“YOU CAN’T MANAGE WHAT YOU DON’T MEASURE.”

ASK YOURSELF...

- How can you solve a problem you can’t see?
- Are you analyzing your organization’s financial ratios & key metrics in conjunction with operational processes & profitability?
- What are the most important financial & operational goals to work towards?
- What key issues might be impacting your revenue & billing department productivity performance?
  - Staff turnover, physician recruitment, development of a new lab, or the opening of a satellite location?
- How can these issues be addressed?
BECOME A BETTER PERFORMER

- Set financial & operational goals
  - Define a set of desired outcomes for improvement
  - Set up a system for regularly checking & acting on data to improve your bottom line

- Identify data sources, including industry benchmarks
  - **Practice Level**
    - Denials
    - Missing charges
    - Payer mix
    - Charge error
    - Charge lag
    - No-shows
  - **Organizational Level**
    - Income statement
    - Operating cash
    - Office collections
    - A/R

Based on MGMA Cost Survey data, medical groups meeting criteria as better performers did so in 3 major areas:

- Profitability & cost management
- Productivity, capacity & staffing
- Accounts receivable & collections

What did they have in common?

1. SPEND MORE TO MAKE MORE

- A pattern in expenses & productivity - the better performers spent more on staff & facilities.

- Despite the higher costs, these groups saw a return on their investment in human capital, physical plant or technology that exceeds expenditures & contributes to a better bottom line.
2. FOCUS ON PRODUCTIVITY & TEAMWORK

- Culture that focused on productivity & fostered teamwork to unify employees & physicians on key organizational values, as well as short- & long-term goals
  - Example: Physician compensation method that rewarded productivity
    - Greater physician productivity = higher profits

3. MONITOR PERFORMANCE AGAINST BENCHMARKS

- Used management tools in annual budget & business planning
- Monitored performance against budgets
- Used dashboards, creating metrics that aligned with strategic objectives
- Closely weighed performance against financial & productivity objectives & benchmark data internally, over time & externally against peer organizations
- Knew the actual costs of doing business ~ managed overhead more effectively

4. CREATE AN EFFECTIVE PHYSICIAN-ADMINISTRATOR TEAM

- Effective physician-administrator team managed the organization
- Clearly defined roles & responsibilities for physicians, administrators & support staff
- Leaders empowered their supervisors to be decision-makers
  - Accountability for productivity & cost efficiency in their areas
5. ESTABLISH GOOD COMMUNICATION

- Good communication among physicians, administrators & staff
- Managers who regularly reported practice performance to both physicians & administration
- Physicians who listened to employees, who took an active role in suggesting improvements & reducing costs

Source: MGMA

6. RIGHT-SIZE THE STAFF

- Employed the right number of employees
- Employed an optimal number of staff per physician to maximize the practice’s most critical resource: physician time

Source: MGMA

7. FOCUS ON PATIENT-CENTERED CARE

- Placed emphasis on patient-centered care
- Clinical staff, business office employees & physicians focused on quality of care, reputation & patient satisfaction
  - Quality & service orientation
  - Dedication to the needs of patients

Source: MGMA
KEY PERFORMANCE INDICATORS (KPIs)

- Quantifiable measurements used to reflect the critical success factors of an organization
- Compares performance to established benchmarks
- Illustrates timeliness & overall collection performance to help evaluate progress towards cash flow & profitability goals.
- Identifies potential problems areas for the CHC to then establish goals to improve collections
- KPI measurement should be done on a routine basis, providing a comparison of trends over time
  - Can be analyzed & used to educate staff & motivate performance
  - Used to facilitate decisions toward continued improvement

DEFINE KPIs

- How will you measure progress towards your goals?
- High performing organizations focus on:
  - Efficiency & utilization
    - Use of resources, including clinician time, space & staff
  - Physician productivity
    - Use work relative value units (RVUs)
  - Clinician time
    - Time spent providing patient care, including related teaching, professional development & paperwork
  - Revenue cycle optimization
    - Average days in A/R, net charges to cash collections, total collections, charge posting lag, missing charge rate, claim denial rate, bad debt rate, etc...

