



Managing the Health Center Revenue Cycle

 **CAPITAL LINK**
www.caplink.org

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Advancing the Financial Strength of TN Health Centers
April 25, 2018



Capital Link - Overview

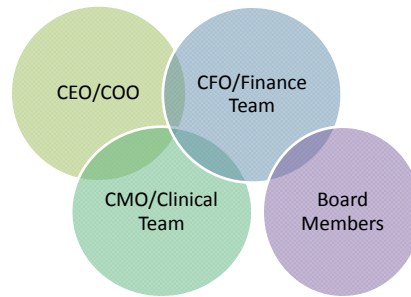
- Launched in 1995, nonprofit, HRSA national cooperative agreement partner
- Offices in CA, CO, MA, ME, MO, SC and WV
- **Over \$1.1 billion** in financing for **over 225** capital projects
 - **Direct assistance** to health centers and complementary nonprofit organizations in planning for and financing operational growth and capital needs
 - **Industry vision and leadership** in the development of strategies for organizational, facilities, operational and financial improvements
 - **Metrics and analytical services** for measuring health center impact, evaluating financial and operating trends and promoting performance improvement

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Advancing Financial Strength (AFS) Program Overview



- Program Custom-Developed with the TN PCA
 - Tools, Trainings, Technical Assistance
- *Not a “CFO Training Program” but an integrated learning experience.*



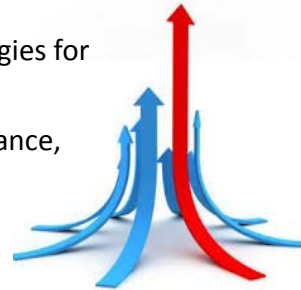
Goal: Financial Sustainability and Access to High Quality Care



AFS Program Overview:

GOAL: *Improve Financial Sustainability and Increase Health Center Readiness for Growth.*

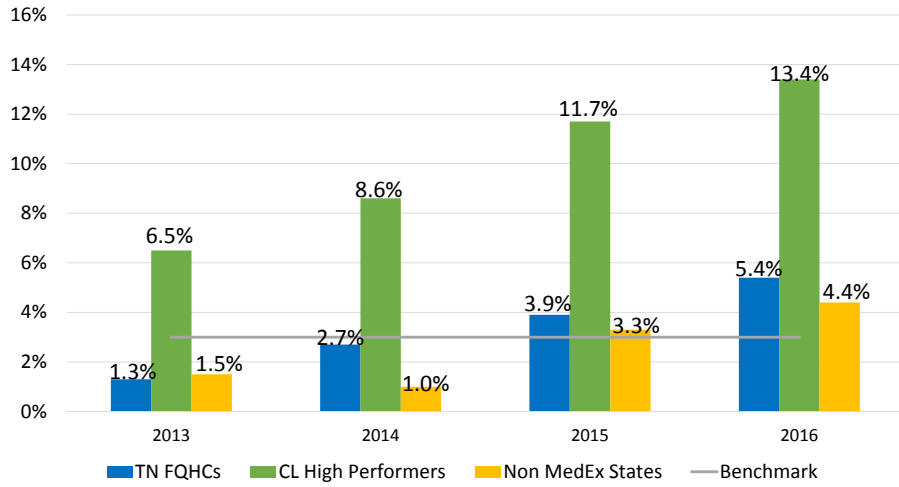
- **Understand:** Assessments and Training on Metrics/Benchmarking (100 Series)
- **Develop Action Plans:** Training and Strategies for Improvement (200 and 250 Series)
- **Implement and Monitor:** Technical Assistance, Support & Tracking (300 Series)



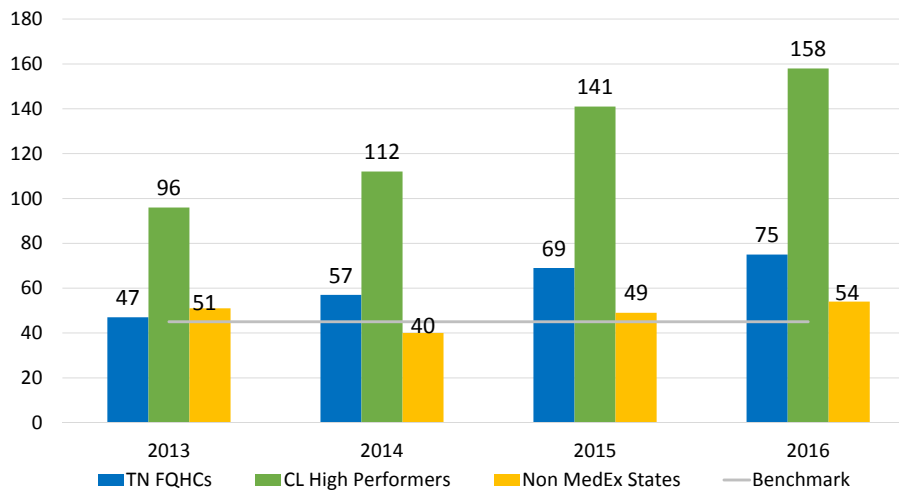
TN PCA Financial Profile: Medians

Key Financial Metrics	Target	TN PCA 2013	TN PCA 2014	TN PCA 2015	TN PCA 2016	Medicaid Non-Exp Median 2016	National High Perf. Median 2016
Operating Margin	> 3%	1.3%	2.7%	3.9%	5.4%	4.4%	13.4%
Bottom Line Margin	> 3%	1.6%	3.6%	5.5%	6.6%	5.6%	12.9%
Personnel-Related Expense as % of Operating Revenue	< 70%	72.0%	68.7%	68.2%	68.8%	70.3%	65.4%
Days Cash on Hand	> 45 Days	47	57	69	75	54	158
Days in Net Patient Receivables	< 60 Days	35	40	32	40	38	37

