



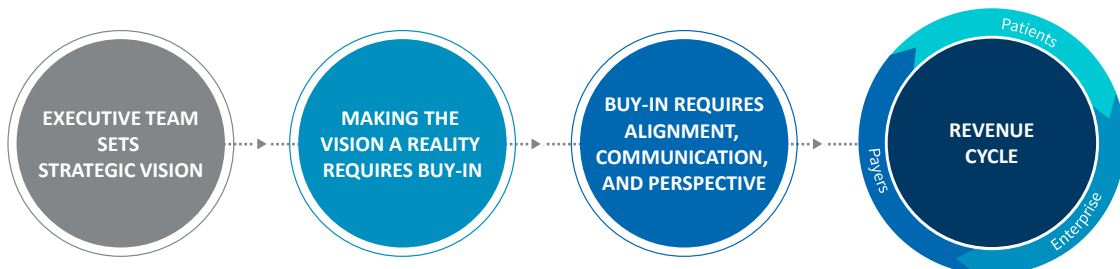
ARTICLE

Your Revenue Cycle Management: Driver of Change and Hub of Organizational Communication

Understanding the impact that the revenue cycle can deliver: With all of us being consumers of healthcare, we understand that the industry is continuously changing: the regulatory landscape adjusts to reflect lessons learned; patient demands change as people take greater responsibility for their own care; providers advance alongside new technology and research; and care delivery models alter based on societal needs.

Hospitals and provider groups must find ways to adapt to these changes, and the revenue cycle can be a vehicle to drive that change, given its unique position of serving three equally important clients: the patient, the enterprise and the payer.

To effectively be that agent of change, the revenue cycle structure and processes must be aligned **to facilitate communication among patients, providers and payers, and the challenges and demands of these three clients must be understood to achieve this alignment.**



Because of the services the revenue cycle team provides these groups, it becomes the lens for alignment and a vehicle to implement change.

Challenges and demands of serving the patients

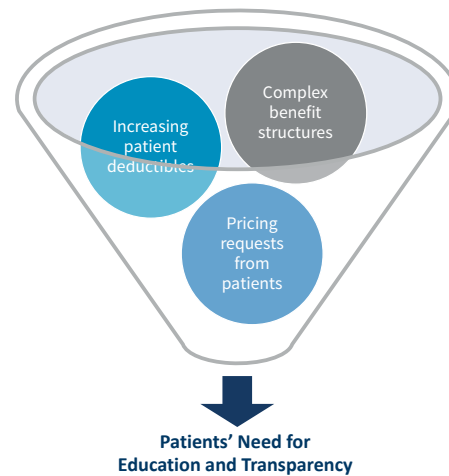
Becoming the ambassador of the patient experience

The revenue cycle sets the tone for the patient experience, since it is often the patient's first and last point of contact with the enterprise. More importantly, the revenue cycle addresses one of the most important patient questions outside of care: *What is my out-of-pocket cost?*

With per capita out-of-pocket expenditure steadily rising, patients are finding themselves bearing more financial responsibility for the services and products they receive. As such, the way in which the patient (or the "customer") consumes healthcare is shifting. To address these shifts, revenue cycle leaders must consider:

- **Simplifying the process from pre-registration to payment by leveraging technology.** Patients want to have a smooth, simple visit that is focused on their healthcare needs, not on registration and payment. Ideally, the patient experience will have them arrive, see the provider, schedule any follow-up visits and leave. The need for the patient to fill out information in the waiting room or take their wallet out at the end of each visit can be eliminated with an optimized pre-arrival process.
- To address billing, the utilization of mobile apps and online portals to collect necessary information, inform/educate patients on balances due, store payment information, and collect or initiate payment plan options prior to the visit enables the practice to provide a comfortable and stress-free visit for the patient while maintaining secure and accurate patient data that will minimize billing errors.
- To address other visit and care needs, these mobile apps and portals can keep patients engaged throughout their healthcare journey with personalized financial and visit information that can be easily accessed and understood. Technology exists to assist patients as they pre-register for a visit, change their payment preferences, access bills and/or make

Providers must be equipped to meet payer requirements as well as answer all patient inquiries



electronic payments, and even see how their insurance may be applied to certain common visits.

