



Let's Discuss the New Era of Revenue Cycle Modernization

hfma™

mississippi chapter

April 24, 2025



Introductions & Agenda



TJ Burdine
Principal



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Director

1

A Challenging Era for Healthcare Providers
20 minutes

2

The Call to Action for Revenue Cycle Leaders
45 min

3

Q & A
15 min

We Want to Hear from You!

Live polling will be used throughout the presentation to get your feedback.

Use this QR code or link to get connected!



<https://pollev.com/brainytrain429>

If you could have any superpower to help you at work, what would it be?



Mind Reader to...??



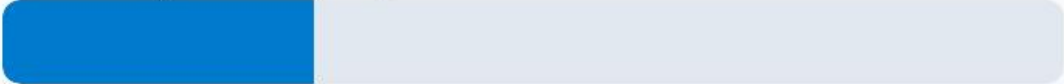
57%

Super speed to finish tasks



27%

Invisibility to work in my office undetected



17%

Teleportation to jump across campus to next meeting



0%

Which office pet would you prefer to have around? [OK, choose 2]



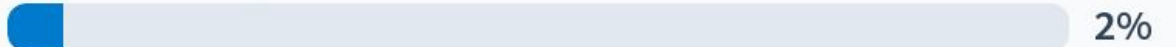
A stress-relieving puppy



A snack-fetching squirrel



A motivational parrot



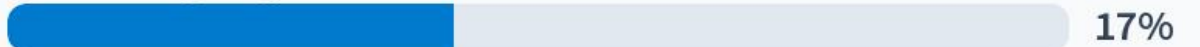
A massage-giving orangutan



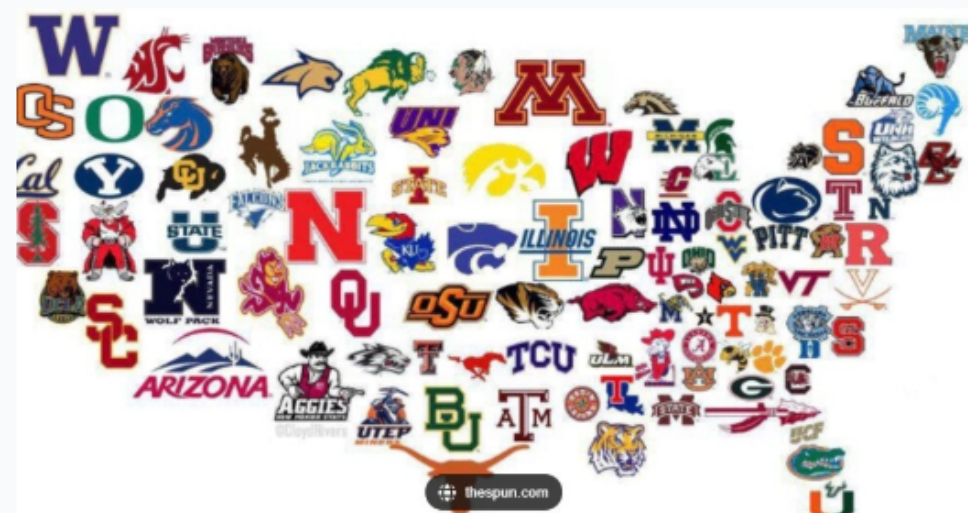
A coffee-brewing robot



An advice-giving turtle



Declare your College Sports Allegiance!!



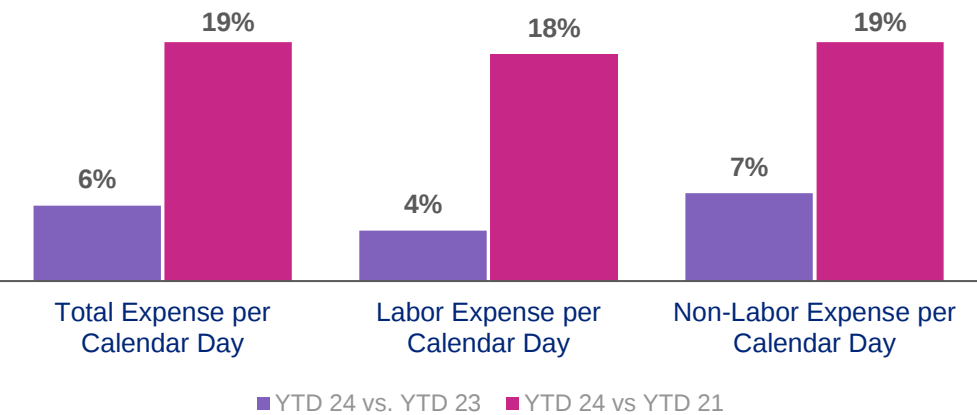
A Challenging Era for Healthcare Providers

Financials Recovering for Many, but not Healed

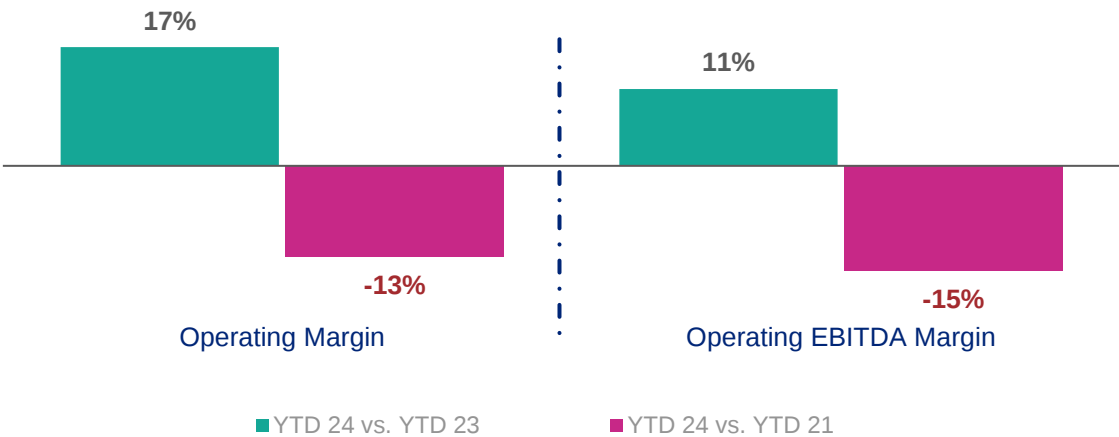
Operating margins highlight financial healing is still underway for most health systems. While many organizations are better off than they were in 2023, performance indicates still a long way to go.



Expenses Moving in the Right Direction



But Not Fast Enough to Fix the Operating Margin Differential



“

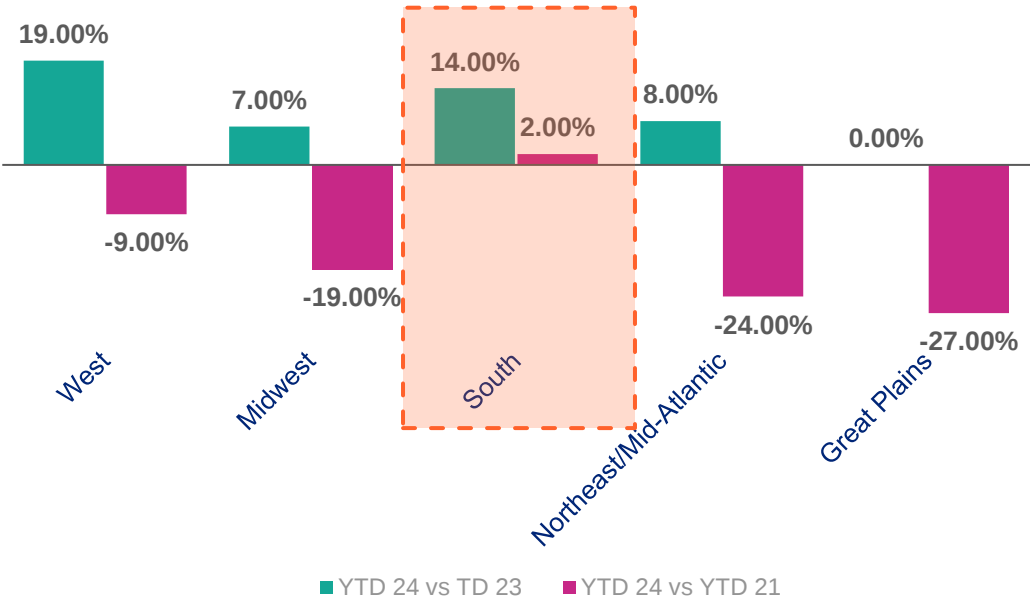
... being asked to do more with less, finding the time with which to identify areas that need improvement and finding the resources to develop ...can seem like an overwhelming undertaking.”

