

Performance Management in the Rural Health Clinic

Idaho Bureau of Rural Health & Primary Care

November 5, 2014

12:45 p.m. – 1:45 p.m.



Jeff Johnson - CPA, Partner
Wipfli Health Care Practice

WIPFLI^{LLP}
CPAs and Consultants

Agenda

- Using Benchmarks to Improve Profitability
 - Why is it Important?
 - A Performance Management Tool
 - Internal Benchmarks
 - External Benchmarks
- Comparison between Hospital-owned and Independent Medical Groups
- 5 Steps to Improve Financial Performance in your Rural Health Clinic
- Conclusions



Benchmarking: Why is it Important?

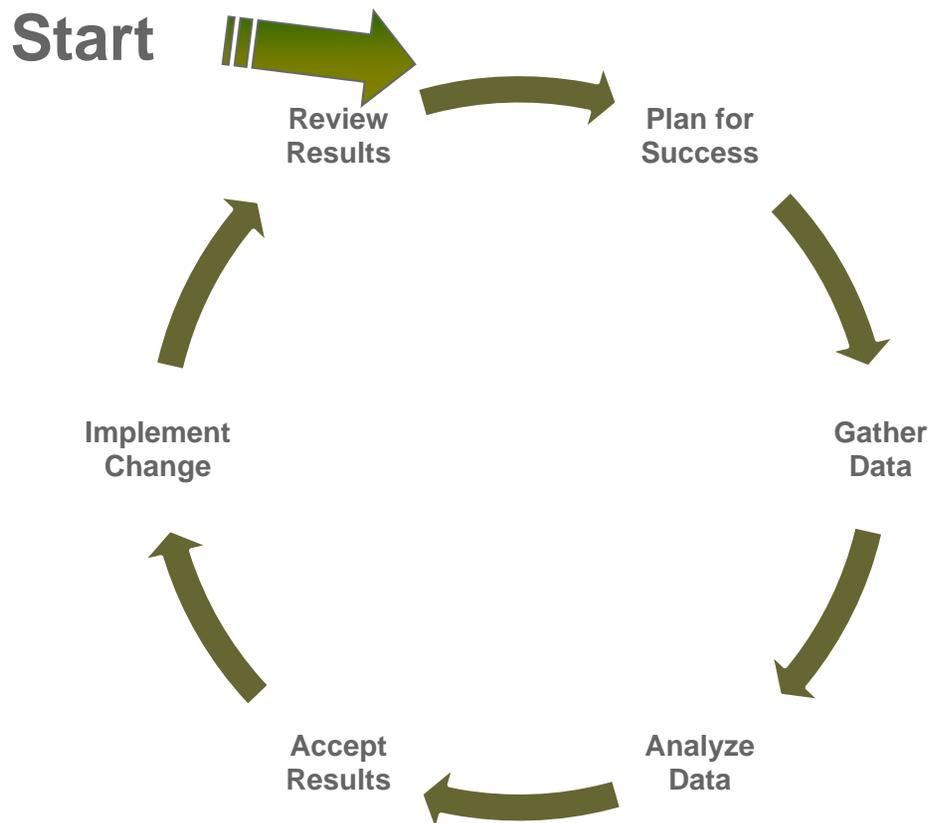
Key Areas Where Benchmarking Can Make a Difference:

Strategy	Strategic	←→	Markets, competitors
Performance Improvement	Organizational	←→	Services, geography
Performance Improvement	Staffing	←→	Number of employees by function or by units of service
Performance Improvement	Operational	←→	Inputs/outputs
Performance Improvement	Financial	←→	Financial ratios
Performance Improvement	Technological	←→	Dollars spent versus efficiency/effectiveness
Compliance	Compliance	←→	Meet obligations and other regulations



Benchmarking: Why is it Important?

Key Approach to Benchmarking Initiatives



Benchmarking helps us to drive the definition of:

- **Targets** - When have we achieved our goals?
- **Alarms** - When do we need to alert the organization to take action?



