Iron County Medical Center

Revenue Cycle Management and Physician Practice Management Process Improvement Project

BKD Health Care Performance Advisory Services

BKD
CPAs & Advisors

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Program Statement

Delta Region Community Health System Development (DRCHSD) Program

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U65RH31261, Delta Region Health Systems Development, $4,000,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Letter

April 22, 2019

Josh Gilmore
CEO/Administrator
Iron County Medical Center
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On behalf of the Delta Region Community Health System Development (DRCHSD) Program, BKD CPAs and Advisors were engaged by The National Rural Health Resource Center (the Center) to provide consulting services for Iron County Medical Center (ICMC, or the Hospital) executive leadership and Board of Directors (BOD). The DRCHSD Program supported this project for ICMC to assist leadership with improving revenue cycle management (RCM) and physician practice management (PPM) processes.

We have completed our analysis of the Hospital RCM and PPM processes and procedures at ICMC. Our services were performed and this report was developed in accordance with our engagement letter dated February 5, 2019, and is subject to the terms and conditions included therein.

We were engaged to provide an analysis of the Hospital RCM and PPM processes and procedures. We have not performed an examination and are not providing any opinion or assurance with respect to our engagement. Likewise, we did not verify or audit any information provided to us. Our work was limited to the procedures described in our above-referenced engagement letter. Had we performed additional procedures, other matters may have come to our attention that would have been reported to you.

This letter is intended solely for the information and use of ICMC executive leadership and BOD and should not be otherwise distributed to third parties not knowledgeable about the information.
We look forward to discussing our report with you at your convenience.

BKD, LLP

Executive Summary

On behalf of the Delta Region Community Health System Development (DRCHSD) Program, BKD CPAs and Advisors were engaged by The National Rural Health Resource Center (the Center) to provide consulting services for Iron County Medical Center (ICMC, or the Hospital) executive leadership and Board of Directors (BOD). The DRCHSD Program supported this project for ICMC to assist leadership with improving revenue cycle management (RCM) and physician practice management (PPM) processes.

BKD performed specific procedures designed to analyze the Hospital's RCM and PPM processes and procedures. Our procedures were performed during January and February 2019, including two days during which BKD personnel were on site at the Hospital. For both the Hospital RCM and PPM analyses, key findings are summarized into a "Top Recommendations" format with suggestions supporting the implementation strategies. Key strategic and environmental considerations underlying both analyses include the following:

- Leadership is actively restructuring the organization to improve financial performance, identify operational efficiencies, and secure access to health care services for the community.
- Leadership continues to build and grow its primary care network in the local market through outreach efforts, community engagement, and an active physician recruitment strategy.
- The Hospital has historically experienced turnover in management positions but has stabilized under current leadership. As the Hospital's financial position improves, leadership is encouraged to consider strategic hires that are additive to improving operational efficiencies and improving the financial position of the Hospital.
- The Hospital is currently implementing a strategic plan to address a number of key operational, clinical and financial areas. Leadership is encouraged to continue to assess and update the plan to reflect ongoing strategic initiatives and consider DRCHSD services that support planning efforts.

Revenue Cycle Management Report and Recommendations

This report presents our findings regarding existing operations in effect on the last day of our visit, Thursday, January 10, 2019, and our resulting observations and recommendations based on interviews with key revenue cycle departments and financial management. We understand that some process improvements may have been incorporated into the Hospital's procedures since our assessment.

Recommendations pertaining to the Hospital's revenue cycle, which follow, were made after a high-level analysis of current Hospital operations and are based primarily on comparisons to available benchmarks, accepted industry best practices from the Healthcare Financial Management Association (HFMA), Key Performance Indicators (KPIs) and the Health Information and Management Systems Society (HIMSS), as well as our experience with other community hospitals. This assessment was not intended to be a complete analysis of all operational procedures and, therefore, would not be expected to identify all opportunities for improvement.

Billing

Overview

The key objective of the billing function is to ensure that a process exists for claim submission in a timely and accurate manner that meets federal, state and other billing guidelines. Health care industry experts estimate that 25% to 30% of all health care claims are denied or rejected. Delays or errors in the initial billing process, or in following up on unpaid or denied claims, could lead to cash flow delays and account balance write-offs.

Summary of Current State

The Hospital has a dedicated billing team consisting of three billers which receive Medicare billing compliance training through Medicare webinars. There is currently one Medicare biller and one Medicaid biller. The Medicare biller has created a Medicare billing policy and procedure manual for the other billers to access when she is not available. The billers report directly to the Billing Office Coordinator.

- Productivity and performance measurement standards are discussed during morning huddles creating individual and team accountability.
- The current accounts receivable (A/R) days are 46, as of January 9, 2019, which is at best practice level for small rural hospitals.
- The billers correct claim edits prior to claim submissions.
- The most common front-end errors are due to outpatient medical necessity (diagnosis) errors related to physician orders for reference lab procedures.
- The most common back-end errors are due to Emergency Room (ER) registration errors.
- A position was recently created in the ER to perform ER registration accuracy audits.
- The department is meeting its policy to bill within 72 hours of discharge, which is consistent with industry best practice.

- The Hospital tracks and monitors six key performance indicators (KPI) to drive performance and should consider implementation of a dashboard to include additional KPIs such as those listed in Table 1 below.

Recommendations to Optimize Billing and Claim Submissions

- Ensure all billers receive annual Medicare compliance training.
- Create biller-specific productivity and error reporting and trend results.
- Monitoring of billing performance for continuous improvement is imperative to ensure that employees are productive and performing quality standards. An attempt should be made to monitor activities in real time or require employees to perform daily activity tracking, at a minimum. Biller quality should be analyzed through a defined process of feedback from downstream functions related to billing and claim submission quality and effectiveness. The Hospital compliance plan should serve as a guidepost for the integrity of billing functions as well as the monitoring of staff performance.
- Continue to adopt standards of performance such as those listed in the Table 1 below.

