

Key Strategies for Modernizing the Revenue Cycle



Staying viable in today's increasingly complex healthcare environment is no easy feat for any hospital or health system. Demands for better clinical quality are prompting organizations to design and implement new care processes and delivery systems that can more efficiently meet payer requirements and patient needs.

At the same time, organizations are being pushed to elevate business operations. Tightening payer reimbursements, evolving regulation, growth in consumerism, and the trend toward integration are putting substantial pressure on today's revenue cycle.

"Change has become the norm," says Tim Panks, senior vice president of finance and revenue cycle management (RCM) for San Francisco-based Dignity Health, a multiple-hospital health system that offers services in 21 states. "Organizations must be creative in how they manage the numerous stressors and ensure they create a firm financial foundation that can flex as the changes keep coming."

As healthcare leaders strive to achieve next-era RCM, they should embrace a strategic approach that marries business performance with customer service. In particular, organizations may want to concentrate on three specific activities: creating a more consumer-friendly payment experience, boosting technology to drive reimbursement, and leveraging external expertise. The following sections closely review each of these tactics, sharing real-world advice on how to pursue them.

Work Toward Consumer-Friendly Payment

Although healthcare organizations have made great strides in providing smoother clinical interactions for patients by improving patient throughput, enhancing discharge planning, and engaging in targeted follow-up care, many organizations fall behind when it comes to financial operations, treating the patient experience in the revenue cycle as an afterthought to the clinical encounter.

With the rise in consumerism plus higher patient out-of-pocket costs in the form of copayments, deductibles, and premiums, today's patient is more focused than ever on the financial experience, wanting to avoid surprises when the bill arrives and make payments quickly and efficiently.

Consequently, forward-thinking healthcare organizations are striving to achieve greater financial transparency with patients. "The revenue cycle today is more consumer driven than it ever has been because healthcare is becoming more consumer driven," says Jon Neikirk, executive director of revenue cycle for Froedtert Health, Milwaukee, a three-hospital system with multiple health centers and clinics. "As a result, organizations should be seeking ways to engage patients in financial communications early in the encounter and provide convenient methods for payment. HFMA has done some meaningful work in this area, developing several patient financial communication best practices. As Froedtert starts down this path, we are looking to those best practices to guide our efforts."

While there are many ways to influence patients' financial experience, following are a few areas that are especially critical.

Providing estimates. The idea of offering patients an estimate of their total charges is relatively new. Even hospitals that shared this kind of information in the past frequently provided it for only a part of the care episode, such as out-of-pocket costs for an imaging test. Now, patients want to know their costs for the entire care episode, including primary care and specialist visits, diagnostic tests, procedures, and therapy.

Software tools that create patient estimates are available, but attaining accuracy can be challenging because of the many variables in the healthcare episode. For example, estimates may not include all physician visits, depending on their timing. Or services may change slightly from the time of the estimate to the time of the actual service. A provider may have obtained a preauthorization for an MRI (magnetic resonance imaging scan) without contrast, for instance, but then the

actual test involves contrast, which changes the price. Other complicating factors include differing insurance benefits packages, pricing for in- and out-of-network physicians, and various pricing structures for different care settings.

Froedtert Health is aiming to provide accurate information about patient responsibility by implementing a patient out-of-pocket cost estimator tool. While not fully in place, the software will eventually enable the health system's revenue cycle staff to generate two types of estimates:

- Consolidated costs for hospital and physician services upon patient request
- Costs for ancillary services, beginning with imaging, provided at the time of service scheduling

This information should help patients make more informed decisions about their care.

Currently, Froedtert patients receive estimates based on hospital charges. Unfortunately, these quotes do not reflect copays, deductibles, or self-pay discounts, which can affect the ultimate cost for the patient. The difference between hospital charges and what patients actually pay is often considerable. "This estimate gives patients a starting point; however, we do encourage them to follow up with their insurance companies for precise figures," Neikirk says. "We are hoping with the new system to provide greater accuracy and clarity and make the estimates more patient friendly."

When deciding on a cost estimator tool, Froedtert also looked at the one housed in its electronic health record. "Sadly, this one is not yet able to consistently provide accurate estimates for our various hospital and clinic locations, whose charges differ based on managed contract rates and designated care settings," says Neikirk. "The new tool, compiling data from the chargemaster and managed and government contracts, is able to generate estimates based on the location of service."

One thing to consider when looking at different cost estimator tools is the ability to integrate these solutions with other front-end processes, such as eligibility verification and financial counseling. An integrated tool will give registration staff a

broader view into the financial clearance status of the patient account. As registration staff work with a patient, they can look across solutions to see if there are any eligibility issues or if the account is cleared for payment. They can also identify patients who could benefit from a payment plan or charity care, which could trigger a referral to a financial counselor for further discussion about payment options. By combining front-end processes, a staff member can see where the account is in its life cycle and anticipate possible payment issues, as opposed to merely completing the registration and addressing problems on the back end.

