REPRINT January 2015

hfm
healthcare financial management association hfma.org

Ben Colton
Andrew Davis

integrating the revenue cycle for improved health system performance

By developing an integrated revenue cycle, a health system can reduce costs and improve financial performance in a way that equally meets the needs of its hospital and physician constituents.

AT A GLANCE

Three integrated revenue cycle models reflect the various levels of integration a health system might find desirable or feasible based on its current circumstances and environment:

- Model A: A single health system executive provides oversight, but physician and hospital revenue cycles are managed separately.
- Model B: A single health system leader provides oversight, with a functional framework for management at the director level.
- Model C: Integration is complete for all processes.

Declining professional service reimbursement and uncertainty over healthcare reform, among other factors, are converging to create an uncertain environment for physician practices across the country. As the ground beneath them shifts, many physician groups are seeking more stable footing through employment or alignment with hospitals and health systems. As a result, many hospitals are finding themselves stretched beyond their traditional scope in managing growing ambulatory enterprises.

Hospitals and health systems can obtain many benefits from tighter alignment with physicians, including a higher continuity of care, a stabilized referral base, and readiness for new payment models. But the costs associated with achieving such alignment can be substantial. These challenges are prompting finance leaders to look for opportunities to consolidate functions across the system, reduce costs, and improve financial performance. One of the most effective means for achieving these goals is to develop an integrated revenue cycle (IRC) that meets the needs of the hospital and physicians alike.

What Is an IRC?

An *IRC* means different things to different organizations. At its basic level, an IRC involves the coordination of revenue cycle activities under a common leadership and team structure. A mature, fully integrated revenue cycle attempts to marry each functional area and directs teams toward common enterprise-level goals. Ultimately, integrating revenue cycle activities presents significant opportunities to produce cost savings and drive strategic alignment, among other benefits.

A hospital or health system can experience three primary benefits from developing an IRC: a reduced cost to collect, performance consistency, and coordinated strategic goals.

Reduced cost to collect. Efficient hospital and physician groups realize a cost to collect of about 2 percent and 5 percent of net collections, respectively. Organizations that develop IRCs can further reduce this cost by combining strategic and operational elements including resources, management, overhead, vendors, IT platforms, and business intelligence.

Performance consistency. An IRC promotes a coordinated management structure and information sharing, which are beneficial in identifying performance trends, highlighting improvement opportunities, and supporting uniform performance across the enterprise. Job codes and pay rates can be combined, employees' roles and responsibilities can be clearly defined, and production and quality rates can remain consistent in all settings.

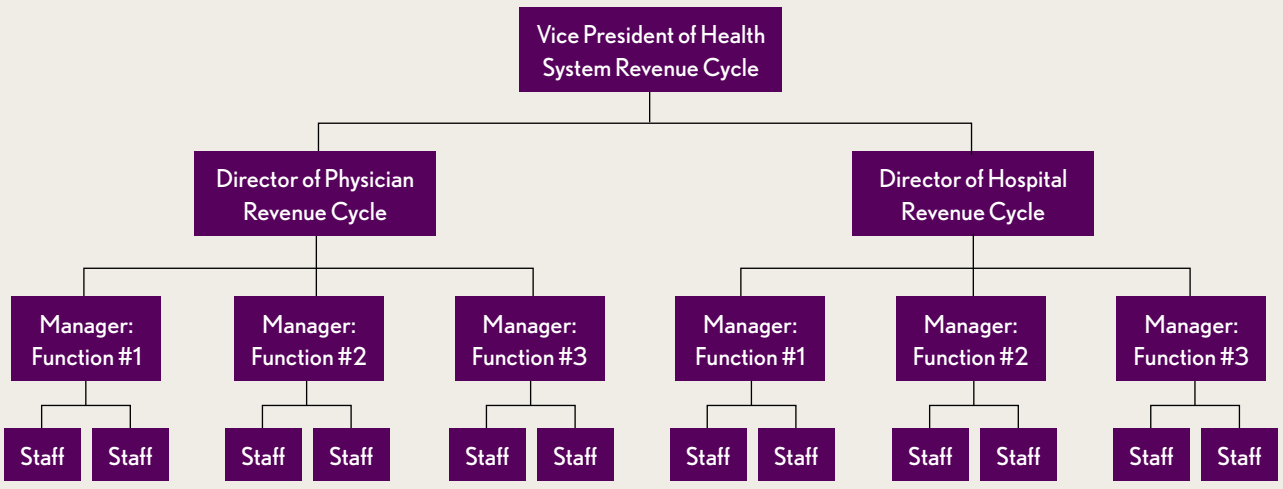
Coordinated strategic goals. Drawing the revenue cycles together presents organizations with an opportunity to align themselves with a shared focus on strategic goals. Hospitals and physicians often can benefit from more targeted managed care, marketing of a truly integrated health system (e.g., common customer service phone line), and synergy on care delivery strategies as a result of aligned revenue processes. Further, because an organization's revenue cycle will become more visible and clearly defined through an IRC, the structure tends to promote improved coordination between financial and nonfinancial units.

