REVENUE CYCLE MANAGEMENT

Best Practices Guide

Greenway
Health™

SERVE. CONNECT. CARE.

REVENUE CYCLE MANAGEMENT:
FINANCIAL STABILITY FOR THE FUTURE OF HEALTHCARE

Introduction

The critical role of effective revenue cycle management (RCM) is unprecedented in healthcare. As multiple regulatory initiatives converge with existing demand for faster billing cycles and cost containment, provider organizations are facing a perfect storm of clinical and financial challenges.

For many practices, the struggle to collect patient responsibility balances is a concern extending throughout the practice. Beginning with front office knowledge gaps limiting a staff's ability to collect monies owed and extending to a lack of proactive management among back-office personnel to ensure payers and patients follow through with payment, practices are leaving valuable revenue on the table. Payment delays can be attributed to a host of issues, including inaccurate coding to the more severe issue of rejected or denied claims that can negatively impact the bottom line.

Often, ineffective approaches to RCM are the culprit. An August 2014 Healthcare Finance article revealed that "even some of the most prominent healthcare systems experience significant losses, primarily within outpatient areas of service," and "there can be a 20-25 percent loss in revenue in certain clinical departments."

Timely revenue cycle processes are critical to future success and positioning, especially in light of the rise of high-deductible health plans (HDHPs) and the increasing number of patients responsible for their own healthcare costs. To better position for future reimbursement challenges, practices must embrace new RCM models and best practices to improve patient collections.

The number of patients with HDHPs and health savings accounts has grown 15 percent annually for several years and now stands at 15.5 million people. It's a trend that is expected to continue, and practices that maintain the status quo in terms of RCM will most likely see a decline in profitability.

The purpose of this guide is to educate provider organizations about evolving challenges to RCM and teach best practices for improving revenue collections. Providers will learn how to effectively train staff and apply processes that promote revenue collection and improve overall financial health. To better equip providers with the tools needed to successfully navigate today's reimbursement landscape, we will also introduce Greenway Revenue Services, an RCM partnership that touches every practice function — from the front desk to the back office — to help manage revenue cycle from initial patient encounter to collection and beyond.

Two icons will be used next to section takeaways, indicating the target for that particular bullet.

Providers   Billing Managers

"In the last six months, we've found they've really helped us with our reimbursements," said Lorena Maunez, billing administrator with South Bay OB-GYN. *"We've increased our revenue, and we're excited to see what the future brings with RCM."*

Optima Women's Health attributes much of its success with RCM to Greenway Revenue Services' team-oriented approach.

"I absolutely love having an RCM team. That's the keyword: team," said Vandna Jerath, M.D., FACOG. *"With a team approach, different people have different roles — you have an account manager; you have a person who works on the collections; you have a person who works on the charges and the payment posting. Everybody is specialized in what they do."*

Greenway Revenue Services knows the nuances of billing for different specialties such as OB-GYN, neurology, gastroenterology, cardiology, pediatrics, internal medicine, orthopedics and pulmonology. The teams offer the tools and training practices need to:

• Track claims data

• Ensure accurate and timely claims submission

• Boost collection rates

• Optimize billing practices

[3]Focus on capturing outpatient charges. Healthcare Finance News. August8, 2014.
http://www.healthcarefinancenews.com/news/focus-capturing-outpatient-charges
[2]January 2013 Census Shows 15.5 Million People Covered by Health Savings Account/High-Deductible Health Plans. Washington D.C.
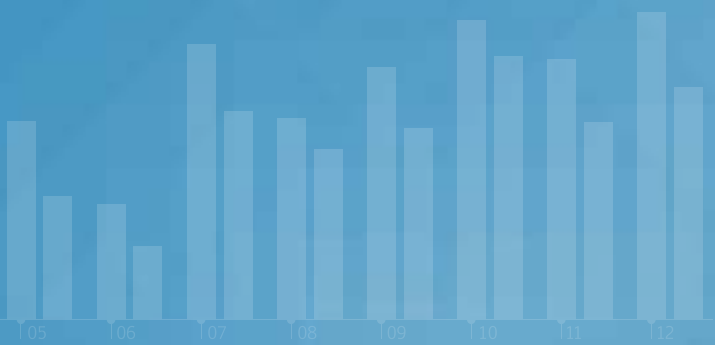America's Health Insurance Plans. June 2013. http://www.ahip.org/HSA2013/

INTRODUCTION

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WHAT IS RCM?

WHAT IS RCM?

In simple terms, RCM refers to the steps that healthcare organizations must take to receive payment for services rendered. Historically viewed as a straightforward back-office function, RCM now touches every aspect of a practice.

A complete RCM strategy is comprised of three main functions:

1) **Generate revenue:** Practice survival and sustainability depend on the ability to generate revenue. By reducing gaps and inefficiencies in scheduling to maximize reimbursement, practices can achieve this goal, but it requires a proactive approach to both scheduling and capture of all necessary patient information and copays up front. When this function of revenue cycle is optimized, practices can increase their revenue by minimizing the number of no shows.

2) **Capture revenue:** Once a patient is called from the waiting room, the clinical encounter begins and extends through the time a patient leaves the appointment. The activity that occurs during this timeframe is foundational to a practice's ability to capture revenue and must be thoroughly recorded. Accurate and complete documentation of services rendered and proper coding of those services is required to receive payment at the highest level.

3) **Collect revenue:** In general terms, back office billing functions enable a practice to collect revenue and round out the RCM cycle. Included in this category are the steps associated with billing, posting and collection of payments and should be viewed by practices as the last step of the RCM process.

