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NEW GOALS, NEW ALLIANCES

The historically adversarial relationship between providers and payers is shifting toward cautious cooperation. p 10

CHARLES KENNEDY, MD
CEO OF ACCOUNTABLE CARE SOLUTIONS FOR AETNA HARTFORD, CONN.
Cost and Care
Healthcare leaders are driving waste from care delivery to cut costs and enhance revenue.

BY MICHAEL ZEIS

Cost containment and revenue cycle activities involve buttressing the organization’s fiscal health through smart spending and ensuring funds that are owed to the organization are, after all, delivered to the organization. Traditional approaches to cost containment often are part of the annual budgeting process, directed by the finance team within administration. The conventional activity of the revenue cycle function is largely to confirm the accuracy and completeness of submissions to payers and troubleshoot claims denials.

With challenges to reimbursements—including the pending need to bear risk and deliver value-based care, and a payer community that has become more aggressive about claims denial—leaders are looking for cost containment and revenue cycle to contribute to financial health in more strategic ways. Intelligence Report research results suggest that care redesign and care standardization can lead to increased provider productivity and can help drive waste out of the care delivery system. IT and analytics remain tactical tools to improve revenue cycle results. And with clinical documentation, some are focusing their improvement efforts on the hospital floor, helping the clinical team ensure that services delivered are completely and accurately recorded.

Gains from care redesign and standardization
At the largest organizations, those with net patient revenue greater than $1 billion, more than half cite care standardization (55%) and care redesign (53%) as being among the top sources of cost-containment gains. Smaller organizations generally rely on more traditional means to achieve gains, and only 26% (small) and 36% (medium) cite care redesign as among their top high-dollar factors in cost containment.

About This Survey. The 2014 Cost Control & Revenue Cycle Survey was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Intelligence Reports. In March 2014, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 344 completed surveys are included in the analysis. The margin of error for a sample size of 344 is +/-5.3% at the 95% confidence interval. A detailed report and analysis can be found online after June 12 at www.healthleadersmedia.com/intelligence/.
Here are selected comments from leaders regarding how they can ensure that cost-containment efforts achieve strategic and sustainable results.

“As an organization, we have consistently done a good job in controlling expenses through rigor and transparency. This will need to continue, along with the need for all members of our leadership team to fully understand the changing payment and performance environment so they can better understand their individual and collective parts.”
—Chief compliance officer of a medium hospital

“It takes an organizationwide commitment. All employees and medical staff members must understand that the viability of their organizations will depend on being more efficient.”
—CEO of a medium hospital

“Ownership of the concept and process from frontline and middle managers is absolutely essential.”
—CEO of a large hospital

“They can’t ensure achieving strategic and sustainable results, given the uncertainties of healthcare.”
—Chief financial officer of a physician organization

“Developing organizational goals and work plans that are time-stamped and assigned to individuals who are accountable for the implementation is essential.”
—Chief nursing officer of a small hospital

“Integration and growth of physician involvement in establishing initiatives and policies to improve strategic goals is needed.”
—Chief operations officer of a large health system

Change is often difficult, and when the process to be redesigned is a clinical process, buy-in from the clinical team is necessary. Daniel J. Moncher, FACHE, MBA, executive vice president and CFO for Firelands Regional Medical Center, a 233-staffed-bed nonprofit hospital with a medical staff of 200 in Sandusky, Ohio, describes the challenge. “[Some might have the perspective] that administration is telling them how to treat their patients,” he says. “But remember, they’re the ones at the bedside. They’re the ones with the training. They’re the ones that have the ultimate responsibility for treating the patients.”

Ann Madden Rice, CEO of the University of California Davis Medical Center, a 619-licensed-bed acute care teaching hospital in Sacramento, California, says the key to earning support for clinical initiatives is to focus on clinical results instead of financial results. “Alignment isn’t going to happen because you’re telling physicians you’re saving money. It’s pretty hard to be passionate about that. But alignment will happen if they can see the quality benefit and see that their patients are more satisfied with the care they’ve received and have better outcomes.”

