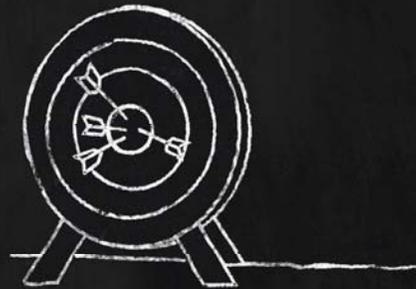**Critical Access Hospital and
Rural Health Clinic Conference**
Focusing on the Quadruple Aim

Creating Connections
Between Leadership
and Business Operations

May 2, 2017

AGENDA

- Identify key performance metrics used in evaluating clinic performance.
- Explore methods used to share clinic performance expectations.
- Discover common strategies for creating a team-based approach to improving results.
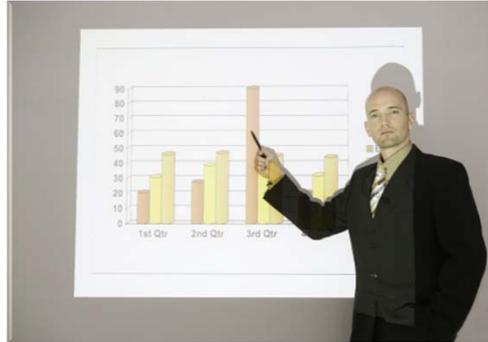
Understanding the Disconnect . . .

Leadership focus:

- Cash flow
- Profitability
- Budget
- Compliance
- Efficiency/productivity
- Cost-effectiveness
- Strategic alignment
- Patient access/experience
- Quality/value

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Understanding the Disconnect . . .

Business Office focus:

- Insurance/demographic verification
- Preauthorizations
- Collections
- Charge entry
- Coding/documentation
- Claim submission
- Payment posting
- Denials/resubmissions
- Account resolution

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. . . To Become Connected

- ✓ Develop a Performance Improvement Team.

- ✓ Use metrics and benchmarks to evaluate and monitor performance/results.

- ✓ Create shared accountability for performance.

- ✓ Collaborate with other departments to achieve success.

- ✓ Focus on prevention.

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. . . and Achieve Results

- ✓ Improved cash flow/financial outcomes.

- ✓ Improved patient experience.

- ✓ Greater staff efficiency/less rework.

- ✓ Increased compliance with coding and documentation requirements.

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Performance Metrics

Performance Metrics

Benchmarking

From Wikipedia, the free encyclopedia

- **Benchmarking** is the process of comparing one's business processes and performance metrics to industry bests or best practices from other companies. Dimensions typically measured are quality, time, and cost.

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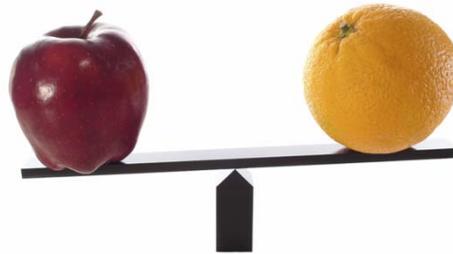
Performance Metrics

