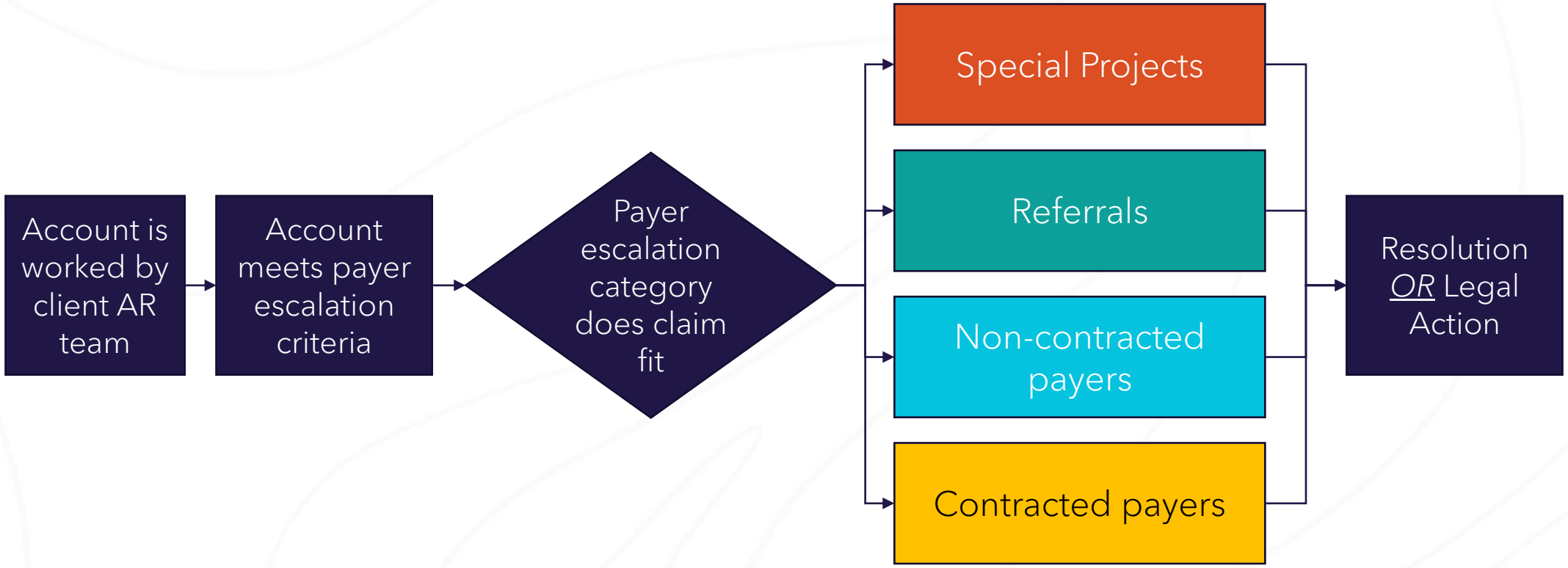
- Oversees relationship with regional client leaders
- Manages daily production team to ensure success
- Responsible for leading special projects and other key initiatives

- Responsible for daily analysis of claims
- Identifies root causes and trends related to payer escalations

Claims must meet a number of criteria to qualify for payer escalations

- Correct host system
- Billing type and form met (e.g., physician billing, hospital billing, CMS 1500)
- AR Dollar threshold met and categorization appropriate
- Agings threshold met, depending on state contract, and/or provider manual
- Payer claim ID is available
- Appeal threshold has been met
- Additional documentation request has been provided

