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Health system sponsored physician employment: keys to success

Part 4: Optimizing the physician revenue cycle

Optimizing the physician revenue cycle

Professional fee cash collections performance is at the core of physician practice management. A high level of physician engagement, strong professional management and functional information technology support a well functioning professional fee revenue cycle operation. Poorly performing revenue cycle operations, on the other hand, result in decreased patient access and patient satisfaction. This is often caused by lack of attention to effective open access scheduling templates, pre-registration processes, and timely capture of pertinent account information, as well as below market physician compensation and/or unsustainable health system subsidies.

About the authors

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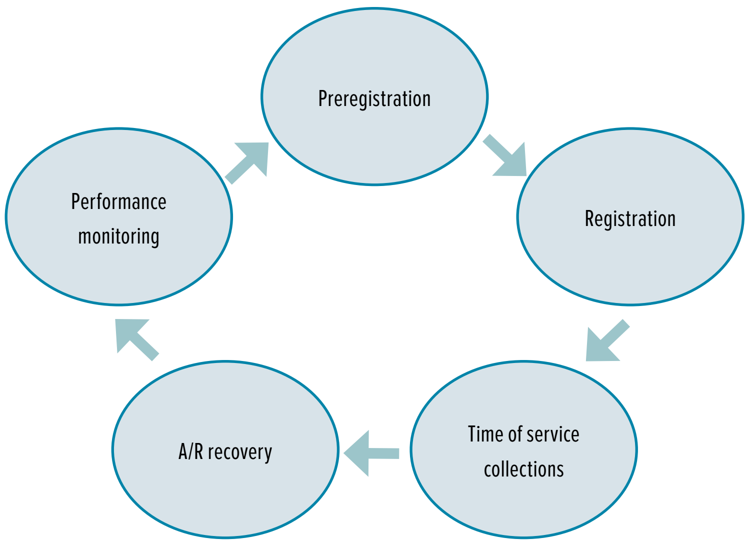
Optimizing the physician revenue cycle through physician engagement & professional management supported by functional systems

This paper, part of a seven part series, "Health system sponsored physician employment: keys to success," focuses on the essential elements of revenue cycle success in the health system sponsored physician enterprise. These elements include:

- Practice management structure and talent working collaboratively with employed physicians
- Physician engagement through physician leadership and aligned financial incentives
- Functional information technology operating on a single database
- Strong revenue cycle reporting

Figure 1: The professional fee revenue cycle



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Professional management structure and talent

Engaged physicians demand strong revenue cycle performance led by a well-organized team of qualified professionals. Key components in the management structure of a robust physician practice revenue cycle operation include:

- Revenue cycle director A single revenue cycle director should be responsible for all elements of the professional fee revenue cycle. This individual should have a deep background in professional fee billing as well as strong financial, technical and personnel management experience. Working in a highly collaborative manner with both physicians and practice site managers, the revenue cycle director is invested in "the business of the patient visit." The revenue cycle director typically reports to the chief executive officer, the chief administrative officer or the executive director of the physician group, depending on the title used. In some larger organizations the revenue cycle director reports to the chief financial officer of the physician employment enterprise, or his or her equivalent.
- CBO manager A single individual should be responsible for operating the professional fee central business office (CBO). This role is focused internally on the CBO and its processes and requires the ability to manage technical and support staff while working with a sophisticated information technology platform. The CBO itself should be organized along functional lines whereby subject matter experts are dedicated to key functions such as claims processing, payment posting, payor specific third party follow-up and reporting and analytics. The CBO manager reports to the revenue cycle director.
- Training function The applications and workflow training function is an essential element of any well run revenue cycle operation. In order to ensure adherence to leading practice policies and procedures, employees at every level require training in the use of information technology and processes, both upon employment and throughout the term of employment. A dedicated training team composed of experts from medical reception and the billing office serves as the liaison between the CBO and the practice, integrating workflows with system functionality.
- Matrix reporting to operations Front desk staff engaged in "the business of the visit" should report to the revenue cycle director. In larger organizations there is typically a revenue cycle manager who oversees front desk staff and reports to the revenue cycle director. But it is the revenue cycle director who ensures collaboration with physicians, practice managers and other clinical operations staff where these functions intersect with the business process.