External benchmarks and internal data can be useful in focusing attention on financial and operational opportunities for improvement.
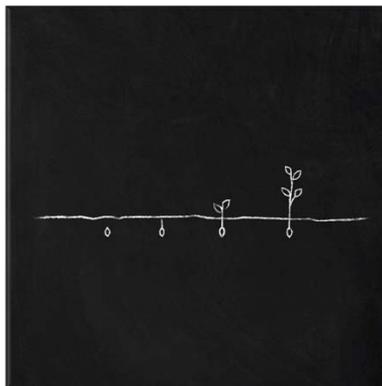
Gaps in comparative key performance indicators can be identified in targeted areas of clinic operations.
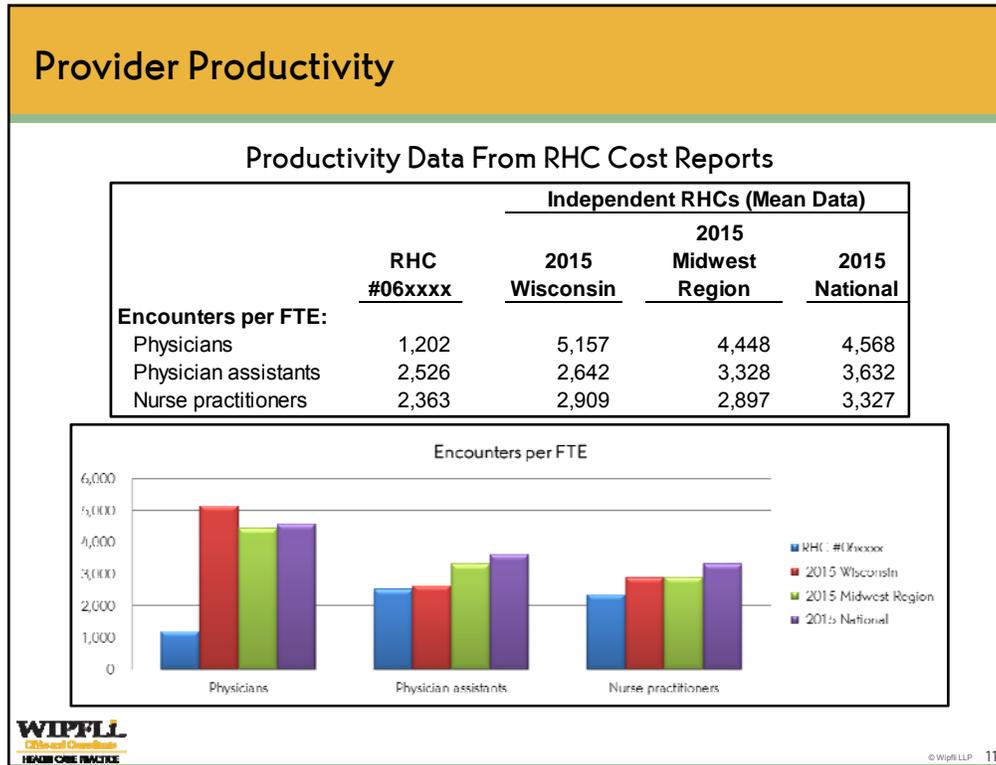
For example:

- Provider Productivity

- Accounts Receivable Management

- Billing and Collections

Provider Productivity

Provider Productivity

Productivity Data From RHC Cost Reports

	RHC #06xxxx	Independent RHCs (Mean Data)		
		2015 Wisconsin	2015 Midwest Region	2015 National
Encounters per FTE:				
Physicians	1,202	5,157	4,448	4,568
Physician assistants	2,526	2,642	3,328	3,632
Nurse practitioners	2,363	2,909	2,897	3,327

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Provider Productivity

Provider Productivity Data - wRVUs

Busy Family Clinic Provider Productivity Analysis Fiscal Year 2014								
Provider Name	Specialty	RHC FTE	wRVU	MGMA Percentile				MGMA Percentile Grouping
				25th	Median	75th	90th	
	Family Practice	1.00	2,100	3,695	4,763	5,887	7,342	<25th
	Family Practice	1.00	2,200	3,695	4,763	5,887	7,342	<25th
	Nurse Practitioner	1.00	1,100	2,333	3,416	4,104	4,797	<25th
	Family Practice	1.00	3,400	3,695	4,763	5,887	7,342	<25th
	Nurse Practioner	0.80	2,100	1,866	2,733	3,283	3,838	<50th
Total		4.80	10,900	15,284	20,438	25,048	30,661	<25th

MGMA Physician Compensation and Production Survey, 2014, Work Relative Value Units by Geographic Section for All Practices

Total actual wRVUs below 25th percentile.

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Provider Productivity

Improving provider productivity is often one of the most challenging yet impactful opportunities for improvement in a medical clinic.

Given the difficulties in provider recruitment, organizations often cannot expand services or care for more patients without finding ways to improve patient flow and throughput in the clinic.

Provider Productivity

Leadership . . . Goal to improve performance through increased provider productivity.

