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The two most astute revenue cycle investments to make in 2022

Health care providers hoping to move past the COVID-19 pandemic have new threats to financial security. First, the increasingly endemic nature of COVID-19 means care delivery networks must remain agile enough to manage waves of patients seeking care from the illness. At the same time, scarcity of resources — including labor — is taking hold across many sectors, leading to widespread economic uncertainty.

According to Chicago-based hospital consulting firm Kaufman Hall, hospital margins could be 11% lower than pre-pandemic levels and 76% of hospitals report having less than 60 days of cash on hand.[1] At the same time, care delivery costs are increasing due to sicker patients, lingering COVID-19 protocols and a shrinking workforce.

A common reflexive approach to these financial burdens is cost-cutting. Given the current climate, it's understandable that most provider organizations will need to make significant reductions in costs. But often, cost-cutting is nearsighted and harms the areas of the revenue cycle best aligned to boost deserved reimbursement for services rendered.

The shortcomings of cost-cutting as a primary focus

Cost-cutting is a well-worn path to solvency in times of financial distress. In 2014, in the long wake of the Affordable Care Act (ACA), tighter federal regulations, and uncertain insurance payout changes, Premier Inc.'s Economic Outlook survey found that 75% of hospital executives reported cutting expenses.[2]

However, cost-cutting can be detrimental if applied as the central financial remedy and if done in the wrong areas of the organization. The Advisory Board has noted that, "Hospitals' and health systems' ability to cut costs has been like many peoples' efforts to be healthier. That dieting fad may help us to lose weight initially (like one-off cost-cutting efforts may lead to lower costs), but it won't be sustainable without broader lifestyle changes."[3]

In fact, many provider organizations fail at the task of making significant cuts to costs. Kaufmann Hall also recently reported that while nearly all U.S. hospitals have set modest cost-reduction targets, only 23% have met even their modest goals.[4]

Cost-cutting done right often involves investment

Targeted cost-cutting can pay dividends if done in the right area. Many health systems struggle with a varied patchwork of differing management styles, processes and business cultures among their facilities. The result of these variations in process is underperforming operations that weigh down a health system, costing it time and money. In order to remedy variations in revenue cycle operations, hospitals need to implement new standardized processes and normalize disparate technologies across facilities. Such changes often require investment in outside consulting, technology and redeployment of staff to create and manage new processes and ensure staff accountability.

Smart investments for a stronger revenue cycle

Two approaches to revenue cycle management that can boost revenue through more targeted investment are:

1. **Refined clinical documentation integrity**
2. **Centralizing functions**

Clinical documentation integrity

It's no secret that improving clinical documentation can directly impact financial outcomes. According to Black Book Research, nearly 90% of hospitals with 150 or more beds and outsourced clinical documentation functions realized at least $1.5 million in appropriate health care revenue and claims reimbursement following clinical documentation improvement (CDI).[5]

However, some health care organizations have become complacent, maintaining a myopic view of CDI's broad impact, and have not taken full advantage of all the tools available to make their CDI program performance shine.

Is your program staffed properly?

Based on an ACDIS CDI Survey, 53% of respondents stated their CDI group was short-staffed.[6] Understaffing means that not all patient documentation gets a proper review for accuracy and completeness, which leads to lower quality scores and reimbursement.

Given the relative shortage of qualified CDI specialists, you can opt to recruit and train your own staff from your nursing or coder ranks. Outsourcing may offer relief since it allows a hospital to leverage expertise from beyond its geographical area. It can also help hospitals manage common turnover issues and the burden of continuously training these valuable personnel to keep them certified.

Use AI to increase efficiency and scope of chart reviews

The use of natural language processing (NLP), a type of artificial intelligence (AI), is increasing in popularity and may be an effective tool to address staff resource deficiencies related to deficiencies related to current workforce shortages. But the type of AI functionality available and how fully it is leveraged by the CDI team can make a big difference in program success. Most NLP-based CDI software reviews patient documentation to find areas of incomplete or inaccurate documentation that is a leading cause of poor coding and improper reimbursement.

