Revenue Cycle Management: What’s Next in Healthcare
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Introduction

The world of managing revenue in a healthcare organization is poised for a radical change. For decades now, the revenue cycle efforts in healthcare organizations has tread heavily down the familiar path of fee-for-service billing. Yet alternate paths are beginning to emerge as organizations focus on quality and minimize expense using techniques such as population health management, coordinated contract management, and leveraging combined electronic medical records (EMRs) and business data. Moreover, government reform and new reimbursement approaches are demanding healthcare organizations provide the best care with the least expense and that healthcare providers share more risk in varying degrees. These market forces have prompted many healthcare organizations to take a step back from traditional revenue cycle management (RCM) approaches and ask “How can a healthcare provider optimize the delivery and quality of patient care in a shifting reimbursement landscape”.

This paper presents the approaches pursued by six different healthcare organizations operating in varied markets, to this very question.

Background

In order to provide insight into this question, HIMSS Analytics, the analytical and research arm of HIMSS Worldwide, conducted research on the revenue cycle management activities and approaches as seen and implemented by six varied healthcare organizations.

Study Design

To facilitate this research, HIMSS Analytics conducted a virtual focus group with healthcare executives. A respected group of six healthcare organization executives, including four Chief Financial Officers (CFOs), a Vice President of Finance & Business Development, and a (Chief Information Officer) CIO/Chief Strategy Officer, agreed to participate in this study. This leadership group represented a variety of hospital sizes, competitive environments and geographies. This paper is a consolidation and presentation of the conversation by this leadership group.

With a limited number of participants, these results are not meant to be a definitive assessment of the market. Rather, they are designed to be a valuable resource to inform the market about the varied approaches and perspectives healthcare organizations and hospital leaders are taking with regard to revenue cycle management.
Common Overall Business Priorities

Healthcare organizations develop and refine their key strategic priorities based on a whole slew of factors including their facility’s characteristics, market, revenue, and staff composition. The path developed and pursued is unique and specific to the circumstances that exist to each organization at any given point in time. Therefore it was significant to begin the focus group off by discussing the participant’s current business priorities. With little surprise, healthcare reform and its anticipated changes tended to shape the group’s priorities. That said, the specific efforts undertaken to prepare for and make the most of healthcare reform varied greatly, to include:

- Physician practice acquisition;
- Recruiting new physicians;
- Physician partnership development;
- Transforming the hospital from “all things to all people” towards “three core clinical care theaters”;
- Growing patient volumes and capturing a greater share of patients from the local area;
- Learning more about population health;
- Changing EMR and financial systems; and
- Changing operations to match best practice.

One of the most common business priorities noted by the participants was “population health”. Most of the organizations represented were experimenting with population health. In fact, several claimed they were using their employee pool to become familiar with population health management techniques. Examples of the type of techniques used by the participants included implementing an on-site clinic for employees and employing physicians dedicated to employee health care.

These organizations appear to be looking at costs from an extremely multi-faceted perspective. They are considering everything on the table in order to find and optimize opportunities to maximize revenue and reduce costs, thereby either directly or indirectly impacting the revenue cycle and revenue results. One participant noted, “Nothing is off the table here. There are no more sacred cows.”

Management Priorities

Having established organizational priorities, the conversation then turned to revenue cycle priorities and in particular, how participants set priorities related to their revenue cycle operation. For many, the approach was to first ensure their revenue cycle effort was properly integrated into one process. This led the participants to discuss the challenges of acquiring and managing new systems as well as the types of systems being considered for acquisition. It was the group’s expectation that systems in the future will have much more
integration and coordination than either best of breed multi-vendor solutions or current one stop solutions.

Once the revenue cycle effort was properly integrated into one process, the group claimed priorities were then defined by their continuous improvement efforts. That said, the group participants noted that it was critical to include both the clinical and business sides of the organization in their revenue cycle improvement efforts.

Participants used a variety of different tactics and opportunities to address their RCM optimization efforts. No holds were barred and many tasks included looking at items outside of the traditional billing process, to include the following:

- New EMR systems which integrate and coordinate RCM activities more tightly;
- Centralization of activities to enhance communication and minimize confusion, including centralization of expertise which has the added benefit of reducing excess capacity;
- Outsourcing of transcription;
- Standardizing and centralizing coding; and
- Engaging in new shared savings and risk taking contracts.

