Case Study

Revenue Cycle Assessment Brings Clarity for VCU Health

Ensemble delivers playbook for turning around financial performance

IMPACT POTENTIAL: Up to $115M Cash Acceleration + Net Income

PRESCRIPTION

Full revenue cycle outsourcing

PROFILE

VCU Health

Organization Type:
Nonprofit academic medical system

Size:
$1.7B NPR; 3 hospitals (in scope)

Location:
Richmond, VA

Relationship:
Client since 2019; Live with full outsourcing since November 2020

BACKGROUND

VCU Health was struggling to align revenue cycle functions across its acute and physician practices and facing an operating deficit. They recognized systemic problems were at play but needed help identifying root causes and long-term solutions.

Approach

A four-month strategic and operational review combined onsite visits, process observation and data analytics to identify opportunities to optimize structure, performance and results.

We interviewed leadership and sat side-by-side with front-, middle- and back-end staff to gain a 360-degree view of revenue operations and the environment. Daily recaps onsite provided opportunity to ask questions, clarify findings and ensure alignment throughout the environment.

Problem

Our multi-layered evaluation exposed multiple challenges, including process gaps and breakdowns between acute and physician practices. A history of inconsistent guidance resulted in an absence of infrastructure, shared strategic vision and transparent communication throughout the system. The system's growing financial losses also resulted in a Moody's downgrade.

Numbers across the board signaled a turnaround was needed.

$62M	12.5%	>62
average cash variance	average first-pass denial rate	average A/R days

Playbook for Success

A comprehensive blueprint mapping a future-state for VCU Health's long-term growth and sustainability ensured a seamless patient experience, accelerated cash collections and minimized revenue gaps.

By coordinating processes across its acute and physician practice, the health system could realize gains in multiple performance metrics, such as:

- Increased point-of-service and back-end cash collections
- Reduced accounts receivable (A/R) days
- Fewer missed charges + write-offs

Assessment

Once root-cause issues were identified and prioritized, our team performed deeper analyses of the systems used, reporting needs, training, coaching and workflow design and identified five key targets for immediate improvement.

Organizational alignment + accountability

A divided operating model between two practice groups meant:

- Lack of alignment or collaboration on vision
- Minimal leadership integration and follow through on overarching initiatives
- Little collaboration on cross-disciplinary efforts to drive performance
- Inconsistent patient experiences across touch points

Denial avoidance strategy

High claim denial rates + subsequent revenue loss highlighted:

- Coding deficiencies
- Insufficient EMR training
- Need for governance and best practices

Data-driven decision making

Void of a unified strategy, the system lacked measures of success, including:

- Defined KPIs and monthly, quarterly and annual revenue cycle goals
- Project prioritization based on net revenue and cash impact
- Minimal productivity and quality tracking benchmarks

System strategy + optimization

Systems review + analysis discovered:

- Need for workpool stratification to avoid task duplication
- Minimal and/or inconsistent use of real time eligibility
- Outdated and/or manual processes
- Lack of automation for charge entry, cash posting and claim statusing tasks

Recommendations

- Strengthen leadership collaboration
- Improve organizational communication
- Establish consistent priorities + expectations
- Standardize reporting + accountability structures
- Create a denial management committee
- Institute true first-pass denial reporting
- Implement best practices + governance
- Improve education + training

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