How Does My Practice Stack Up Against the Best?

MS MGMA
June 18, 2015

Doral Jacobsen, Senior Manager
DHG Healthcare
Agenda

1. Transformation
2. Payer Common Themes
3. Benchmarking
4. Common Quicksand
5. Questions
1. Transformation
Getting from here to where?
Our Transformational Point of View

**CLINICAL MATURITY LEVEL**

**CLINICAL ENTERPRISE MATURITY (CEM)**
A concept unique to DHG Healthcare, the CEM is a qualitative evaluation that measures numerous characteristics associated (among other things) with the state of an organization’s physician enterprise in combination with its overall clinical integration accomplishments and planning.

**Change Management Themes:**

- **“Do More Get More”**
  - **PEOPLE**
  - **RIGHT CARE, RIGHT PLACE, RIGHT TIME**

- **FEE FOR SERVICE**
  - **PROCESS**
  - **COMMUNITY HEALTH MANAGEMENT**

- **VOLUME**
  - **TECHNOLOGY**
  - **VALUE**

**MARKET STAGING**
An evaluation of an individual market’s level of evolution with respect to resident payment models. This concept, which DHG Healthcare has developed and applies in our business planning practice, considers evolutionary facts such as depth of non-FFS transition, level of consolidation, employer base, and similar characteristics.

**MARKET STAGE**
Shaping the Curve
Market Urgency…Get the Timing Right

PAYERS & EMPLOYERS & COMPETITION DICTATING THE PACE

RISK READINESS
2.

Payer Common Themes
Payer – Common Themes

- Triple Aim
- High performing narrow networks
- Patient Liability Increasing
- Increasing transparency & cost focus
- Focus on quality measures
- Provider profiling
- Value based payment methodologies rolling out

Government Payers  Major Commercial Carries  Employers  Your Organization
Triple Aim

Manage Population Health

Reduce Per Capita Cost

Enhance the Experience of Care

Ideal Care System

Source: Advisory Board Webinar | Don Berwick 2008
Patient Liability Increasing

Characteristics of People with Difficulty Paying Medical Bills

In 2012, the majority of people with difficulty paying medical bills had employer-sponsored private insurance (ESI)

- Orange: Private - ESI (54%)
- Yellow: Private - Individual (9%)
- Dark blue: Medicaid (4%)
- Light blue: Medicare (3%)
- Light blue: Uninsured (30%)

Source: Kaiser Family Foundation analysis of 2012 National Health Interview Survey (NHIS) data. Includes all people who reported problems affording medical bills within the past year, and/or gradually paying past bills over time, and/or having medical bills they cannot afford to pay at all.
Transparency – BCBS Example in NC

Estimate Your Health Care Costs
Keep Yourself and Your Wallet Healthy

Information at Your Fingertips

It's important to find—and get—the best quality healthcare you can afford. And since many health plans require you to pay some of your medical care, it's important to know what you are paying for.

The Health Cost Estimator makes it easy to look up costs for:
- Doctor's office visits and fees
- Surgical/nonsurgical procedures
- Hospital and clinic fees

Are You a Member?

We've created a search just for you. Simply log in to Blue Connect and go to HealthNAV to see costs for services based on your health plan.

FAQs

► Where does this information come from?

► How do I use this information if I'm not a BCBSNC customer?

Anyone can use this tool to estimate how much they could potentially pay for more than 1,200 non-emergency medical procedures. The tool will provide average cost information across hospitals and other providers based on BCBSNC's most popular health plan, Blue Advantage, and our narrow network plan, Blue Value. You can use this tool to help compare different networks before buying a plan. It can also alert you to significant differences in the cost of a procedure so you can ask questions before deciding where to receive care.

► Does this tool tell me the price I will pay?

