

3 ways health systems should rethink margin management

Margin management requires a more strategic playbook

Health system margins hover at historically thin levels as the industry prepares for additional financial pressure in 2027. Organizations face both far-reaching policy shifts and narrower reimbursement changes that can materially affect performance. Leaders will need to look for even more margin improvement opportunities.

Solutions will differ by organization. A larger health system with a positive operating margin likely has more flexibility than a community provider operating near or below breakeven. Yet the general market sentiment is clear: Margin pressure is not a future threat; it's already here. In August, 72% of hospital CFOs and financial leaders said their organizations were operating at margins of 2% or lower.¹

To improve margin performance, health systems need to connect margin management more deliberately to enterprise strategy. Leaders should assess which established approaches still serve the organization, how those approaches must adapt to current conditions, and where policy changes or organization-specific performance indicate a need for new approaches.

The three areas health systems should consider revisiting are pricing and reimbursement strategy, clinical documentation and coding integrity, and the creation of value and economies of scale. Organizations need to create a data-driven view of the revenue and cost opportunity in each area, then determine where action is most urgent.

1. Align pricing with enterprise strategy, not rate optimization alone

Pricing decisions should reflect both reimbursement opportunity and the role a service plays in the market. Organizations should compare prices with local competitors and national peers, but every benchmarking discussion should begin by asking: Benchmarking against whom? Reimbursement that falls slightly below a national peer does not automatically justify a price increase in the local market.

One health system, for example, found that it was being reimbursed fairly, and in some cases slightly below comparable organizations nationally, but was priced high relative to competitors in its local market. Higher prices made sense for specialties where the organization was differentiated. But the higher prices made less sense for widely available services, such as primary care visits and X-rays, particularly when the price was discouraging patients from using newer facilities. This example demonstrates why organizations should evaluate how price affects utilization, patient acquisition, and downstream growth rather than just pursuing the highest allowable rate in isolation.

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2. Treat documentation and coding as margin-preservation tools

Clinical documentation and coding have traditionally supported incremental revenue capture. They are also tools for preserving margin performance as procedures move off the inpatient-only list, fewer conditions qualify as complications or comorbidities (CCs) or major complications or comorbidities (MCCs), and the inpatient mix shifts away from more highly weighted surgical diagnosis-related groups (DRGs). Even accurate and complete documentation cannot fully offset those changes.

Targeted provider education can, however, prevent avoidable margin deterioration. At one regional health system in the Southeast, targeted provider education improved case mix index by about 0.5%, a modest result compared with historical double-digit improvements. However, applying 2026 DRG and relative-weight assignments to the pre-education patient population showed that case mix index otherwise would have declined by almost 12%, which would have meant about \$2 million in lost reimbursement. For many organizations, the immediate goal of documentation improvement should therefore be to maintain performance levels, not simply optimize DRGs. In this example, a modest case mix index improvement helped the organization avoid a much larger deterioration in reimbursement.

Personalized education can make documentation improvement more actionable for clinicians. Rather than relying on broad training, organizations can use provider-level data and record reviews to identify specific documentation opportunities, then tailor education to the clinician's specialty. This approach focuses attention on the concepts most relevant to each provider and supports more complete and accurate documentation at the point of initial capture.

3. Move shared services beyond centralization

Many health systems have already centralized corporate functions and reduced process variation. However, centralization alone does not yield better financial performance. The next step is to move from a first-generation focus on inputs and cost reduction to a second-generation focus on skill mix, functional outcomes, and enterprise value.

First-generation shared services typically select an operating model already in use within the health system and replicate it across the system. The emphasis is on consolidating teams, reducing process variation, and lowering head count across functions like human resources (HR), supply chain, revenue cycle, marketing, information technology (IT), and managed care contracting.

Second-generation shared services ask a different question: How does the function use scale to provide more value and create a better end result? The objective changes from trying to reduce inputs to improving outcomes. Revenue cycle management illustrates the distinction. A first-generation shared-services organization may continue to emphasize net revenue collections or cost-to-collect in isolation. A second-generation organization evaluates yield by considering both the total cost of revenue cycle services — including labor, vendors, and technology — and the effectiveness of collecting the revenue associated with that cost structure.

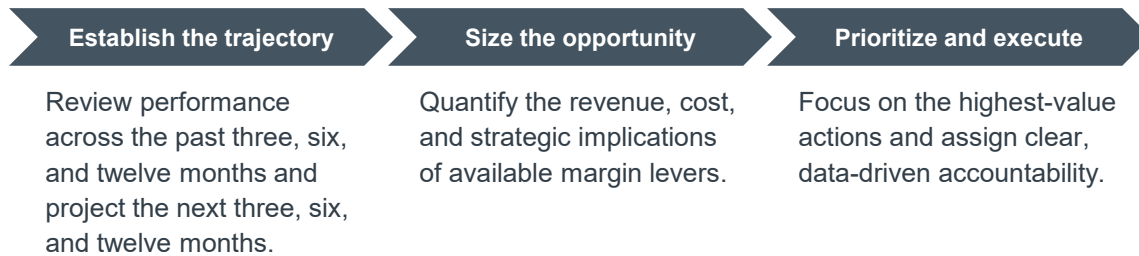
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One ambulatory multispecialty provider in the Northeast appeared highly efficient based on its revenue cycle cost-to-collect. However, its net collections performance and revenue per work relative value unit (wRVU) both fell in the bottom quartile. The organization had achieved apparent cost savings while leaving revenue uncollected. Second-generation shared services avoid pursuing cost reductions that weaken overall margin performance.

What to do next

Time is limited for provider organizations preparing for additional financial pressure in 2027. Leaders should begin by developing a forward-looking view of margin performance. How has performance changed over the past three, six, and twelve months? What is the expected trajectory over the next three, six, and twelve months? This analysis can help organizations identify where pressure is emerging and where intervention is most urgent.

Organizations should then size the opportunities available across their margin playbooks. Rather than pursue every lever at once, leaders should assess the financial value and strategic implications of each opportunity, prioritize the actions most likely to improve performance, and establish clear, data-driven accountability for execution.



Struggling with margin performance?

Optum consulting experts can help you determine which levers are most meaningful to pull.

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Endnote

1. Morse S. More than 70% of CFOs report margins of 2% or less. *Healthcare Finance*. April 21, 2026.