Table 1: Key Revenue Cycle Management Indicators

KPI	*KPI Day or Percentage*	*Hospital KPI Reported*
Days from Discharge to Bill	3–5 Days	3–5 Days
Clean Claim Rate	95%	73 %
% of POS Collections to Revenue	5% of Self Pay	5%
Rebill % of Total Primary Claims Billed	< 5%	No Report
Registration Accuracy Rate	97%	50%
Registration Denials as % of Total Revenue	< 3%	No Report
Gross Days in A/R	40–50 Days	46 Days
% of Net Revenue Collected	100%	90%

Patient Registration

Overview

The patient access and registration functions ensure accurate patient financial information prior to receiving services or directly upon admission to avoid claims rejections or denials. Continuous evaluation of the quality of registrations is imperative to the patient's overall impression of the organization's billing process. Registration is the point of entry where patients form their first impressions of the Hospital. There should be a focus on quality and accountability for errors.

Summary of Current State

- There are registration staff in the outpatient departments, the specialty clinic and emergency department.

- Financial counseling is attempted at the time of registration, and all uninsured patients are screened for Medicaid eligibility.
- Registrars are requesting copays and discussing financial responsibility, but there is opportunity to evaluate accuracy through individualized monitoring efforts.

Recommended Processes to Optimize Patient Registration

- Utilize online documentation systems to facilitate the management of patient insurance cards, driver's license, financial assistance applications, income documentation requirements for those applications, and other written communications.
- Due to current limitations of the practice management software, there may be opportunities to increase the percentage of Advance Beneficiary Notices (ABNs) obtained when medical necessity is checked at the time of registration.
- Encourage consistent messaging among registration staff when discussing patient payment obligations and options for payment.
- When required, ABNs should be obtained 100% of the time.
- Perform insurance verification with each registration.

The following list of common, preventable registration errors seen in rural hospitals is provided to assist the Hospital with focused areas for in-service training:

- Wrong insurance plan, and/or missing or invalid policy or group number
- Patient not eligible on date of service
- Private pay patient with insurance
- Medicare primary when patient is covered with Medicare HMO
- Medicare listed as primary and should be secondary
- Duplicate medical record numbers
- Medical necessity
- Missing prior-authorizations or pre-certifications
- Transposed digits for SSN, DOB, Policy or Group #
- Address verification failure
- POS collection failure

Patient Registration Improvement Opportunities

1. Evaluate and adopt standardized policies and procedures as needed to ensure authorization documents are obtained prior to service.
2. Ensure all other documents necessary for registration are timely and accurate.

Financial Counseling

Overview

Financial counseling should focus on identifying eligibility for third-party sponsorship and/or eligibility for charity care under state, local or Hospital programs. Financial counselors should provide estimates for patient out-of-pocket expenses, collect patient out-of-pocket expenses and negotiate payment plans for the remaining patient balances.

Summary of Current State

A financial counselor was recently hired to improve financial yield by performing the following functions:

- Actively monitor and work collections
- Review radiology and infusion schedules to ensure the procedures are pre-certified prior to the procedures being performed
- Communicate with all inpatient admissions regarding payments prior to discharge
- Ensure authorizations are available on orders prior to registration
- Screen all patients for Medicaid eligibility

Recommended Processes to Optimize Financial Counseling

- Patients registered as Medicare only should be screened for active Medicaid eligibility and/or eligibility for state, local or hospital financial assistance programs.
- Leverage online technology solutions for Medicaid and financial assistance applications.
- Patients with prior balances should be notified timely, and steps toward amicable resolutions should be made.
- Adopt standards of performance such as those in Table 2 below:

Table 2: Key Performance Indicators (KPIs) for Financial Counseling

KPI	*Best Practice Standards*	*Hospital Baseline*
Medicaid eligibility screening for uninsured patients	100%	95%
Medicaid eligibility screening for Medicare only patients	100%	95%
% uninsured IPs screened for financial assistance	95%	100%
% emergency department patients screened for financial assistance	80%	100%
% deposits collected for elective services prior to service	100%	50%
% IP patient-pay balances collected prior to discharge	65%	< 10%
% of time options for account resolutions are discussed with IPS	100%	100%
% of financial assistance applications approved within 10 days	100%	100%
% of Medicaid approvals received within 30 days	100%	50%

Collections

Overview

Effective collections start with properly engaging the patient well in advance of rendering care. Patients expect timely, clear and concise financial information, as well as a fair process for resolving payment issues.

Summary of Current State

- One staff person performs up-front collections and ensures patients receive three statements prior to collections according to the Hospital collections policy.
- Hospital outpatient registrars have low registration error rates, compared to most peer rural hospitals, and regularly perform insurance eligibility checks.
- There is an opportunity to improve the current financial position of the Hospital by consistently collecting copays and patient balances.

Recommended Processes to Optimize Collections for Registration Staff

- Educate and verbally communicate collection policies with patients prior to the time of service.
- Demonstrate consistency in key aspects of timely account resolution from billing disputes to payment resolution.
- Avoid duplicate patient contacts.
- Offer financial counseling and clear communications regarding collections policies to patient or family members in the ER after the patient is stabilized.
- Verify insurance eligibility for non-emergency patients before and/or during treatment.
- Begin initial payment collection at the time of ER visits and after initial medical screening.
- Create work-lists for high-dollar accounts.
- Establish routine monitoring of the performance of selected collection vendors to assess results and return on investment.
- Provide remote access to the collection vendor's information system for accessing reports.

Note: As a result of the highly publicized Emergency Medical Treatment and Active Labor Act (EMTALA) violations and other industry-wide consumer oriented legal initiatives such as the Medical Debt Responsibility Act, the health care industry's POS collection practices are under increasing scrutiny. The Hospital's ER collection efforts must be aligned with the EMTALA regulations. ER POS collections represent an opportunity to collect 1% to 3% more in net revenue.

Denials

Overview

The process for denial management can have a major impact on the Hospital's bottom line. Managing denials requires a process that enables staff to identify trends and take proactive, corrective action. High-performing hospitals focus on account management to build accountability within the departments.