It's an estimate.
Quality Metrics

**View360 Online – Screenshot**

View360 online enables physicians and their staff to track month-to-month care and quality information for their UnitedHealthcare patients through a secure interactive website.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Measure</th>
<th>Total Opportunities</th>
<th>Open Opportunities</th>
<th>Success Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>Breast Cancer Screening - Mammogram</td>
<td>74</td>
<td>21</td>
<td>72</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Cervical Cancer Screening - Pap Test</td>
<td>26</td>
<td>14</td>
<td>46</td>
</tr>
<tr>
<td>Colon/Cancer Screening</td>
<td>Colon/Cancer Screening - FOBT, Flex Sig., Colonoscopy</td>
<td>284</td>
<td>206</td>
<td>43</td>
</tr>
<tr>
<td>Diabetic Care</td>
<td>Diabetic Care - HbA1c</td>
<td>56</td>
<td>56</td>
<td>100</td>
</tr>
<tr>
<td>Diabetic Care</td>
<td>Diabetic Care - Nephropathy Screening</td>
<td>56</td>
<td>56</td>
<td>100</td>
</tr>
<tr>
<td>Diabetic Care</td>
<td>Diabetic Care - Eye Exam</td>
<td>56</td>
<td>56</td>
<td>100</td>
</tr>
<tr>
<td>Diabetic Care</td>
<td>Diabetic Care - LDL-C Screening</td>
<td>56</td>
<td>56</td>
<td>100</td>
</tr>
<tr>
<td>Glaucoma Screening (8+</td>
<td>Glaucoma Screening (8+)</td>
<td>237</td>
<td>226</td>
<td>44</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Osteoporosis - Fracture (Female 51+ Yrs)</td>
<td>8</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Preventive/Ambulatory Services Access</td>
<td>Preventive/Ambulatory Services Access (0-4 Yrs and Older)</td>
<td>422</td>
<td>322</td>
<td>77</td>
</tr>
<tr>
<td>Spirometry</td>
<td>Spirometry - COPD Assessment and Day</td>
<td>2</td>
<td>1</td>
<td>95</td>
</tr>
<tr>
<td>Well Child - Adolescents (2-18 Yrs)</td>
<td>Well Child - Adolescents (2-18 Yrs)</td>
<td>8</td>
<td>5</td>
<td>62</td>
</tr>
</tbody>
</table>

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"New Math"

Value = Quality/Cost

Quality = Evidence Based Metrics

Cost = Episode of Care

How many times did you meet the measure?

100%

How many times your peers met the measure?

92%

107%

You

100%

Peers

97%

103%

Professional

$100

$95

Surgery

$95

$100

Facility

$200

$185

Pharmacy

$25

$28

Total

$420

$408

Variance

Index

5

105%

-5

95%

10

108%

-3

89%

12

103%

107% / 103% = 104% Practice performs 4% better than peers.
## How do you stack up?

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>UHC QUALITY</th>
<th>UHC EFFICIENCY</th>
<th>CIGNA CARE DESIGNATION</th>
<th>BCBS TIER</th>
<th>BCBS TIER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider A</td>
<td>** Quality and Cost Efficiency Criteria Met</td>
<td>** Quality and Cost Efficiency Criteria Met</td>
<td>Not listed on Website</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Provider B</td>
<td>** Quality and Cost Efficiency Criteria Met</td>
<td>** Quality and Cost Efficiency Criteria Met</td>
<td>Not enough information to evaluate.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Provider C</td>
<td>* Quality Criteria Met</td>
<td>No Met</td>
<td>Effective 1.1.14</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Provider D</td>
<td>Not enough data to evaluate.</td>
<td>* Cost Efficiency Criteria Met</td>
<td>Not enough information to evaluate.</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Value-based payment models align with a provider’s risk readiness.

