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The Link Between RHC Operations & Financials

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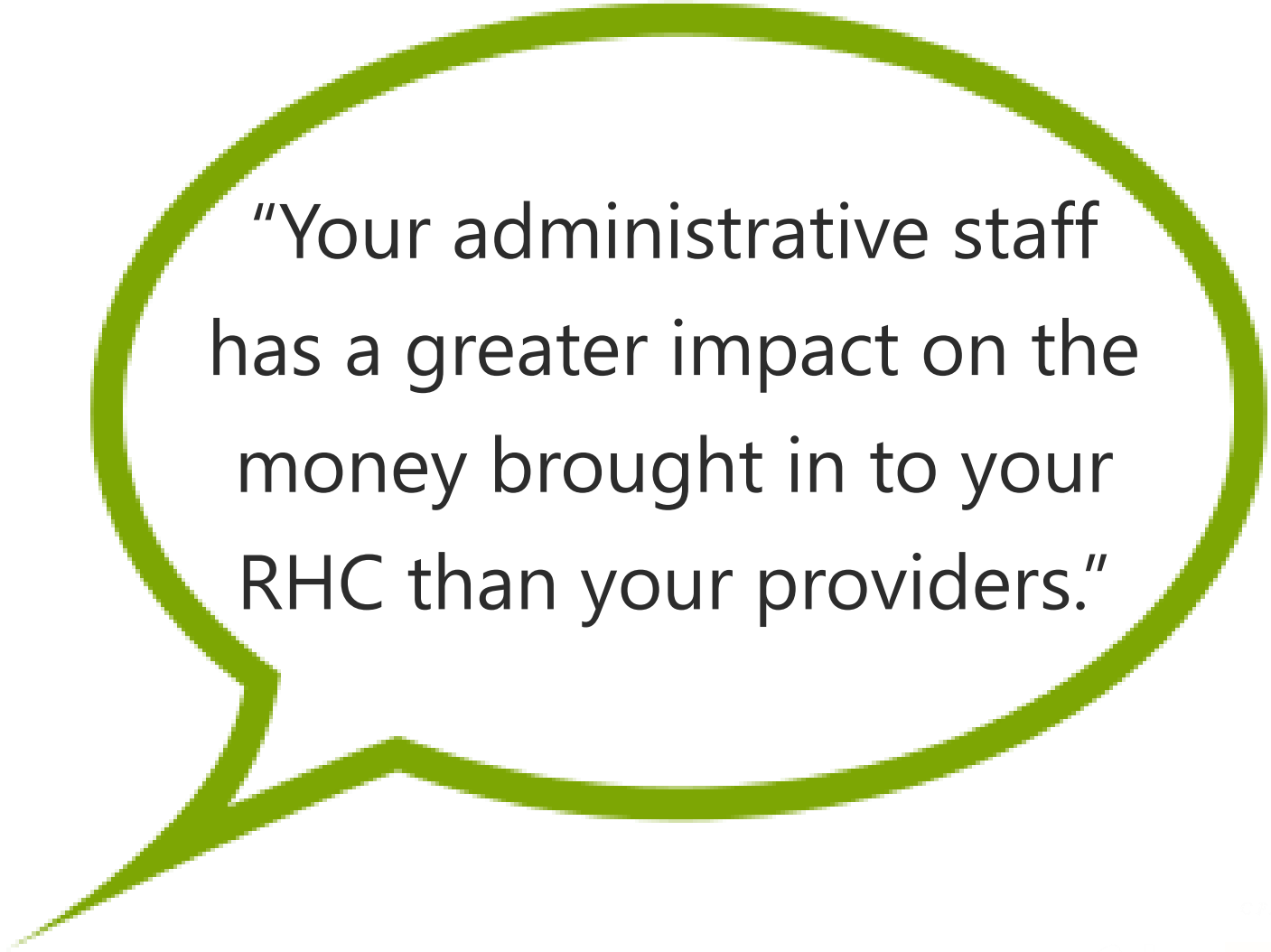
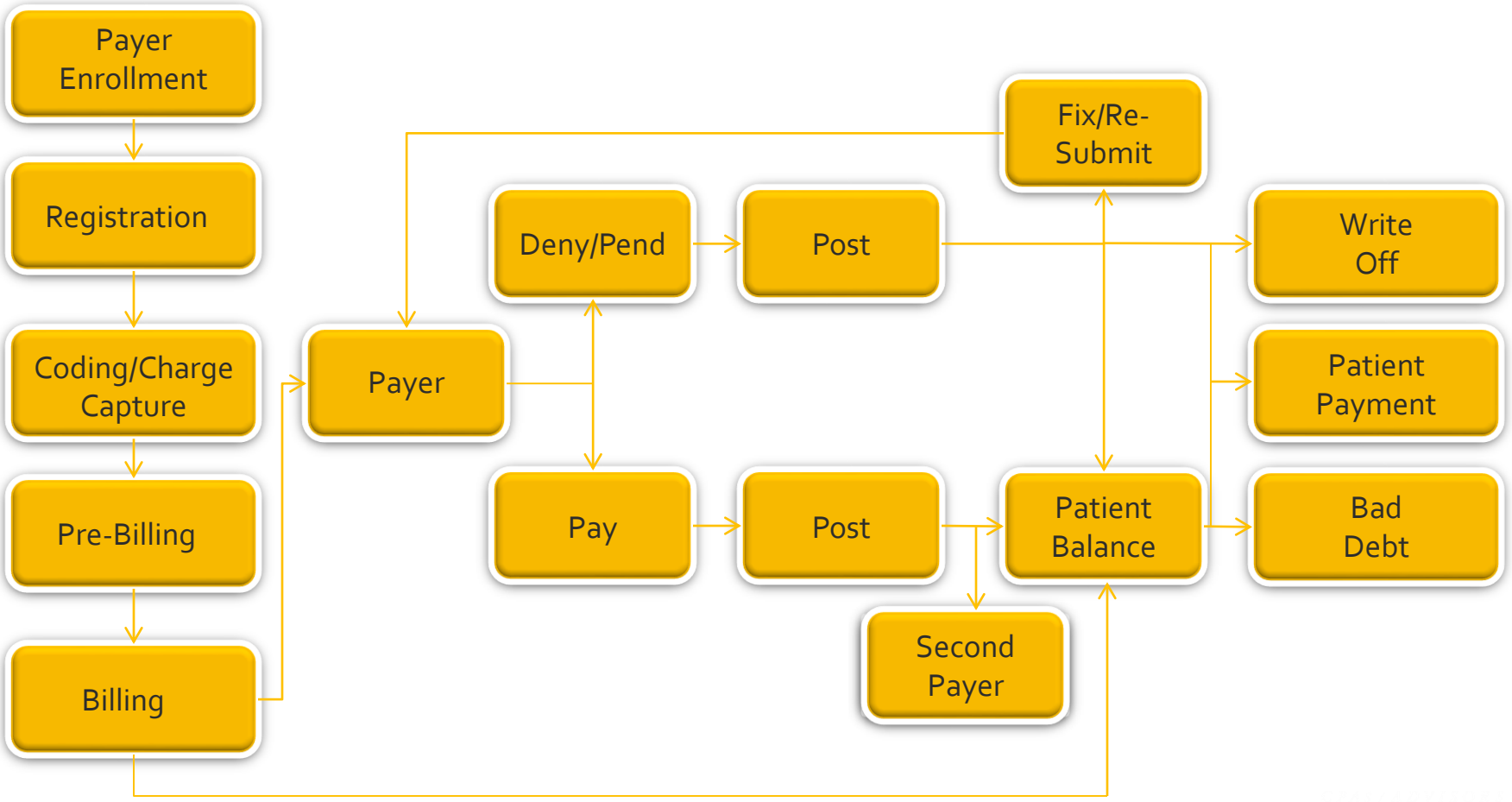
What if I told you…