Summary of Current State

- The Hospital has a denial tracking system embedded in Athena, but may be unable to financially support a full denials management team.
- The majority of denials are tied to front-end eligibility and registration errors mainly from the emergency room.
- The current front-end denial rate is at 16.9% compared to a KPI of <4%.

Recommendations:

BKD recommends that the Hospital follow best practices for denial management by closely monitoring the criterion listed below from the account/remittance advice:

- Payor and type
- Reason
- Department
- Percentage of revenue submitted
- Denials as percent of gross revenue
- Denial over-turned (percentage)
- Payor rejects as percent of remit revenue processed

Revenue Integrity/Charge Description Master (CDM)

Overview

The CDM is one of the most complex master files within the Hospital's revenue cycle and is subject to many updates, often quarterly. Ongoing maintenance is essential to ensure proper charging for services and supplies within financial and regulatory parameters and will aid in risk mitigation.

Summary of Current State

- One staff person currently maintains and manages edits to the CDM. The last CDM assessment was performed in June of 2017.
- The Hospital receives quarterly updates through a product embedded in Athena which interfaces with TruCode encoder software.
- The Hospital successfully responded to recent regulatory changes and posted the current charge master to their website effective January 1, 2019.
- The Hospital has a current pricing policy and increases rates annually.

Recommended Processes to Optimize CDM Maintenance

- Develop a CDM committee that includes representation from clinical and business departments as well as health information management (HIM)

Emergency Department (ER) Evaluation and Management (E/M) Services Reporting

Overview

A part of the Federal Balanced Budget Act of 1997 required HCFA (now CMS) to create a new Medicare "Outpatient Prospective Payment System" (OPPS) for hospital outpatient services, which is analogous to the Medicare prospective payment system for hospital inpatients known as "Diagnosis Related Groups" or DRGs. APCs or "Ambulatory Payment Classifications" are the government's method of paying for facility outpatient services for the Medicare program. APCs apply only to hospitals and have no impact on physician payments under the Medicare Physician Fee Schedule.

Facility coding guidelines are inherently different from professional coding guidelines. Facility coding reflects the volume and intensity of resources utilized by the facility to provide patient care, whereas professional codes are determined based on the complexity and intensity of provider performed work and include the cognitive effort expended by the provider. As such, there is no definitive strong correlation between facility and professional coding and, thus, no rational basis for the application of one set of derived codes, either facility or professional, to the determination of the other on a case-by-case basis.

Summary of Current State

- The facility-based ER E/M levels are being reported based on the Hospital's E/M acuity level score sheet that has not been updated in several years.
- One coder captures all infusions, injections and ER bedside procedures.
- 12–15 ER charts are coded per day.
- 98% of admissions come from the ER.

Chart 1 below represents the bell curve of the Hospital's ER visit distribution for dates of services January 1, 2018, to December 31, 2018:

Chart 1: Hospital ER Facility Claim E/M Distribution

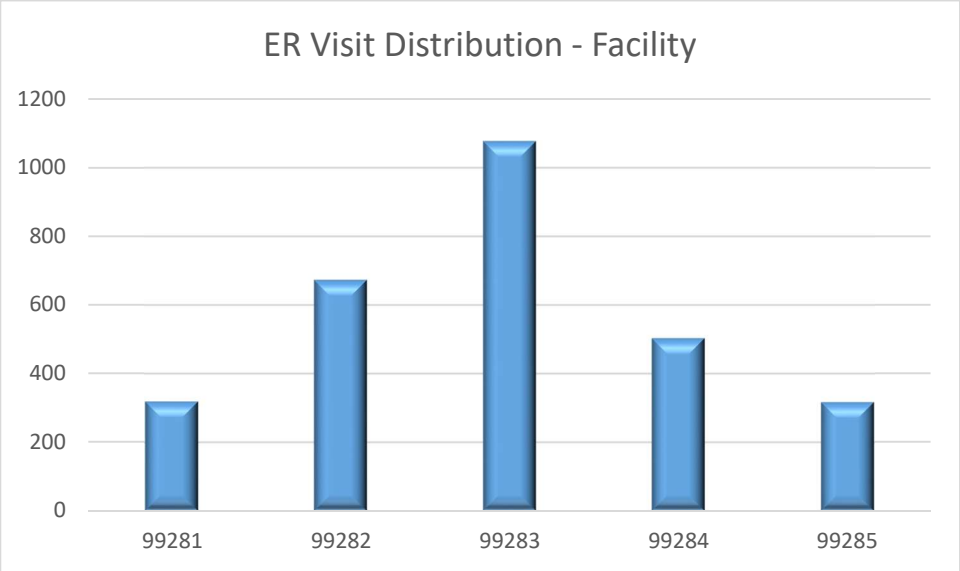
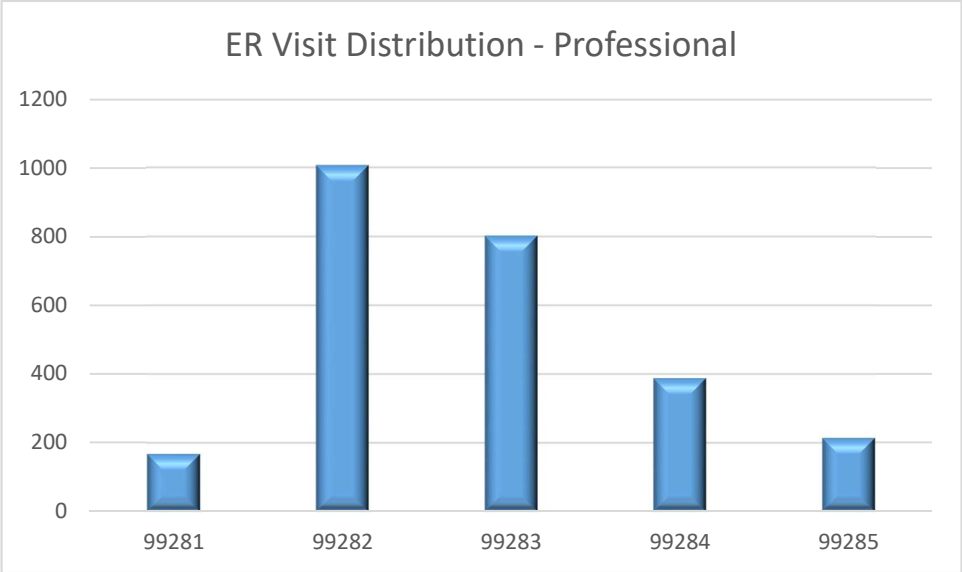


Chart 2 below represents the bell curve of the physician' ER visit distribution for dates of services January 1, 2018, to December 31, 2018:

Chart 2: Hospital ER Professional Claims E/M Distribution



The distribution is high for the mid-level 99282 E/M code. We would expect to see a more even distribution between all levels, including levels 3 and 4.

