Healthy Competition for Data

Acute care division of a Virginia IDN automates revenue cycle management.

By Richelle Fleischer

Competition is a great motivator. When a new acute care hospital moved into our backyard and started to reduce our market share and profit margins, we were motivated to improve the efficiency of our operations using data from an automated revenue cycle management package. Today, we've reduced accounts receivable (A/R) days and bad debt below national averages in the acute care division of Riverside Health System (RHS), while increasing cash collections.

RHS is a Virginia-based integrated delivery network of three acute care hospitals, the largest physical rehabilitation hospital in the state, seven long-term care facilities and numerous health clubs. We employ more than 5,000 employees, including 165 physicians. The 714-bed acute care division, comprising the three hospitals, discharged 24,000 patients and generated $777 million in gross revenue last year.

We were the only game in town until another acute care hospital moved into the Newport News area in 2001 and started reducing our market share. When I arrived at RHS in August 2002, like many healthcare facilities, we did not have a progressive approach to revenue cycle management. We did not actively collect at time of service. We didn't accept credit cards. We didn't even have a cashier's window in the lobby.

Furthermore, our legacy system's reporting capabilities were limited. A monthly paper-based report gave us an historical summary level snapshot of our accounts receivable, but we had no usual daily financial reports for cash, adjustments or A/R. It didn't take robust reporting, however, to spot a $20 million coding backlog when our monthly revenue was $65 million. The average A/R days in our three acute care hospitals had climbed to 78, compared to the Healthcare Financial Management Association's benchmark of 55 days for acute care facilities. Furthermore, our bad debt was 7 percent of gross revenue when it should be no more than 5 percent.

To improve our revenue cycle management, we needed to get back to financial basics and to obtain more robust reporting tools.

People and Processes First

To gather the "low hanging fruit" like reducing the obvious coding backlog, we addressed process and people issues first, before technology. Typically there are three steps to processing a chart through medical records—assemble the chart, analyze for deficiencies and code the chart before billing. When we discovered a shortage of staff was causing a bottleneck in analyzing deficiencies, we flip-flopped the process to code the chart before analysis. After all, most missing physician signatures don't affect the coding. Transposing coding with analysis allowed patient accounting to bill and collect money faster, reducing our coding backlog from $20 million to one day's accounts receivable, e.g., $735,000.

The former patient accounting director had billers manually reviewing printed "clean" claims monthly be-

cause he didn't trust the edits in the automated bill scrubber. We fixed the edits, freeing up billers from working clean claims and sent the claims directly to the insurance companies. We also accelerated our billing schedule, invoicing patients the day after the insurance company paid. Previously, we assigned each patient a cycle statement date, say the fifteenth of the month. A patient's insurance may pay on the sixteenth of the month, but we would not bill that patient until the fifteenth of the following month on their cycle statement date.

Next, we tracked technical denials, those denials we should be able to prevent by obtaining the correct authorizations or verifying patient coverage. A team of 15 people from medical records, care management, patient access, insurance verification and patient accounting determined that most of our problems stemmed from lack of communication. For example, we discovered our case managers were manually filing patient authorizations—critical for account billing—instead of electronically sending them to patient accounting. It wasn't that our people weren't working hard—we needed to work smarter.

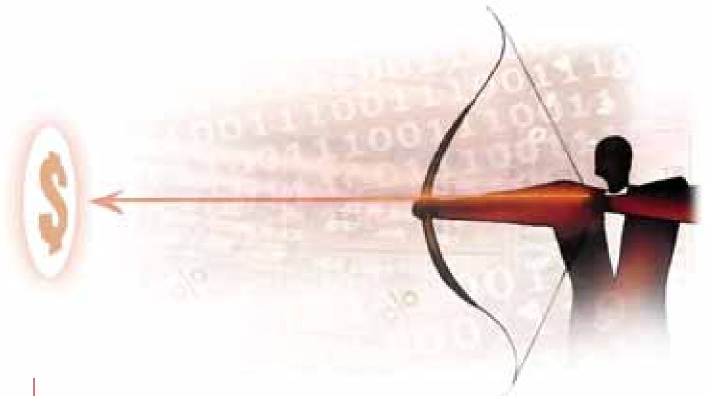
Close, But No Benchmark

By the end of 2003, we had picked all the low hanging fruit. Our A/R days were down from 78 to 57, but we still weren't at the 55-day benchmark. I knew there were more opportunities, but it's hard to triage the problem if you can't *see* the problem. We needed better reporting tools.

