Managing the Health Center Revenue Cycle

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Michael Holton, Manager
RSM McGladrey, Inc.
Michael.Holton@mcgladrey.com
Session Goals

- Identify Internal and external influences that prevent health centers from successfully managing their revenue cycle.

- 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?
What are the Steps in the Revenue Cycle?

- Appointment Scheduling
- Registration/Certification
- Patient Reception
- Clinical Visit/Service Delivery
- Documentation and Coding of Visit
- Charge Processing/Check Out
- Patient Statement & Claim Production
- Claims & Patient Payments Processing
- Denied Claims Management
- Accounts Receivable Oversight & Collections
Influences on the Success of Revenue Cycle Management

• **Complex Reimbursement Systems for FQHCs**
  – All Inclusive Rates for Medicare & Medicaid versus non-covered services on same visit
  – Managed care issues, wraparound billing, new services, etc.
  – Confusing nature of these systems within health center management, front office, back office, providers, board, and patients

• **Front Office Cooperation & Data Integrity**
  – Registration Information gathered or entered incorrectly
  – Updating of patient information at each visit
  – Amount of Information processed at front desk; ex. = charge processing at cashier
  – Training – there is frequently high turnover of front desk staff; and thus making sure that all staff understand their responsibilities is crucial
  – Front office collections efforts have impact on A/R process, balances/Co-pays
  – A feedback loop with the billing department must be established so that front desk staff understand the impact of their actions.
Influences on the Success of Revenue Cycle Management

• Provider Performance
  – Incorrect coding; down coding or service not covered
  – Provider not eligible/credentialed
  – NEW EHR issue….Provider hasn’t completed Medical Record, thus claim won’t show as active in PMS
  – Site credentialing – set up as FQHC, clinic #
  – Coding – don’t even know E&M basics
  – “Buy-in” to billing and collections issues
  – Understanding of revenue cycle
  – Health center business issues understanding

• Practice Management System
  – Many do not allow for charge processing at the cashier’s desk
  – Most do not adequately post charges, discounts and allowances based on FQHC needs
  – Systems are not designed to catch obvious errors, i.e., male/pap smear;
  – Many do not even add or subtract properly when reports are run at different times or in different formats; patient statements are wrong or confusing
Influences on the Success of Revenue Cycle Management

• Dis-Connect Between Billing Manager/Department and Executive Management
  – Do not talk the same language
  – Billing policies and procedures need to be written cooperatively
  – Regular meetings between operations, management, and billing should take place

• Board and Executive Management
  – Written Policies and Procedures, approved by Board, for Revenue Cycle
  – Collection Policies and Procedures in writing; staff is supported by Board and Management
  – Adequate reporting system for monitoring status and progress on efforts towards improvements
  – “Buy-in” to billing and collections issues
  – Understanding of revenue cycle
  – Inadequate staffing for front office or billing department
Revenue Cycle Infrastructure
The Revenue Cycle

In any sequential process, problems at the beginning flow downstream. To understand these processes, it is necessary to understand cycle time (how long it takes to get done) vs. process time (how long it takes to do an individual step)
Sample Health Center Workflow
Objectives when Reviewing Revenue Cycle

- Strong internal control procedures
- Collection of proper billing information
- Proper recording of revenue
- Maintenance of subsidiary accounts receivable
- Collection of information for management reporting
- Satisfy Federal reporting requirements
Establishing Policies and Procedures

• Set of expectations

• Many health centers are strong in policies and weak in procedures

• Steps for revising policies & procedures:
  – Board and management affirm commitment to process
  – Identify goals and implementation date
  – Develop internal committee
  – Conduct gap analysis
  – Develop appropriate policies and procedures
  – Implement; distribute written policies and procedures
  – Reinforce that compliance with policies and procedures is central to health center mission
  – Reinforce through regular education and training
  – Monitor & take action against violators
Establishing Policies and Procedures

- **Required Billing & Collections Policies & Procedures**
  - Proper completion of encounter forms
    - E & M guidelines, CPT/ICD-9 (10) coding, provider name, date of service, signature/initials
  - Proper medical record documentation
    - Data capture, timeliness, addenda, confidentiality, final review prior to submission, record retention policy
  - Billing/claims review (compliance with False Claims Act)
    - Policies/procedures to identify violations, discrepancies reported immediately, repairing problem billing practices, “covering” providers, dealing with billing company (if appropriate)
  - Internal audit policy
Ensuring Compliance with Policies and Procedures – Compliance Review