Health Information Management (HIM)

Overview

Clean claim submission is dependent on completion of the coding processes. Errors and delays in the process will impair revenue cycle performance. Operational controls should be established to monitor performance of the tasks in completing the coding process.

Summary of Current State

- The HIM director is a certified contractor that does not work on site.
- The HIM department has two certified coders, certified through the American Academy of Professional Coders (AAPC).
- All coding is being completed when information is sufficient, not 100% complete.
- The HIM director utilizes TruCode encoder for coding purposes.

Recommended Processes to Optimize HIM

- Provide alerts for incomplete cases > 5 days after discharge
- Provide alerts for incomplete or late queries
- Obtain and review the Program for Evaluating Payment Patterns Electronic Report (PEPPER).
- Adopt standards of performance for the Hospital such as those in Table 3 below:

Table 3: Key Performance Indicators (KPIs) for HIM Coding

Key Performance Outcome Measures and Productivity HIM Coding	***Best Practice Standards***
DNFB* HIM work in process % of revenue or A/R days	5%
Avg. days in pending queue from entry into queue	3
Avg. days in pending queue days from DOS or discharge	3
Coding status incomplete > 5 days (DNFB) a total cases	5%
IP charts coded per coder per day	20–30
Observation charts coded per day per coder	30–40
Outpatient surgery charts coded per coder per day	3–34
OP charts coded per coder per day	150–210
ER charts coded per coder per day	150–210

**DNFB (Discharged Not Final Billed)*

Utilization Review/Case Management (UR/CM)

Overview

Case management activities are dependent on access to significant real-time clinical data on each admission, as well as access to rules and guidelines governing the definition of what admission parameters are within the realm of reimbursable care. Admission and clinical data are required on each admission, including real-time information on elapsed time from admission, expected duration of admission and clinical parameters of the admission. Best practice for a rural hospital is for the case manager to report to the chief financial officer, and clinical senior management to promote the delivery of care in an efficient manner. It is essential the case manager have a means of escalation within the hierarchy of both clinical practice and management.

Summary of Current State

- Two RN staff persons perform UR/CM functions.
- Average Length of Stay (LOS) is 2.1 days.
- There is a dedicated UR committee and plan.
- InterQual admission criteria is utilized by the UR/CM nurses to support medical necessity of inpatient status.

- Alerts on observation cases are obtained where LOS is approaching the 24-hour limit.
- Alerts on cases approaching a previously defined limit on inpatient days of care, whether defined by Medicare's Two Midnight Rule or precertification of care by the patient's insurance are obtained.
- A daily inpatient census with admission and clinical data is kept.
- Alerts to physicians and management on cases approaching a previously defined limit on inpatient days of care are provided.
- Alerts to physicians and management on cases where the discharge will require continued care, *i.e.*, home care or transfer to another facility or SNF or other long-term care are provided.
- Operational reports of delayed discharges with aging, reason for delay and associated costs of delay are provided.

Recommended Processes to Optimize UR/CM

- Adopt standards of performance for the Hospital such as those in Table 4 below:

Table 4: Key Performance Indicators (KPIs) for UR/CM

Key Performance Indicators UR/CM	***Best Practice Standards***
Observation cases w/LOS > 24 hours	0%
Cases denied reimbursement due to "inappropriate admission"	0%
Cases w/discharge delays (by reason for delay)	0%
Ratio of the LOS actual average over expected average	1:1
Current admission population on SNF wait list	9%

Table 5 below is provided to summarize our recommendations related to the Hospital RCM.

Table 5: Review of Top RCM Recommendations

1	Adopt process to monitor up-front collections of the outpatient Hospital registrars to identify and measure opportunities for improvement.
2	Continue efforts to develop a business office related compliance program that will strengthen collection processes.
3	Develop departmental and individualized productivity measures and monitoring for the billers.
4	Develop a process to monitor and manage denials and contract compliance..
5	Restructure ER registration processes and assess oversight to reduce denials associated with front-end eligibility and registration errors.
6	Consider cross-training billers on different payor methodologies to improve productivity and accuracy.
7	Continue to adopt the standards of performance, monitor and report for the following financial KPIs: • Rebill % of Total Primary Claims Billed • Registration Denials as % of Total Revenue • Rebill % of Total Primary Claims Billed

Physician Practice Management Report and Recommendations

Overview of Services Provided

On behalf of the DRCHSD Program, BKD CPAs and Advisors were engaged by the Center to provide consulting services for ICMC executive leadership and BOD. The DRCHSD Program supported this project for ICMC to assist leadership with improving RCM and PPM processes. BKD performed specific procedures designed to evaluate certain business and clinical operations, including registration, scheduling, check-in, medical record documentation and coding processes, claims processing, provider productivity and compensation with benchmarking, and levels of physician alignment.

This summary addresses the results of the procedures performed. Specifically, BKD assisted by conducting on-site interviews with key management and members of clinic staff, analyzing practice information, evaluating workflow processes and reviewing key performance indicators against established benchmarks. BKD also conducted interviews with providers practicing in the Hospital and the Family Care Rural Health Clinic (RHC) with the intent of targeting key aspects of practice operations which affect Hospital profitability.

