A new model for effective revenue cycle modernization

Amid the rapid change the health care industry is experiencing, hospital and health system finance leaders may be among those feeling the most impact.

An already complicated environment is getting even more complex. Federal regulation, characterized by ICD-10 and the Recovery Audit Contractor (RAC) program, is most often unfunded and difficult to manage. The rising popularity of high-deductible health plans has led to a rise in consumerism and changing patient expectations. Consumers want a friendlier, less convoluted way to receive and pay for care. Additionally, because consumers are shouldering a larger share of their health care expenses, there is increased pressure on hospitals to collect in a more efficient manner, while maintaining the sympathetic aspect of a caregiver.

And the economics are changing. Health insurance reform has made health services more available and affordable to all, shifting supply and labor costs.[1] The trend toward outpatient care shows no sign of ebbing. And with value-based reimbursement shifting the way money is exchanged, significant pressure is now on chief financial officers (CFOs) to rethink the way they manage the revenue cycle. More and more, the C-suite is forced to make decisions that pit investing in administrative and financial operations against investing in clinical excellence.

> "Working with a revenue cycle partner has really changed the dynamic among our finance leaders at Dignity Health. One hospital CFO who reports to me said that he used to spend 30 percent of his time on the revenue cycle. Now that we started our partnership, he says he spends only 5 percent of his time on revenue cycle and can spend the rest of his time on more strategic concerns."
>
> **Michael Blaszyk, CFO (retired)**
> Dignity Health

This paper will discuss how the developing economics of value-based care is convincing revenue cycle leaders to consider new strategic alternatives to the status quo. It will also provide insight into contracting options, a strategy road map, advice for evaluating solution partners and guidance on transitioning an organization from managing a revenue cycle to working with a revenue cycle partner.

Asking hard questions about revenue cycle expertise

The value-based era of health care is causing provider organizations to rethink how they structure the revenue cycle. As accountable care organizations and hospitals begin to take on the clinical and financial risk of patient population health, the way they will be paid will be altered significantly. The current revenue cycle revolves primarily around billing, collecting from insurers and resolving patient claims on an individual claim basis. But in a purely risk-based world, insurers will essentially capitate their reimbursement for a certain population. Under such a scenario, the type of revenue cycle services required of a hospital or health system would dramatically change.

While the market isn't yet to that point, that's the direction it's headed. Also the industry weans itself off of volume-based reimbursement, managing the revenue cycle will likely get more complex. Then, as fee-for-value takes hold, hospitals will need to devote revenue cycle resources differently to ensure proper revenue, resource allocation and compliance.

The momentum toward value-based purchasing is increasing. By fiscal year 2018, the Centers for Medicare and Medicaid Services intends that only half of its payments will be traditional fee-for-service.[2] The Health Care Transformation Task Force, a consortium of 20 large provider, payer, purchaser and patient advocate organizations, pledged that 75 percent of their businesses will be "operating under value-based payment arrangements by 2020."[3] The future is coming.

The question that health care executives need to ask themselves is, "Does my revenue cycle management organization have what it takes to thrive in the next era of health care?"

Pay-for-quality flips revenue cycle on its head

The next era of health care requires new thinking about revenue cycle management. Being paid for value means that quality of care, rather than volume of services, will be the key driver behind profitability. As providers work to maintain and increase corporate focus on quality of care, more hospital and health system executives are using outside partners to manage their revenue cycle. Many realize that revenue cycle management is not an organizational core competency. In fact, in some ways, it draws attention away from their central mission.

“No one chooses a certain hospital because they’re great at billing,” said Michael Blaszyk, chief financial officer (retired) of Dignity Health, a nonprofit health system serving communities in 21 states. “Payers and patients pay for health care services, not for administrative services. And while the revenue cycle is an essential part of the patient experience and critical component of fulfilling our mission, it is not the mission.”

And yet, the provider revenue cycle can’t be left to chance. An organization can certainly run an efficient, compliant, accurate revenue cycle, but to do so takes continuing investment in technologies that reduce costs and improve performance in a highly complex, expensive and ever-changing environment.

“I can’t tell you how many situations I’ve heard of where hospital executives needed to decide between investing in revenue cycle technologies or patient care,” Blaszyk said.