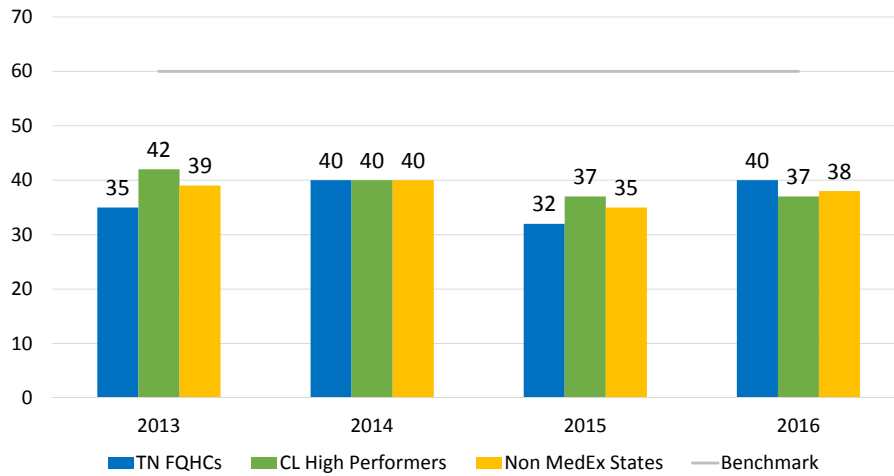
Operating Margin - Medians



Days Cash on Hand - Medians



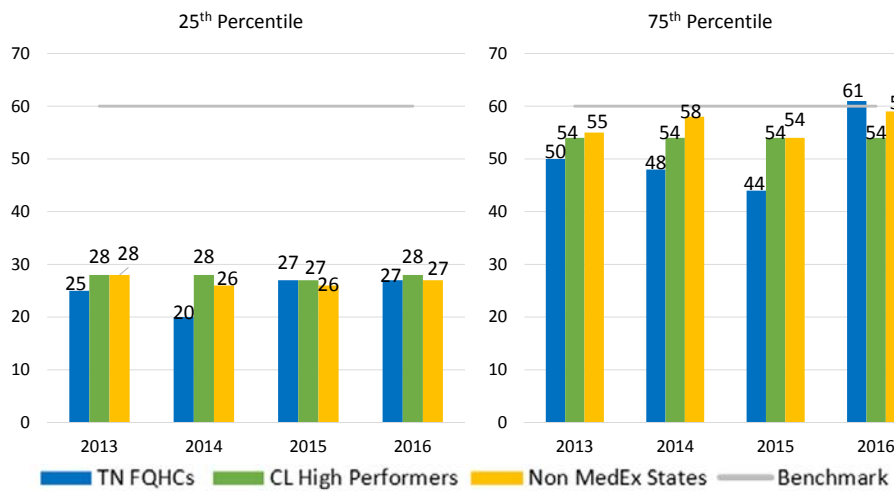
Days in Net Patient Receivables - Medians



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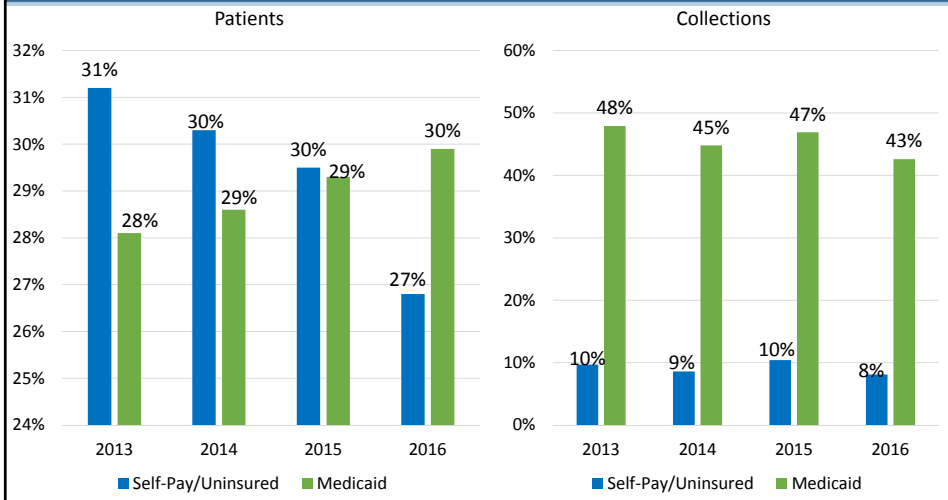
Days in Net Patient Receivables – 25th & 75th Percentiles



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TN PCA Median Patients & Collections as a % of Total



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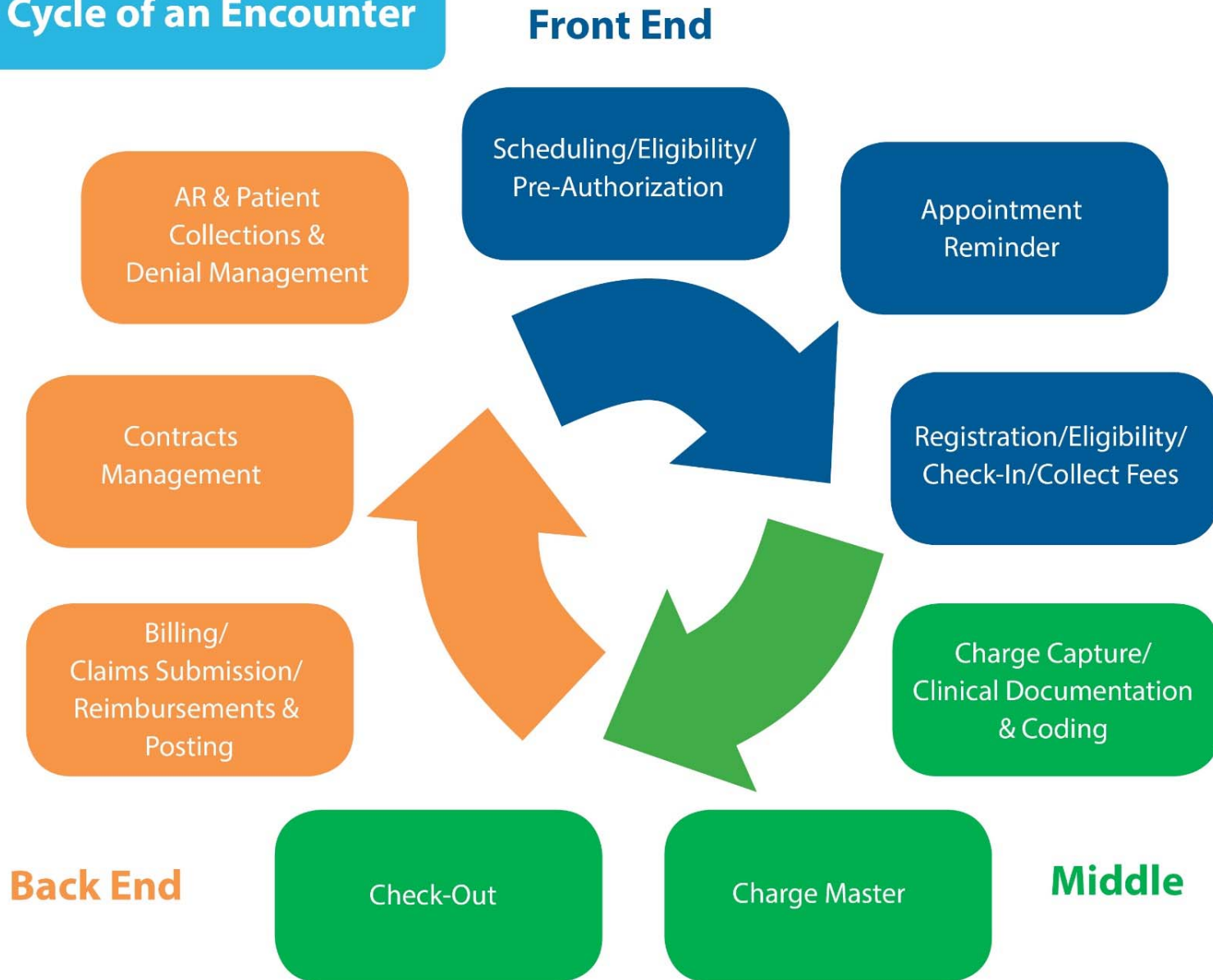
Managing the FQHC Revenue Cycle