One participant stated that it is critical to align physicians so that they are managing utilization in coordination with organizational efforts. This includes the “whole process of care of the patient and managing wellness up front.” By managing physician (income) risk the idea is the healthcare organization can motivate the physician to enhance prevention and value of services while minimizing volume. As one participant stated, “The key to what we are looking for is greater value, and it’s a total change of mindset.”

This approach signifies a shift from a model of managing sickness to a model of managing wellness. The key to making this shift is to establish tighter relationships with physicians. Several participants were engaged in buying physician practices and bringing more physicians on-board to manage volume, control leakage, and instill the wellness management philosophy while protecting and potentially expanding their market share. The overall goal of being the low cost, high quality provider with the largest footprint in their market was the primary driver, with the feeling that having that status would drive physicians to the organization as well as enhance referral business.

A New Revenue Cycle Paradigm – Total Revenue Management

Perhaps one of the most notable themes emerging from the above conversation was the near universal recognition that healthcare organizations must move away from a dependency on revenue generated by fee-for-service volumes. While fee-for-service is still a large part of many healthcare organizations' revenue stream, the executives in our focus
group acknowledged the need to institute a corporate strategy which maximizes the value of care delivered. This is an approach many are calling Total Revenue Management (TRM).¹

**Information Technology Considerations**

Interestingly, all of the organizations represented in this study were in some form of transition with respect to key EMR and/or financial applications. All organizations also felt the need to take better advantage of leveraging the combination of EMR and financial data. There was a distinct desire to consolidate this data into a central data warehouse where it could effectively be leveraged for population health management, self-insurance analysis, identifying and mitigating risk (business and clinical) factors, and overall strengthening the decision support area of the organization.

Those representing smaller healthcare providers expressed concern about having the staff and talent to effectively engage and master these more advanced analytical skills. Where this was a concern, the healthcare organization was looking for "plug and play" type analytical solutions that were targeted and tailored to specific needs the organization could address.

**Analytics is Insightful**

Given the mention of “analytics”, the group conversation then turned to the use of analytics in their organizations. All participants agreed that analytics is an empowering tool for understanding and revealing revenue cycle activities, and acknowledged the need to understand their data in order to know how to best target their total revenue management opportunities. Several participants noted that it is beneficial and important to link clinical and financial data to gain better and deeper insight into the workings of the organizations and issues along the revenue cycle.

While the tools, sophistication and depth of analytical insight varies by organization size, the group recognized analytics was not a function only applicable to larger organizations. For larger organizations, the analytical task is perceived to be easier because these organizations tend to have the infrastructure to support sophisticated data warehouses with consolidated data from both internal and external sources, as well as dedicated analytics teams. For smaller organizations, the task is perceived to be harder. That said, the participants were impressed with the innovativeness of smaller organizations to meet their analytical needs by using simple office productivity tools to gain needed insights.

An example of revenue analytics used by many in the group was what they called “improving the margin”. This exercise refers to using analytics to identify practice patterns and specific approaches being used within the organizations to facilitate patient care. Each organization had a team that regularly reviewed high cost patient care approaches. These teams then developed a profile of best practices and facilitated conversations with staff and

¹ Gartner, March 28, 2013 - Top Actions For Healthcare Delivery Organization CIO’s, 2013: Become Obsessed with Total Revenue Management, Vi Shaffer
physicians to present their findings. This practice was regarded by the participants as a standard ongoing process improvement process that greatly impacts the profitability of the organization.

**Contract Management and Tracking ROI**

When asked about their contract management and payment compliance efforts, most all of the participants claimed to have contract modeling tools in place, defined by the group as a tool designed to identify insurance patient outliers. The organizations represented used a wide variety of contract management and other supporting tools to support the revenue cycle environment. These included decision support tools, pro-forma tools for calculating ROI and return, tools for pulling and aggregating both clinical as well as financial data, and of course a variety of homegrown solutions. Organizations without a contract modeling tool, claimed they did not have the infrastructure in place to support the tool. The participants thought a contract management tool would be useful for organizations serving a high Medicaid patient population but did not believe it was a high priority given limited resources.

The group made it clear that tracking return on investment (ROI) is typically done at a high aggregated level, with of the explicit purpose to gain or justify decisions for a board directive. Otherwise, ROI was not aggressively tracked project by project unless needed for a special case.