Such choices contributed to Dignity Health’s decision to externalize its entire revenue cycle to a solution partner. The right RCM partner can provide essential focus on the revenue cycle model, and can subsequently invest in the size, the scale, the technology and know-how to do it better.

“For us, it was not only about the technology, it was also about the predictability of our revenue cycle,” Blaszyk said. “Finding a revenue cycle partner helped protect us from inflation by creating a predictable cost structure through the fixed-fee nature of our contract.”

With all of these benefits, there can sometimes be drawbacks as well. To CFOs and other health system executives, having an outside partner deploy new revenue cycle approaches may make them feel like they’ve lost some control, or that there is one less lever to pull to achieve financial performance. To revenue cycle staff, such a change brings up concerns of losing jobs or transitioning to a less optimal workplace. “It’s a huge change,” Blaszyk said. “The key is finding a partner that has experience with and success in working through these concerns.”

As shifting revenue cycle operations to vendors has gained in popularity, some organizations have found themselves in arrangements where they truly lost control, and their former employees found themselves in a less than positive work environment. As such, systems and their vendors often developed an adversarial relationship. But a new partnership model is emerging to modernize the revenue cycle. In this new model, system control is contracted, payment arrangements are mutually beneficial, financial performance is enhanced and employees find promising career growth opportunities.

Vendor or partner? It's a question of commitment.

One externalization model that grew to prominence in the early 2000s was the gainsharing model. This method was attractive to hospital executives because it allowed them to pay for value. With upgraded technology or with more efficient processes, vendors promised incremental increases in revenue or quicker cash flow, of which they would take a cut.

Gainshare models seemed like a win-win. Health care providers would be freed up to focus investment and strategy on their core competencies. Their revenue cycle vendor would focus on what they do best. If the vendor did what it said it would do, more money would go to the health system as well as the vendor. In practice, however, these types of arrangements often ruined vendor/client relationships for one of two reasons: First, it's nearly impossible to pinpoint the true value that a vendor delivers, and second, these arrangements often caused the hospital/system to pay more than they should. When it was time to determine the value of the vendor's work, it became an antagonistic negotiation more often than not.

The intricacies of collecting a health care dollar are immense. Each payer — be they Medicare, Medicaid or commercial plans — has unique rules for reimbursement. The fundamental question for health care CFOs — "Would I have collected this on my own, or did the vendor do a better job than I could have?"— is extremely difficult to answer. The math for such an equation isn't hard and fast. It's open to interpretation.

Some revenue cycle vendors use a "black box" method of determining the value of their work, where the vendor determines its value by a proprietary calculation, then tells the client what they owe. Vendors often make more money under such an arrangement, but the bad blood it generates can ruin any rapport the vendor has had with the client.

Figure 1: Road map to partnership

But a new partnership dynamic is growing within the industry — one that doesn't put health systems at odds with their solution partners. It's still pay-for-value, but it focuses on key operational metrics other than revenue. The metrics are easy to agree upon because they are objective, measurable and standardized throughout the industry: A/R days, cash collections, denial rates, coding accuracy and days to completion, to name a few. Both sides agree to the targeted metrics upfront.

Such an arrangement is typical of a partnership, where both parties — health system and solution partner — are focused on the overall success of the business. Such success requires mutually beneficial results, shared vision and a willingness to put the needs of the ultimate customer — the patient — first.

When health systems and revenue cycle solution partners are tightly integrated, a CFO doesn't need to be concerned that she or he is losing a revenue lever, because the lever still exists.

By giving over day-to-day revenue cycle responsibility to an organization whose sole focus is billing and collecting, while maintaining open lines of communication, the financial executive can maintain visibility and influence, while putting more focus on the system's strategic initiatives.

