

Before the House Subcommittee  
On Oversight and Investigations  
Of the House Veterans' Affairs Committee

*Testimony of Donald N. Blanding  
Healthcare Information Technology Consultant  
Novus LLC  
Fargo, ND*

*Executive Director Information Technology (Ret)  
Fairview Health Services  
Minneapolis, MN*

*Wednesday, May 7, 2003*

Thank you Mr. Chairman and distinguished members of the Subcommittee for providing me with the opportunity to appear before you today. My name is Don Blanding, and I've spent the last 18 years of my career in healthcare information technology, nearly all of it as Executive Director for Information Services at Fairview in Minneapolis, Minnesota. The Minneapolis / St. Paul Metropolitan area has been a highly competitive environment for healthcare dating back to the 1980's. HMO's have been big players for some time. Likewise, employer coalitions have been used to leverage bargaining power and reduce healthcare costs. As a healthcare provider, this translates into increased competition and reduced margins.

Fairview Health Services is a \$1.5 billion dollar not for profit healthcare company consisting of seven "care systems". Each care system includes a hospital, clinics, a skilled nursing facility and home care. The largest care system includes Fairview University Medical Center, the teaching hospital of the University of Minnesota, and surrounding facilities. There are two other large metro care systems and four smaller care systems located in Rural Minnesota.

Much of my time at Fairview focused on revenue cycle management. For our purposes today, I'll define revenue cycle management as all of those processes required to insure the successful and timely capture of revenues due the institution for patient care provided. Care may be provided in many settings, including clinics, hospitals, ambulatory care centers, skilled nursing facilities, and in the patient's home. Revenues come from Medicare, Medicaid, private insurers, HMOs, and the patient. In the next few minutes I'd like to highlight just a few of the more critical steps in the revenue management cycle and, in some cases, how they might be addressed. My focus will be typical hospital visits. Please note that nearly all of this effort takes place long before the patient bill or insurance claim is ever produced.

For example, pre admission and pre certification take place before the patient presents at the facility. Accurate patient demographics and "certifying" that the patient is indeed insured for the upcoming procedure needs to be done very early in the process. Large institutions have a computerized list (referred to as the master patient index or MPI) of names of former patients and guarantors. Fairview's MPI consists of 3.3 million names. When a patient presents, it's understandably important that, before adding a new entry to the MPI, that we are not creating a duplicate entry. Creating multiple MPI entries for the same person has obvious clinical and financial ramifications. Likewise, assigning the presenting patient with the wrong MPI number is equally problematic.

At Fairview, computer logic assists the admitting clerk in finding the right match. Phonetic searches help locate similar names and addresses. If the computer "thinks" that a wrong choice has been made, the admitting clerk and their supervisor receive an automatically generated email. Once it's been determined that an error has occurred, the computer includes logic, for example, to combine clinical and financial history of two MPI entries for the same person, likewise, logic exists to separate information belonging to two people but collected under one MPI entry. Reports are also generated that are designed to track occurrences of these problems. These reports are used to help isolate trouble spots and take appropriate action. Actions may include staff training, improving procedures and processes, and working with unique payer requirements.

Once admitted to the facility, it may be determined that additional procedures are medically necessary. Another certification process is now done for the same reason as prior to admitting: To verify insurance coverage.

During the hospital stay the process of charge capture becomes important. Simply stated, this amounts to making sure that the right supplies, pharmaceuticals, lab

tests, x-rays, etc., are charged to the right patient account. In some hospitals, a dispensing machine not unlike a candy vending machine is used for supplies and some pharmaceuticals. The caregiver must key in their identification and the patient's account number before the item is dispensed. This somewhat expensive approach effectively forces the caregiver to document how the dispensed items are used. The charge master is a computer file that contains an entry for every conceivable item, service, room utilization, etc., that might be charged to the patient. At Fairview University Medical Center, the charge master contains 300,000 entries. These entries are maintained in over 15 departments. Keeping the charge master populated with timely, accurate data is a challenge in itself.

In a capitated or prospective payment environment, providers are paid based upon previously arranged contracts that itemize fixed payments for specific procedures, regardless of the costs incurred by the provider. In these cases, charge capture has no impact on the amount the provider can expect to be paid. Payment is independent of the cost (charges) incurred by the provider. However this cost information is every bit as much important in tracking the expenses incurred in treating a given episode. Only then do we know the margin between the cost of providing the service and the payment received.

The January, 2003 GAO report makes reference to a 1999 VA initiative to establish "reasonable charges" for a particular service. As I understand it, this initiative positioned the VA to more accurately charge payers for services provided. In my experience this is only the beginning in a negotiation process to determine what the payer is willing to pay for that service. I'm unsure as to how this works with the VA and their payers.