And the Pace of Recovery is Not Always Equal

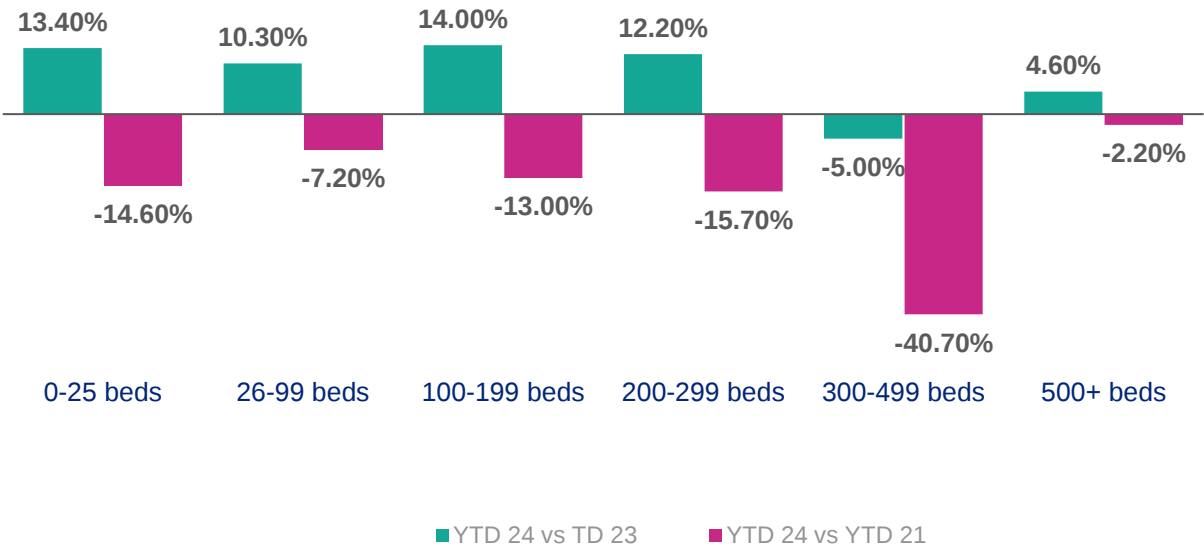
Operating margin performance continues to lag in comparison 2021, with significant differences based on organizational size and regional geography. Several distinct factors contributing to the high-performers' prosperity include scalability, higher outpatient revenue, swift reductions to contract labor, and lower average length of stay.



Operating EBIDA Margin Differential by Region



Operating EBIDA Margin Differential by Provider Bed Size

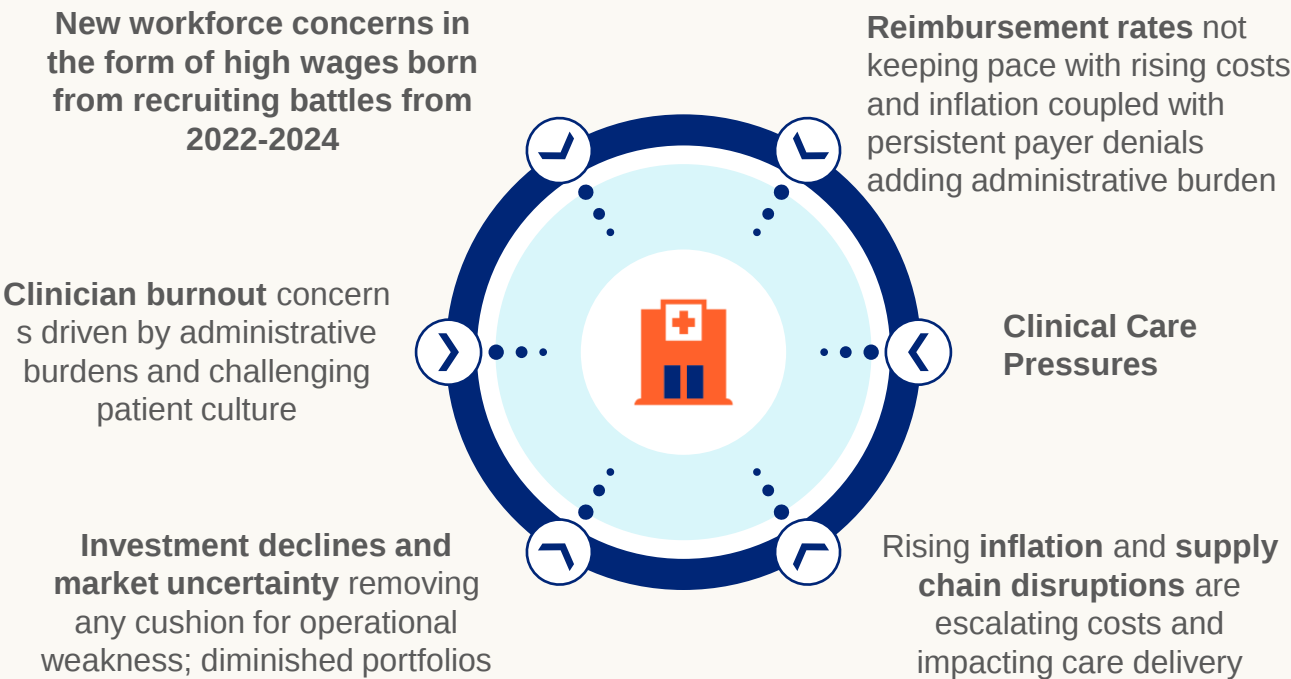


Adapting to New Operational and Economic Realities

Healthcare’s financial predicament over the last 12–18 months...and continuing... is being described in strong terms. These financial headwinds are upending healthcare’s traditional status as “recession-proof.”



A confluence of factors exacerbating 2024 stress

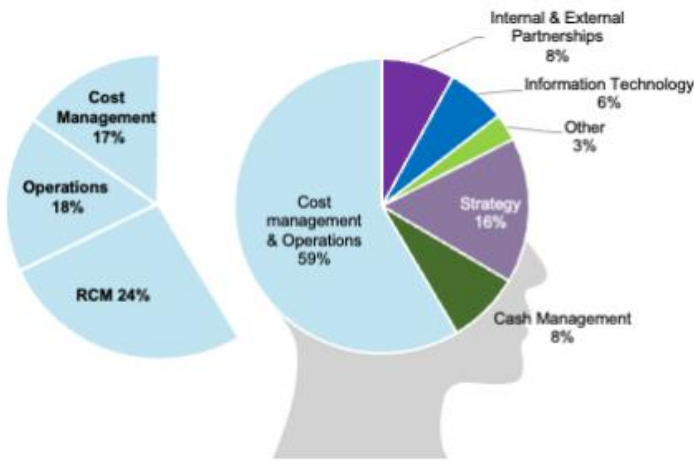


“

This is the first time in my 30-year career during which my beds are full, and I have no margin.”

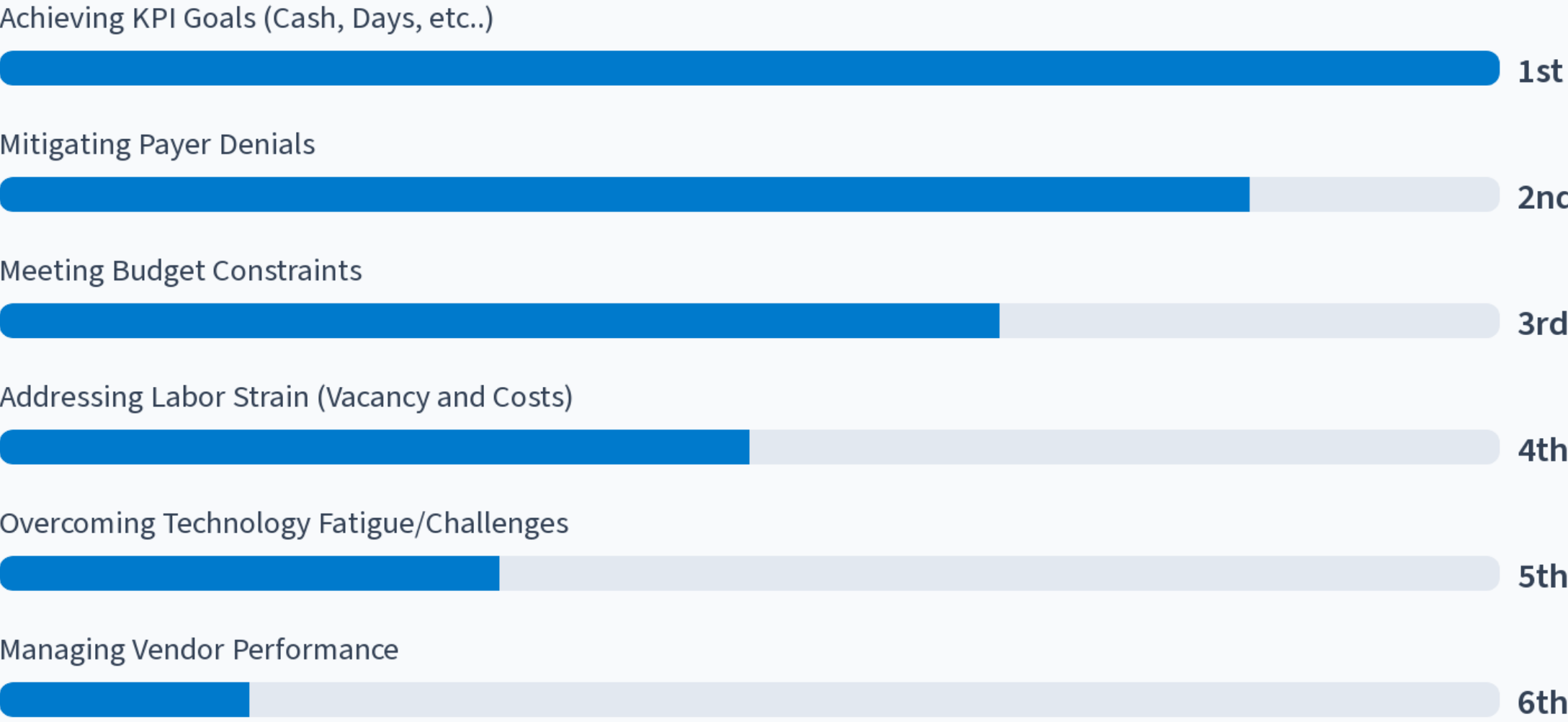
- Health System CEO, Q4 2023

How Health System CFOs Spend Their Time



CFOs spend 24% of their time on Revenue Cycle

Rank the importance of challenges impacting your revenue cycle operation this year:



Which strategic imperative do you believe is most crucial to the future success of your health system?