Payer escalation claims fall into 1 of 4 potential workflows



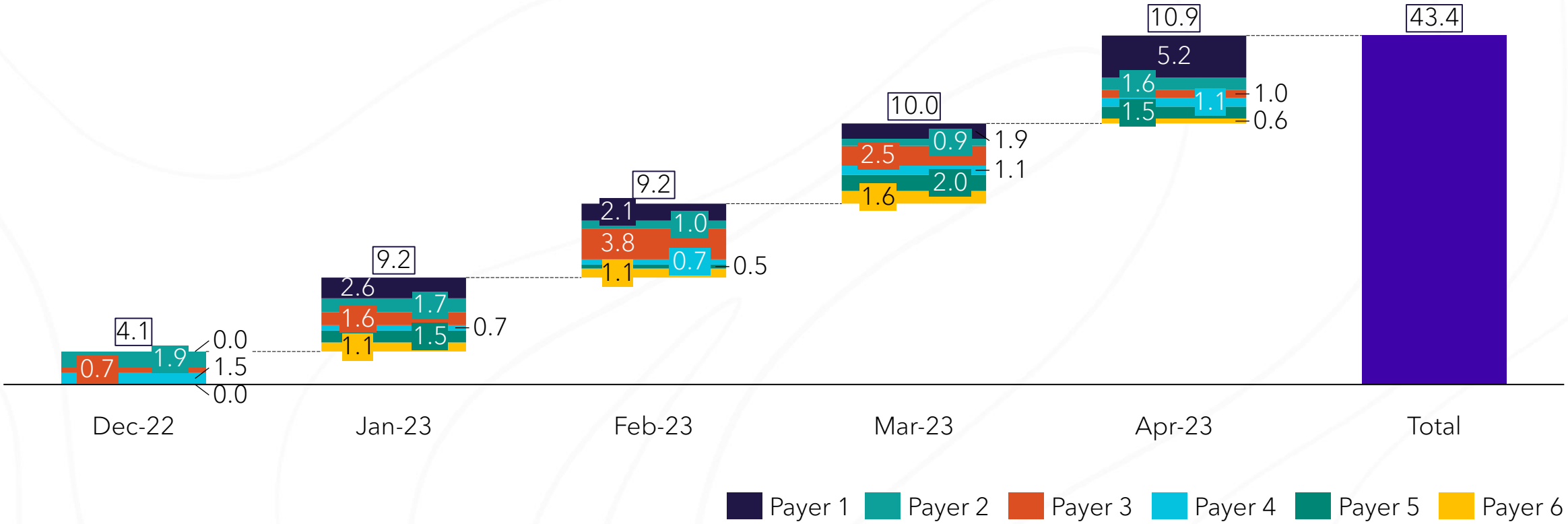
- Once claims are ingested into the payer escalation workflow they are categorized into one of four categories
- Special projects are identified through data analytics and predictive technologies to determine bulk issues and other high dollar claims that requires specialized attention
- Provides flexibility to leverage external law firms or in-house counsel

A successful payer escalation team can be operationalized in 4-6 months

	Setup (1 month)	Pilot (1-2 months)	Operationalization (2-3 months)	Production (Go-Live)
Description	Initial assessment to determine opportunity and create structures to support payer escalations work	Pilot program to ensure proof of concept and tailor for client	Operationalize payer escalations function	Go-live with production staff and begin full support
Key Activities	• Analyze payer data • Categorize outstanding AR • Setup of internal meetings • Setup of payer meetings	• Stand up pilot team with a national payer • Review results from pilot • Evaluate ROI for actual/forecasts	• Hire team of leaders and production staff • Ensure access to all systems and payer portals • Coordinate with clients on procedures and processes for escalations	• Full integration team to support client needs • Coordination with client legal and managed care teams on escalations

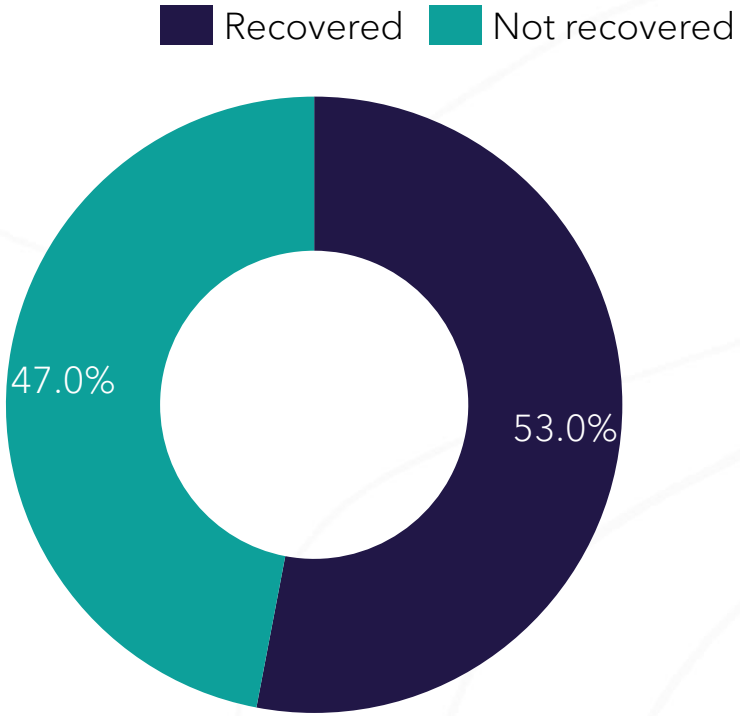
Payer escalation team has recovered over $43M to date for one partner

