Hospitals and health systems continue to endure a transformation unlike any the industry has previously experienced. But at a time when change has become a perpetual mainstay, one thing has remained consistent – the need to maximize revenue while maintaining exceptional levels of care quality and patient satisfaction. As a result, deploying a high-performing revenue management program will only continue to be a necessity for providers to survive and thrive during healthcare’s transformation.

Approximately 40 revenue cycle and finance experts from health systems and other organizations across the country convened in Chicago in Fall 2016 for the first annual FORCE (Forum of Revenue Cycle Experts) conference. Hosted by Navigant healthcare practice McKinnis Consulting Services, FORCE offers an opportunity for attendees, primarily users of the Epic electronic health record (EHR) system, to network and share best practices around what’s working – and what isn’t – in revenue management.

INDUSTRY TRENDS DRIVING REVENUE CYCLE MANAGEMENT’S EVOLUTION

Though the goal remains the same, the revenue management landscape is evolving dramatically, driven by a series of seismic shifts in the industry:

The Value-based Journey

For many providers, revenue management may not be top of mind with regard to value-based care. But the transition to accountable care organizations, bundled payments, and other alternative payment models is adding another costly layer of documentation requirements with new clinical and financial goals attached to them.

It’s common for 3 to 5 percent of provider cash flow to evaporate through the revenue cycle due to improper registration, documentation, coding, and back-end processes.

A lack of properly executed core revenue management functions leave providers facing lost revenues and cash flow, as well as missed opportunities for value-based bonuses and potential value-based penalties.
EHR Implementation

An EHR is much more than a clinical tool – it also automates part of the revenue cycle. EHRs contain all of the touch points and data elements to ensure payment, including registration, insurance eligibility, authorization, revenue capture, coding, and claim scrubbing. With an effective EHR system, as a clinician documents care that’s delivered, charge capture takes place automatically in the background. This can allow for:

- Application of diagnoses for rapid claim generation with minimal back-end review and clinician follow-up.
- Automation of payer-specific claim manipulations to reduce scrubber errors and denials.
- Automatic (instead of manual) processing and review of late charges.
- Routing of denials to departments causing the error, improving front-end education opportunities by driving accountability.

The IT-Clinical-Back Office Nexus

The traditional separation between IT, frontline clinicians and the back office dissolves when an EHR system is installed. An inability to effectively bridge these gaps can result in retention of manual processes where automation could have occurred, increasing the likelihood of charging errors and bottlenecks. This can lead to a double-whammy of clinicians revolting against their participation in the revenue cycle and missed revenue capture opportunities, further invigorating the cash gap post-live.

ICD-10 Coding

Medicare’s ICD-10 grace period allowing for provider payment for less-than-specific codes will cease as of October 2016, after which the agency will more closely scrutinize and audit claims that require greater specificity. This coincides with the EHR movement, whereas coding now depends on how physicians – not trained coders – document patient encounters. Physicians unknowingly defaulting documentation, copying, and pasting content, or selecting level codes with reduced coder audit levels, will lead to incorrectly coded accounts and overcharging or undercharging – presenting both compliance and revenue risks.

Integrating EHR Systems with Revenue Cycle Processes at St. Luke’s University Health Network

Richard Madison, vice president of revenue cycle services at St. Luke’s University Health Network (Bethlehem, Pa.), describes how his network implemented a new EHR at the Navigant McKinnis FORCE conference in this video from H&HN.

REVENUE INTEGRITY: A BRIDGE TO SYSTEMWIDE REVENUE MANAGEMENT COLLABORATION

Developing a high-performing revenue integrity (RI) department is likely to be one of a health system’s most important revenue management efforts, especially during an EHR transition and into the shift to value-based reimbursement.

According to Navigant McKinnis, the objective of an RI department is to identify, correct, and optimize the processes and systems that can lead to lost revenue opportunities. This includes ensuring that procedures, items, and services are documented, captured, billed, and paid according to the terms of regulators and payers.

