Back to basics to ensure RCM quality

Transcript

00:00:06 – 00:01:12

ADRIANNE BOYLEN:
Hello and welcome. I'm Adrianne Boylen, and I lead our Healthcare CFO Advisory Practice, which includes our revenue cycle practice. Today I'm here with my colleagues, Francis Hollweck as well as Brian Holman, who focus exclusively in revenue cycle management.

As we enter the new year, we continue to see new technologies and advancements are being developed to help clients recover from the higher expenses due to COVID as well as the reduced volumes. And from a Grant Thornton perspective, we're very supportive of these tools and capabilities and help clients deploy items like machine learning, AI and other tools.

But first, it's about getting back to basics and ensuring that you have the fundamentals in place for a sound organization. I'd like to start by asking about the shift toward patient experience. Brian, can you describe for me some of the driving factors for this continued shift that's moved from a "nice to have" to "an imperative" for our healthcare organizations?

00:01:14 – 00:03:32
BRIAN HOLMAN:
Thanks, Adrianne, and certainly looking forward to the discussion today with the group.

There has certainly been more of an emphasis on the patient experience in recent years. And I would even call it the consumer experience moreso than the patient experience. So, if you look at how we consume entertainment, for example, there are so many different options to choose from, whether it be Hulu, Peacock, Netflix and a whole host of others. For healthcare, patients are essentially consumers of medical care, and there's a lot of different options to choose from. So, I think it's important to look at the patient experience through the lens of a consumer.

In terms of the factors placing more of an emphasis on the consumer experience, one of the driving forces is the continued trend of increased out-of-pocket expenses for patients. So, with theoretically more medical bills to pay, consumers expect convenience to pay for their out-of-pocket expenses.

In addition, it's becoming increasingly more complex for consumers to understand how much they owe on a medical bill. So being able to educate the consumer and be transparent about what they may owe has become more important.

Another factor, and I alluded to this earlier, is increased market competition and other nontraditional care delivery models. Depending on patient symptoms, patients can go to urgent care to get seen quickly on the same day, they can schedule a telehealth visit to get care virtually, they can walk into a CVS or Walgreens to get vaccines, so there's a lot of options to choose from when it comes to healthcare. Making sure the healthcare experience meets the consumer's needs is critical. Otherwise, they can likely get that care somewhere else.

And lastly, going back to the entertainment example, just like we want to easily flip on our favorite TV show, we want easy access to our medical care. And companies like Amazon, Starbucks, they've rewired our expectations for speed and ease of use. Consumers don't want to wait on hold for 10 minutes before talking to a human and then getting bounced around to different departments to schedule a medical service. Rather, they want that easy access to care and a seamless experience throughout their episode of care.

00:03:34 – 00:03:54
ADRIANNE BOYLEN:
I absolutely agree, Brian. That ease of access is driving this and what people are accustomed to, as well as things like the higher deductible plans and the advancement of price transparency. Can you share some tactical actions that organizations can take to help really bring this to life?

00:03:55 – 00:05:45
BRIAN HOLMAN:
Absolutely. So, many of the common things I've seen and heard organizations doing to enhance the patient experience really go back to basic, fundamental concepts. The way providers communicate to patients has changed significantly. For example, providers will send appointment reminders through a text message as opposed to a staff member picking up the phone and reminding the patient of their appointment.

Secure chat is a great way for patients to communicate with their provider or clinical team. And then patient portals have become very commonplace, where patients can do a variety of things like schedule their care, complete pre-registration items such as forms, access billing statements, and pay their bills. The portals have really become the mechanism for patients to own part of their medical journey without having to directly interact with the provider or waste time on the phone.

As a specific example, we've worked with a health system for the last several years that's grown exponentially via mergers and acquisition. And through these mergers and acquisitions, we have supported them in implementing a single electronic medical record system across all of their divisions, which has allowed the patient to use a single patient portal to meet many of their needs at any of the health system's locations and really promote a unified patient experience.

Lastly, like I mentioned earlier in the conversation about increased out-of-pocket expenses, providers are really focusing on patient education as well. So, organizations are putting more rigor around accurate patient estimates, promoting price transparency and strengthening their financial counselor teams to ensure that patients have a better understanding of when and how much they owe. In summary, if providers take care of their patient population, patients will take care of the providers.

00:05:46 – 00:06:15

ADRIANNE BOYLEN:

That is so true, Brian. We really need to meet each other where they are and communicate and interact in ways that are most conducive for the patient as well as their families.

With that, I'd like to switch topics a little bit and talk more about some of the blocking and tackling efforts on the back end of the revenue cycle. Francis, can you share some of what you're seeing in the market?

00:06:17 – 00:08:48

FRANCIS HOLLWECK:

Great question, Adrianne, and happy to be here with you, Brian. COVID threw us all for a loop, but it's time to move forward. Skilled resource pools have become tougher to find, retain and financially support. More importantly, and perhaps more than ever, would be the basic idea to squeeze every penny out of your receivables with a very tactical approach.

To start, I'd recommend a re-evaluation of your entire work queue strategy. It's no longer enough to have payer, age and balance strategies aligned with teams.
This tactic typically leads to high-dollar account over-touching, while low-dollar accounts get kicked down the road or sent to a vendor. RCM management needs to validate that the right accounts are touched by the right skillset at the right time, and not to simply deploy the “emergency-of-the-day” approach.