Benchmarking: Why is it Important?

Should Our Benchmarks Be Internal or External?

External Benchmarks - Summaries for a given performance measure, typically from a similar group of clinics or hospitals or both (peers in terms of size, revenue, etc.).

External benchmarks can serve to influence the setting of targets and alarms.



Benchmarking: A Performance Management Tool

Should Our Benchmarks Be Internal or External?

External Benchmarks

Advantages:

- Provide insights and learning about outcomes achieved at similar organizations—great for incremental improvement.
- Allow the organization to target based on “best practices.”
- Allow the organization to set alarms based on the peer group average.
- Tend to be available for measures that are commonly used or required.
- Provide context for organization performance (are we good, bad, middle of the pack?).



Benchmarking: A Performance Management Tool

Should Our Benchmarks Be Internal or External?

External Benchmarks

Disadvantages:

- Provide limited learning opportunity without information on the unique operating circumstances of other organizations.
- May give unattainable best practices (each organization in the peer group produces results that are an outcome of its unique processes).
- May not match up with the measures the organization should be using.
- Provide an excuse to avoid performance measurement (“we are different so that does not apply”).
- May cause the organization to miss opportunities for significant “breakthrough” improvements.



Benchmarking: A Performance Management Tool

Should Our Benchmarks Be Internal or External?

Internal Benchmarks

Internal benchmarks are generated within the organization through:

- Historical comparison
- Link to business objectives
- Organizational requirements
- Management estimates



Benchmarking: A Performance Management Tool

Should Our Benchmarks Be Internal or External?

Internal Benchmarks

Advantages:

- Match the exact measure used by the organization; this allows the organization to pick the best measures for each objective.
- Reflect the uniqueness of the organization (not possible to claim “we are different”).
- Support breakthrough strategies and improvement.
- Are easy to obtain and very timely (do not have to wait for compilation by another organization).

Disadvantages:

- May show improvement but still be below standards without external context.
- Reinforce existing behaviors without aggressive target setting.



FREE Benchmarking to NARHC Members

NARHC Offers its Member RHCs Free Benchmarking (Also free to Wipfli clients)

Members may request Benchmarking annually.

Information for requesting the Benchmark report can be found on the www.narhc.org website / member portal / benchmarking.

NARHC has 2012 cost report data on most clinics. The 2013 data will not be available until later this year. You may attach your 2013 cost report to the email request for benchmarking.

Questions:

- Call the NARHC office at 866-306-1961 or email rdavis@narhc.org
- If Wipfli client, call Jeff Johnson or Katie Raebel at 509.489.4524, or email us at jjohnson@wipfli.com or kraebel@wipfli.com



Hospital-Owned Medical Groups Versus Independent Medical Groups



Financial Indicators

Primary Care Single Specialty Medical Groups Net Income (Loss) Per FTE Physician

Median Data	Not Hospital Owned	Hospital/IDS Owned
2009	\$6K	(\$160K)
2010	\$5K	(\$143K)
2011	\$9K	(\$165K)
2012	(\$60K)	(\$162K)
2013	\$6K	(\$225K)

Source: Medical Group Management Association Cost Survey; primary care single specialty medical groups; net income excluding financial support. (1-877-275-6462)



Financial Indicators

Hospital-Owned Versus Independent Medical Groups

Median Primary Care Physician **Work RVUs** Per FTE Physician

	Not Hospital Owned	Hospital/IDS Owned
2009	6,231	5,654
2010	7,360	5,332
2011	6,817	5,267
2012	5,174	5,742
2013	6,909	5,678

Source: Medical Group Management Association Compensation and Production Survey (Primary Care includes FP with OB; FP without OB; Internal Medicine; Pediatrics)



Financial Indicators

Hospital-Owned Versus Independent Medical Groups **Median Primary Care Physician Compensation** Per FTE Physician