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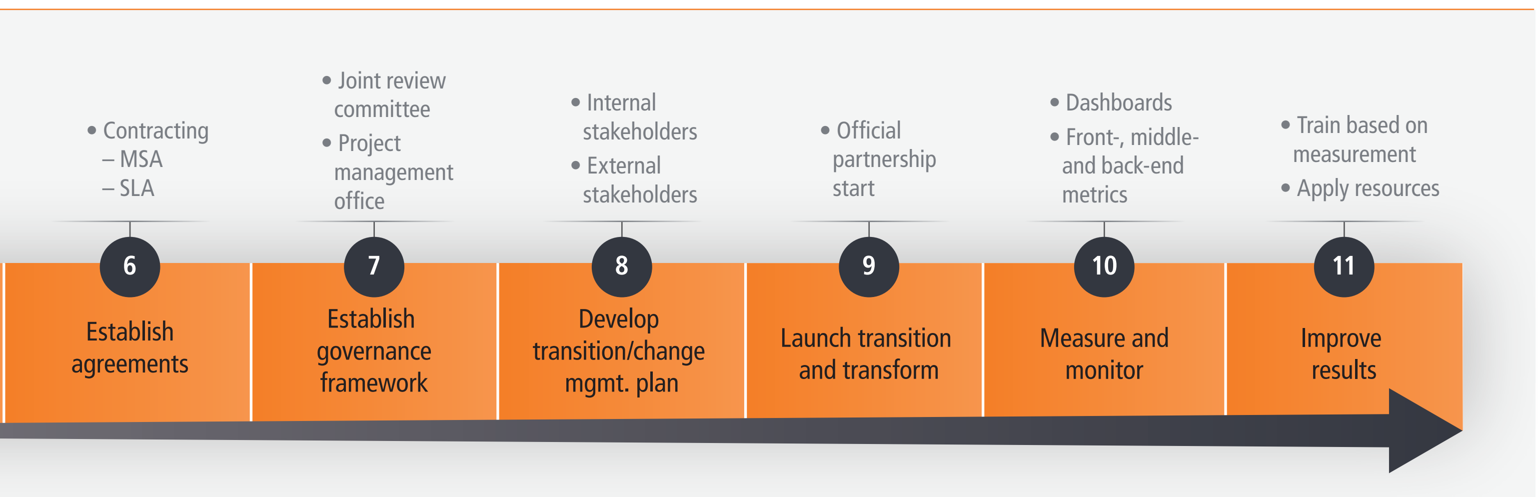
The road map

Many health system CFOs have seen the value in finding a revenue cycle partner who can take over day-to-day operations. They understand that such a partner is built for revenue cycle management and can likely do it better than hospitals and health systems. These finance leaders would rather not spend their resources becoming an expert in the complexity, the changing rules, the staffing levels and the volume. Such CFOs don't want to deal with all the fluctuations in payment procedures and the regulations that seem to change daily. They also understand that it's not inconsequential if something goes wrong. They are putting their neck on the line, so decisions can't be made rashly.

Therefore, finding the right partner and negotiating the right agreement must be done systematically and with great care. Figure 1 represents a road map that finance leaders can use to help them take the right steps and come to the right conclusions. Reference pages 6–7 for a more detailed description of each of the 11 steps.



1. **Conduct a revenue cycle assessment.** To get a true picture of the revenue cycle's current state, CFOs should conduct an assessment of their staff's level of productivity, the efficiency of their processes and their level of automation. Doing so will help them determine how their internal functions compare with the rest of the industry. It will also help them decide whether they need to make a significant investment in trusting it to a partner.

2. **Identify a goal or desired objective.** The key question health system executives should ask during this stage: What is the end goal that externalizing the revenue cycle will help accomplish? Is it to develop more capabilities in value-based care? To avoid having to invest in revenue cycle technology and/or expertise? To manage the increasing complexity of the revenue cycle? To improve revenue or compliance? Or simply to maintain a predictable revenue cycle cost?

3. **Evaluate and quantify the opportunity.** With an assessment of the organization's revenue cycle people, processes and technology in hand and an overarching goal in mind, the next step is to dig into the numbers. This is where finance executives see where revenue opportunities lie. Using the revenue cycle assessment to discover where gaps exist, they can determine the cost of filling the gap on their own versus using a partner.

4. **Assess alternatives.** After current levels of performance are compared with industry best practices, it's time to evaluate solution partners. Organizations should have initial discussions with potential partners, answering questions such as: What are the benefits and drawbacks of each organization? Do their advantages outweigh their costs? Which potential partner has the technology, the processes and the staying power to help us achieve our objective? Does the culture of the partner align with our culture?

