

# Enterprise Revenue Management

## Reinventing How Health Systems Manage Revenue and Can Improve the Economics of Care

Shrinking margins. Escalating debt. Uncollected payments. These are just a few of the challenges that keep a healthcare executive up at night and struggling to keep hospital doors open. But with the healthcare industry treading water under the weight of considerable financial strain, it's an unpleasant reality for many. Not only is it difficult to admit defeat but it is even more disconcerting to deal with the aftermath: patients struggling to access needed healthcare services and to understand their financial responsibility for those services and – in the most severe cases – hospital closings, out-of-work employees, and loss of healthcare access for entire communities.

Unless the economics of care improve – and not just incrementally but dramatically – the healthcare industry will continue to struggle and its constituents from providers to payors to patients will feel the painful pinch of what's become an unforgiving financial reality. To create a brighter financial future, healthcare organizations need to go beyond simply improving current revenue cycle management processes.

What's the answer? A complete reinvention of the healthcare industry's approach to fiscal matters by creating a new category of financial management: enterprise revenue management

### **Frightening Financial Realities**

If you consider the following facts, it's easy to recognize just why radical change is needed in the healthcare industry's financial world.

- The average aggregate hospital margin could reach zero by 2013, if bad debt as a percentage of revenue grows at 10% per year as hospitals fear<sup>1</sup>
- Healthcare costs now represent 16% of the Gross Domestic Product and are projected to hit almost 20% by 2017<sup>2</sup>
- Healthcare spending is rising by 7% compounded annually<sup>3</sup>
- Uncompensated care cost U.S. hospitals \$31.2 billion in 2006, representing 5.7% of annual hospital expenses and an 8% increase from uncompensated care costs in 2005<sup>4</sup>
- The percentage of hospitals with negative total margins has been hovering between 20% and 30% between 2000 and 2006, according to recent statistics from the American Hospital Association<sup>5</sup>
- Even though the United States clearly and substantially outspends all other nations, the U.S. healthcare system ranks last compared with

five other nations on measures of quality, access, efficiency, equity, and outcomes, according to a report from the Commonwealth Fund<sup>6</sup>

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### **Revenue Cycle Management Shortcomings**

Contributing to these dismal bottom-line results – and, perhaps even more importantly, calling attention to the urgent need to rethink the industry’s financial management paradigm – is the fact that current revenue cycle management practices are falling short. Most obviously, the administrative burden associated with typical revenue cycle practices is simply too onerous, as it consumes a large portion of insurance premiums.

These administrative burdens include:

- Enrolling individuals in health plans
- Paying health insurance premiums
- Checking insurance eligibility for a particular service
- Getting an authorization to refer a patient to a specialist
- Filing a claim for payment for healthcare that has been delivered
- Requesting or responding to additional information in support of a claim
- Coordinating the payment of a claim involving two or more insurance companies
- Notifying the provider about the payment of a claim

To add further complexity, there is inconsistency about how these various transactions take place — by mail, by phone or by reference on the Internet. In addition, providers and payors often have different processes, systems and methods of communication, and very few have taken advantage of electronic interchange. Currently, much of the information is entered manually, decreasing staff productivity and providing opportunities for error throughout the process.

Not only inefficient, current revenue cycle management is ineffective as well. Consider the following:

- 80% of patient self-pay net revenue is never collected<sup>7</sup>

- Hospital bills sit for an average of more than 10 days before being sent out<sup>8</sup>
- Uncompensated care rose 44% from 2000 to 2006 <sup>9</sup>
- Hospitals lose \$1.2 billion each year due to business office rework<sup>10</sup>
- About \$20 billion in hospital revenue is lost each year due to coding and charging inaccuracies <sup>11</sup>

### **Unexpected Wrenches: Emerging Trends**

Further exacerbating the need for a new revenue cycle management category is the fact that the current paradigm does not accommodate several emerging healthcare industry trends such as:

- **Baby boomer demands.** By 2030, the proportion of the U.S. population aged 65 years or older will double to more than 70 million. With this graying of the population will come unprecedented demands on public health, aging services and the nation's healthcare system, according to the Centers for Disease Control, Atlanta.