- **Helping patients understand their insurance coverage, benefits, financial responsibility and financial assistance options prior to service.** Over the last 10 years, higher deductibles, copayment rate increases and non-covered benefits have contributed to patients needing and demanding to know how much services will cost them. Unfortunately, due to system complexities, many patients do not have a firm understanding of their insurance coverage and how services are billed. Consequently, the enterprise cannot simply be a provider of care, but also needs to be a financial educator and assistant.
- Financial clearance staff in the past have focused only on verifying insurance eligibility and requesting authorization. This team now needs to expand its scope and be well trained and thorough in the processing of encounters. In other words, they need to be able to understand the patient's insurance better than patient themselves. To do this, staff need to validate coverage and benefits, and understand the calculation of price estimates based on outstanding deductible, coinsurance and maximum out-of-pocket (OOP). Additionally, this team should be well-versed and comfortable with having financial conversations with patients prior to service so that patients can be

informed of their financial responsibility and provided with options on how they can meet that responsibility.

- **Streamlining external communication channels.** The revenue cycle and billing process is complicated, and often there is not a “one size fits all” answer to specific billing and insurance information. Given the high costs of care, patients expect quick communication and the ability to find answers to billing-related questions. Leading practice options for the revenue cycle to address these demands include patient portals, outsourced 24/7 chat services to answer questions, Q&A forums for common questions, and a billing-specific phone line staffed by well-trained customer service representatives.

Challenges and demands of serving the enterprise

Unpacking what it takes to maximize revenue

A goal of the revenue cycle is to ensure that the provider (and/or enterprise) is being reimbursed the maximum amount for services rendered. The way in which these funds are captured has changed over time, which has required organizations to adapt to those changes. This also means that the revenue cycle must change and adapt, and those changes must be in line with enterprise goals. To change and satisfy enterprise demands, revenue cycle managers must consider the following challenges:

- **Ensuring the organization has a supportive management and governance structure.** It is important to recognize the needed alignment and support between organizational goals and revenue-cycle goals. Having an appropriate governance structure in place that includes clinical champions is necessary to ensure that enterprise goals are met. One way to encourage involvement is by arming clinicians who are on change committees with detailed analytical data, so that they become more engaged and can more easily make informed decisions. Revenue cycle is the team that will provide and explain the story behind the analytical data. Without the numbers and context of the revenue cycle, the enterprise could be in danger of

losing these clinical champions.

- **Knowing which data analytics to use and invest in.** Determining which key performance metrics to use in order to measure success can be a daunting task for the enterprise. Data analytics encompass everything from simple Excel spreadsheets to advanced automation or RPA technology. These analytics measure a variety of critical enterprise indicators, such as productivity, costs and patient outcomes, as well as financial data that includes denials, bad debt and patient liabilities. Predictive analytics also should be considered, as they can cover anything from forecasted cancellations (which are used to understand the number of open slots necessary to accommodate walk-in patients) to payment plans that are tailored to fit each individual patient.
- Providers acknowledge the positive impact that reporting and analysis have on the business, but they may be reluctant to engage unless the revenue cycle team can meet the challenge of making data analysis more enterprise-friendly. A revenue cycle investment in business intelligence and technology for the creation of dashboards is crucial for monitoring and producing clear, actionable outcomes focused on areas of opportunity within the enterprise.
- **Review how to best utilize electronic health records (EHR) and related efficiencies.** Charge capture is a critical part of the revenue cycle, but often does not get as much attention as it should. While revenue integrity staff are responsible for charge entry, clinical staff are responsible for the documentation that supports the charge. This may seem like a simple process, but each year health systems experience losses in revenue from incomplete documentation and incorrect coding that lead to missed charge capture.
- EHR clinical solutions and optimizations are the most common default method for charge capture. However, the EHR must be optimized regularly as system updates/upgrades become available, in order to maintain efficiencies and sustain revenue integrity.