A recent successful strategy we deployed at a large system in Chicago was this concept of “insurance propensity to pay.” Let me say that again: Insurance propensity to pay—not self-pay. In this strategy, we evaluated payer denial rates on specific types of claims to understand the types of denials and more importantly, the resource allocations devoted to them. We were amazed at the number of small-dollar appeals, say less than $250, that were unsuccessful—and more importantly, the wasted time spent on these low-dollar claims. We learned that unless there was better documentation and coding up front, the claim had near-zero appeal success. Better to cut your losses, at times, and move on to the next account. We found this improved touch effectiveness and allowed the teams to better manage those high-volume but low-dollar accounts that tend to collect dust in your AR.

We developed this unique methodology to assess an entire receivable at the account level, based on each account's unique disposition. For example, its denial type, the service and payer combination, the physician, the balance and more. We then categorize, prioritize, and enforce that the correct accounts get worked by the follow-up teams.

I'll wrap up by saying this was a prime example of where using existing data and by going back to basics—and without some special application or new technology—we could show positive cash results and improved AR health.

00:08:50 – 00:09:04
ADRIANNE BOYLEN:
Thanks, Francis, for sharing that and really how we helped an organization get back to basics focused on the AR and ensuring accounts don't age out. Are there other areas that you think are important to focus on these days?

00:09:05 – 00:10:16
FRANCIS HOLLWECK:
Well secondly, and it sounds cliché, but organizations should re-evaluate their denials management performance and their relationships with their payers and their representatives. You'd be surprised how many organizations tell us that they have denials "covered" until they see our analysis. The national average for initial denial rate—and by that I mean denied dollars to charges—is around 11½%. I'd ask our audience, where are they performing? Further, I'd ask our audience, when was the last time you met with your top-five payer representatives? It sounds almost too basic, but strengthening payer partnerships will speed resolution for key accounts and even support resolving bulk issues. Even if it's just a handful of large-dollar accounts that get resolved, it's more than worth it.

And lastly, don't be afraid to say this is unacceptable to your payer counterparts. Hospital claims data is often superior to what the payers can organize when it comes to denial administrative burdens, for example. So, focus on receivables and re-examine your payer relationships to get back to basics.

00:10:18 – 00:10:59
ADRIANNE BOYLEN:
Thanks so much for sharing that, Francis, and I couldn't agree more. That relationship with your payers is imperative to have to resolve conflicts and accelerate overall payments as we go forward.

As we began the conversation, we talked about the enhancements in technology and pairing that with the fundamentals. And so now, we'd like to shift to that technology aspect of the conversation. Francis, can you share a little bit about where you'd suggest organizations begin?

00:11:00 – 00:12:36
FRANCIS HOLLWECK:
Absolutely. And this topic can be polarizing for our audience, but before jumping on board the latest technological phenomenon, take inventory of your critical systems and

technologies. Develop a systems and capabilities library. It always amazes me to see how many redundant technologies are deployed at large organizations.

For example: eligibility screening is a common one. A recent assessment we conducted at a smaller organization showed overlapping and competing and, at times, conflicting systems to test for patient eligibilities. It simply led to more denials and rework and was an unnecessary IT expense.

So again, ask yourself if you're utilizing those technologies to their fullest potential. Are they actually solving the business problem you need them to, or are they just masking the root cause? At a minimum, this technology inventory, and even moreso a functional capabilities inventory exercise, will help you prepare and focus your priorities onto the correct new tool.

I'd simply close with, when evaluating these new options, focus on technologies that solve your challenges, not just those that manage the symptoms. For example, keystroke simulators may help kick the can on administrative denials or resolve small balance debits and credits. But challenge yourselves and your teams to solve why those scenarios occur in the first place.

And Brian, I just talked a little bit about automation. Can you share some examples of what you've seen in the market and how clients have deployed some of those newer tools?

00:12:38 – 00:14:25

BRIAN HOLMAN:

Yeah, great question, Francis, and automation is certainly a hot topic that gets discussed in a lot of different forums these days.

In the market, I'm seeing organizations really take a step back and try to identify where there are automation opportunities. This is usually the hardest part, so it's important to go back to those documented policies and procedures and review end-to-end processes to identify the steps in the process that can present an automation opportunity.

A piggyback to this is doing time studies so you can see the discrete tasks that personnel are doing and how much time they are spending on each. With one of our clients, we are actually supporting them with standing up an internal automation center of excellence which is dedicated to identifying automation opportunities and executing on those opportunities across the organization. We helped them develop a tool to identify which processes might be ripe for automation, and then prioritized those opportunities based on benefit and complexity to roll out.

I think it's important, though, to start out small, do pilots, conduct thorough testing before rolling out automation too quickly or broadly, as the consequences can be wide ranging if not done right. Also, don't forget about the other side of the coin.
In other words, if automation is going to do something that an organization's people used to do, where can the organization leverage those resources to focus on higher complexity tasks that automation cannot solve? Organizations have to assess where best to redirect their resources because using automation to leverage resources better is really where the value comes in.

00:14:26 – 00:14:55

ADRIANNE BOYLEN:

I couldn't agree with you more, Brian, and thank you both for providing your perspectives on technology. As you mentioned, there's much that can be done with technology today while not losing sight of the core operational processes.

I'd like to thank again Brian and Francis for joining me today. This was so much fun. For those listening, thanks for joining us and we look forward to talking with you about how we can help your organization address similar concerns.