Managing the Health Center Revenue Cycle

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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
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

- Staffing
- Productivity
- Improved Access & Financial Sustainability
- Utilization
- Patient Satisfaction
- Clinical Outcomes
- Financial Operations
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

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Operating Margin - Medians

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<tr>
<th>Year</th>
<th>TN FQHCs</th>
<th>CL High Performers</th>
<th>Non MedEx States</th>
<th>Benchmark</th>
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<td>1.0%</td>
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Days Cash on Hand - Medians

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

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<td>2016</td>
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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?
Success Requires Getting Many Pieces Right

Process Imperatives Before, During, and After Visit

**FRONT END**
- Collect and validate critical demographic and service data elements
- Utilize automated technologies to verify insurance coverage in advance of the visit
- Set payment exceptions and establish payment solutions before services are delivered

**MIDDLE**
- Confirm or complete pre-registration workflows
- Collect co-payments and execute collections agreement
- Comprehensive documentation of patient care supported by coding and charge capture technologies

**BACK END**
- Reconcile charges to appointments in a timely manner
- Submit and track all claims, coordinate benefits
- Manage insurance denials and appeals; and execute automated patient-pay solutions

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.
Making The Connection

Life Cycle of an Encounter

Front End
- Scheduling/Pre-sort
- Pre-Authorization
- Appointment Reminder
- Registration/Eligibility/Charges

Middle
- Change Capture/Clinical Documentation/Accounting

Back End
- Check-Out
- Charge Master

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

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**Life Cycle of an Encounter**

**Front End**

- Scheduling/Eligibility/Pre-Authorization
- Appointment Remider
- Registration/Eligibility/Check-in/Collect Fees
- Charge Capture/Clinical Documentation & Coding

**Back End**

- Check-Out
- Charge Master

**Middle**

- Contracts Management
- Billing/Claims Submission/Reimbursements & Posting
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

PEOPLE

TECHNOLOGY

METRICS

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**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?
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

- **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.

**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?

**CONFIRMING AN APPOINTMENT**

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

- **NO SHOW RATE**
- **CALL ABANDON RATE <2%**
- **REMEMBER CALL RATE 100%**

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

**Key Functions of Registration/Financial Counseling Staff:**

- Review financial policies, procedures, and financial responsibilities.
- 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:**

1. Does your clinic have written protocols and procedures for staff to follow during the patient “check-in” process?
2. How are staff oriented/trained on this “check-in” process?
Metrics

- **POS CASH COLLECTIONS RATE**: 75-80%
- **REGISTRAR REGISTRATION RATE**: 40
- **SCREENING RATE OF UNINSURED**: >98%
- **CONVERSION RATE OF ELIGIBLE UNINSURED**: >95%

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

- 51% BELOW LIMIT
- 49% ABOVE LIMIT

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 is supported by coding and charge capture technologies.
- Consistent coding of patient diagnoses codes on 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?

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**Metrics**

- **Total Charge Lag Days**: 7 days
- **Charge Capture Error Rate**: >10%

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### 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-pay, self-pay, prompt pay options, and past due account balances.
• Collect payment.

Questions to Evaluate the Effectiveness of Checkout 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

• Days to Charge Entry
  Same day or 24 hours

• Billing Accuracy
  75-80%

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Back End

BILLING, CLAIMS, PAYMENT PROCESSING, REIMBURSEMENT, POSTING

ACCOUNTS RECEIVABLES, PATIENT COLLECTIONS, DENIAL MANAGEMENT

Key Functions of Billing Staff

- Code and bill claims.
- Establish contracts with payers.
- Monitor eligible and allowable services.
- Document payment and post 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

- **% 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, financial, and 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 payments and manage accounts.
- 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

**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.

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**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

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.
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.
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, note reason for visit and present complaint(s), 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.
IN HOUSE COLLECTIONS 45-70 ACCTS. PER FTE
- DAYS IN A/R: 40
- DENIAL RATE: 5%

TOTAL DENIALS BY PAYER AS % OF NET REVENUE ≤ 5.0%
- AGED A/R AS % OF BILLED A/R BY PAYER GROUP: 40-45 Days

% CLAIMS BILLED ELECTRONICALLY: 95%
- DAYS TO CLAIMS SUBMISSION: 2

SCHEDULE OCCUPANCY RATE: 95% Capacity
- PRE-REGISTRATION RATE: >98%
- INSURANCE VERIFICATION RATE: >98%

REMINDER CALL RATE: 100%
- CALL ABANDON RATE: >2%

POS CASH COLLECTIONS RATE: 75-80%
- REGISTRAR REGISTRATION RATE: 40
- SCREENING RATE OF UNINSURED: >98%
- CONVERSION RATE OF ELIGIBLE UNINSURED: >95%

TOTAL CHARGE LAG DAYS: 7 days
- CHARGE CAPTURE ERROR RATE: >10%

# CHARGE MASTER ITEMS UPDATED IN REPORTING PERIOD:
- 100%
- AGING REPORT UPDATE REQUESTS: Yes
- ANNUAL PROCEDURAL CODES CHANGES IN PLACE BY JAN: Yes

Revenue Cycle Management KEY PERFORMANCE INDICATORS

Life Cycle of an Encounter

Back End

Front End

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

- POS CASH COLLECTIONS RATE: 75-80%
- REGISTRAR REGISTRATION RATE: 40%
- SCREENING RATE OF UNINSURED: >98%
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Middle: Charge Capture, Clinical Documentation & Coding

- **Total Charge Lag Days:** 7 days
- **Charge Capture Error Rate:** >10%

- **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.
Middle: Charge Master

100% OF CHARGE MASTER ITEMS UPDATED IN REPORTING PERIOD

AGING REPORT ON UPDATE REQUESTS

ANNUAL PROCEDURAL CODES CHANGES IN PLACE BY JANUARY OF EACH YEAR

BILLING

Middle: Checkout

DAYS TO CHARGE ENTRY: Same Day or 24 Hours
Back End: Billing, Claims Submission, Remittance Advice, Payment Processing, Reimbursement, and Posting

% CLAIMS BILLED ELECTRONICALLY 95%

DAYS TO CLAIMS SUBMISSION: 2

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 ≤ 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

IN HOUSE COLLECTION TARGET
45-70 ACCTS. PER FTE

DAYS IN A/R
40

DENIAL RATE
5%

Contact Us for More Information

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