Make sure your team is fully leveraging all aspects of the intelligence offered in the software and seeks solutions driven by clinically intelligent technology. Clinical intelligence comprises capabilities that emulate, automate or provide decision support for revenue cycle processes that rely on clinical knowledge and reasoning. It leverages sophisticated AI and a clinical knowledgebase to identify gaps in documentation including clinical validation and potential quality events. Since CDI and value-based care reimbursement are tightly linked, using clinically intelligent CDI technology helps ensure that value-based care initiatives are being handled appropriately by your CDI team.

CDI and coding are intrinsically linked and integrating them further through technology allows more effective use when faced with reduced staffing levels. Pairing your CDI technology with computer-assisted coding (CAC) on one integrated platform supercharges efficiency and collaboration among CDI specialists and coders.

The use of natural language processing (NLP), a type of artificial intelligence (AI), is increasing in popularity and may be an effective tool to address staff resource deficiencies related to COVID-19.

AI may also help alleviate physicians' administrative burden. According to a 2016 study published in the Journal of Medical Internet Research, "NLP can help reduce physician workloads, including clinical documentation time demands."[7] However, achieving these improvements depends upon NLP being clinically intelligent, built with underlying clinical knowledge and content. In the era of physician burnout, which has only worsened due to the pandemic, anything that helps reduce a physician's workload can help retain valuable physicians and allow them to focus more on patient care.

Consider outpatient CDI

Some organizations have expanded their CDI programs beyond the traditional inpatient realm into outpatient settings. Outpatient CDI is often an unrealized opportunity for improving financial outcomes.

According to Deloitte Insights, hospital inpatient stays have declined 6.6% over the past decade, despite population growth and demographic shifts (such as an increasingly older, sicker Medicare population). In contrast, from 2005 to 2015, visits to outpatient facilities increased by 14%, from 197 visits per 100 people in 2005 to 225 visits per 100 people in 2015.[8] This trend toward outpatient care presents a more enticing argument for expansion of CDI into outpatient settings.

Since outpatient CDI is structured and executed much differently than inpatient CDI, it's often best to take iterative steps for this type of expansion. The emergency department (ED) is a good place to start. From an ease of management perspective, the ED is generally part of the same hospital where the inpatient CDI program resides. As noted in an ACDIS CDI Journal article, not only does CDI in the ED offer outpatient opportunities, but the documentation from these encounters directly affects the documentation if (or when) patients move to the inpatient setting.[9] CDI in the ED helps to both reduce denials and ensure present on admission (POA) documentation is accurate, which affects a hospital's hospital-acquired conditions (HAC) metric and the potential financial penalties related to CMS' HAC reduction program.

A shift to outpatient

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Don't overlook the medical necessity connection

The determination of whether a patient should be admitted to a hospital as an inpatient or not has a big effect on the level reimbursement from payers — inpatient claims are generally paid $2,000 to $3,000 more per patient encounter than outpatient.[10] A patient's clinical documentation drives the initial assessment of a patient's need for inpatient admission so if it is inaccurate, it could corrupt the utilization review process and adversely impact reimbursement.

Investment in utilization review resources, such as more utilization review nurses and physician advisors, and AI, can benefit your CDI program. These experienced staff can uncover documentation deficiencies early in the patient encounter by ensuring proper patient status and recommending documentation improvements to attending physicians.

"De-silo" functions

During financially challenging times, organizations may find it difficult to maintain their level of staffing. Furloughed or laid-off staff creates numerous challenges related not just to getting the volume of work done, but also breaking critical process links that can render those processes ineffective. For example, where once most charts were getting some level of review by the CDI group, now only 50% of charts may be reviewed. Non-reviewed charts are open to documentation problems that will filter through the revenue cycle. However, many of these resource constraints can be eased by centralizing certain revenue cycle functions.

Centralizing certain functions can make fragmented operations work more efficiently as well as reduce the number of resources needed to support that area.

Centralize to do more with less

Many revenue cycle functions still operate in silos, using disparate processes across multiple facilities and often realizing uneven results. Much of this fragmentation has to do with acquisitions of other organizations with incomplete assimilation of cultures, processes and technologies between the merged companies.

Centralizing certain functions can make these fragmented operations work more efficiently as well as reduce the number of resources needed to support that area and allow you to repurpose resources to other critical tasks.