Revenue Cycle: A Bird's Eye View



Front Office Functions…

Verifying insurance

Collecting patient copays

Determine need for the visit/time allotted

Communicating patient expectations

Appointment reminders

Signing in patients

Taking care of registration paperwork

Collecting outstanding balances

Discussing payment

Updating annual paperwork

Updating demographic information

Verifying reason for visit

Scanning insurance cards

Collecting secondary insurance info

MSP Forms

Verifying patient records received

Determining discounts for self-pay patients

Issuing ABN when necessary

Answering patient questions

Answering the phone

Scheduling patient appointments

Enrolling patients in patient portal

Enrolling patients for e-statements

Providing work/school excuses

Handling medical records release forms

Making sure patients understand referral process

Entering messages for clinical staff/providers

…Financial Implications

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98% Accuracy

Provider Enrollment

If it wasn't credentialed correctly on the front end, it will cause problems on the back end.

- Provider licenses
- Provider DEAs
- Malpractice insurance
- Prescriptive authority for mid-levels
- Applicable CME
- Signed contracts
- Taxonomies, NPIs, PTANs, oh my!

Scheduling

- What type of scheduling does your RHC use?
  - Open-Access/On-Demand
  - Templates
  - Self-Schedule (usually via Patient Portal)
  - Walk-In
- Be aware of productivity standards for your providers
- Reason for patient visit
- Consideration for multiple visits on the same day
- No “one-size fits all” approach to scheduling

Multiple Visits on the Same Day

"…encounters with more than one RHC provider on the same day, or multiple encounters with the same provider on the same day, constitute a single RHC visit and is payable as one visit…"

Medicare Benefits Policy Manual, Chapter 13, Section 40.3

- Exceptions to the rule:
  - Subsequent illness or injury the requires additional diagnosis or treatment = 2 billable visits
  - Medical visit and mental health visit = 2 billable visits
  - Medical visit, mental health visit, and IPPE = 2 or 3 billable visits
- For the cost report 1 AIR = 1 visit

Marketing Considerations: IPPE & AWV

IPPE – qualifies for billable visit on the same day

AWV – does not qualify for billable visit on the same day

How many patients in your RHC will be turning 65 this year?

How many of those patients are already on your schedule for their IPPE?

How many patients are already on your schedule for their AWV?

Do your providers even know what the IPPE and AWV visits require?

No Show Rate

- Track your no-show rate monthly:

$$\textbf{No Show Rate} = \frac{\textbf{Missed Appointments}}{\textbf{Total Appointments}}$$

- Track no-show rate by provider to see if it is a scheduling issue, or something else.
- Review your appointment reminder processes
  - Does the process need to be changed?
  - Is it a technology issue?
- No Show = No Money

Provider Productivity

visits per year

visits per year

Productivity is calculated per FTE.
Not meeting these standards will impact your RHC rate.

"Comparison is the ~~thief of joy~~"

only way to know how you are doing.

- Amanda

Benchmarking

bench·mark

/ˈben(t)SHmärk/

verb

gerund or present participle: **benchmarking**

evaluate or check (something) by comparison with a standard.
"we are **benchmarking** our performance **against** external criteria"

- show particular results during a benchmark test.
  "the device should benchmark at between 100 and 150 MHz"

4 Types of Benchmarking

4 Types of Benchmarking: Defined

Internal

- Comparing departments, business units, providers, within the same business.

External

- Comparing a department or business unit with another. Also called Competitive Benchmarking.

Functional

- Comparing a specific function in one business with the same function in at least one other external company.

Best Practices

- Comparing a specific business function or department at 2+ companies in a different industry. Also called Generic Benchmarking.

Benchmarking Resources for RHCs

- National Association of Rural Health Clinics (NARHC)
  - www.narhc.org
  - Free for NARHC members! Specific to your RHC.
- Medical Group Management Association (MGMA)
  - www.mgma.com
  - Can compare by specialty, practice ownership, region, number of providers, etc.
- Healthcare Financial Management Association (HFMA)
  - www.hfma.org
- Other: Consultants, Non-Profit Organizations

Financial Foundation

Reports you should be running and reviewing monthly:

- Total Visits by Provider/Provider Productivity
- No Show Rate
- Charges, Payments, Adjustments
- Profit & Loss (Income Statement)
- Gross & Adjusted Collection Percentage
- Payer Mix Analysis
- A/R Aging
- Days in A/R
- Quality Indicator Reports (Payer Specific)

Payer Mix: Who pays what?