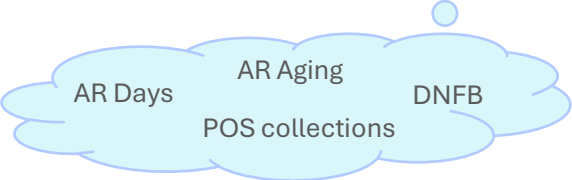
Emergence of a New Mindset for Revenue Cycle Modernization

Performance focus pursues excellence....an impact focus favors value



Evolving Measures of Success

Focus on meeting legacy key performance measures



Focus on maximizing net revenue, collections, patient satisfaction through technology and targeted “programs”

$$\frac{\text{Cash Collections}}{\text{Expected Reimbursement}}$$

Focus on balancing revenue performance and operational costs to maximize **yield**

$$\frac{\text{Cash Collections} - \text{Expense}}{\text{Expected Reimbursement}}$$

Shifting Mindset

Does our team get the job done?



Are we performing as well as we should?



Are our services a good **value** for the organization?

Are we making the right investments in people, services, and technology?

Five “No-Regrets” Strategies for a New Era

Imperatives for 2025 and beyond to preserve margin and improve yield



Pursue Coordinated Cost-to-Collect Reduction Measures

Deploy a multi-year strategic approach to identify and adopt lower cost and better-quality alternatives for administrative revenue cycle and medical group services and tasks.



Broaden and Strengthen Revenue Assurance Actions

Leverage analytics to pinpoint net revenue capture opportunities and explore meaningful investments that deliver value across fee-for-service and value-based care arrangements.



Drive Financial Success with Intelligent Automation

Utilize leading edge automation technologies to drive improvements in revenue collection and key performance metrics, mitigate workforce challenges, enhance business intelligence and achieve workflow efficiencies.



Design a New Approach to Engage Your Hybrid Workforce

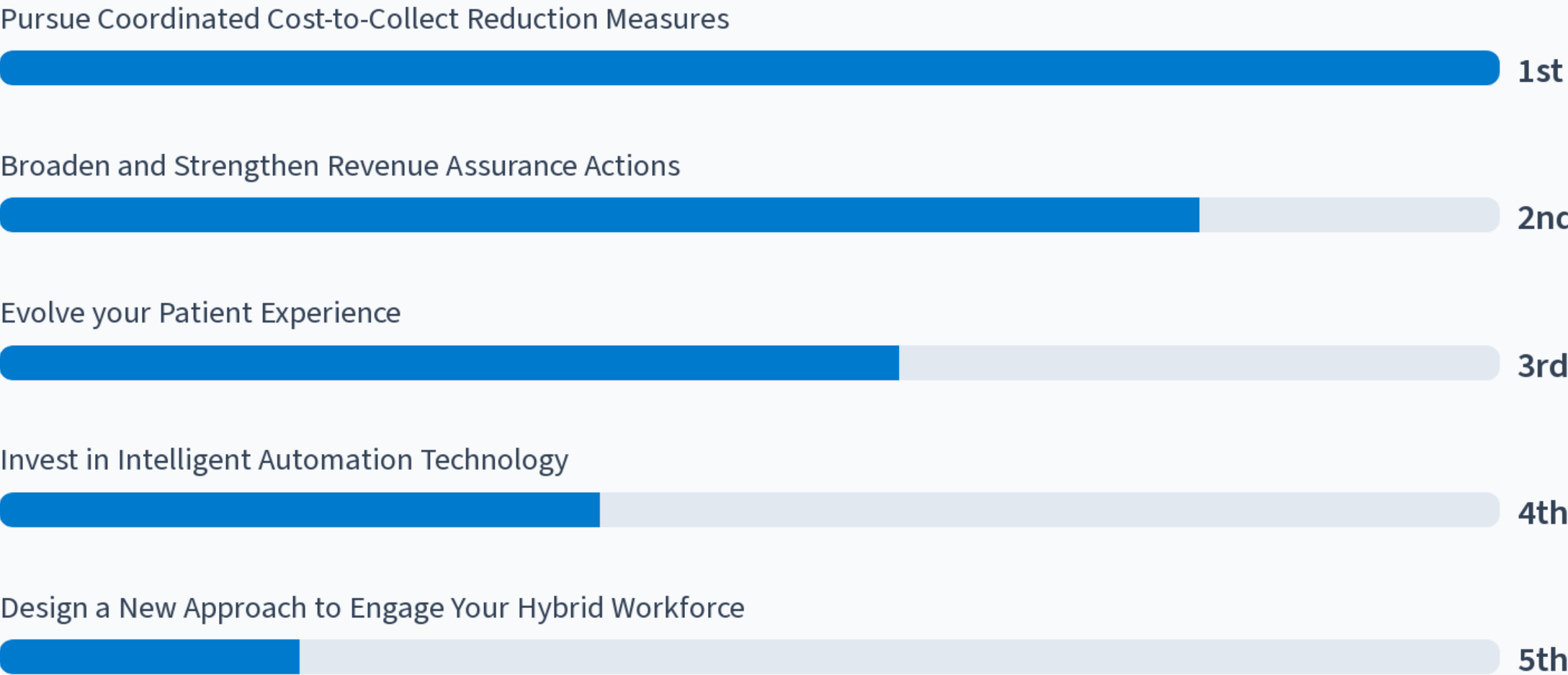
Broaden recruitment and staffing tactics, adopt retention strategies, leverage automation as a member your team, and enhance culture to achieve a resilient, hybrid workforce with an emphasis on “top of capability” performance to become the employer of choice.



Evolve your Patient Financial Experience

Expand access to care, engage patients in their health, and offer personalized digital and self-service options to enhance patient loyalty and retain lifetime value while simultaneously reducing customer service costs.

Rank these five "no-regrets" strategies in order of priority for your organization:

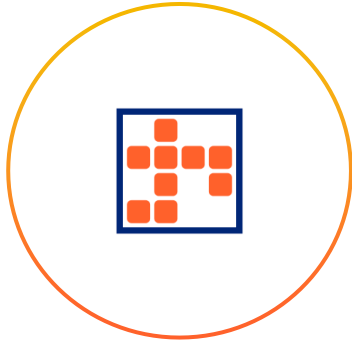


Broaden and Strengthen Revenue Assurance Actions

Chargemaster and Pricing

Revenue Assurance Imperatives

Each revenue cycle department plays a role in the efficient capture, maximizations, and protection of revenue from the services provided.



Capture

- Acute care CDM and ambulatory fee schedule optimization
- Charge capture process and education, including service line engagement and education
- Standardized and streamlined charge reconciliation process and protocols



Maximize

- Coding and documentation quality audit programs
- **Physician documentation educational programs**
- **CDI Programs to monitor ensure accurate documentation of patient acuity**
- Market rate analytics and managed care payer negotiations
- **Strategic Pricing**



Protect and Recover

- Structured denial prevention program
- Contractual underpayment ID and recovery program
- Drive awareness of regulatory changes impacting reimbursement (e.g. CMS site neutrality)
- Add-on specialized recovery services (tDRGs, Auto/Liability, zero balance reviews) to extend business office

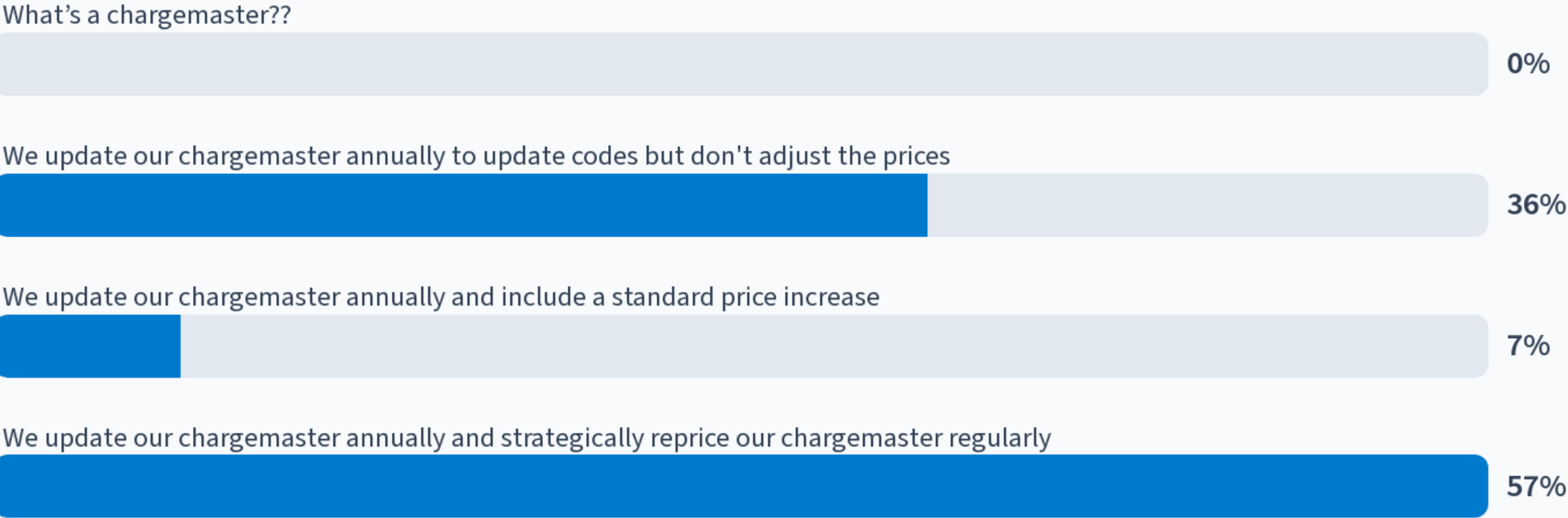
Establishing an accurate, complete, and comprehensive chargemaster sets the foundation for successful revenue capture



Annual chargemaster review and optimization enables Revenue Integrity to focus on:

- Identification of **net new** revenue opportunities
- Prevention of **at-risk** revenue loss
- Pro-active charge issue resolution
- Denial prevention & management
- Reduced claim errors and back-end resource requirements

When is the last time you addressed the accuracy and prices contained in your Chargemaster?



