6 Critical Impact Factors of Health Reform on Revenue Cycle Management

Pyramid Healthcare Solutions Thought Leadership Series
The healthcare industry is undergoing significant change in the face of the Affordable Care Act, and these reforms and others will not just affect patients and medical professionals. They also will dramatically impact the lifeblood critical to the financial well-being of healthcare providers – revenue cycle management.

With reimbursement reductions and shifts in patient volumes, hospitals face up to a 25 percent decline in revenue over the next five to ten years. Reducing the cost structure, driving efficiencies and accelerating the cash flow will be key strategies for healthcare leaders over the next few years. The health reform era will drive experimentation with value based payment models as an alternative to the traditional fee for service model. Future revenues will be based upon clinical outcomes, quality and cost efficiencies, and less dependent upon patient volumes. These accountable care models will reward providers on their ability to achieve these performance metrics. Revenue cycle leaders will need to understand how to modify their people, processes and systems to manage new value based payment models.

There is concern, rightly so, among healthcare executives and revenue cycle professionals on possible effects on their financial operations and cash flow as major changes occur. To ensure future success, hospitals and other health providers must closely examine their entire revenue cycle operation and adapt their thinking and methodologies to better meet today's new realities.

This paper highlights several reform driven revenue cycle impact factors, including reimbursements and cash flow pressures, higher patient volumes, new payment models, ICD-10 transition, industry consolidations and outsourcing.

### 1. Reimbursement & Cash Flow Pressures

Eroding margins are compelling healthcare organizations to review their revenue cycle people, process and technology to optimize cash flow. Reimbursements will continue to decrease with expected Medicare reductions as well as Medicaid expansion in 2014. Experts predict that 62% of the funds for expanding health insurance coverage will come from Medicare cuts. The Healthcare Financial Management Association's (HFMA) recent survey of 300 hospitals indicated declines in patient revenue and cash on hand. The Centers for Medicine & Medicaid Services (CMS) will increasingly tie reimbursement to positive outcomes, preventable readmissions, unnecessary care reduction and hospital acquired conditions. Adverse outcomes will result in penalties.

In the last few years, the industry has seen a significant rise in self-pay and bad debt as patients have lost insurance or insurance coverage has shifted the cost to the patient. Expanded coverage under health reform will continue this trend as patients choose high deductible health plans or patients elect to go without insurance.
It is more critical than ever for healthcare providers to implement revenue cycle strategies to accelerate cash collections. Optimizing the front end of the revenue cycle is critical since poor data capture results in revenue losses on the back end. Revenue cycle financial outcomes are tied directly to the patient intake flow, which begins at pre-registration and follows through scheduling, registration, treatment, claim submission, and collection.

Revenue cycle front-end personnel must act as financial counselors to enable point of service collections. Real time analytics modeling and scoring will come into play as patients are analyzed and segmented according to their ability to pay. Other tools such as point of service payment estimators to enable increased collection earlier in the revenue cycle also are being implemented by providers across the nation.

Reimbursement reductions as well as increased self-pay demands that providers optimize RCM performance and decrease expenses by pursuing strategies such as business process improvement, automation, point of service collections, claims management and real time analytics.

2. Higher Patient Volumes

It is estimated that the insurance mandate will create 32 million new covered lives in 2014. As healthcare demand increases significantly once coverage expands to the uninsured, revenue cycle teams will be required to track large quantities of new information that includes compliance, reimbursement, eligibility for Medicare, Medicaid and private insurance, coding, billing and collections.

Due to these higher patient volumes, healthcare providers will need to analyze staffing levels and capabilities. This evaluation will determine their ability to complete these tasks, implement training for new processes, and incorporate any new, more robust health information and financial management systems.

Higher volumes and newly insured patients can create complexities for revenue cycle staff. 17 million are expected to be insured through expanded Medicaid increasing the need for eligibility verification processes. Other newly insured patients will come from health insurance exchanges which may require a higher level of benefit management as well as increased patient communication. There can also be a rise in denied claims as these new and varied insurance plans come to market. Providers must focus today on honing their front end and back end processes and technology to mitigate challenges in AR management before health reform kicks into full gear in 2014. Forecasting staffing needs for increased volumes must also be considered by revenue cycle leaders.

3. Value Based Payment Models

With financial pressures growing and the focus on quality outcomes, alternatives to traditional fee-for-service (FSS) reimbursement are gaining in popularity. With this focus on
cost-effective, efficient and quality services, new payment methods such as bundled payments, patient-centered medical homes and Accountable Care Organizations (ACO) are becoming more prevalent. These models of care emphasize elimination of wasteful spending, better health information management and improved clinical outcomes.

CMS, for example, just announced 106 new ACO programs, nearly doubling the national total. ACO is the pay-for-performance model that is based on outcome rather than fee for service. Many hospitals are experimenting with variations of the ACO method.

Bundled payments provide payment for a number of varying services and these arrangements have the potential to lower claim expenses for payors, and can generate both market and financial advantages for healthcare providers. Hospitals and other groups will need to determine what conditions and procedures constitute a “bundle” and how to disburse payments based on performance metrics.

Another new method, patient-centered medical homes, is designed to support multiple types of primary care within a hospital service area and also seeks to reduce costs. Patients receive very personal, high-quality coordinated treatment, and providers can take a more comprehensive approach to managing their patients’ care.

