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Face the Future with Confidence

DEVELOPING AN ACTIONABLE REVENUE CYCLE DASHBOARD FOR CRITICAL ACCESS HOSPITALS

September 2018

Internal Audit, Risk, Business & Technology Consulting

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PROFILE OF A CRITICAL ACCESS HOSPITAL

Government Requirements for Critical Access Hospital (CAH) Designation

- Must be in a rural area and 35 mile drive from any other hospital or 15 mile drive in mountainous area
  - If changing demographics (e.g., urban sprawl) changes location of CAH from rural to anything other, hospital is given 2 year transition period to adjust to being just a IP hospital.
- Must furnish 24-hour emergency care seven days a week using onsite or on-call staff
- Must maintain no more than 25 inpatient beds; these beds can also be swing beds
  - Can maintain separate IP rehab and IP psych beds at up to 10 each
- Must maintain an Average Length of Stay (ALOS) of 96 hours or less
  - This is not needed at initial certification but is needed in all subsequent certifications to CAH status
  - As of 2018, physicians no longer need to attest that he/she believes the patient will not need to stay in the hospital longer than 96 hours.

PROFILE OF A CRITICAL ACCESS HOSPITAL

Hospital Reimbursement Dynamics

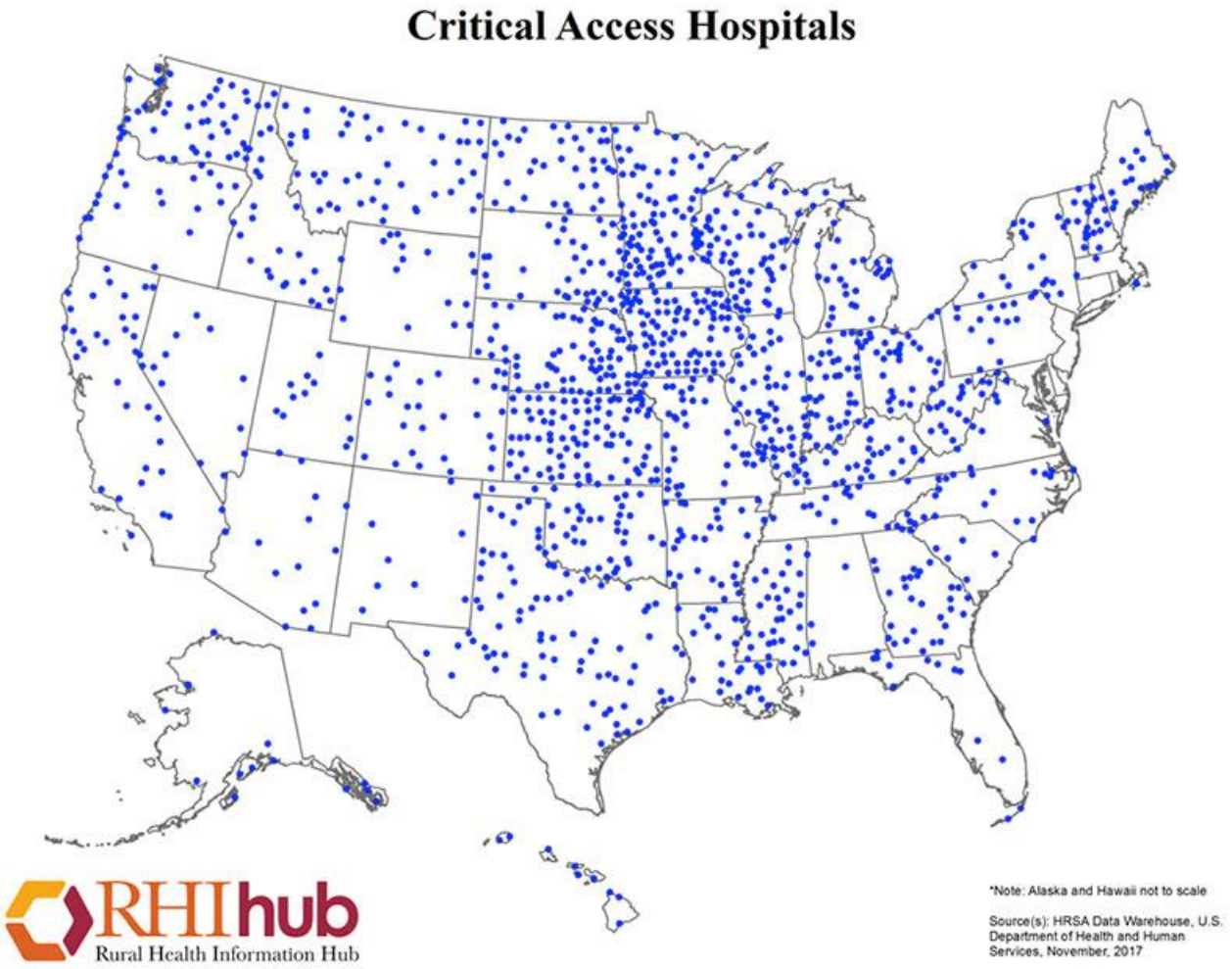
- CAHs are paid for most inpatient and outpatient services at 101% of Medicare reasonable costs
- CAHs **are not** subject to the Inpatient Prospective Payment System (IPPS) or Hospital Outpatient Prospective Payment System (OPPS)
  - Not reimbursed on MS-DRGs but still report MS-DRGs in claims
  - May report APR-DRGs depending on state Medicaid reporting requirements
- CAHs **are** subject to Medicare Part A and Part B stipulations, such as deductibles and co-pay amounts.
- CAH Distinct Part Units (DPUs)
  - In IP rehab and IP psych units, services are paid based on the Inpatient Rehabilitation Facility PPS and Inpatient Psychiatric Facility PPS structure