Multi-state Health System Addresses Pricing Inconsistency

Summary

- A multi-state health system was looking to address pricing disparities resulting from years of acquisitions
- They worked with Optum Advisory to deploy intelligent pricing analytics of managed care contracts and revenue usage data

Goals

- Normalize pricing across multiple regional facility CDMs
- Sustain or improve charge positioning in local markets relative to competitors
- Improve annual net revenue where possible within specific service lines while avoiding an aggregate increase in charges

Multi-state health system

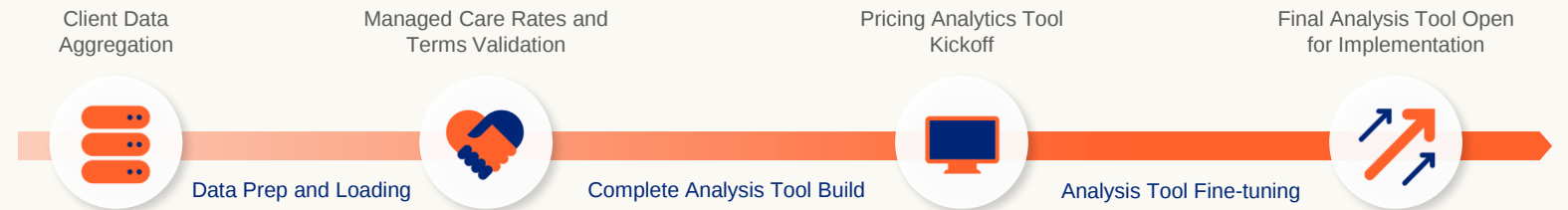


Figure 1.0- Strategic Pricing Timeline and Milestones

Solution Set:

- Benchmark health system's current prices to the target region to market competitors
- Calculated pricing adjustments to simultaneously meet client's strategic goals and modeled net revenue impact
- Normalized/Calibrated prices for CPT codes to create a standard shared charge master price
- Provided ongoing tracking of revenue achievement

Impact

\$560K

Projected revenue increases for net sensitive CDM line items

4:1

Return on investment



Gross Revenue Neutral

Strategic upward and downward adjustments to CDM line items charges accomplishes client's gross revenue neutrality goal



Maintained or improved market position for market charge levels

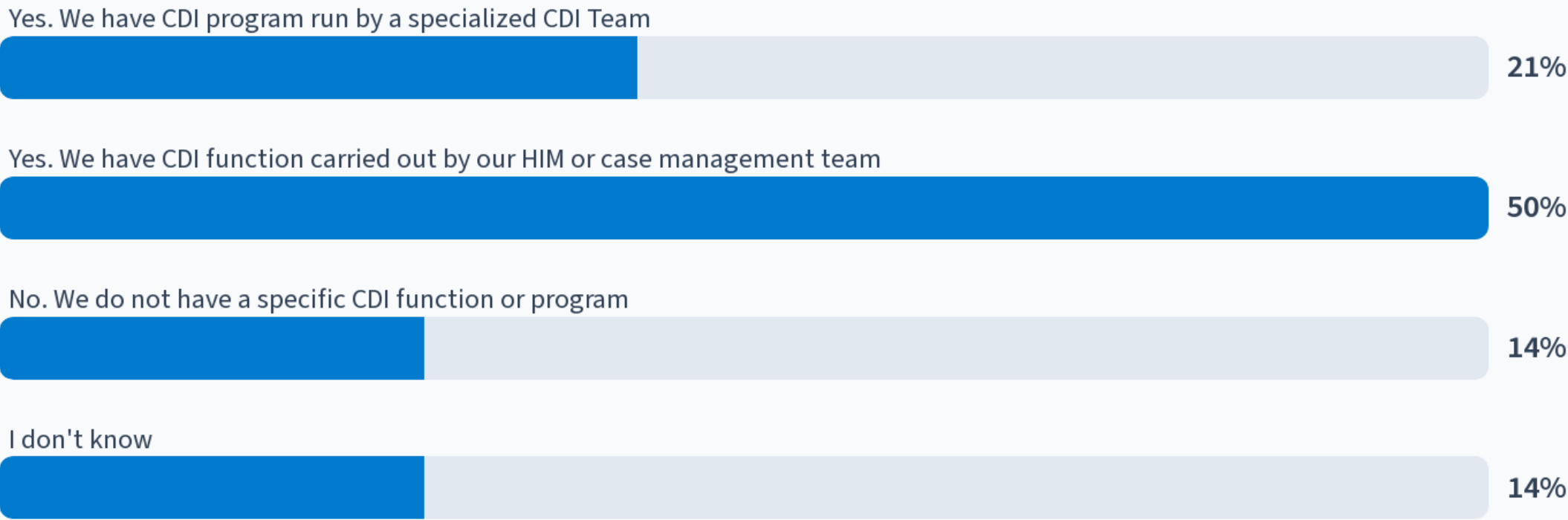
Shared a tailored pricing study for each hospital confirms current and expected changes relative to regional competitors

Questions and Comments

Broaden and Strengthen Revenue Assurance Actions

CDI Programs

Does your hospital or health system have a CDI program focused on inpatient services?

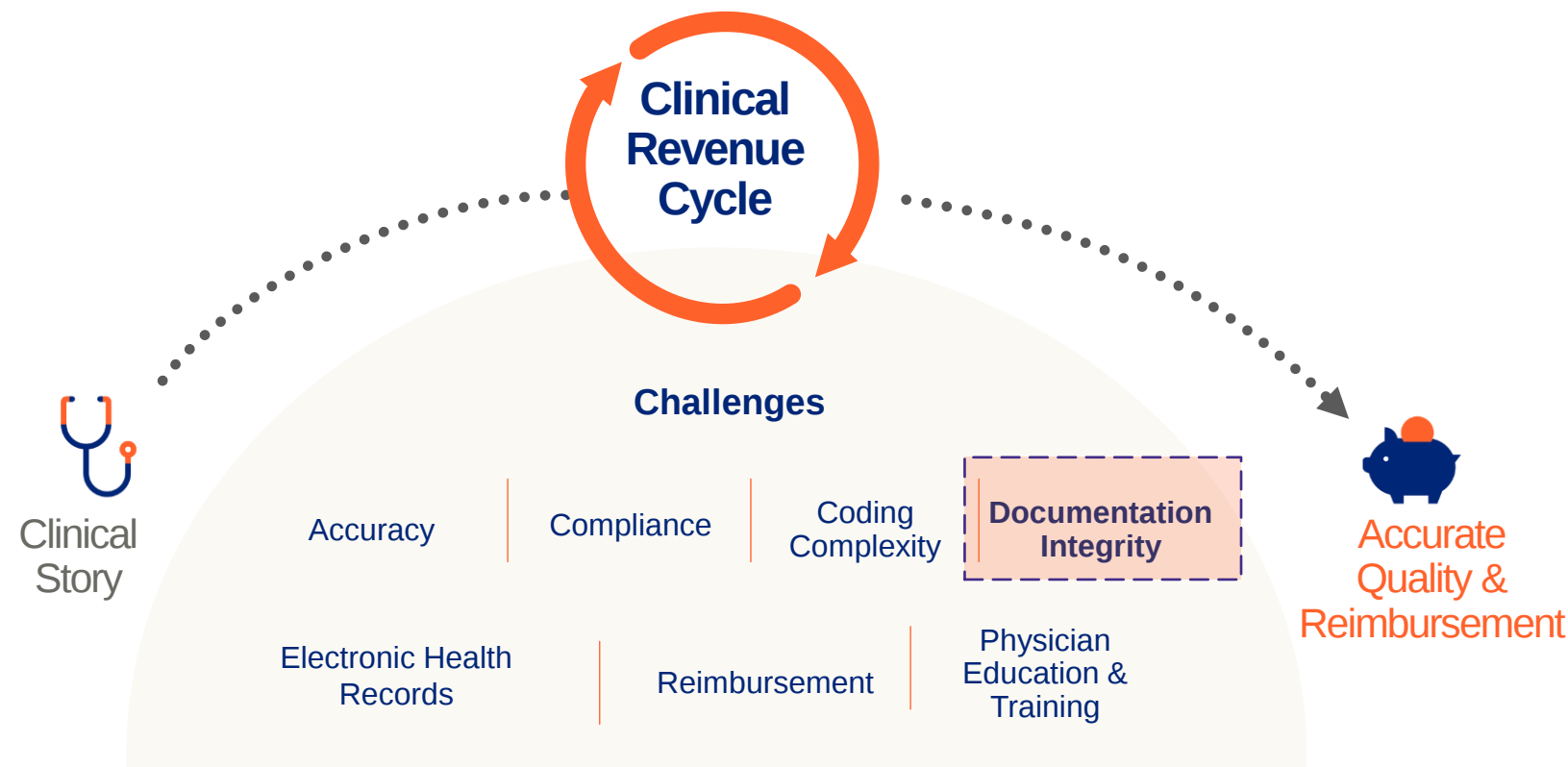


Underscoring the Importance – and Complexity – of Documentation

“

Achieving meaningful improvements in quality and patient experience requires **tight alignment between providers and operational teams.**”