How Does RCM Differ From Traditional Billing?

Within traditional fee-for-service care delivery models, billing was characterized by the tasks and functions performed in the back office and was not often viewed as a shared responsibility between front office, back office and clinical staff. Today, billing strategies must evolve and mature within provider organizations to reflect clinically driven RCM models that proactively address payment even before a patient enters the office door.

For example, clinically driven RCM would involve conducting eligibility checking before a patient arrives in the office. But it's not just about financial aspects. Clinically driven RCM takes an overall proactive approach to patient health, including reaching out to patients to remind them when it's time for check-ups, services and procedures that may be required to maintain control over chronic conditions, such as diabetes and high blood pressure.

As healthcare's lean, quality-driven healthcare climate continues to unfold, revenue cycle depends on the complete and accurate documentation of patient information, beginning at the point of registration and extending through the

Takeaways

- Practices should not make the mistake of believing revenue cycle management only applies to the back office. Front office, back office and clinical staff all play an important role in bringing in revenue.

- Only 62 percent of practices review delinquent claims.

clinical documentation process. One single gap in data can significantly impact revenue streams.

For instance, if the front office staff is unable to get all the patient information required for payment or fails to check for eligibility, the downstream impact can be significant billing delays or irreversible claim denials. Lack of proactive outreach up front can also lead to workflow inefficiencies as back-office staff members are forced to spend valuable time correcting front office errors rather than engaging in timely follow up with payers.

The reality is that only a fraction of problematic claims are ever resolved. Greenway Health research finds that only 62 percent of practices review delinquent claims and only 59 percent of secondary claims are filed due to back-office time constraints.

Often, RCM practices that hinder optimal billing performance can be traced back to four common mistakes in practices:

1) **Not focusing on process:** Billing glitches can originate in many areas of practice operations, especially during times of peak scheduling. When many patients are coming in and out of the doors of a provider organization, key patient information may be miscommunicated, overlooked or even lost. Billing processes must be standardized and optimized as a "cycle" that is clinically driven and embraced by all staff.

2) **Neglecting critical information:** There are a lot of documents that move through a practice. While managing all the critical information contained in these documents may seem overwhelming, it is a task that providers must embrace to optimize revenue opportunities. For instance, when organizations understand the nuances of payer contracts, they are in a better position to fully leverage payment and negotiations. Equally important is staying on top of edit reports, explanation of benefits forms and other claims issues, and making sure denied claims are reworked and resubmitted as needed.

3) **Failing to follow up:** Many strategies are employed by provider organizations to improve collections, including appeals, tracers, collections letters and payment plans. While these tactics are a good first step, many fall short of success due to lack of follow-up. Often, by the time a practice realizes a patient has not responded, it's too late to collect the money owed.

4) **Drowning in details:** Details are important, but when billing practices become all about miniscule issues,

organizations can neglect the bigger-picture revenue opportunities. For example, if practices look for trends, such as repeated claims denials for the same services or claims that are denied for registration errors, processes can be reworked to eliminate the potential for those errors to occur in the future.

How Can a Practice Measure Financial Health?

Before an effective, clinically driven RCM strategy can be implemented, an understanding of current financial health must exist. Practices can leverage a number of best practice metrics to make this determination.

DAYS IN ACCOUNTS RECEIVABLE

A four-provider family practice started with 104 days in AR in April when they first adopted Greenway Revenue Services. By September, it was down to 63 days, an improvement tied to the expert claims scrubbing provided by Greenway's RCM teams and proactive follow-ups with payers on outstanding claims to ensure practices are paid as quickly as possible.

The days in accounts receivable (AR) measurement represents the length of time it takes on average for a claim to be paid.

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WHY SHOULD PRACTICES USE GROSS COLLECTIONS TO CALCULATE FINANCIAL METRICS?

Measurements that include all charges tend to be arbitrary in nature and are not a reflection of what a practice can actually receive in reimbursement.

Internal Greenway Health research found that 79 percent of providers are dealing with 10 or more payers. This makes it difficult — if not nearly impossible — for

[3]Woodcock, Elizabeth. Billing Blunders: Is Your Practice Making Costly Mistakes? Physicians Practice. 2009.
http://www.naturopathic.org/files/For_Members/Practice%20Development/Finance/Insurance%20Billing%20Blunders.pdf

practices to track and manage all fee schedules effectively. For this reason, practices often set their own fees high enough to ensure the greatest capture of revenue while recognizing that real-world reimbursement from any given payer will be lower than what is reflected on the provider fee schedule.

The metric that really matters is the net collection rate, because it is a reflection of the reimbursement a practice can actually receive. The total days in AR based on gross charges is always lower than total days in AR based on gross collections. As such, practices should avoid using this metric, as it will result in skewed, unrealistic expectations.

WHY IS DAYS IN AR IMPORTANT?

When money is tied up with payers, practices lose momentum with cash flow as well as opportunities to invest and earn interest. Therefore, maintaining a low days-in-AR metric benefits a provider organization.

Also, providers must often meet the parameters associated with timely filing limits — a deadline established by insurance carriers requiring that claims be filed within a certain period from the date the service was provided. Once this deadline has passed, it is often difficult to receive any payment for services rendered, making these deadlines much more favorable to insurance carriers than providers.

It is not uncommon for commercial carriers to require that claims be filed within 90 days of the date of service. While that timeframe may seem ample, the nuances of a busy practice can make these parameters challenging, especially without a solid RCM strategy that addresses days in AR.