IRC Structures

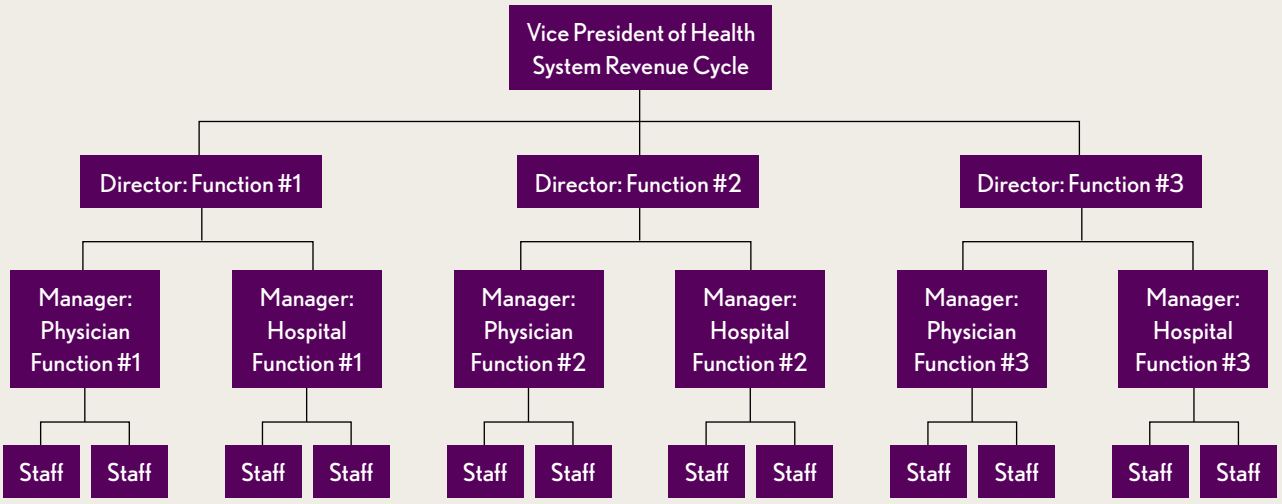
Three common team structures reflect the various degrees of revenue cycle integration.

Model A: Oversight by a single health system executive, with physician and hospital revenue cycles managed separately. This model maintains a divisional structure with minimal integration. Under this model, all professional and hospital billing activity, as well as the other components of the revenue cycle, continue to function independently; integration is achieved solely through the appointment of a single revenue cycle leader to ensure consistent monitoring of enterprise-level performance, to establish a single point of accountability, and to provide a liaison to external parties. Ideally, this model can serve as a segue to more advanced types of integration as the political climate allows.