BENEFITS OF USING A KPI APPROACH

- Concentrate your attention on the elements critical to your success
- Have insight to internal trends & be informed about potential problems & opportunities
- Use an evidence-based management approach to make decisions
IDENTIFY OPPORTUNITIES FOR IMPROVEMENT

- Examine KPIs by payer, specialty & best practice ranges to find areas for improvement
- Regularly review data in custom dashboards or reports
- Data should reflect daily/monthly performance, quarterly & annual summaries of how your organization is performing

EXAMPLE KPI SPREADSHEET

<table>
<thead>
<tr>
<th>KPI</th>
<th>Description</th>
<th>Benchmark</th>
<th>Sample CRC 1</th>
<th>Sample CRC 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of net outstanding &gt; 30 days</td>
<td>Total accounts receivable amounts outstanding over 30 days divided by total accounts receivable balance</td>
<td>10.1%</td>
<td>49.0%</td>
<td>48.75%</td>
</tr>
<tr>
<td>Days gross PFS charges in accounts receivable</td>
<td>Average days of gross PFS charges tied up in accounts receivable owed to the practice or in AR collection</td>
<td>35.5d</td>
<td>58.3</td>
<td>25.71</td>
</tr>
<tr>
<td>Percentage of claims collected electronically</td>
<td>Total collections divided by expected reimbursement after being put into account contractual payment agreements</td>
<td>98.62%</td>
<td>97.39%</td>
<td>98.83%</td>
</tr>
<tr>
<td>Gross PFS collection percentage</td>
<td>Total collections divided by gross charges</td>
<td>55.76%</td>
<td>40.00%</td>
<td>31.57%</td>
</tr>
<tr>
<td>Percentage of claims billed electronically</td>
<td>Number of claims billed electronically divided by the total number of claims</td>
<td>75.0%</td>
<td>(100% for payers who are 80% or above in claims)</td>
<td>100%</td>
</tr>
<tr>
<td>Days to change status</td>
<td>Days from date of service to date charge is posted in the practice management system</td>
<td>Same day or 24 hours</td>
<td>Same day</td>
<td>24 hours</td>
</tr>
<tr>
<td>Days to claim submission</td>
<td>Days from date of service to date a claim is submitted to the insurance company for payment</td>
<td>2 days</td>
<td>2 days</td>
<td>~2 days</td>
</tr>
</tbody>
</table>

ORGANIZING YOUR BILLING DEPARTMENT
POLICIES & PROCEDURES

- Should reflect the goals, mission & values of the CHC
- Documented, compliance driven policies & procedures are essential in achieving consistent operations & outcomes:
  - Formal & specific addressing key components
  - Augments training
  - Assists with evaluating & improving processes
  - Assists in assuring standardized application of policy content
- Policies need to be reviewed regularly & updated to incorporate on-going changes in operations.

TRAINING PROGRAM

- Do you have a training program?
- What is included?
- What is it based on?
- Who is responsible?

TRAINING PROGRAM

- Comprehensive training
  - Practice management system is just a component
  - On-the-Job (OTJ) training should be a part, not the entirety
  - Effective trainer
  - Written training materials
  - Dedicated time
  - Competency assessments
TRAINING PROGRAM

- Written, compliance driven policies & procedures
  - Undocumented = leaves room for interpretation
  - Detailed guidance in procedure format
    - Billing third-party payers
    - Credit balances
    - Insurance follow-up
    - Small balance adjustments
    - Budget plans
    - Bad address
    - Patient correspondence

JOB RESPONSIBILITIES

- Cross-training
  - All tasks should have back-up person assigned
  - Critical processes should not stop when responsible party absent
  - Educate staff on priorities when balancing their own tasks with a coworker’s

JOB RESPONSIBILITIES, CONT.

- Answer for any given task or process
  - Who is responsible for completion?
  - Who is the back up?
  - How often does this process occur?
  - How do I measure the quality of work performed for this process?
  - Does the responsible individual understand my expectations?
  - Is the current person responsible the best person to complete this task?
JOB STRUCTURE

➢ Reporting relationships
  ▪ Minimize number of reporting relationships
  ▪ Create and publish an organization chart
  ▪ All staff should be able to clearly answer who they report to

JOB STRUCTURE, CONT.