Greenway Revenue Services clients see an average decrease of around 31 percent in days in accounts receivable, or DAR, based on a weighted average for Greenway Health clients with valid benchmark data that had their 36-month anniversary with Greenway Health prior to July 2015.

GREENWAY REVENUE SERVICES IN ACTION

Experienced RCM teams are available to proactively reach out to the payers well in advance of a timely filing limit, decreasing the likelihood that claims will be outstanding for too long.

By assuming the burden of AR management, a dedicated Greenway Revenue Services team does the heavy lifting for you. Our professionals are experts in both the ambulatory product and your billing processes, offering deep experience managing payments with all the insurance carriers. Greenway Revenue Services helps practices by:

- Conducting regular insurance follow-up
- Scrubbing claims to ensure that your practice is paid as quickly as possible on the highest percentage of visits
- Preventing delays in cash collections through seamless integration of the solutions and services

Lake Shore Obstetrics & Gynecology case study

After implementing Greenway Revenue Services, Chicago-based Lake Shore Obstetrics and Gynecology was able to:

1) Increase monthly gross charges
2) Reduce days in AR to an average of 23 days
3) Realize the majority of claims paid within 30 days

CLEAN CLAIMS RATIO

Also known as the first pass ratio, the clean claims ratio is the percent of claims that are paid at first submission. A clean claim is the ultimate goal of any billing process. It has never been rejected, does not have a preventable denial, has not been filed more than once and contains no errors.

Understanding the clean claims ratio is important, because the time a provider organization spends reworking denials can be extensive. Staff must review the original claim, identify the reasons for the denial and then rework the entire claim for resubmission. Once completed, the claim cycle must be restarted, delaying receipt of monies. In addition, some claims that are denied on first pass are never paid.

As claims are denied over time, the billing staff needs to analyze where breakdowns occur, identify trends and implement new processes that will improve the outlook. Otherwise, a provider organization will continue to perpetuate its mistakes, reimbursements will fall short and the entire organization will suffer.

USING THE CLEAN CLAIMS MEASUREMENT

A practice files 1,000 claims per month and maintains a 90 percent clean claims ratio. Of the claims filed, 91 percent were paid without any further action and 9 percent required rework. With this knowledge, a practice can:

- **Determine staffing needs:** If a practice needs to rework 100 claims a month, a calculation can be made that considers the average number of claims a full-time employee can work a day (usually 50) to determine the number of employees needed. Foundationally, this determination can be made by factoring in the number of touches a claim requires during rework. These could include entering the rejection or denial, calling the payer for details, researching coding mistakes, refiling the claim or posting another denial.

- **Measure costs:** If the average cost of rework is $25 per claim and 100 claims a month require rework, it costs a practice an average of $2,500 a month to work unclean claims. In addition to an employee's hourly rate, a practice should factor in overhead costs such as benefits (30 percent of salary), facilities, hardware and electronic filing fees directly associated with unclean claims.

GREENWAY REVENUE SERVICES IN ACTION

Greenway Revenue Services examines clean claims metrics across an entire organization. By analyzing this data, our experts can:

- Teach best practices to the front office staff to ensure correct and updated patient information on claims.
- Make sure the practice always verifies patient eligibility before the patient arrives.
- Look over the claims to make sure staff members follow carrier-specific coding guidelines and correct modifier usage.
- Make sure the correct medical documentation is attached to claims.

Fair Oaks Women's Health Case Study

After implementing Greenway Revenue Services, Fair Oaks Women's Health was able to clean up claims through the services' ongoing monitoring and correction of billing errors.

> *"Greenway Revenue Services identified $75,000 in charges that were sitting in the computer because of a minor issue that they were able to fix and send out right away."*
>
> —Bryan S. Jick, M.D., FACOG
> Fair Oaks Women's Health

NET COLLECTIONS RATIO

The net collections ratio is the percentage of total potential reimbursement collected out of the total allowed amount. Denial rates, unreimbursed visits and other factors affect the net collections ratio. Notably, statistics suggest that 65 percent of denials, nationally, are never reworked, negatively impacting this measurement of financial health for many practices.

The net collections ratio is critical, because it represents the efficiency at which the revenue cycle is working for a practice and is the ultimate indicator of success with collections. Consider that an important component of net collections is bad debt and the ability to specifically manage patient collections. In most scenarios, patient net collections percent is lower than payer net collections percent.

Patient deductibles are increasing. Because it is harder to collect money owed by a patient, practices will need to become more skilled and proactive in collections as the number of HDHPs continues to rise.

GREENWAY REVENUE SERVICES IN ACTION

Greenway Revenue Services improves net collections ratios for provider organizations by finding errors and omissions that result in denials, unreimbursed visits and other uncaptured revenue opportunities. Greenway Revenue Services teams will go over a monthly reporting package that allows practices to easily monitor financial health and identify root causes for collections issues. Our experts also consult with you on monthly calls to develop and reinforce best practices that ensure long-term success.

South Bay OB-GYN Medical Group

On its own, South Bay OB-GYN Medical Group was bringing in revenue at approximately 70 percent of total billing. After just six months of working with Greenway Revenue Services, the practice increased collections by 50 percent.

PERCENTAGE OF CLAIMS BELOW 60 DAYS

Practices track the percentage of claims below 60 days for many of the same reasons they track days in AR. An important aspect of AR management, effective management of this metric recognizes that a dollar received today is more valuable than a dollar received in the future.