"The aging of the U.S. population is one of the major public health challenges of the 21st century. With more than 70 million baby boomers in the United States poised to join the ranks of those aged 65 and older, preventing disease and injury is one of the few tools available to reduce the expected growth of healthcare and long-term care costs," says Julie Louise Gerberding, MD, MPH, Director, Centers for Disease Control and Prevention.<sup>12</sup>

As such, healthcare organizations will strive to provide more services and to emphasize preventive care but will continue to struggle with revenue models that are designed to pay for services rendered.

- **Consumer-directed care.** The rise of consumer-directed care is making it difficult for healthcare organizations to continue operating under established models. A consumer-directed health plan is a health plan product that, when combined with a health savings account or a health reimbursement arrangement, provides insurance coverage and a tax-advantaged means to help save for future medical expenses.

With these plans, consumers are more likely to pay attention to their health and become much more proactive when selecting and working with healthcare providers. The idea is that by shifting control of the

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first dollars spent to consumers – and giving them information about healthcare costs and quality – consumers will become more cost-conscious buyers of healthcare services. The bottom-line vision: With these plans, consumers will shop and think about value in the same way they make purchasing choices about other goods and services and, therefore, healthcare services will improve while costs decrease.

The challenge? Current provider systems were not designed to accommodate these changes, and most cannot be modified to adjust to the unique demands of a consumer-directed model.

As a PricewaterhouseCoopers Health Research Institute report noted, “Managed care was designed to put control where there was none. Today’s trend toward consumerism attempts to inject something that’s been missing from health benefits: a consumer who cares more about cost and quality.”<sup>13</sup>

- **Pay-for-performance.** Healthcare organizations also are coping with pay-for-performance programs, which reimburse providers based on clinical outcomes as well as quality, structural and even patient satisfaction measures.

For example, the Centers for Medicare & Medicaid Services Hospital Quality Initiative, a demonstration project that was launched in 2005, aims to reward hospitals for superior performance based on certain measures of quality as well as to reduce payments to hospitals that fall below a clinical baseline threshold.

In addition, some healthcare payors are discontinuing paying for care delivered as the result of medical errors. For example, starting on Oct. 1, 2008, Medicare will no longer pay extra for eight specific conditions that could generally be avoided if the hospital followed proven preventive procedures or common sense precautions.

Many of the current revenue cycle management solutions in place today cannot account for these issues and report them accurately in order to justify payment under these new guidelines.

### **Beyond Improving the Current Economics**

Certainly, there is an urgent need to improve financial outcomes in light of the current challenges facing the industry. However, many organizations are on the treadmill track, going faster and faster ... improving and re-engineering current processes ... but not really getting anywhere.

Consider the following: A study released by America's Health Insurance Plans, Washington, D.C., shows that about 75% of claims were submitted electronically in 2006, up from just 24% in 1995. Such automation is, in fact, paying dividends: The Centers for Medicare and Medicaid Services reports that the healthcare industry saved more than \$25 million as providers submitted only 80 million paper claims in 2006, compared to 114 million in 2005.

The problem? It looks as if this electronic data interchange – long considered the Holy Grail of healthcare financial success – simply is not enough. Although this automation has helped the healthcare industry realize a bounty of benefits, the bottom-line is that current revenue cycle management practices, regardless of how much they are optimized, simply are not enabling financial success.

What's more, current revenue management cycle models do not accommodate the needs of consumer-directed healthcare and pay-for-performance programs.

Healthcare providers, for example, are now required to collect a greater share of payments directly from consumers — and revenue management processes and systems often are not set up to accommodate such collections. In addition, providers now need to tie clinical and quality measures to charges — and the revenue management sides of healthcare organizations typically do not communicate effectively with the clinical departments.

Payors also face new challenges. Instead of simply providing a one-size-fits-all policy to employers, payors now need to customize their policies to individual consumers. In addition, because consumers are becoming more involved in clinical decisions and more responsible for the financing of their care, insurers need to set up systems that offer more transparency and more direct communication with subscribers.