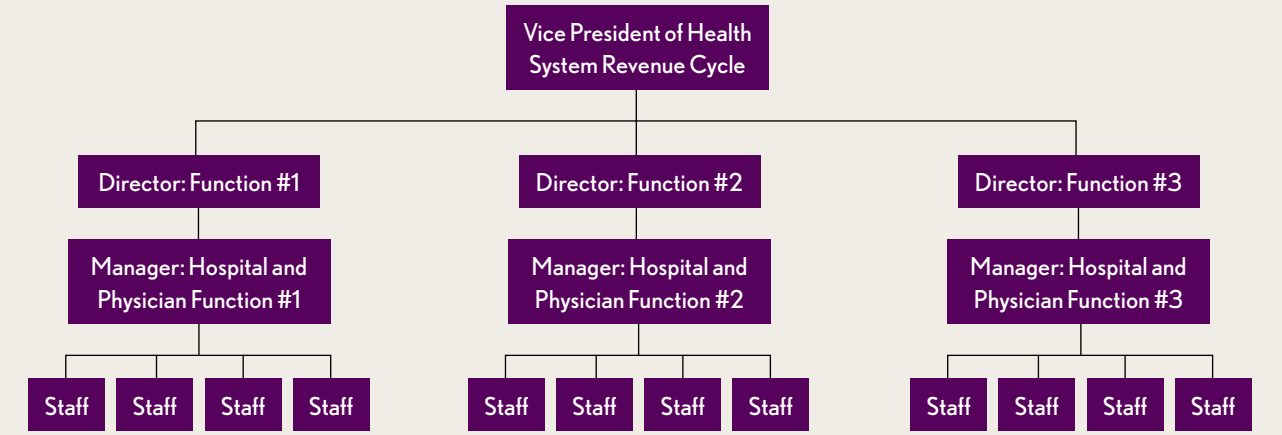
MODEL A: SINGLE HEALTH SYSTEM LEADER OVERSIGHT OF SEPARATE PHYSICIAN AND HOSPITAL DIVISIONS



MODEL B: SINGLE HEALTH SYSTEM LEADER OVERSIGHT, WITH DIRECTOR-LEVEL MANAGEMENT BY FUNCTION



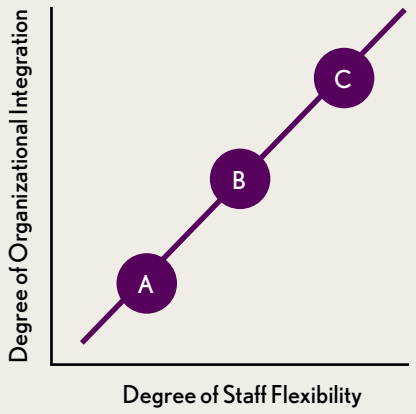
MODEL C: COMPLETE INTEGRATION OF ALL PROCESSES



Model B: Oversight by a single health system leader, with a functional framework for management at the director level. Under this model, in which integration remains limited, single directors are assigned responsibility for different functions of the revenue cycle, with each director managing both professional and hospital components. Although staff are almost exclusively involved in physician or hospital activities, informed management oversight empowers directors to identify efficiencies and make a gradual shift into further integration.

Model C: Complete integration of all processes. Under this model, all staff are fully conversant in both hospital and physician components of their functional area. A full integration of skills among staff members requires a more advanced recruitment process with higher levels of staff training, education, and monitoring. Directors and managers, however, will enjoy a much more flexible workforce for purposes of inventory management (e.g., outstanding accounts receivable [A/R] follow-up, coded charts, denials appeals).

FLEXIBILITY OF THE 3 IRC MODELS RELATIVE TO DEGREE OF INTEGRATION



It is worth noting that the appropriateness of each model will depend on the organization's operational, financial, and cultural tolerance—not all models will work in every situation. Nonetheless, institutions that maintain high-performing professional and hospital revenue cycles delicately balance efficiency with concentrated skill levels in areas where focus is appropriate. This IRC "sweet spot" is often found in hybrids of Models B and C across the revenue cycle, and it allows organizations to take advantage of the centralized management and standards presented in Model B and the cross-functional staff indicated in Model C.