The aging of AR is calculated by viewing an aged trial balance (ATB), which is a summary of all receivables by age and by percentage of total. For example, if an account has been outstanding for 34 days, it is part of the "31-60 day" category. Each category includes all accounts that have aged for a particular period of time and are typically categorized as 0-30 days, 31-60 days, 61-90 days, 91-120 days and more than 120 days. To arrive at the percentage of claims below 60 days, the total dollar of each category is tabulated along with the percentage of total accounts receivable outstanding.

GREENWAY REVENUE SERVICES IN ACTION

While many practices calculate the percentage of AR less than 90 days, Greenway Revenue Services calculates the percentage at 60 days to more proactively support the focus on clinically driven RCM practices. As with days in AR, proactive follow-up and scrubbing of claims enables our team of experts to decrease the percent of claims that hit 60 days.

Practices should examine AR aging by payer to better identify areas of revenue improvement opportunity. For this reason, Greenway Revenue Services includes insurance aging reports in its monthly consults.

Otolaryngology Physicians of Lancaster Case Study

By leveraging Greenway Revenue Services, Pennsylvania-based Otolaryngology Physicians of Lancaster reduced AR days by almost 60 percent, from 52 to 20 days. The organization achieved a claims paid rate of 92 percent within 60 days, versus its previous 90 percent in 180 days, saving $2,000 every month in staff and billing costs.

> *"Our experience with Greenway has been 100 percent positive. They've helped us do a complete 180 in our billing department."*
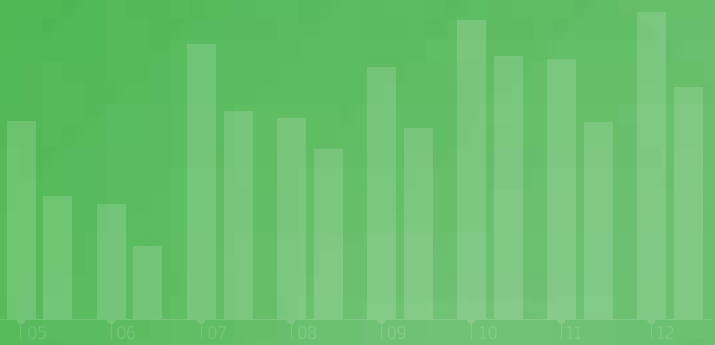
—Marie Anderson

Front Office and Billing Manager, Otolaryngology Physicians of Lancaster

Takeaways

- It is important that practices are aware of their days in AR, clean claims ratio and net collections ratio. These three financial metrics can help measure a practice's success and help staff determine where there is room for improvement. Practices should track these trends on a monthly basis.

- Only 59 percent of secondary claims are filed.

- 12 percent of practices never update their payer fee schedules.

NO LONGER JUST
BACK OFFICE

NO LONGER JUST BACK OFFICE

Gone are the days when billing was contained in the back office. While roles in a practice used to be segregated, today all staff must engage in clinically driven RCM practices. Fully optimizing RCM requires that all staff be cognizant of how they contribute to the bottom line.

Front Office Responsibility

RCM begins with the first staff and patient encounter, which should actually occur before a patient enters the office by having front desk staff collect insurance information pre-visit. Many practices are addressing the need to proactively obtain payment information by requiring insurance information before an appointment is scheduled.

Once information is obtained, front office staff must then confirm a patient's eligibility before an appointment. That way, if there are any inconsistencies, the front desk can get them reconciled in advance of treatment and billing. Queries regarding primary and secondary coverage should also be made, as a practice can often leave money on the table if it only files claims for primary insurance.

According to Greenway Health market surveys, practices only file 59 percent of secondary claims. During this time of declining reimbursements and rising costs, practices cannot afford to ignore sources of revenue.

Appointment reminders are another critical part of the RCM equation and should be handled by the front desk, whether automated through text or actual phone calls. If a patient does not show up for an appointment, the practice loses revenue for the missed appointment and also the opportunity to generate revenue by filling the opening.

If possible, the practice should collect the demographic and medical information before the patient comes in, which creates efficiencies in the registration process. Consider that time taken to complete needed patient information in the office could eat into the physician's time to see that patient. Practices can leverage online patient portals to accomplish this task or email out a registration packet ahead of an appointment, requesting that patients fill out forms before they arrive.

Once an appointment is scheduled, needed information is gathered and the patient arrives for an appointment, the front desk is responsible for collecting the copay. While practices engage various strategies for collecting this revenue, the task should be completed before the patient leaves the office.

Collecting small copays after a patient has left is a tedious, cumbersome task that many practices view as a waste of time. However, it can add up to significant revenue over time.

As HDHPs rise, front desk staff members need to be better trained and equipped to discuss money with patients. Many staff have not had to engage in discussions related to money under fee-for-service arrangements and may not be adequately trained to discuss finances with patients. Therefore, strategies for education will need to be deployed.

Front desk staff need to be well versed in discussing the costs of each treatment and procedure to educate patients regarding their fees. Practice executives will also need to clearly identify parameters for turning patients away. Questions that may need to be answered include:

- Will the practice see patients who do not have insurance?
- Will the practice see patients who cannot pay their copay at the time of service?
- Will the practice see patients who owe money from past visits?
- Does it matter how much a patient owes?

A good RCM vendor will provide consultation and education for front desk staff. If a vendor sees some way that the front desk is inefficient, it will step in and give advice. RCM vendors monitor and ensure that these best practices are happening.

