OPTIMIZING REVENUE AND FINANCIAL PERFORMANCE IN YOUR RHC

Kentucky RHC Summit
July 28, 2023

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REVENUE CYCLE IMPROVEMENT

Understanding the revenue cycle processes
Opportunities for improvement

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Revenue Cycle: All of the administrative, clinical and financial workflows which represent the "life cycle" of a patient account from patient engagement through payment resolution for an encounter, an episode of care or a series of recurring encounters.

The inter-related functions, when executed efficiently, result in the maximum net reimbursement (net revenue) in the shortest amount of time (net A/R days). A weakness in any of the individual processes can directly affect the overall revenue cycle performance.

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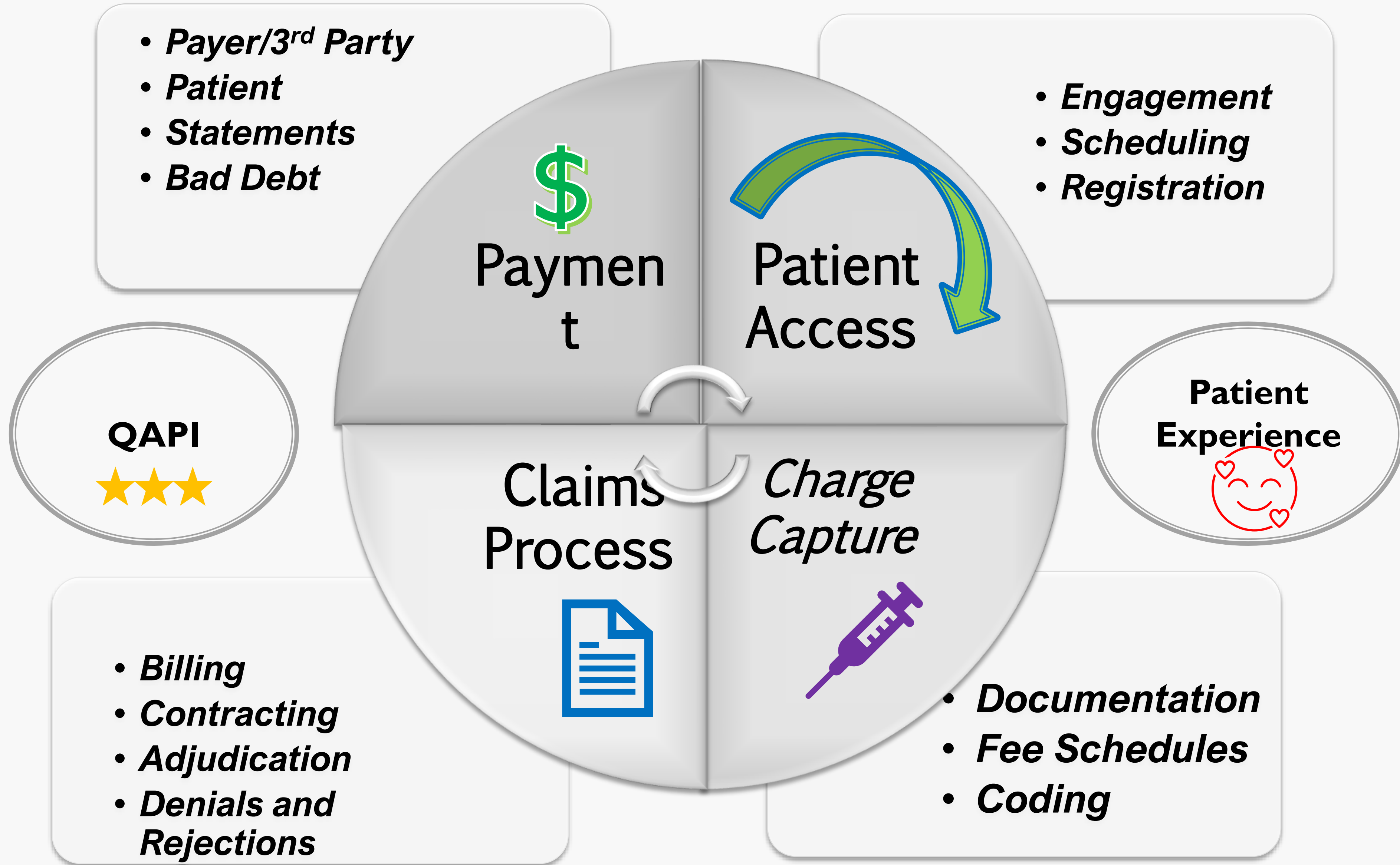