Once the patient leaves the hospital, several steps are required prior to preparing the patient bill. First the medical record (the "chart") must be completed at the nursing station. Then the physician dictates the discharge summary and signs the resulting transcribed report. Historically, the process often stopped here because physicians failed to sign these reports (attestation) in a timely manner. In an effort to improve cash flow, we wait for physician signatures in only the most complicated cases (such as solid organ transplant).

Coding then takes place in the medical records department. Medical records coders review the chart and, with computer assisted logic, assign ICD9 codes to the procedures described by caregivers. Computers further analyze this and assign a diagnostic related group (DRG) for the episode of care. Remember that the DRG is the code that provides the payment from Medicare. There are several computer software packages available to assist in the coding process. Only now can the

patient bill and insurance claim be produced. The Fairview benchmark here is six to ten days post discharge, depending upon the institution and the complexity of the case.

Once the bill and claim are produced, the cycle continues by tracking by payer, the number of elapsed days prior to payment, referred to as days in receivable. This varies considerably by payer, as most are in no hurry to pay their bills. (Interestingly enough, Medicare is often one of the more timely payers.) Days in receivable by payer reports direct management to the areas that need the most attention.

Bad debt is also monitored and is probably the most watched over statistic. Bad debt may be defined here as amounts determined to be uncollectable due to a problem in any of the processes in the revenue management cycle. Bad debt is tracked by payer, by institution, by procedure, and any other way that helps to isolate problems. A bad debt rate of 1.75% (of total revenues) is an achievable goal. Considering that many of our country's not for profit hospitals struggle to reach a positive bottom line and revenues may exceed expenses by 1 to 2%, the bad debt ratio is an important management tool.

## **SUMMARY:**

Many hospital employees and staff have an impact on the revenue management cycle. To improve collections, each process needs to be carefully analyzed and documented. To the extent possible, the focus should first be on the process, not the people.

All of these processes are measurable. Measurements provide goals and objectives for employees and staff. Policies and procedures can be put in place to meet the objectives. Managers and staff need to be held accountable for meeting the objectives.

Many reasons may be offered as to why the revenue cycle is problematic or where objectives can not be met:

- \* Our patients are older
- \* Our patients are sicker when they first present
- \* Our payer mix is skewed to difficult, low paying insurers
- \* Our staffing levels are too low.

My response to these arguments is to first establish goals and objectives which include staffing levels and then look for “20% -80% situations, where 80% of the problem is in 20% of the occurrences. Further, industry benchmarks are available, and need to be applied.

Having had the opportunity to review prior studies done at Veterans’ Administration hospitals, including the recent work by the GAO, I would further share the following observations.

First, there seems to be an emphasis on collections after the patient bill or insurance claim is produced. This is too late. The focus needs to be on the processes discussed, starting before the patient is admitted. Insurance companies deny payment primarily because of problems that occur in these processes.

Secondly, the GAO report makes reference to “missed billing opportunities”. Reference is made to one study where 5.5% of the patient episodes that could have been billed were not billed. This simply would not be an issue in the private sector. If a patient is seen, a bill is produced.

Thirdly, the GAO report is silent on the subject of co pays. A co pay is the amount the insurance company expects the patient to pay before any care is provided. In my experience, these collections are closely monitored against established metrics. If it’s not happening now, the VA should be doing the same.

Fourthly, the GAO report includes text on the use of professional fees (“pro fees”) and facility fees. Pro fees are the provider’s charges and facility fees are the charges for the use of the “facility”, in this case the VA. In my experience, payers have very little interest in this distinction. Claims for facility fees are often simply ignored. The VA should monitor their success in this arena.

We’re all familiar with the significant changes in health care economics over the past 20 years. Prospective payment, shorter hospital stays, significantly more expensive procedures, lower staffing levels, reduced physician compensation, and many other factors add to the stress and frustrations for those of us in the industry. It would appear that the VA needs to step up to the plate, address these issues in terms of benchmarks already available, knowing that VA employee job descriptions and accountabilities may change, and along with it some temporary increases in stress levels during the process.

Finally, this should NOT be looked on as an initiative to reduce the quality of health care available to veterans. Rather, it is a series of process improvements to collect revenue for care provided in a manner consistent with the patient care and financial management found in nearly all of the leading healthcare organizations in the country. An improved revenue cycle allows opportunities for improved patient care without further burden to the taxpayer.

Thank you for allowing me to testify.