• Look at all Policies and Procedures

• Having a well-established compliance plan can reduce risk of fraud and abuse, as well as potential penalties

• Compliance plan also goes beyond Policies and Procedures by:
  • Defining appropriate behavior and helping improve employee behavior
  • Promoting self-evaluation, problem detection and resolution
  • Promoting open communication
Front Desk Issues

- Training – there is frequently high turnover of front desk staff; and thus immediate training of all staff is crucial
- Proper completion of registration form (make all tasks as self-explanatory or routinized to reduce the amount of personal interpretation)
- Front desk may be the source of errors in billing system, which then flow through to all other processes
- Excessive wait times resulting from slow patient processing
- Eligibility verification
  - Use an on-line system if available
  - Aggressively screen uninsured patients for Medicaid eligibility
  - Have a system in place for Presumptive Eligibility for pregnant women (particularly among undocumented persons)
  - Systematically screen uninsured children for eligibility
- A feedback loop with the billing department must be established so that front desk staff understand the impact of their actions
Role of the Practice Management System

- Schedules appointments
- Stores patient demographic information
- Stores provider demographic information/contract terms
- Allows for entry of service information
- Creates transactional billing information
- Supports electronic billing (if applicable)
- Performs basic transaction-level accounts receivable management
- Generates reports
- Interfaces with other systems (EMR, others)
Increase Production

A. Review fill rate of appointment slots. If high number of appointment slots are unfilled, become more aggressive in scheduling.

B. Correlate third next available appointment to provider productivity. If 3rd next available appointment time is long (> 2 weeks) and provider productivity is low (< 4,500 visits/FTE), schedule more aggressively.

C. Improve efficiency – appointment slots should be 15 minute increments, 30 minutes for new patients, physicals and procedures.

D. Providers might need to work harder. If time spent in clinic seeing patients is less than 32 hours per week, replace provider administrative time with clinical time.

E. Look for ways to keep exam rooms full at all times; productive environment; eventually incentive-based compensation.
IMPACT OF APPOINTMENT SCHEDULING ON PROVIDER PRODUCTIVITY

Management should:

➢ Ensure a steady flow of patients for providers
  ✔ Providers see the patients who are presented to them

➢ Consider provider-specific no-show and walk-in rates to estimate the number of daily appointment slots that should be double-booked for each provider

➢ Conclude provider schedules (i.e., availability) and scheduling templates (i.e., standard time slots by clinical specialty for each appointment type) as policy
  ✔ Deviation from this policy should require the Chief Medical Officer’s approval
  ✔ Don’t put Schedulers in the unenviable position of debating scheduling issues with providers
Select Measures for Appointment Scheduling

- Average Number of Rings Before Calls Are Answered/Call Drop Rate/Rate of Calls Placed on Hold/Average Hold Time - Measured at Peak and Non-Peak Times
- Percentage of Reminder Phone Calls (where contact is made and where language precluded communication)/Postcards Completed (mailed versus returned)
- No-Shows By Provider - Need Definition
- Walk-Ins By Provider – Need Definition
- Patient Cycle Time
- Percentage of Unfilled Appointment Slots
Objective - To provide the highest possible quality of care to the maximum number of patients

Providers should:

- Direct questions/comments/requests regarding appointment scheduling to the appropriate manager, not the staff person who performs the function.
- Discuss schedule changes with the Chief Medical Officer as soon as possible (and secure approval, as appropriate).
- Arrive at work at least 15 minutes before their first appointment each day (everyone needs prep time).
- Resist the natural tendency to treat all the conditions of medically complex patients who have been noncompliant (e.g., repeat no-shows) during a single visit.
- Establish a protocol to identify and then reschedule noncompliant patients.
Monitoring staff conformity with defined processes is required to ensure continued compliance.