- Fee for Service
- Performance-Based Contracts
- Bundled/Episode Payments
- Shared Savings
- Shared Risk
- Capitation
- Capitation + PBC

Accountable Care Programs

Centers of Excellence

Performance-based Programs

Degree of Provider Integration

Level of Financial Risk

SOURCE: UHC
# Payer Ratings

## Average Reimbursement Rate

<table>
<thead>
<tr>
<th>INSURER (A-Z)</th>
<th>LESS THAN MEDICARE</th>
<th>100% OF MEDICARE</th>
<th>101 - 105% OF MEDICARE</th>
<th>106 - 110% OF MEDICARE</th>
<th>ABOVE 110% OF MEDICARE</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>15%</td>
<td>16%</td>
<td>19%</td>
<td>18%</td>
<td>20%</td>
<td>12%</td>
</tr>
<tr>
<td>Blue Plans</td>
<td>12%</td>
<td>14%</td>
<td>18%</td>
<td>19%</td>
<td>27%</td>
<td>11%</td>
</tr>
<tr>
<td>Cigna</td>
<td>16%</td>
<td>17%</td>
<td>18%</td>
<td>17%</td>
<td>19%</td>
<td>13%</td>
</tr>
<tr>
<td>Harvard Pilgrim Health Care</td>
<td>18%</td>
<td>17%</td>
<td>13%</td>
<td>12%</td>
<td>12%</td>
<td>28%</td>
</tr>
<tr>
<td>HealthNet</td>
<td>24%</td>
<td>22%</td>
<td>13%</td>
<td>12%</td>
<td>7%</td>
<td>22%</td>
</tr>
<tr>
<td>Humana</td>
<td>19%</td>
<td>21%</td>
<td>19%</td>
<td>15%</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>Kaiser Foundation Health</td>
<td>17%</td>
<td>22%</td>
<td>11%</td>
<td>8%</td>
<td>18%</td>
<td>23%</td>
</tr>
<tr>
<td>Medical Mutual of Ohio</td>
<td>20%</td>
<td>19%</td>
<td>16%</td>
<td>10%</td>
<td>10%</td>
<td>26%</td>
</tr>
<tr>
<td>Oxford Health Plans</td>
<td>26%</td>
<td>20%</td>
<td>11%</td>
<td>12%</td>
<td>8%</td>
<td>23%</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>18%</td>
<td>15%</td>
<td>18%</td>
<td>16%</td>
<td>21%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Current Medicare Penalties

*Eligible professionals who were unsuccessful in meaningful use and electronic prescribing will receive a 2% penalty in 2015

Source: MGMA SRG Webinar May 2015
Value Based Payment Modifier

• Medicare
  – Value Based Payment Modifier
    • Based on historical data affecting all by 2017
    • The modifier will be budget-neutral for Medicare and will adjust Part B payments based on the quality and cost of care delivered.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>4.0%*</td>
<td>2.0%*</td>
<td>0.0%</td>
</tr>
<tr>
<td>Average Quality</td>
<td>2.0%*</td>
<td>0.0%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Low Quality</td>
<td>0.0%</td>
<td>-2.0%</td>
<td>-4.0%</td>
</tr>
</tbody>
</table>

* Physicians who score in these categories who treat high-risk beneficiaries could receive an additional one percentage point in bonus money. (2015 rule)

MACRA

Ensures a **5-year period** of stable, **annual updates** of **0.5%** in order to transition to new payment system in 2019

**MIPS**

- Maximum adjustment +/- 4% in 2019 up to +/- 9% in 2022*

  - Composite Score
  - **30%** Quality (e.g. PQRS)
  - **30%** Resource Use
  - **15%** Clinical Practice Improvement Activities
  - **25%** Meaningful Use

- Additional bonuses up to **10%** for exceptional performance

* Sliding Scale assessment

**APM**

- **Annual 5% Lump Sum Bonus** 2019-2024

  - Qualifying APM
  - Certified EHR
  - Payment based on quality measures
  - Financial risk
  - **Medical Home***

  - Percentage of payments

*PCMH exempted from downside risk requirement
Patient Centered Medical Home

PCMH Practices Earn More in Total Medical Revenue after Operating Cost than Non-PCMH Practices

Patient centered medical home (PCMH) practices spend $42.56 more per patient in total general operating costs than non-PCMH practices, but earn $65.54 more per patient in total medical revenue after operating cost.