Educating patients. While leveraging technology to provide patients with comprehensive financial information is valuable, this information must be given in context. For many patients, "deductible," "copay," and "coinsurance" are new terms that may be confusing. An organization cannot merely hand patients a cost estimate and hope they understand it—the facility must spend time walking individuals through the figures, showing them their responsibility, and communicating how the organization came to the total price. Unfortunately, many entities are not equipped to sufficiently educate patients so they can make informed decisions about payment. This requires a concerted effort from the health system to identify staff to take on these conversations and ensure they occur in an informative yet compassionate manner.

Delivering easy-to-understand patient statements. Going hand in hand with the patient estimate is a user-friendly statement that clearly describes what the patient owes and why. This document should be straightforward and clearly communicate what the patient has already paid (if there are copays and deductibles), what the patient owes, and the agreed upon payment time frame. Ideally, a health system should offer a single patient statement that combines both the hospital and physician charges. Not only does this prevent the patient from receiving multiple bills from different departments—a chief patient dissatisfier—it can also mitigate confusion, prompting the patient to pay on time and in full. For more ideas on how to make patient bills more

approachable, organizations should review HFMA's patient-friendly billing project, which offers multiple tips and strategies (<https://www.hfma.org/patientfriendlybilling/>).

Offering different payment options. Providing clarity is one way to make the financial experience more approachable; however, organizations should also consider making it more convenient. A key method for doing this is to present diverse payment options. While this may be groundbreaking in health care, other industries have been employing a variety of payment strategies for years, offering accessible options and the ability to manage functions online. Although every consumer would like payment to be easy, how each defines that convenience varies. Consequently, an organization should think about providing multiple payment venues, including via point of service, a call center, the mail, telephone, online tools, and mobile solutions. Some organizations are even starting to take the patient's credit card at the bedside using an encrypted card reader, which makes it easy to collect secure payments because a financial counselor does not have to leave the room with the card and run it somewhere else.

"Froedtert is in the midst of looking for ways to make payments more convenient, especially for the younger generation, which has come to expect the expediency that technology offers," says Neikirk. "One option under consideration is connecting with patients on their mobile devices, giving them the ability to pay bills using their cell phones."

Ultimately, the patient is an ideal source of information on how to make the financial experience user friendly. Patients have become much more vocal about what they expect, and organizations that listen to them can hone front-end processes to meet patient needs. Whether through patient surveys, advisory councils, or feedback from call centers, organizations should take patient suggestions and comments seriously. "In the end, we need to meet our patients where they want to be met," Neikirk says. "And this may mean completely reenvisioning how we communicate about and collect payment."

Boost Technology to Speed Accurate Reimbursement

While organizations aim to bolster the patient financial experience, they are also working to improve the efficiency of the revenue cycle—limiting waste, streamlining processes, and promoting accuracy. Employing technology is an effective strategy for achieving these goals.

Nearly every aspect of the revenue cycle—from documentation and coding to charge capture, claims submission, and denials management—can benefit from automation. These tools can limit human error and encourage greater accuracy while facilitating faster payment, ultimately driving revenue and improving cash flow. Following are some key revenue cycle functions that can benefit from technology.

Charge capture. These solutions let organizations be more precise when capturing charges, helping facilities monitor and elevate revenue integrity enterprise-wide. By highlighting missed opportunities for charges, this tool is able to improve accuracy and comprehensiveness. Solutions can also facilitate benchmarking, enabling performance comparisons across facilities, settings, and/or regions. Not only does this allow organizations to identify underperformers, but it can also encourage greater use of best practices. Organizations can also monitor the results of any new charge capture initiatives by regularly reviewing the benchmarked data. This can illustrate the need for further education or tweaks in the process. Even if an organization uses a charge capture tool in multiple locations where there are process differences, the technology can encourage greater comparability and limit variation.

Computer-assisted coding (CAC). This is a newer software tool that some hospitals and health systems have invested in to prepare for ICD-10. Froedtert Health has implemented a CAC system in all three of its acute facilities within the past two years for both inpatient and outpatient services. The tool streamlines the coding process by highlighting key words and paragraphs in the documentation that are particularly important for coding and also suggests codes for a diagnosis or procedure. Even though this software does not code

per se, it does help coders be more efficient—basically having them validate instead of coding “from scratch.” By helping the coder be more proficient, the software can mitigate some of the productivity hit associated with ICD-10.

Clinical documentation improvement (CDI). This kind of solution is very helpful when trying to elevate documentation. Not only does it assist organizations in generating more complete records through physician prompts, alerts, reminders, and drop-down menus, it can also guide training and auditing. The software is able to pinpoint the right cases to review during audit using clinically based algorithms. Basically, the technology lets the CDI department work by exception—something that revenue cycle departments have been doing for years. It highlights a subset of accounts, showing where there are possible improvement opportunities. Typically, it also houses a communication tool between CDI and health information management.