REVENUE INTEGRITY DEPARTMENT RESPONSIBILITIES

- Provide regular, structured organizational awareness and education
- Identify organizational KPI metrics for revenue
- Design/implement process for monitoring revenue
- Identify root causes through thorough analysis
- Develop/oversee work plans for process improvement
- Maintain oversight over designated functional areas
- Coordinate with cross-functional teams to resolve charge integrity issues
Revenue management’s evolution is increasing the need for new approaches aimed at enhancing collaboration and communication among the back office, clinicians and the C-suite. A robust RI department should drive this collaboration, “acting as a bridge between revenue management and all other areas of a health system,” said Navigant McKinnis Director Kent Ritter.

Ritter emphasizes cross-department collaboration to bridge the gap between often-siloed clinicians and the back office. Key to this is open interaction with clinical teams in a way that doesn’t seem forced.

> “Conversations need to focus on how the revenue management journey mutually benefits both departments, and ways to work together to achieve shared goals.”

**KENT RITTER**  
**DIRECTOR, NAVIGANT MCKINNIS**

Ongoing communication and education, including classes, online tutorials and a revenue management handbook, can play a key role through the change process. At the same time, a top-down approach centered around hands-on participation among health system leadership helps to establish expectations for the clinical department to take ownership of such critical revenue management functions as charge review, claim edits, revenue validation, and outpatient code editor referrals.

“Revenue integrity isn’t just a handoff – it’s a way to transform the revenue cycle,” Ritter said. “Active participation across multiple departments – including senior leadership – is necessary to achieve to be successful.”

### Revenue Integrity: Pre- vs. Post-Implementation

<table>
<thead>
<tr>
<th>FOCUS AREAS</th>
<th>PRE-RI</th>
<th>POST-RI</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Integration</td>
<td>RI functions divided across revenue cycle/finance.</td>
<td>Established single, systemwide department.</td>
</tr>
<tr>
<td>Charge Description Master (CDM) Maintenance</td>
<td>CDM maintained largely by single individual within finance.</td>
<td>Dedicated CDM team composed of RI, charge integration, finance.</td>
</tr>
<tr>
<td>Revenue Reconciliation</td>
<td>Lacks revenue management policy/process.</td>
<td>Increased focus on monitoring revenue variances and charge capture improvement by implementing systemwide revenue management P&amp;P, task force.</td>
</tr>
<tr>
<td>Charge Lag Performance Monitoring</td>
<td>Timeliness of charges not closely monitored systemwide; opportunity to standardize charge review workflow.</td>
<td>Ensures charge review work queues appropriately staffed, worked; increased focus on charge lag reporting, coordination with departments.</td>
</tr>
<tr>
<td>Underpayment Follow-Up</td>
<td>Unclear process to identify, follow up on underpayments.</td>
<td>Policy/procedure in place for underpayment handoffs; Epic system enhances/automates workflow.</td>
</tr>
<tr>
<td>Revenue Cycle Organizational Structure</td>
<td>RI functions decentralized across system; high quantity of direct reports to chief financial officer causing issue resolution delays.</td>
<td>Implemented centralized RI structure improving efficiency of issue escalation and solution.</td>
</tr>
<tr>
<td>Revenue Analytics</td>
<td>No existing reporting team; limited reporting on internal productivity/performance.</td>
<td>Designated revenue analytics team within RI focused on preventing revenue leakage via enhanced reporting/dashboards.</td>
</tr>
<tr>
<td>Operational Impacts</td>
<td>No clear ownership of work queues, revenue-related workflows and issue escalation/resolution processes.</td>
<td>Assigned ownership of work queues/workflow; developed quality productivity reporting and accountability structure with clear processes.</td>
</tr>
</tbody>
</table>
REVENUE MANAGEMENT: PROGRAM GOALS AND PROVIDER SUCCESSES

An effective revenue management program must promote accurate and timely capture of patient revenue, including rapid resolution of pending revenue, while providing a forum for communication and escalation of charge entry or other charging-related issues. Doing so can help hospitals and health systems:

- Reduce variability in gross revenue capture.
- Improve visibility around charging issues and opportunities.
- Increase accountability around gross revenue capture and understanding across the organization.
- Reduce late, missing, and/or inaccurate charges.
- Minimize denials and write-offs.
- Improve net revenue capture/revenue maximization.

Provider Success: Edward-Elmhurst Health

Created in July 2013 by the merger of Elmhurst Memorial Healthcare and Edward Hospital, Edward-Elmhurst Health (EEH) serves 2 million residents in Chicago’s western suburbs.