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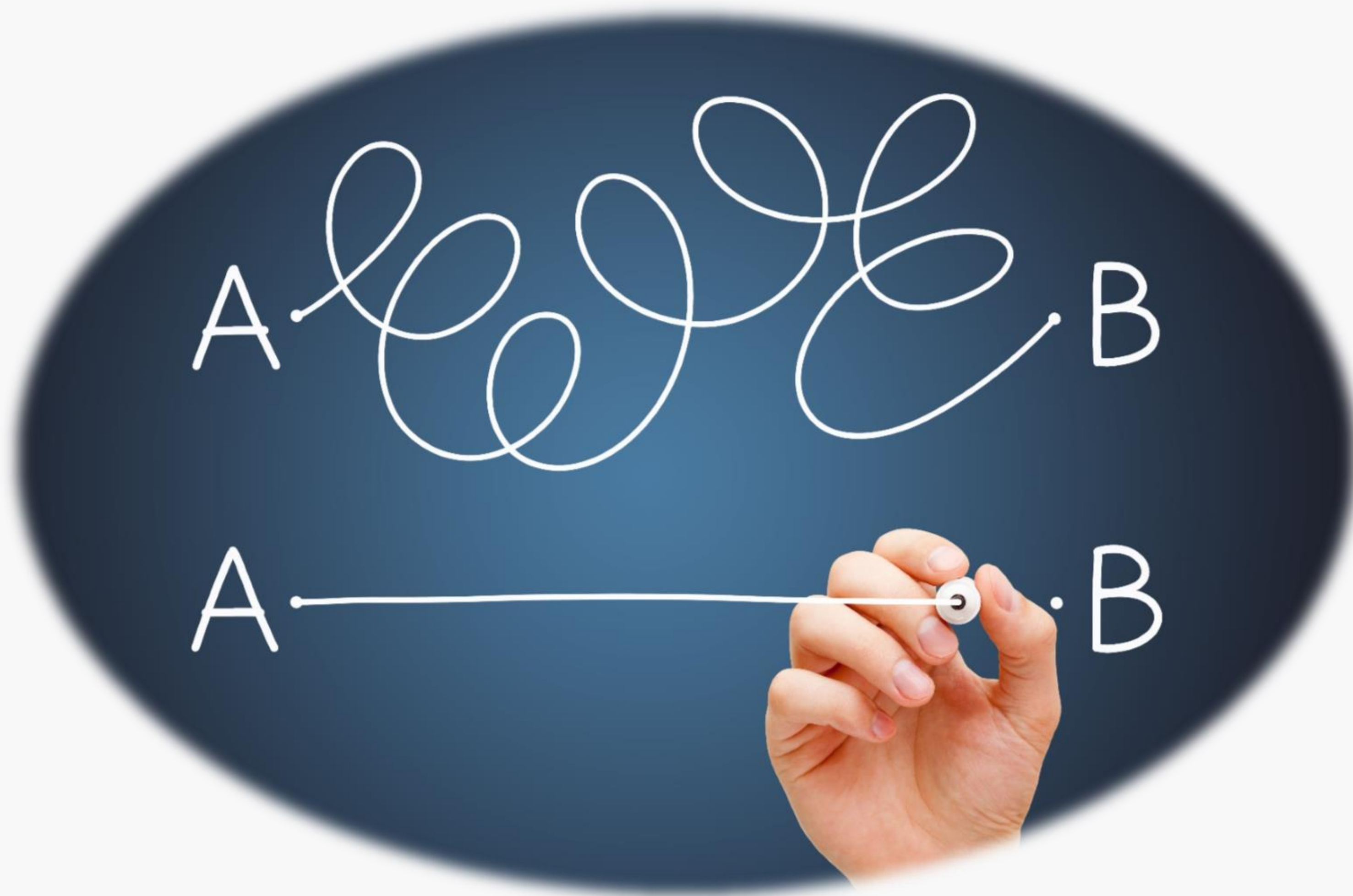