**Focus on High Volume with High Costs**

While not specifically ROI, some participants did claim their organizations had detailed financial analytical programs around key organizational drivers: physicians, patients and quality. One participant noted that their organization was looking at “10 different clinical areas of focus and looking for massive variation by physician, breaking down in detail what that translates into in total cost of the patient.” Key areas of concern were sepsis, implants, and cardiac work such as stents. These higher volume, high cost, and more importantly services subject to great practice variations, were seen as the most fertile ground for cost saving opportunities. Clinical and business data related to these episodes of care were easier to track in meaningful quantities as well as the ability to compare and identify a best practice that is defensible and presentable with minimal controversy. Participants noted that often times, their analytical quest often begins with a simple question such as “why does one physician cost me more money than another when they are doing the same procedure?”

The general outcome of these analytics activities was identifying physician “outliers”. The action that resulted from these efforts usually results in a private, “polite” conversation with the physician to review the analytics research. Participants claim there is a sincere attempt to walk through the decisions that support the care process, with an eye towards understanding different ways to treat that might be less costly or improved. This conversation is often a hard one to have with busy physicians and those that are convinced their methods are beyond reproach. Having “one on one” conversations seems to be the best approach to minimize defensive behavior.
Moving Forward

Participants were then asked to share their vision for the future of revenue cycle. The group generally agreed that revenue cycle is getting more attention as payment reform and risk sharing take hold. Healthcare organizations are aware of the need to look more closely at this area and have the responsibility to understand their exposure and risks associated with anticipated changes in their markets. One participant’s organization took a very progressive approach and is working with their population to sign them up for insurance before they even engage with the hospital or have medical issues. This was cited as an example of understanding your customer base and potential patient population and effectively ensuring that population has the ability to pay if they engage with your healthcare organization. The participants agreed this was a proactive approach.

Another organization was spending their energy on the “up front processes” to ensure all the important insurance information, billing codes, etc... data was correct. This hospital was even talking about giving handheld computers or tablets to physicians in order to maximize the likelihood of capturing critical information in an accurate and timely manner. “We want to replace [the process] some of these community guys who still walk around with index cards and write things down that never get billed”.

Other healthcare organizations are using analytics on the back-end to identify work lists, spotlight variances in care and best practices, claiming it is critical to incorporate both clinical and business related financial data. A basic tenant for this capability is to understand the need for the analytical infrastructure, tools and staffing. Building out the decision support area, acquiring and managing the data needed to identify opportunities and keeping this all working and functioning were seen as a priority.

Conclusion

Today’s healthcare organization is faced with the need to manage a multiplicity of variables impacting their revenue. As evidenced in this study, organizations can vary in the way they tackle these challenges. This study also suggests healthcare organizations are beginning to more firmly grasp the concept of leveraging analytics in the spirit of total revenue management efforts. Making “gut” decisions about running a healthcare facility and optimizing care quality and costs is not something that can be tolerated in today’s environment. Executives have to know what is worth doing and ensure the numbers are telling them it was done after the fact.

The findings of this study also suggest that revenue cycle management has blossomed into Total Revenue Management and is all inclusive of anything that can be done to manage revenue now. This includes the traditional space of RCM and beyond into cost containment, understanding, engaging, and managing your patient population and associated expense dependencies. Healthcare organizations are experimenting and getting up to speed in this space just as quickly as a new healthcare reimbursement paradigm is demanding it, a paradigm which is radically different than we’ve seen during the last few decades.
Appendix – HIMSS Resources

HIMSS is a global, cause-based, not-for-profit organization focused on better health through information technology (IT). HIMSS leads efforts to optimize health engagements and care outcomes using information technology. Visit www.himss.org.

HIMSS is a part of HIMSS WorldWide, a cause-based, global enterprise producing health IT thought leadership, education, events, market research and media services around the world. Founded in 1961, HIMSS WorldWide encompasses more than 52,000 individuals, of which more than two-thirds work in healthcare provider, governmental and not-for-profit organizations across the globe, plus over 600 corporations and 250 not-for-profit partner organizations, that share this cause. HIMSS WorldWide, headquartered in Chicago, serves the global health IT community with additional offices in the United States, Europe, and Asia.

HIMSS Medical Banking and Revenue Cycle Management Improvement Homepage
http://www.himss.org/library/medical-banking?navItemNumber=21157

Healthcare Transformation Project Program Website
www.himss.org/transformation