GREENWAY REVENUE SERVICES INCLUDE:

- System alerts that prompt patient payment upon check-in
- Best practices training to ensure accurate policy ID and referral entry and upfront payment collections
- Copay systems tables for accurate collections

Clinician Responsibility

Traditionally, many clinicians have felt that their primary responsibility is treating and helping patients — not generating revenue. Unfortunately, in a time of declining reimbursements and rising costs, it is no longer possible for the clinician to be ignorant of finances. ICD-10 coding rules alone present new challenges, requiring that clinicians be

Takeaways

- Front office staff play a significant role in patient collections. The front office staff should understand that their role contributes to practice revenue and take that responsibility seriously. Their role in patient collections will increase further as the industry experiences a rise in HDHPs.

- Only 32 percent of patients who owe money receive a collection letter from the practice.

- Clinicians can no longer deny their role in generating revenue. They need to be cognizant of documentation practices and capture all details of care.

cognizant of documentation practices to ensure they are capturing all details of the care they are providing.

A good RCM vendor will share best practices with the office and can also suggest different codes if they believe the physician is undercharging for services. Revenue services teams track the performance of all staff in a practice and make suggestions on ways they can improve.

GREENWAY REVENUE SERVICES INCLUDES:

- Flexible templates for optimized data capture
- An easy-to-use application that promotes compliance with payer documentation requirements
- E&M coding tools to ensure you can bill at the highest clinically appropriate level for each visit

Integrated Clearinghouse

The role of the clearinghouse is to provide an interface for claims management. Clearinghouses receive claims from a practice management system by an interface and move that information to the appropriate payers, both government and commercial.

Greenway Clearinghouse's first pass ratio is over 99%.

In the role of facilitating claims processing, clearinghouses may receive information containing nonstandard elements in a nonstandard format and move that information into a format that will be acceptable to the payer intended to pay the claim. The reverse may also be true: Standard transactions received by the clearinghouse may be put into a nonstandard format for the receiving organization.

Not all clearinghouses are alike. Some clearinghouses have high claims acceptance rates and good editing processes with short time frames for reviewing claims for billing conflicts. Clearinghouses should provide the medical practice with ease in viewing, editing, correcting and submitting claims.

Greenway owns its own clearinghouse. Therefore, our RCM team will be able to see the claim and understand its status all the way up to the payer. This eliminates delays that would be associated with an RCM representative reaching out to a clearinghouse to get more information. Greenway Clearinghouse's first pass ratio is over 99 percent.

Patient Responsibility

With the rise in HDHPs, patients are gaining more responsibility for their bills. Practices need to be more diligent at focusing on patient payments. There are six best practices to improve patient collections:

1. **Gather patient insurance and contact information before patients arrive for an appointment**
   Staff should be prepared to collect complete and current insurance and contact information when a patient calls to make an appointment. Patients can be given the option of mailing or emailing information.

2. **Verify insurance eligibility and identify any amounts due from patients prior to patient visits**
   Prior to a patient's appointment, provider organizations should check with payers to verify coverage and clarify payer rules.

3. **Collect copays and other patient-responsible balances at the front desk when the patient checks in**
   The best time to collect payment from patients is when you have the opportunity to do so face to face. Practices need to develop and communicate clear policies to patients, enforce them routinely and consider the option of rescheduling non-emergency appointments if the requirement is not met.

4. **Offer multiple payment methods**
   Make the process of paying a bill easy through flexible options that include cash, check or credit/debit card. This practice will increase the likelihood of collecting amounts due while the patient is in the office and can streamline overall billing processes.

5. **Offer payment plans and track them**
   For procedures that extend beyond the health savings account, or for uninsured patients, establish plans that let patients pay over time and train staff on how to communicate these options to patients effectively and track them properly.

6. **Make follow-up part of the routine**
   Perseverance is key to maximizing collections for patients who don't make timely payments, yet many offices don't routinely call patients who have outstanding balances. Develop a routine, proactive timeline for initiating phone contact, and create a script for staff to follow.

Print this out as a reference for improving patient collections.
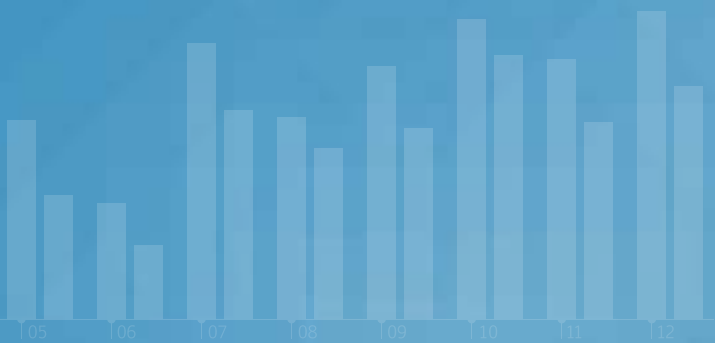
VALUE-BASED
PAYMENT MODELS

VALUE-BASED PAYMENT MODELS

What Are Value-based Programs?

Value-based programs are contracts with payers such as the Center for Medicare & Medicaid Services (CMS) and Aetna that tie reimbursement to the quality of care a practice gives its patients. These payment models are evolving in response to the rising costs of chronic conditions, which represent 85 percent of all healthcare expenditures.

Most value-based programs are designed to align with healthcare's "Triple Aim" — improved population health, enhanced patient and provider experience through better quality and satisfaction, and reduced per capita cost of healthcare.

How Are Physicians Paid Under These Programs?

Traditionally, physicians have been compensated on a fee-for-service (FFS) basis. Under this model, physicians are compensated for each "widget" of care they sold. In essence, individual procedures, tests and other events generated revenue. Today, payers increasingly use quality and cost measures as a way to adjust physician reimbursement.