PROFILE OF A CRITICAL ACCESS HOSPITAL

Unique Profile and Challenges of Critical Access Hospital

- About 1,300 CAHs in all states except, DE, RI, CT and NJ and it is the primary healthcare model for rural areas in the United States
- CAHs receive about 80% of their reimbursement from Medicare and Medicaid
  - Thus, CAHs are highly susceptible to changes in CMS regulations and state Medicaid cuts
- 101% payment on charges **does not** necessarily mean profit as often private payors do not cover costs of services
  - 40% of CAHs maintain negative operating margins according to American Hospital Association study
- Due to small size, CAHs cannot participate in most Medicare Pay for Performance models because they lack the minimum size and patient volumes
  - Strong push to incorporate CAHs in quality care programs and tailor P4P metrics for CAHs (e.g., readmission reporting)
- Many CAHs participate in joint ventures or are owned by larger health systems to support the hospital and provide benefits associated with economies of scale
- CAHs typically treat a poorer and older population in rural communities. They are the often primary source of healthcare for rural communities

PROFILE OF A CRITICAL ACCESS HOSPITAL



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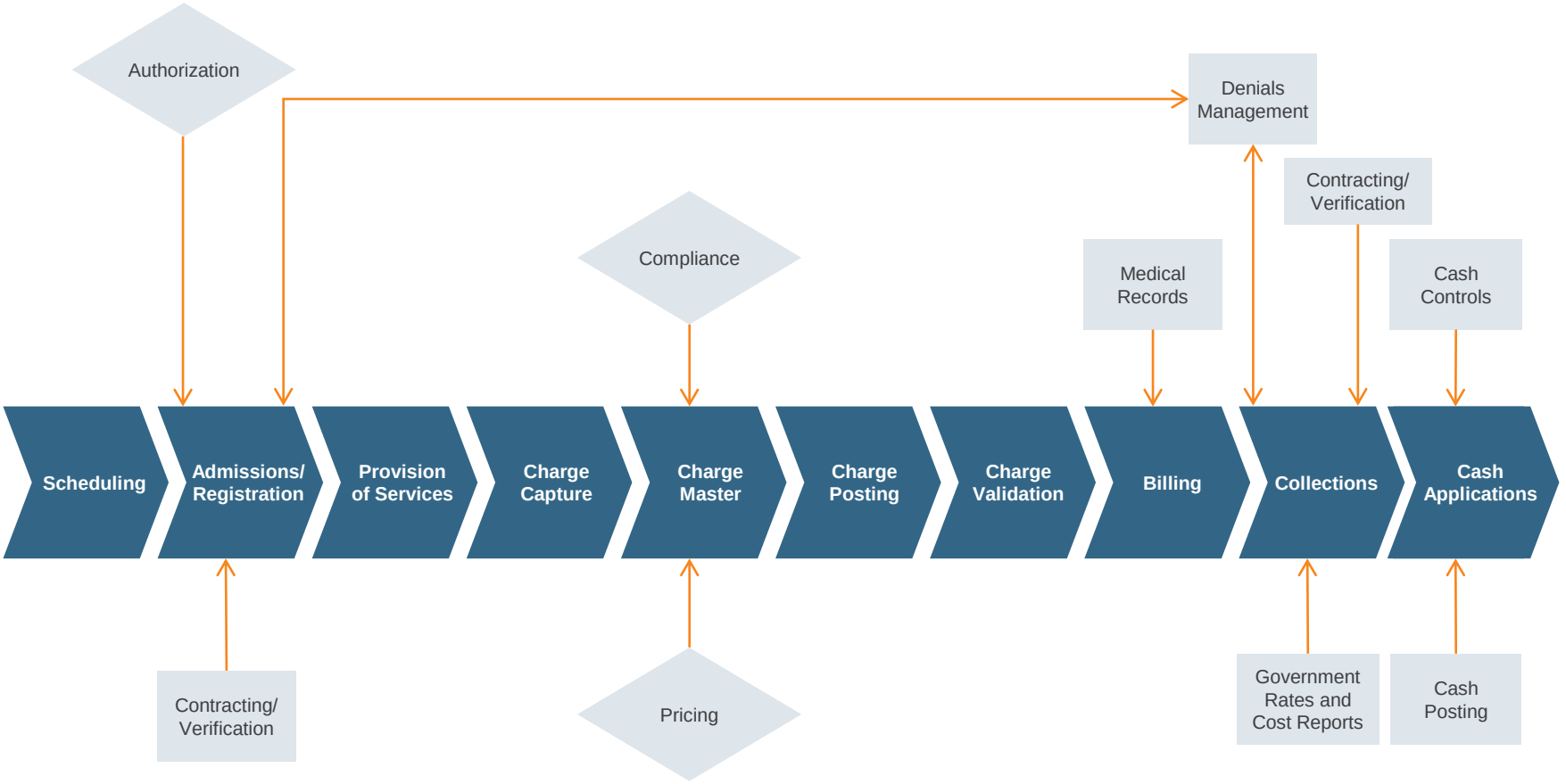
KPI TRENDS IDENTIFY ISSUES ALONG REV CYCLE

Deficiencies and avoidable mistakes in key revenue cycle components undermine the effectiveness of a healthcare provider's revenue cycle. Healthcare providers typically fail to realize as much as 5% in net revenue due to a lack of effective internal controls mitigating financial, regulatory, and operational risks.

Developing accurate and useful Key Performance Indicators (KPIs) allows revenue cycle leaders to pinpoint deficiencies within the revenue cycle process and optimize them.



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GOALS OF REVENUE CYCLE DASHBOARD

Identify Metrics that Accurately Gauge CAH Financial Health and Pinpoint Problems

- When selecting metrics to evaluate on a regular basis, consider metrics that help answer the following questions, such as:
  - Is my payor mix changing?
  - How long is it taking to final-code and bill a claim?
  - Am I getting paid for the services I am providing?
  - Am I getting paid less than what my private payor contracts stipulate?
  - How much money am I forfeiting because of denials and why?
  - Are changes I made to the revenue cycle functions working or not?