	Not Hospital Owned	Hospital/IDS Owned
2009	\$206K	\$205K
2010	\$219K	\$211K
2011	\$239K	\$199K
2012	\$232K	\$229K
2013	\$236K	\$235K

Source: Medical Group Management Association Compensation and Production Survey (Primary Care includes FP with OB; FP without OB; Internal Medicine; Pediatrics)



Financial Indicators

If Hospital-Owned and Independent Medical Groups are similar in the following areas:

- Professional service production
- Work Relative Value Units (wRVUs)
- Physician compensation

Where are the differences to explain the large operating losses of Hospital-Owned/IDS Medical Groups?



Financial Indicators

Potential areas of difference may include:

- Ancillary Service Production
- Collections/Adjustments
- Practice Overhead Costs



Financial Indicators

Hospital-Owned Versus Independent Medical Groups **Median Ancillary Service Production** Per FTE Physician

2013 Report	Not Hospital Owned	Hospital/IDS Owned	Variance
Clinical Lab	\$150,000	\$14,000	92%
Radiology	\$122,000	\$40,000	67%
Nonprocedural	\$117,000	\$50,000	57%
Total	\$389,000	\$104,000	73%

Source: Medical Group Management Association Cost Survey; multi-specialty practices; Procedure and Charge Data.
 (1-877-275-6462)



Financial Indicators

Hospital-Owned Versus Independent Medical Groups **Median Primary Care Single Specialty Medical Revenue** Per FTE Physician

	Not Hospital Owned	Hospital/IDS Owned
2009	\$707K	\$426K
2010	\$747K	\$437K
2011	\$778K	\$460K
2012	\$251K	\$479K
2013	\$766K	\$487K

Source: Medical Group Management Association Compensation and Production Survey (Primary Care includes FP with OB; FP without OB; Internal Medicine; Pediatrics)



Financial Indicators

Hospital-Owned Versus Independent Medical Groups Median Collection Indicators

2013 Report	Not Hospital Owned	Hospital/IDS Owned	Variance
Gross Collections	65%	50%	32%
Months in A/R	1.36	1.61	18%

Source: Medical Group Management Association Cost Survey; multi-specialty practices; Accounts Receivable, Collection Percentages, and Financial Ratios. (1-877-275-6462)



Financial Indicators

Hospital-Owned Versus Independent Medical Groups Median Overhead Indicators

2013 Report	Not Hospital Owned	Hospital/IDS Owned	Variance
Operating cost per FTE physician	\$445,000	\$387,000	13%
Operating cost as percent of revenue	57%	72%	26%

Source: Medical Group Management Association Cost Survey; primary care single specialty practices; Operating Costs (excluding NPP cost). (1-877-275-6462)



Financial Indicators

Observation #1

The difference in financial performance between Hospital-Owned and Independent Medical Groups may have more to do with the transfer of ancillary service revenue to the Hospital than any other single factor.



Financial Indicators

Observation #2

A conclusion about the financial performance of a medical practice cannot be reached without conducting a more detailed comparative analysis.



5 Steps to Improve Financial Performance in Your Rural Health Clinic

1. Monitor Key Financial Indicators
2. Produce Meaningful Financial Reports
3. Review Practice Fees and Explanation of Benefits (EOBs)
4. Review Coding Profiles
5. Analyze Write-Offs and Adjustments



Step 1 - Monitor Key Financial Indicators

**Compare to Historical
and External Data at Least
Annually**



Step 1 - Monitor Key Financial Indicators

- Productivity (Gross production, RVUs, Encounters)
- Collection percentages
- Accounts receivable ratio
- Procedure frequency
- Accounts receivable aging
- Cost per visit



Step 1 - Monitor Key Financial Indicators

Work Relative Value Unit (wRVU) Production

All Physicians

(Median Values)

Anesthesiology	6,484	Ophthalmology	8,330
Cardiology (Inv.)	7,946	ENT	6,743
Cardiology	7,070	Pediatrics	5,024
Family Practice	4,827	Radiology	8,814
Oncology	4,234	General Surgery	6,712
Internal Medicine	4,581	Orthopedic Surgery	8,241
Neurology	6,873	Urology	7,518
Ob/Gyn	6,547		

Source: Medical Group Management Association Physician Compensation and Production Survey 2013 report based on 2012 data.