Training Objectives

- Provide ready-to-use ideas as well as numerous key strategic practices and tools to use to optimally manage your revenue cycles.
- Establish an understanding of influences on health center revenue cycle management.
- How can we improve on processes that result in more efficiencies and bigger dollars?

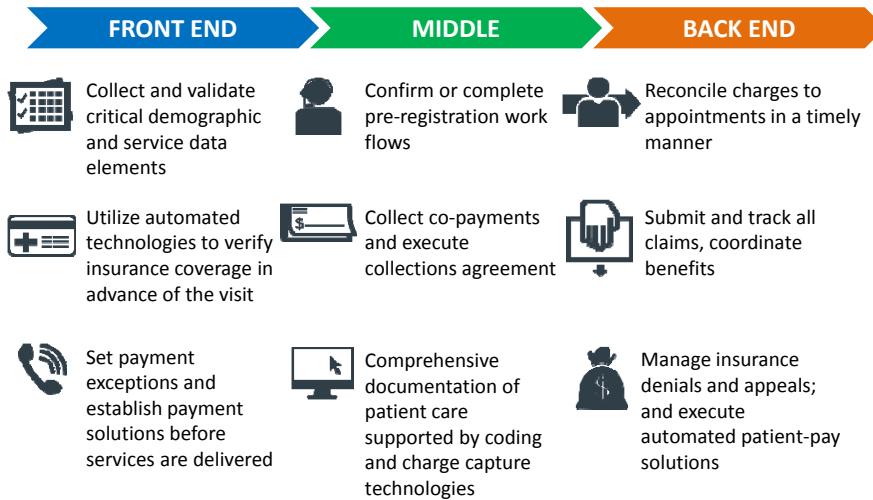


Life Cycle of an Encounter



Success Requires Getting Many Pieces Right

Process Imperatives Before, During, and After Visit



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High Performing Revenue Cycle Commonalities



- Organizational culture that elevates the importance of the revenue cycle.
- Master areas important to their particular circumstances.
- Accelerate improvements.
- Take action and execute strategies to achieve goals.
- Understand the connection between RCM and the clinic's bottom line.

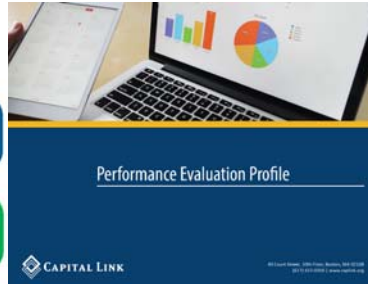
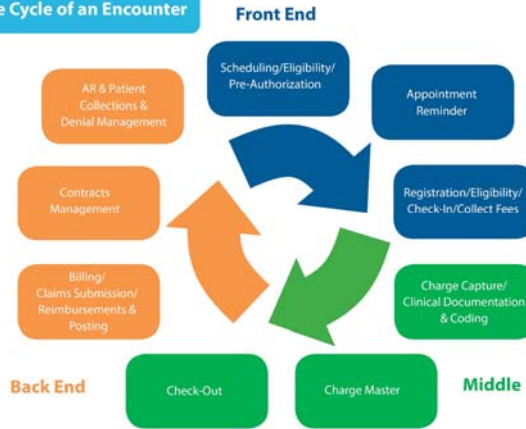


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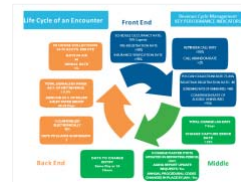
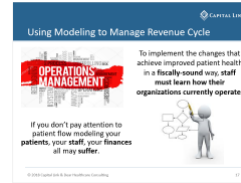
Making The Connection

Life Cycle of an Encounter



Putting It All Together

- RCM Toolkit
- Workflow Mapping
- SOP for PPTM
- Specific Metrics & Evaluation Tools