➢ Supervisory position considerations
  ▪ Is there a need?
  ▪ What attributes are best suited?
  ▪ May not be most senior person
  ▪ “The best players don’t always make the best coaches”
  ▪ Definition of new responsibilities

JOB DESCRIPTIONS

➢ Often overlooked
➢ Opportunity to provide direction to staff
➢ Define
  ▪ Responsibilities
  ▪ Expectations
  ▪ Reporting relationships
  ▪ Necessary knowledge, skills & abilities (KSAs)
JOB DESCRIPTIONS, CONT.

- Not just a tool for posting an open position
- Useful tool for evaluation of job performance and any necessary disciplinary action
- Clear documentation of duties
  - May protect organization in
    - Hiring selection
    - Promotions and compensation
    - Disciplinary actions up to firing

JOB DESCRIPTIONS, CONT.

- Descriptions should be:
  - Comprehensive
  - Specific
  - Objective
  - Available for review
  - Updated regularly

A PICTURE IS WORTH A THOUSAND WORDS

- When fully utilized, organizational charts provide managers with the information they need to:
  - Make decisions about organizational structure & resource allocation
  - Provide a framework for change & measuring the financial & operational effects
  - Communicating structural & operational information to all employees
  - Visualize the company structure to quickly assess the organization's ability to meet current & future goals
STAFFING

- Frequently wonder if you have appropriate staffing
- Correct number of staff?
  - With correct qualifications?
    - And correct responsibilities?
DETERMINE APPROPRIATE STAFFING

➢ How does current staffing compare to available benchmarks?
➢ How do staff members spend their time?
➢ How productive are staff members currently?
   ▸ Measure specific workload ranges
➢ Is performance substandard?

STAFFING

➢ Staffing levels
   ▸ Better performing practices actually have higher billing staffing than others
     o Total support staff cost per FTE physician
       ▸ Better performers: $189,375
       ▸ Others: $232,719
     o Total business operations support staff cost per FTE physician
       ▸ Better performers: $43,118
       ▸ Others: $56,330
     o Total front office support staff cost per FTE physician
       ▸ Better performers: $38,123
       ▸ Others: $45,047

* Source: 2012 MGMA Performance & Practices of Successful Medical Groups

STAFFING

➢ Total patient accounting (e.g., billing & collections) support staff per FTE physician
   ▸ Better performers: 0.51
   ▸ Others: 0.58

* Source: 2012 MGMA Performance & Practices of Successful Medical Groups
STAFFING

Feedback & recognition
- Staff, department & organization receive feedback regularly
- Improvements are celebrated

Adaptability
- Continuous research & education
- Open to changing processes

EXTERNAL STAFFING BENCHMARKS

- Snapshot comparison to health center data
- Broad guidance on national trends
- Not prescriptive
- Multiple ways to measure staffing levels
  - Staffing or cost per FTE physician/provider
  - Staffing per work RVUs
  - Staffing cost as a percent of total medical revenue

EXTERNAL STAFFING BENCHMARKS, CONT.

- Data sources:
  - Medical Group Management Association (MGMA)
    - http://www.MGMA.com
  - Uniform Data System (UDS)
    - http://bphc.hrsa.gov/uds/
PRACTICE MANAGEMENT SYSTEMS

- Most practices only use approximately 50% of their system’s capabilities
  - Utilizing staff hours instead of automation

- Leverage technology
  - Capabilities
    - Electronic payment posting
    - Document management
    - Claims scrubber
    - Eligibility
    - Staff performance
  - Support
    - Ongoing upgrades & enhancements
    - Issue resolution
  - Review notes from initial implementation
    - Recognized benefits expected
    - Desired functionality been implemented
  - Periodic assessment
    - Identify areas unused or underutilized
DETERMINE HOW STAFF SPEND THEIR TIME...

- Have staff members estimate the number of hours each day spent on specific tasks
- Group tasks into major areas of billing & collections functions, such as:
  - Insurance follow-up
  - Patient collections
  - Payment posting
  - Claims submission
- Calculate how many FTEs are working within each area
- Compare to available benchmarks

HOW DO STAFF SPEND THEIR TIME?