Patient Scheduling and Registration

Overview

The patient scheduling and registration functions ensure accurate patient financial information prior to receiving services or directly upon check-in to avoid claims rejections or denials. Continuous evaluation of the quality of registrations is imperative to the patient's overall impression of the RHC and Specialty clinic's billing process. Registration is the point of entry where a patient forms their first impression of the clinic. There should be a focus of quality and accountability for errors.

Summary of Current State

Hospital and clinic management continue to lead efforts and make progress on patient scheduling and registration accuracy, including providing consistent training and education to clinic staff. Through clinic discussion with staff, it was noted there are some minor registration errors that occur at the specialty clinic and RHC. The discrepancies are corrected by the billers during the daily review process in conjunction with the scrubber software to prevent claims from being denied by payors. The most common discrepancies as reported by clinic billers and management are patient insurance listed incorrectly in the system and incorrect date of birth.

RHC management began tracking no show patient visit amounts starting in September 2018. High no-show rates can be the cause for many clinic operational inefficiencies and creates holes or "down time" during the day creating lost revenue implications for the clinic. While the RHC is not at full capacity from a volume standpoint (410 patient visits per month on average from September 2018 to December 2018), excessive no-shows could exacerbate clinic inefficiencies if RHC volumes begin to increase.

Table 6 below contains the number of no-shows by provider since RHC management began tracking.

Table 6: RHC September 2018 through December 2018 No Shows

Provider	Sept-2018	Oct-2018	Nov-2018	Dec-2018	Monthly Average
Byerley, FNP	5	12	10	11	9.50
Savage, FNP	9	9	10	11	9.75
Garriga, MD	11	10	6	8	8.75
Yankowitz, DPM	2	2	1	6	2.75
Total	***27***	***32***	***30***	***36***	***31.25***

The RHC management no-show and patient visit tracker is a good start to monitoring the scheduling processes and ensuring the clinic check-in operations are efficient throughout the day. By developing a no-show rate metric, which measures the number of no shows against the number of scheduled patient encounters, the RHC will be able to glean more context around current performance and benchmark against the industry best practice of < 5%.

Recommendations

Below are recommendations related to patient scheduling and registration opportunities:

- Identify and monitor the most common registration errors occurring to establish benchmarks for clinic performance. Metrics should be tracked on a monthly basis and reported to management and associated clinic physicians. Filters for clinic, provider, error type and receptionist should be included in the report.
- Calculate clinic no-show rate, continue to track the number of new and established patient visits scheduled and completed, number of cancellations, and number of walk-in visits on a daily basis.

RHC Productivity Levels

Overview

Ensuring providers maintain a busy clinic schedule is a key factor in ensuring the community receives timely access to appropriate medical care and prevents patients from leaving the area to seek services elsewhere. Tracking and monitoring provider productivity is essential to understanding how the clinic is performing operationally and also allows management to understand capacity of providers to take on additional patients prior to recruiting another provider which is time-intensive and can be very costly.

Summary of Current State

Utilizing Work Relative Value Units (wRVUs) is the most common and accepted standard method of comparing providers' productivity against their peers. BKD obtained clinic Common Procedural Terminology (CPT) codes and calculated wRVU amounts for Dr. Garriga and Nurse Practitioners

Jennifer Savage and Susan Byerley Skinner for June 2018 through November 2018 from billing data provided by ICMC.

WRVU totals were calculated for six months and annualized for market data comparison purposes as outlined in Table 7 below. Based on wRVU productivity benchmarks from the Southern U.S. Region, Dr. Garriga is performing at the 33rd percentile of productivity. It was noted he held clinic several days a week as a primary care provider at the RHC, seeing routine patients for primary care services in order to assist with clinic demand and to maintain compliance with RHC regulations.

Jennifer Savage is performing at the 51st percentile, which includes her professional services for nursing home patients at the hospital. While her productivity is in line with market comparisons, there is still capacity for her to see more patients if demand at the RHC increases.

Susan Byerley is performing at the 17th percentile, indicating she has additional capacity at the clinic. It was noted Mrs. Byerley sees many of the pediatric patients that present at the RHC, which is important to be able to provide these services to the community. To account for this pattern, we have blended family medicine and pediatric specialty benchmarks for a comparison that more closely matches her patient panel.

Table 7: Provider wRVU Benchmarking

			Market Data Benchmarks				
Provider	**Total wRVUs**	**Ranking**	**10th %tile**	**25th %tile**	**Median**	**75th %tile**	**90th %tile**
Francisco Garriga, MD	4,040	33P	3,018	3,885	4,770	5,856	7,123
Jennifer Savage, FNP	3,271	51P	1,613	2,436	3,225	4,053	4,971
Susan Byerley, FNP	1,784	17P	1,311	2,287	3,211	4,064	4,909

Note: Data represents Work Relative Value Unit (wRVU) benchmarks for a Rheumatologist and FNPs located in the Southern U.S. region, based on a blend of Medical Group Management Association (MGMA), Sullivan Cotter Association (SCA) and American Medical Group Association (AMGA) 2018 market surveys. Susan Byerley benchmarks are an equal blended benchmark of FNP Family Medicine and NP Pediatrics specialties.

It was also noted during interviews that Dr. Garriga does not see patients younger than 14 years of age at the RHC for primary care services due to his Internal Medical specialty requirements. To provide appropriate levels of coverage for pediatric patients, Dr. Paul Rains, DO, is scheduled to provide coverage a few days a week along with the nurse practitioner regular office hours. BKD noted that ICMC leadership is actively seeking recruitment of a family medicine physician into the area in order to provide a more consistent physician primary care presence and to allow Dr. Garriga to focus his attention on Rheumatology patients.

Recommendation

Expand current utilization of pay for performance plans for providers by developing a benchmarking comparison of provider data to market data. Benchmarking should include best practices in compensation calculations based on wRVUs in cases with lower volumes. The benchmarking comparison should be measured and reported to providers on a monthly basis.