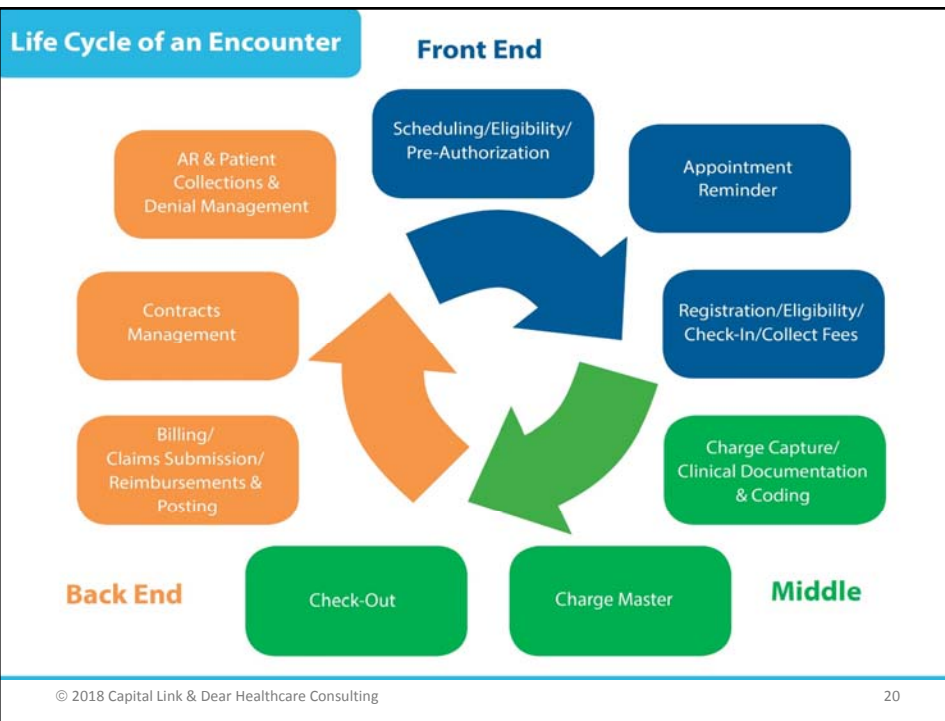


The Importance of Patient Flow Modeling

Visually conveying processes to a practice so they can look for ways to improve their processes to increase efficiency, reduce errors, and improve outcomes.

LIFE CYCLE OF A PATIENT ENCOUNTER

Scheduling, Pre-Authorization, Appointment Reminder, Registration, Eligibility, Check-in, Collect Fees, Clinical Assessment, Charge Capture, Clinical Documentation and Coding, Charge Master, Check-out, Billing, Claims Submission, Reimbursements, Posting, Contracts Management, Accounts Receivable, Collections, Denial Management



Using Modeling to Manage Revenue Cycle



To implement the changes that achieve improved patient health in a **fiscally-sound way**, **staff must learn how their organizations currently operate.**



If you don't pay attention to patient flow modeling your **patients**, your **staff**, your **finances** all may **suffer**.

Revenue Cycle & Silos



EVERYTHING WITHIN THE PATIENT ENCOUNTER IS INTERCONNECTED.



Process Perception, Reality & Ideal

- Perceived Process
- Realistic Process
- Ideal Process



Key Areas To Consider

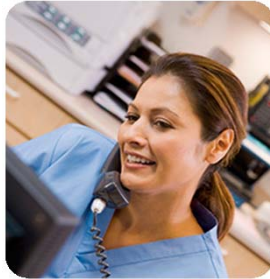


Front End: Scheduling, Eligibility, and Pre-Auth

SCHEDULING,
ELIGIBILITY, PRE-
AUTHORIZATIONS



APPOINTMENT
REMINDER



REGISTRATION,
ELIGIBILITY, CHECK-IN,
COLLECT FEES



Front End: Scheduling, Eligibility, and Pre-Auth

Key Functions of Front Desk Staff

- Confirm and schedule patient appointments.
- Assess a patient's needs in order to schedule with the appropriate provider.
- Update patient demographic and insurance information.

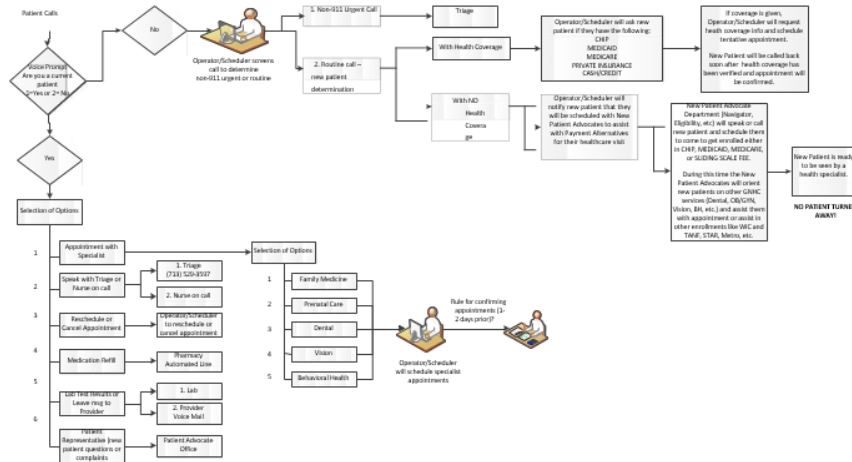


Questions to Evaluate the Effectiveness of the Scheduling Function

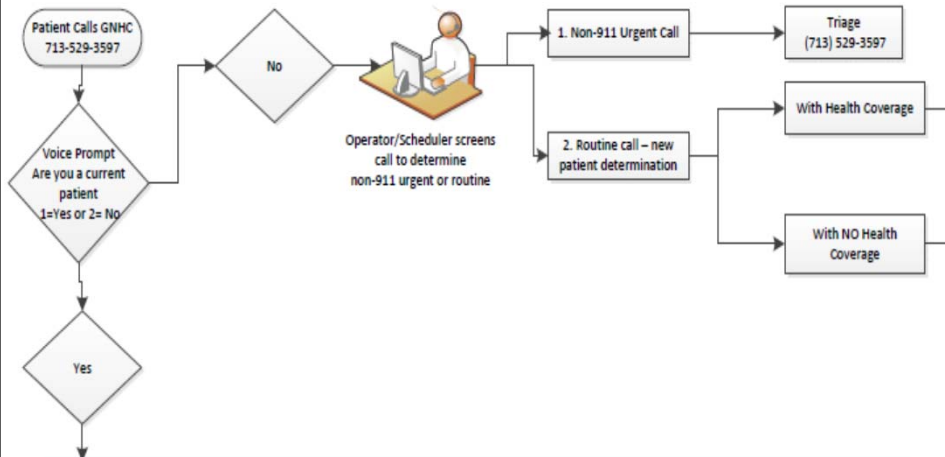
Does your clinic have an electronic system for appointments that collects contact info, insurance/payment source, and other patient information?



