# Revenue Recovery Strategies for Hospitals and Health Systems

# EXECUTIVE SUMMARY

Amidst ever-evolving industry changes and challenges, progressive revenue cycle managers are actively pushing back on trends that have eroded operating margins by adopting new techniques to maximize revenue.

In this whitepaper, we introduce the idea of optimizing revenue recovery before, during and even after the standard claim lifecycle. An inversion of the denial management process, we explore the approach of identifying errors and exceptions upfront by minimizing downstream denials through proactive insurance discovery searches focused on the care departments and patient services which typically result in significant revenue leakage.

Using this approach, healthcare providers large and small have transformed their revenue capture capabilities, receiving an average of 39.5% insurance identification matches on uninsured accounts.[1]

# FINANCIAL CHALLENGES CREATED AND ENLARGED BY THE PANDEMIC

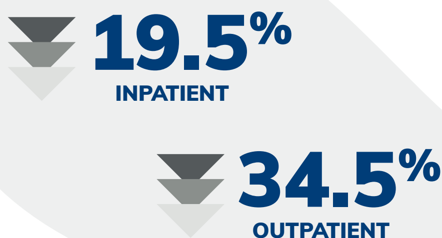
All of healthcare is looking for revenue right now. Experts agree, stating that financial challenges are the number one issue facing hospitals today.[2] More specifically, nearly three-quarters of hospital leaders are either moderately (52%) or extremely (22%) concerned about the financial viability of their organizations.[3]

Greek philosopher Heraclitus summed up this situation well nearly 2,500 years ago when he said, "The only constant in life is change." Increasing healthcare costs, medical billing complexity and self-pay patients have historically caused revenue leakage. Now, on top of that, the COVID-19 global pandemic has triggered complex changes to insurance and patient interactions and volume, making it even more difficult for healthcare providers to meet their financial obligations.

Combined, these changes have catalyzed our new reality:

## Patient volume is down

Hospital and healthcare systems have seen patient volumes decline, 19.5% for inpatient and 34.5% for outpatient.[4]




## The payer mix is shifting

Driven by the economic climate during the pandemic, estimates indicate that more than 10 million employees and dependents lost employer-sponsored coverage by August 2020. About half will enroll in Medicaid, and the other half will become uninsured.[5]

A survey of health system and hospital executives determined the following predictions[6] in the wake of the COVID-19 pandemic:

**70%** are expecting an uptick in Medicaid patients

**69%** are expecting a decrease in commercial coverage

**68%** see an increase in self-pay customers

**MORE THAN 40%** of hospitals report increases in the percentage of uninsured or self-pay patients due to COVID.[3]

## Bad debt is increasing

Nearly half of hospitals (48%) have seen bad debt and uncompensated care increase because of COVID.[7] Additionally, claims denials have increased by 11% during the same time.[8]

# HOSPITALS' NEW NORMAL

Despite a series of positive medical innovations in recent months, from vaccines to therapeutics, a recent report published by the American Hospital Association found that by the end of of 2021, hospital margins could be 10-80% below pre-pandemic levels.[9]

It's estimated that 25% of hospitals had negative operating margins before the pandemic.[9] Now, looking at the impact on margins for 2021, optimistic recovery scenarios could actually increase the number of hospitals operating with negative operating margins to 39%, while pessimistic scenarios predict that number to nearly half of all hospitals.[9]

# SOLVE REVENUE LEAKAGE AT THE START OF CARE

Healthcare leaders across finance, quality and operations are feeling the pressure of alarming margins. Some pandemic-driven variables such as patient volume can't be controlled; they're almost impossible to be proactive against. However, when it comes to changes in insurance mix and the rise in patient bad debt, strategies can be applied to appropriately capture the revenue associated with the care that has been provided – preventing revenue leakage and, over time, increasing operational margins.

Only 11% of hospital executives point to ineffective revenue cycle management (RCM) processes as a leading contributor to bad debt[10], yet expected reimbursements leak from many organizations' revenue systems.