Key Consideration When Selecting Metrics to Track

- Given the limited resources CAH leaders have at their disposal, only focus on metrics that will point to an action plan and strategically prioritize these plans.

Some Metrics Important for Typical Hospitals Not Applicable to CAHs

- Case Mix Index (CMI) is less important for CAHs as they are not paid on MS-DRGs and thus higher-weighted MS- or APR- DRGs do not directly correlate to higher reimbursement.

PAYOR MIX

Understanding Payor Mix Provides Insights into Shifting Demographics of Patients

Metric Calculation

$$\frac{\text{Inpatient Days for Payor}}{\text{Total Inpatient Days} - \text{Nursery Bed Days} - \text{Nursing Facility Swing Days}}$$

$$\frac{\text{Outpatient Charges for Payor}}{\text{Total Outpatient Charges}}$$

Nursing swing beds are paid differently when for SNF designated and should be pulled out. Nursery bed days are also excluded as they are rarely paid on Medicare

Average Composition for Medicare

- According to Flex Monitoring Team, a consortium of rural health research centers, the median inpatient Medicare payor mix was about 73 percent for CAHs in 2015.

How to Use the Metric

- Trend changes in payor mix. Note that Medicare pays 101% of allowable costs but state Medicaid payment ratios may vary. Identify private payors that represent an increasing portion of inpatient stays and utilize that when considering how to prioritize managed care contract negotiations.

DAYS IN GROSS ACCOUNTS RECEIVABLE

Utilize A/R Trends and Benchmark to Measure Health of Billing Collection Functions

Metric Calculation

Gross Accounts Receivable: [Row B]
Gross Revenue: [Row P]
Days in Gross Accounts Receivable: [Row B] ÷ ([Row P] ÷ 365)

Metric Median for CAHs

- According to Flex Monitoring Team, a consortium of rural health research centers, the median Gross A/R days in 2015 was **50.8 days** for CAHs. Top performing hospitals achieve A/R days around 36.
  - This metric does not deduct write-offs

How to Use the Metric

- Trend the metric to see if A/R days are increasing or if you are well above the median. If so:
  - Explore which payors maintain the longest A/R days. For problem payors, determine if you are frequently receiving denials or requests for additional information.
  - Determine if Discharge Not Final Coded (DNFC) has increased, contributing to longer A/R.
  - Commission an assessment of billing and collection processes to identify opportunities to streamline.

BREAKOUT OF AGED A/R

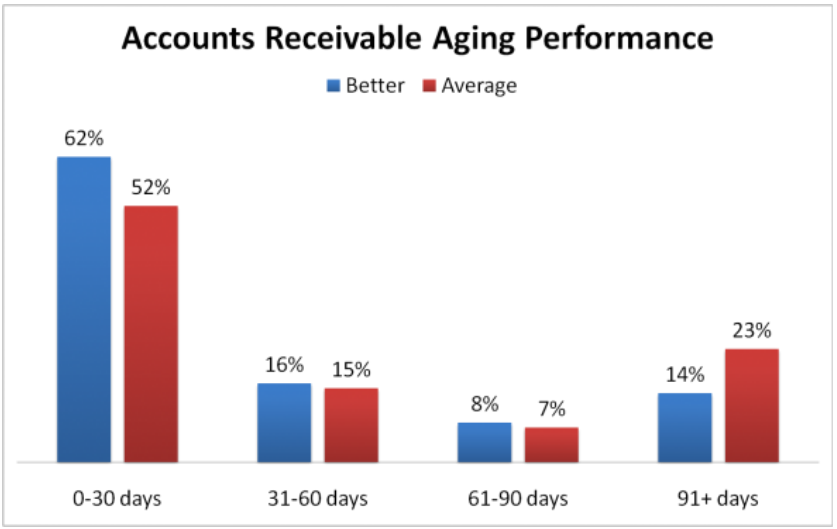
Utilize Aged A/R Days to Determine which Accounts to Prioritize

Metric Calculation

- Categorize outstanding claims by days post discharge (IP) or post date of service (OP). Categorize by 30, 60, 90 and 120 days out.