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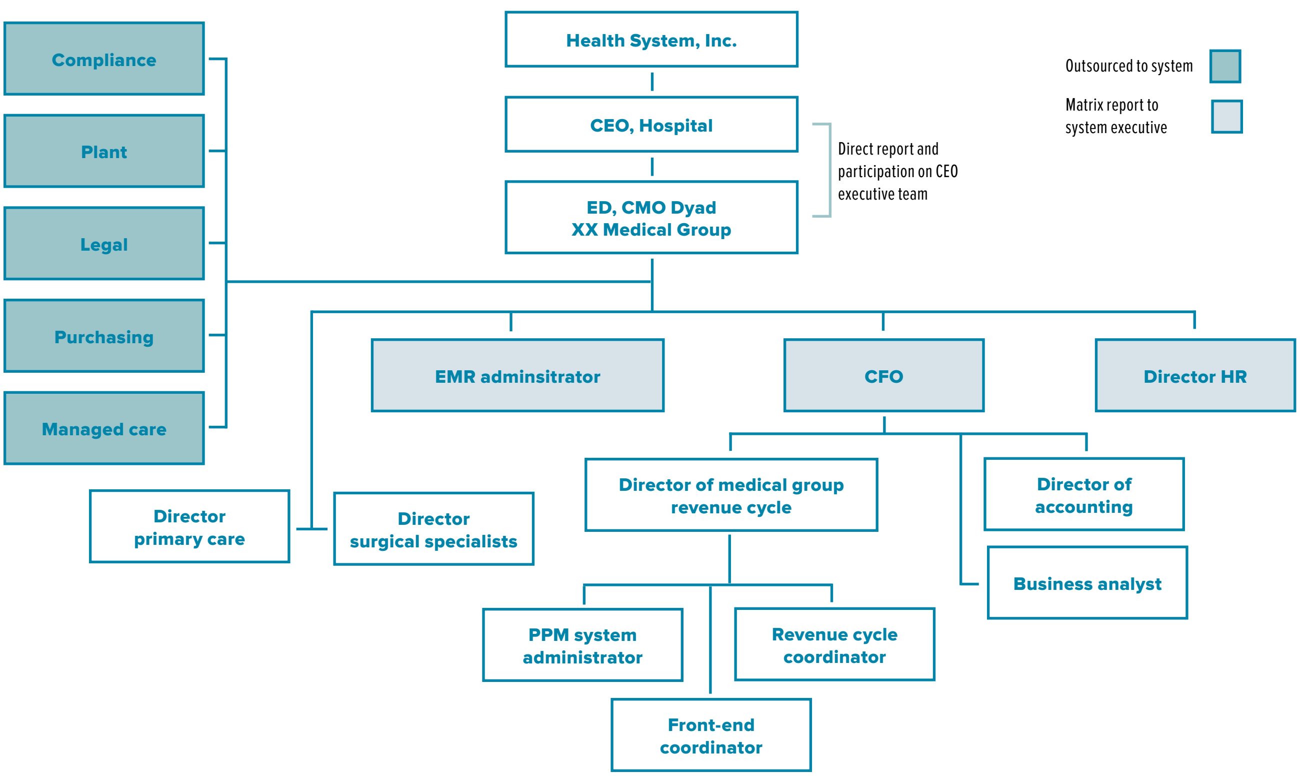
Why a "revenue cycle director?"

The revenue cycle director is responsible for overall revenue cycle functions and their accuracy and efficiency. Policies and procedures impacting the entire visit process are centralized and based on leading practices. In this way, consistency is maintained in operations and training, management of the business cycle and information technology applications. In addition, the revenue cycle director is best positioned to coordinate with the health system, ensuring that the two processes of hospital and professional billing are appropriately coordinated, and that system policies are consistently applied with electronic links at appropriate levels.

Figure 2 is an organizational chart illustrating the reporting relationships described above. The key to making this work is to assign clear lines of accountability and responsibility and to monitor performance at every level.

Figure 2: Aligned physician enterprise



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Enterprise master patient index

There should be a single, enterprise-wide master patient index, or EMPI hosted by the hospital and populating the practice management system and electronic health record for the employed physician components of the integrated enterprise. This arrangement permits one source of patient demographics and insurance information. It should be updated at every point of contact with the patient, and there should be a process in place for validation of accuracy and acceptance into the EMPI by the hospital. The EMPI provides a single patient identification vehicle by which information can easily identified and transmitted via a health information exchange from one referring provider to another. The EMPI facilitates cross-referral between and among providers without regard to which information system platform is used.

Centralized vs. decentralized: hybrid model is best

Certain functions should be centralized, including the charge master, claims submission, payment posting, insurance recovery and appeals, customer service and training/education (typical CBO functions). Other functions are best performed at the front-end practice site, including registration edits, point-of- service collections, coding and charge capture and management of denials caused by data entry errors. In this way, front desk staffs have responsibility and accountability for key functions where they have the best information and the best access to the physician of record and the patient.