All Primary Care Practices, Total General Operating Cost and Total Medical Revenue After Operating Cost Per Patient

Source: MGMA Data Dive 2014
3. Benchmarking
Benchmarking Relevance

• Why Benchmark?
  – Better Performers provide benchmark key metrics to providers and staff on a regular basis
  – Goal Setting
  – Motivation
  – Your mirror
  – Reporting to business owners any gaps
  – Dispel myths (i.e., appropriate staffing levels)
  – Because = What gets measured gets managed....
Comparing financial results with industry Benchmarks enables organizations to understand performance within the context of peer groups.

<table>
<thead>
<tr>
<th>MGMA Category</th>
<th>Benchmark</th>
<th>Sample</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medical Revenue</td>
<td>$612,745</td>
<td>$485,908</td>
<td>-21%</td>
</tr>
<tr>
<td>Total Operating Cost</td>
<td>$597,097</td>
<td>$229,861</td>
<td>-62%</td>
</tr>
<tr>
<td>Total Med Rev after Oper Cost</td>
<td>$132,053</td>
<td>$256,047</td>
<td>94%</td>
</tr>
<tr>
<td>Total Provider Cost</td>
<td>$422,455</td>
<td>$461,516</td>
<td>9%</td>
</tr>
<tr>
<td>Est Total Med Rev after Ops &amp; Provider Cost</td>
<td>-$317,529</td>
<td>-$205,470</td>
<td>-35%</td>
</tr>
</tbody>
</table>

Benchmark: MGMA Multi Spec Hos Owned 2014 - per FTE MD Southern.
Financial Comparisons - Slice it by Cost

Category Cost Comparison

<table>
<thead>
<tr>
<th>Category</th>
<th>Benchmark</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>55%</td>
<td>62%</td>
</tr>
<tr>
<td>NPP</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Support Staff</td>
<td>31%</td>
<td>18%</td>
</tr>
<tr>
<td>Bldg &amp; Occ.</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Supplies</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Financial Comparisons - Total Op Costs a % of Medical Rev

- **Total Operating Cost**: $1,000,000
- **Total Medical Revenue**: $500,000
- **Total Medical Revenue/Total Operating Cost = 50%**

- **Best Practices**: 55% and others at 70%
New Patient Lag Time = length of time it takes for a new patient to be seen in a practice from the time they call to schedule their appointment
- Best Practices have shorter lag times
- Best Practices have 10% same day apts
Patient Access - No Show Opportunity

If No Show rates improve, cash flow improves as well as the likelihood of patient retention. **Best Practice No Show Rate = 4%**.

<table>
<thead>
<tr>
<th>No Show Rate</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13%</td>
<td>17%</td>
<td>15%</td>
<td>19%</td>
<td>13%</td>
<td>12%</td>
<td>19%</td>
<td>18%</td>
<td>19%</td>
</tr>
</tbody>
</table>

**Est Additional Revenue from No Show Reduction**

<table>
<thead>
<tr>
<th>If B &amp; D Improve:</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$28,534</td>
<td>$57,067</td>
<td>$106,478</td>
</tr>
<tr>
<td>$50,000</td>
<td>$53,239</td>
<td>$159,716</td>
<td>$212,955</td>
</tr>
<tr>
<td>$100,000</td>
<td></td>
<td>$159,716</td>
<td>$212,955</td>
</tr>
<tr>
<td>$150,000</td>
<td></td>
<td></td>
<td>$212,955</td>
</tr>
<tr>
<td>$200,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$250,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$300,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$350,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$400,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10% Improvement 20% Improvement 30% Improvement 40% Improvement 50% Improvement

$142,669

$266,194

$114,135

$85,601
Cancelling clinics close to the day of the appointment decreases patient satisfaction, causes unnecessary administrative burden, and increases the likelihood that patients will choose another healthcare provider.

