FEATURE STORY

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spinning straw into gold smarter bad debt management

Meridian Health overpaid one collection agency $97,000 in fees, and that was just *one* reason to improve its bad debt management.

AT A GLANCE

To improve its bad debt management, Meridian Health focused on these three areas:

- Automatic rules-based workflow to control compliance with policies and procedures
- Agency management and monitoring
- Use of analytic technologies to manage recoveries

With razor-thin margins, healthcare providers are beginning to tap a once overlooked area of revenue potential: bad debt management. Hospitals generate more than $25 billion a year in uncompensated care charges, which include bad debt. This figure is expected to rise as healthcare costs continue to grow, the numbers of uninsured patients increase even as unemployment decreases, and the insured face higher out-of-pocket obligations.

Problems with bad debt management exist in operational inefficiencies, communication with and tracking of collection agencies, and control over debt policy adherence. Technology can help providers reduce these problems, but the healthcare industry has also been slow to adopt technology and methods that have been proven in the consumer credit and finance industries.

Assessing the Problem

Meridian Health, a not-for-profit health system serving central New Jersey, struggled with these same limitations in bad debt management. In 2004 alone, bad debt cost totaled $30.5 million out of net patient service revenue of $678 million, and accumulated annually. Much of the bad debt was considered uncollectible, and systems did not exist to delete accounts or determine when collections efforts were exhausted.

A merger left the organization working with 10 collection agencies. With no monitoring tools, Meridian had no clear-cut way to determine which agencies were delivering the best return on bad debt investment. Even among agencies that sent performance reports—and several didn't—the reports did not allow an apples-to-apples comparison.

Invoices from collection agencies were paid without a way to verify their accuracy. A voucher for payment could include thousands of accounts, but

without automated systems and adequate staff, Meridian had resources to check only payments of $1,000 or more.

A staff member once found a $1,000 "payment" sent from an agency that was actually an allowance. This discovery led to a full-blown audit of the agency. Meridian found that in one year alone, it had overpaid the agency $97,000 in fees. Although it was believed that the mistakes were not fraudulent, managers realized that the errors they had discovered resulted from an accounting system that lacked the ability to detect and prevent these types of errors and possibly others.

Taking Action

After discovering the errors described above, Meridian conducted a study to compare the financial impact from remaining with the existing accounting system against the cost of deploying a new debt management system. The results suggested that deploying a new system was more cost-effective.

After selecting the system (with appropriate due diligence), Meridian contractually obligated each of its collection agencies to install the system's agency software and connect in real time to Meridian if the agencies wanted to continue working with the health system. Agencies were connected to Meridian's debt management system one at a time, starting with the primary agencies. Because most of the agencies did not have in-house technical expertise, Meridian's IT staff provided implementation and support. Deployment across the agencies took one year, at a cost of $236,000, which included support for a full-time IT engineer, plus $250,000 in annual operating expenses.

The next steps for Meridian were to fully implement the new debt management system by focusing on three areas that would provide the means for improvement:

> Rules-based workflow to control compliance with policy and procedures
> Agency management and monitoring to track and enforce compliance
> Integration of analytic technologies to manage recoveries

Rules-Based Workflow

To establish rules-based workflow management capabilities, Meridian needed first to define its collections work flow processes, policies, and procedures, including communication and data exchange with agencies and all tracking and reporting needs. The health system translated work flow policies and procedures into rules, and scripted the rules into the debt management system, thereby automating its policies and procedures for consistent execution everywhere in the organization.

One example of a new automated policy was in account management. Meridian's policy is to give primary collection agencies 180 days to collect an account. After that time, agencies are supposed to send accounts back to Meridian to be forwarded to a secondary agency. The new system disclosed that only one agency was complying, while the others were holding accounts and not working them for up to three years.

Meridian automated this policy in the new debt management system to enforce agency adherence. As a result, accounts were sent to secondary agencies according to the policy. Secondary recoveries increased and double charges were

> New technologies, including advanced predictive analytics, that have successfully managed recoveries in financial services for many years are slowly finding their way into healthcare debt management.

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Like unpaid claims, slow-paying claims cost healthcare organizations revenue. When claims are wrongfully delayed by payers, persistence and due diligence are crucial. Read about steps providers can take to manage payment of slow-paying claims in "Effective Appeal Strategies and Denial Management" in the February 2007 issue of *Revenue Cycle Strategist*. To subscribe, visit www.hfma.org/rcs.

eliminated. In the first year, Meridian recovered $1.3 million in secondary revenues, and today the health system continues to enjoy more than $1 million in additional revenues annually.

Another example of a new automated policy was in patient payments and agency referrals. Meridian's policy was to not accept agency charges for patient payments received within 15 days of the agency referral. In this 15-day period, the agencies wouldn't have had a chance to work the account, so any payments would be a result of the hospital's own activities. The ability to automate this rule and monitor the exact date of payment and agency referral on an individual account level enabled Meridian to enforce the 15-day policy with all its agencies and generate $285,000 in savings in the first year.