Step 1 - Monitor Key Financial Indicators

Total Ambulatory Encounters by Specialty per FTE Physician

All Physicians

(Median Values)

Anesthesiology	1,246	Ophthalmology	4,623
Cardiology (Inv.)	3,774	ENT	3,639
Cardiology	3,991	Pediatrics	3,891
Family Practice	3,764	Dermatology	5,588
Oncology	2,593	General Surgery	1,769
Internal Medicine	3,369	Orthopedic Surgery	3,401
Neurology	1,950	Urology	3,241
Ob/Gyn	2,828		

Source: Medical Group Management Association Physician Compensation and Production Survey 2013 report based on 2012 data.



Making Productivity Comparisons

Sample RHC Cost Report Comparisons

	Independent RHCs		Prov.-Based RHCs	
	Western	National	Western	National
Encounters per FTE:				
Physicians	4,428	4,677	4,300	4,085
Physician assistants	4,077	3,594	3,856	3,215
Nurse practitioners	3,411	3,340	2,905	2,939
Clinical Psychologist/Social Worker	1,801	1,459	1,523	1,842

Source: Wipfli LLP & National Association of Rural Health Clinics: Rural Health Clinic Benchmark Report



Step 1 - Monitor Key Financial Indicators

$$\text{Gross Collection Percentage} = \frac{\text{Collections}}{\text{Gross Production}}$$

2013 Report	Not Hospital Owned	Hospital/IDS Owned
Gross Collections	65%	50%
Months in A/R	1.36	1.61

$$\text{Months in Accounts Receivable} = \frac{\text{A/R}}{\text{Average monthly Charges}}$$



Step 1 - Monitor Key Financial Indicators

Collection percentage influenced by:

- Practice payor mix
- Government reimbursement
- RHC/PBC status
- Managed care fee schedules
- Practice fees
- Billing and coding
- Collection follow-up



Step 1 - Monitor Key Financial Indicators

Procedure Frequency Analysis Sample Production Analysis Report

John Smith, M.D.

Procedure Code	Description	Current Month		Year to Date	
		Quantity	Charges	Quantity	Charges
99211	Office visit, est, level 1	10	\$200.00	120	\$2,400.00
99212	Office visit, est, level 2	35	1,330.00	420	1,598.00
99213	Office visit, est, level 3	140	7,420.00	1,690	89,040.00
99214	Office visit, est, level 4	8	544.00	96	6,528.00
99215	Office visit, est, level 5	2	220.00	24	2,640.00
	Subtotal evaluation and management	XXXX	XXXX	XXXX	XXXX



Step 1 - Monitor Key Financial Indicators

Overhead Percentage =

$$\frac{\textit{Total expenses (excluding provider compensation)}}{\textit{Net Patient Service Revenue}}$$



Step 1 - Monitor Key Financial Indicators

Overhead Percentages

	<u>2008</u>	<u>2012</u>		<u>2008</u>	<u>2012</u>
Multispecialty	63%	64%	OB/GYN	61%	72%
Anesthesiology	12%	10%	ENT	53%	55%
Cardiology	51%	62%	Pediatrics	64%	63%
Family Medicine	67%	78%	Radiology	30%	29%
Oncology	82%	83%	General Surgery	49%	64%
Internal Medicine	86%	77%	Orthopedic Surgery	47%	52%
Neurology	61%	72%	Urology	55%	62%

Source: Medical Group Management Association Cost Survey.