**Revenue cycle and effective documentation**

Research findings underscore the importance of effective documentation to revenue cycle success. Improving documentation is dominant among the standard steps used to optimize revenue cycle performance now for 72%

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**Income and outflow: Optimize both**

The percentage of respondents identifying revenue cycle as the bigger overall factor in maintaining or improving contribution margins (32%) and those identifying cost containment as the bigger factor (34%) are nearly equal. But in the three-year time frame, a higher percentage of respondents expects that cost-containment efforts will be a bigger overall contributor than revenue cycle to their organizations (41% in three years compared to 34% now). A higher percentage of small organizations than large expects to benefit from cost containment in the future: More than one-third (39%) of those with net patient revenue below $250 million expects bigger contributions from cost containment in the three-year time frame, compared to 28% now. Rice notes that pressure on operating margins requires that organizations focus on both revenue cycle and cost containment. “We need to be laser-focused on both issues. It’s important to get every dollar that we’re entitled to through our revenue cycle improvement efforts, and at the same time manage our costs ever more effectively.”

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**What is your organization’s biggest barrier to achieving sustainable cost reductions?**

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Government mandates</td>
<td>39%</td>
</tr>
<tr>
<td>Physician-hospital relationships</td>
<td>15%</td>
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<tr>
<td>Unsupportive organizational culture</td>
<td>13%</td>
</tr>
<tr>
<td>Insufficient integration with care partners</td>
<td>10%</td>
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<tr>
<td>Lack of technology in place to achieve goals</td>
<td>7%</td>
</tr>
<tr>
<td>Concerns about quality or safety trade-offs</td>
<td>6%</td>
</tr>
<tr>
<td>Poorly defined organization leadership and goals</td>
<td>6%</td>
</tr>
<tr>
<td>Support and direction from the board</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
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</tbody>
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www.healthleadersmedia.com
And 55% expect that documentation improvements will be the revenue cycle activity to deliver the most financial benefit over the next year, again making it the top overall choice. Says Rice, “Improving documentation has been on our to-do list for decades, it seems, but it continues to be very, very important. And the electronic health record has made some improvements in that, but you still have to have well-trained professionals to accurately capture what they did for a patient, the services they provided, and then get that converted into a billable activity.”

For some, the emphasis has shifted from the billing transaction itself to the entry of the documentation of the care into the record at the point of delivery. Says Jennifer Nichols, senior director of revenue cycle operations for Kaleida Health, a four-hospital health system serving the Buffalo, New York, area, “The focus used to be on the transaction, the billing act. Now we’re making sure that we are accurately reflecting all the good work that we did up until the point of billing. [We want to make sure] that we’re billing based on the most accurate and complete information.” Nichols adds that clinical documentation improvement activities have benefits beyond the revenue cycle function. “Beyond the immediate financial benefits, quality documentation plays into value-based purchasing, as well. In the long run, quality scores are improved by enhanced and appropriate documentation. And there are very few service lines that would not benefit from a very focused and effective clinical documentation integrity program.”

Healthcare leaders recognize that IT can help them target claims denials. Thirty-five percent now use IT to target inappropriate claims denials, and another 32%, including 35% of respondents from hospitals, expect to begin using IT to target inappropriate claims denials within the next year. Changing regulations and the need to keep up with payers provides the impetus for many, Nichols suggests. “What is changing is how quickly regulations are evolving and how rapidly the payers seem to be able to respond. Payers are becoming so much more sophisticated about mining the data that’s coming into them. For us it’s a focus to do more predictive analytics around denials, and address denials before they occur rather than just reacting to them,” she says.

As care delivery must transform in light of healthcare reform, so must administration transform, Nichols says. “We see organizations transforming clinically to meet quality outcomes, to meet payer and other reimbursement requirements, to be competitive in an ever-tightening landscape, to be attractive to other clinical partners, and to be the choice of referral for physician practices in the area. It’s not possible for us to transform clinically without transforming financially as well.” And to successfully adapt to the changes, she says, “As an industry we have to recognize that revenue cycle begins in the clinical area. Even when we centralize upstream administrative areas like scheduling, it is clinical services that drive the process.”