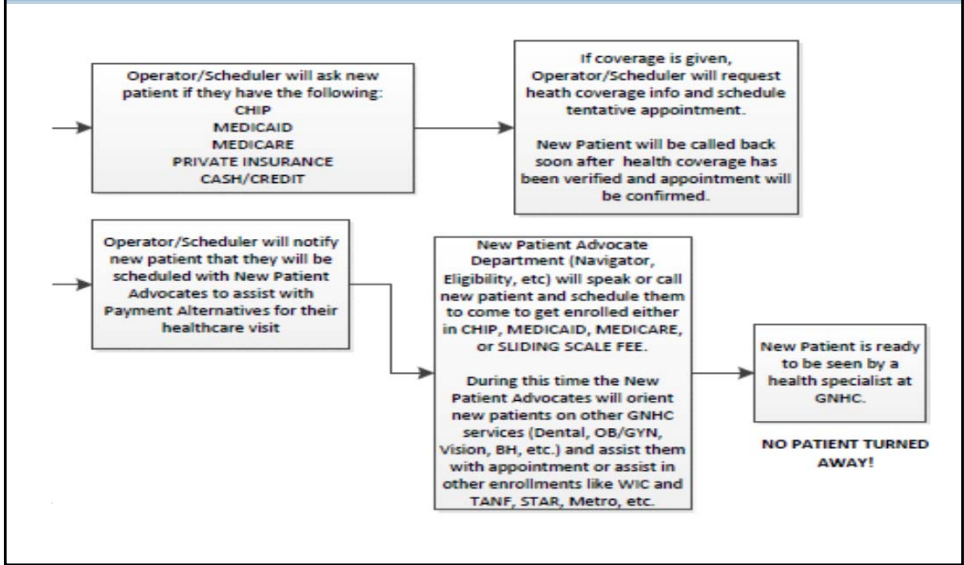
Front End: Scheduling, Eligibility, and Pre-Auth



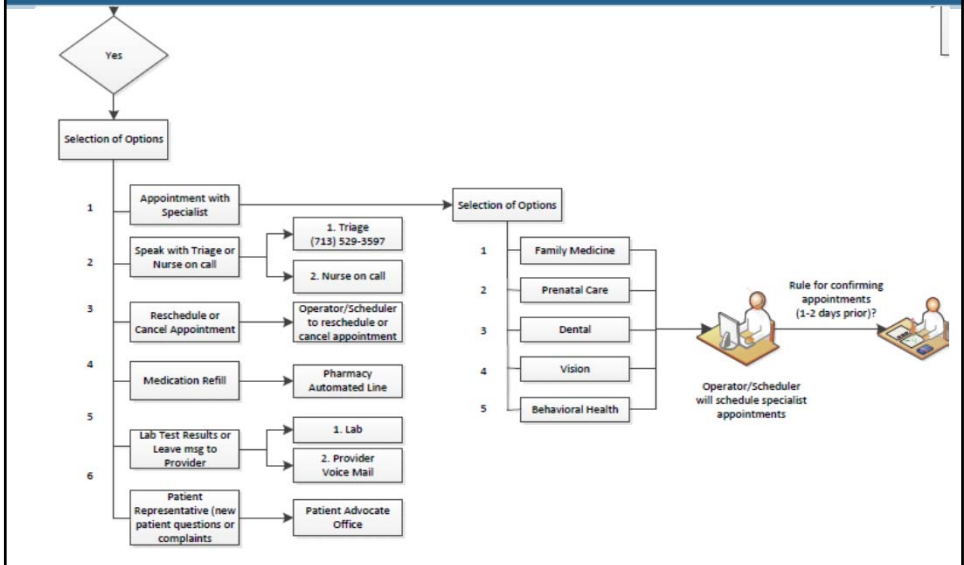
Front End



Front End



Front End



Simplified Patient Scheduling

- Make all appointments the same length.
- Improve efficiency –appointment slots should be **15-20 minute increments**
- Review fill rate of appointment slots.
- Start all visits on time.
- Make appointments as close to the time of request for care as possible.



Scheduling Policies And Procedures

- Provider time in clinic **seeing patients** should be at least **32 hours** per week (full time) 8 hours admin time.
- Providers see the patients who are presented to them.
- Deviation from this policy should require the Chief Medical Officer/Chief Nursing Officer's approval.
- Monitoring staff conformity with defined processes is required to ensure continued compliance.

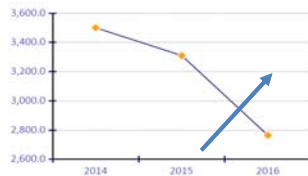
DON'T PUT SCHEDULERS IN THE UNENVIABLE POSITION OF DEBATING SCHEDULING ISSUES WITH PROVIDERS!



Metrics



Physician Visits



SCHEDULE OCCUPANCY RATE
95% Capacity

PRE-REGISTRATION RATE
>98%

INSURANCE VERIFICATION RATE
>98%

Front End: Appointment Reminder Call

Key Functions of Front Desk Staff

- Contact patients by phone or electronically.
- Most Practice Systems have the capability to program and automate reminder calls/emails.



CONFIRMING AN APPOINTMENT

“Let me know if you can’t make it.”
“We’re expecting you. We’ve dedicated this appointment to you.”

Questions to Evaluate the Effectiveness of the Appointment Reminder Function

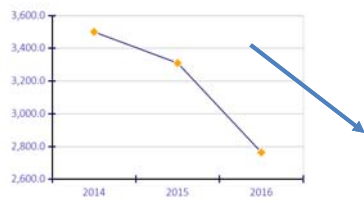
Does your health center make reminder calls in advance?
Is an email or text reminder sent?



Metrics



NO SHOW RATE



REMINDER CALL RATE
100%

CALL ABANDON RATE
<2%

Front End: Registration, Check-in, & Collect Fees

Key Functions of Registration/ Financial Counseling Staff:

- Review financial policies, procedures, and financial responsibility
- Collect patient fees
- Work with insurance companies to verify coverage and eligibility.
- Provide financial counseling resource for uninsured patients.



Questions to Evaluate the Effectiveness of the Registration/ Check-In Function

Does your clinic have written protocols and procedures for staff to follow during the patient "check-in" process?

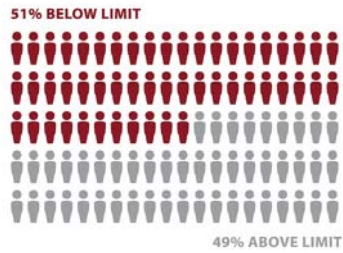
How are staff oriented/trained on this "check-in" process?