Step 1 - Monitor Key Financial Indicators

MGMA Reported Staffing FTEs and Cost Percentages

	<u>A</u>	<u>B</u>	<u>C</u>		<u>A</u>	<u>B</u>	<u>C</u>
Multispecialty	4.5	3.5	30%	OB/GYN	3.7	2.9	30%
Anesthesiology	0.3	0.2	5%	ENT	3.8	2.5	25%
Cardiology	4.3	3.3	29%	Pediatrics	3.6	3.2	26%
Family Practice	4.0	3.1	35%	Radiology	1.4	1.4	13%
Oncology	4.3	*	16%	General Surgery	2.4	2.0	24%
Internal	3.4	2.9	35%	Orthopedic Surgery	4.5	2.8	23%
Neurology	2.5	2.4	28%	Urology	4.3	3.5	26%

(A) = Total median support staff per FTE physician

(B) = Total median support staff per FTE provider

(C) = Support staff salaries and benefits as a % of total medical revenue

Source: 2013 Medical Group Management Association Cost Survey.



Making Cost Comparisons

Sample RHC Cost Report Comparisons (continued)

	Independent RHCs		Prov-Based RHCs	
	2012 <u>Western</u>	2012 <u>National</u>	2012 <u>Western</u>	2012 <u>National</u>
Costs Per Encounter:				
Total Direct Cost of Medical Services	\$68.27	\$65.88	\$99.29	\$91.16
Facility Cost	\$10.93	\$9.51		
Total Overhead Cost	\$59.98	\$48.73		
Total Allowable Cost per Actual Encounter	\$117.80	\$117.59	\$172.17	\$165.07
Total Allowable Cost per Adjusted Encounter	\$112.02	\$106.92	\$168.22	\$156.74
Cost per pneumococcal injection	\$137.31	\$126.73	\$204.25	\$152.81
Cost per influenza injection	\$45.49	\$39.37	\$59.85	\$51.71
Medicare Percent of Visits	21.5%	26.7%	21.2%	25.1%

Source: Wipfli LLP & National Association of Rural Health Clinics: Rural Health Clinic Benchmark Report



Step 2 - Produce Meaningful Financial Reports

Produce Meaningful Financial Reports and Review Them!



Step 2 - Produce Meaningful Financial Reports

Key Reports to Monitor in Your Practice

- Production and Compensation Analysis
- Provider Productivity
- Ancillary Service Revenue
- Staffing Analysis
- Accounts Receivable
- Financial Analysis (overhead expenses)
- Balance Sheet, Income Statement, and Cash Flow



Step 2 - Produce Meaningful Financial Reports

Production and Compensation

Sample Production Analysis

Provider Type	FTE	Actual Production	Benchmark Production	Variance	% of Benchmark
Internal Med	1.00	403,648	565,000	(161,352)	-29%
Internal Med	1.00	835,593	565,000	270,593	48%
Internal Med	1.00	311,561	565,000	(253,439)	-45%
Fam Practice w/OB	1.00	445,368	632,000	(186,632)	-30%
Fam Practice w/OB	0.60	263,964	379,200	(115,236)	-30%
Nurse Practitioner	0.92	163,275	253,000	(89,725)	-35%
Nurse Practitioner	0.77	206,927	212,000	(5,073)	-2%
TOTAL	6.29	2,630,336	3,171,200	(540,864)	-17%



Step 2 - Produce Meaningful Financial Reports

Provider Productivity

Sample Productivity Comparison

Provider Type	FTE	Actual wRVU	Annual Benchmarks	Variance	% of Benchmark
Family Practice	1.00	4,173	4,845	(672)	86%
Family Practice w/OB	1.00	2,874	4,924	(2,050)	58%
Ob/Gyn	1.00	5,502	6,687	(1,185)	82%
Pediatrics	1.00	3,809	5,062	(1,253)	75%
Nurse Practitioner	0.58	1,249	1,541	(292)	81%
Physician Assistant	1.00	1,849	2,032	(183)	91%
TOTAL	5.58	19,456	25,091	(5,635)	78%