The revenue cycle fixes are relatively simple once you identify where the failures are. Fix it at the point of failure not just one at a time.

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1.

Patient Access

- *Patient Engagement*
- *Marketing*
- *Community Perception*
- *Ease and Speed of Scheduling*
- *Registration and Admission Experience*
- *Customer Service Model*

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Who exactly are your patients? Who are your prospective patients?

Know the demographic profile of your community or service area:

- Age
- Gender
- Ethnicity
- Health & Insurance Status
- Income
- Educational Attainment
- Average Commute Time
- Household status
- Competition/Referral Base

Do an “I” exam!

- Are you stuck in your old ways?
- Are you getting in your own way?
- Are you provider or patient-centered?
- Are you meeting your patients where they are?
- Are you competitive?
- Are you convenient?
- Are you empowering your employees and staff?
- Are you building a team?

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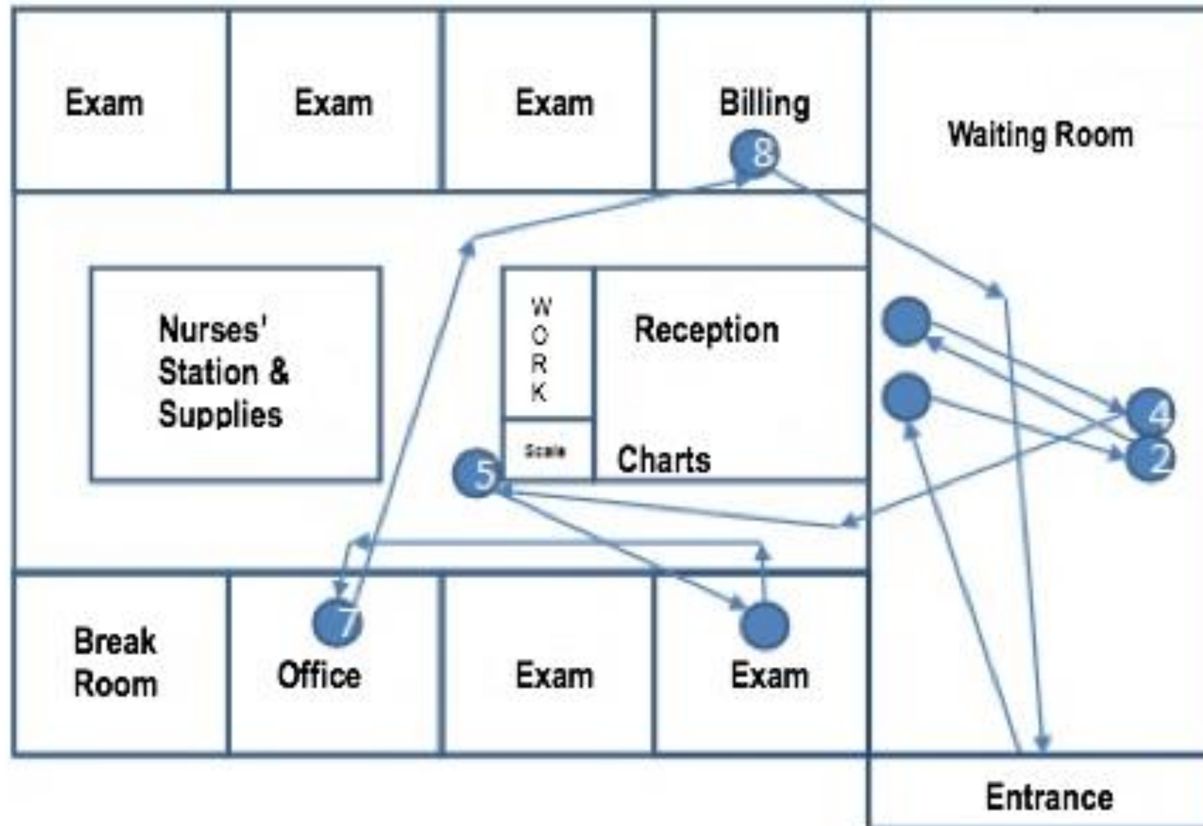
Identify Patient Workflow