Metrics



Half of Today's Uninsured Have Incomes Below the New Medicaid Limit (138% FPL)



POS CASH COLLECTIONS RATE
75-80%

REGISTRAR REGISTRATION RATE
40

SCREENING RATE OF UNINSURED
>98%

CONVERSION RATE OF ELIGIBLE UNINSURED
>95%

Middle

CHARGE CAPTURE,
CLINICAL
DOCUMENTATION,
CODING



CHARGE
MASTER



CHECK OUT



Middle: Charge Capture, Documentation & Coding

Key Functions of Clinical and Billing Staff

- Ensure comprehensive documentation of services are supported by coding and charge capture technology.
- Consistent coding of encounter diagnoses codes on the encounter form.
- Periodically audit visit notes and compare them to encounter forms.



Questions to Evaluate the Effectiveness of Charge Capture, Clinical Documentation, and Coding Function

Does your health center use an encounter form/superbill? How is it kept up to date?

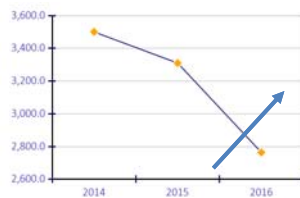
Does your health center have written protocols and procedures for staff on documentation, coding, and charges?

What is your health center's system for entering service charge data? Do charges match clinical documentation?

Metrics



NET REVENUE



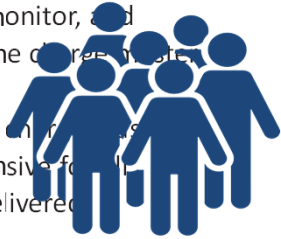
TOTAL CHARGE LAG DAYS
7 DAYS

CHARGE CAPTURE ERROR RATE
>10%

Middle: Charge Master

Key Functions of Financial Management Staff

- Manage, monitor, and maintain the charge master.
- Ensure the charge master is comprehensive for all services delivered.
- Ensure all items are defined in the charge master and captured for reporting.



Questions to Evaluate the Effectiveness of Charge Master Function

Does your organization have tools in place to aid in tracking and management of the individual charge item records in the charge master file?

Does your organization have a formal charge master change management process; a formal annual charge sheet/ticket review process?

Metrics



WHAT THEY MEASURE

These metrics provide insight on charge master integrity during periods between full annual audits.

CHARGE MASTER ITEMS UPDATED IN REPORTING PERIOD
100%

AGING REPORT ON UPDATE REQUESTS
YES

CODE CHANGES IN PLACE BY JANUARY
YES

Middle: Checkout

Key Functions of Financial Counselors/ Checkout Staff

- Educate patient on health center financial policies including co-payments, prompt pay options, and due account balances.
- Collect payments.



Questions to Evaluate the Effectiveness of Check out Function

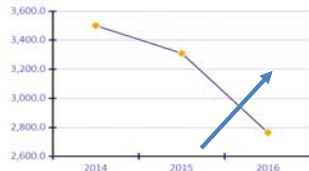
Does your health center have written protocols and procedures for staff for the patient checkout process?

How are staff trained on this process?

Metrics



BILLING ACCURACY



DAYS TO CHARGE ENTRY
SAME DAY OR 24 HOURS

NEXT APPOINTMENTS SCHEDULED
75-80%

Back End

BILLING, CLAIMS,
PAYMENT PROCESSING,
REIMBURSEMENT,
POSTING



CONTRACTS
MANAGEMENT



ACCOUNTS
RECEIVABLES, PATIENT
COLLECTIONS, DENIAL
MANAGEMENT



Back End: Billing, Claims Submission, Payment Processing Reimbursement, and Posting

Key Functions of Billing Staff

- Code and bill claims.
- Establish contracts with payers.
- Monitor eligible and non-eligible services.
- Document payer and amount to patient's account.
- Prepare statements.
- Process all billing issues quickly and accurately.
- Keep records of collections and status of accounts.



Questions to Evaluate the Effectiveness of Billing/Claims Function

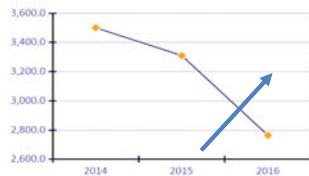
- Does your health center have a Practice Management System with a "review" feature?
- Does your health center use a clearinghouse (third party) to review claims (using edit codes) before being sent to the payer?



Metrics



CASH FLOW



% CLAIMS BILLED ELECTRONICALLY
95%

DAYS TO CLAIMS SUBMISSION
2 DAYS

Back End: Contracts Management

Key Functions of Contracting/ Finance Staff

- Conduct review of complex language and financial analysis with major payers.
- Implement legal and regulatory business requirements through negotiations.
- Initiate the managed care plan, operations, obligations, and responsibilities inter-departmentally throughout the health center.
- Communicate and resolves issue.



Questions to Evaluate the Effectiveness of Contracts Management Function

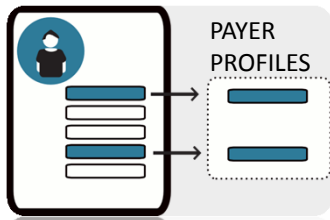
- Does your health center have a comprehensive payer profile on file for each managed care contract?
- Does the health center know what the key terms of the contract are and how they impact it?

Metrics



TOTAL DENIALS BY PAYER AS A % OF NET REVENUE
 <5%

AGED A/R AS A % OF BILLED A/R BY PAYER
 15%



Back End: Accounts Receivable, Patient Collections, & Denial Management

Key Functions of Billing, Claims & Collections Staff

- Collect and enter claim information.
- Post insurance and patient payments and manage denials.
- Submit claims and follow up with insurance carriers on unpaid or rejected claims.
- Answer patient inquiries on account status and charges.



Questions to Evaluate the Effectiveness of AR, Collections & Denial Management Function

How often does the health center review A/R?

Does your health center have systems to track if a payer has not acted on a claim?

Does your health center regularly modify or appeal denied claims, as appropriate?

Metrics



DAYS IN AR
40-45 DAYS

DENIAL RATE
5%

WHAT THEY MEASURE

Days in accounts receivable is the number of days before patient payments are collected.







The denial rate measures claims that are unpaid.



Group Exercise

Select Process


Processes needed to prepare a patient flow modeling map include:

- Answering Phones 
- Patient Scheduling 
- Collecting Fees 
- Patient Workup 
- Completing new patient paperwork 
- Claims Submission & Processing 

Detailed Workflow Maps

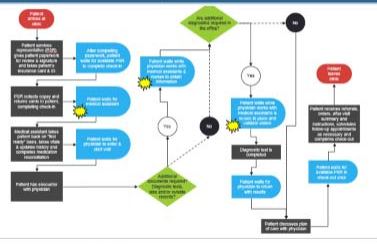
Detailed Workflow Maps

- Here are two flow charts showing the patient flow modeling of “patient check-in”.
- Both figures are accurate descriptions of the same process at a particular clinic.



