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integrated revenue cycle coordination between insurers and providers to ensure revenue accuracy

AT A GLANCE

To ensure revenue accuracy, healthcare providers should focus on the following activities:

- > Improving internal processes
- > Solving for imbalances in information
- > Establishing oversight controls

Traditional revenue cycle management arrangements that focus solely on billing and collections are no longer in the world of delegated risk models, especially for Medicare Advantage (MA) populations.

These arrangements inextricably tie together the financial outlook for both insurers and providers, with the providers taking on most of the financial risk. Providers are now accepting a percentage of the premium payment received from the Centers for Medicare & Medicaid Services (CMS) for their MA members. But they also should take steps to ensure that payment is accurate.

Today, many provider revenue cycle leaders are taking an innovative approach to managing their value-based payments, which is improving the accuracy of their MA premium payments by millions of dollars annually. Under a delegated risk model, revenue inaccuracies affect the provider in a much bigger way than they do the insurer.

Steps to Ensure Accuracy

Shared-risk models have taken providers into a new world of revenue cycle management that requires evolved processes and controls to ensure revenue accuracy. These efforts should be focused on the following three activities.

Improving internal processes. As discussed below, MA payments are tied to the evaluation of encounter-based documentation that establishes how payments will

be adjusted for risk and account for quality of care. Complete and accurate documentation paired with end-to-end completeness of information as it travels from one system through the other is critical to ensuring capitated payments align with the risk of the population managed.

Solving for the imbalance in information. Under value-based contracts, insurers must complete an array of operational and reporting activities to ensure providers' revenues are accurate. Many providers, however, lack the insight to confirm that the insurers are fulfilling this requirement. Providers should negotiate a clause in their risk contracts that ensures they have timely access to this information to gain transparency into insurer activities.

Establishing oversight controls. With access to the applicable CMS regulatory reports, providers should establish ongoing monitoring processes to proactively identify issues that affect revenue accuracy.

Key Factors Affecting Revenue Accuracy

Multiple factors impact the premium payment received from CMS for covered MA members, including the following, in particular:

- > Risk coding and documentation
- > Encounter reporting
- > Medicare secondary payer (MSP) and end-stage renal disease (ESRD) entitlement determinations

Risk coding and documentation. The importance of effective coding risk and accurate capture of diagnoses is not a new concept for providers. Yet these areas have become more important with the expansion of risk-bearing arrangements, which place even greater emphasis on complete documentation of all appropriate medical diagnoses to the appropriate level of specificity. Ineffective hierarchical condition category (HCC) documentation can result in lower risk-adjustment factor (RAF) scores for a population, and ultimately, a negative impact on revenue. For example, a 2 percent decline in a RAF score deficit can translate into a decrease in revenue amounting to as much as \$150 per member per year (PMPY).

HOW AN INTEGRATED REVENUE CYCLE REFLECTS COORDINATION BETWEEN INSURERS AND PROVIDERS

Key Elements of Provider Revenue Cycle

- > Scheduling
- > Insurance Verification
- > Medical Records
- > Patient Payment Collection
- > Registration
- > Coding and Charge Capture
- > Claim Submission and Billing
- > Payment Posting

Integrated Revenue Cycle

- Risk Coding and Documentation**
Complete and accurate risk documentation to the appropriate level of specificity
- Encounter Reporting**
Complete data transmitted through many systems to submission and acceptance by the Centers for Medicare & Medicaid Services
- Medicare Secondary Payer (MSP) Designation and Coordination of Benefits**
Correct end-stage renal disease entitlement and MSP status determinations
- HEDIS and Stars**
Accurate capture and submission of CPT, HDPS, ICD-10, and revenue codes
- Action to Address Compliance Threat**
Prevention of overcoding in encounter documentation and of MSP overpayments

Key Elements of Insurer Revenue Cycle

- > Enrollment/Eligibility
- > MSP Validation
- > Risk Adjustment
- > Member Premium Collection
- > ESRD Validation and Reporting
- > Quality Reporting
- > Encounter Reporting

The financial opportunity cost of incomplete coding is too significant for providers to rely on insurers to take the lead, especially when the insurers may be subject to only 15 to 20 percent of the financial risk.

Although risk coding is not new to providers, insurer-driven initiatives have led to disparate reporting and processes across contracts, adding disruption and additional work for providers. Providers now can dictate how information sharing fits into their workflows, creating a risk documentation improvement process that is insurer agnostic. The financial opportunity cost of incomplete coding is too significant for providers to rely on insurers to take the lead, especially when the insurers may be subject to only 15 to 20 percent of the financial risk.

Value-based payment arrangements also elicit greater regulatory scrutiny on the accuracy of risk documentation and the potential false claims issue related to overcoding and reporting. A federal judge recently ruled the U.S. Justice Department can move forward with a lawsuit against UnitedHealth Group Inc. claiming that the company wrongly retained more than \$1 billion in Medicare Advantage revenues.^a A thorough risk documentation improvement process that looks at both under- and overcoding is necessary to safeguard against such potential compliance issues.

Encounter reporting. Once diagnoses have been captured, both the insurer and provider are responsible for ensuring that information is transmitted through the many information systems, from the patient visit through CMS reporting, without any data degradation.

a. Raymond, N., "U.S. Can Sue UnitedHealth in \$1 Billion Medicare Case, Judge Rules," Reuters, U.S. Legal News, Feb. 18, 2018.

Nonetheless, some data degradation is inevitable, which in turn results in lost revenue.

Most data quality issues exist prior to regulatory submission, meaning that the data quality issues tend to occur either with the provider, as a result of limitations in its internal data management processes and in its ability to transmit encounter information, or with the insurer, as a result of its imperfect ability to ingest the information and generate a complete and accurate submission to CMS.