Step 2 - Produce Meaningful Financial Reports

Ancillary Service Revenue

Outpatient Ancillary Service Charges

	Clinic Performed	Hospital Performed	Total
Clinical Lab	\$ 50,000	\$ 150,000	\$ 200,000
Radiology	25,000	75,000	100,000
Nonprocedural	60,000	40,000	100,000
Total	\$ 135,000	\$ 265,000	\$ 400,000



Step 2 - Produce Meaningful Financial Reports

Staffing Analysis

	FTE	MGMA	
		Median	Variance
Total Physician FTEs	4.00		
Front and Back Office:			
Reception	2.00	2.00	0.00
Business Office/Insurance/Coding	2.00	5.00	-3.00
Medical Records	1.00	1.00	0.00
<i>Total Front and Back Office</i>	<i>5.00</i>	<i>8.00</i>	<i>-3.00</i>
Nursing (includes float staff):			
Registered Nurses	1.00	1.56	-0.56
Licensed Practical Nurses	1.00	1.52	-0.52
Medical Assistants/Nursing Support Staff	2.00	3.00	-1.00
<i>Total Nursing</i>	<i>4.00</i>	<i>6.08</i>	<i>-2.08</i>
Clinical Laboratory	2.00	1.96	0.04
Radiology/Imaging	0.00	0.00	0.00
<i>Total Ancillary</i>	<i>2.00</i>	<i>1.96</i>	<i>0.04</i>
Administration	1.00	1.00	0.00
Housekeeping	0.00	0.00	0.00
<i>Total Administration</i>	<i>1.00</i>	<i>1.00</i>	<i>0.00</i>
TOTAL	12.00	17.04	-5.04
FTE Staff per FTE Physician	3.00	4.26	-1.26



Step 3 - Review Practice Fees and EOBs

Benefits of Reviewing Fees and EOBs

- Evaluate current fee schedule
- Identify opportunities to increase fees
- Review and negotiate discounted fee arrangements
- Develop composite listing of most common services
- Compile payor mix statistics



Step 3 - Review Practice Fees and EOBs

Preparing the Fee and EOB Analysis

- Identify the “Top 50” most common services:
 - Selected by annual review and/or volumes
 - Should account for 70% to 80% of practice revenue and volumes
- Determine most common payors:
 - Five to ten different payors
- Develop matrix of fees and allowed amounts:
 - Allowed amounts from EOBs or contracts



Step 3 - Review Practice Fees and EOBs

Sample Payment Analysis Report

Family Medical Practice

Procedure Code	Description	Current Fee	Medicare Fee	Medicaid Fee	PPO Fee
99211	Office visit, est, level 1	\$35.00	\$20.00	\$15.00	\$35.00
99212	Office visit, est, level 2	55.00	42.00	19.60	50.00
99213	Office visit, est, level 3	95.00	70.00	26.84	115.00
99214	Office visit, est, level 4	120.00	103.00	38.85	128.00
99215	Office visit, est, level 5	165.00	138.00	84.78	145.00



Step 4 - Review Coding Profiles

Conduct a Coding Review of Internal Code Utilization (Physician Profiling)



Step 4 - Review Coding Profiles

Compare to:

- Self (changes over time)
- Same specialty peers:
 - Within the practice
 - Outside the practice