Chief Medical Officer
7-HOSPITAL SYSTEM IN
MIDWEST

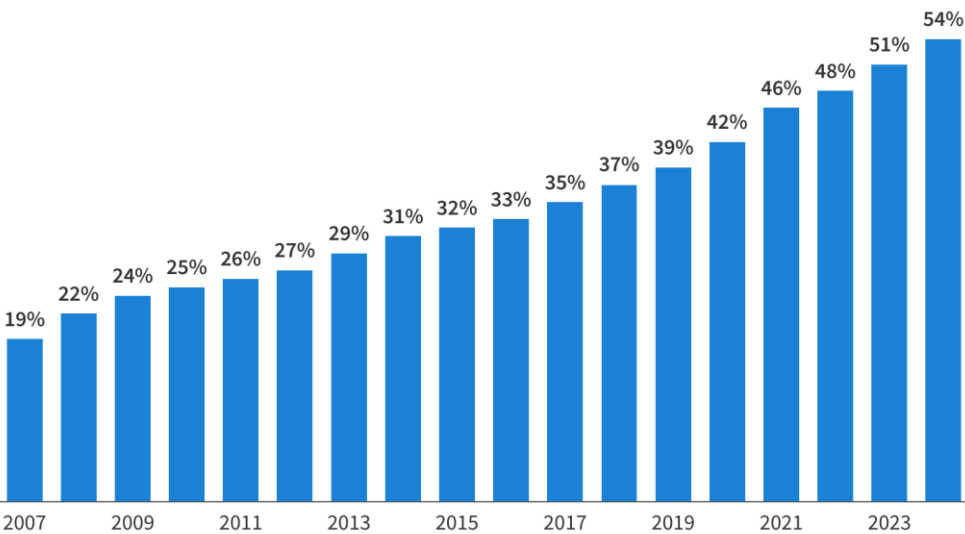


Medicare Advantage Has More Than Doubled Since 2007

CMS risk-adjusts the capitated payments to Medicare Advantage (MA) plans based on an enrollee’s “risk score” – a measure of the expected costs associated with a person’s care. Risk adjustment aims to accurately predict expected health care costs, encouraging plans to compete for beneficiaries based on price and quality, not health status. To ensure these capitated payments accurately reflect the expected cost of providing health care to each beneficiary, CMS uses a process called “risk adjustment” to adjust payments based on the health status of enrollees.

Figure 1

Total Medicare Advantage Enrollment, 2007-2024



Note: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.6 million people are enrolled in Medicare Parts A and B in 2024.
 Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024.

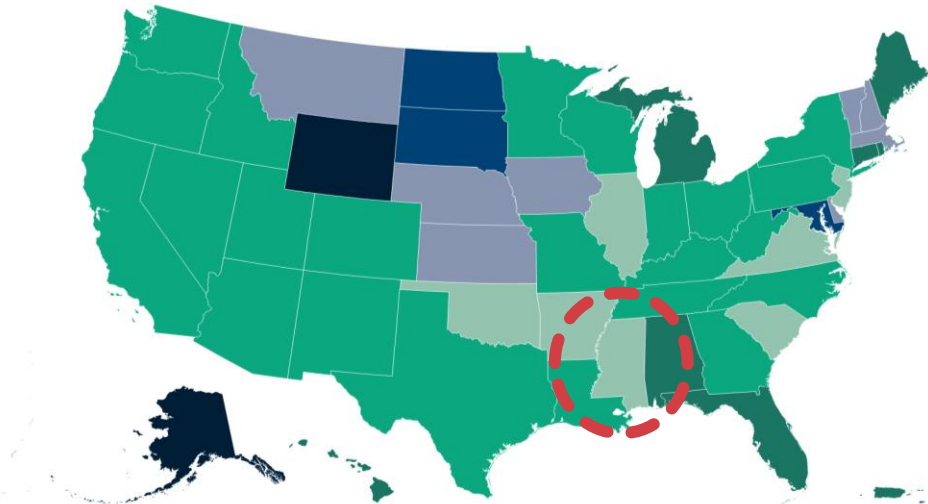


Share of Beneficiaries Enrolled in Medicare Advantage in 2024, by State

Click on the buttons below to see enrollment data for 2024 and 2014:

2024 2014

■ < 20% ■ 20%-30% ■ 30%-40% ■ 40%-50% ■ 50%-60% ■ ≥ 60%



Note: Includes only Medicare beneficiaries with Part A and B coverage.
 Source: KFF analysis of CMS Medicare Advantage Enrollment Files and March Medicare Enrollment Dashboard, 2014 and 2024.



How and why providers should scale their HCC risk capture

1

Providers (and managed care leaders) are embracing and experimenting with value-based risk-adjustment payment models.

2

Accurately defining, documenting and managing population complexity is more critical than ever.

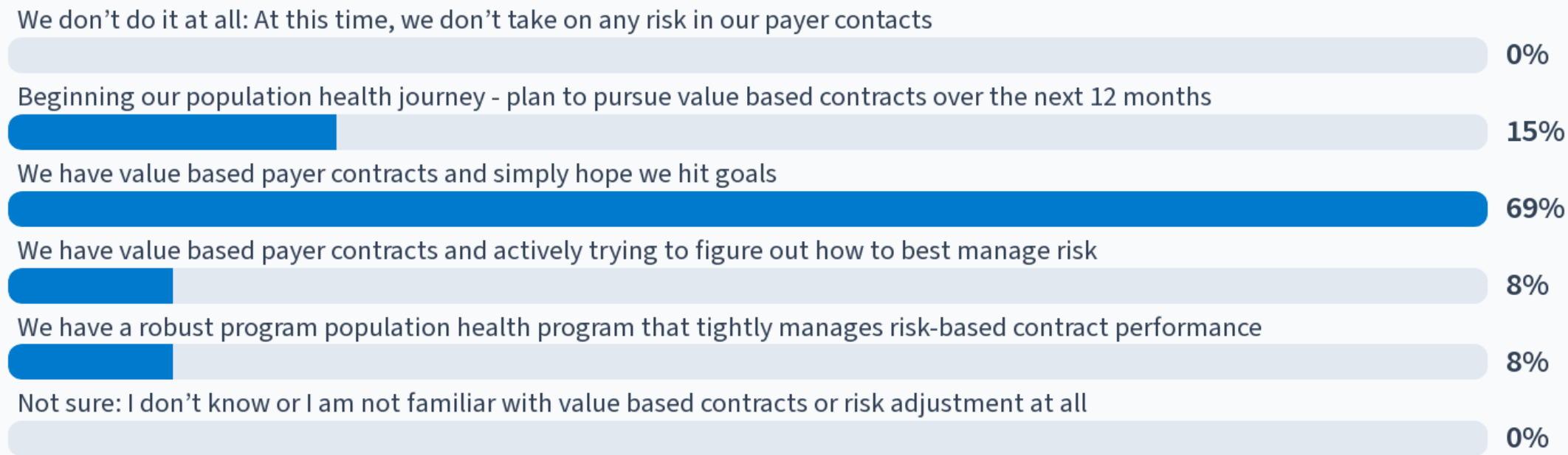
Hierarchical condition categories (HCC) codes are used to determine care funding under value-based payment programs within CMS, HHS and Medicaid risk-adjustment models. But without the right support, risk-adjusted conditions can be difficult for providers to document.

3

Most providers have invested some infrastructure to facilitate complete and accurate documentation that supports HCCs. Yet to realize care and financial goals, they must consistently improve performance year over year.



How would you describe the level of focus on Risk Adjustment/Value Based Care and the use of an "Ambulatory CDI" program



The case for a programmatic investment in HCC capture



Providers must document HCCs every year

Along with cost-reduction strategies, HCC supportive documentation is an important part of a value-based care program. HCCs must be documented annually to determine the complexity of a patient's care.

Harness the power of the EHR to deliver critical information directly at the point of care. This can help ensure providers accurately record patients' complexity.



Improve care quality

By improving documentation of HCC-related diagnoses, **providers can identify patients with the highest levels of clinical risk and deploy the right care management services to meet their treatment needs**. Specifically, providers can use HCC markers to identify unmanaged chronic conditions, create (and document) appropriate patient interventions, and implement care plans to close chronic care gaps.

HCC capture is a highly effective tool for improving chronic care gaps

88%



Median chronic RAF gap closure with EHR-embedded best-practice solution

97%



Highest percentage of chronic RAF gap closed with EHR-embedded best-practice solution

The case for a programmatic investment in HCC capture (Cont.)



Improve provider satisfaction

Complete and accurate HCC capture can **positively affect care funding in risk-adjusted payment programs** (e.g., Medicare ACOs or Medicare Advantage risk contracts). It ensures care funding corresponds to the complex and chronic care needs of the covered patient population.

Providers who practice and commit to complete and accurate risk documentation are also better positioned to negotiate favorable risk contract terms going forward.



Improve provider effectiveness

By more accurately and completely diagnosing and documenting risk-adjusting conditions, providers ensure that they get credit for care they are already providing. But the wrong approach can quickly limit progress. Most providers find paper-based processes and bolt-on technologies to be cumbersome and disruptive to their clinical workflow. The most progressive health systems present real-time HCC decision support to providers at the point of care through EHR optimization. This allows providers to more efficiently and effectively address clinical gaps.

Top 3 physician challenges to improving HCC capture

70%

Challenges to workflow modification

57%

Lack of provider visibility into opportunities at point of care

52%

Lack of provider visibility into own performance

A team-based workflow is crucial to document patient complexity

ACDI staff use defined processes to support providers in fully capturing complexity of patients and their care

Pre-Visit

Establish a sustainable *pre-visit* process to support the identification of highly probable care gaps.

Post-Visit

Close coding gaps prior to submitting the claim, leveraging NLP-powered review of 100% of encounters before claim submission.