Business Office . . . Goal to identify and remove the barriers to improved productivity.
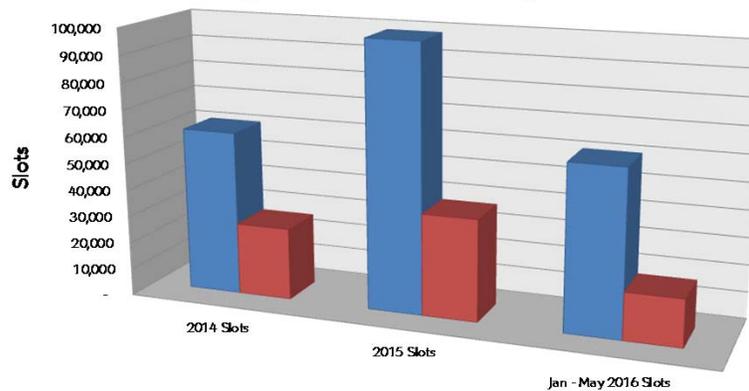
Provider Productivity

- One element of practice operations often cited as a common cause of lost productivity is patients who do not show for appointments.

- Reducing patient "no-shows" can be an effective means to achieving improved provider productivity.

Provider Productivity

Sample Clinic has utilized only 37% of the available appointment slots for its providers over the last 29 months.

Appointment Slot Utilization by Year

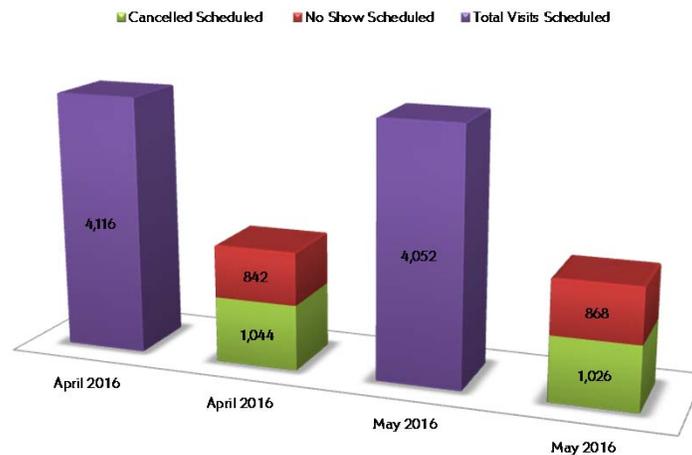|	2014 Slots	2015 Slots	Jan - May 2016 Slots
Available Appt. Slots	61,126	98,841	60,981
Total Appts. Booked	26,784	37,743	17,499

Provider Productivity

Determining your current
"no-show" rate:

# of patients that did not show for a scheduled appointment
# of patients scheduled

No-show rates of 5% - 10% are not uncommon.

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Provider Productivity

For Sample Clinic, nearly 50% of scheduled appointments resulted in
cancellations or no-shows. The no-show rate was approximately 20%.

■ Cancelled Scheduled   ■ No Show Scheduled   ■ Total Visits Scheduled

4,116

842

1,044

4,052

868

1,026

April 2016

April 2016

May 2016

May 2016

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Provider Productivity

Step 1: Determine your current **"no-show"** rate.

Step 2: Determine causes for no-shows:

- Are certain days likely to have more no-shows?

- Are certain times of the day likely to have more no-shows?

- Are certain patients likely to have more no-shows?

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Provider Productivity

Step 3: Consider using common methods of reducing/managing no-shows:

- Appointment reminders.
  - Text messages, emails, phone calls, cards, etc.
- Follow-up for missed appointments.
- Charging for missed appointments.
- Blocks for same-day appointments.
- Limited appointments for "frequent fliers."
- Ready list for fill-in patients.

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Provider Productivity

Discussion of Effective Strategies Used to Reduce No-Shows

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Provider Productivity

Metrics to Be Tracked

- Provider productivity (wRVUs and/or patient visits).

- Appoint slot utilization.

- No-show rate.

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Accounts Receivable Management

Accounts Receivable Management

Accounts receivable represent amounts owed to the organization by patients and third-party payers (insurance, Medicare, Medicaid, etc.).

Improving the management of accounts receivable will result in a reduction in the total amount of the receivable and an increase in cash flow.

Accounts Receivable Management

Leadership . . . Goal to reduce receivables and improve cash flow.

Business Office . . . Goal to identify and remove barriers to reduce the time between service delivery and cash receipts.

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Accounts Receivable Management

Revenue Cycle Lag Times

The time it takes to convert a service to payment is often too long.