Step 4 - Review Coding Profiles

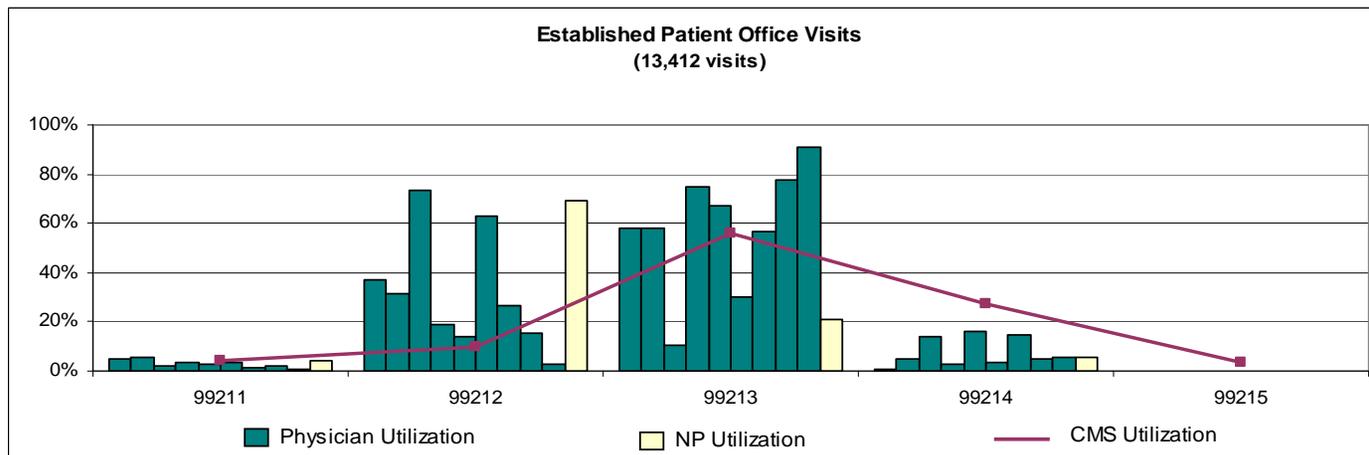
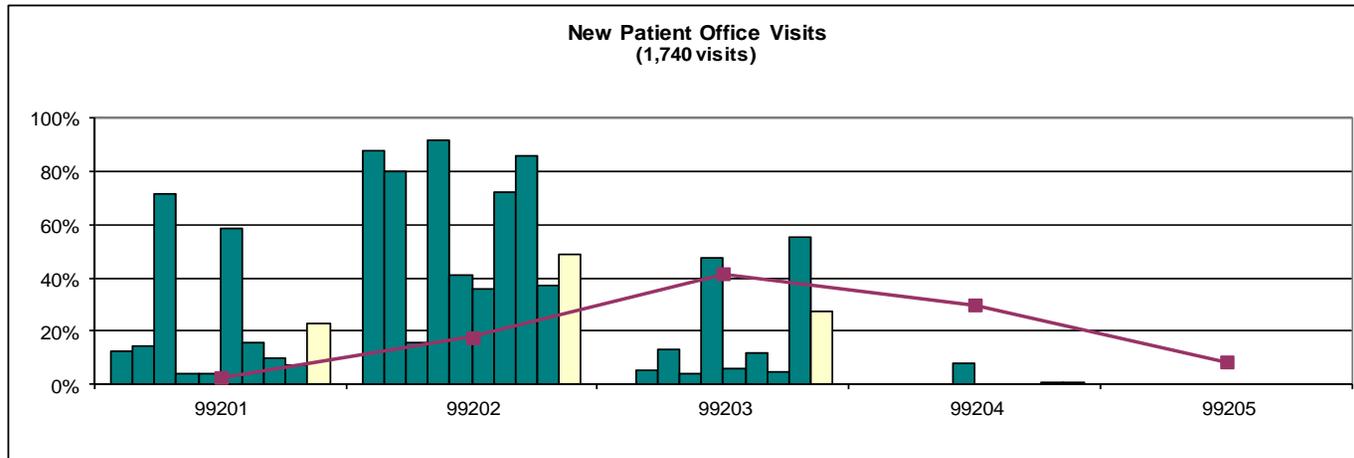
E/M Level of Service Use

ABC Family Practice Clinic (10 Providers)
 Change in Revenue: E/M Code Utilization
Established Patient Office Visits