- Medicare = 80% of RHC AIR (less 2% sequestration)
- Traditional Medicaid = PPS Rate or APM (minimum $99.75 in KY)
- Medicaid MCOs = Wrap Payment Process
- Medicare Advantage = How are you contracted?
- Commercial = Does not recognize RHC status. Payer fee schedule dependent.
- Self Pay = Depends on RHC's financial policies.

RHC Best Practice Tip!

Medicare + Medicaid should account for roughly 40% of your RHCs payer mix.

Fee Schedule

You should be reviewing your RHC fee schedule EVERY year.

You should know how your fee schedule was developed:

- Based on customary fees?
- Based on Anthem allowable?
- Based on RBRVS?
- Based on a percent of Medicare?

RHC Best Practice Tip!

RHCs should adjust their fee schedules annually in accordance with Medicare Allowables and the Medicare Economic Index (MEI). Most practices set their charges at 120-150% of MPFS.

If I've heard it once…

Here's why it matters:

PATIENT COINSURANCE

Fee Schedule										
	2015		2016		2017		2018		2019	
	MPFS	MPFS * 150%	MPFS	MPFS * 150%	MPFS	MPFS * 150%	MPFS	MPFS * 150%	MPFS	MPFS * 150%
99212	$ 40.64	$ 60.96	$ 40.18	$ 60.27	$ 40.71	$ 61.07	$ 41.27	$ 61.91	$ 42.27	$ 63.41
99213	$ 68.22	$ 102.33	$ 68.26	$ 102.39	$ 68.91	$ 103.37	$ 69.30	$ 103.95	$ 70.32	$ 105.48
99214	$ 101.56	$ 152.34	$ 100.89	$ 151.34	$ 101.69	$ 152.54	$ 102.57	$ 153.86	$ 103.31	$ 154.97
99215	$ 137.42	$ 206.13	$ 136.33	$ 204.50	$ 137.29	$ 205.94	$ 138.67	$ 208.01	$ 138.82	$ 208.23

Coinsurance w/ Updated Fee Schedule vs. Without Update Fee Schedule - 5 Yrs.										
	2015		2016		2017		2018		2019	
	CPT Count	Coinsurance	CPT Count	Coinsurance	CPT Count	Coinsurance	CPT Count	Coinsurance	CPT Count	Coinsurance
99212	688	$ 12.19	688	$ 12.05	688	$ 12.21	688	$ 12.38	688	$ 12.68
99213	6577	$ 20.47	6577	$ 20.48	6577	$ 20.67	6577	$ 20.79	6577	$ 21.10
99214	5932	$ 30.47	5932	$ 30.27	5932	$ 30.51	5932	$ 30.77	5932	$ 30.99
99215	48	$ 41.23	48	$ 40.90	48	$ 41.19	48	$ 41.60	48	$ 41.65
		$ 325,708.00		**$ 324,483.95**		**$ 327,313.37**		**$ 329,784.38**		**$ 333,322.40**
									5 Yr. Total	**$ 1,640,612.10**
No Update		**$ 325,708.00**		**$ 325,708.00**		**$ 325,708.00**		**$ 325,708.00**		**$ 325,708.00**
									5 Yr. Total	**$ 1,628,540.00**
									5 Yr. Diff.	**$ (12,072.10)**

…I've heard it 1000 times.

Fee Schedules: Things to Remember

- You must treat all patients the same regardless of payer.
- Your fee schedule also impacts your self-pay patients.
- If a majority of your payments from your commercial payers is equal 100% of your charge, you likely are not charging enough for your services.
- Do not ask other RHCs what their fees are – that could be considered price fixing…which is illegal.
- If you use a sliding fee scale (i.e. NHSC sites), make sure you not only update your fee schedule annually, but make sure you are using the most current Federal Poverty Guidelines.
- Setting fees is an art, not a science.

