# Integrations and achieving synergies

## Transcript

LANCE BEDER: I do want to pull that thread just briefly on the revenue cycle because, you know, Glenn, in doing diligence, and Adrianne, from your perspective in doing performance improvement, the revenue cycle is 80% of the effort in healthcare transactions. And generally, when we get involved in evaluating the revenue cycle, we've built a number of methodologies and processes to go through diligence in the revenue cycle. and we identify areas for improvement. Those are areas that could be enhanced during the process of diligence or identified as a post-transaction improvement objective.

Glenn, maybe just talking about some of the revenue cycle challenges that you've had, what would you say is the top two issues on diligence in a healthcare provider around revenue?

GLENN BARENBAUM: I think there's always room for improvement, and it's a dynamic reimbursement system here we have in the U.S., the number of governmental payers and commercial payers, and that's constantly getting negotiated. Concepts like value-based care are being implemented at some of these physician practices. And at the crux, the physicians are looking to provide healthcare services, not necessarily enhance their revenue generation. That being said, you can do both together. So, you know, physicians are looking to provide the best medical outcomes and at the lowest cost and get reimbursed as much as they can with the commercial payers.

So I would say, what we see in the diligence perspective is that it is a bit of a moving target, and there's a lot of benefit from really having dashboards, having key tools, to understand the changes in the payer environment. And that's where you can professionalize those tools to really accelerate the growth once a new owner owns that business.

ADRIANNE BOYLEN: And I would just say, once you have the deal signed, from a revenue cycle standpoint, a real key aspect is making sure you have a plan for how to collect on the tail of that AR as you move forward. So, oftentimes people are thinking ahead about what they'll do going forward as a combined entity, but you don't want to ever lose sight of that tail from the original organization that was purchased.

LANCE BEDER: Yeah. Now, we're talking specifics about healthcare, you know, lingo and talking about tails. Glenn, back to you on training. transactions. You know, one of the things that we've heard from the healthcare community, the transaction healthcare community, is that deals are taking longer to do. And I don't know if you've got a viewpoint of why that's happening, but maybe you can share on that.

GLENN BARENBAUM: Well, I think the bar is definitely increased. I mean, a lot of private equity firms are using debt as a tool to help buy businesses. And if they're going to their investment committee or a partner that's lending debt, they need to ensure diligence is clearly explained of what was accomplished and what the historical financial results were observed, and how it bridges to the forecast.

So I do think that with the confidence level and the economy where it is today and the cost of debt is definitely taking the process to really get sign-off on consummating these deals a little longer.

LANCE BEDER: And maybe just touching on another point is what subsectors in healthcare are you generally seeing in trend at the moment?

GLENN BARENBAUM: I think that these sectors kind of go in waves. So, I think, you know, five, six, seven years. ago we saw a lot of physician practices. Orthopedic was very popular. We're seeing that come back. Behavioral health is certainly a wide and broad sector and we're seeing anywhere from recovery and drug abuse, behavioral health companies to pharmacy, and really helping people with their medical conditions. So, behavioral health, home was very hot, right, and then there's a reimbursement change recently. So I think we'll see some more home, health and hospice in the future. Labor issues definitely impact all these businesses, and hospitals are trying to figure out how to equalize some of the labor costs in their organizations.

ADRIANNE BOYLEN: Those are all businesses I've been helping in just in over the past few months so that's exactly right.

LANCE BEDER: So back to you Adrianne. You know, the infamous battle of deciding to insource or outsource in physician groups, especially around revenue cycle and the back office, what are you seeing? And maybe share examples of trends that might be coming.

ADRIANNE BOYLEN: This is such a touchy subject. A lot of people go back and forth on what the right answer is. My personal opinion is that it's probably a best of breed, and what are those things that make the most sense to outsource those areas that you don't have enough people to support and really go after. Focus on that or the lower-risk areas. Those are opportunities to outsource. However, no one can do it as well as you yourself will and the attention that you want to pay. And so keeping some of it in-house makes a lot of sense versus maybe giving full control to another organization.

GLENN BARENBAUM: I think that's a common theme that I hear a client say, “No one's going to care about my business more than myself.” So, to the extent they have the capacity to drive their revenue cycle management processes, I think most organizations do. But to Adrianne's point, there's a lot of opportunity to outsource less critical parts of the cycle.

ADRIANNE BOYLEN: And the same is true even in accounting and finance functions, right? You can outsource some of your accounts payable or different areas that maybe aren't as critical. But maybe your revenue accounting, you want to keep that in-house—as an example.

LANCE BEDER: Adrianne and Glenn, thank you very much for sharing your insights today. They're profound, they're action-based, they come from a real source of experience, and I think that the audience watching today would actually find it very insightful. Thank you very much for watching. Have a great day and see you soon.