- Example:

<table>
<thead>
<tr>
<th>Area</th>
<th>Example CHC Hours/wk</th>
<th>Example CHC FTEs per 20,000</th>
<th>Adjusted FTE Benchmark per 20,000</th>
<th>Benchmark * FTE per 20,000 claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance follow-up</td>
<td>60</td>
<td>1.50</td>
<td>2.00</td>
<td>4.15</td>
</tr>
<tr>
<td>Patient Collections</td>
<td>20</td>
<td>0.50</td>
<td>1.01</td>
<td>1.61</td>
</tr>
<tr>
<td>Payment posting</td>
<td>80</td>
<td>2.00</td>
<td>1.01</td>
<td>1.61</td>
</tr>
<tr>
<td>Claims submission</td>
<td>50</td>
<td>1.25</td>
<td>0.90</td>
<td>1.39</td>
</tr>
<tr>
<td>Other</td>
<td>50</td>
<td>1.25</td>
<td>0.90</td>
<td>1.39</td>
</tr>
<tr>
<td>Total</td>
<td>220</td>
<td>5.50</td>
<td>5,005</td>
<td>10.05</td>
</tr>
</tbody>
</table>

HOW PRODUCTIVE ARE YOUR STAFF?

<table>
<thead>
<tr>
<th>Task</th>
<th>Example CHC</th>
<th>Benchmark per hour *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge entry without registration</td>
<td>30</td>
<td>55-75</td>
</tr>
<tr>
<td>Payments posted manually</td>
<td>200</td>
<td>75-125</td>
</tr>
<tr>
<td>Includes</td>
<td>0</td>
<td>10-13</td>
</tr>
<tr>
<td>Account follow up by phone</td>
<td>10</td>
<td>6-12</td>
</tr>
<tr>
<td>Account follow up and appeal</td>
<td>2</td>
<td>3-4</td>
</tr>
<tr>
<td>Account follow up claim status &amp; rebel</td>
<td>45</td>
<td>12-60</td>
</tr>
<tr>
<td>Self pay follow up</td>
<td>11</td>
<td>10-13</td>
</tr>
<tr>
<td>Patient account inquiries</td>
<td>17</td>
<td>15-18</td>
</tr>
</tbody>
</table>
REVENUE CYCLE ENHANCEMENT PRIORITIES

#1: Decrease re-work

#2: Increase automation

#3: Increase productivity

MISSING REVENUE

➢ What’s your process for charge reconciliation?

➢ What % of charges is your health center missing?

➢ How do you account for off-site services?

MISSING REVENUE

➢ Missing Charge Rate: < 1%

  • < 1% of charges missed on audit (quarterly) of encounter form to charges entered

  • Processes in place to ensure all encounter forms are entered into the practice management system

  • Processes in place to ensure no missed offsite visits
IDENTIFY TRENDS

➢ Have charges declined, increased, or remained the same?
➢ Is there anything out of the ordinary?
➢ Are all charges posted?
➢ Is the cycle time from Date of Service (DOS) to claim submission reasonable based on established standards in your practice?
   ▪ Make a point to post charges within a set timeframe
   ▪ Review variances from these standards

ACCOUNTS RECEIVABLE MANAGEMENT

➢ Who’s managing your accounts receivable?
➢ What information do they provide?
➢ What changes have they implemented within the last 60 days?

ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

➢ Competent management
   ▪ People & accounts receivable management skills
   ▪ Focus needs to be on management activities
   ▪ Ability to affect change in the organization
ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

- Monitoring tools, such as KPIs
  - Monitored & reported to executive management monthly
  - Feedback provided to staff
  - Visualization is often beneficial

ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

- Performance indicators
  - Average days in accounts receivable (A/R)
    - Annual revenue divided by 365 days = average daily revenue
    - Current accounts receivables divided by average daily revenue = average days in A/R
    - Best practice: 29.01%
    - Average: 40.33%

ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

- Percent of A/R over 90 days old
  - Best practice: 4.07%
  - Others: 4.85%

- Adjusted fee-for-service (FFS) collections
  - Best practice: 99.49%
  - Others: 96.70%

- Gross FFS collections
  - Best practice: 60.75%
  - Others: 52.99%

* Source: 2012 MGMA Performance & Practices of Successful Medical Groups
ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