5. **Jointly develop a transformation plan to achieve the objective.** After the opportunity is confirmed and the right partner is identified, the provider and the revenue cycle firm will mutually develop a goal-based transformation plan. Firm representatives should be able to provide critical guidance that will help organizations develop an ambitious yet realistic strategy, establishing clear priorities, identifying needed technology and human resources, and developing implementation timelines. In addition to transformation planning, provider organizations should take time in this step to conduct due diligence and work with the chosen partner to develop the term sheet upon which the final contract will be developed.

6. **Establish clear service agreements to govern the process and management.** At this critical juncture in the partnership timeline, the provider works closely with the chosen partner to establish a master services agreement (MSA) and various service level agreements (SLAs). At this point, providers will want to request agreement language that provides for availability, turnaround time, response time and standing meetings, as well as the metrics for which the solution partner will be incentivized.

7. **Establish and execute a governance structure.** The MSA and SLAs will provide the basis for governance between the two partnering organizations. At this point, the groups will jointly develop a framework to guide how priorities will be set, how decisions will be made and how the two partnering organizations will work together to ensure results are delivered as expected. They will also determine how results will be monitored and reported. It's critical at this juncture to ensure all stakeholders have a say and establish a plan to incorporate their viewpoints.

8. **Develop the transition management and change management plan.** Such a plan would address both impacted employees as well as non-impacted employees. This step is crucial to the overall success of the project. Change management and communication planning helps all stakeholders — internal and external — prepare for change, and it helps organizations minimize the dip in performance that is inevitable during these types of transitions. See the section on transitioning from in-house to externalization for a deeper look at change management and communication planning.

9. **Launch transition and transformation initiatives.** At this point, the planning tapers off and the execution begins. Agreements are settled, communication and change management plans are ready, a governance framework is in place, and both the health system and revenue cycle firm are primed for the partnership. The parties will sign the appropriate contracts to start the official relationship and announce the partnership to their respective organizations. There will be some time between the announcement and the actual transition. During the interim, the communication plan will go into full swing. Meetings will be held with transitioned employees and with the employees who remain. Employee newsletters and email lists will be utilized to their fullest extent. Issues management and community relations professionals will proactively reach out to stakeholders. The goal is not only to communicate and respond to concerns throughout the transition, but to also communicate clearly and comprehensively *beyond* the transition.

   Simultaneous to the partnership transition, the organizations will initiate the business transformation. Based on the transformation plan and MSA, the revenue cycle partner will implement new technologies, redesign process workflow and realign the organizational structure. While the transition plan work will wane at some point, the transformation plan is ongoing. Process workflow will evolve based on feedback. Tools and technologies will be upgraded and optimized. Training and quality improvement initiatives will be carried out.

10. **Measure and monitor performance and results.** After the transition happens, systems need to monitor performance. The solution partner will keep track of previously agreed upon metrics and report those metrics based on previously agreed upon timing and methods in the service agreements. The revenue cycle partner should provide health system leaders with dashboard views into patient access, coding and documentation improvement, billing, compliance and collections, based on the system leaders' need to know.

11. **Continuously work together to improve results and manage/remove obstacles.** Because the partnership is based on mutually beneficial incentives, the provider and revenue cycle partner will work together to ensure the partnership's success. Using performance, quality and training feedback loops, they will take steps to improve upon success metrics and see that the new normal is better than conditions prior to the transition. As with any partnership, surprises will come up that weren't anticipated and accounted for in the original agreements. As partners, the revenue cycle firm and the provider will jointly manage and remove any such obstacles and maintain the positive trajectory of the revenue cycle.

Evaluating end-to-end revenue cycle management options

There are a number of choices for revenue cycle management partnerships, all with different strengths and weaknesses. No one solution partner is perfect for every provider. Providers should choose one whose technology, processes and culture best fit the objectives of their partnership decision.

The following are some guidelines that will help providers make the right decision:

Compare degree of flexibility. When solution partners provide a service, the more standardized it is, the easier it is for them to manage. But expecting a provider to fit seamlessly into every aspect of a partner's process isn't realistic. Providers will be better served to choose a partner that can mold its services to fit the provider's needs.

Determine commitment to technology. One of the major benefits of revenue cycle externalization is that providers do not have to constantly invest to be on the cutting edge of technology. That's the job of the solution partner. Providers need to be certain that their chosen partner is committed to using the latest technology to gain every available revenue collection advantage and meet stringent compliance requirements.