In December 2003, The Advisory Board Company, of which RHS is a member, asked us to participate in a hospital study to show how a robust reporting package could reduce accounts receivable. The Washington, D.C.-based company researches and analyzes best practices in healthcare. During their visit, they demonstrated their new revenue cycle performance program, known as Revenue Cycle Compass. The program uses a technology platform and revenue cycle analytics developed by MedeFinance Inc. of Emeryville, Calif.

Having touched bases with a large hospital in Wisconsin that was using the product, we felt it was just the robust revenue cycle reporting package we were looking for and the perfect "bolt-on" product to our patient accounting system.

We signed the contract with The Advisory Board Company and in January 2004, RHS implemented Revenue Cycle Compass. Because Compass was provided as an on-demand hosted applications model, implementation was fast and easy, with no hardware to buy or software to maintain. Running the financial analytics software through a hosted application requires RHS to regularly transfer all data to the applications vendor. Our biggest initial investment, therefore, was determining what format to send the data in and developing the 88 data elements for each account that we would send in a nightly feed.



Compass allowed us to move from working from assumption and gut to working by fact.

Thinking Analytically

I'm very comfortable with the Web and database analytics, so using Compass was intuitive for me when it was rolled out in April. Our management team was more comfortable with mainframe computers but game to learn more about PCs and the Internet. The Advisory Board Company staff taught classes onsite at RHS and conducted weekly Webinars tailored to the individual departmental needs of patient accounting, registration and medical records. Some of the training was very basic, like learning how to use a mouse and how to drill down for information using links. The exciting part was that our staff also learned how to think more analytically about the data and what questions to ask rather than having canned reports pushed at them.

Compass allowed us to move from working from assumption and gut to working by fact. The ATB (Age Trial Balance) function reflects all transactions on open accounts, including payments and adjustments. There are 27 different ways to analyze the data and all within clicks of the mouse. By being able to drill-down to view data by any category such as payer, patient type or financial class against the age of the account, we can identify choke points or bottlenecks, such as coding backlogs, duplicate claims or slow payers, and remove them or build realistic payment schedules during contract negotiations.

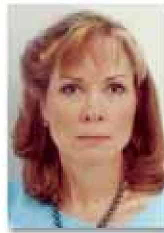
When we found the number one reason that insurance companies denied our claims was because of duplicates, we changed our processes and have dramatically reduced sending dupes. We can also compare the success of time-of-service collections across facilities and even within facilities by registration location. Viewing the age of the account by current financial class (e.g., self-pay after Medicare), compared to original financial class (e.g., Medicare) allows us to see greater exposure to patient liability and bad debt than we previously realized.

Below Benchmark

Because there is now a common platform and the data is more visible, we can compare and contrast data from all three acute care facilities as if there was a single centralized database, instead of getting static reports from three separate hospitals. Since all the directors of the hospitals can see the entire database, this fosters healthy competition among them for the better results. Plus, we can write specific alerts. For example, an e-mail alerts me when charity and bad debt hit a certain level. I also have an automatic alert set to praise the manager of medical records when her backlog falls below a certain threshold.

Today, accounts receivable in the acute care division of Riverside Health System stands at 43.5 days, well below the industry benchmark of 55 days. That's a 44 percent reduction from the 78 days three years ago. Technical bad debt fell from $4.7 million to what is estimated to be $1.5 million this year—a drop of 68 percent. Total bad debt has fallen from $39 million to $31.5 million, dropping from 7 percent to 4.5 percent of gross revenue, again, below benchmark. Revenue has remained fairly flat, yet our cash collections have increased from $254 million in 2003 to what looks to be $265 million this year, indicating we are collecting more than we ever have—old money as well as new money.

Our revenue cycle analytics have paid huge dividends, helping us collect more money faster, write fewer bad debts, turn over denials faster and drop our accounts payable below industry averages. To gain the competitive edge, we plan to continue process improvements and reduce A/R below 40 days.



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