One Client's "Lag" Time Between Key Revenue Cycle Steps:

Process	Avg. Days	Comments
DOS to Signature Date	9	Wide range of timing (from zero to 64 days)
DOS to Claim	32	Reflects client's 30-day claims submission policy
Claim to Payment	69	With a wide range (from 27 to 106 days, with clustering at 45-55)

- The signature lag is longer than this clinic's identified goal of one week and the industry standard (< 72 hours, with best practice moving to within 24 hours).
- The claim lag is longer than industry standard, which is moving to less than one week.
- The payment lag is long given this clinic's payer mix; it would be closer to industry standard of 10-14 days with electronic payment posting.

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Accounts Receivable Management

Sample Payer Mix Aging Review and Analysis

| | Days in A/R | | | | | | Analysis | |
Description	0-30	31-60	61-90	91-120	121+	TOTAL	% Over 90 days	> 90 Days as % of Total A/R
MA	583,887	302,420	239,713	199,047	219,970	1,545,037	27%	32%
MA MGD CARE	244,918	209,888	125,383	123,523	155,287	858,999	32%	18%
BC/BS	244,366	181,548	67,745	57,347	121,366	672,372	27%	14%
PRIVATE PAY	38,532	21,087	42,364	35,312	240,957	378,252	73%	8%
UBH CLAIMS 1	92,314	83,955	19,277	8,187	133,455	337,189	42%	7%
UNITED HC	45,007	27,181	20,074	11,752	58,661	162,674	43%	3%
	1,627,255	1,083,857	595,268	488,758	1,083,040	4,878,177		
	33%	22%	12%	10%	22%	100%		

- Substantive amounts over 90 days involve a limited number of payers.
- MA is this clinic's largest payer, and 32% of Total A/R is over 90 days.
- Private pay balances are mostly over 90 days (73%).

NOTE: Table includes only payers with $120,000 or more in A/R.

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Accounts Receivable Management

Accounts Receivable Aging Analysis

Sample RHC Actual Data: Current 21%, 31 - 60 Days 6%, 61 - 90 Days 5%, 91 - 120 Days 3%, 121+ Days 65%

Comparative Data: Current 59%, 31 - 60 Days 12%, 61 - 90 Days 8%, 91 - 120 Days 6%, 121+ Days 15%
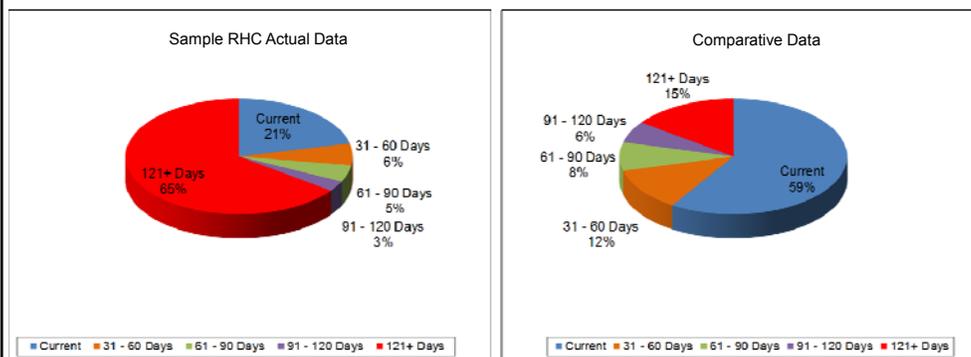
- Substantial amounts over 120 days; confirmed lack of A/R follow-up process.
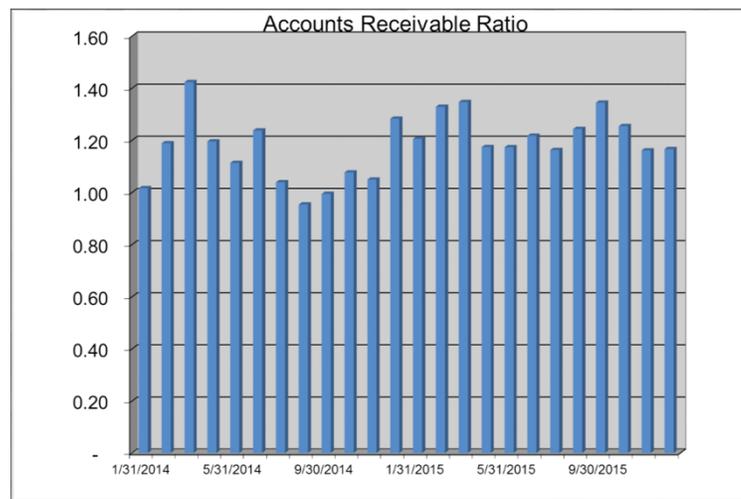
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Accounts Receivable Management