The following payment methods are the most common in value-based programs:

How Is Quality Measured?

Within value-based initiatives, quality is measured by using clinical "measures," which are generally fractions that represent performance on a key clinical indicator, such as providing body mass index screenings to patients or the A1C levels of a provider's diabetic patients. In essence, the payer compares clinical performance nationally, sets a performance "mean" and adjusts compensation based on performance against that mean.

Some value-based measures are process based, whereas other measures are outcomes based. Examples of process based measures include:

- Percentage of adults who had blood pressure screened in the last two years
- Percentage of patients who received a flu vaccination
- Percentage of patients who received depression screening

PAYMENT TYPE	DESCRIPTION
Incentives or penalties	Based on quality and/or cost measures, a physician's FFS reimbursements are adjusted either up or down by a certain percentage.
Care coordination fee	In addition to receiving FFS, physicians collect a set monthly per-patient "care-coordination fee." A care coordination fee is money given to compensate the practice for organizing non-visit patient care activities between the patient, their providers and any acute care facilities (hospitals) to ensure the patient gets the right care at the right time.
Shared savings	Physicians are reimbursed FFS and a share of the savings, generally up to 50 percent, generated for the healthcare system through preventative care and population health management. How much savings a practice generates is calculated by measuring cost per patient against national benchmarks set by the payer and then adjusting the rate for quality. If a practice saves the system $1.2 million as measured against its peers, they collect up to $560,000.
Capitated payments (or full-risk)	These contracts pay providers a straight fee per patient per month and eliminate FFS entirely. Therefore, if the rate is $100 per month per patient and a practice has 1,000 patients, they will receive $100,000 per month from the payer, **regardless of what services are delivered or whether a patient even utilizes the provider**.
Blended payments	Many contracts will use a mix of the payment models above. For example, a payer may offer shared savings and a care coordination fee, while still allowing a provider organization to capture FFS reimbursements.

Examples of outcome based measures include:

- Percentage of patients discharged from an acute care hospital and readmitted within 30 days
- Percentage of diabetic patients whose blood glucose is uncontrolled (A1C < 8)
- Percentage of patients with high blood pressure whose blood pressure is lower than 140/90

How Is Cost Measured?

Cost is measured by analyzing per-patient/per-month healthcare expenditures and by looking at per-patient/per-month expenditures related to certain chronic conditions, such as coronary artery disease.

Specific Value-based Programs

PROGRAM NAME	DESCRIPTION	PROVIDER REIMBURSEMENT
Accountable Care Organization (ACO)	An ACO is a group of provider organizations that aims to provide highly coordinated care while reducing costs. These organizations usually consist of multiple practices that have allied to participate in ACO programs offered by CMS or private payers. It has 33 different quality measures in four domains: patient experience (surveys on the quality of doctor communications, shared decision making, etc.), care coordination (medication reconciliation, discharge follow up, etc.), preventative health (BMI screenings, immunizing the population, etc.), and at-risk population (A1C levels for diabetics). ACOs measure cost by per patient per month.	Shared savings, adjusted for quality measure performance, and FFS. In private ACOs, payment may be shared savings and FFS; or other blended payments.
Patient-Centered Medical Home (PCMH)	A PCMH is a model for individual practices that focuses on providing coordinated and comprehensive care. The National Clinical Quality Association (NCQA) recognizes practices that track specific measures and undergo certain process changes aimed at patient access, care coordination, population health management, continuous improvement and other elements. Private payers then allow these practices to participate in their PCMH programs.	Care coordination fee plus FFS adjusted for quality measure performance
Value-based modifier	The value-based modifier adjusts Medicare reimbursement based on quality and cost. Generally, organizations that provide high quality care for a low cost get an incentive, and those who provide low quality care at a high cost receive a penalty. Quality measures are aligned with PQRS. It applies to groups with 100 providers or more in 2015. In 2016, it applies to groups with 10 or more, and in 2017, it applies to all of them. Incentives and penalties change by the year.	Incentives and penalties tied to quality and cost performance.
Medicare Advantage	Medicare Advantage is a program where CMS contracts with private payers and pays them capitated payments for Medicare services. The private payers then contract with provider organizations for the delivery of these services. The capitated payments are based on Hierarchical Condition Categories (HCC) codes, which are diagnosis codes that reflect the risk a patient presents. Payers receive more money for higher-risk patients.	Varies, generally FFS and shared savings. Private payers may change FFS reimbursement based on keeping diagnosis codes up to date, so the payer is compensated the right amount.
Comprehensive Primary Care Initiative (CPCI)	CPCI is a CMS program that is no longer accepting entrants. The program develops core capabilities in patient access, planned and preventative care for chronic conditions, risk-stratified care management, patient engagement and care coordination.	FFS, shared savings, care coordination fee of $15-$20 (called care management) per patient per month
Chronic Care Management Fee	Practices that have five certain capabilities are permitted to bill CMS once a month per patient for non-visit care management activities, such as medication reconciliation or monitoring the patient's condition. The five capabilities are 1) use of a certified EHR, 2) maintaining an electronic care plan, 3) ensuring patient access, 4) facilitating transitions of care and 5) care coordination.	$41.92 care coordination fee

How Will Value-based Models Affect RCM?

Within value-based payment models, it is no longer enough for a practice to document what procedures and services it provides. Now, they are required to track a host of quality measures in order to be reimbursed.