Spaghetti Mapping

Follow the motion to identify areas for improvement; eliminate redundancy; ensure charge capture; and streamline processes for both patients and staff.

Common Roadblocks in Patient Access/Registration

- Not having the right people in those roles. Making sure the front desk understands how important they are. Update job descriptions and job codes.
- Staff not adequately trained or don't have the tools they need. Don't assume they know what to do.
- Establishing medical necessity or getting authorization prior.
- Incomplete/poorly designed forms/duplicated info.
- Patient demographics not verified.
- Health plan not verified.

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- Registration errors/omissions.
- Payer tables not well maintained—too messy to pick correct one. Tables need cleaning up.
- Secondary Medicare Payer questionnaire
- Third-party liabilities/Workers Comp determination. Make sure your staff is knowledgeable about how different health plans are structured.
- Understand High Deductible Plans and off-setting HSA and MSAs.

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Upfront/POS Collections

- Have a financial counselor or supervisor available to discuss payment options. Protect your patient access staff from confrontation.
- Verify coverage and deductibles in advance. Use system add-in tools to reduce on-phone time or bottlenecks. Register with payer portals.
- Train staff to be casual but direct about the patient's anticipated cost share of the service.
- Good customer service does not mean we are too nice to take care of business.

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2.

Services Provided

- *Communication and Education*
- *Medical Necessity*
- *Charge Capture Processes (clinical side)*
- *Clinical Documentation*
- *Optimization of Technology*
- *Chargemaster and GL Mapping (finance side)*

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Aspects of Providing or Rendering Clinical Services

- Patient Interface/Patient Experience
- Staff Training and Skill
- Documentation of Services
- Technology: Hospital or Clinic Information System, Clinical Equipment, Medical Record
- Clinical Documentation
- Charge Capture
- Financial Policies: Pricing Transparency, Patient Education and Counseling, Staff Training

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RHC Service Line Opportunities

- Create service lines which meet the patient demographics of your service area or for the population you want to reach.
- Make sure those services are qualified RHC services. Discuss new services with your RHC Consultant/Cost Report Preparer.
- Do what you can do best
- Don’t be a copycat.
- Explore:
  - Patient Centered Medical Home
  - Care Management Services
  - Home or Residential Services
  - Swing Bed Services
  - Open Access Scheduling

COMMON PROBLEMS WITH CHARGE CAPTURE AND CLINICAL DOCUMENTATION

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Common Roadblocks in Charge Capture

- Workflow inefficiencies—redundancy in processes, redundancy in footsteps, redundancy in data collection.
- Poorly designed templates or forms
- Illegible or poorly designed notes (handwritten)
- System limitations and security matrix problems
- System Tables/Files not updated or linked correctly
- Visits or Days not Reconciled

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- Missed Charges (Who enters what? How captured? Who audits?)
- Other Charge Errors
- System Descriptions/Naming Conventions
- Hybrid Charge Capture
- Charges for services not performed; wrong service captured.
- Late Charges
- Chargemaster/Fee schedule errors (code mismatches, obsolete codes, missing codes)
- Failure to update fee schedules

- Services Performed but not documented or not captured. Sub-system crossover problems.
  - Lab
  - Injections and Infusions
  - Nursing Services
  - Provider Services (Bedside)
  - Pharmacy
  - Imaging
- Order not on chart/ Telephone Orders
- Chief Complaint not addressed or Diagnosis is inconsistent with CC.