Patients also are struggling to find their way in a changing healthcare industry. Certainly they are seeking to become more educated and informed healthcare consumers — especially in light of the fact that nearly half of families who filed for bankruptcy in 2001 cited medical costs as a driver, and more than one-quarter cited illness or injury as a specific reason for bankruptcy, according to a 2005 study published in *Health Affairs*.<sup>14</sup> As consumers become more aware of this reality, they will start to demand more sophisticated data that provides insight into the connection between what they are spending and clinical outcomes.

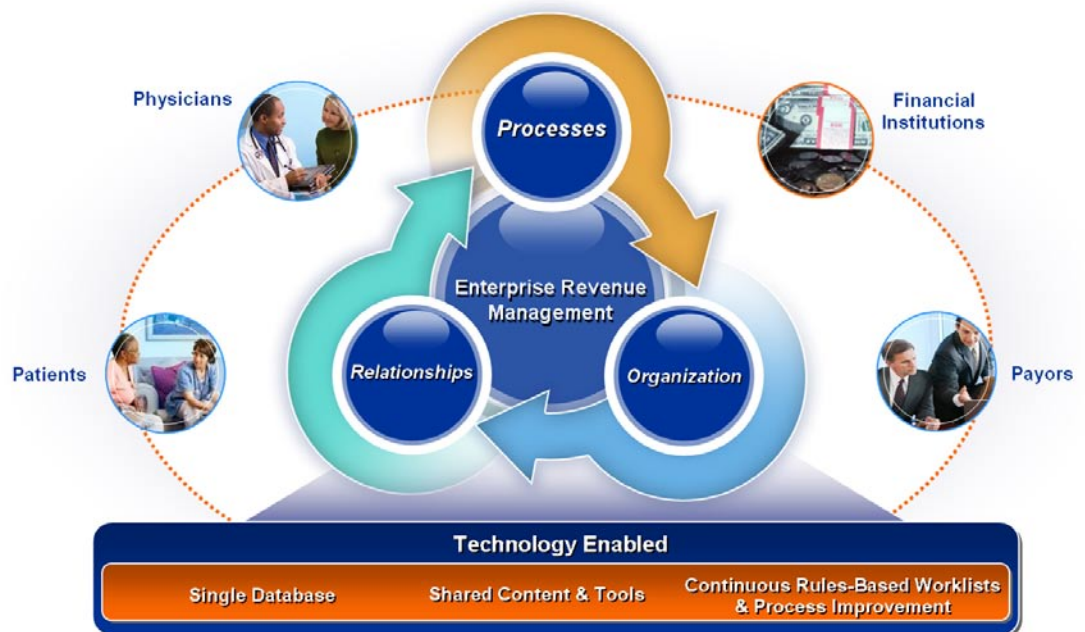
### The Creation of a New Category: Enterprise Revenue Management

These challenges call for dramatic change, not simply a revved-up version of current revenue cycle practices. What's needed is the creation and implementation of an entirely new category of financial management: *enterprise revenue management*.

Enterprise revenue management is a new healthcare business discipline designed to improve the economics of care by automating financial processes and connecting key healthcare stakeholders: hospitals, payors, financial institutions, physicians and consumers. With enterprise revenue management, healthcare organizations use software, services and connectivity to completely reinvent the way they manage and collect revenue.

This new paradigm reinvents processes, relationships and organizational structures associated within the three pillars of financial management – consumer management, access management and business management – and, in doing so, vastly improves the economics of care (See Figure 1).

FIGURE 1: REINVENTING REVENUE MANAGEMENT



*Consumer management* includes the interactions between healthcare organizations and patients. Under the traditional revenue cycle process, consumers adopted a passive role. With enterprise revenue management, however, consumers actively participate in all facets of their care. Patients can go online and compare prices of procedures,

request service online, and even conduct some basic pre-registration activities online from home or work — one less thing to worry about on the day of a procedure.

Therefore, processes are changed to accommodate increased patient involvement. Relationships are altered as consumers no longer sit on the fringes but are intimately involved in decision-making. And, organizational structures change to make it possible for consumers to easily contact appropriate resources within healthcare enterprises in order to make appropriate clinical and financial decisions.

