OPEN MINDS

AleraHealth

Bringing market intelligence, management advice, and strategic insights to the health and human service organizations serving consumers with chronic conditions and complex needs

Hitting 93% & Beyond: Why Revenue Cycle Management Best Practices Start At The Top

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Today’s Agenda

- Introduction To Revenue Cycle Management (RCM)
- Leadership’s Role In RCM
- Phases Of RCM
- Best Practices
- Example Reports
- Discussion
- Glossary

Meet Your Hosts

Sharon Hicks, MBA, MSW, Senior Associate, *OPEN MINDS*

Sharon Hicks, MBA, MSW, has more than 40 years of experience in the health and human service field. She has extensive expertise and a wide range of experience in health plan management, clinical operations management, and technology. A recognized thought leader among her peers, Ms. Hicks is a regular keynote speaker at industry conferences and association meetings, as well as the author of hundreds of articles and resources for professionals in both clinical and executive roles.

Lauren Frantz, Chief Revenue Officer, *OPEN MINDS*

Lauren Frantz brings extensive experience in marketing, business development, and growth strategy to the *OPEN MINDS* team. As Chief Revenue Officer, she leverages expertise in strategic business development and market expansion, go-to-market strategy, integrated marketing and sales optimization, brand engagement, and digital marketing.

At *OPEN MINDS*, Ms. Frantz has led enterprise consulting engagements, developed market-entry strategies for new products and services, and advanced initiatives to strengthen client positioning.

Introduction To Revenue Cycle Management (RCM)

Why RCM?

Well-Run RCM Can:

Improve cash flow	Improve account receivable (A/R) percentages	Maximize reimbursement	Minimize administrative burden	Deliver more reliable data for reporting and management	Support growth of the organization

Revenue Cycle Management Best Practices Start At The Top

- Senior leadership
- Clinical service deliverers
- Front Desk/Insurance Verification
- Clinical supervisors
- IT staff for interoperability
- Payer contract managers (internal)
- Billing staff
- Accounts receivable staff

RCM is not just a billing workflow—it is an company-wide strategy that impacts operations, compliance, technology, patient experience, and financial performance.

Leadership plays a critical role in setting the direction, alignment, and accountability tactics to keep the process moving.