Consider how much of your organization's bad debt is due to missing or incorrect eligibility and coverage information. Greater efficiency or automation of related processes later in the revenue cycle won't solve this challenge. Instead, invest in solving the root cause of downstream denials and write-offs. Start by improving patient access. This addresses revenue leakage from the start of care, solving bad debt challenges with greater efficacy at every point of the care, and claims, journey.

# REGAIN CONTROL OF YOUR REVENUE

A panel of executives was asked how they prioritize their revenue collection issues, and a majority identified "claims payment"(48%).[11] An additional report identifies that the number one reason for claims denials is incorrect eligibility information[12], and yet another indicates that 27% of all denials stem from registration and eligibility issues.[8]

While people and process improvements can overcome some of the challenges that can lead to denials, there are still two top causes of revenue leakage during patient access that will exist regardless of downstream claims management changes:

## Misidentified self-pay patients

Patients who present as having no insurance are one of the fastest-growing segments of care coverage. Yet, up to 40% of these patients[13] may have coverage that they were unaware of, did not want to disclose or were unable to state.

## Unidentified secondary payers and coordination of benefits

75% of hospital and healthcare systems stop identifying coverage after the first match.[14] Additionally, the presence of multiple payers – especially the growing applicability of Medicaid and Medicare coverage – presents new challenges for identifying applicable coverage and coordinating the application of benefits in the proper order.

# RECOVER REVENUE AT THE FRONT AND BACK END

Given the effects of the pandemic and industry changes, progressive revenue cycle professionals are learning that their current denials management process is causing revenue leakage, contributing widely to the negative operating margins plaguing hospitals and healthcare systems. We propose an inversion of the typical denial management process; to perform exception reporting upfront, therefore minimizing downstream denials by identifying active coverage for categories of patient care that typically result in your most significant sources of revenue leakage.

Before turning denial management on its head, though, it's worth understanding the three common types of patient coverage.

## Underinsured or self-pay patients

This is typically the largest category of revenue leakage and the fastest growing. Many underlying situations drive this use case, and most tend to point back to collecting money from individuals. That said, not all examples head in this direction. For varied reasons, some people elect not to inform healthcare providers of existing insurance. And others are unaware of existing insurance or retroactive government programs that could potentially help support them.

Ultimately, this is a use case worth prioritizing. Typically, 1% to 5% of self-pay accounts that have been written off as bad debt have billable insurance coverage.[14] If you can research these priority patients, examining coverage beyond what they have communicated, there's a viable opportunity to fill in details that can lead to coverage and revenue rather than write-offs to charity care, bad debt or a payment plan.

## Unknown patient coverage (common in unexpected patient interactions)

Emergency care is not planned, often resulting in more significant financial uncertainty for patients and the organizations trying to capture the revenue for their services provided.

This use case can arguably benefit the most from a bigger focus on eligibility determination, especially in the back end of the revenue cycle. While there may not always be an immediate way of gathering basic patient details to run standard eligibility checks, there is still the opportunity to check patient information against active coverage databases after the point of care.

While a bit more work downstream, the results speak for themselves. Many revenue cycle specialists would rather a claim be corrected and paid on the back end versus written off to collections.

## Insured patients

Depending on your mix of denial use cases, it may be worth researching even those who present as insured patients and you've verified coverage for.

This group presents opportunities to identify if patients have secondary or even tertiary payers. It's also good to check patients for changes in coverage, particularly after open enrollment. These patients may be eligible for but not yet enrolled in Medicaid, or they may have retroactive Medicaid coverage available. It's not only critical to be aware of this for the potential revenue recovery, but also to set up new claims for success with the proper sequence of filing and updated information in place.

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For self-pay patients, insured patients and those for whom coverage is unknown, there's opportunity to realize the revenue available at three different stages of the revenue cycle. That's three chances to turn a potential denial into a revenue-generating, paid claim!