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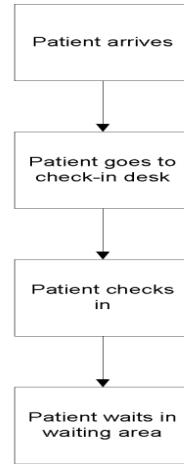
Detailed Workflow Maps



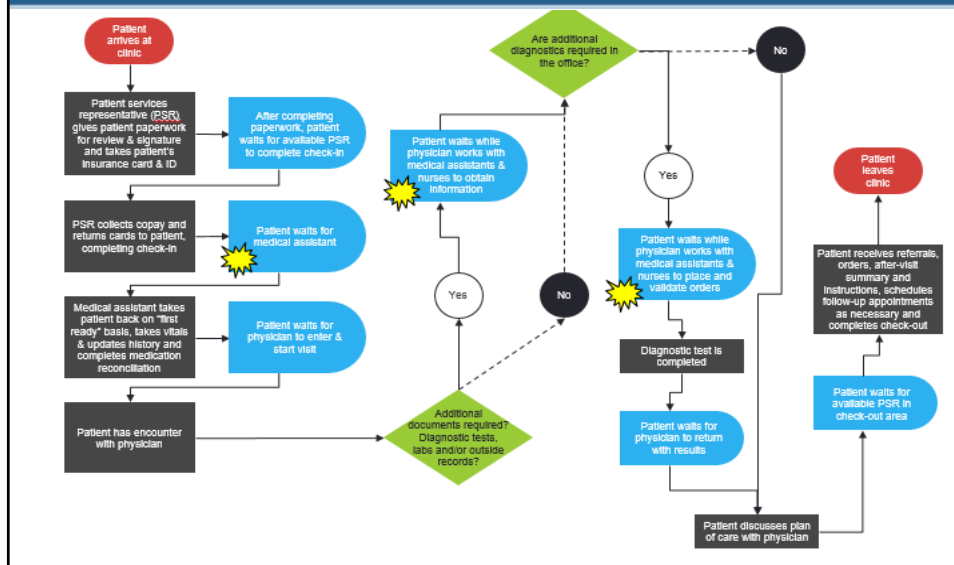
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Detailed Workflow Maps

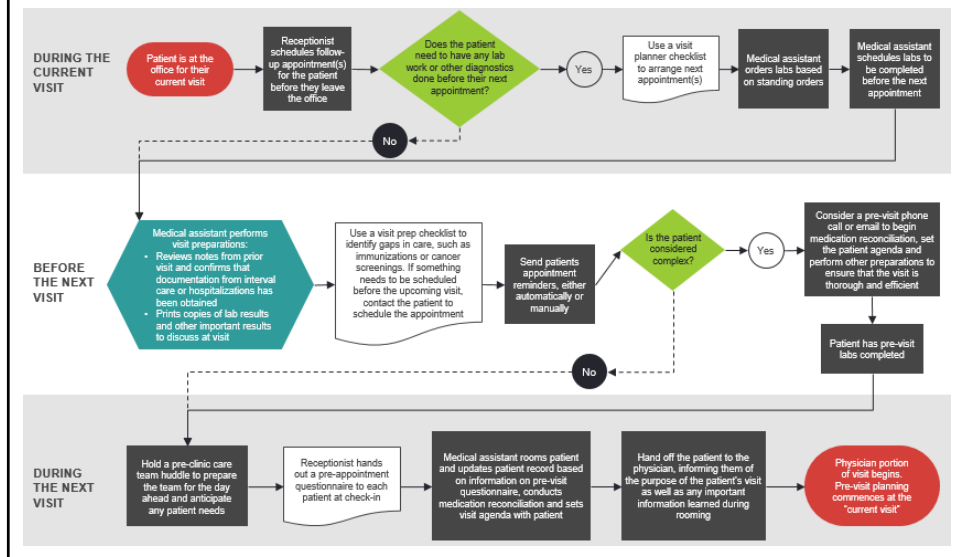
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- Both figures are accurate descriptions of the same process at a particular clinic.



Detailed Workflow Maps



Detailed Workflow Maps



Process Mapping Example: Rooming a Patient

- Process begins when the MA gets the patient from the waiting area; this is represented by a rectangle.
- The following steps of the process are all represented by rectangles: collect weight and height data, place patient in exam area, and collect clinical data.
- Then, a question about whether patient preparation is required is represented by a diamond.
 - If yes, the Workflow Map continues with patient preparation and then goes on to the next question.
 - If not, the Workflow Map skips to the next question.
- The next question is about whether equipment is available.
 - If yes, the Workflow Map continues with equipment preparation and then goes on to the final process step.
 - If not, the Workflow Map skips to the final process step.
- The final step of the process is to inform the provider that the patient is ready to be seen; this step is also represented by a rectangle.



Validate & Analyze

- You can use your process map to assess problem areas for improvement by examining some of the following:
 - Bottlenecks and other sources of delays
 - Rework due to errors
 - Role ambiguity
 - Duplicated efforts
 - Unnecessary steps
 - Sources of waste
 - Variations
 - Hand-offs



Reflection Questions – Design & Implementation

- Is there a problem with current performance? Desire better results?
- Have you been skipping any critical steps?
- Are all steps necessary? Are there areas of unnecessary duplication or redundancy?
- How often do you have to do each step?
- Are there areas that rely on an individual to remember to do something? Any process that relies on memory is prone to error.
- What happens if the process breaks down? Do you need a fail-safe mechanism? A contingency?
- Can some steps be done simultaneously?
- Is there a more logical way to sequence the steps?

Reflection Questions - Staffing

- Could someone be hired to perform this step?
- Could this step be outsourced?
- Is there any technology that would make this process more efficient or easier to complete?
- Is there an entirely different approach to the task(s)?
- Who might handle a specific task very well? An exemplar? Can you study their patient flow modeling?



RCM Toolkit & Metrics Review

RCM Toolkit

- Toolkit provides an overview of the revenue cycle management process and best practices for each function.
- It also includes suggested key performance indicators and helpful resources.
- For health center leadership teams and revenue cycle staff.