These new payment models can positively impact revenue for high-performing providers. The challenge for revenue cycle departments will be that current healthcare information systems were not designed to process bundled payments based on performance metrics. Many do not offer the business intelligence capabilities needed to manage quality and workflow across the enterprise. Revenue cycle leaders must understand what their limitations are before going down the road of these alternative payment models. The key to being successful in this new paradigm is strong collaboration between the clinical, financial and technical sides of the healthcare organization. Seamless integration will be required to drive quality outcomes and reimbursement.

4. ICD-10 Transition

The transition to ICD-10 medical coding is a critical development. With a compliance deadline of Oct. 1, 2014, the new medical coding system will affect more than just coding, reimbursement rates and billing, but impact electronic health records systems and other key data and analytics technologies, too. If your organization has not already developed an action plan for ICD-10, then you are already behind. Not preparing for and implementing the new ICD-10 codes can...
cause payment delays and negatively affect the revenue cycle.

As part of this preparation, it is important to conduct an extensive assessment of clinical documentation processes to find situations that require more data to assign the appropriate ICD-10 code. Ensuring that clinical documentation is accurately captured leads to improved quality of care, better cash flow and billing processes, and improved clinical and financial audit results.

Training will be of utmost importance. Physicians need documentation updates and coders need sufficient training, which is not something that can be completed in a couple of meetings. Hospitals must dedicate resources, labor and time toward mastering the new ICD-10 coding system. A confidently trained staff will limit disruptions in workflow and reimbursement. In addition, with the government mandate to cut costs, attention must be given to all medical coding practices, which can yield desired results through reduced errors and other improvements.

Planning for the months after the implementation deadline is also critical. Organizations need to have plans in place to accommodate the productivity and cash flow decreases that are expected while the industry learns to resolve the issues associated with ICD-10 billing – from increased denials to adjudication challenges.

5. Rise in Industry Consolidation

Another key trend impacting revenue cycle management is consolidation. As reimbursement is tied to the quality of care, hospitals must control all facets of the care continuum from pre-acute to post-acute care. The ability to control what happens to the patient before and after their hospital visit is critical in enhancing reimbursement.

Expanding market share as well as economies of scale are other drivers for consolidation. Hospitals are merging as well as acquiring physician groups and outpatient facilities at a high rate. Those hospitals and physicians that remain independent will have a difficult time existing in the new environment. Hospital and physician merger activity will require the consolidation of existing business office operations, creating a need to reevaluate revenue cycle infrastructures and financial systems. This can be an opportunity for revenue cycle leaders to reassess their current structure and implement best practices in their centralized business office.

6. The Growth of Outsourcing

Faced with labor and resource shortages, and an increasing need to accelerate cash flow and manage costs, healthcare providers are looking to outsourcing as a viable strategy. The demands outlined in this paper will drive an increased number of providers to consider outsourcing all or parts of their revenue cycle. Managing the revenue cycle effectively requires a focus on claims data accuracy, proper use of technology, knowledge of ever-changing payor/coding stipulations, efficient follow up and key performance indicator monitoring.
The burden of managing this with reform initiatives such as the ICD-10 conversion, value based payment models and increased patient volumes can overwhelm understaffed and inexperienced revenue cycle departments. Revenue cycle outsourcing will be a key strategy for healthcare organizations as they prepare for the major changes coming this year and in the years ahead.

Providers are increasingly outsourcing aged AR (insurance and self-pay) and experiencing immediate efficiencies. Hospital staff can focus on working the new AR, increasing their productivity. Aged A/R collection rates can rise by leveraging a vendor with advanced technology, process and experience. Typical arrangements are on a contingency basis, minimizing the investment required. By outsourcing non-core or lower value tasks to a trusted business partner, it leaves the larger balance insurance accounts, government and other billing and follow-up work to the healthcare organizations’ staff.

The conversion to ICD-10 will require assistance from vendors with credentialed and trained staff. Hospitals must decide whether they prefer to spend the time and money to train their own staff or to simply outsource it to a firm with trained ICD-10 personnel. Hospitals that prefer to develop their own staff will require an outside firm to provide dual coding assistance while their staff gets up to speed.

At the physician group level it is more common and cost effective to outsource their entire revenue cycle from billing to collections, gaining benefits by eliminating overhead and management of an area few physicians have the desire or understanding to oversee.

Conclusion

The next few years will bring major shifts in the healthcare marketplace. Healthcare providers will face significant challenges with reduced reimbursement, industry consolidations, higher patient volumes and resource shortages. Revenue cycle leaders will be juggling multiple initiatives including ICD-10 conversion; performance based payment models, cash collection and cost control. In order to steer their organizations through this dynamic healthcare environment, healthcare companies must integrate their clinical, financial and technical areas to drive, measure and manage quality through their care continuum.

Revenue cycle leaders must begin to plan today for coming changes that will impact their cash flow. Examining the entire revenue cycle operation, identifying gaps and developing a strong plan of action will be required to maintain cash flow and transition into the future of healthcare.

Outsourcing can be a viable strategy to accelerate cash flow and control costs
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About Pyramid Healthcare Solutions:

Founded in 1985, Pyramid Healthcare Solutions (PHS) partners with healthcare organizations to assess, validate and resolve gaps in their revenue cycle, leading to improved and sustainable financial results. PHS offers a complete suite of revenue cycle solutions, including HIM Departmental Management, Coding Services (on-site and remote), Release of Information, Patient Financial Services and Extended Business Office, Physician Practice Management and Cancer Registry. Headquartered in Clearwater, FL., PHS employs more than 300 credentialed, knowledgeable healthcare professionals and best practices developed with more than 500 clients. PHS is a subsidiary of the Avantha Group. The Avantha Group is a $4B global corporation operating in 90 countries with more than 25,000 employees worldwide.

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