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Physician engagement through leadership and incentives

A myth of physician practice management is that physicians do not play a central role in professional fee revenue cycle operations. Therefore in many organizations, the full responsibility is left to the practice management team or the CBO. The result is that physicians are disengaged from cash collections performance. The key to success is to engage physicians in revenue cycle performance through financial incentives for effective cash collections, by providing meaningful and useful reports and including physicians in governance functions that affect policies and procedures.[1]

A second myth of physician practice management is that the performance of the CBO is the pivotal success factor for professional fee cash collections. While CBO performance is an essential element of success, it is important to recognize that by the time the CBO processes a patient claim, the patient has been registered and has arrived at the clinic, and charges have been captured, coded and entered into the practice management information system. If these "front-office" functions are performed well, the CBO, or "back-office" will perform well.

Put another way, the front desk operations within the clinic setting are the single most important part of the process. There are several reasons for this:

- This is where accurate patient demographic and insurance information is captured.
- This is where charges are entered into the practice management system and reconciled with patients seen by the physician.
- This is where a human face close to the physician is able to request time of service payments and overdue past balances

The human face at the front desk performing these functions is the financial steward of the practice. This individual should be managed with a focus on compliance to revenue cycle policies and procedures. Since front desk staff most often takes their cue from the physician(s) they support, the influence that an employed physician can have on the effectiveness of front desk operation should not be underestimated. Physicians who have a financial stake in the professional fee revenue cycle will reinforce best business practices with their front desk staff.

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Aligning physician incentives is critical

A critical element of revenue cycle success is the alignment of incentives for financial success between the employed physician and the health system. This is most effectively accomplished through a physician compensation plan in which professional fee cash collections matter greatly to the physician because they have a material impact on his or her income. The well-crafted compensation plan helps incorporate designated physician leaders at the practice site and enterprise levels in oversight of revenue cycle operations.[1] The recognized best practice for physician engagement in revenue cycle success includes the following components:

- Financial incentives tied to cash collections
- Robust, actionable performance reporting at the individual physician and practice site levels
- Oversight through an enterprise-level physician dominated committee that is focused on revenue cycle, information technology and related finance matters

Unlike most health system sponsored physician groups, mature physician group practices – such as the Mayo Clinic or the Cleveland Clinic – have a long standing culture of physician compliance with a standard approach to policies and procedures. Newer and less mature health system sponsored physician practices that tie physician compensation to professional fee cash collections and take active steps to engage physicians in the revenue cycle process consistently outperform those that do not.

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Keys to living out “physician led, professionally managed”

Assuming incentives and governance are aligned in a “physician led, professionally managed” model, there are essential practices that make living out this mantra a reality. These include:

- Transparency It is essential that physicians are afforded complete transparency and clear, open communication regarding revenue cycle performance.
- Updated encounter forms Encounter forms should be developed in consultation with physicians who will be using them.
- EMR templates for charge capture Physician input templates within the electronic medical record should be designed to facilitate charge capture through an electronic transfer into the practice management system.
- Accountability at the physician level Revenue cycle performance reporting must be at the physician level as well as practice site and enterprise-wide levels.
- Education Physicians should be afforded the opportunity to learn, and if necessary, re-learn revenue cycle policies and procedures that are germane to their practices and their income potential. Education should be offered at times and in ways that accommodate their availability and learning styles.
- Access to certified coders A dedicated team of certified coding experts should be available to physicians seeking guidance as well as integrated into physician education and feedback programs.
- Trusting relationship When physicians are at risk for cash collections performance, a high-trust relationship with the revenue cycle team is essential. Physician participation on the revenue cycle policies and procedures and information technology committees is essential to building and maintaining this trust.

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Own or co-source the central business office

For most large physician employment operations – typically those over 50 physicians – cost effectiveness dictates that the organization have its own, dedicated central business office to provide claims submission, payment posting, insurance recovery, appeals and customer service functions. For start-up or smaller operations, it may be cost effective to "co-source" the CBO, meaning that a qualified third party vendor provides both the practice management information technology platform and CBO functions on a percentage of cash collections basis. In either case, the CBO needs to be staffed for success by teams of billing experts who are organized and focused by payor category as opposed to geography or by practice site.

Current technology allows for the vast majority of CBO functions to be conducted in an automated or paperless environment. The key is for either the owned or co-sourced vendor CBO to be tightly aligned with the front end of the revenue cycle and on the same IT platform.