Point of Care



Questions and Comments

Drive Financial Success with Intelligent Automation

Automation Fundamentals

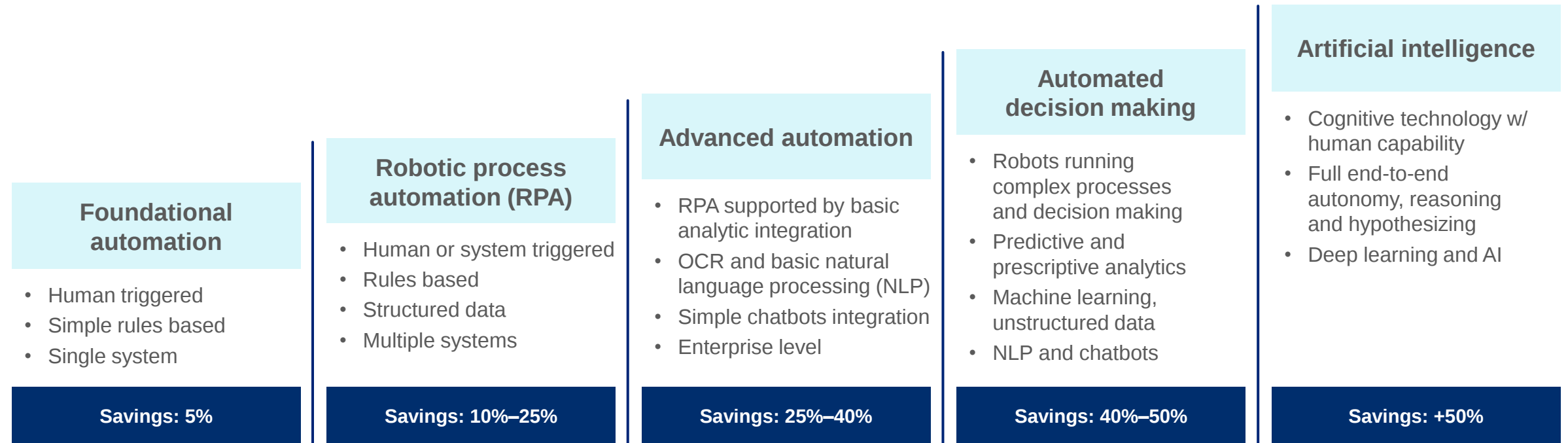
How do you feel about the "rise of automation" and its ability to improve healthcare over the next 2 years?

14



The Automation Continuum is Steep and Accelerating

Developed via third-party automation technologies leveraged externally by service vendors or internally by health system programmers...or packaged into SaaS



Where are these automation types most commonly found?



In revenue cycle specifically, how far along are you on your automation journey?



82%



Trying – we have not started or have a few technologies in place, but have not explored true automation (RPA, AI, etc.) within our revenue cycle

12%



Competing – we leverage technology and automation for key functional areas in our revenue cycle, but still can invest further

6%



Transforming – we leverage technology and automation across all functions and locations in our revenue cycle

The Gains and Benefits of Automation are Easy to See...

The following are key value drivers through deploying healthcare provider automation across the continuum of capabilities:



Cost Efficiency / Growth Augmentation

Optimize staffing, reduce outsourcing, provide opportunity to operate more efficiently with health system growth



Revenue Enhancements

Improve cash collection, DNFB and A/R metrics through greater expediency of claims processing and reduction of underpayments and denials



Quality Improvement Enhancements

Reduce and/or eliminate human error and improve efficiencies from manually transposing information from several systems into a single source



Improved Patient / Provider Satisfaction

Improved patient experience with more timely and accurate statement processing and credit balancing

8:1

Average automation gains and benefits in year one

60%

Estimated number of health care tasks that have automation potential

3-9 months

Average time to design and implement automation

**dependent upon complexity*

How confident are you in the ability of automation to reduce healthcare costs?



Successfully
achieving ROI from
automation among
providers is fleeting at
times...



Over 50% of automation investments fail to achieve their desired ROI

Providers must be very strategic and diligent in identifying use cases for automation investments with synergy and interrelationships to achieve the desired benefits of automation.

Is early adoption of AI technologies worth the risk?

AI is changing the healthcare industry, but not all organizations are adopting it at the same pace. Some are early adopters, and others are waiting to see how things play out. Unpack the different strategies for AI adoption and learn about the approach that may be right for your organization.

Maximizing the Value of Investments in Automation

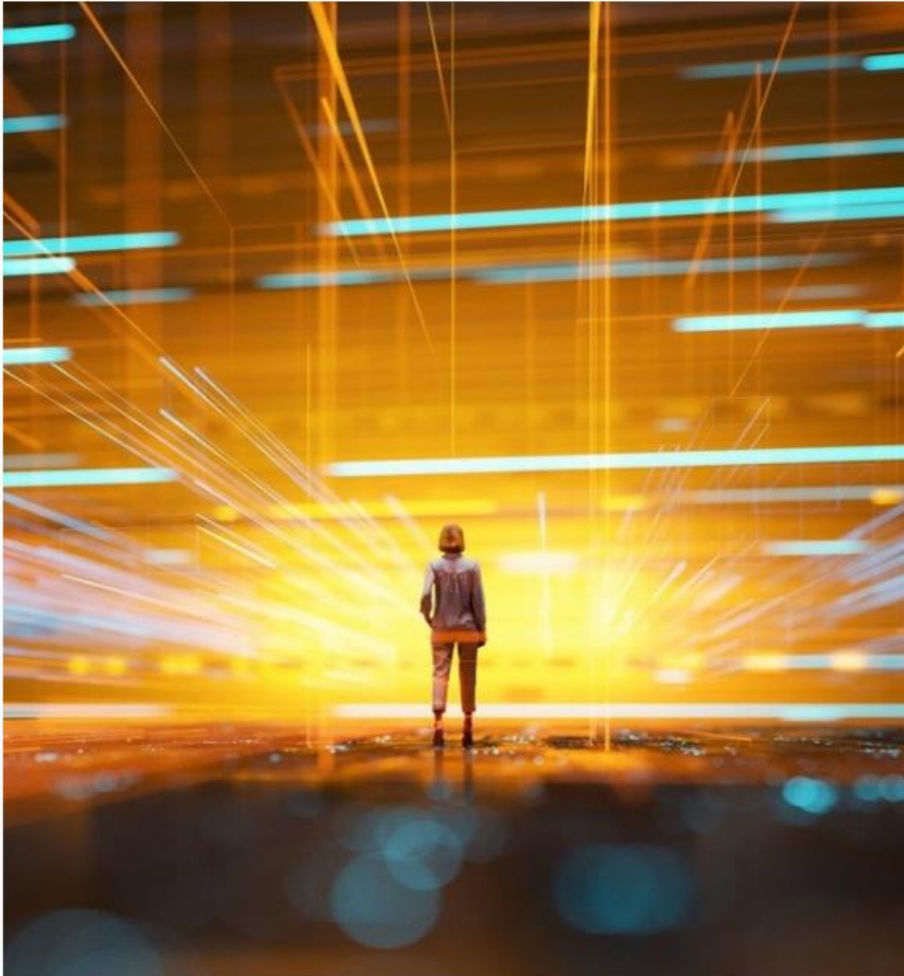
Unlock the full potential of artificial intelligence (AI)-enabled process automation to drive strategic goals and maximize your investment.



Artificial intelligence

AI will be a key differentiator for healthcare organizations between future success and failure. However, those who move first will not necessarily succeed — **it will be those who move thoughtfully.**

What is the biggest challenge in implementing automation in healthcare settings



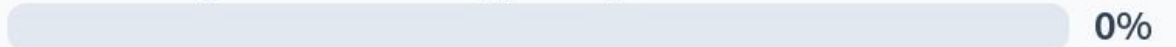
High initial costs (Budget)



Don't know how to get started



Determining who owns strategy and operations of bots



Integration with existing systems



Staff adaptation to new reality..Resistance to change



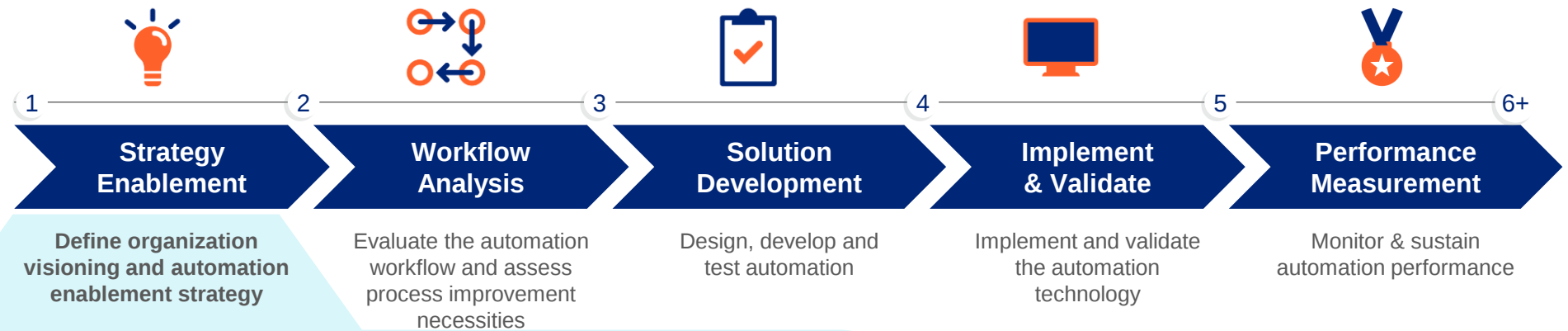
Data security and privacy concerns



Start Simple to establish momentum and structure

With an emphasis on planning, facilitate automation workshop sessions to build enthusiasm and a targeted strategy for revenue cycle automation, install intelligent automation solutions, and provide comprehensive change management support. Build upon initial successes in building “simple” automations (typically 3-7 processes) before tackling more complex automation.

“This is awesome,
I want everything.”