With *access management*, the goal is to support a “patient-friendly” entry into the health system. For example, patients should not be asked the same questions at multiple points during the admission process. All information needed to inform patient treatment, help meet regulatory requirements, and collect full payment for services delivered should be collected at the beginning of the process.

Under the current revenue cycle model, however, healthcare providers deal with inordinate delays and significant rework because relevant information typically is not collected early in the process. Additionally, in some cases multiple information systems are used, not seamlessly sharing patient information. With enterprise revenue management, however, processes are reengineered so that tasks that were typically performed after discharge are now performed at the beginning of the patient interaction process (See Figure 2).

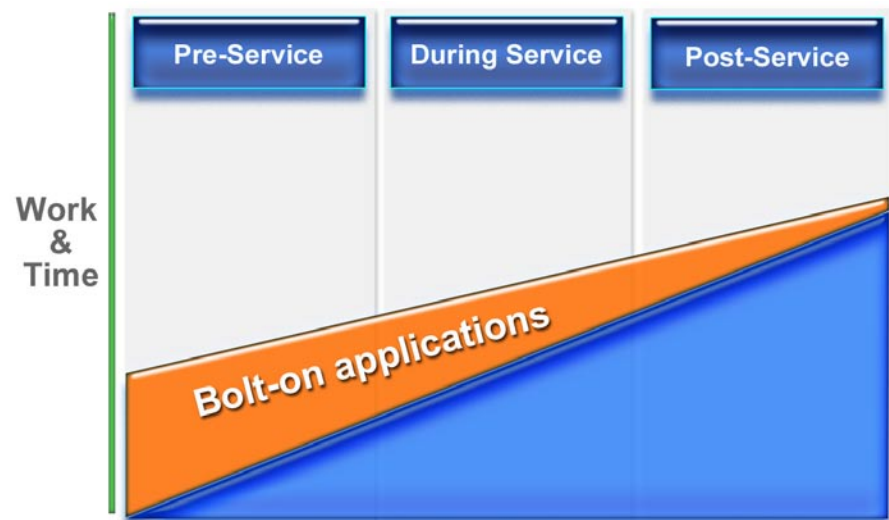
In the current model, the first person the patient sees after walking into the hospital is often a registrar with little to no knowledge of the billing system. There is currently a desire in the industry to elevate the skill sets of those individuals, helping them to become more financially aware. Under the new model, this new “access professional” would ask the right questions at registration, properly articulate to the patients their financial responsibility and – when warranted – engage a case manager earlier to ensure appropriate reimbursement by payors.

*Business management* covers the creation of charges, distribution of claims and receipt of payments. For example, the part of the billing cycle that occurs between the time a patient is discharged and the time a health system submits a “clean claim” currently averages up to 14 steps with three handoffs. With enterprise revenue management, the billing cycle is potentially collapsed with just four steps and no handoffs.

*With enterprise revenue management, organizational structures can be modified so that just one centralized department handles all access management functions across the enterprise.*

With enterprise revenue management, billing information is shared – creating greater transparency – and ultimately changing the way providers, payors and patients interact. With this increased transparency, all constituents can get a better handle on financial matters. Health systems also have the option to change organizational structures as well — for example, allowing the centralized billing office to handle billing across the enterprise. This solution also gives health systems the option to provide a single bill for patients if they wish — a bill that includes all services provided throughout the health system, from the doctor’s office through the various hospital departments to homecare.

FIGURE 2: A NEW WORKFLOW: PROACTIVE, EFFICIENT, EFFECTIVE



In addition, under the enterprise revenue cycle management model, information is shared across the entire healthcare continuum from physician practice to health system to payor. Interchanges between the provider and its financial institutions and payors would happen electronically, making relationships among all parties more collaborative and transparent to the patient.

Under the current revenue cycle management scheme, each entity would need to have employees dedicated to access management, and most processes would happen manually with unnecessary use of paper and faxes. With enterprise revenue management, organizational structures can be modified so that just one centralized department handles all access management functions across the enterprise.