The co-sourced CBO model is significantly more integrated into practice revenue cycle performance than an outsourced billing company. Both outsourced and co-sourced models avoid the costly capital investment of owning your own software. But only the co-sourced model depends upon the health system sponsored revenue cycle team to own and manage denials caused by coding or other front end errors, as well as clean claim submission on a common IT platform. Figure 3 illustrates the pros and cons of outsourcing, full ownership of the practice management system and in-house CBO, and the co-sourced model.

Figure 3: Comparison of outsourced, owned and co-sourced CBO models

1. Outsourced billing company	2. Own practice management software with central business office	3. Co-sourced ASP* model
Little connection between front and back ends of the revenue cycle - may not utilize same revenue cycle system	Complete control over revenue cycle intake to output with robust practice management tools	Complete access to practice management software. Service is dependent upon client for error correction to clean claim
Issues/concerns pointed in both directions - one of many clients	"One neck tie to pull" - 100% focus on one entity	Front and back end tasks managed via work list - one of many clients
Diverse talent pool - little first hand knowledge	Small talent pool	Diverse talent pool - first hand knowledge via vendor client representative
Claims errors delayed	Claims errors immediate	Claims errors immediate
Limited or no capital costs	Capital outlay	Limited or no capital costs
Cost: Percent of net clinic revenue	Cost of billing	Payment: percent of net clinic revenue

*The "Co-sourced ASP Model" refers to a situation in which a practice management information system vendor (may also include the EMR) provides software on an "application service provider" or ASP basis in which the medical group effectively leases (vs. purchases the software) and the medical group has full access to the file structure.

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Information technology selection

Whether your organization chooses to acquire and own its practice management system and EMR or whether the IT platform is leased through a co-source vendor, there are a number of critical issues that should be considered in selection of these systems. Often health system senior leadership is led to believe that there are unique advantages to selecting an IT platform that is fully integrated with the hospital's information technology. Experience has demonstrated that it is far more important to select a best of breed physician practice technology versus a sole source health system-wide vendor.

Physician practice management is a wholly different business than hospital operations. Invariably, the best of breed information technology required to operate a large, complex physician practice is not comparable in functionality to fully integrated systems. Moreover, the industry-wide Health Level-7 interface is an excellent solution to integrating quality practice management systems with hospital IT platforms. HL-7 allows hospitals and practice management systems to work together without compromise to provide physicians and staff with the information capabilities they need.

Key criteria for physician practice management and ambulatory EMR technology selection includes the following:

- Ability to operate with a single enterprise-wide master patient index
- Robust security that will accommodate multi-site employed physician operations. This will also accommodate multiple private practice management service (MS0) clients to maintain the integrity of individual physician practice data.
- Vendor with a deep history and broad client base, having evolved over time versus a new and "revolutionary" approach
- Flexible reporting tools that provide operating reports for management and staff as well as physician and site-specific dashboards of key indicators

In addition, the EMR system selected should be certified by the Certification Commission for Health Information Technology, a not-for-profit organization recognized by the federal government for certifying electronic medical record system technology such that it will qualify for federal stimulus payments. Key characteristics in selection of the EMR include, but are not limited to:

- Computerized order entry capability (CPOE)
- ePrescribing capability
- Defined templates for documentation, coding and charge capture
- Interface with hospital systems for laboratory, diagnostic imaging and other test reporting
- Facilitated charge capture to the practice management system
- Intelligent tools for current medical terminology (CPT®) and ICD9 coding capture from physician documentation

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Process for information system selection

Selection of an information system and EMR vendor will have profound implications for the future performance of the physician practice enterprise. This activity is best facilitated by a third party consultant with extensive industry knowledge and experience in working with a broad range of information system platforms. The consultant can serve as a facilitator of the process, putting pre-selected vendors through the steps required to demonstrate meaningful differences in functionality.

Once a facilitator has been identified, a features and functionality requirements list should be developed in consultation with a team of users who will serve as a steering committee for system selection. A well-crafted list of individual features and functionality would include approximately 70-80 criteria for the practice management system and additional 60-70 criteria for the EMR. The steering committee should assign relative weights to the features and functionality criteria identified as well as to identify any "deal-breaker" criteria – features and functionality that must be available – in order for a vendor to be seriously considered.

The steering committee should be composed of representatives from the following key stakeholders:

- Physicians
- Revenue cycle director
- Receptionists
- Billers
- Clinic nurses
- Finance director (of the physician enterprise)
- Health system CIO or designee
- Consultant/facilitator

No more than five or six vendors should be identified to receive a request for proposal. These should be selected based on historical track record, client base, ability to integrate with multiple EMR systems. Following receipt of written proposals that are reviewed and scored by each member of the steering committee, no more than three vendors should be selected to provide a half-day demonstration.