Physician Operations – Charge Lag

Overview

Minimizing the Lag Time (date of service to date of bill release) is critical to a timely and efficient billing and collections process. Clinic providers, coders and staff responsible for charge entry all play a role in minimizing Charge Lag Time. The inability to effectively manage lag time can result in financial implications related to timely filing and potentially missed charges.

Summary of Current State

It was noted during conversations with revenue cycle and clinic management (RHC & specialty clinic), that great focus has been placed on reducing Charge Lag Time. The industry target for lag time is less than three days in the clinic setting.

Currently the six-month average for the RHC is 5.4 days (above target), while the specialty clinic is 2.5 days (below target). Table 8 below provides monthly detail by provider and clinic. Based on industry experience, this is very good performance for clinics in a rural health care setting.

Table 8: Charge Lag by Clinic and Providers

RHC	Jun – 2018	Jul – 2018	Aug -- 2018	Sept -- 2018	Oct – 2018	Nov -- 2018	6 mo. CAGR	6 mo. AVG (Days)
RHC Total	**2.13**	**7.86**	**2.52**	**7.96**	**2.04**	**6.28**	***24.0%***	**5.4**
Garriga, MD	2.30	2.71	1.91	2.16	1.97	2.12	***-2.0%***	**2.2**
Savage, FNP	2.20	12.39	3.38	12.14	2.12	8.70	***32.0%***	**8.7**
Yankowitz, DPM	2.75	2.12	2.37	3.58	2.65	2.94	***1.0%***	**2.7**
Byerley, FNP	1.83	1.93	1.83	2.11	1.92	1.95	***1.0%***	**1.7**

Note: Source is ICMC Revenue by Charge Code report filtered by service department Charge lag was calculated based on service date and post date for each encounter.

Specialty	Jun – 2018	Jul – 2018	Aug -- 2018	Sept -- 2018	Oct – 2018	Nov -- 2018	6 mo. CAGR	6 mo. AVG (Days)
Specialty Clinic Totals	6.9	4.8	1.9	1.0	1.8	1.0	***-39.0%***	**2.5**

Note: Source is ICMC Revenue by Charge Code report filtered by service department Charge lag was calculated based on service date and post date for each encounter.

Overall, it was observed that the focused efforts have improved the lag time across the clinics; however, Jennifer Savage, FNP, appears to be an outlier pushing the RHC above the target threshold due to nursing home rounds five to six days per month.

Recommendations

Measure and monitor provider and clinic lag time on a weekly basis, continue to maintain performance overall, and identify root-cause issues driving the high lag time for Mrs. Savage when it occurs.

The following is recommended lag time best practices policy:

- Providers will be responsible for documenting all services within 24 hours of the date of service. Providers to submit all procedures and diagnosis codes within 24 hours of rendering services in the office, and 48 hours for services out of the office.
- Charges should be entered within 48 hours of the date of coding.
- Up to 48 hours should be allotted for staff to review and edit charges before submitting. This period is between the date of coding and the date of charge entry.
- Staff will submit claims within 72 hours of charge entry.
- Staff to submit claims on a daily basis.
- Lag times for key processes:
    - Date of service to date of documentation: 0 to 24 hours
    - Date of documentation to date of coding: 0 to 48 hours
    - Date of coding to date of charge entry: 0 to 48 hours
    - Date of charge entry to date of claim release: 24 to 72 hours
- Any outlier for the above processes should be reported to clinic and revenue cycle management, and a performance improvement initiative should be enacted.

Physician Operations – PPM Operations KPIs

Overview

A KPI dashboard for practice management is a critical tool utilized to manage the operations and financial performance of a medical practice. The KPI dashboard serves as a barometer for performance in many key areas that can alert executives and management of potential problem and allows them to proactively take action to resolve those problems.

Summary of Current State

Currently RHC and specialty practice management tracks the number of patient visits and no shows on a weekly basis. The ICMC finance department also calculates operational stats (number of visits, imaging tests, etc. by provider and location) to understand productivity and volume trends. It was also noted that practice management staff will receive revenue cycle metrics for

review from the business office periodically. Providing this information is essential to aiding the practice managers in identifying improvement opportunities within the clinic.

Recommendations

There are four common areas that practice management typically tracks and monitors practice revenue cycle performance. They are as follows:

- A/R & Collections
- Patient Access
- Charge Entry
- Account Resolution

Select four metrics—one at least from each category—from the example scorecard attached in Appendix A and track on an ongoing basis. Metrics should be selected through collaboration between the business office and clinical management. Metric definitions can be found in Appendix B. It is recommended the four metrics will be in addition to the physician practice management KPIs listed in Table 9 below.

The provider wRVU benchmarking metrics below were addressed in the RHC Productivity Levels section above and Charge Lag time was addressed in the Physician Operations – Charge Lag section. Currently, ICMC executive leadership tracks physician percentage of A/R over 90 days. At the time of this report, A/R over 90 days was 24%, which is slightly higher than best practices but good performance for rural health care providers based on industry experience.

The metrics should be reviewed by ICMC executive leadership monthly and by any management committees as deemed appropriate by ICMC executive leadership. These metrics should also be a part of an overall practice management KPI dashboard that incorporates productivity metrics listed above.

Table 9: Baseline Physician Practice Management Tracking Measures

Anticipated Outcome	Tracking Measure	Standard	Hospital Target Level	Baseline Value at Time of Report
Enhanced Provider Productivity(1)	Family Medicine Physician	4,700 – 5,200	5,200	N/A – benchmark & target for future physicians
	Rheumatology Physician (with primary care clinic)	5,000 -- 6,000	6,000	4,040
	Advanced Practitioner – Family Medicine/Child Health	3,200 – 4,000 wRVU	4,000 wRVUs	3,271 (Savage) / 1,784 (Byerley)
Enhanced Revenue Capture	Denial rate	7%	TBD	In development
	Percentage of A/R over 90 days(2)	18.8%	15%	24.0% (as of 01.03.2019)
	Charge Lag(3)	< 3 days	< 3 days	RHC (5.4 days) / Specialty Clinic (2.5 days)

(1) Data represents Work Relative Value Unit (wRVU) benchmarks for a Rheumatologist and FNPs located in the Southern U.S. region, based on a blend of Medical Group Management Association (MGMA), Sullivan Cotter Association (SCA) and American Medical Group Association (AMGA) 2018 market surveys. Susan Byerley benchmarks are an equal blended benchmark of FNP Family Medicine and NP Pediatrics specialties.