ACTUAL UTILIZATION					REDISTRIBUTED UTILIZATION			VARIATION
CPT	Fees	Units	ABC %	\$ Prod	Units	CMS%	\$ Prod	\$ Prod
99211	\$ 35	1,200	3%	\$ 42,000	1,744	4%	\$ 61,027	\$ 19,027
99212	55	11,000	25%	605,000	3,654	8%	200,953	(404,047)
99213	95	28,750	66%	2,731,250	25,985	60%	2,468,547	(262,703)
99214	120	2,600	6%	312,000	11,165	26%	1,339,835	1,027,835
99215	165	80	0%	13,200	1,083	2%	178,642	165,442
		43,630	100%	\$ 3,703,450	43,630	100%	\$ 4,249,004	\$ 545,554
TOTAL VARIATION								\$ 545,554



Step 4 - Review Coding Profiles



Step 4 - Review Coding Profiles

Cautions:

- Consider the data source:
 - Payor-specific results might not be consistent with your patient or case mixes
 - External data includes everyone else's mistakes too



Step 5 - Analyze Write-Offs and Adjustments

- Organize write-off and payment categories by payor, using practice management system
- Compare payments received with expected amounts
- Appeal inaccurate payment amounts
- Monitor and manage payor mix



Step 5 - Analyze Write-Offs and Adjustments

Are write-offs and adjustments reasonable?

Sample Payment Analysis Report

Family Medical Practice

Adjustment Code	Description	Current Month		Year to Date	
		Amount	Number of Items	Amount	Number of Items
49	Medicare write-off	\$9,500.00	225	\$85,500.00	2,025
50	Medicaid write-off	7,500.00	230	67,500.00	2,070
65	PPO discount	550.00	70	4,950.00	630
66	PPO withhold	950.00	250	8,550.00	2,250
63	Transfer to collectors	1,500.00	25	13,500.00	225
55	Courtesy discount	150.00	3	1,350.00	27
56	Bankruptcy filed	250.00	5	2,250.00	45
	Adjustment totals	<u>\$20,400.00</u>	<u>808</u>	<u>\$183,600.00</u>	<u>7,272</u>



Step 5 - Analyze Write-Offs and Adjustments

Test of Reasonableness

Family Medical Practice

Description	Payor Mix	Total Charges	Adjust. Percent	Calculated Amount	Actual Amount	Variance
Medicare	15%	\$270,000	25%	\$67,500	\$86,500	\$19,000
Medicaid	5%	90,000	60%	54,000	67,500	13,500
PPO	25%	450,000	5%	22,500	13,500	(9,000)
Self-pay	5%	90,000	30%	27,000	17,100	(9,900)
Commercial insurance	50%	900,000	1%	9,000	15,000	6,000
All payors	100%	\$1,800,000		\$180,000	199,600	\$19,600



Step 5 - Analyze Write-Offs and Adjustments

Variations may be caused by:

- Incorrect classification due to posting errors
- Misunderstanding of payment arrangements
- Premature write-off of patient balances
- Monetary diversions



Conclusion

- Hospital-based clinics continue to report financial losses.
- Opportunities for financial improvement can be identified through periodic monitoring and analysis.
- Benchmarking efforts can uncover opportunities to improve performance.
- Management of physician practices, especially primary care, is increasingly challenging with declining reimbursement, higher overhead, and strains on provider recruitment/retention efforts.
- Leaders can use this information to dig deeper into the root causes and implement solutions that can improve efficiencies, enhance profitability, and deliver increased value to stakeholders.



Questions



Speaker Information

Jeff Johnson, CPA
Partner – Wipfli Health Care Practice
Wipfli LLP
201 W. North River Drive, Suite 400
Spokane, WA 99201
509.232.2498
jjohnson@wipfli.com



WIPFLI^{LLP}

CPAs and Consultants

www.wipfli.com