![Graph showing estimated lost new patients and annual lost revenue due to bumped new patients.](image-url)
Focusing on maximizing potential Revenue Cycle optimization opportunities will have a positive impact on the Enterprise bottom line.

- **Enterprise Adjusted Collections**
  - Adjusted collections (Payments/Charges - Expected Adjustments) represents the amount collected based on the estimated “collectable” amount also known as “net collections”.
  - Best Practices collect a much higher portion of the collectable dollar (about 98%).
## Revenue Cycle – Unexpected Adjustments

Unexpected adjustments are a road map for identifying opportunities in operations improvement. There is significant opportunity in collecting “unexpected” adjustments for all practices.

<table>
<thead>
<tr>
<th>Est Annual</th>
<th>Practice 1</th>
<th>Practice 2</th>
<th>Practice 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentialing</td>
<td>$129,085</td>
<td>$20,996</td>
<td>$270,142</td>
<td>$420,223</td>
</tr>
<tr>
<td>No Auth</td>
<td>$57,630</td>
<td>$6,863</td>
<td>$22,273</td>
<td>$86,765</td>
</tr>
<tr>
<td>Out of Network</td>
<td>$8,737</td>
<td>-</td>
<td>$11,949</td>
<td>$20,686</td>
</tr>
<tr>
<td>Small Balance</td>
<td>$5,063</td>
<td>$1,985</td>
<td>$563</td>
<td>$7,611</td>
</tr>
<tr>
<td>Collections</td>
<td>$374,668</td>
<td>$144,039</td>
<td>$182,461</td>
<td>$701,168</td>
</tr>
<tr>
<td>Bankruptcy</td>
<td>$16,314</td>
<td>$879</td>
<td>$5,072</td>
<td>$22,265</td>
</tr>
<tr>
<td>Timely Filing</td>
<td>$952</td>
<td>$3,527</td>
<td>$412</td>
<td>$4,892</td>
</tr>
<tr>
<td>Patient Balance</td>
<td>$8,617</td>
<td>$4,036</td>
<td>$8,891</td>
<td>$21,544</td>
</tr>
<tr>
<td>Discount</td>
<td>$8,617</td>
<td>$4,036</td>
<td>$8,891</td>
<td>$21,544</td>
</tr>
<tr>
<td>Administrative</td>
<td>$433</td>
<td>$12</td>
<td>$286,784</td>
<td>$287,229</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$601,499</strong></td>
<td><strong>$182,336</strong></td>
<td><strong>$788,548</strong></td>
<td><strong>$1,572,383</strong></td>
</tr>
</tbody>
</table>
Revenue Cycle - AR Aging

AR Aging indicates if accounts are being moved through revenue cycle process efficiently, although there could be revenue opportunities that are mis-categorized in contractual adjustments. **Best Practices** have less than 10% in 90+ and collect about 60% of possible dollars in the first 30 days.
Revenue Cycle - Charge Lag by Practice

Charge lag days represent the average number of days between when the service was provided and when the charge was posted in the practice management system. **Best practices** enter charges more expeditiously than others (within 2 - 4 days).

<table>
<thead>
<tr>
<th>Practice</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
<th>Oct-14</th>
<th>Nov-14</th>
<th>Dec-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prac 1</td>
<td>17.73</td>
<td>17.40</td>
<td>19.56</td>
<td>11.23</td>
<td>13.86</td>
<td>11.34</td>
<td>11.38</td>
<td>16.01</td>
<td>10.13</td>
<td>8.75</td>
<td>16.79</td>
<td>13.70</td>
</tr>
<tr>
<td>Prac 2</td>
<td>26.49</td>
<td>27.05</td>
<td>30.94</td>
<td>5.52</td>
<td>8.86</td>
<td>13.18</td>
<td>7.98</td>
<td>10.43</td>
<td>5.64</td>
<td>5.80</td>
<td>4.62</td>
<td>6.01</td>
</tr>
<tr>
<td>Prac 3</td>
<td>18.70</td>
<td>14.76</td>
<td>23.27</td>
<td>20.63</td>
<td>20.73</td>
<td>33.67</td>
<td>13.65</td>
<td>16.45</td>
<td>14.16</td>
<td>16.55</td>
<td>35.01</td>
<td>20.89</td>
</tr>
</tbody>
</table>