Example Calculation

Develop a 3 year trailing average to indicate if you are above or below average collection.



How to Use the Metric

- Trend the metric to see if A/R days is increasing or if you are well above the median. If so:
  - Develop a SWAT team to tackle 90+ day aged accounts and high dollar accounts.
  - Determine which 90+ day accounts to write-off and which to pursue based on dollar amount and payor type (e.g., higher likelihood of need to write off self-pay 90+ day accounts)
  - Group unpaid accounts by payor and research contract stipulations for commercial payors to determine if multiple accounts can be brought to payor rep for review and resolution.

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DENIALS BY ANSI CODE

Investigate Denials by Type to Determine Where in Revenue Cycle Action is Needed

Metric Calculation

- Analyze 835 data to examine what is the denials rate by American National Standards Institutes (ANSI) codes to understand if payors are denying claims at a higher and determine root causes. For example, is denials for medical necessity increasing and for which payors.
- These standard ANSI codes are listed on (http://www.wpc-edi.com/codes):
  - **Claim Adjustment Reason Codes (CARCs):** Communicate why a claim or service line was paid differently than it was billed.
  - **Remittance Advice Remark Codes (RARCs)**: Communicate additional explanation for an adjustment already described by a CARC, or convey information about remittance processing.
  - Note that although ANSI codes are standardized, payors may use them differently and the organization should conduct a denial codes mapping exercise to ensure accurate and actionable code categories (e.g., prior authorization issues or coding issues).

DENIALS BY ANSI CODE

Example Codes and Descriptions

Denial Non-Payment Reasons and Associated Denial Amount

Non-Payment Reason	Adjustment Code	Adjustment Reason	Sum of Adjustment Amount
Coordination of Benefits	OA23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	$134,851.70
Medical Documentation / Necessity	CO59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	$131,530.48
Coding Bundled Charges	CO97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	$83,657.91
Non-Covered Charges	CO96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	$78,569.51
Past filing dead line	CO29	The time limit for filing has expired.	$54,348.53
Coding	CO8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	$47,171.59
Verification of benefits	CO27	Expenses incurred after coverage terminated.	$17,420.24
Missing Documentation (Non-Medical Records)	PR227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	$15,243.24