Vendor product demonstrations should be prescribed by the facilitator so the steering committee may benefit from seeing each vendor demonstrate its features and functionality in the context of "real life" processes. As was done in the written proposal stage, demonstrations should be scored by each member of the steering committee based upon previously weighted criteria.

Following product demonstrations, the steering committee should select one preferred vendor and one back-up vendor. This continuing sense of competition keeps the preferred vendor focused on the health system's needs throughout the negotiation process and it provides an alternative option in case, for whatever reason, a final contract cannot be executed with the preferred vendor.

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Getting from here to there: contract negotiation, installation and implementation

Once a preferred and back-up vendor have been selected, a process that typically lasts 30 to 60 days (longer for larger organizations), the vendor contract can typically be negotiated into final form within 15 days with the assistance of the consultant/facilitator and legal counsel. There are many fine points to be addressed in the vendor contract, including the ability of the enterprise to offer the technology to private practices through an MSO leasing initiative as well as final pricing, warrantees and guarantees.

Prior to system implementation, the vendor must install the hardware, software and connectivity and create the unique system file structure that tailors the software to your organizational structure and daily operating procedures. This installation process typically lasts approximately 60 days for start-up and smaller organizations and takes longer for larger organizations.

Following installation, system implementation is characterized by documenting workflows, developing new policies and procedures, conducting staff training and making definitive plans for “go-live” and post “go-live” follow-up. Implementation activities may be conducted concurrent with installation and will generally require 90-150 days from the date of vendor contract signing. Implementation for large, complex physician practice operations takes longer.

The above process and timelines represent five to seven months of focused activity from the delivery of the RFPs to “go-live.” Using a co-sourced vendor as described above will shorten the process to three or four months.

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Conclusion

Management of the revenue cycle is an intensive, process-management endeavor. Success requires a strong management team with a revenue cycle director accountable for the entire process, a high level of physician engagement, robust information technology and strong reporting tools. Selection and implementation of the physician practice management information system to support the entire process is critical. Careful attention to the keys to success highlighted in this paper will make a significant difference in the outcome.

Health system sponsored physician employment: keys to success

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Case Study

Optimizing the physician revenue cycle

Phoebe Putney Memorial Hospital
Albany, Georgia

Gail Carter is responsible for business office, medical information services, chargemaster/charge capture, reimbursement and physician billing for Phoebe Putney Memorial Hospital. Gail Carter is responsible for business office, medical information services, chargemaster/ charge capture, reimbursement and physician billing for Phoebe Putney Memorial Hospital. Ms. Carter brings tremendous expertise and insights to understanding physician revenue cycle.

PHOEBE PUTNEY HEALTH SYSTEM

Gail Carter
Vice President, Revenue Cycle
Phoebe Putney Memorial Hospital

About Phoebe Physician Group

The Phoebe Physician Group started in 1997 when physicians were hired to service the needs of rural health clinics. Initially, the original medical services organization served only a billing function and shared a tax ID number with the hospital. Phoebe Putney Memorial Hospital billed in a month what the entire group billed in a year. Yet, as more physicians joined the physician group, it was clear that Phoebe Putney needed a structure to coordinate and govern these employed physicians. The number of physicians, physician assistants and nurse practitioners for whom the MSO is billing, has doubled between 1997 and 2009. In twelve years, revenue has grown from $12 million to $65 million. As of September 2009, Phoebe Physician Group now has 85 physicians and 31 midlevel providers. By January 2010 these numbers are scheduled to increase to 116 and 38 respectively.

Reinventing the physician organization

There was an initial recognition by the management team that the physician enterprise organization could not continue as a simple billing function. As a result, the MSO's management team created a separate entity with its own tax ID number and physician finance committee oversight. With its own tax ID, the physician practices are not subject to Joint Commission. The physician finance committee, is chaired by a physician, consisting of seven MDs, the physician practice group administrator, a CFO and a service line administrator.

In the new enterprise, a leadership dyad of a physician leader and a professional manager with physician practice management experience was put in place. A finance director/CFO and MSO finance professional reporting to Ms. Carter was hired to focus on the physician practice needs.

The MSO and hospital remain in strategic partnership since they both share a common goal of making the physician enterprise financially successful.

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As additional physician practices have been acquired, the revenue cycle activities of those practices have been transitioned and brought under the MSO.

