Office of Internal Audit

Patient Revenue Audit of Cash Collection Rates and Patterns

September 20, 2016

Dr. Kirk A. Calhoun, M.D.
UT Health Northeast
11937 U. S. Hwy 271
Tyler, TX 75708

Dear Dr. Calhoun:

We have completed a risk-based operational audit of Patient Revenue Cash Collection Rates and Patterns. The audit was completed since an assessment of UT Health Northeast's revenue cycle processes and systems indicated that the calculation of the institution's net collection rate was not accurate by industry standards and management's concerns about variances in cash reports used in various areas of operations and finance. The objective of the audit was to review the data and mechanisms available to model and assess predictability of collectible clinical revenue relative to actual cash collections (the net collection rate) at both the institutional level and by service line.

The original scope of the engagement was FY 2014 through FY 2015 and was expanded to include the first quarter of FY 2016. The audit methodology included interviews with institutional leaders and subject matter experts. The team reviewed documents, records, communications, policies and procedures as part of the audit process. Data analysis procedures were performed on adjustment code dictionary sets in the patient financial system. Internal Audit collaborated with the Information Technology database analyst to modify and correct the net collection rate calculations. In addition, data analysis procedures were performed on various cash reports and source documentation.

Net Collection Rate

The inaccuracy of the net collection rate can be attributed to the fact that UT Health Northeast does not have the tools/technologies to effectively manage internal collections processes. There are systemic obstacles that prevent the automated calculation of the institution's net collection rate. First, the complexity and unreliability of the Meditech Reimbursement Manager module prevents the calculation of expected versus actual collections at the individual patient account level. The second obstacle is the design of the interface of claims adjustment transactions between Meditech and PeopleSoft prevents an automated calculation of expected versus actual collections at the provider and department or service line level. In addition, inconsistent and incorrect mapping of patient revenue adjustment codes within the Meditech and PeopleSoft application dictionaries prevents accurate identification of controllable vs. non-controllable

adjustments and detail at the department or service line level. These obstacles were communicated to senior leaders and further directed to the institution's Patient Revenue Cycle Advisory Committee for review and disposition in consideration of additional investments in people, processes and technology. Resolution of the systemic obstacles attributing to reporting deficiencies within the current systems has been tabled since decisions have been made for UT Health Northeast to move from the current patient information system to an alternate and more robust patient information system. Purchasing additional technologies and correcting mapping and interfaces within the current systems will be costly and not deemed highly beneficial in the short term considering the impending move to a new patient information system. The Patient Revenue Cycle Advisory Committee agreed upon an acceptable substitute metric to calculate cash collections as a percentage of net hospital and physician revenue and has identified this measure as a key performance indicator. A baseline and goal has been set and the results are monitored by this committee each month.

Patient Revenue Cash Flow Patterns and Accuracy of Reports

Upon analyzing the patient revenue cash flow patterns, we found that the methodologies currently being used for providing leaders with monthly and daily patient revenue cash collection goals, one formal and another informal, are not convincing in their ability to inform leaders real-time whether they are meeting either their baseline or their strategic revenue goals. Leaders have expressed concerns that financial reports used by operations and finance do not consistently agree in cash collection amounts. We compared several key cash reports and underlying data and found that the reports in use were not inaccurate but were designed with differences in the method for collecting or presenting the data. For example, data for some cash collection reports was obtained by cash posting dates versus bank deposit dates. Cash collection patterns were affected by the day of the week, holidays, and weekends and when deposits were recorded by the bank. We did not find cash flow patterns and reporting were the result of staffing or productivity issues. The results were communicated to senior leaders and further directed to the Patient Revenue Cycle Advisory Committee for review and resolution. An institutional cash dashboard has been adopted and is posted on the UT Health Northeast Centerlink site for access by all employees. Management in operations and finance are in the process of reviewing various reports in use and are approving or retiring unnecessary or duplicative reports.

This audit was conducted in accordance with guidelines set forth in The Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing.* We appreciate the assistance provided by management and other personnel and hope the information presented in our report is helpful.

We reviewed the data and mechanisms available to model and assess predictability of collectible clinical revenue relative to actual cash collections (the net collection rate) at both the institutional level and by service line and provided the detailed results to senior leaders and the Patient

Revenue Cycle Advisory Committee for consideration of additional investments in people, processes and technology.

Sincerely,

Gail Lewis

Gail Lewis,
Interim Director, Chief Audit Executive

cc:

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