Senior revenue cycle leaders play a critical role in the transition to implement value-based care into their organizations. This transition requires healthcare organizations to change, which impacts their revenue cycle. New payment models and organizational changes, including new roles and responsibilities, need to be implemented. Even more, establishing stronger payer relationships, leveraging data analytics and breaking the barrier between physician and hospital revenue streams are critical.

The transition from fee for service to value-based reimbursement requires planning. To meet value-based goals, hospitals will need to leverage population health, which will reduce their procedure volume and thus revenue. With revenue decreasing, hospitals have to improve margins as much as possible. The key is to reduce costs, while developing an integrated, strategic approach that ensures patients receive the needed care and coded appropriately with a reduction in unnecessary readmissions.

Adreima explores the top 5 challenges of the changing role of revenue cycle leaders in a value-based world and the strategies and best practices to pave the road to success.

1. Identifying the correct path for patient financial resolution

   Patient Access will continue to become a focus area as payer dynamics evolve and the role of the patient in the revenue cycle increases. Are you ensuring that your patients are being screened for alternative funding sources?

   A key strategic challenge that hospitals need to focus on is ensuring patients have coverage. Effective eligibility and front end services are critical for hospitals to manage their uninsured and underinsured. An increasing portion of the population is without medical insurance and is unaware that they may qualify for government assistance programs such as Medicaid, Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Nearly 46% of individuals are uninsured or underinsured with almost half of those individuals being eligible for financial assistance under the ACA.
A second key strategic challenge for Patient Access is correctly identifying patients that are within a narrow network during the registration process. This is critical in order to provide education and assistance but also important for accurate population management. The ACA has caused health plans to increase their use of narrow network plans, in an effort to control cost. While cost-effective, these narrow network plans leave patients unknowingly vulnerable to the financial burden of out-of-network care.

Adreima reduced the number of uninsured by approximately 5% since ACA by helping patients understand their options and reduce the risk of uncompensated care by 80%.

2. Improving the patient experience

In an era where perceived value and actual value have become part of the entire healthcare experience and will drive reimbursement, are you getting a 94% patient satisfaction?

Insurance deductibles have risen each year, as have patients struggling to pay unexpected bills. Hospital executives recognize that the patient experience involves more than clinical excellence. It also includes superior customer service from the first encounter to the last.

Patient Concierge programs provide the necessary education to high touch and high frequency patients, so they can understand and manage their bills and insurance. This hands-on added service enhances a patient’s overall experience during their hospital stay and increases patient satisfaction and revenue for the hospital.

Best practice hospitals assign patients a financial advocate who helps them navigate the financial and administrative aspects of their healthcare, beginning with preadmission and continuing throughout the entire revenue cycle.

Adreima has realized a 29% increase in payment rates for patients in our high-touch concierge program with a 94% patient satisfaction rate. This results in an increase in patient satisfaction, patient loyalty, and collections.

3. Accurately coding DRG assignments

Are you capturing your correct reimbursement through your coding?

Inaccurate DRG assignments and reimbursement can negatively impact a hospital’s bottom line. When physicians fail to provide enough information to code a claim correctly, hospitals miss out on earned revenue due to missing codes or incomplete documentation to substantiate the codes that were used. Other cases, the codes are there, but the information isn’t complete, so a portion of the claim is denied causing rework and lost money. Frequent code auditing is necessary to ensure accuracy.
Accuracy is also critical for population health analysis and management. Population health management develops care protocols to ensure patients receive the right care at the right time in the right setting. The patient diagnosis determines the level of care needed and is continuously monitored so that when early warning signs develop, they are dealt with right away before the patient ends up in the ER.

Bundled payment reimbursement for procedures such as joint replacements also increases the importance of accurate DRG assignments as maximum reimbursement for the procedures provided is necessary for payment distribution to the appropriate providers.

The ultimate goal is improving patient health by delivering the right services to the right patient at the right time. All providers, including physicians and hospitals, must operate on defined criteria to ensure better patient outcomes and maximum reimbursement.

4. **Transitioning from denial management to denial prevention**

   Are you obtaining your entire reimbursement dedicated to your facility and your patient?

   No one can afford to give up revenue in today’s healthcare marketplace. Yet every day, U.S. hospitals write off approximately 3-4 percent of net patient revenues as a result of claim denials. For a median-size facility, that’s more than $14 million annually. Despite major efforts, denial rates have hovered around 24 percent—and may increase in the months ahead.

   While the denial rate for ICD 10 claims was only 1.6% from November 2015 to February 2016, nationally that equaled to $12.9B in reimbursement for the nation’s hospitals. By optimizing your revenue cycle and eliminating denials, you increase efficiencies and improve workflow that provides an increase in cash flow. Hospitals need to work smarter, not harder. Integrating tools that focus on quality vs. quantity of work, hospitals can reduce the number of “touches” to resolve a claim and increase efficiency. With the reduction in operating costs and time to collect, hospitals get access to cash faster.

   Value-based care focuses on providing quality care in the most efficient and cost effective manner. Physicians, who control medical decisions and thus affect healthcare costs, are incentivized to deliver the right care in the right setting at the right time. To ensure maximum reimbursement in this value-based environment, it is critical that providers institute strategies to prevent medical necessity denials.

   Retrospective denials negatively portend a deviance from evidence based medical processes and desired outcomes. Innovative providers utilize highly trained clinicians to support the accurate and timely determination of patient status thereby ensuring compliance, preventing denials, increasing efficiency, decreasing costs associated with open accounts receivable and safeguarding revenue.

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**Adreima realized an 80% conversion rate for denied clients in inappropriate admission status and medical necessity.**

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**Adreima has been able to overturn 92% of complex clinical denials, money that would have otherwise been lost.**
5. **Transitioning to a consumerism healthcare environment**

*Did you know that over 23% of hospital revenue comes from Patient Responsibility?*

Nationwide, patient satisfaction rates drop by more than 30 percent from post-discharge through the billing office process. High-deductible health plans coupled with an increasing number of underinsured patients are resulting in explosive growth within a hospital’s self-pay payment class. In 2002, patient responsibility represented 10% of hospital revenue. Due to increasing high-deductible plans, it now exceeds 23%.

With more patients using high deductible plans, there are more people who do not understand their health insurance plans. Many of these patients are being sent to collections for self-pay. A patient-friendly program helps educate patients to understand their insurance and out-of-pocket expenses before the procedure and also understand payment programs to help them pay their responsibility.

This education enhances your revenue cycle by helping you to understand your patient behavior and propensity to pay with the added benefit of an increase in patient satisfaction scores. With reduced bad debt and increased cash flow, the hospital’s bottom line is positively impacted.

**Adreima has 15-28% blended collections on self-pay accounts putting performance in top 98% of best practice benchmarks**

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**About Us**

Adreima provides patient-centered, clinically integrated revenue cycle services to approximately 600 hospitals nationwide. This unique approach combined with the deep connections we build with our clients helps them achieve results by recognizing the full value of services provided. Adreima realizes these results for each client by our insightful analytics, and taking measured action to improve outcomes. Our experts continuously translate the market to help you achieve compliance and regulatory readiness.