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DENIALS BY ANSI CODE

Use of Denials Data to Develop Action Plans to Optimize Revenue Cycle

How to Use the Metric

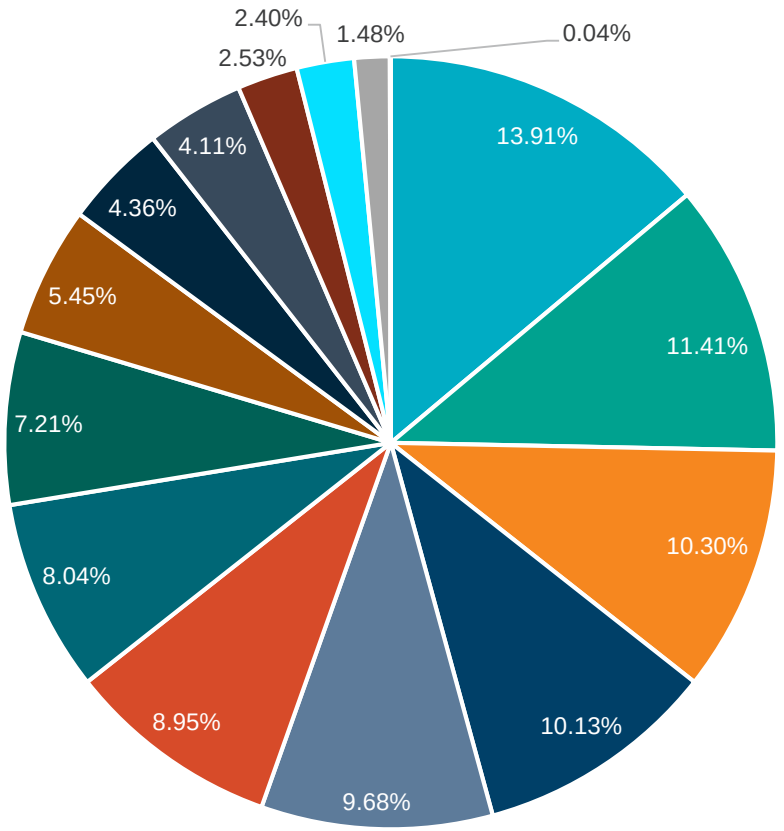
- Examining denials by ANSI code/denial category allows the organization to determine largest denial root causes and develop an action plan to proactively manage denials. Examples by common denial category include:
  - Medical Necessity:
    - Review case management/utilization review functions to identify issues with proper placement of patients in the correct class and Length of Stay (LOS)
    - Conduct a medical record review to determine if documentation in the medical record is sufficient to support patient services received and inpatient stay (important for commercial payors)
      - Although CAHs not subject to IPPS, still subject to denials for medical necessity, especially by private payors
  - Missing Documentation (Non-Medical):
    - Track which documents payors are requesting frequently, resulting in initial denial, to develop process repairs ensuring requested documents provided at initial billing
  - Credentialing:
    - Identify providers not currently enrolled in certain plans (e.g., BCBS or UHC) and work to enroll these providers. Develop a process for determining how far back provider contract stipulates provider can become retroactively enrolled and claim can be rebilled.
  - Prior Authorization/Coordination of Benefits:
    - Conduct a process assessment of patient access to determine process opportunities to reduce provision of services without confirming benefits and appropriate benefactor
      - Confirm all benefits and authorization for scheduled procedures multiple days in advance of encounter date.

DENIALS BY ANSI CODE

Example Breakout of by Denials Category

Sample Reports and Dashboards

	Denial Dollars	%
Verification of Benefits	$6.793K	13.91%
Provider Information	$5.571K	11.41%
Additional Documentation Required	$5.030K	10.30%
Benefits Coverage	$4.946K	10.13%
Coding	$4.724K	9.68%
Medical Policy	$4.370K	8.95%
Referral/Authorization	$3.925K	8.04%
Denied - not specific	$3.522K	7.21%
Credentialing	$2.661K	5.45%
Coordination of Benefits	$2,127K	4.36%
Billing Deadline Exceeded	$2.007K	4.11%
Claim Data	$1.234K	2.53%
Format	$1.171K	2.40%
Patient Demographics	$723K	1.48%
Service Contract	$19K	0.04%



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USEFUL BENCHMARKS

Key Denials Metrics and HFMA Industry Standards

Healthcare Financial Management Association (HFMA) defines the clinical initial denials rate to be **less than 5%** and the technical initial denials rate to be **less than 3%** with a combined overall initial denials rate **not to exceed 4%.** HFMA also establishes the denials overturned by appeal rate as 40% - 60%. Best practice organizations have been able to achieve an overall denials write-off rate less than 0.5% on a consistent basis.

Hospitals and Health Systems: Denials KPIs*	Target
Overall denials rate as a percent of gross revenue	≤ 4%
Clinical denials rate as a percent of gross revenue	≤ 5%
Technical denials rate as a percent of gross revenue	≤ 3%
Rate of additional collection for underpayments	≥ 75%
Rate of appeals overturned	40 – 60%
Electronic eligibility rate	≥ 75%
Physician pre-certification double-check rate	100%
Case managers' time spent securing authorizations rate	≤ 20%
% of high-revenue managed care contracts modeled (80/20 rule)	100%
Total denial reason codes	≤ 25
Initial Zero Paid Denial Rate	≤ 4%

*Note This is for health systems and not specific to CAHs. Low volumes and higher percentage of governmental payors may skew metrics compared to typical hospitals

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USEFUL REFERENCES

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