- Measure process time
- Measure cycle time
- Identify bottlenecks
- Review exam room utilization
- Review patient satisfaction surveys
- Directly observe patient flow
- Identify space needs of operations
- Review health center space layout
- Review provider schedules and appointment scheduling

Create a continuous feedback loop that informs ALL parties.

- Oftentimes the best forum for communication is facilitated peer-to-peer interaction.
Identifying Action Steps to Achieve Financial Stability

Clean-up Billing and Collection Efforts

A. Review current billing functions and analyze current provider documentation

B. Analyze areas where revenue can be enhanced by identifying problems with rates, bad debts, increasing A/R, etc.

C. Improve coding for quicker claims adjudication turnaround and reimbursement

D. Set up Collection Policy and Procedure and enforce it

E. Perform denial analysis

F. Perform revenue cycle review

G. Identify bottlenecks

H. Identify annual dollar amounts associated with improvements

I. Have system for screening uninsured’s eligibility for Sliding Scale
Management Responsibilities

- Management must establish billing and collections direction for staff that result in maximization of revenue from all sources
- Management needs Board “sign-off”
- Management sets the tone, so all (CEO with final say-so) must agree on approach
- Management must monitor and oversee activities to assure staff is executing based on the planned approach
Collecting Patient Accounts

- **Establish Collections System** – a collections system should be established that includes policies and procedures approved by the Board of Directors and should create knowledge within the communities served that the health center expects payment for services rendered.

- This system should be managed by in-house staff and not rely on outside agencies.

- An important component of successful collections systems in health centers is to adopt the policy that if patients ignore all requests for payment or ignore making arrangements for payment, that the health center will restrict services until such time as the patient makes arrangements for payment.

- It should also be noted that by certifying and placing a patient on the sliding fee scale, they have been given a payment status that is based on their ability to pay, and they should pay their part.

- Here are the important component parts of a collection system that must be in-place:
Process for Collecting Patient Accounts

- Must send statements monthly to all patients. Statements should be somewhat easily understood by the reader and have the current month’s new charges and any old balances, showing a total amount due the health center.
  - Dunning notices should be sent for past due amounts each month. The theme throughout the aging of the account is the request that patients contact the center’s financial department and make arrangements for payment.

- If at 120 days past due, the patient hasn’t made any effort towards payment or arrangements for payment, a letter should be sent informing the patient that if they do not contact the center’s financial department and make arrangements for payment within the next 30 days, their account will be placed on restriction and they’ll be asked to find another doctor. A list of these patients should be shared with providers and providers can determine that there are certain patients with chronic conditions that should not have any restrictions placed on their account.

- At 150 days if those patients contacted at 120 days still make no effort to contact the financial department and no effort to make payment arrangements, they should be sent a letter stating that until they make such arrangements, their account will be placed on “restricted status” and they cannot receive services from the health center.
Process for Collecting Patient Accounts

- Restricted accounts’ balances should be written off as bad debts at the 150-day mark. Lists or computer flags should be shared with front office personnel and instructions issued to the effect that if a restricted account patient calls for an appointment or presents as a walk-in, they must be told that their status is restricted and that until they receive clearance from the financial department, they cannot be seen at the health center.

- An installment plan system must be established by the health center that allows patients to make payments on at least a monthly basis. There must be a staff person to manage this system and assure that payment plan statements are mailed monthly and notices and phone calls are made for those missing payment due dates.

- Another collections staff person should be hired easily justified by monies now paid to the collection agency.

- Policies and procedures for this system should be in writing, approved by the entire Board of Directors, and the policy should be shared with patients during registration and re-certification of the sliding fee scale, and at visits if needed.
Checklist for Management Activities

Management should:

- Develop and maintain a detailed billing and collections policies and procedures manual that delineates procedural differences for each payer
  - Revise job descriptions, as appropriate
  - Assign responsibility and include a timeframe for completion of each defined task
  - Educate ALL staff about newly defined policies, procedures, job functions, and regulatory changes
  - Monitor staff adherence to newly defined policies and procedures
Checklist for Management Activities

Management should:

- Establish electronic funds transfer with each payer, whenever possible and/or

- Define procedures to ensure timely bank deposits (i.e., within 24 hours of receipt) and identify the responsible party(ies)
  - Bank deposits should **not** be made by a staff member who can adjust patient accounts
Checklist for Management Activities