- **Significantly High**
- **Moderately High**
- **Close to Benchmark**
Revenue Cycle - Time of Service Collections (TOS)

• Why is this so important to track?
  – Medical Bills – bottom of the priority list
    • Folks will first pay the essentials
  – “Wealth Without Risk” by Charles Givens
    • Page 21-22 – don’t pay your medical bills – interest free
  – Patients feel it is a RIGHT not a privilege
  – We enable this behavior
  – Better Practices – 68% have face-to-face encounters with patients regarding billing/collections.

• 25% - 30% of the collectible dollar now comes from the patient...this will not get better...
Best Practices collect patient responsibility at time of service over 90% of the time. Ratio most important = possible/actual.
Revenue Cycle - Claims Management Benchmarks

- **Submission**
  - Daily
  - Electronically at least 96%

- **Lag Times**
  - Charge Entry – Submission < 72 hours
  - Service to Charge Entry < 48 hours

- **Denials**
  - < 4% on 1st submission
  - Appeals Filed within 5 days of posting

- **Claims Worked per AR Staff**
  - 110 Claims a Day

Revenue Cycle - Claims Management Benchmarks

- **Scrubbing**
  - All Claims
  - Verify Eligibility 90%

- **QA Audit**
  - 5% per team member per month

- **Missing Charge Audit**
  - 10% of claims per month
Production Benchmarks

• Better Performers
  – Compare individual performance to internal and external peers 57% of the time compared to others at 49%
  – Employ non physician providers 63% of the time compared to others at 46%
  – Ensure optimal staffing to leverage physician time 68% of the time compared to others at 50%
  – Establish productivity targets for the practice 27% of the time compared to others at 18%
  – Provide open access scheduling 33% of the time compared to others at 24%
Common Quicksand

- No active review of contract performance annually
- High demographic data entry errors
- Inadequate review of claims prior to submission
- Lack of effective follow up “closes the loop” with payors
- Adversarial relationship with Provider Relations representatives
- Less than optimum use of technology - software capabilities, website functionality
- No verification of eligibility and benefits both pre-visit and retroactively if appropriate
Common Quicksand

- No routine time to discuss AR issues on a routine basis with staff and providers
- Less than optimum training is occurring routinely
- Front office team not engaged in AR performance
- Collect patient responsibility *after* they see the provider
- Inadequate staff skill sets for job functions
- Lack of written policies and procedures
- Practices try to do too much - outsource when it makes sense
Common Quicksand

• Fee schedules not loaded in PM software
• Submission of paper claims and payments manually
• Lack of tracking Revenue Cycle trends systematically
• Lack of communicating Revenue Cycle trends systematically to staff and providers
• Providers not engaged in the business stats
• Team leaders not identified and/or empowered
• Task oriented approach instead of team
• Unclear job definitions – staff does not know what a “good job” looks like...
• Better performing practices:
  – Closely monitor practice performance in relationship to industry benchmarks
  – Identify activities that have a positive effective on their bottom line and provide mechanisms for ensuring that the activities continue
  – Identify activities that have a negative effect on practice performance and make improvements
  – Strive to ensure excellence in patient care and satisfaction
  – Create a pleasant work environment
  – Understand strengths and weaknesses
  – Cultivate open lines of communication among all staff from physician to receptionist
5. Questions?