- Percent of claims billed electronically
  - Best practice & average: 95%*

- Days to charge entry
  - Best practice & average: Same day or 24 hours

- Days to claim submission
  - Best practice & average: 2 days

- Bad debt due to FFS activity per physician FTE
  - Best practice: $10,054*
  - Average: $23,200*

* Source: 2012 MGMA Performance & Practices of Successful Medical Groups

ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

- Measure performance to determine success
- Set goals for financial performance related to the revenue cycle
- Various performance indicators

ACCOUNTS RECEIVABLE FOLLOW-UP

- Is your denial rate close to benchmark?
- What happens when a claim is not paid?
- How many outstanding claims do you have?
- What guidance is provided to staff on prioritization of claims?
ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

- Claim Denial Rate
  - Target = < 5% of total claims
  - Reduce re-work & get paid faster
  - Improve cash flow

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

- Formal denial analysis
- Use denials to train & make operational changes
- Denial analysis spreadsheet or system generated reports

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

- Prevention is key
  - Monitoring denials is an ongoing basis
  - Provide feedback to staff, providers & management
  - Implement changes as appropriate
  - Re-educate staff & providers collectively & individually
ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ Sample follow-up policies – do you have something similar?

1. Claim submitted to commercial insurance
2. After 45 days, check claim status online or call. Resubmit, if necessary.
3. After 65 days, telephone call to payer with notes documented on account, move to patient due, if applicable.

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ “Unresolved claim” policy
  ▪ In theory, either a third-party or the patient should pay every claim
  ▪ Practically, it is not cost efficient to resolve every unpaid claim

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ Staff productivity indicators
  ▪ Outstanding claim follow-up
    ○ 800 – 1,000 claims per month
ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

- Patient collections after the visit
  - Accuracy
  - Understandable statements
  - Speed
  - Follow-up

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

- Quick follow-up on non-payment
  - Tighten statement cycles
    
    | Days from Initial Statement | Billing Cycle Item     |
    |-----------------------------|------------------------|
    | 30 days                     | 2nd statement          |
    | 45 days                     | 1st pre-collect        |
    | 60 days                     | 2nd pre-collect        |
    | 75 days                     | Refer to agency        |

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

- In-house collection efforts
  - Daily productivity target per FTE
  - 45 to 70 accounts worked
  - Can use 70 contacts per FTE per day as a reasonable expectation
  - On average it takes 2.5 contacts to achieve account resolution
ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ In-house collection efforts, cont.
  ▪ Low dollar high volume accounts
  ▪ Two methods of sizing the collection effort
    □ Dollar amounts to be collected (over $75, $100, $200, etc.)
    □ Available staff

➢ Collection action report

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ Patient Consequences
  ▪ Make money owed an issue – past balances are not ignored
    □ Payment plans
    □ Collection agency
    □ Attorney

COMPLIANCE CONSIDERATIONS

➢ Identify areas of risk
  ▪ Conduct an internal assessment to identify if you are in compliance with payer regulations
  ▪ Look for patterns – find resolutions/solutions
  ▪ Correct any identified compliance or billing issues

➢ Perform internal retroactive & concurrent compliance audits
AVOID PITFALLS

- Articulate accountability & responsibility for the entire revenue cycle
- Establish an effective staffing organization, infrastructure & expertise
- Provide appropriate leverage of IT & management reporting
- Monitor leading indicators to assess billing & collection performance
- Streamline systematic revenue cycle processes
- Develop and enforce compliance-driven policies, procedures & practices

SUSTAIN THE BENEFITS

- Key to success = consistently maintaining data collection & analysis
- Embed a philosophy of continuous improvement throughout your organization
- Provide education to everyone who contributes to your goals
- Share reports (& progress towards goals) with appropriate staff & stakeholders

QUESTIONS
DISCLOSURE

Information contained in this presentation is informational only & is not intended to instruct hospitals & physicians on how to use, or bill for health care procedures. Providers should consult with their respective insurers, including Medicare fiscal intermediaries & carriers, for specific information on proper coding & billing for health care procedures. Additional information may be available from physician specialty societies & hospital associations. Information contained in this presentation is not intended to cover all situations or all payers’ rules & policies. Reimbursement laws, regulations, rules & policies are subject to change.