Developing a cross-functional revenue management committee composed of key stakeholders from clinical operations, finance, revenue cycle, and IT departments, as well as physicians, was an important first step for the newly formed health system. Essential to the success of such a committee is making sure a hospital’s clinical and financial executives are actively championing the program, according to EEH Vice President of Finance Jeff Friant.

“These can’t be paper champions – they need to be shoulder to shoulder with revenue leadership helping to lead the process and break down silos.”

JEFF FRIANT
VP OF FINANCE, EDWARD-ELMHURST HEALTH

With leadership and team members in place, EEH worked with Navigant to establish strategic metrics and goals, and to include an annual timeline based on previous experiences.

“It’s important to put pen to paper with specific goals and dates to hold people accountable and move this type of program forward,” Friant said. “We try to stick to what we’ve set as much as possible, but we understand the need to be flexible in adapting to change.”

To ensure staff is properly prepared to achieve goals, EEH provides ongoing education and training for clinical operations owners on such issues as cost center or provider-specific charges, volume, and revenue; specialty specific revenue reconciliation methods; and revenue monitoring tools.

Committee interaction – how (in-person, over the phone, WebEx) and how often to meet – also needs to be considered, with each meeting including a clear agenda and follow-up steps to properly set expectations. As maintaining a committee’s initial momentum can be a challenge, especially for systems spread out over multiple geographical regions, Friant suggests having executive sponsors lead the charge so that meetings are consistently held and committee goals, policies, and procedures are regularly reviewed and updated.

“This was a complete change management process for us, and some days we’d take one step forward and two steps back,” Friant said. “But it’s a journey, and having a well-developed revenue management committee was vital to seeing the process through.”
Provider Success: University of Michigan Health System

In February 2012, University of Michigan Health System (UMHS) completed its migration to Epic. However, UMHS experienced complications with the implementation leading to a post-conversion period of decreasing gross patient revenues, increasing accounts receivable, and diminishing cash flow. These challenges, coupled with the existing organization structure within the revenue cycle, represented critical financial risks to UMHS that needed to be addressed quickly.

UMHS partnered with Navigant McKinnis, which performed a comprehensive revenue cycle assessment that revealed key revenue cycle components were lacking in structure and performing below industry best-practice metrics. The revenue cycle assessment identified such areas of risk as self-pay collections, call abandonment rates, revenue integrity/analytics, underpayment recovery, denial management, strategic pricing, and charge capture.

UMHS leadership engaged Navigant McKinnis to manage the large scope of technical and operational issues contributing to the system’s post-live performance. The resulting partnership stabilized and optimized targeted areas of UMHS’ revenue cycle, as well as improved key performance metrics.

Candidate for Bill (CFB)

- CFB accounts receivable (AR) day metric reduced from 20 days at project inception to 5.8 days.
- Outstanding CFB dollars reduced to $89 million.

Candidate for Bill – AR Days

Self-Pay Collections Optimization

- Generated net benefit of more than $12.5 million by increasing the global self-pay yield.
- Reduced call abandonment rate from a metric high of 72.6 percent to a best-practice metric of 4 percent.
- Reduced patient correspondence backlog from a high of 3,300 to a low of 23.

Call Abandonment Rate – Percent

Reducing the abandonment rate from 72.6% to 4% drove increased account resolution and increased patient satisfaction amongst the client’s patient base.

Strategic Pricing

- Increased net benefit by $6.5 million using strategic pricing rather than historic across-the-board price increases.

STRATEGIC VS. ACROSS-THE-BOARD PRICING - NUMBER OF CHARGES (DOLLARS)

- 98.3% of total charges (11,077) unchanged through strategic pricing initiative.
- Strategic pricing initiatives ($6.54 million) of total charges resulting in greater net benefit.
- Across-the-board price increase results in lower overall net benefit.
About Navigant

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant’s professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the Firm primarily serves clients in the healthcare, energy and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant’s practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.

McKinnis Consulting Services is part of Navigant Consulting, Inc. A portion of the results detailed in this paper were derived through engagements McKinnis conducted prior to its integration into Navigant.