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- Discrepancies in the Record (gender/laterality/HPI & Exam)
- Diagnosis Sequencing is incorrect
- Diagnoses coded that were not addressed/related to visit.
- Lab results not on chart or reviewed
- Poorly Designed or Written Notes/Templates
- **Inadequate EHR Mastery**
- **Unsigned or Incomplete Records (30 days?)**
- **Bills on hold for provider review/finalization.**

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3.

Claims Process

- *Contracting and Credentialing*
- *NUBC Guidelines*
- *System Configuration*
- *Edits*
- *RTP*
- *Claim Adjudication*
- *Managing Denials*

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DELAYS AND HOLD-UPS IN CLAIMS PROCESSING

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- Clearinghouse/Software Problems/EDI Issues
- Submitting Duplicate Claims
- Missing or incomplete patient information
- Claim submitted to wrong payer
- Use of non-specified diagnosis or procedure codes
- Conflicts with payer’s business rules
- Sometimes payers do make mistakes

Best Practices in Claims Management

- Start with Patient Access/Registration because it's where the claim is created.
- It's easier to prevent denials in the first place than to correct them on the back end.
- Have periodic internal "tracer" audits as part of your revenue cycle function as well as your compliance plan.
- Establish relationships with your partners: Payers, Clearinghouse, Outsourced Vendors.

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4. Payment

- *Deductibles and Coinsurance*
- *Primary Insurance*
- *Secondary Insurance*
- *Patient Responsibility*
- *Transparency*
- *Patient Statements*
- *Financial Policies*
- *Managing Bad Debt*

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MAXIMIZING COLLECTIONS

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- Educate and train staff about:
  - Deductibles and Coinsurance
  - Types of Insurance Plans
  - Financial Policies
  - Script them, if necessary.
- Educate patients about financial responsibility.
- Be caring but not apologetic.
- Have clear financial policies. Apply them consistently.
- Have online payment options and point of service payment options. Make it easy.
- Be timely in filing, in sending statements and in managing bad debt.

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Getting Paid Quickly: It is Possible!

- Patient Access staff must know how to talk about patient responsibility.
- Insurance Verification is worth the cost.
- Establishing Medical Necessity is NECESSARY.
- Timeliness in everything. Being proactive.
- Speak up—payers make mistakes, know how to escalate an issue, clear communication.

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BUILDING AN EFFECTIVE REVENUE CYCLE TEAM

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- Recognize Individual Strengths, Knowledge and Skills
- Leave Personal Agendas Outside the Door
- Strive for a Common Goal or Outcome. Be missional.
- Seek for Performance and Process Improvement
- Incentivize In a Way that Strengthens Your Team

- Prevent Silo-ing!
- Encourage Collaboration
- Reward Problem-solving and creativity
- No one gets thrown under the bus!
- Zero tolerance for blame-shifting
- Accountability and Responsibility

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- Maintain community engagement.
- Timely and Clear Statements
- Create Buy-In
- Positive patient-staff-community relationships
- Help patients overcome doubts about technology
- Remember that the patient is our customer. Know your community demographics.

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SHOULD YOU OUTSOURCE PARTS OF YOUR REVENUE CYCLE MANAGEMENT?