Management should:

- Establish a liaison with each third-party payer

- Conduct periodic (e.g., quarterly) meetings with a provider representative from each major payer to resolve problem bills and payment issues, and clarify regulatory and claims adjudication changes

- Define the content, format, and production frequency and distribution points of accounts receivable (A/R) management reports (e.g., days in A/R, dollars in A/R)
Reimbursement/Revenue Optimization

A. Analyze revenue versus cost of payer categories – a health center will have a difficult time surviving if it’s losing money on Medicaid. Compare cost per visit vs. your PPS rate. If cost is more than 5% higher, determine what factors trigger a successful rate appeal in your state.

B. Monitor managed care wraparound payments – compare managed care payments plus wraparound payments vs. PPS rate times managed care visits.

C. Analyze shifts in payor mix and changes in visit volume.

D. Analyze trends in capitated revenue per member per month.
# Profit And Loss Analysis By Payor

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<th>Medicare</th>
<th>Self-pay</th>
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## COST ALLOCATION:

| Total Costs | 1,100,000 |

Allocation of non-allowable costs:

| Laboratory - self-pay only | (125,000) | 125,000 | 125,000 |
| State grant - medicaid only | (75,000)  | 75,000  | 75,000  |

Allocation of allowable costs:

| Based on cost report rate | (900,000) | 450,000 | 90,000 | 360,000 | 900,000 |
| TOTAL ALLOCATED COSTS     | -         | 525,000 | 90,000 | 485,000 | 1,100,000 |

## REVENUE ALLOCATION:

| Patient service revenue, net | 500,000 | 80,000 | 80,000 | 660,000 |
| CHC grant                    |         | 425,000 | 425,000 |        |
| State grant                  |         | 75,000  |        | 75,000  |
| TOTAL ALLOCATED REVENUE      | 575,000 | 80,000 | 505,000 | 1,160,000 |

**PROFIT / (LOSS)**

|                | 50,000 | (10,000) | 20,000 | 60,000 |

**NOTE:** Actual cost per visit per cost report equals $90 whereas the PPS rate is $100.
Medicare

- Are you over the cap? Look at ways to increase visits enough to get your rate below the cap
- Will DSMT or MNT services result in getting costs below the cap?
- Increase your market share of Medicare patients.
- Are you billing wraparound for contracted MA plans?
- How about the PFFS MA plans; billing should result in 80% of cost rate, 20% of charges minus any co-pay.
Medicaid

- Alternative Reimbursement Plan - Is there a cap? Look at ways to increase visits enough to get your rate below the cap
- Are there services reimbursable under PPS that could improve reimbursement?
- Opportunities for applying for a change in scope of services, (i.e., increased costs, new services, intensity of services etc.)
- Do you get your PPS rate for crossover claims?
- PPS rate appeals, due to increased costs…not enough revenue.
A community health center is required to offer discounts to patients without insurance who live below 200% of the Federal poverty level.

- The discount schedule is defined by the Board of Directors of the health center.

- The level of poverty is defined based on income and family size by the federal government. It is updated each year and is published in the federal register in February.
PAYOR TYPE -- SELF PAY

Section 330 regulations require that the schedule of discounts conform with the following guidelines:

- Full discount to individuals and families with incomes at or below those set forth in the most recent Federal poverty income guidelines (100 – 200% of FPL)

- No discount to individuals and families with annual incomes greater than twice those set forth in the Guidelines (>200% of FPL)

- Except that nominal fees for services may be collected from individuals with incomes at or below such levels where imposition of such fee is consistent with project goals (<100% of FPL, accounts for over half of health center self-pay patients nationwide)

Section 330 statute further requires that “a health center has made and will continue to make every reasonable effort to secure from patients payment for services in accordance with such schedules.”
Some Issues with the Sliding Fee Scale

- What is a family?
  - Estranged husband/wife and kids
  - Parents
  - Others living in same household
  - Head of household not living in household

- What is Income?
  - Gross or net?
  - What is used to determine?
  - Tax Returns with business losses
  - Again, who is head of household
  - Attestation statement
    - Further proof of income
Questions and Answers

www.rsmmcgladrey.com

michael.holton@mcgladrey.com