Workflow management. These tools can drive efficiency by automatically routing issues, such as lack of documentation, incorrect codes, or denials, to the correct department for further examination and response, ensuring the appropriate people address problems and prevent anything from falling through the cracks. This type of software enables accounts to easily move through a revenue cycle or patient financial services department, getting specific information to the right employee at the right time. For example, the software can route denials to a designated revenue cycle staff person or department depending on the reason for the denial, the payer responsible, or the denials’ potential collectability. This lets an organization prioritize its resources and resolve issues more quickly and efficiently. Plus, when the same person receives multiple denials around the same topic or for the same payer, it can highlight trends the organization can then address to prevent future issues.

Although robust denials management has always been important, it will increase in significance post-ICD-10 as payers and providers wrestle with the nuances of the new code set. In addition, as the industry shifts to value-based care, denials management will become even more essential. As such,

workflow management tools are becoming a must-have for organizations looking to remain viable long term.

Regardless of the technology an organization uses, there should be a way to analyze whether a solution is making improvements. Although it can be difficult to tie a change to one specific tool, especially when an organization has implemented new processes, facilities can leverage key performance indicators (KPIs) to highlight improvement that could link back to new automated solutions. For example, KPIs for denials management include the financial clearance ratio and the number of accounts that have gone through upfront insurance verification. Days in accounts receivable (A/R) and A/R days greater than 90 can also point to possible problems with denials.

Before implementing a solution, an organization should determine what KPIs that technology could impact and collect a baseline of performance. During and after implementation, the organization can then monitor the KPIs to see if the technology is having a positive or negative effect. If there are better results, an organization may be able to tie improvement, at least in part, to the technology. Conversely, if there is a drop in performance, that may highlight a larger problem.

Leverage Outside Expertise

As pressure to improve performance grows, it is becoming more challenging to not only understand the kinds of changes that are required to elevate revenue cycle functionality, but also figure out the best ways to make those changes. Moreover, there are financial considerations because leaders often have to choose between investing in clinical and revenue cycle operations, particularly when there is a limited amount of available dollars. When the main business is providing patient care, revenue cycle improvements tend to get set aside for another day—and that day may never come.

To improve revenue cycle functionality, efficiency, and productivity, a number of health systems are turning to outside RCM firms to obtain the sorely needed expertise in every

phase of the revenue cycle, from enhancing patient eligibility verification to creating more seamless handoffs between front- and back-end operations to facilitating denials management. External experts can add industry insight and knowledge that may be out of reach to healthcare organizations by themselves. For example, revenue cycle technology has become so complex that some healthcare organizations lack the appropriate expertise to choose, implement, and maintain new and cutting-edge systems. In these cases, organizations are seeking expert partners to help navigate new technology.

For San Francisco-based Dignity Health, limited capital for revenue cycle improvement drove the decision to partner with a health information and technology firm. The need to standardize processes and technology across the system's network of hospitals was another factor. The organization looked to partner with a firm that offered a mixture of technology and services to elevate the revenue cycle while preserving resources.

"Capital constraints within health care are growing," Dignity's Panks says. "In partnering with a firm that provides expertise in technology, we can mitigate some of those constraints and pursue improvement initiatives."

One area in which Dignity's technology firm works is adding bolt-on software tools to the organization's existing information systems, such as the electronic health record and financial systems. "The purpose of this effort is to improve efficiency in front-end workflow, elevate charge capture and clinical documentation, and remove wasteful practices in claims processing," says Panks. "Moreover, our partner helps us standardize various components of the revenue cycle, such as coding, which allows for greater flexibility in managing accounts across the integrated health system. In the past, making technology enhancements could take a long time. However, with the partnership, our organization can be more nimble and responsive to innovation."

Dignity Health's partner is also responsible for training revenue cycle staff on new processes and technology. "This is

crucial because technology does not drive change on its own—in fact, automation without change management can result in a fatal mistake," says Panks. "It's an ambitious task to make change happen and do it the right way. The ability to mold culture, enhance staff understanding, and implement reliable processes can't be undervalued. Whenever you're dealing with technology, the external expertise is critical to ensure you're maximizing the solution so it fully meets your organization's needs."

Dignity Health is also benefiting from its partner's expertise in structure—including identifying opportunities to centralize, decentralize, or even outsource functions—as well as methodology—including pinpointing the optimal way a function should be managed and what kind of policies and procedures should be used in this capacity.