Currently, the CMS ACOs must track 33 quality measures.[5]

As physician compensation moves away from FFS to shared savings and outcomes-based models and practices embrace new team-based approaches to care, the ability to successfully balance quality initiatives and revenue processes is becoming a far more complex process. Practices must now track multiple payer contracts and manage quality metrics reporting, requiring additional resource allocation.

Many physicians are discovering that the talent and technology needed to get the job done efficiently and effectively is beyond their current capabilities or will require investment dollars that simply do not exist. In response, many practices are considering the advantages of collaborating with an RCM vendor.
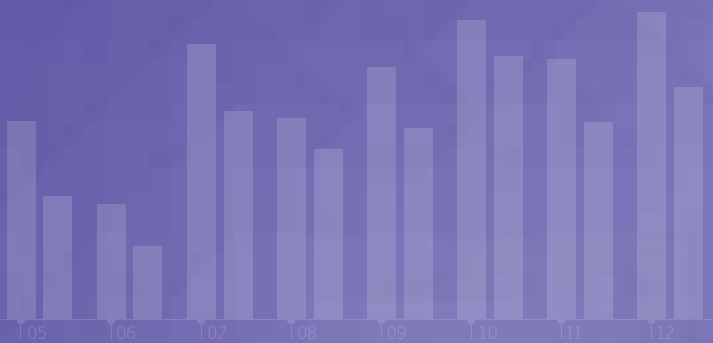
Revenue services vendors have the benefit of working with many practices who participate in value-based payment models, creating economies of scale. A good RCM vendor can help a provider organization navigate the uncertain waters of the value-based climate and ensure revenue is optimized.

Takeaways

- Costs to treat chronic conditions are rising. Value-based programs tie reimbursement to the quality of care a practice provides to its patients instead of using a fee-for-service (FFS) compensation model.

[5]http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Shared-Savings-Program-Quality-Measures.pdf

HEALTHCARE'S ICD-10 OPPORTUNITY AND CHALLENGE

HEALTHCARE'S ICD-10 OPPORTUNITY AND CHALLENGE:
ARE YOU LEAVING MONEY ON THE TABLE?

ICD-10 is an unprecedented undertaking in healthcare — one that touches every area of practice operations. Implementing the ICD-10 code sets will result in many potential costs to physicians, including education and training, changes in health plan contracts, coverage determinations, increased documentation, changes to superbills, information technology system changes and possible cash flow disruption.

The American Academy of Orthopaedic Surgeons, along with 11 other healthcare organizations, released a study conducted by Nachimson Advisors, LLC, which suggests that the Department of Health and Human Services (HHS) has underestimated the cost of implementing the ICD-10 code set. According to the study results, the implementation cost for a three-physician practice could be as much as $83,290, while a 100-physician practice might pay more than $2.7 million. [6]

Even if the practice has not yet experienced a decrease in revenue, it is predicted that payers will be tightening edits throughout the year. Therefore, what was projected to be a big bang is now expected to be a gradual shift.

The Post-ICD-10 Revenue Challenge

There are three major causes to potential revenue loss in the post-ICD-10 landscape:

- Increased back office staff time checking claims
- Increased denials due to incorrect coding/lack of specificity
- Increased documentation time for physicians.

BACK OFFICE STAFF IS SPENDING MORE TIME CHECKING CODES, TAKING THEM AWAY FROM REWORKING CLAIMS

ICD-10 offers detail that allows for accurate descriptions of technologies and procedures — a progressive step forward to more accurate reflections of care delivery in coding. While the increase from approximately 13,000

ICD-9 codes to approximately 68,000 ICD-10 codes is expected to enhance care delivery and reimbursement, it also means increased work for the back office who must review the accuracy of claims before they go out.

Because documentation practices will need to reflect increased specificity, the back office must spend additional time checking to make sure the physicians are providing the needed detail when recording their care to code claims accurately. Facing these new responsibilities, practices may find that the back office hits its work capacity and no longer has the resources to rework claims in a timely fashion — or rework some claims at all. On the other hand, if the back office allocates the time needed to rework claims, it may be forced to spend less time checking the original claims, resulting in a decrease in first time pass rate. All resource allocation options required for ICD-10 point to decreases in revenue.

By collaborating now with an RCM vendor, practices can maintain a healthy revenue stream and avoid the expenses and effort associated with hiring additional back office staff to increase work capacity. Practices benefit from the breadth of staff available through an RCM vendor as well as the depth of experience in reworking claims.

INCREASED DENIALS CAUSED BY INCORRECT CODING/LACK OF SPECIFICITY

Despite having taken the needed steps to prepare for ICD-10, the probability for increased denials is high. This is because ICD-10 impacts every area of a practice from front office to physician documentation, and to coding and billing. While one area may be operating at full competency, another may fall short.

ICD-10 codes now include such nuances as site specificity, laterality, type of encounter, combination codes and place of occurrence codes — a level of detail physicians are unaccustomed to documenting. The reality is that many physicians have worked in the industry for decades, and changing the way they practice medicine will require focused energy and time.

[6] Law Lindsay, Porucznik, Mary Ann. Switching to ICD-10: The impact on physicians. American Academy of Orthopaedic Surgeons; February 2009. http://www.aaos.org/news/aaosnow/feb09/reimbursement1.asp

Takeaways

- Events like ICD-10 highlight how clinicians are increasingly contributing to bringing in revenue. Clinician documentation has a direct impact on claim acceptance.