Examine financial clarity. Revenue cycle firms must be clear about how they're going to make money. The standard metrics method of proving value is much preferred to the black-box gainsharing method, where the vendor tells the provider how much their service is worth. Simple flat fees without incentives aren't the way to go, since they aren't sufficient to incentivize revenue cycle improvement. Solution partners should be clear about the measurements they will use to prove their value and earn inducements.

"Clear incentives with the vendor are extremely important," Blaszyk said. "For Dignity Health, we chose to focus on transparent operational metrics rather than fuzzy and complex gainsharing concepts."

Analyze level of continuous improvement. Change appears to be the one constant in the revenue cycle industry, and a solution partner must be prepared to lead change, to further streamline the revenue cycle and to add incremental value to its customers. If a potential partner is prepared to do these things, the partner's current customers will be good sources of information. System leaders should ask what metrics the solution partner tracks and how well the partner makes improvements.

Study patient and physician experience. Because patients and physicians interact with the revenue cycle, the decision to externalize will affect them as well. Solution partners must prove their ability to not only maintain, but improve the patient experience. The key to determining this is the solution partner's employees. System leaders should talk to employees and find out how aligned they are with the corporate mission, vision and values. In addition, they should talk to physicians aligned with the system to see if they have an improved experience with the revenue cycle.

Transition and implementation from in-house to externalization

The transition to revenue cycle externalization most often involves moving employees from the purchasing organization to the contracted organization. As discussed briefly in the road map section, this movement of people and responsibilities needs to be done with great care and a constant focus on the key priorities of the relationship. The movement of employees and responsibilities should be considered from multiple angles, including productivity and morale of transitioning employees, and communication with remaining employees.

From the perspective of the transitioned employees, their livelihood, career path and emotional health are concerns that affect their productivity. Therefore, there is almost always a decline in performance during the changeover. Employees will be deeply concerned about whether they will keep their job. They will wonder about their salary, their benefits and their retirement. They'll worry about whether they will fit in with the new culture and whether they will have the same opportunities for growth. Their concerns should be management's concerns as well.

"Transitioning the revenue cycle to an external partner takes a tremendous amount of effort and engagement by both organizations. This type of activity is something that occurs over a long period of time. You can't just sign the deal, implement the transformation plan and then forget about it. It takes a long-term commitment."

Michael Blaszyk, CFO (retired)
Dignity Health

There is a real risk that revenue cycle departments could lose key people when providers externalize. Revenue cycle partners can absorb the loss of a few staffers, but failing to keep employees with deep institutional knowledge will make success much more difficult.

Change management planning should be part and parcel of every transition. Provider and solution partner planners should prepare to anticipate and address every concern employees could have. To maintain operational performance during the changeover, the right partner will provide a better overall compensation package for provider revenue cycle employees to stimulate optimism about the move. Both provider and solution partner should also work together to identify and retain specific employees that are key to the success of the partnership.

Employees who will remain with the provider are not to be neglected. Many middle- and upper-level revenue cycle managers will continue as health system employees and, based on their responsibilities, will need updates on the success of the venture. Constant communication with executives is crucial. Plan for regular reports to directors and managers whose roles are dependent on the revenue cycle. Provide consistent updates to the entire organization through standard channels using messaging developed within the communication strategy.

Revenue cycle externalization helps providers prepare for the new era of health care.

As the new fee-for-value reimbursement system takes shape, lower costs will likely mean even narrower margins for hospitals and health systems. Add to that the enormous administrative costs of running acute care facilities, and it’s no wonder that strategic health care CFOs are refocusing on their core clinical business and transitioning their revenue cycle functions to a partner.

Just as accountable care organizations and other value-based initiatives remove clinical costs from the system, the externalization model takes administrative costs out of the system.

The right partner will understand the client system’s core mission and align to its values.

While the process of transitioning an in-house revenue cycle to an external partner is time- and resource-consuming, the end results can be well worth it. Finance leaders can focus more on strategic initiatives, revenue cycle employees can find expanded career opportunities, and the solution partner can focus its effort and investment entirely on making the revenue cycle world-class.