- **Ensure a stringent internal communications process.** Many components are involved in the process to effectively capture, bill and receive revenue. Frequently, when organizations lose revenue to poor charge capture, claim denials or bad debt, they struggle to identify and communicate the root cause to prevent similar issues from occurring. Enterprises need concrete communication procedures and owners to ensure that the maximum amount of revenue is captured in the shortest amount of time. In the case of denials, an established team comprising front-end, charge capture/coding and back-end SMEs that meets regularly to review established reporting can help. This team can then leave with assigned action items to review accounts, identify root causes and propose mitigation solutions.
- **Cost Containment and Reduction.** Revenue cycle leadership faces the strain of cost containment each year. Most enterprises expect the revenue cycle team to reduce cost-to-collect while processing additional account volume and reducing errors. Being able to know and leverage today's available technology is key in the cost-reduction battle. Robotic process automation (RPA), claim scrubbers, payment estimators, patient portals and registration kiosks are just a few technology enhancements that the revenue cycle team can leverage to reduce costs; however, revenue cycle leadership must analyze the ROI of new technology with a great measure of accuracy and be confident that implementation will be managed to a set schedule. Beyond technology that can bolster automation, revenue cycle leaders need an effective implementation team that can design workflows to fit the new technology, allocate resources appropriately, and establish and monitor staff productivity. These layers make up the key components to cost effectiveness.

Challenges and demands of serving the payers

Being a liaison between the enterprise and payer

Considering commercial insurance companies and government payers as revenue cycle “customers” could be considered a stretch by some; however, revenue cycle staff provide a long list of services to payers and must meet the differing demands of how those services are provided in order to receive payment.

In helping to serve the payer, revenue cycle leadership must consider the following:

- **Working within the complex workstreams for coverage and benefits via verification and authorization.** Plan verification and authorization is critical to the financial clearance process, but savvy revenue cycle staff know this is not enough given the complexity and diversity of patient plans. There are terms in patient plans dictating what procedures are covered or not covered, and limits for frequency and duration, which will only be caught in the adjudication process. To catch these specific terms before performing the procedure, staff may need to sift through pages of detailed plan information or call the payer directly, which is time-consuming and frustrating. Even when the terms are found, the staff may not know if the patient has already exhausted those benefits or if another provider has submitted a claim since the last review.
- There is some good news. By configuring systems appropriately to track patient care, establishing a robust verification process, and maintaining continuous training of the financial clearance staff, risks of non-payment and increased write-off can be mitigated.
- **Increasing claims accuracy.** Payers want accurate information in a distinct order with specific documentation that backs up the charge. Optimization of the EHR and the use of intelligent automation can reduce claims errors and aid in getting those claims out the door more quickly.

Cleaner claims equate to faster turnaround and fewer delays in reimbursement.

- **Given there is not an unlimited supply of cash, it is in everyone’s interest to ensure payment accuracy.** The payer is working with a finite amount of resources. If that pool of resources is to be increased, the funds to accomplish this come from the patient, an employer or the government. In all cases, it is reasonable for the payers to assume some level of fiscal conservatism. As such, they want to ensure that unnecessary or incorrect payments are not dispensed. Integrated and automated RCM processes are examples of ways in which payers can be more confident.
- **Communication from the payer side.** Effective communication is one of the most integral steps to accurate billing and payments. However, communication is also one of the most challenging processes that providers and payers face. It isn’t often as easy as picking up the phone to have a conversation; there is a specific process for communication of denials, and sometimes an appeals process must be initiated, which causes further delays. Having the ability to integrate activity between the clearing house and payers, along with having specific strategies in place for communication, will aide payers in making timely, accurate payments.
- **Working within new policy and payment model changes.** Most healthcare-related policy is centered around the revenue cycle. Regulations such as payment model changes or price-transparency mandates requiring disclosure of negotiated rates provide significant challenges for payers. It’s important to note that payers are not fully comfortable with the concept of price transparency, since it can create pressure to be more competitive in order to prevent consumers from switching plans. Transparency can cause consumers to switch to plans with better network rates, larger network presences, or to payers who cover a broader array of services. Having standardized charge masters that can be linked with up-to-date payer contract information allows the health system to provide accurate price estimates to its patients, which ultimately builds trust with patients

and allows them to make informed decisions when choosing plans that meet their needs.