Accounts Receivable Aging Trend Analysis
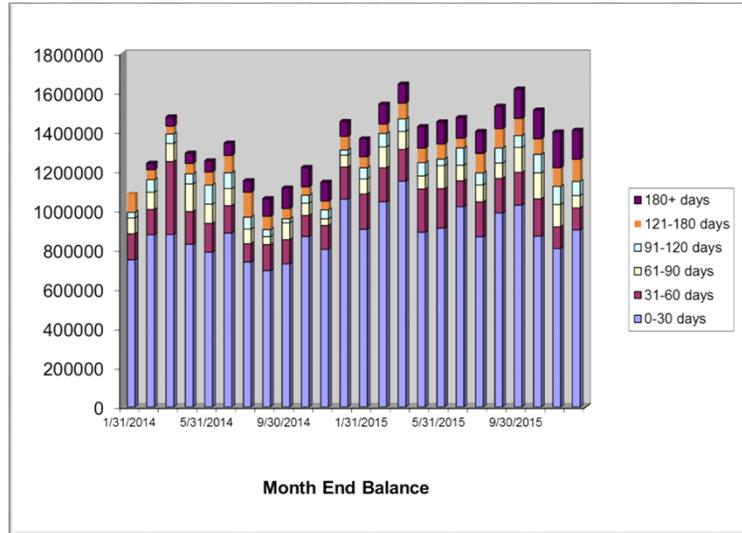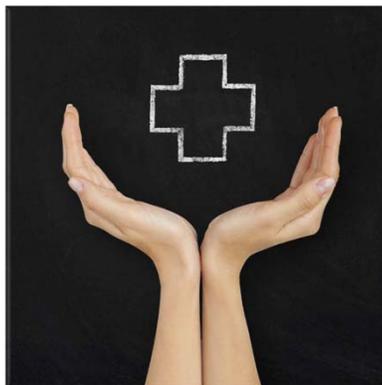

Accounts Receivable Management

Accounts Receivable Ratio Trend Analysis

Accounts Receivable Management Metrics

Metrics to Be Tracked

- Lag time from date of service to provider signature (diminishing, to within 48 hours for clinic visits and three to seven days for hospital).
- Lag time from provider signature to claim filing (diminishing, to within 48 hours).
- Unbilled encounters (diminishing; 0 over 7 days from DOS).
- Total accounts receivable ratio (target 1.0 months).
- Accounts receivable aging (over 120 days < 15%; over 120 days for third-party payers is -0-).
- Credit balance accounts (over 60 days is -0-).

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Billing and Collections

Billing and Collections

- Timely and accurate billing along with efficient and effective collections can lead to improved accounts receivable management (i.e., cash flow), as well as increased profitability.