Submission challenges also account for some issues in data quality. For more than a decade, insurers have prepared and submitted risk-adjustment data to CMS via the Risk Adjustment Processing System (RAPS). Starting in 2015, CMS introduced a new system, the Encounter Data Processing System (EDS), which requires insurers to submit much more detailed data for use in determining risk adjustment payments. The migration from RAPS to EDS has increased the complexity of insurer reporting, with material financial implications for MA plans.

Inaccurate encounter reporting also affects the accurate calculation of quality measures for the Healthcare Effectiveness Data and Information Set (HEDIS), administered by the National Committee for Quality Assurance, and Five-Star Rating System, administered by CMS. The agency includes 17 HEDIS measures as part of its overall calculation of star ratings for providers participating in Medicare Advantage, including preventive/stay health measures (e.g., adult BMI assessment, colorectal cancer screening) and chronic condition management measures (e.g., medication review, controlling

blood pressure, various diabetes care measures). The performance calculation is based on the accurate capture and submission of CPT, HCPCS, ICD-10, and revenue codes. Based on our analyses performed, a decline in star rating from 4.0 Stars to 3.5 Stars can precipitate a revenue loss as great as \$300 PMPY.

Establishing processes to ensure complete and accurate encounter reporting requires both internal controls and insurer oversight controls.

On the provider side, data degradation can occur anytime information is transmitted from one point to another, so controls should ensure the following are accomplished:

- > The provider receives all data generated at the point of care.
- > All information is making it through each system.
- > All information that should be reported to CMS is being sent to the insurer.

Proper oversight controls also are imperative because providers' revenues are tied to an insurer's ability to accurately report encounter-based information to CMS. Controls should periodically review the insurer's CMS submissions throughout active reporting periods to ensure that the following actions are taking place:

- > Insurers are submitting all encounter information provided for both quality (Stars) and risk adjustment (RAPS and EDS) reporting.
- > Errors occurring during the submission process that have financial impact are being consistently addressed.
- > All submissions are compliant and in accordance with CMS regulations.

MSP designation and coordination of benefits.

Value-based payments depend on the accuracy of MSP and entitlement status determinations. When a patient has additional insurance apart from Medicare, the coordination of benefits (COB) process determines which insurance plan has the primary payment responsibility. If Medicare is the primary payer for a patient, the MA plan receives a primary (higher) premium payment from CMS, which is then translated to the provider's value-based payment. As a result of an inaccurate determination, meaning a provider

receives a secondary premium instead of primary one, the provider would face a premium shortfall—amounting to \$450 to \$500 (according to our analyses) per inaccurate member determination, on average, in such situations—and a complex COB situation with the patient's other insurers.

Beyond MSP designation, patients with ESRD also require special classification reported to CMS. Accurate and timely ESRD entitlement determinations by CMS are dependent on the submission of a 2728 form from a dialysis facility to confirm diagnosis. Delays in submission—or worse, inaccurate submissions that are not accepted by CMS—result in significant medical cost incurred without adequate premium revenue to cover. Although the number of patients with ESRD is small, the difference in monthly premium between a member with ESRD and one who does not have ESRD is \$5,000 per month, on average.

CMS's alphabet soup of periodic reports presents a challenge for any provider to turn applicable data into actionable insights, but the financial opportunity cost of not doing so is too significant to blindly place all responsibilities on the insurer.

Enrollment categorization across MSP and ESRD is a particularly complex process. CMS continually collects disparate information from various sources that affect the capitation payments reflected in the monthly membership report, and because of a lack of either awareness or wherewithal, many insurers do not have efficient process in place for validating the capitation payments and recouping lost dollars. The financial recovery opportunity is especially high for the first MSP analysis effort, because CMS allows validation, reconciliation, and corrective payments for up to six prior years.

Devising an integrated revenue cycle can create a new level of transparency and two-way information sharing geared toward ensuring revenue accuracy both parties.

Implications for MA Contracts

When negotiating in risk-bearing MA contracts, providers should make it a priority to include provisions that grant them access to all information submitted to and reported back from CMS as it pertains to their populations. Without such a provision, providers will not receive the information they need to properly oversee their integrated revenue cycles, and more likely will receive only incomplete or modified information that does not provide the level of transparency and assurance needed to evaluate revenue accuracy.

Through acceptance of responsibility for tracking this information, providers can negotiate for certain data files that would allow them to assess the degree of revenue accuracy in their risk-based payments. CMS's alphabet soup of periodic reports presents a challenge for any provider to turn applicable data into actionable insights, but the financial opportunity cost of not doing so is too significant to blindly place all responsibilities on the insurer.

Devising an integrated revenue cycle can create a new level of transparency and two-way information sharing geared toward ensuring revenue accuracy both parties. In our experience, health systems taking control of these revenue processes, and identifying and correcting issues themselves, have reported revenue gains of \$8 million to \$12 million for a 30,000 attributed lives contract.

In delegated risk contracts, there are clear benefits to providers to be gained from implementing processes or tools to collect the required data sources and

actively and routinely monitor revenue accuracy. And as noted previously, this process should start as early as the contracting stage, with a focus on negotiating a contract provision that ensures the provider has access to data sources that allow it to establish comfort with payment levels in delegated risk contracts.

For providers that own a health plan, these processes can be immediately implemented to uncover areas of financial opportunity in the short term. Once these areas are identified, the plans can take corrective action to resolve issues and recover lost revenue.

Collecting and analyzing these data sources will arm providers with an understanding of areas for risk coding improvement, help inform conversations with insurers on where to recoup underpayments (or correct overpayments) in situations involving MSP and COB, and guard both parties against compliance risk. Better collaboration in all these areas will improve the payment yield in capitation agreements. ■

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