"The relationship, structured as a joint venture and managed via a management services agreement, includes 30 service line agreements (SLAs) that are measured either on a monthly or quarterly basis to verify that performance is maintained or improved," Panks says. "The SLAs are benchmarked according to Dignity Health's peer group in the HFMA MAP Keys—industry-standard metrics used to track revenue cycle performance, including net days in accounts receivable and the number of denials. Our goal is to reach the 75th percentile in the HFMA MAP App for certain indicators during the first five years."

In addition to strengthening Dignity Health's revenue cycle capability, Panks says the new partnership is also enabling the organization to provide a higher level of service to patients by delivering a smoother, more seamless experience.

Like Dignity, many large health networks are shoring up their financial foundations through partnering with vendors. Entering into a formal partnership, such as a joint venture, may not be suitable for every organization, but carefully considering how external expertise can help elevate performance—especially in the revenue cycle—should be part of long-term strategy for hospitals of all sizes.

In that context, here are some essential steps for ensuring a successful partnership.

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ENABLING AN EDUCATED AND SATISFIED PATIENT POPULATION

Ron Jones, CEO, Optum360, discusses how connecting care delivery and payment can improve patient satisfaction to support a more streamlined revenue cycle.

What role does patient satisfaction play in the modern revenue cycle?

The essence of consumerism is to take an active role in decision making, and an uninformed consumer generally becomes a frustrated one. With this in mind, asking patients to make care decisions without knowledge of the financial ramifications is unreasonable—and has a direct impact on their satisfaction level. To improve patient satisfaction, providers need to make significant shifts in the connection between and communication of the clinical and financial aspects of care.

Providers must assess how care delivery and costs are being communicated to patients and ensure the two parts are interrelated. Improving patient satisfaction hinges on enabling better interaction by educating individuals about their benefits and options and supporting them in

navigating the healthcare system. This includes accurately estimating patient cost by providing out-of-pocket estimates and verifying insurance eligibility to better equip patients to make informed decisions. Additionally, payers and providers should seek a mutual solution to streamlining efficiencies so details regarding care delivery and financials can be communicated effectively.

An educated population of patients will know the copays, deductibles, and coinsurance that they owe at the time of service, leading to increased point-of-service cash collections. Further, when patients receive a bill later, they will understand how their benefits applied to the charges and the portion they are responsible for paying. By equipping patients with knowledge and helping to avoid surprises in the cost of care, providers can expect fewer delays in the payment process, reduced administrative costs, a more streamlined revenue cycle, and overall more satisfied patients.

Source: Optum360

Select the right partner. A vendor that is a true partner will help implement and support the systems and strategies it supplies. The company should be willing to commit to understanding the healthcare organization's revenue cycle needs and suggest ways to integrate existing systems and processes with new tools and functions. Additionally, with larger technology deployments, a partner should help manage the change process, garnering employee buy-in and support of new procedures and workflows. Should there be a problem with the revenue cycle, such as elevated A/R days or increased denials, a partner should be willing to commit resources to address the issue. The distinction of a good vendor is how it goes about collaborating with an organization to pinpoint and resolve problems.

Promote transparency in the relationship. Candor underpins any successful arrangement. If performance is not improving, it may not necessarily be the fault of the technology or the revenue management firm. Oftentimes there are organizational issues at play. Perhaps employees are reluctant to change work habits or the organization has not fully committed to new technology. Before agreeing to an external partnership, organizations should make sure they lay the cultural groundwork, by getting staff buy-in and support, as well as leadership commitment. If problems arise, organizations should avoid playing the blame game and instead work together with their external partner to uncover and resolve systemic issues.

Commit internal resources to sustain performance.

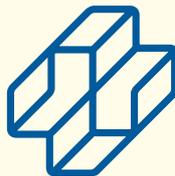
While selecting the appropriate partner is fundamental, organizations should also commit designated internal resources to provide support, monitor progress, and ultimately help the organization achieve long-term sustainability. Having a dedicated point person who works with the external firm can ensure the relationship remains collaborative and productive, and that issues are identified and resolved before they escalate. This person can also help ensure the project stays on budget and on target given the organization's other strategic goals.

Embrace Flexibility

The new healthcare paradigm is altering how leaders approach revenue cycle challenges. Being open to new methods and solutions is necessary to achieve patient-centered, value-based care. Everyone needs to continue to adapt, elevating operations to rethink, retool, and reenergize their financial operations—for many of the same reasons they have improved their clinical operations. From large-scale initiatives that bundle enhanced revenue cycle functions with overall organization performance, to new technology implementations, to effectively leveraging outside expertise, modernizing the revenue cycle requires not just a few steps, but a journey toward automated, integrated, and higher functioning.



No matter what goals you're pursuing, Optum360™ offers the services, technology, and analytics to help you get there. With deep experience at every stage of the revenue cycle—from patient registration through coding, billing and payment—our experts can deliver scalable solutions attuned specifically to your needs and challenges.



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