- Improved billing and collections involve more than reducing the cycle from service delivery to cash receipts, it is also increasing the amount of cash that is ultimately received.
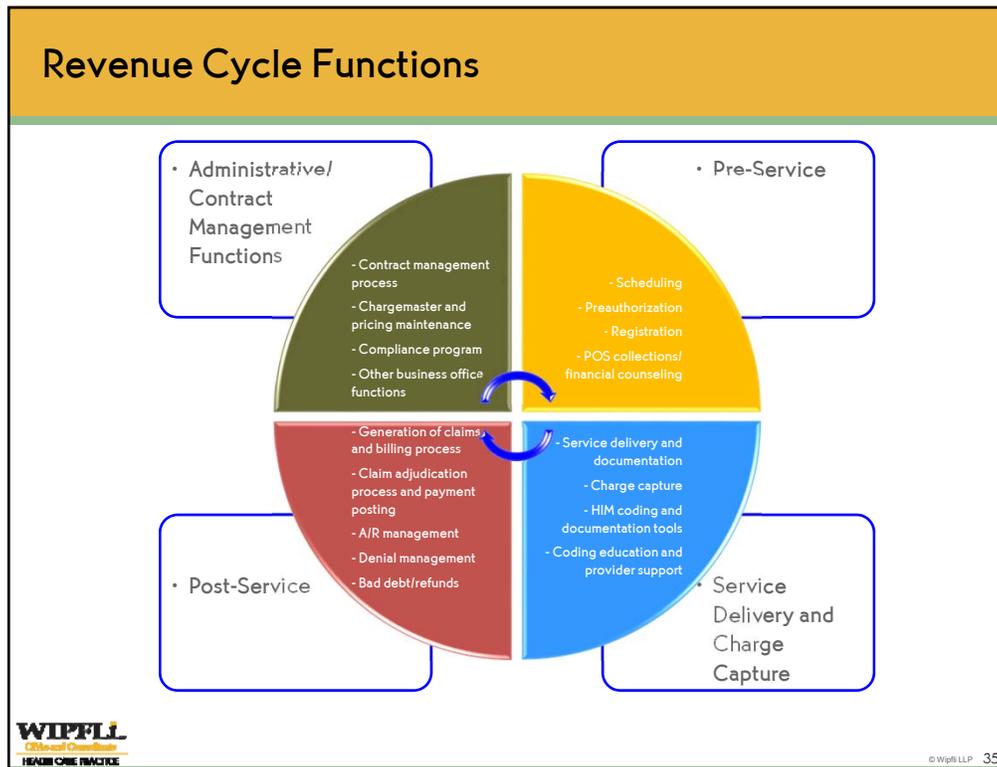

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Billing and Collections

Leadership . . . Goal to increase collections and improve profitability.

Business Office . . . Goal to identify and remove barriers to collecting payments and increasing payments received.

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Revenue Cycle Functions

- Administrative/ Contract Management Functions
  - Contract management process
  - Chargemaster and pricing maintenance
  - Compliance program
  - Other business office functions

- Pre-Service
  - Scheduling
  - Preauthorization
  - Registration
  - POS collections/ financial counseling

- Post-Service
  - Generation of claims and billing process
  - Claim adjudication process and payment posting
  - A/R management
  - Denial management
  - Bad debt/refunds

- Service Delivery and Charge Capture
  - Service delivery and documentation
  - Charge capture
  - HIM coding and documentation tools
  - Coding education and provider support

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Billing and Collections

Payer Denial Review and Analysis

Top denials (and ensuing write-offs) generally fall under a limited number of categories, frequently issues that are avoidable.

Top 20 Denials/Write-Off Analysis

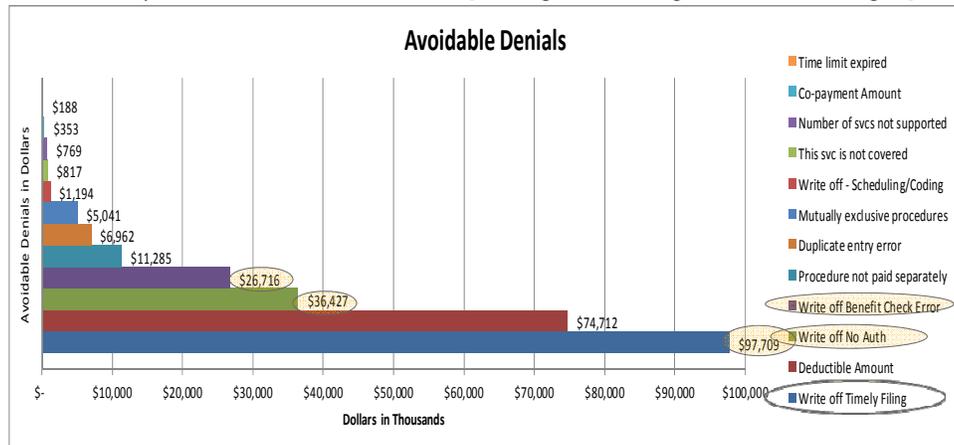| Code Description	Un-Avoidable	Avoidable	Total Write-off $	Total Write-off %
Write-off timely filing		$ 97,709	$ 97,709	37%
Write-off no auth		$ 36,427	$ 36,427	14%
Write-off benefit check error		$ 26,716	$ 26,716	10%
Deductible write-off	$ 74,712		$ 74,712	28%
Procedure not paid separately	$ 11,285		$ 11,285	4%
Charges exceed contracted fee	$ 7,620		$ 7,620	3%
Mutually exclusive procedures	$ 5,041		$ 5,041	2%
Totals	$ 101,034	$ 164,172	$ 265,206	
	38%	62%		