Build enthusiasm

Automation seldom achieves ROI on its own, organizational buy-in and top-down support is critical

Think big — start small

- ROI is seldom achieved within provider organizations through 1–2 task automations
- Focus on automating wholistic workflows and processes

Relevant use case selection

Identify use cases most pertinent for your organization — don't constrict yourself to a vendor menu

Questions and Comments

Financial Experience

Addressing the Triple Aim for a Reimagined Experience

1/3 of Americans consider switching to another provider who offers a better experience

79% of Americans want to use technology when managing their healthcare experience

81% of Americans believe scheduling appointments online would make the scheduling process easier



Mirror the level of excellence in the clinical experience

- Senior leaders from prestigious organizations nationwide emphasize the need to elevate the patient's financial experience to match clinical quality.
- Patient feedback indicates that the financial experience is crucial in guiding their choices about where and when to receive care.

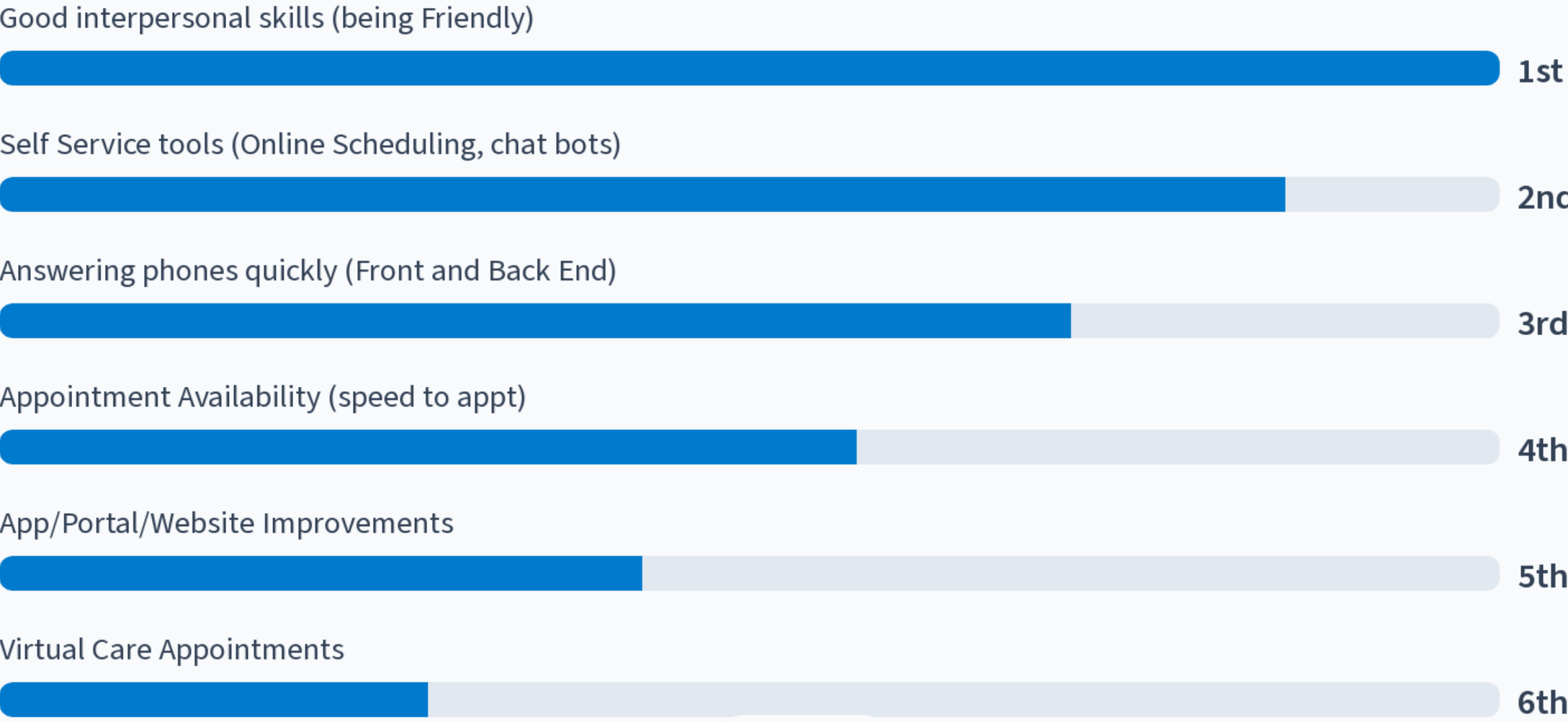
Focus on the “non-clinical” experience

- Optimizing the financial experience improves the overall patient experience.
- National research and industry-wide data indicate the financial experience heavily influences patient loyalty and payment likelihood.
- Opportunity to enhance loyalty and retention, maximizing customer lifetime value.

Seize the first-mover advantage for a consumer-focused experience

- Our research and extensive roundtable dialogues with leadership across the country continue to suggest an opportunity.
- Be among the first organizations to truly deliver a transformed patient financial experience.
- Differentiate and attract patients through this transformation.

Rank the following based on what you think will most benefit a patient's experience:

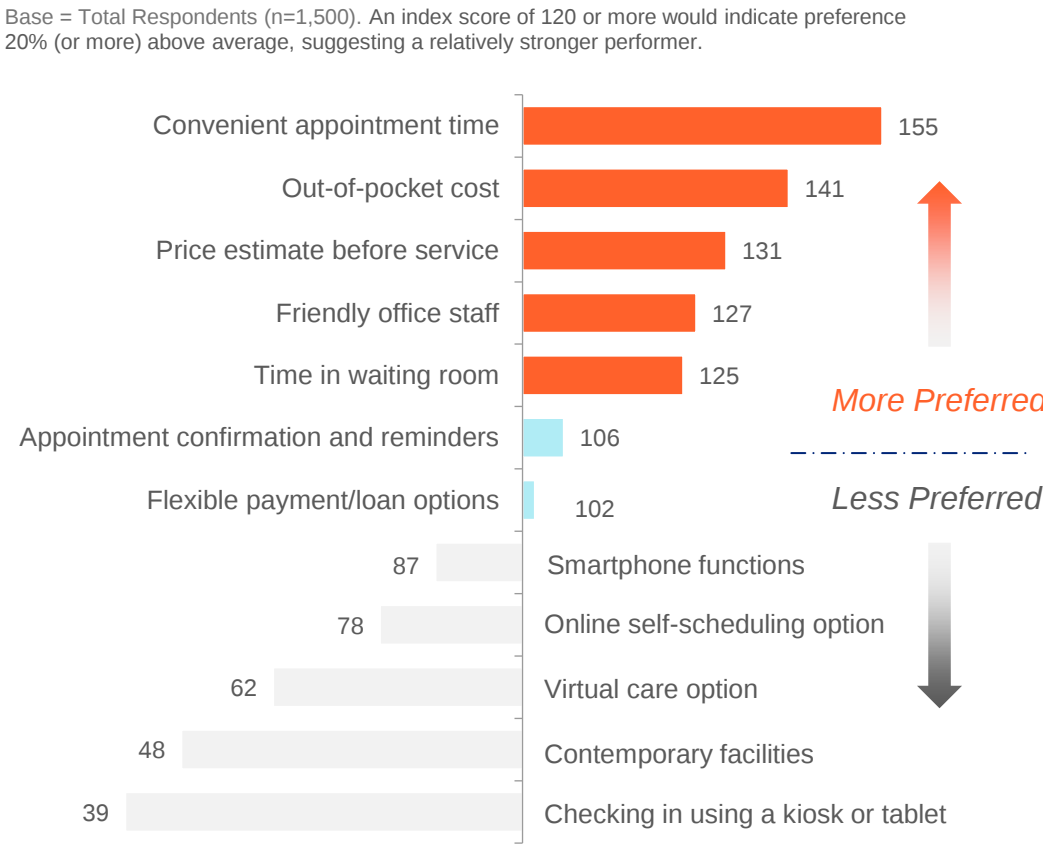


SEE MORE ▾

Don't let “Shiny Things” be the Centerpiece of Your Experience

Consumers want consideration for me, my time, and my money. While patients may adopt purposeful technology, it does appear to overshadow the desire for fulfillment of foundational elements of the experience.

Indexed Importance Scores



The overall experience delivered is determined by the combined performance within these core competencies:

Service Standards	Aesthetics
 - Degree of Process excellence - Financial Clearance focus - Whole-system consistency - Workflow management - Staff/Service availability	 - Dialogue/Behavioral Rigor - Service recovery options and staff empowerment - Print and Web content and design - Branding Consistency
Technology Offerings	Management
 - Transparency/Estimation - Self Service Options - Green & Mobile options - Technology “stickiness” and incorporation	 - Performance metrics (hard and soft) across journey segments - Staff Motivation and Incentives - Staff Training and QA - Survey feedback

Do you know how well you are performing?

Dig Deeper into the VoC on a Regular Basis to Understand Your Market

Voice of the Customer (VoC) insights are often focused on the clinical experience, leaving the financial experience largely an unknown for revenue cycle leaders.