Organizational Considerations

A benefit common to all IRC models is that they seek to streamline and coordinate leadership, which is typically a costly resource. Consolidating management and establishing a single point of accountability not only reduces total FTEs, but also provides consistency and transparency across the enterprise, enabling the organization to reduce duplicative efforts and adopt more efficient and effective staffing models.

Again, the considerations driving the decision to develop an IRC vary among organizations. Scott Williams, associate vice president in Duke University Health System's revenue cycle organization, explains that Duke's primary driver for an IRC between the hospital and faculty practice plan was inconsistent performance in various pockets of physician and hospital collections. "The consolidated revenue cycle was created with intentions of capitalizing on capable management and leaders across both enterprises, and as a result, both sides of the house are industry high-performers today," he says.

When deciding of which functional areas to combine as the organization transitions to greater integration, the typical place to start is with a common customer service and self-pay follow-up team. This step not only promotes improved patient satisfaction by creating a single point of contact for billing-related questions, but also presents an opportunity for efficiency by reducing overall call volumes across the enterprise. Other areas that organizations find ripe for significant consolidation include cash applications and data exchange management.

Technology will play a major role in where and how integration can occur. Organizations that leverage a common patient-accounting platform find more opportunities to integrate, as some tasks (e.g., changes in demographic information, insurance updates) can be completed just once within the patient account. However, before consolidating functions and reducing FTEs, decision makers should understand that professional and hospital revenue cycles are not equivalent, and the details associated with certain tasks can be fundamentally different (e.g., UB-04 protocols versus CMS-1500 protocols).

How a health system is organized financially is another key consideration. A physician base with any level of interest in its collections and A/R performance may be hesitant about an IRC because highest-dollar accounts receive the most attention—and hospital dollars are significantly higher than physician dollars.

Legacy Health in Portland, Ore., has a large and growing physician group with a vested interest in its own collections. Terrie Handy, the vice president of revenue cycle operations who oversees Legacy's IRC, stresses the need for

collaboration and coordination across professional and hospital teams while still preserving their unique functional sets. "Given the specialized administrative oversight that is needed for professional fee billing, with all of the unique nuances, we need to keep it separate," Handy says.

Handy's perspective is shared by Cliff Skinner, director of business services for the University of California, San Francisco (UCSF) Medical Group, who believes health systems without some version of an IRC model are sacrificing efficiency and cost savings. But Skinner also believes combining professional and hospital billing and collections activities could have consequences. "The professional fees could get shunted aside," he cautions. "However, there is tremendous benefit to centralized cross-functional activities like denial management, charge corrections, and packaged billing like we see with our transplant and international patients."

The circumstances at Legacy and UCSF are not unique. Most organizations need to manage hospital and physician finances separately, giving leadership pause about adopting a fully consolidated IRC. Nonetheless, some organizations in highly integrated environments find that managing the bottom line of the entire health system is more important than keeping separately healthy hospital and physician revenue cycles. These organizations often can discover additional efficiencies. For instance, systems that believe "all dollars are golden" (e.g., $100 for the hospital is as valuable as $100 for the physician) will sometimes use a Model C single A/R follow-up team, in which one representative is responsible for all physician and hospital charges on a single patient encounter and work is prioritized by the dollar value and age of the account. However, while this model may generate incremental revenue at a reduced cost to the enterprise, the physician revenue cycle's performance may suffer as greater effort is focused on higher-balance hospital claims.