### Why Existing Information Systems Fall Short

This paradigm shift, however, cannot be accomplished with existing technologies. As a matter of fact, existing revenue cycle management systems fall short because they are:

- **Old and outdated.** Current revenue cycle systems were developed and installed in the 1970s and 1980s. While many of these systems have been updated to meet changing needs, their core was built around an antiquated model designed to support the healthcare industry as it existed then.
  - **Piecemeal creations.** Because revenue cycle management systems were created decades ago, vendors have been adding advanced features and functionality through bolt-on products. Putting all of these pieces together is becoming too much of a strain for healthcare organizations. According to a report from KLAS<sup>15</sup> Research, providers are, in fact, envisioning the day when these bolt-on products become a thing of the past and are replaced with systems that offer all functions as part of their core functions.
  - **Non-integrated.** Most revenue cycle management systems operate independent of clinical systems. As such, there is little connection between the clinical and financial sides of the healthcare organization. As the financial and clinical parts of the business become intricately intertwined, however, these independent systems are losing much of their relevance. The new model requires solutions that tie together both the clinical and revenue management sides of the business and offer a truly “open” platform.
  - **Not built to handle financial complexity.** Current systems are built to handle straightforward financial relationships. Healthcare revenue matters, however, are becoming increasingly complex. Information systems, therefore, need to support individualized health plan coverage; tie payments to clinical outcomes; and discern the patient’s share of the overall bill, which can vary from patient to patient. Furthermore, as these systems become more closely tied together, health systems will have the opportunity to make sound clinical decisions based on the potential financial impact to the patient and to the system.
  - **Lacking customer service functionality.** Current systems also are designed mainly to meet the needs of providers and payors — leaving consumers out of the loop. As consumers are becoming more active in the care and revenue process, information systems need to be designed to provide information and education to consumers throughout the care and billing process.
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*With this solution, health systems can stay connected, electronically and in real-time, with their patients, payors, banks and suppliers, improving workflow across all areas of the business.*

### **Reinventing Revenue Management**

The Horizon Enterprise Revenue Management™ Solution is specifically built to support enterprise revenue management as it emerges as a new category of financial management for the healthcare industry.

The industry's first truly comprehensive revenue management solution, it leverages the power of McKesson's extensive portfolio — featuring new provider-based software, RelayHealth® connectivity services, and access to the InterQual® gold standard clinical decision support criteria used by payors and providers across the United States. At the same time, the solution is “open,” working with both McKesson and non-McKesson clinical solutions.

With this solution, health systems can stay connected, electronically and in real-time, with their patients, payors, physicians and banks improving workflow across all areas of the business. The solution will also better enable financial managers to predict cash flow and net revenue by understanding the payment history by payors and the anticipated patient throughput.

By leveraging the following functions and features, Horizon Enterprise Revenue Management can help healthcare organizations create a new financial reality.

*Enterprisewide connectivity* makes it possible to manage financial matters across the entire patient care experience, regardless of where care is delivered. Such connectivity enables collaboration across the entire organization from physician practice to hospital to health system. A common database holds links between key information across the enterprise while separate application databases hold application specific data, which can be synchronized across the enterprise. The common database includes staff, patient and department data. Separate transactional databases contain revenue, clinical and ancillary data. Horizon Enterprise Revenue Management can connect data from all of these departments, providing a complete and seamless view of billing across departments.

*Collaboration* is encouraged because access to information is available around-the-clock from any location, patient specific information is displayed through a common interactive patient banner and an intuitive user interface makes the system inviting for all users.

*Intelligent automation*, powered by advanced workflow capabilities, enables optimal flow of work and information across the entire enterprise. With this “smart” automation, processes are automated

based on industry best practices and events are triggered automatically. Most importantly, the system manages an enterprise's financial functions by exception, not inspection — making it possible for healthcare leaders and staff members to be alerted to important issues in real time. Instead of just automating processes, the system intelligently pushes tasks to specific staff members, optimizing how work cascades across the system. As a result, bottlenecks are eliminated.

*Advanced analytics* provide real-time intelligence to executives and staff members through dashboards and executive scorecards. As such, performance can be improved on a continual basis.