Revenue cycle becoming a driver of change and hub of communication, while addressing the needs of three clients

Our approach: Revenue cycle is the rally point for integration and alignment

The three clients of the revenue cycle (the patient, the enterprise and the payer) face a unique set of issues with specific solutions, but as industry experts, we know that these problems need to be addressed in an integrated fashion to see true progress. When integration isn’t present, impactful symptoms — such as reduced cash flow, decreased patient satisfaction, increased cost to collect, and staff fatigue — will become prevalent. As we cultivate the idea of integration to overcome the many challenges listed above, organization leaders should look to the revenue cycle to implement larger strategic change.

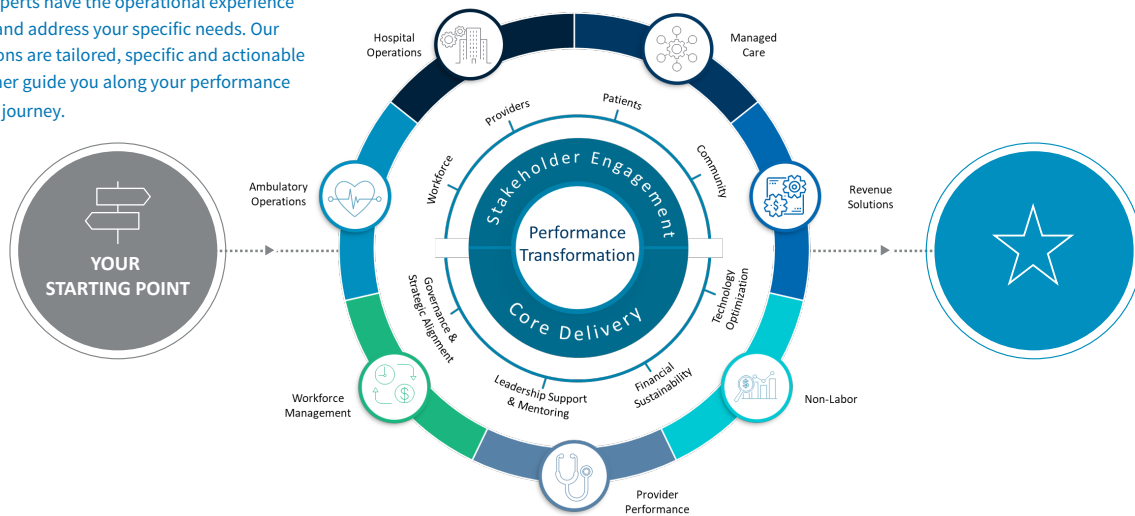
To effect change, the revenue cycle needs to break down silos and process knowledge gaps via communication, which starts by making sure that each revenue cycle team member understands the whole picture and not just their individual component. Knowing the ways in which the parts work together is a critical first step to improvement and change, and this is where the “rally point” begins.

In addition to communication, organizations should work on standardization within system facilities. This allows all three clients to have a clear picture of processes and expectations. Eliminating the use of different charge masters and pricing, for example, would prove to be beneficial in helping the revenue cycle team overcome many of the challenges discussed. Standardization does not mean organizations cannot be competitive to local markets but helps to make it so clients can have straightforward expectations for what to expect at facilities in similar areas.

While not the end-all solution, through communication and standardization the revenue cycle team can realize significant alignment, which will reduce the current strain.

The Performance Transformation journey

FTI's team of experts have the operational experience to understand and address your specific needs. Our recommendations are tailored, specific and actionable in order to further guide you along your performance transformation journey.



A focus on communication and standardization will also help align and coordinate stakeholders to the strategic vision from leadership. As a result, the entire organization will work more effectively and efficiently, overcoming some of their greatest problems by default.

FTI can help

FTI Consulting is an independent global business advisory firm dedicated to helping organizations manage change, mitigate risk and resolve disputes. Due to our unique mix of expertise, culture, breadth of services, and

industry experience, we have a tangible impact on our clients' most complex opportunities and challenges.

FTI Consulting has built its success based on hiring experienced healthcare experts who understand the complex challenges and demands the revenue cycle faces. Our experts have worked both personally in the field and with clients who have successfully overcome these challenges. The value-add of having this advanced knowledge of the entire healthcare landscape helps improve revenue cycle alignment and organizational success.

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