Gross Collection Percentage

$$\textbf{Gross Collection Percentage} = \frac{\textbf{Payments}}{\textbf{Charges}}$$

Will change depending on the fee schedule.

GCP is just a snap shot to give you a rough idea of how much you have collected in comparison to how much you charged out.

It does not account for payer mix, payer contracts and other variables.

Adjusted Collection Percentage

$$\textbf{Adjusted Collection Percentage} = \frac{\textbf{Payments}}{\textbf{(Charges – Adjustments)}}$$

According to the American Academy of Family Practice:

"The ACP should be 95% at a minimum. The average collection rate is between 95-99%. The highest performers achieve a minimum of 99%. Use a 12-month time frame when calculating the ACP."

Time frame allows for the natural progression of the revenue cycle. The ACP metric takes into account revenue lost to things such as uncollectible bad debts (coinsurance & deductible), untimely filing, incomplete charting, and other non-contractual reasons for non-payment.

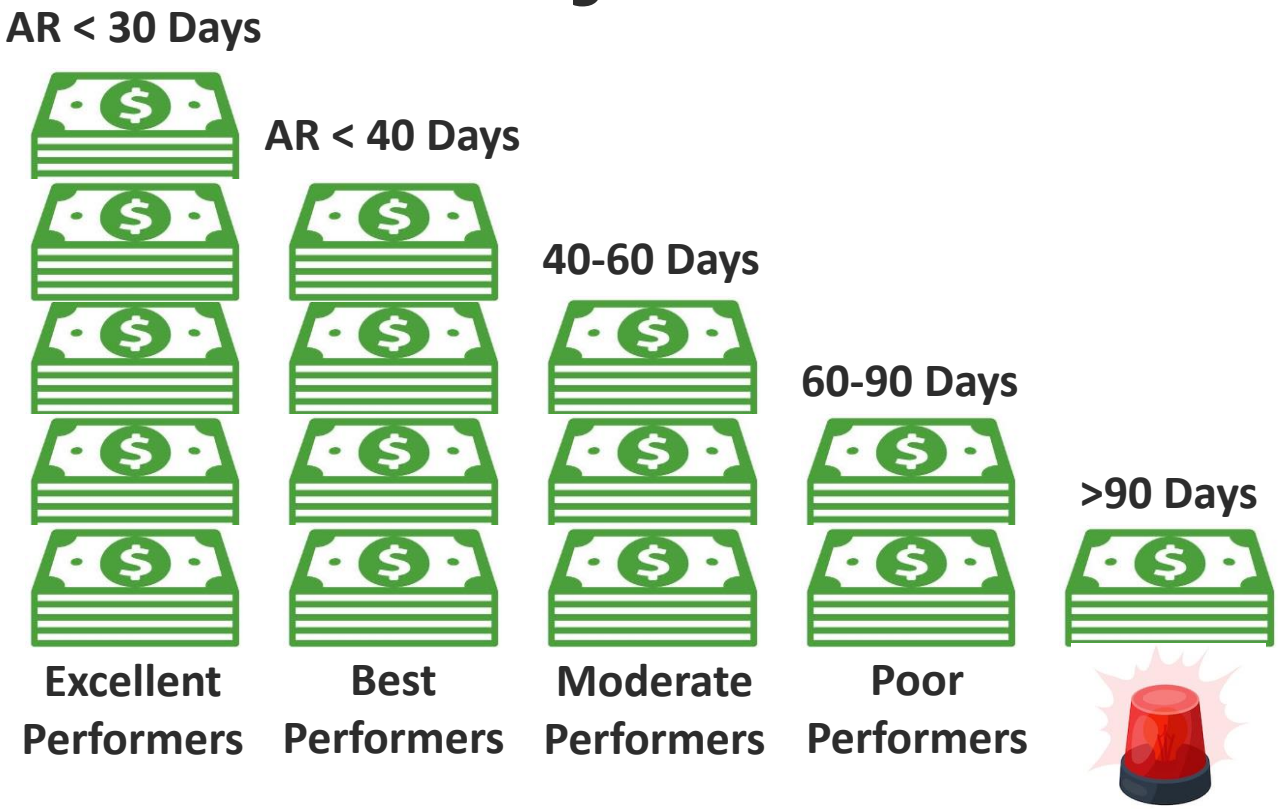
Adjusted Collection Percentage

*Because of the way RHCs are reimbursed, it is NOT uncommon to see RHCs with ACPs greater than 100%.

Days in A/R

How long does it take to get paid for services rendered?

$$\textbf{Days in A/R} = \frac{\textbf{(Total A/R – Credits)}}{\textbf{Charges}}$$



Days in A/R

Days in A/R is an indicator of how the efficiency and effectiveness of your revenue cycle processes.

Things to consider:

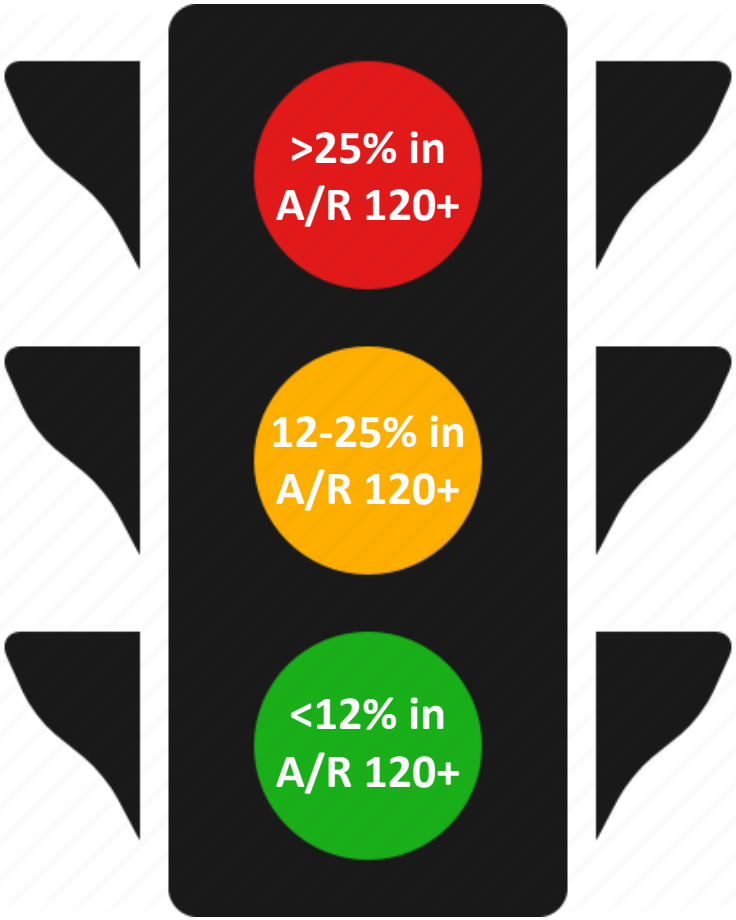
- Accounts in collections. Calculated days in A/R **with** and **without** collections revenue.
- Credit balances. Subtract credits from your receivables for true reflection of your days in A/R.
- Payment plans. Are your payment plans extending your days in A/R metric? Your practice should have a policy.

Aged A/R or A/R 120+ Days

You should monitor all aged A/R monthly.

- Monitor by provider and payer
- 0-30 days should account for 50% or more of your total AR.
- 120+ days should account for no more than 12%.