For example, as eight oncologists became part of the physician group, the professional fees were unchanged and not diminished by the transition from a hospital based group. The revenue cycle activities are now under the tax ID of Phoebe Physician Group while the chemotherapy infusion rooms and the facility fees remain hospital based.

Redesigning the revenue cycle

The revenue cycle redesign created a hybrid of centralized functions along with decentralized functions.

The centralized business office (CBO) holds the charge master, claims management, payment posting, customer service and ongoing education functions. Charge master and claims management is now done centrally so there are consistent practices and charges across the clinics within what is appropriate within the specialties. The fee schedules as negotiated with the payers are loaded into the system. An error report is generated when payments do not match the fee schedule. The hospital and clinics work together to get best practice in place for payment posting and this function is in the CBO. The education professional for orientation of new employees and ongoing education is with the CBO to teach consistent practice.

Decentralized functions include registration, coding and charge entry at the site of service and management of denials and errors caused by the "front end" (physicians and personnel). This keeps the practice sites involved and accountable for revenue cycle success. The front end revenue cycle activities and people report to practice managers who report to the practice director. This director reports to the Phoebe Physician Group administrator and medical director in their dual leadership role.

Designing solutions

In October 2008, using an outside consultant, the MSO developed a revenue cycle process improvement plan with completion dates and defined responsibilities:

- Developed and implemented policies and procedures in support of all components of the cycle
- Initiated a formal education program for personnel on the front and the back ends of the revenue cycle.
- Sourced benchmarks from MGMA which are being considered for individual productivity measures and incentive plans.
- Selected timeliness, collections from each payer category and percent of net forecasted revenue as measures of productivity.

Table 1: CBO key indicators of performance

Key metrics	Ratios Net revenue/visits
Visits	Net revenue/visits
Revenue	Net revenue/wRVU*
Collections	percent of expected copayments received
Insurance Patient	percent of accounts receivable by aging category
Claims on hold for edits at month end	Value of claims unbilled (for edits)
Missing charges	Value of missing charges
Gross days in accounts receivable	percent of accounts receivable sent to collections
Accounts receivable by age and category	
Bad debt write-offs	
Patient balances sent to collections	*wRVU – Relative value units

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To ensure that the technology functionality increased automation and reduced human error, the MSO contracted with a consultant to build an interface with the hospital's practice management system.

> **Example:** Pre-acquisition, 13 radiologists at the hospital had outsourced professional billing. As these radiologists were hired into the physician group, an automated charge transfer ensured that the correct information from the hospital radiology information system was transferred to the Phoebe Physician Group practice management system for professional fee radiology billing.
>
> Bringing this function into the MSO resulted in a savings of approximately $150,000 and reduced the total billing-to-charges expense ratio to 8% compared to 11% when the function was outsourced.

In addition, the MSO also developed and implemented additional enhancements:

- Tooled the practice management system for easy retrieval of key information in support of increased time of service collections
- Automated and categorized tasks in the MSO to reduce denial turnaround time
- Set up a server folder and posted denials by practice for assigned staff in each clinic to work those denials while the MSO monitored the progress.

In order to improve accuracy of demographics, insurance information and time of service collections, the plan also included the redesign of practice activities and the active involvement of practice directors, site managers, site personnel and CBO personnel.

The group worked collaboratively with the hospital to develop a plan for patient payments outstanding. Some of the process improvements included:

- Verifying insurance before making appointments
- Making financial counselors available to help staff and patients understand other options when necessary
- Reorganizing the CBO to improve throughput and reduce insurance accounts receivable.

Enhancing training

Practice personnel, both acquired and new hires, were trained to access new features within the practice management system in support of revenue cycle protocols:

- Discussed patient payment expectations during telephone scheduling, at reception, and at discharge from the visit
- Verified formal insurance verification prior to the scheduled visit
- Updated demographics and insurance information in real time at the point and time of service
- Corrected errors and built knowledge into the training program with the utilization of trending from automated edits lists for claims rejected for error
- Managed timely charge entry and cash controls the same day as service
- Hired project staff to work aged accounts

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Table 2: Revenue cycle improvements

CBO key metrics	Dec. 2008 prior to redesign	Sept. 2009	Improvement
Gross revenue	$65 million	$65 million	—
Average collection rate	40%	44%	4%
Gross days in accounts receivable	77	63	14
Insurance	42	32	10
Patient	226	206	20
Net revenue/wRVUs*	$59	$66	$7
Average monthly patient payments	$261,000	$307,000	$46,000

*wRVU – Relative value units

Communicating with physicians

The Phoebe Physician Group developed a monthly physicians' dashboard that was initially piloted with gastroenterologists now in the physician entity. Since the MSO is now billing for about 100 physicians, this dashboard with the individual's data is scheduled to be rolled out to every physician in the Phoebe Physician Group.