As Nichols suggests, the focus for more organizations is on minimizing denials through complete and accurate documentation at the point of service, on the hospital floor.

**Factors that thwart containment efforts**

Far and away, government mandates is the factor cited most often by industry leaders (39%) as providing the biggest barrier to achieving sustainable cost reductions. But only 17% of large hospitals pick government mandates as their top barrier to sustainable cost reductions, compared to 49% of small hospitals and 39% of medium hospitals, an indication that some have yet to come to grips with mandates.

Nichols approaches mandates with resolve: “I can’t necessarily change government mandates. But I can change how I can respond to them.” Still, government mandates have a cumulative effect—there are so many. Nichols notes that many small increments in reimbursement penalties can add up to a large amount at risk. “Any individual financial penalty would not necessarily be unbearable. But there is a whole series of things lining up right now.

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**WHEN IT COMES TO MAINTAINING OR IMPROVING CONTRIBUTION MARGIN, WHICH OF THE TWO IS THE BIGGER OVERALL CONTRIBUTOR AT YOUR ORGANIZATION NOW?**

<table>
<thead>
<tr>
<th>Revenue cycle improvement efforts</th>
<th>32%</th>
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<tbody>
<tr>
<td>Cost-containment efforts</td>
<td>34%</td>
</tr>
<tr>
<td>Equal</td>
<td>35%</td>
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</tbody>
</table>

**WHEN IT COMES TO MAINTAINING OR IMPROVING CONTRIBUTION MARGIN, WHICH OF THE TWO DO YOU EXPECT TO BE THE BIGGER OVERALL CONTRIBUTOR AT YOUR ORGANIZATION IN THREE YEARS?**

<table>
<thead>
<tr>
<th>Revenue cycle improvement efforts</th>
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<tbody>
<tr>
<td>Cost-containment efforts</td>
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<tr>
<td>Equal</td>
<td>28%</td>
</tr>
</tbody>
</table>
Taken together, it becomes very, very serious. [It’s going to be] 9% at risk at the end of 2017. That could be a game changer for many institutions. It may make the difference between viability and nonviability for them.”

Rice suggests that the high percentage of respondents troubled by mandates may be an indication that administrators and clinical staff who should be attentive to patient care may be distracted by compliance and reporting issues. “Seeing government mandates, which are outside of our control, as the biggest barrier at 39% is very concerning. That may affect our ability to take care of the large number of patients who need our services.”

Nearly one-quarter of large hospitals (23%) say that physician-hospital relationships are the top burden preventing sustainable cost reductions. Buy-in to cost initiatives presents a barrier, as well. Overall, 15% say that physician-hospital relationships hold them back, and 13% say an unsupportive culture is a barrier.

Moncher of Firelands connects patient satisfaction with the organization’s financial health, and notes that the whole organization is expected to participate. “We can be great with quality, we can care for people, and we can get them to their next level of care or home in a technically competent and successful manner, but if patients leave here and they’re not satisfied with their experience, it’s going to hurt us long-term.” This relationship between patient care and financial performance is becoming part of the organization’s culture, thanks to its Head and Heart program, which was conceived about a year ago by Firelands’ quality executives to stress the importance of empathy in dealing with patients. The program was reviewed and approved by the board of directors, and is actively supported by the organization’s CEO to address organizational culture and the potential impact on revenue.

**Bringing analytics to bear**

Fifty-three percent of respondents expect that IT investments aimed at revenue cycle improvements will outstrip IT investments aimed at cost containment over the next three years. This is especially the case at small organizations. Nearly half of the respondents from organizations with less than $250 million in net patient revenue (49%) expect that IT investments supporting revenue cycle

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**OF THE FOLLOWING CLINICAL ACTIVITIES, WHICH THREE PROVIDED THE HIGHEST DOLLAR VALUE IN COST-CONTAINMENT CONTRIBUTIONS IN THIS FISCAL YEAR?**