Digging Deeper into Systematic Experience Monitoring

Surface Level Probing

- Achieved via system level “experience” surveys
- × Wide scope/non-specific
- × Focused on ratings
- × Focused on clinical
- × Retrospective

Financial Experience Surveys

- Narrow Scope/specific
- Focus on broader PFE experience and preferences
- × Retrospective

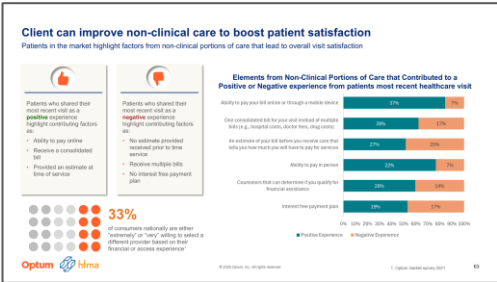
Targeted Feedback

- Post encounter
- Near real time
- Tech investment
- × Narrow Scope- applicable encounter level feedback

Multi-segment Real-time

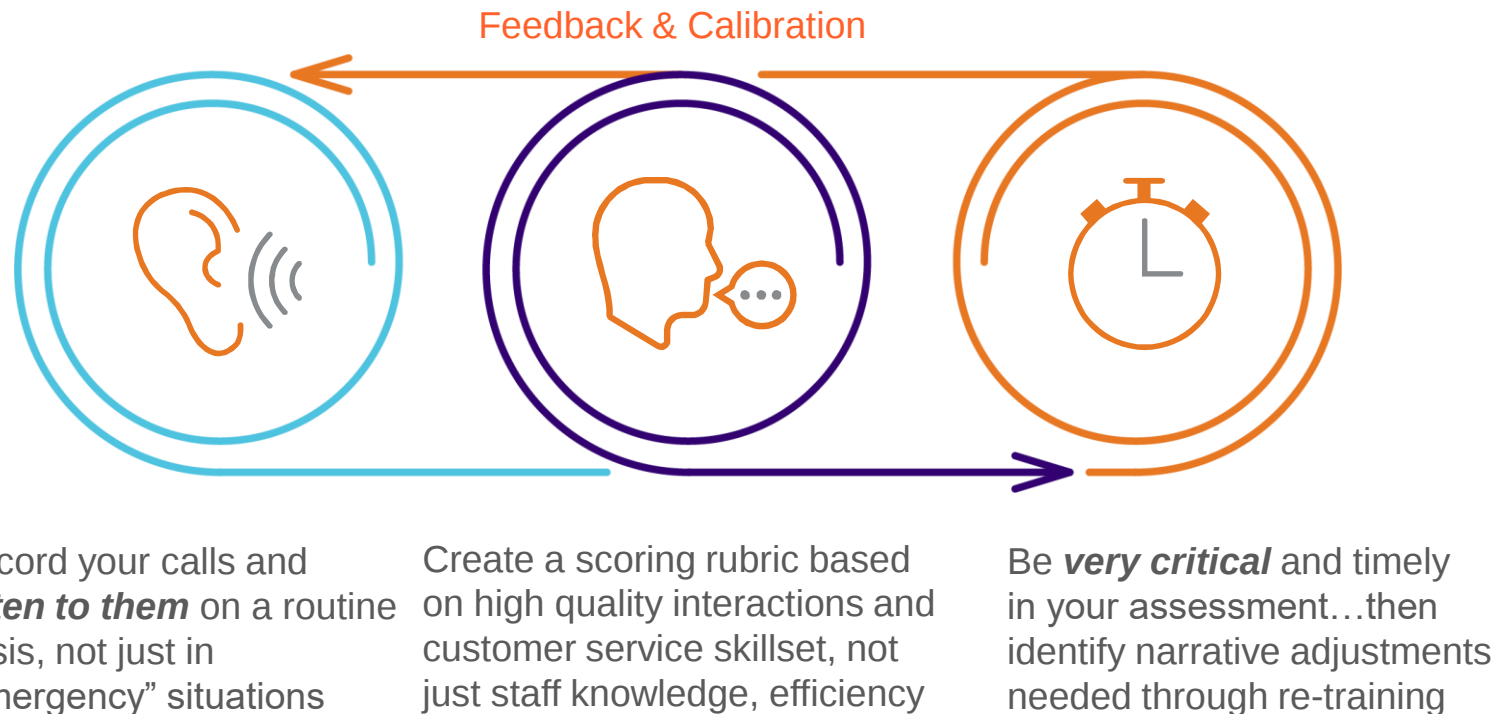
- EMR integrated
- Real time triggering
- Encounter segment specific feedback (Sched, reg, cust.serv.)

Ex. Post-call micro surveys



Commit to rigorous management of your interaction quality

Successful operations rely on a regimented approach to measuring and managing the quality and control of patient interactions. The key step is a commitment to listening...and then acting.



We find that patients will generally rank the importance of agent effectiveness well above agent personality preferences. This tells us that a knowledgeable agent is more impactful than a generically friendly agent...but why not have both!!



Automating Measurement

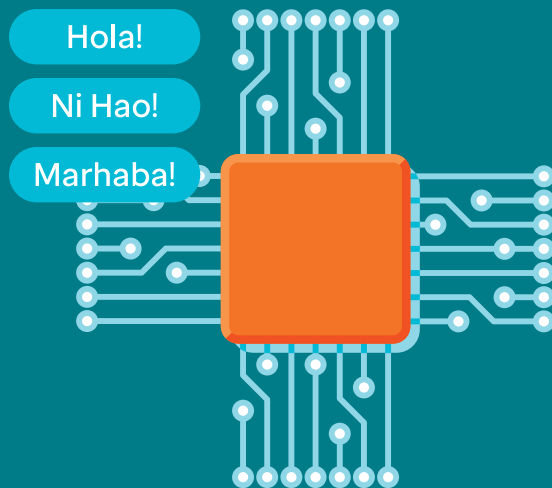
Next level commitment to conversational quality and consistency can be achieved with automation/AI



Embracing Automation Evolves Contact Center Efficiency

Conversational AI

Value: Enable self-service, expand coverage and supported languages



- Real-time integration with the EMR (Epic as Phase 1) to match patient identity and predict intent (focused on established patients)
- Mimic retail-like experience (i.e. frequent flyer experiences by calling the airline)
- Ability to support additional languages while expanding 24/7/365 self-service for common use cases

Agent Co-Pilot

Value: Improve first pass patient resolution, increase patient satisfaction by reducing call time

- Real-time call summarization for more detailed encounter documentation in the EMR
- Deliver agent guidance and suggestions based on the ambient call listening
- Real-time sentiment analysis and feedback prompt to identify a need for escalation or remediation
- Automated record pull from EMR to present agent a summary encounter which reduces the number of questions to improve the patient experience



Innovation happens when Knowledge Management is combined with 21st century language models

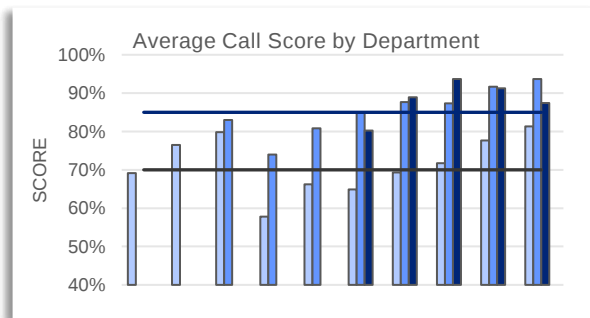
Transforming Financial Experience by stacking Micro Improvements

Challenge: Legend Medical Center's remarkable clinical quality and experience exceeded that of non-clinical areas, particularly for personal interactions regarding financial matters. Leadership acknowledged the damage of this discrepancy on the overall perceptions of the health system and were dedicated to adopting meaningful changes. Immediately following a comprehensive diagnostic assessment of its financial experience, Legend Medical Center extended their partnership with Optum Advisory (OA) to guide the advancement of culture, services, and technology to better meet patient expectations.

Action: With a unified mission this industry-leading effort rallied around a leadership-defined set of core financial experience values that manifested into guiding principles for future improvements. These guiding principles and the associated 18-month implementation roadmap created an achievable plan for a range of immediate tactical improvements and a foundation for future decision making.

Improved Call Performance Nets Positive Patient Experience

Achievements across narrative quality, patient feedback, and team member reward and recognition



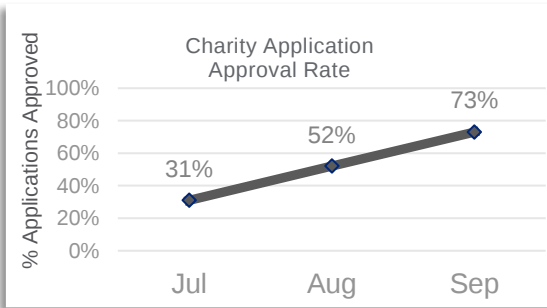
"I had the pleasure of speaking with [the patient] who expressed how pleased she was with the outstanding customer service that [the agent] provided."

I had questions related to my account and had the real pleasure of talking to [the agent]. She was very patient, professional and bottom line - got the job done."

I really want to acknowledge [the agent] for helping get my lab results to my PCP. She went above and beyond to do her job and that made a difference in my day today."

Adjusted Workflow drive Expedites Charity Application Approval

Achievements in optimizing workflow and leveraging available data to improve the patient experience

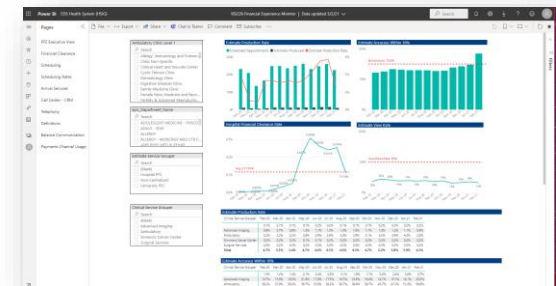


Improved process impacts experience directly and indirectly:

- Eliminated manual follow up with a subset of patients
- Reduced charity denials caused by lack of documentation
- Improved turnaround speed on charity approvals
- Freed up staff capacity to serve patients with more complex financial situations

New Performance Data Infrastructure Supports PFE Program Sustainability

Achievements in cross departmental collaboration to ensure data is automated, digestible, and available for leadership in a central platform



PFE Performance Dashboard Highlights

- Aggregated multi-sourced data for clear visibility into operational areas that matter most to the patient
- Refined slicers and views to support drilled-down reviews and action planning
- Leaves room for data set and metric expansion

Questions and Comments