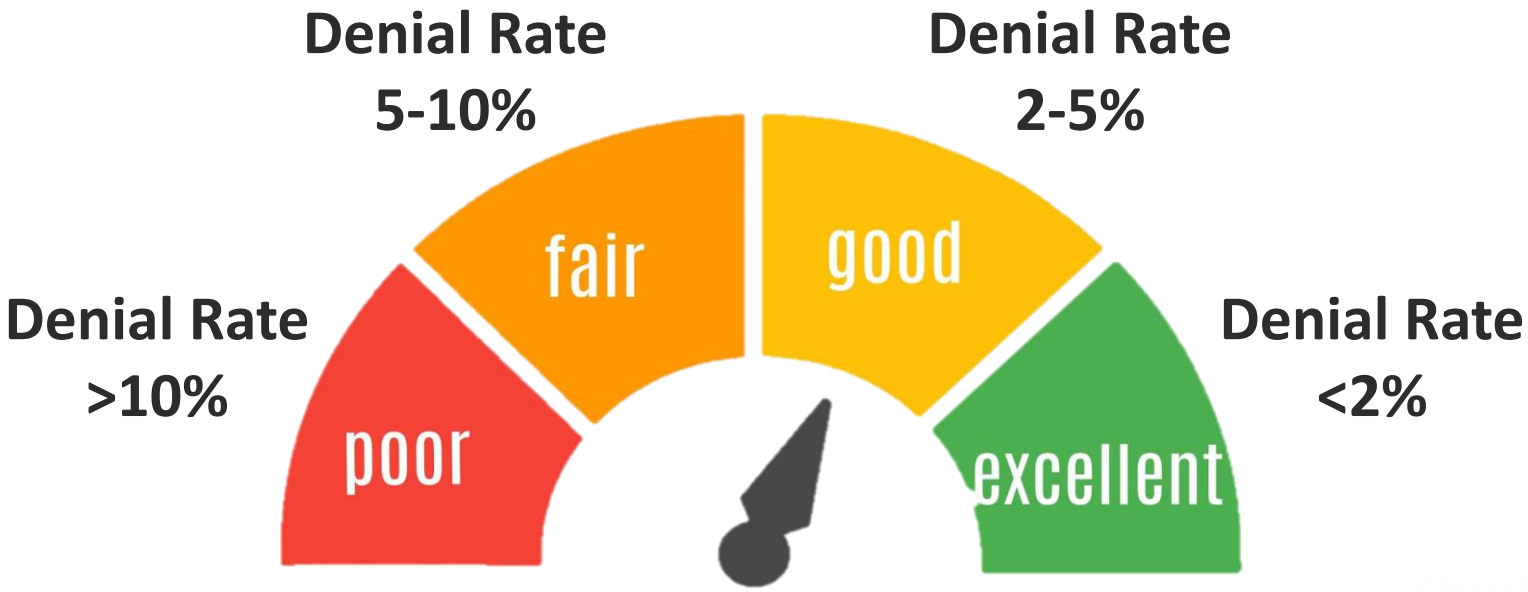
Significant A/R in 120+ usually indicates a problem: issues with claims processing, issues with payer contracts or provider enrollment, large patient balances, technology issues.



Denial Rate

Your denial rate compares the number of denials or rejected claims in comparison to your total charges.

Your denial rate should not be more than 5% of your total charges.



Denial Management Opportunities

Number of rejected claims for “No coverage at the time of service”

Patient calls to the business office where patient is providing primary or secondary insurance information

Patient statements showing copayment balances due (Commercial)

Front office and back office barriers

What we should be monitoring:

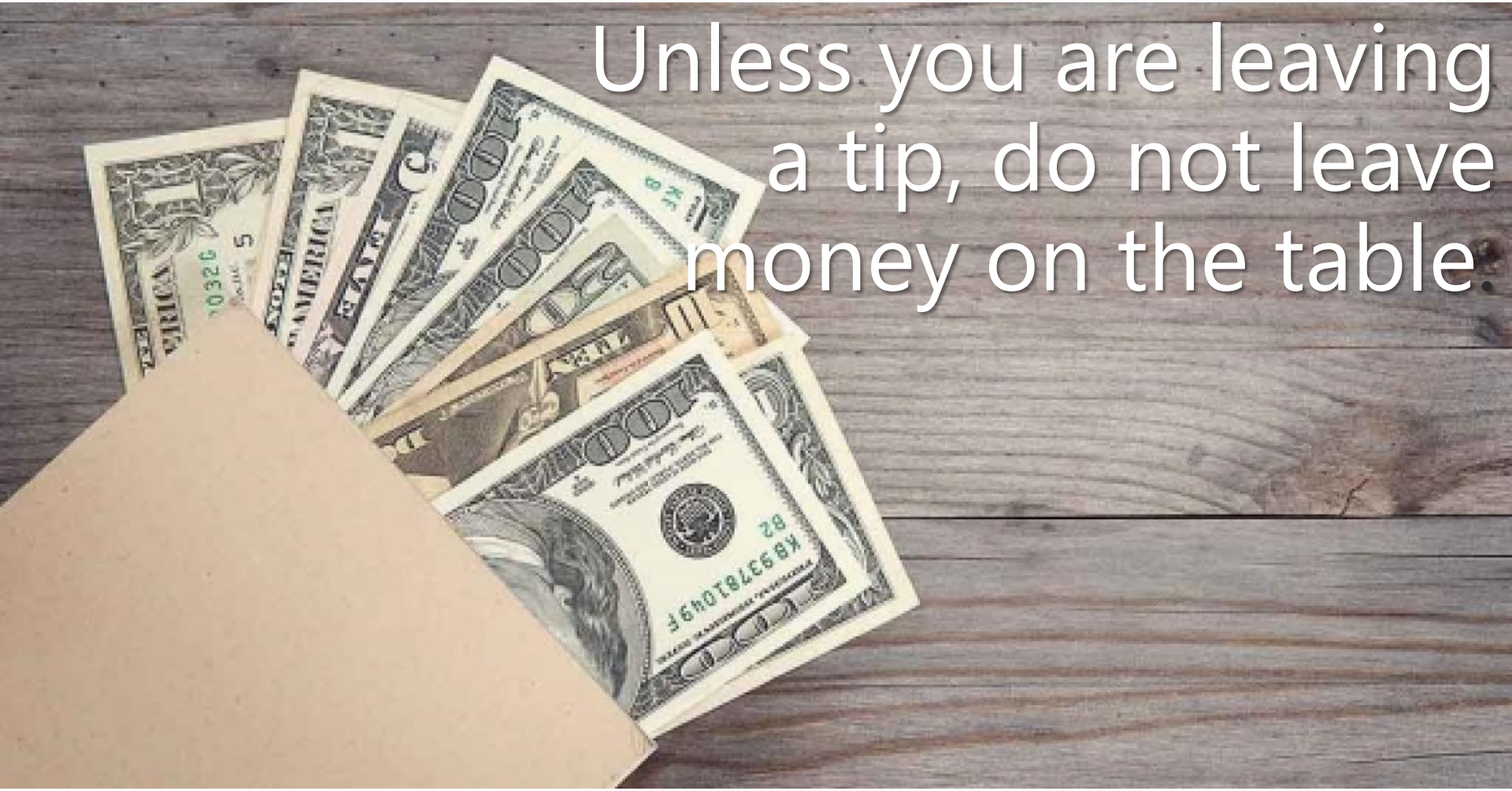
% of Denied Claims

Denial Reasons

Denial by Payer

Aged Accounts Receivable

Bottom line…



Questions

Contact Information

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Ms. Dennison is a valued member of Blue & Co.'s Revenue Cycle team, with a focus in Rural Health Clinics and physician offices. Amanda has significant experience in the RHC certification process from application through implementation, and has worked frequently to setup RHCs in Kentucky, Indiana, Ohio, Illinois, and Florida, to name a few. Ms. Dennison is a Certified Professional Coder (CPC) through the American Academy of Professional Coders (AAPC), a Certified Rural Health Clinic Professional (CRHCP) through the National Association for Rural Health Clinics (NARHC), as well as a Rural Health Certified Billing Specialist (RH-CBS) through the Association for Rural & Community Health Professional Coding (ARHPC).