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Pros & Cons of Outsourcing RCM in Rural Healthcare

Pros

- Can Fill Skill and Rural Workforce Gaps
- Advanced Health Information Technology
- Standardized Processes
- Economy of Scale
- Objective Input

Cons

- Loss of Local Workforce
- Moving Processes farther from the Knowledge Base
- Loss of Staff Engagement/Buy-in
- Loss of Control
- “Rural” is different

- Enter 3rd party relationships with clear expectations
- Establish and maintain clear communication
- Expect routine phone calls, reports, and collaboration.
- Don't let the tail wag the dog!
- Evaluate the vendor's performance
- Maintain local staff involvement and buy-in

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MIND THE STORE

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AIR calculation

Total Allowable RHC expenses

____

Total Visits Meeting the RHC encounter definition

= AIR (RHC Encounter Rate)

Subject to Upper Payment Limits

Non-RHC Costs excluded for lab, technical components, medical telehealth, and other non-RHC services. Costs for incident-to services stay in.

If visits increase without costs increasing, the rate decreases.

Visits that don't meet the RHC encounter definition are excluded. (nurse visits, medical telehealth, non-RHC services)

Denominator is subject to the productivity standards.

CREATING A CULTURE THAT PROMOTES PRODUCTIVITY, PERFORMANCE AND PROFIT

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Healthcare Safety Net Provider Improvement Model*

Revenue Cycle Performance Improvement

Consistency of Data Reporting/Accounting Methods

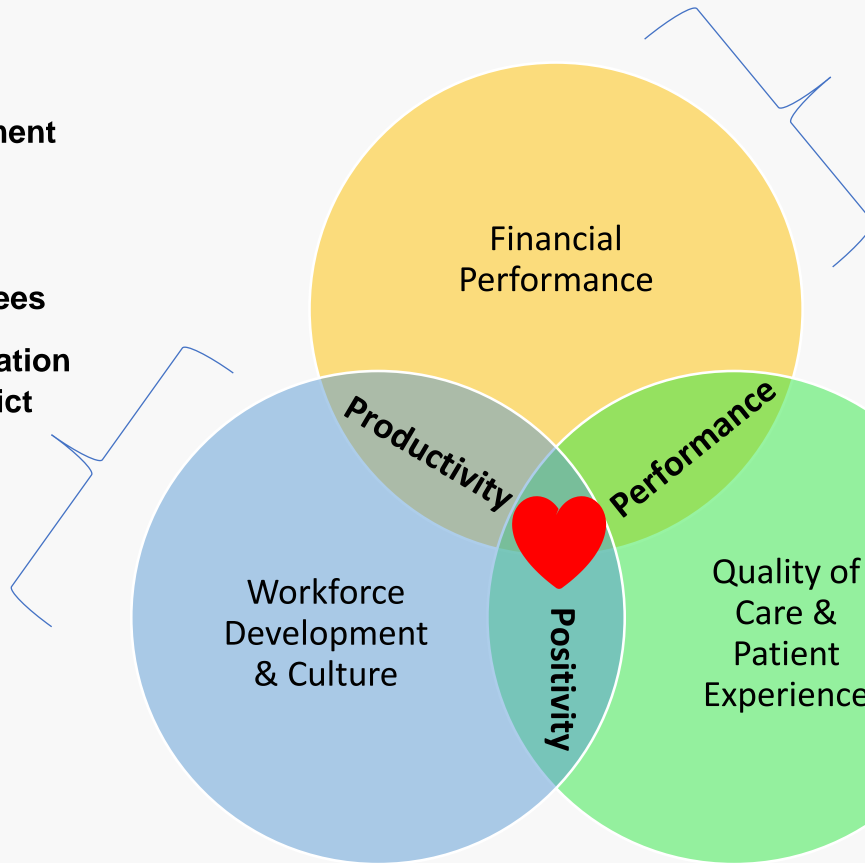
Optimization of Systems

Leadership Development

Team-Based/Servant Leadership Models

Empowering Employees

Improved Communication Styles/Creative Conflict



“Digestible” QAPI

Increased Patient Engagement

Rebranding

Patient-Centered

Competitive

Convenient

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QUESTIONS, COMMENTS, DISCUSSION?

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Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 25 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. Patty currently serves on the Board of NARHC.