(2) Source is ICMC Physician A/R Aging Report as of 01.03.2019. Baseline value includes all physician departments. Emergency Room, Med Surg, Outpatient Services, RHC, Specialty Clinic and Operating Room included.

(3) Source is ICMC Revenue by Charge Code report filtered by service department Charge lag was calculated based on service date and post date for each encounter.

EMR and Practice Management Systems

Overview

Practice Management Systems are software systems that deal with day-to-day operations of medical practices, such as capturing patient demographics, scheduling appointments, maintaining registry of insurance payors, performing billing tasks and generating reports. Practice management systems are often connected to EMR systems. While some information between the two systems may overlap, in general, the EMR system is used for assisting the practice with clinical matters. The integration of the EMR and practice management system is considered the best practice for clinic operations but is often a challenge to implement.

Summary of Current State

RHC and the specialty clinic staff and providers mentioned a desire to continue to identify opportunities to enhance Athena EHR capabilities around efficient accessibility of imaging, lab and inpatient reports during clinic visits. Hospital and clinic management are aware of this concern and are actively working with the EHR vendor to identify potential solutions for further enhancement of imaging, lab and inpatient report integration across the EHR and patient record.

Recommendation

Continue to fully assess barriers believed to be the result of limited EMR capabilities to accessing patient results and histories seamlessly with input and assistance from providers and Athena representatives.

PPM Quality Metric Reporting

Overview

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) consolidated and changed the payment system for doctors who treat Medicare patients. Under MACRA eligible clinicians either participate under the Merit Based Incentive Payment System (MIPS) or under the Advanced Alternative Payment Model (AAPM) track. Each has its own set of requirements for participation and incentives. Practices and leadership must understand the reporting requirements and stay current as the regulation is complex and there are numerous changes each year.

The 2017 MIPS performance year required a low threshold of participation to avoid a penalty (negative payment adjustment on Medicare Physician Part B services). In 2018, the financial implications increase as the ICMC practice(s) may receive a 5% positive or negative adjustment based on how they perform. It is important that practices have a plan to establish MACRA reporting status for providers, procedures for data capture and reporting, and approval process for metric submission under the program.

Summary of Current State

Historically ICMC and the practices have participated in the various CMS physician reporting programs, which many rural health care organizations struggle to do given the complexity of the regulations. In 2017, ICMC was able to successfully report the required amount of information to participate and avoid a negative payment adjustment under the MIPS. ICMC leadership is in the process of reporting and working through measures for 2018 and 2019 to successfully report again.

Recommendation

Continue to assess MIPS participation for eligible clinicians, reporting processes and potential performance scoring benefits as identified in the MACRA final rule. The following are areas for the clinics and ICMC leadership to continue assessing:

- Determine clinician eligibility using National Provider Identifier (NPI) at https://qpp.cms.gov/participation-lookup
- Analyze practice(s) reporting and scoring implications based on the following MIPS special status designations:
    - Small Practice
    - Nonpatient facing
    - Health Professional Shortage Area (HPSA)
    - Rural
    - Hospital-based

- Seek provider participation to select quality metrics to track and report each year
    - Select a minimum of 12 quality measures approved by CMS for MIPS reporting. Access list here: https://qpp.cms.gov/about/resource-library.
- Identify point person(s) for tracking and monitoring Cost category, Promoting interoperability (PI) and Improvement activities
- Identify method of reporting data to CMS:
    - Registry
    - Claims
    - EHR
    - CMS Web Interface
    - Other

Table 10: Review of Top PPM Recommendations

1	Patient scheduling and registration improvement opportunity recommendations: • Identify the most common registration errors and work with clinic management to establish benchmarks for performance. Metrics should be tracked on a monthly basis and reported to management and associated clinic physicians. Filters for clinic, provider, error type and receptionist should be included in the report. • Develop no-show rate, continue to track number of new and established patient visits scheduled and completed, number of cancellations, and number of walk-in visits on a daily basis.
2	Expand current utilization of pay for performance plans for providers by developing a benchmarking comparison of provider data to market data. Benchmarking should include best practices in compensation calculations based on wRVUs in cases with lower volumes. The benchmarking comparison should be measured and reported to providers on a monthly basis.
3	Measure and monitor provider and clinic lag time on a weekly basis, continue to maintain performance overall, and identify root-cause issues driving the high lag time for Mrs. Savage when it occurs on occasion.
4	Select four metrics—one at least from each category—from the example scorecard attached in Appendix A and track on an ongoing basis. Metrics should be selected through collaboration between the business office and clinical management.
5	Continue to fully assess barriers believed to be the result of limited EMR capabilities to accessing patient results and histories seamlessly with input and assistance from providers and Athena representatives.
6	Continue to assess MIPS participation for eligible clinicians, reporting processes and potential performance scoring benefits as identified in the MACRA final rule.

Combined Action Plan

The findings and recommendations listed above will be presented to the Hospital's Board of Directors, management, physicians and guests invited by Hospital management. The presentation will be divided into three distinct phases, as follows:

1. Executive Summary and Strategic Environmental Considerations
2. Hospital Revenue Cycle Management
3. Physician Practice Management

After presenting findings and recommendations, BKD and the Center will work with Hospital management to conduct a detailed review of both the RCM and PPM reports for the purpose of prioritizing recommendations and developing action plans. The action plans will be aligned with key performance indicators, which management will work to track and report to the Center.