Other automated policies support compliance with the Health Insurance Portability and Accountability Act of 1996. Meridian deployed rules to restrict the delivery of patient information to agencies so only HIPAA-compliant information is shared and only when necessary. Before, agencies had full access to patient data from the accounting system. In addition, Meridian deployed rules to prevent agencies from using attorneys who had not been authorized to collect on their accounts. Through the new system, Meridian is able to assign contracted attorneys and automatically transfer accounts to selected attorneys when needed.

Agency Management and Monitoring

The second area where Meridian has focused its efforts, agency management and monitoring, includes file management, performance and payment, and contracting.

Historically, an agency would occasionally appear to be performing a poor job collecting on accounts, but the agency would claim certain files were never received. In Meridian's new debt management system, accounts are sent to agencies through the system, which then requires agencies to confirm receipt. Meridian tracks the actual files sent to agencies and thereby eliminates discrepancies.

The process by which agencies are paid has also been completely revamped. Instead of sending invoices, agencies now record all their activities through the new system, and the system pays agencies based on their collection percentage. The new process ensures both accuracy and timely payment. Within two years of implementation, collection fees have been reduced by one-third from $3 million annually, and fees have continued to decrease.

Meridian has also worked on improving the monitoring and reporting of agency performance by defining standard performance metrics and reports. The use of such metrics provides a clearer view of all agency activities, allowing Meridian to measure the net back from each agency in a consistent manner. Meridian uses the information to make an apples-to-apples comparison across its vendors and set goals based on the average net back performance and the results of its top-performing agency.

With this information, Meridian has determined which agencies have been providing the best ROI. The health system has selected four primary agencies from the original 10 with which it had contracts. Having each agency's bottom-line impact in black and white has strengthened Meridian's ability to terminate some agencies and renegotiate contract terms with others to lower their collection fees.

Next Steps: Analytic Insight

New technologies, including advanced predictive analytics, that have successfully managed recoveries

ABOUT MERIDIAN HEALTH

Meridian Health is a not-for-profit health system serving central New Jersey. The system includes four hospitals, home care agencies, outpatient and ambulatory care centers, and rehabilitation and behavioral healthcare facilities and programs. Highlights of Meridian Health include the following 2006 data:

- $877 million in system revenues
- 7,600 employees
- Almost 1,500 physicians in its network
- 55,389 hospital inpatient admissions
- 276,195 patient days
- 5.0 days average length of stay
- 158,740 emergency department visits

in financial services for many years are slowly finding their way into healthcare debt management. In general, analytics work within rules-based systems to provide intelligence about what actions to take on an individual account level to improve outcomes.

Meridian is working to deploy analytics to achieve three different objectives:

> Target accounts that are most likely to pay in order to prioritize resources.

> Select accounts that should be kept in house rather than sent to a collection agency or attorney.

> Optimize the assignment of accounts to agencies based on their performance in collecting on certain types of bad debt accounts.

For each type of analytics, Meridian will define the metrics that will measure the performance of the model, and the reports that will allow it to test, track, and improve performance over time.

Implications

Meridian's new approach to managing bad debt uncovered additional types of errors. Agencies had not been reconciling cash daily. They also had not been recognizing allowances or closing out accounts when their collection efforts had ended. For some accounts that had been sent to secondary agencies, Meridian was being charged fees by both primary and secondary agencies.

After the new system was implemented, managers began to better understand the full impact of all the errors on their bottom line. They also realized that the agencies Meridian had trusted with its collections and public reputation lacked their own systems to ensure and report on their performance and compliance with Meridian's policies.

Meridian's new approach showed a payback in less than six months, which surpassed expectations. One year after implementation, write-offs to bad debt decreased by $8 million, and bad debt as a percentage of net patient service revenue decreased by 1 percent. After two years, total collection fees decreased from $3 million to less than $2 million. The ongoing revenue stream has improved more than $1 million in secondary recoveries per year since implementation. Overall, these results are attributable to the new debt management system combined with improvements in Meridian's revenue cycle.

The technologies proven in financial services have the necessary flexibility to adjust to the unique needs of health care.

As the healthcare industry continues to evolve and bad debt worsens, the question is not *if* providers will take steps to improve debt management, but *when*. Although the recovery needs of health care differ somewhat from those of financial services, the goals are similar: Collect the most debt possible, use resources efficiently, provide excellent customer service, and comply with legal and regulatory guidelines. Of course, the approach to bad debt management takes into consideration the ability of patients to pay. Policies and procedures are also in place to identify patients who lack the ability to pay for healthcare services and provide financial assistance as needed. The technologies proven in financial services have the necessary flexibility to adjust to the unique needs of health care. Adoption should be slow and careful, but now is the time to begin. ●

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