Table 3: Physicians' monthly dashboard (part 1)

Physician:	**Provider 2**	**Current Month:**	**August 2009**
Location:	**101 Health Care Blvd**	**Date of Report:**	**09/22/09**
Specialty:	**FAMILY PRACTICE**	**Enter # of Month Here:**	**2**

Revenue Centers:

	Charges Month	Charges YTD	Count Month	Count YTD
Office	$ 33,407	$ 64,788	394	725
Hospital	$ 2,253	$ 12,637	18	110
Procedures	$ 1,455	$ 4,813	10	27
Ancillary	$ 2,808	$ 5,602	57	117
Injectables	$ 3,656	$ 7,487	75	143
Total	$ 43,579	$ 95,328	554	1,122
New Patients:	N/A	N/A	9	33

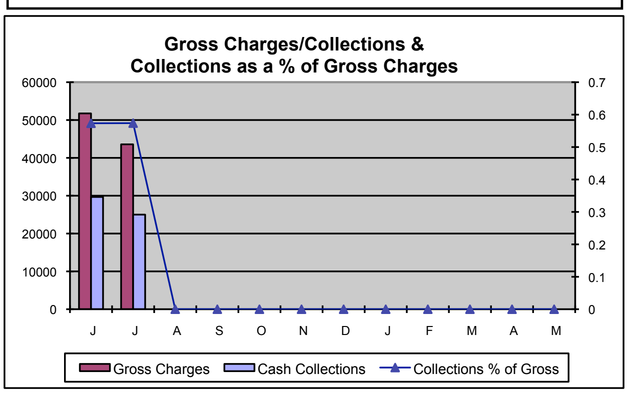
	Actual Month	Actual YTD	Target Month	Target YTD
Patient Visits:	306	563	313	626
Worked RVU's:	274.8	637.5	353.0	706.0

Key Indicators:

	Month	YTD	Prelim Target
Payments % of Gross	57.4%	57.4%	63.0%
Payments/Visit	$ 81.71	$ 97.11	$ 106.47
Payments/WRVU	$ 91.00	$ 85.76	$ 94.43
Wkd RVU's/Visit	0.9	1.1	1.1
Bad Debt % of Prof Chgs	0.0%	0.0%	3.0%
Avg Co-Pay/Visit	$ 5.63	$ 6.38	$ 8.00

Payments & Bad Debt:

	Month	YTD	AVG
Total Payments	$ 25,004	$ 54,674	$ 27,337
Co-Payments	$ 1,723	$ 3,591	$ 1,795
Payments on Account	$ 4,149	$ 7,322	$ 3,661
Bad Debt Expense	$ -	$ (5)	$ (3)



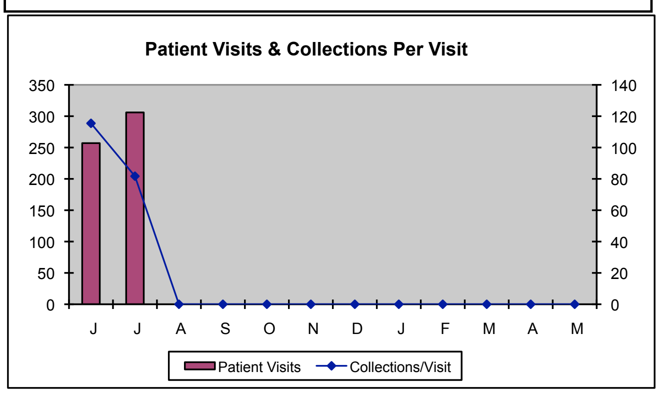


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Table 3: Physicians' monthly dashboard (part 2)

Accounts Receivable Aging Analysis by Major Payor: (Including Credit Balances)