Example Revenue Cycle Scorecard -- ICMC Specialty Clinic and RHC

	Key Metric	Best Practice - Median
A/R & Collections	Total A/R Per Physician	$124,399
	Aged A/R as a Percentage of Total Billed A/R (90 days & greater)	≤18.8%
	Days Gross FFS Charges in A/R	<36.0 Days
	Days Adjusted (Net) FFS Charges in A/R	<64.5 Days
	Gross FFS Collection Percent	≥51.8%
	Adjusted FFS Collection Percent (Net Collection Rate)	≥97.4%
Patient Access	Scheduled/Slot Utilization	>90%
	Cancellation Rates	10-12%
	No-Show Rates	<5%
	Pre-Auth/Pre-Certification	>90%
	Eligibility/Benefit Checks	>98%
	Patient Access - Accuracy Rate: Demographic, Financial & Insurance Data	≥95%
	POS Collections as % of NPR	>4-8% (2% if only co-pays)
Charge Entry	Charge Lag Days - Outpatient	<3 Days
	Charge Lag Days - Inpatient	<7 Days
	Serviced Not Billed (SNB)	<5 Days
Account Resolution	Initial Denial Rate	<5-9%
	Operational Write-Offs	<3%

Practice KPI Formulas

Metic	Definition	Formula
Total A/R Per Physician	Measures the average profit or loss of a FTE physician, determines the financial health on a physician FTE level; can be used for tracking and trending the profitability of the entity based on a physician level; supports the need for strategy development to minimize losses	Total physician A/R Number of FTE physicians
Aged A/R as a Percentage of Total Billed A/R (90 days & greater)	Amounts owed to the practice by patients, third-party payers, employer groups, and unions for fee-for-service activities before adjustments for anticipated payment reductions, allowances for adjustments, or bad debts. Amounts assigned to "Accounts receivable" are due to "Gross fee-for-service charges". Assigning a charge into "Accounts receivable" initiates at the time a practice submits an invoice to the payer or patient for payment	Total A/R >90 days Total outstanding A/R* *Total billed A/R amount for all payers in reporting month, aged from discharge date
Days Gross FFS Charges in A/R	Calculates the average number of days it takes to collect payment on services rendered; measures revenue cycle effectiveness and efficiency, determines the effectiveness of patient care collections and can be used for budgeting and cash flow projections	Gross patient service A/R Average daily net patient service revenue* *Most recent three-month period (Total number of days in past three (3) months)
Days Adjusted (Net) FFS Charges in A/R	Calculates the average number of days it takes to collect payment on services rendered; measures revenue cycle effectiveness and efficiency, used as a potential proxy for DCOH ("Cash Inventory"); determines the effectiveness of patient care collections and can be used for budgeting and cash flow projections	Net patient service A/R Average daily net patient service revenue* *Most recent three-month daily average of total net patient service revenue
Gross FFS Collection Percent	Gross collection rate for fee-for-service charges, provides opportunity to increase collections, decrease collection costs, and accelerate cash flow	Actual cash collections Average gross patient service revenue* *Most recent three-month average of total gross patient service revenue
Adjusted FFS Collection Percent (Net Collection Rate)	Measures revenue cycle efficiency, supports the valuation of current A/R, and predicts income, provides an opportunity to increase cash flow and forecasts accuracy of expected revenues	Actual cash collections Average net patient service revenue* (or gross charges - contractuals - charity - discounts) may also substract bad debt *Most recent three-month average of total net patient service revenue
Scheduled/Slot Utilization	Trending indicator that scheduling department functions are timely, accurate, and efficient	Total number of scheduled slots during day of service Total number of available slots on schedule during day of service
Cancellation Rates	Trending indicator that scheduling department functions are timely, accurate, and efficient	Total number of cancelled encounters Total number of scheduled encounters* *Total in reporting month
No-Show Rates	Trending indicator for tracking patient no-show rates	Total number of no-show encounters Total number of scheduled encounters* *Total in reporting month
Pre-Auth/Pre-Certification	Trending indicator that measures what is actually authorized versus the total population that requires authorization	Number of patient visits or encounters authorized Number of patient encounters requiring authorization* *Total in reporting month

Practice KPI Formulas

Metic	Definition	Formula
Eligibility/Benefit Checks	Trending indicator that patient access functions are timely, accurate, and efficient	Number of verified encounters Number of registered encounters* *Total in reporting month
Patient Access - Accuracy Rate: Demographic, Financial & Insurance Data	Number of encounters with correct demographic, financial and insurance data input into patient accounting system, as a percentage of total encounters reviewed; can be measured daily, weekly or monthly	Error number – free accounts post – audit Total number of audited accounts* *Total in reporting month
POS Collections as % of NPR	Provides opportunity to increase collections, decrease collection costs, and accelerate cash flow, identifies opportunity for increased POS collections	Total POS collections* Total cash collected/expected for all payers (NPR) *Collected prior to or at time of service and up to seven (7) days after discharge and/or patient cash collected on prior service(s) at the time of a new service
Charge Lag Days - Outpatient	Measures charge capture workflow efficiency and identifies delays in cash, accelerates cash flow	Average days from service date to revenue recognition date (charge posting date)
Charge Lag Days - Inpatient	Measures charge capture workflow efficiency and identifies delays in cash, accelerates cash flow	Average days from service date to revenue recognition date (charge posting date)
Serviced Not Billed (SNB)	Trending indicator of claims generation process, indicates RC performance and can identify performance issues impacting cash flow	Gross dollars for services rendered but not final billed - including charge review & claim edits Average daily gross patient service revenue* *Monthly gross patient services revenue divided by number of days in the reporting month. This is a single month daily average, not a three month rolling average
Initial Denial Rate	Tracks payer denials and impact cash flow; trends payment opportunity and process improvement, drives root cause accountability in the revenue cycle processes	Amount of invoices/claims denied (in $) Total invoices/claims billed (in $)* *Total in reporting month
Operational Write-Offs	Trending indicator of final disposition of lost reimbursement, where all efforts of appeal have been exhausted or provider chooses to write off expected payment amount, indicates provider's ability to comply with payer requirement and payer's ability to accurately pay the claim	Gross or net dollars operational write-offs (typically avoidable) Average monthly gross or net patient service revenue* *Most recent three-month average of total net patient service revenue