## Underinsured or self-pay patients

Before moving forward from patient intake to billing, make it a priority for all staff to focus on generating (and maintaining) an accurate master patient file with up-to-date information.

This is a critical step because denials are increasing. Payer systems have increased efforts to identify diagnosis-related group (DRG) downgrades and medical necessity issues, driving faster denial rates. The growing complexity and varying requirements make it nearly impossible to form an immediately successful claim submission while meeting medical necessity requirements.

This step will accelerate revenue recognition, reduce lost revenue from denials and write-offs, and improve operating margins for your organization. More specifically, you can potentially benefit by:

- Finding previously unknown active, billable insurance for patients who present as self-pay. As mentioned previously, 1-5% of patients written off as self-pay have billable insurance coverage.[14]
- Finding additional payers for a patient who presents as having only one form of coverage. For example, a patient presents their situation as having either Medicare or Medicaid, when in reality they have both Medicare and Medicaid – meaning you have double the opportunity to realize the full revenue available for services provided.

## Mid-cycle claims optimization

Once you've prioritized coverage discovery during patient intake, it's time to shift focus to all claims actively making their way through the revenue cycle.

The clock is ticking on unpaid claims. Take a look at everything in the 30- to 90-day category. Where is each claim experiencing a roadblock to payment? Is a system or human error causing these issues? How can you avoid future denials and payment delays?

With the increased predisposition from payers to challenge claims, it's crucial to prioritize resubmissions next. Research shows that as many as 60% of claims denials are never corrected and resubmitted for payment.[15]

## Back-end revenue recovery

Evey hospital executive and their teams aim to reach projected revenue earnings, but in today's environment, it's rare to even come close. However, with the prior two stages done correctly, bad debt and revenue uncertainty can drop dramatically, instead replaced with better earnings driven by more effective, detail-oriented processes.

The key is that when coverage discovery is paired with eligibility verification during patient access, you can virtually eliminate downstream delays and revenue leakage. It's no longer sufficient to focus on denial management as a means to recover uncollected funds. With the principle of turning patient access into the foundation of each claim's successful payment, revenue cycle professionals can secure cleaner claims at less effort and frustration – in the end, driving an organization much closer to its projected revenue.

# ABILITY INSURANCE DISCOVERY

High-performing financial results are the product of many effective resources and processes working together. To maintain strong numbers and improve margins, an innovative approach to patient access and the revenue cycle is required. ABILITY Insurance Discovery helps ensure that every applicable payer is identified for a claim. Its robust algorithms search patient information against public and private payers to identify primary, secondary and tertiary coverage – with confidence scoring and differentiating managed care and advantage plans. This quick search yields an average of 39.5% insurance identification matches on uninsured accounts[1], allowing more claims to go directly to payers vs. being misidentified as self-pay, charity or bad debt.

## Advantages for your organization

- **Recover lost revenue**

  Put payment responsibility back in the hands of payers, not patients. Move more accounts from self-pay and bad debt into approved and paid claims with the help of accurate insurance information discovered upfront.

- **Improve cost-to-collect ratios**

  Replace manual, individual insurance searches with quick batch inquiries that confidently identify payers for multiple patients in just seconds.

- **Decrease days in A/R**

  Bill the appropriate payer from the start of the claim's lifecycle, reducing reimbursement delays and recovering labor costs that would have been spent on reworking claims.

- **Increase patient satisfaction**

  Take the burden of financial responsibility off patients. When you work directly with payers, patients' stress is lower and their care experience is more positive.

## Application features

- **Easy identification of primary, secondary, and tertiary coverage**

  Identify active insurance coverage from Medicare, Medicaid and commercial payers, in one place.

- **Advanced algorithms**

  Access a list of probable payers that are most likely to cover each patient is built for you.

- **Batch search capabilities**

  Speed up the search process by inquiring coverage for multiple patients at a time, against all payers.

- **Dynamic filters**

  Organize results by patient name, transaction date, coverage status, NPI, payer and more. The view is configurable to how you and your team work best.

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