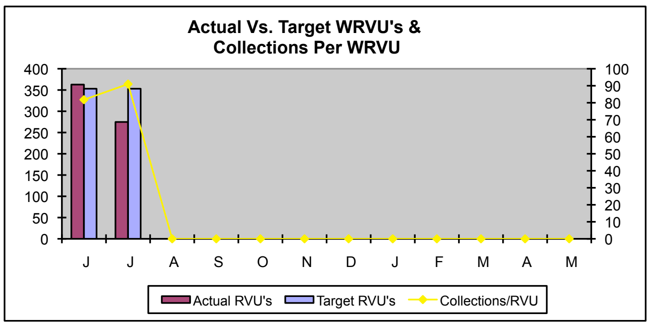
	Current	30+	60+	90+	120+	150+	180+	Total	
Medicare	$ 5,792	$ 75	$ 10	$ 25	$ 97	$ 97	$ -	$ 6,096	12.3%
Medicaid	$ 5,740	$ 684	$ 1,436	$ 734	$ 75	$ -	$ 276	$ 8,946	18.1%
BCBS	$ 7,301	$ 911	$ 893	$ -	$ -	$ -	$ 20	$ 9,125	18.4%
HMO	$ 4,191	$ 125	$ 732	$ 729	$ 134	$ -	$ -	$ 5,912	11.9%
Other	$ 3,546	$ 396	$ 655	$ 325	$ -	$ -	$ -	$ 4,921	9.9%
Self Pay	$ 1,722	$ 2,962	$ 1,457	$ 1,774	$ 1,287	$ 1,453	$ 3,906	$ 14,562	29.4%
TOTAL	$ 28,292	$ 5,154	$ 5,184	$ 3,587	$ 1,593	$ 1,550	$ 4,202	$ 49,561	100.0%
	57.1%	10.4%	10.5%	7.2%	3.2%	3.1%	8.5%	> 90 Days	GOAL
								22.1%	< 20%
Benchmark	>55%	>15%	<10%	<8%	<6%	<4%	<2%		

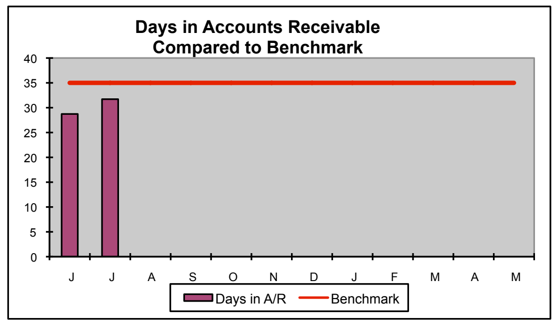
Collection Ratio Analysis (9 Mos. History - 3 Mos. Lag)	
2006/Apr	92.0%
2006/Mar	91.1%
2006/Feb	95.6%
2006/Jan	95.3%
2005/Dec	97.3%
2005/Nov	98.5%
2005/Oct	95.8%
2005/Sep	98.3%
2005/Aug	99.4%

Payor Mix Analysis

	$ Month	$ YTD	% Month	% YTD
Medicare	$ 6,708	$ 14,268	15.4%	15.0%
Medicaid	$ 10,750	$ 25,082	24.7%	26.3%
BCBS	$ 14,412	$ 32,746	33.1%	34.4%
HMO	$ 5,295	$ 10,790	12.2%	11.3%
Other	$ 5,965	$ 11,375	13.7%	11.9%
Self Pay	$ 449	$ 1,067	1.0%	1.1%
Total	$ 43,579	$ 95,328	100.0%	100.0%

Total Days in A/R Outstanding		31.7
Benchmark Days in A/R		35.0
A/R $'s Better/(Worse) Benchmark		$ 5,135
RVU Analysis	**Current**	**YTD**
RVU Variance from Target	(78.2)	(68.5)
Cash Impact of Variance	$ (6,708)	$ (5,873)





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Lessons learned

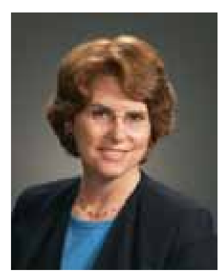
Ongoing steps in the Phoebe Physician Group revenue cycle performance improvement journey includes:

- An effort to improve collections at the time of service
- Consistency of message
- Financial counseling at the point of service
- Converting acquired practices over time into the core MSO data base without disruption to the physicians' practices

As the roll out of the physicians' dashboard to each physician member of the Phoebe Physician Group continues, the group is now also beginning the implementation of an ambulatory electronic health record.

In more than 11 months of efforts and transformation, Phoebe Physician Group has clearly demonstrated that management of the physician revenue cycle is critical to the success of the physician led, professionally managed physician enterprise.

This case study is summarized from comments by Gail Carter on August 25, 2009 as part of the 2009 VHA CEO Affinity Group teleconference series.



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End note

1. Part two of this VHA/Southwind white paper series speaks directly to “Aligning incentives through physician compensation” and provides a specific model that addresses alignment of physician and hospital incentives for effective professional fee cash collections performance.

   Part three of the series is focused on “Organizational structure, governance and management” and provides additional guidance on physician engagement through governance.

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