Denials with <2% impact are hidden

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Billing and Collections

Pre-Service Data Accuracy

Most of this clinic's denials could have been avoided. Two of the top four are intake/pre-service focused. Timely filing is the largest denial category!

Avoidable Denials

Legend:
- Time limit expired
- Co-payment Amount
- Number of svcs not supported
- This svc is not covered
- Write off - Scheduling/Coding
- Mutually exclusive procedures
- Duplicate entry error
- Procedure not paid separately
- Write off Benefit Check Error
- Write off No Auth
- Deductible Amount
- Write off Timely Filing

Values: $188, $353, $769, $817, $1,194, $5,041, $6,962, $11,285, $26,716, $36,427, $74,712, $97,709

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Billing and Collections

Top Medicare Claim Errors *(NGS, February 2017)*

B-7:
- This provider was not certified/eligible to be paid for this procedure/service on this date of service.

CO-19:
- Claim not covered by this payer/contractor.

CO-140:
- Patient/insured health identification number and name do not match.

CO-B9:
- Patient is enrolled in hospice.

MA-122:
- Missing/incomplete/invalid initial treatment date.

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Billing and Collections

Payer Contract Management Process

- Do you use a payer "report card" approach to analyzing contracts?
  - Payment accuracy rate
  - Number of days in A/R
  - Pattern for accounts past 60 days in A/R
  - Percentage of claims under appeal
  - Percentage of claims reprocessed
  - Ease of customer service
- Who are your "best" and "worst" payers?

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Billing and Collections

Metrics to Be Tracked

- Percentage of avoidable claim denials (decreasing - target 0%).
- Percentage of new patients having eligibility and benefits checked before service (target 100%).
- Percentage of eligible copays collected (increasing).
- Average total charges per encounter (consistency).
- Provider/coder team coding accuracy rate (improving).
- E/M utilization patterns compared to:
  - External same-specialty norms.
  - Internal same-specialty use.

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Revenue Cycle Metrics – Contract Management

Metrics to Be Tracked

- Practice payer mix and recent trends
- Payer contract provisions and comparative performance/grading
- Collection/payment rates by payer
- Payer profitability analysis (comparison of payer reimbursement and cost of services provided)
- Fee schedule/chargemaster maintenance

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Summary and Conclusion

Summary and Conclusion

Rallying around an improvement project can:

- Connect and align leadership and business office
- Create teamwork and transparency
- Remove departmental barriers
- Enhance communication
- Improve results!

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Summary and Conclusion

Improvement Team Tasks

- Identify leadership goals and objectives.
- Perform initial assessment:
  - Establish metrics and identify benchmarks
  - Determine baseline performance and gaps
  - Develop improvement targets/goals
  - Document the "current state"

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Summary and Conclusion

Improvement Team Tasks (Continued)

- Conduct formal meetings (structured, scheduled, with agendas and minutes) within departments and across them.
- Integrate staff accountability and rewards for reaching targets.
- Report progress broadly, and celebrate successes.
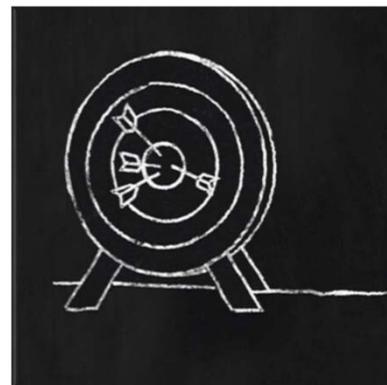

Questions?

Thank you!

Today's Presenters:

Jeff Bramschreiber, CPA
Partner, Health Care Practice
920.662.2822
jbramschreiber@wipfli.com

Vicki Mueller, CPA
Director, Health Care Practice
920.662.2890
vmueller@wipfli.com

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