> “To succeed in modernizing our revenue cycle, we had to develop a partnership. Both parties needed to be a great fit. They needed to have a shared vision, and both of us needed to have to work hard to make the partnership successful.”
>
> **Michael Blaszyk, CFO (retired)**
> Dignity Health

Case study

Dignity Health, a not-for-profit health system with nearly 40 hospitals, had invested heavily in the revenue cycle. But the need for further investment due to new regulations and an altering reimbursement landscape caused its top finance leaders to consider and eventually make the transition to revenue cycle externalization as its preferred solution.

Based in San Francisco, Dignity Health had done all it could on its own to streamline and optimize its revenue cycle. They built and expanded on administrative service centers and consolidated many of the functions that could be centralized, all in an effort to take advantage of the scale that an organization with more than 56,000 employees could provide. But Dignity Health leaders saw that providing compassionate, high-quality, affordable care required an equally impressive revenue cycle to improve the patient experience.

The health system was in the midst of implementing a new electronic health record system across its facilities, while at the same time working to implement the mandated ICD-10 code set. Both projects required significant technology upgrades and workflow modifications. And, while both projects were essential to modernizing care and improving quality, the costs were significant.

Implementation costs, however, were only a small factor motivating Dignity Health's leaders to seek a revenue cycle partner. They believed there was latent value within the health system that could be unlocked if they no longer needed to put as much emphasis on billing and collecting. Additionally, they saw that there was strategic value in the investment they had already put into their internal revenue cycle consolidation.

"Our decision came down to ordering priorities," said Michael Blaszyk, Dignity Health CFO (retired). "We chose to focus more on patient experience and providing quality of care. We found that transformational revenue cycle technologies, especially those that focused on improving clinical documentation and coding, could enhance our quality improvement initiatives. Moreover, we saw that there was a tremendous amount of efficiency to be gained from scaling our revenue cycle operations into a much larger organization, where revenue cycle is the core capability."

Highlights

Less than two years into the joint venture with Optum360, Dignity Health:

- Reduced employee turnover
- Aligned employees with company objectives according to engagement survey results
- Reduced bad debt by a third
- Achieved cash collections of more than 100 percent of baseline target
- Decreased A/R days to lowest level since partnership began

Dignity Health chose Optum360 as a partner, and a future vision of revenue cycle management formed. The concept was to create an organization dedicated to transforming the registration, documentation, billing and payment system to work better for value-based providers and to deliver a more satisfying experience for patients.

To do so, Dignity Health leaders understood that their initial focus needed to be on a smooth transition. As with most external revenue cycle arrangements, Dignity Health planned to transition nearly its entire 1,700-member revenue cycle staff to be employed by its newly formed partner, Optum360.

Dignity Health executives worked closely with the Optum360 transition team to communicate the new organization's progress with board members and mission leaders. The transition team spent a significant amount of time focused on retaining talent and on change management.

A key to their change management and retention strategy was a robust stakeholder analysis process. Dignity Health and Optum360 leaders met frequently with a group of 30–40 representatives from across the health system, considering the roles of every person affected by the change.

From those discussions, they determined that certain elements from the employees' former Dignity Health experience should be transferred to their Optum360 experience — years of service and paid time off, for example. In addition, the leadership team emphasized maintaining a sense of stability through the transition. For the most part, reporting structures and leaders remained the same.

All employees, not just those affected by the transition, needed to be well-informed at the right time. The announcement that the Dignity Health revenue cycle group would be transitioning to Optum360 was the first step in a comprehensive communication plan. Dignity Health cascaded news of the change throughout its leadership hierarchy. They created a toll-free number and an internal website to help employees learn about the new company — everyone who called or emailed got a response. The plan included a 30-page "frequently asked questions" document, which served as a single source of truth for anyone who had questions or was providing answers. Key leaders from both Dignity Health and Optum360 traveled to system sites to talk about the change and answer questions face to face.

"Change management was critical to our success, and both organizations put in an extraordinary amount of work to make the transition successful," Blaszyk said. "For a venture like this to work, the two sides must be true partners. It's really a long-term commitment by both Optum360 and Dignity Health."

With an eye toward transforming the provider and patient experience, and utilizing a model of standard, widely accepted metrics to measure value, Dignity Health and Optum360 continue to work together to build a best-in-class organization.

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