Payer escalation recoveries by major payer, $M

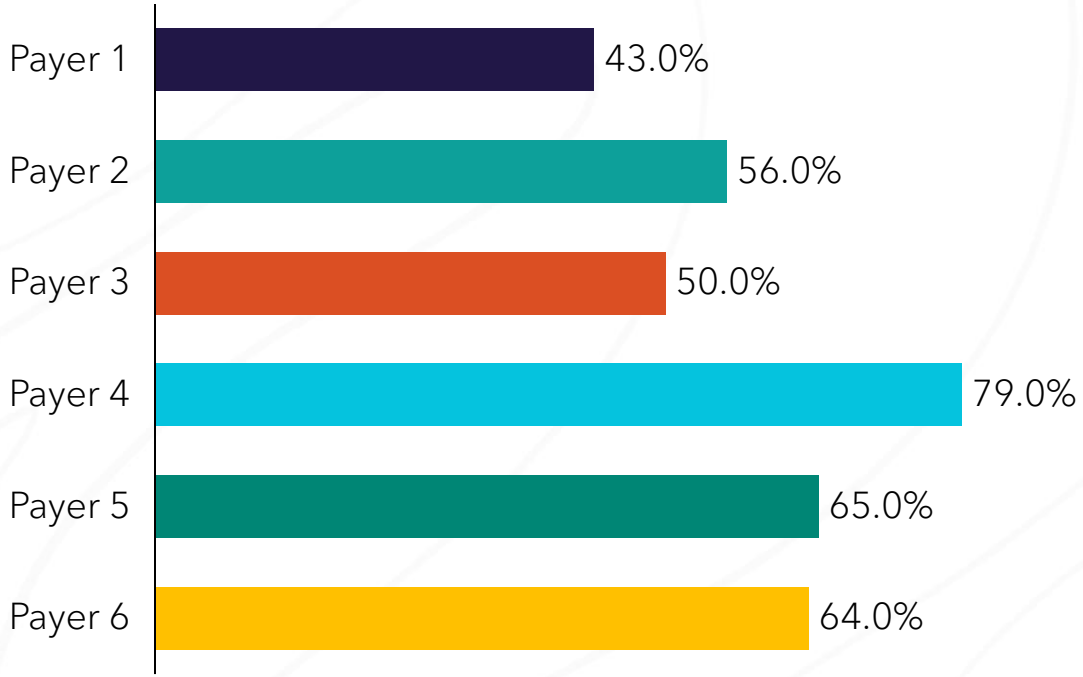


We've recovered dollars on between 43%-79% of claims escalated

Overall Recoveries on Escalated Claims, % Volume

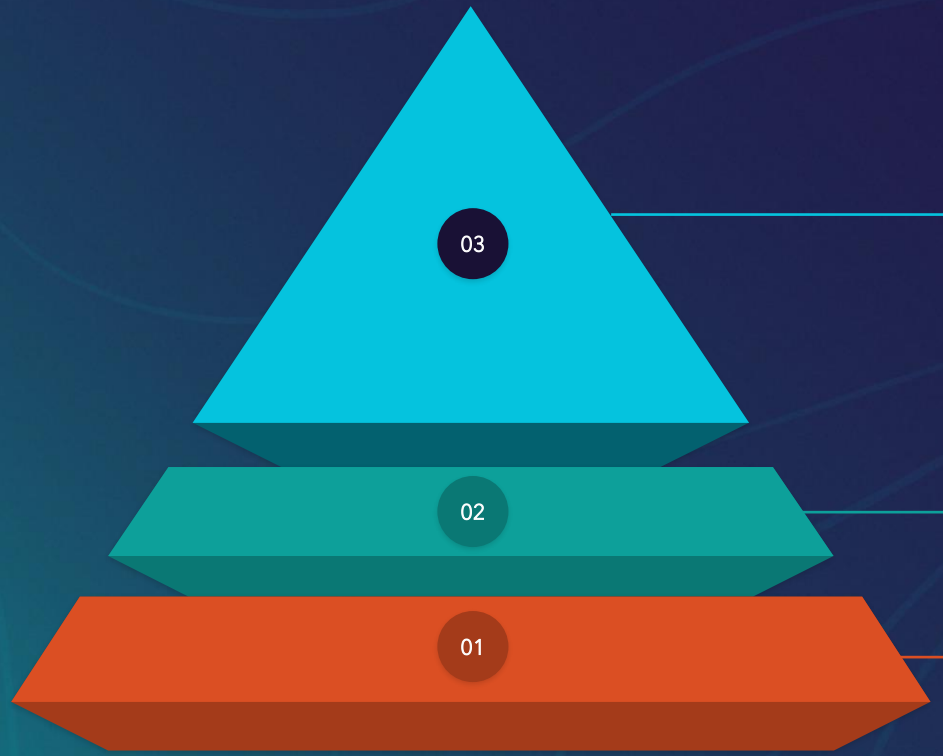


Recovery Success Rate by Payer, % Volume



~50% of dollars escalated have been recovered through the Payer Escalations Team

Q&A



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