If a goal of improving consistency is a driver for combining revenue cycles, obvious back-end functions should not be the only areas under consideration. Service access and coding/charge capture functions across ambulatory and acute environments present a substantial opportunity to combine otherwise disparate work flows. Individual clinics or academic departments may have sophisticated internal processes but can also present an inconsistent patient experience. Williams comments that Duke's IRC includes all of these functions, helping tremendously with common eligibility and registration data, internal performance benchmarking, staff expectations, and product consistency.

Integrated Revenue Cycles: Key Considerations At a Glance

Financial

- Is the organization's financial health managed at a component level (e.g., hospital versus physician) or at a system level (e.g., "all dollars are golden")?
- Will stakeholders within the organization be affected by changes to revenue cycle performance? Will physician compensation be driven by collections, for example?
- Is there sufficient cash reserve to sustain operations as the organization transitions?

Operational

- What levels of operations within the enterprise will the integrated revenue cycle (IRC) encompass?
- Does the current IT infrastructure support the development of an IRC? If not, should technology be a barrier?

Organizational

- How averse is the organization to change?
- Where will the IRC sit in the organization and to whom does the leader of the IRC report?
- What kind of disruption will this change create?
- Can executive leaders in the organization sacrifice time spent on competing priorities and focus on change management?

Managing the Change

Health system leaders often recognize the significant benefits of an IRC, but frequently are stalled by internal organizational barriers. Major areas of sensitivity include:

ENTERPRISE FUNCTIONS THAT CAN POTENTIALLY BE ENCOMPASSED BY AN INTEGRATED REVENUE CYCLE

Division of Revenue Cycle	Staffing Function
Front End	Scheduling
	Registration/arrival
	Eligibility/benefits
	Preauthorizations/precertification
	Pre-visit financial counseling
	Price estimations
	Charity care/Medicaid eligibility
Coding and Charge Capture	Charge router
	Chargemaster
	Coding
	Non-coding HIM (medical records, release of information)
Back End	Billing
	Accounts receivable follow-up
	Denials management
	Packaged billing (e.g., transplant, research, international)
	Electronic data interchange
	Insurance payment posting
	Insurance credit balance
	Patient payment posting
	Patient credit balance
	Self-pay collections
	Customer service

> Physician dynamics and expectations
> Concerns about layoffs
> Competing organizational priorities
> Technological limitations
> Geographical restrictions

Institutional structure and politics matter, so it is incumbent on every organization to determine the most appropriate path to integration. Like Duke, some systems have benefited from integrating all levels of service access, charge capture, coding, and back-end functions simultaneously. Others, like UCSF, have started on a more moderate path, combining only areas such as customer service and self-pay. Each of these organizations understands its unique environment and has chosen paths and levels of difficulty that are agreeable with its cultural and political climate.

Most organizations need a change agent to champion the detailed, complicated, and sensitive work necessary to integrate and consolidate. This leader should be fully invested in increasing revenues and efficiency while reducing costs associated with the revenue cycle. He or she will be responsible for making difficult staffing decisions, combining budgets, determining cost allocation methodologies, standardizing job codes, creating common policies and procedures, and facilitating other logistical details. This change agent will be an important leader throughout the organization's transition to an IRC.

Integration Is Inevitable

Many leading institutions have adopted an IRC model in some form, resulting in greater staff engagement, efficiency, and accountability. In many cases, the increased visibility and recognition of the revenue cycle also encourages non-financial units in the system to engage the IRC in making positive process changes. The pace of integration across health care is not likely to slow, so health systems should find ways to align revenue functions with specific organizational goals. Adopting and effectively managing an IRC can have a tremendous impact on an organization's ability to deliver on its strategic mission. ■

About the authors

Ben Colton, MBA, is a senior manager, ECG Management Consultants, Inc., Seattle, and a member of HFMA's Washington-Alaska Chapter (bcolton@ecgmc.com).

Andrew Davis, MSHA, MBA, is a senior consultant, ECG Management Consultants, Inc., Seattle, and a member of HFMA's Washington-Alaska Chapter (adavis@ecgmc.com).