- Efficient use of clinical labor: 55%
- Improved utilization of clinical resources: 49%
- Care standardization: 47%
- Care redesign: 31%
- Provide care in ambulatory/outpatient settings: 27%
- Consolidating/centralizing clinical functions: 27%
- Targeted budget reductions: 26%
- Across-the-board budget reductions: 13%

**WHICH OF THE FOLLOWING STEPS ARE PART OF YOUR ORGANIZATION’S ROUTINE REVENUE CYCLE OPTIMIZATION PROCESS?**

- Improve documentation: 72%
- Minimize denials: 63%
- Improve pre-service collection from patients: 62%
- Improve post-service collection efforts: 59%
- Use IT to automate revenue cycle functions: 56%
- Predetermine payment amounts, payment information: 42%
- Use IT to target inappropriate claim denials: 35%
- Use payer specialists in revenue cycle staff: 30%

Multi-response
INTELLIGENCE REPORT: COST AND CARE

FOR THE MOST RECENT FISCAL YEAR, WHAT IS YOUR BEST ESTIMATE OF YOUR ORGANIZATION'S YEAR-OVER-YEAR SAVINGS FROM COST-REDUCTION PROGRAMS?

- 0%: 3%
- 1%: 6%
- 2%: 17%
- 3%: 23%
- 4%: 8%
- 5%: 20%
- 6%-10%: 19%
- 11%-15%: 2%
- More than 15%: 2%

will be higher than IT investments supporting cost containment, while that dips to 42% and 35% for medium and large organizations, respectively.

Nichols identifies three factors that may contribute to smaller organizations being more inclined to make revenue cycle-related IT investments. “First,” she says, “some tools that used to be very expensive are starting to become more affordable to smaller and midtier hospitals. Second, smaller organizations are probably slightly behind larger organizations in deployment of IT-based revenue cycle solutions” and need to catch up. And then there is know-how. “There’s better understanding [in the industry] of how technology tools can help, more sophistication about using analytics to support revenue cycle.” Adopters at this stage will likely have a shorter learning curve than earlier users.

Nearly half of respondents (49%) expect to see top financial benefits in the next three years by using analytics to support productivity monitoring. This includes 57% of large hospitals. While only 10% of respondents claim to have integrated clinical and financial data, another 57% are underway. The success of cost-containment efforts on the clinical side of the business may depend on increased clinical efficiency, which makes productivity monitoring and the integration of clinical and financial data vital.

Impact of efficient clinical design

Pursuing financial health through care redesign and care standardization provides results that may not be as direct and may be more tenuous than financial benefits from straight-ahead cost-cutting activities or revenue cycle improvements. Further, we can expect initiatives that involve clinical efficiencies to take more time than conventional cost-cutting efforts to deliver results. For these reasons, taking a broader perspective on financial health means assuming additional levels of risk.

For Rice, determining the organization’s position on risk is part of the CEO’s job. “We’re in a risky business. And doing nothing is taking the biggest risk of all. This involves not just looking at the ROI, and not just looking at how quickly an investment is going to pay back, but we have to ask, ‘What’s the risk if you don’t do it?’ ”

At UC Davis, taking on small projects with less exposure is one way of limiting risk as one moves forward. “We’re trying to get more of our staff involved in smaller rapid projects so that we can make incremental progress,” says Rice. UC Davis’ CFO, Tim Maurice, MBA, accepts the limitations of conventional benchmarking or budgeting, and looks at the inputs to financial health in what he calls a “holistic” way. He asks, “Are we going to continue to do cost containment the way we’ve done it before, which is to establish a benchmark and if we don’t hit the benchmark, make cuts? Or are we going to take a more holistic approach and look at what are we trying to achieve in terms of quality and effectiveness, determine what inputs are needed to achieve that quality, and reduce those inputs that don’t add value?”

When costs can’t be cut any more, and when revenue has been optimized, organizations have to focus on efficiency, which means examining processes and removing waste. We see that this next step in fostering financial health is complicated and risky. But we see that many organizations are dealing with the complexity and shouldering the risk, which means those that don’t may face a serious competitive disadvantage.

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