One area often ripe for centralization is utilization review (UR). Having a central group manage patient status determinations (inpatient versus outpatient) makes a lot of sense for a complex process that warrants standardization. Tabitha Hapeman, manager of the Resource Management Center and Patient Financial Services at Sentara Healthcare, centralized her UR group. As she explained, "Centralized utilization review allows for maximum efficiency and effectiveness of process. Hospitals should be able to ensure appropriate reimbursement and to have confidence that those dollars are safe from future audits."

"Centralization makes so much sense for systems that want a standardized process for UR," said Tabitha. "Every year, payers make it more challenging to obtain authorizations. Tracking that behavior and centralizing the knowledge in one department allows us to keep up with those continuing changes. And it's difficult to ensure a compliant process if that process is being performed in multiple sites with different leaders."

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>
> *— Tabitha Hapeman*

Use technology to drive standardized processes

As functions are centralized, implementing modernized, standardized processes can help deliver more consistent outcomes and reduce operational variation that leads to inefficiency and errors. Technology is a vital tool to help drive standard processes through:

- **Workflow** — establishes a consistent work method and helps ensure effective team handoffs
- **Business rules** — applies and enforces process guidelines, and can help mandate that certain critical information is captured before a worker can move to next steps in the process
- **Artificial intelligence** — clinically intelligent AI can provide early process insights that prevent errors and inform sound decisions, so processes work smarter

Technology serves as a powerful tool to enforce process accountability. As new technology-driven processes are rolled out, leverage analytics to identify any potential problems with process functions.

Merge front-end and back-end revenue cycle functions

Traditionally, front-end (patient access) and back-end (claims, collections, denials) revenue cycle areas have been very siloed. However, there are many points of connection between these two areas that warrant a more interwoven partnership. A large amount of the denials that back-end staff need to resolve originated on the front end. Instead of focusing on collections post-service, a more conjoined front and back office can figure out strategies to increase patient payments up front during check-in, which reduces the collections burden on the back end. This results in more revenue for the organization.

Invest in areas that bring a return

During challenging times, it's understandable to hold the purse strings tight. But investment in certain areas can improve financial outcomes by providing better revenue integrity, efficiency and effectiveness. One key question to ask yourself is, "What is the risk of not investing?"

For information on Optum revenue cycle solutions visit Optum360.com.

For more information visit **optum.com/contactus.**

Sources:

1. Financial Effects of COVID-19: Hospital Outlook for the Remainder of 2021. KaufmanHall, September 2021.
2. Grajewski B. Why are hospitals cutting costs? Becker's Hospital CFO Report. beckershospitalreview.com/ finance/why-are-hospitals-cutting-costs.html. Accessed June 25, 2020.
3. Kerns C, Connelly E. Why health systems need to stop treating cost-cutting like that new dieting fad. Advisory Board. advisory. com/ research/health-care-advisory-board/ blogs/ at-the-helm/2017/12/health-systems- margins. December 14, 2017. Accessed June 25, 2020.
4. Hansard S. Hospitals aren't meeting their own modest cost-cutting goals. Bloomberg Law. bloomberglaw.com/health-law-and- business/ hospitals-arent-meeting-their-own- modest-cost-cutting-goals. November 15, 2019. Accessed June 25, 2020.
5. 2016 Black Book CDI Survey. Black Book Market Research.
6. ACDIS survey: 53% of CDI programs are understaffed, poll indicates. *CDI Strategies*. 2019;13(54). acdis.org/articles/acdis- update-53-cdi-programs-are-understaffed- poll-indicates. Accessed June 25, 2020.
7. Krauss G. Outpatient CDI: Follow the money. ICD-10 Monitor. icd10monitor.com/ outpatient-cdi-follow-the-money. September 9, 2019. Accessed June 25, 2020.
8. What are the benefits of clinical documentation improvement (CDI)? EHR Intelligence. ehrintelligence.com/ features/what-are-the- benefits-of-clinical-documentation-improvement. June 29, 2018. Accessed June 25, 2020.
9. Ambulatory CDI efforts: Get thee to the ED. *CDI Journal*. 2017;11(3). acdis.org/ articles/ ambulatory-cdi-efforts-get-thee-ed. Accessed June 25, 2020.
10. Based on Optum Physician Advisor Solutions experience.

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