RCM vendors bring specific change management expertise to the ICD-10 environment, offering advanced services such as coaching and education for the entire practice, not just filing claims. Through ongoing phone calls, an RCM vendor will spot weaknesses in the revenue cycle and address them with the offending parties. Also, because a practice is paying a third party to make sure their finances are healthy and stable, physicians are more likely to make an effort to change.

INCREASED DOCUMENTATION ACTIVITIES

The specificity of ICD-10 naturally brings a permanent increase in physician documentation activity. Regardless of whether RCM activity is optimized, practices are still poised to lose money, because they cannot treat the same number of patients. More time spent with documentation means less time with patients, resulting in a direct decrease to revenue.

Even if it only seems like an incremental increase per patient, once these numbers are compiled across the entire day, month and year, the end result can be substantial. To break even, a practice not only needs to maintain its net collections rate but also increase it.

RCM vendors can provide the extra resources needed to make this happen. Because third-party vendors benefit from economies of scale, these services can be provided more cost efficiently and with greater expertise than what most providers are able to afford.

GREENWAY REVENUE SERVICES IN ACTION

The Greenway Revenue Services team helps practices with ICD-10 by:

- Spotting obvious mistakes early on, allowing providers to fix them before it ever gets sent to the payer
- Filling the productivity gap as providers learn ICD-10 coding, improving cash flow through efficient RCM
- Keeping practices up-to-date on changes in payer rules, which will most likely change due to ICD-10

"Thanks to the Greenway Revenue Services team, ICD-10 is a total non-issue for us. It's a great partnership."

—Phyllis Wright
Practice Manager, Lake Shore Obstetrics & Gynecology

ICD-10 is an unprecedented undertaking in healthcare — one that touches every area of practice operations.

There are three major causes to potential revenue loss in the post-ICD-10 landscape:

Increased back office staff time checking claims

Increased denials due to incorrect coding/ lack of specificity

Increased documentation time for physicians

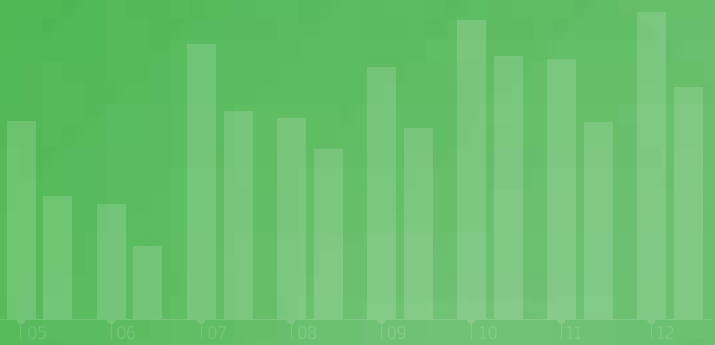**13,000** ICD-9 codes to **68,000** ICD-10 codes

ICD-10 is expected to enhance care delivery and reimbursement; it also means increased work for the back office who must review the accuracy of claims before they go out.

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RCM VENDORS

RCM VENDORS

Considerations for Using an RCM Vendor

Such a broad change requires providers and staff to truly believe in the benefits of a value-based model.

- Physicians need to approach the questions of insourcing or outsourcing collections from a scale and internal capacity perspective.

- There are two factors that usually come into play when determining whether or not to collaborate with an outside revenue cycle management vendor: 1) staff management and 2) will it help financial metrics?

- A good RCM vendor will be able to demonstrate an ROI. If a practice is paying a vendor to handle billing, they should see their revenue increase. That increase should at least cover the cost of the revenue cycle services.

A four-provider family practice realized a 12 percent increase after adopting Greenway Revenue Services. Average payments were $218,000 12 months prior to Greenway. Post-adoption, payments climbed to $246,000 due to the Greenway team's ability to search out errors and omissions that resulted in denials, unreimbursed visits and other uncaptured revenue opportunities.

Does an RCM Vendor Make Sense for Your Practice?

While ROI is a critical part of the equation, the choice to outsource is not always made on finances alone. Some practices make the strategic choice for an RCM vendor to reduce staff burden and headaches.

Practices should still be able to decrease the number of billers on staff when they collaborate with an RCM vendor, allowing them save the money on the salary they would have paid. They can also reassign staff previously engaged in billing to a revenue-generating role.

IMPORTANT QUESTIONS TO ASK A THIRD-PARTY VENDOR:

1. **Vendor call center questions:**
   Where are the call center employees located? A growing number of RCM companies employ people abroad, a fact that they should disclose. Practices should find out what the call center hours will be, the employees' language skills and their knowledge of local laws and regulations.

2. **Industry best practices:**
   Are employees certified and familiar with industry best practices?

3. **Vendor reports:**
   What reporting is provided? The most effective way for a practice to assess its vendor's performance is through reporting. Reports should be provided on a regular basis.

4. **Transparency questions:**
   In addition to receiving reports, is there an analyst assigned to your practice to walk you through the numbers and answer any questions? Do you work with one team, or will you be passed among many different people? A good RCM vendor will assign you a team to work with, so you can build a relationship with them.

5. **Money transfers:**
   Where to and how often is money transferred? Does the RCM vendor first collect on behalf of the client and then send them a check? Does the money go straight to the practice? Is the money sent to a lockbox? The way an RCM company handles this could affect a practice's ability to meet its financial obligations.

6. **Clearinghouse:**
   Do you have a fully integrated clearinghouse? Clearinghouse integration enables a more efficient process for the entire revenue cycle.

7. **Practice management system:**
   Would you purchase this vendor as your PM? If you are not comfortable with the PM system, you should not trust the vendor with your finances.

Print this out as a reference for improving patient collections.