With *clinical integration*, the system makes it become the first clinically informed financial system, making it possible to be aware of financial processes across all care settings. In addition, this clinical integration enables continuous medical necessity checking, coordinated care planning and case management as well as collaboration of orders and scheduling.

Although Horizon Enterprise Revenue Management is built on established best practices rules, tables and workflows, individual healthcare organizations can tailor the system to their unique needs by relying on sophisticated *customization capabilities*. This flexibility allows them to custom design applications including data elements, screen flows, and business rules.

Built on the *Horizon Architecture™* platform, the system offers high levels of reliability, high performance, overall cost effectiveness, affordable scalability, interoperability and adaptability.

As such, the architecture can support the plethora of financial management applications that need to traverse across the enterprise. Horizon Architecture is an innovative information technology platform that meets the healthcare enterprise's fundamental requirement, delivering highly reliable performance in a remarkably simple, agile and cost-effective way. The architecture combines the best elements of the evolving Web services model with service-oriented application architecture, advanced model-based development and a segmented database strategy. It utilizes the most recently accepted standards to ensure longevity and tolerance for changing technology vendors and gives customers the flexibility for system integration in diverse technology environments.

With McKesson's *change management resources*, creating a new way of managing revenue – while a significant undertaking – becomes a

manageable process. Backed by more than 30 years of experience and bringing unparalleled implementation resources to the table, McKesson is easing the transition to enterprise revenue management. More specifically, McKesson offers dedicated implementation resources with proven expertise, process redesign and change management built into the implementation process, comprehensive transformation planning, innovative Web-based customer education, automated data migration tools, automated testing and extensive online support.

### **Improving the Economics of Care**

Enterprise revenue management is not just about improvement. Instead, enterprise revenue management is about change. Big change. With enterprise revenue management, the healthcare industry sets its sights on a new Holy Grail. No longer content just to automate existing processes, enterprise revenue management is aiming for real-time adjudication.

Processes, relationships and organizational structures will be reinvented, making it possible to empower all constituents – providers, payors and patients – to have access to all relevant information when it is needed (See Figure 3).

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FIGURE 3: FINANCIAL PERFORMANCE BENEFITS

<b>Improve Productivity</b>	Experience up to 20% reduction in registration times
	Increase patient access to information and functionality
	Post up to 90% payments electronically
<b>Increase Revenue</b>	Increase new revenue by 2% to 4%
	Improve claim denial rates to less than 1%
	Reduce bad debt up to 20%
<b>Improved billing cycle efficiency</b>	Eliminate delay between services rendered and claim submission
	Reduce A/R days by 5 to 10 days below industry best practices
<b>Reduced cost of ownership</b>	Reduce ongoing maintenance of third party hardware and software up to 40%
	Eliminate up to 80% of interfaces and separate application upgrades

Consumers, for example, will register for services online and pay their portion of the costs at the point of services — and will benefit from access to cost estimate, appointment calendars and online payment options. Providers will collect payment at the point of care, vastly improving their financial status through the elimination of the vast resources currently spent trying to receive payment for services after the fact. Payors and financial institutions benefit from simplified electronic transfers, shared real-time information and the receipt of clean claims, which will significantly cut costs.

The end result? Enterprise revenue management will go well beyond improving current processes — and will actually improve

the overall economics of care. Enterprise revenue management will emerge as a new financial management discipline capable of creating a new paradigm for healthcare organizations. Instead of experiencing the significant pain associated with current revenue cycle practices, enterprise revenue management will empower healthcare organizations to dramatically improve upon today's best practice standards of financial performance and will empower healthcare organizations to set a new best practice standard for financial performance and dramatically improve the economics of care through improved productivity, increased revenue, improved billing cycle efficiency and reduced cost of ownership.

**For More Information**

For more information, visit [www.mckesson.com/horizonerm](http://www.mckesson.com/horizonerm).

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## McKesson Provider Technologies

5995 Windward Pkwy.  
Alpharetta, GA 30005

[www.mckesson.com](http://www.mckesson.com)  
1.800.981.8601

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