Having *efficient* and *effective* processes across the many functions that comprise the revenue cycle in a health center is critical to financial sustainability.

Life Cycle of an Encounter

Front End

Revenue Cycle Management KEY PERFORMANCE INDICATORS

IN HOUSE COLLECTIONS
45-70 ACCTS. PER FTE

DAYS IN A/R
40

DENIAL RATE
5%

SCHEDULE OCCUPANCY RATE:
95% Capacity

PRE-REGISTRATION RATE
>98%

INSURANCE VERIFICATION RATE
>98%

REMINDER CALL RATE
100%

CALL ABANDON RATE
>2%

TOTAL DENIALS BY PAYER
AS % OF NET REVENUE
≤ 5.0%

AGED A/R AS % OF BILLED
A/R BY PAYER GROUP
40-45 Days

POS CASH COLLECTIONS RATE: 75-80%

REGISTRAR REGISTRATION RATE: 40

SCREENING RATE OF UNINSURED: >98%

CONVERSION RATE OF
ELIGIBLE UNINSURED
>95%

% CLAIMS BILLED
ELECTRONICALLY
95%

DAYS TO CLAIMS SUBMISSION
2

TOTAL CHARGE LAG DAYS
7 days

CHARGE CAPTURE ERROR
RATE
>10%

Back End

DAYS TO CHARGE
ENTRY
Same Day or 24
Hours

CHARGE MASTER ITEMS
UPDATED IN REPORTING PERIOD:
100%

AGING REPORT UPDATE
REQUESTS: Yes

ANNUAL PROCEDURAL CODES
CHANGES IN PLACE BY JAN : Yes

Middle

Front End: Scheduling, Eligibility, and Pre-Authorization



SCHEDULE OCCUPANCY RATE:
95% Capacity



PRE-REGISTRATION RATE
>98%



INSURANCE VERIFICATION RATE
>98%

Front End: Appointment Reminder Call



REMINDER CALL RATE 100%



CALL ABANDON RATE
>2%

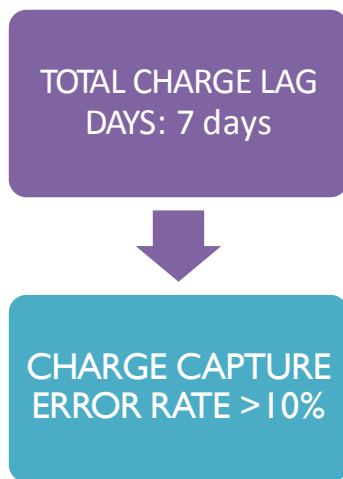
Front End: Registration/ Eligibility/Check-in/Collect Fees



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Middle: Charge Capture, Clinical Documentation & Coding



- **Charge lag time** is the length of time required to get a claim out the door. Charge lag delays payer remittances and affects the ability to collect balances due from patients.
- **Charge capture error rate** (done through chart audits) provides insight into the accuracy of capturing codes and charges on the services provided to ensure compliance to regulations and appropriate reimbursement.

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Middle: Charge Master

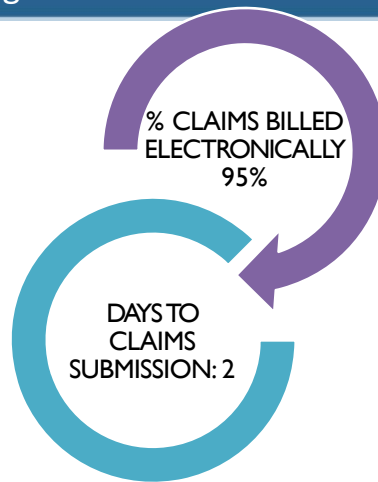


Middle: Checkout

DAYS TO CHARGE ENTRY:
Same Day or 24 Hours



Back End: Billing, Claims Submission, Remittance Advice, Payment Processing, Reimbursement, and Posting



Common Billing Issues



- Incorrect patient information
- Upcoding (downcoding)
- Unbundling (bundling)
- Documentation not supporting code(s)
- Lack of documentation
- Lack of medical necessity
- Incorrect modifier usage
- Wrong diagnosis or procedure code
- Duplicate claims



Key Attributes of Successful Billing Departments



- Understand each piece of the revenue cycle
- Defined responsibilities
- Effective communications
- Leverage technology
- Written policy & procedures
- Comprehensive training
- Individual accountability
- Appropriate staffing
- Competent management
- Monitoring tools
- Feedback & recognition
- Adaptability



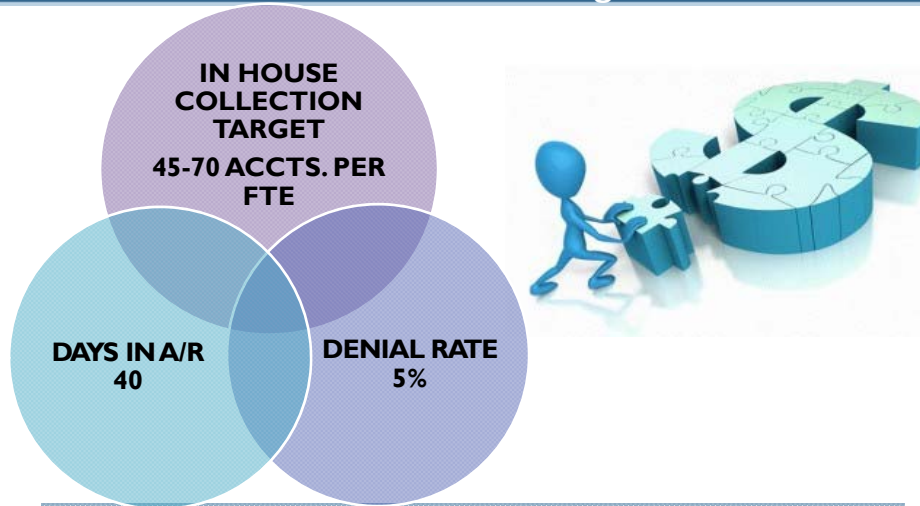
Back End: Contracts Management



TOTAL DENIALS BY PAYER AS % OF NET REVENUE
 $\leq 5.0\%$

AGED A/R AS % OF BILLED A/R BY PAYER GROUP
40-45 Days

Back End: Accounts Receivable (A/R), Patient Collections & Denial Management



Contact Us for More Information

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