Challenges In Behavioral Health

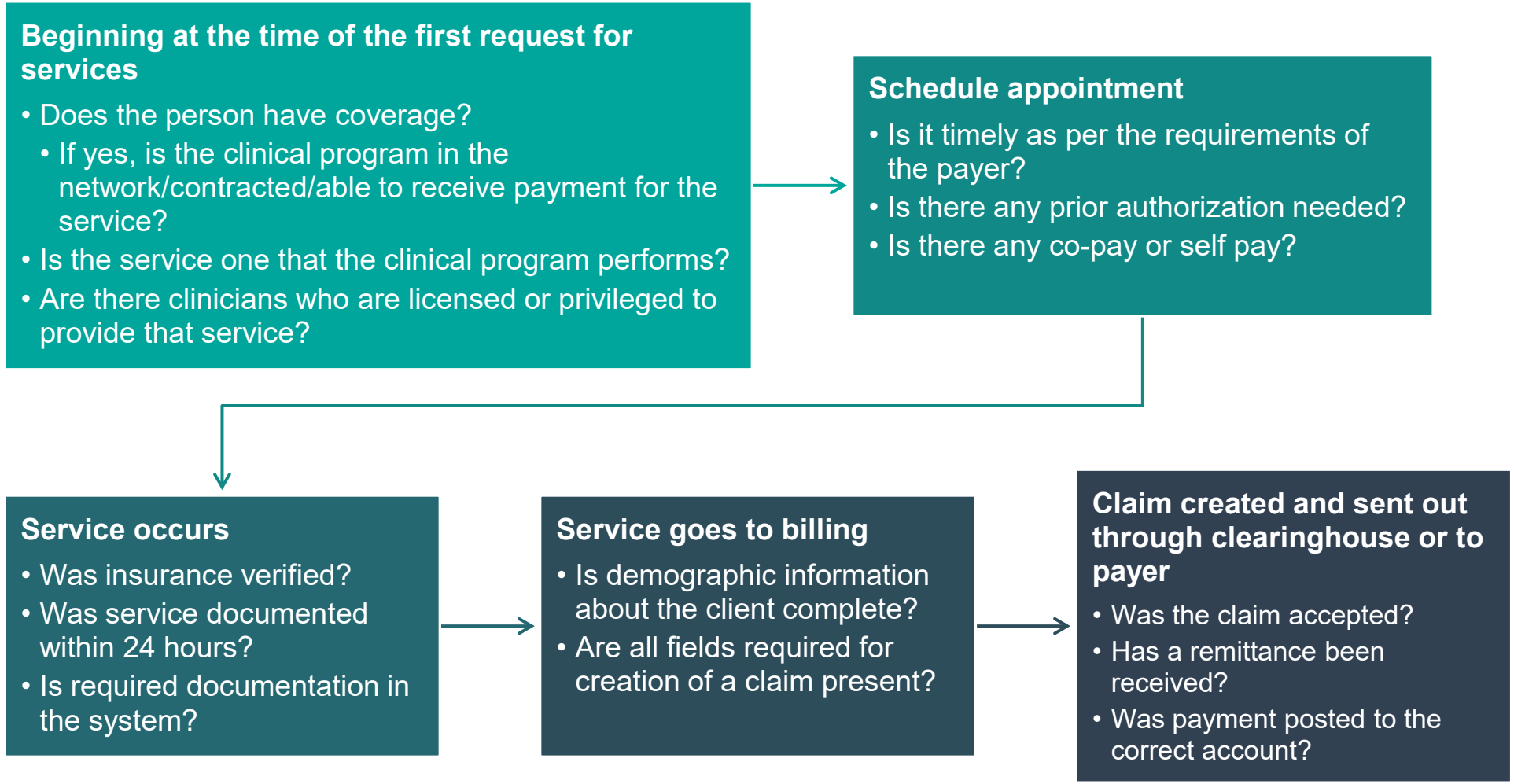
Behavioral health billing has its own set of complexities, including:

- Variability in definitions of service by state
- Varying session lengths and intensity levels
- Multiple providers involved in a single consumer's care
- Specific documentation requirements for mental health services
- Differences in coverage and authorization requirements among payers for behavioral health services
- Complexities around billing for group therapy sessions or in-patient behavioral care
- Challenges in coding for co-occurring mental health and substance abuse disorders

What Is RCM?

- RCM is the process used by health care systems to track the revenue from consumers.
- RCM begins when the initial appointment is requested and ends after the final payment of balance is completed.

Understanding The RCM Lifecycle



The Goal: 100% Of Services Completed Are Compensated!

What is your organization's net revenue collection rate for services?

What are your organization's top three reasons for bad debt/uncollectable?

Do you have any unbilled services and why?

What is the one thing you think that could be done differently that would improve collection rates?

Leadership’s Role In RCM

Leadership's Role In RCM

Leadership Set Strategy & Financial Priorities

- Leadership sets financial performance goals, investment priorities, and risk tolerance and compliance
- Organizations rely on leadership to adapt the RCM approach to meet the changing reimbursement models, regulations, and technology

RCM Requires Cross-Department Alignment (Not Just Finance)

- Leaders coordinate across all departments including clinical, IT, compliance, and operations teams
- Without leadership the process can breakdown in the different departments and lead to revenue leakage

Leadership Drives Culture, Accountability & Change Management

- Leaders mentor teams, enforce performance standards, and help communicate why the system is needed and matters, which helps improve adoption and outcomes

Technology Transformation Should Be Led From The Top

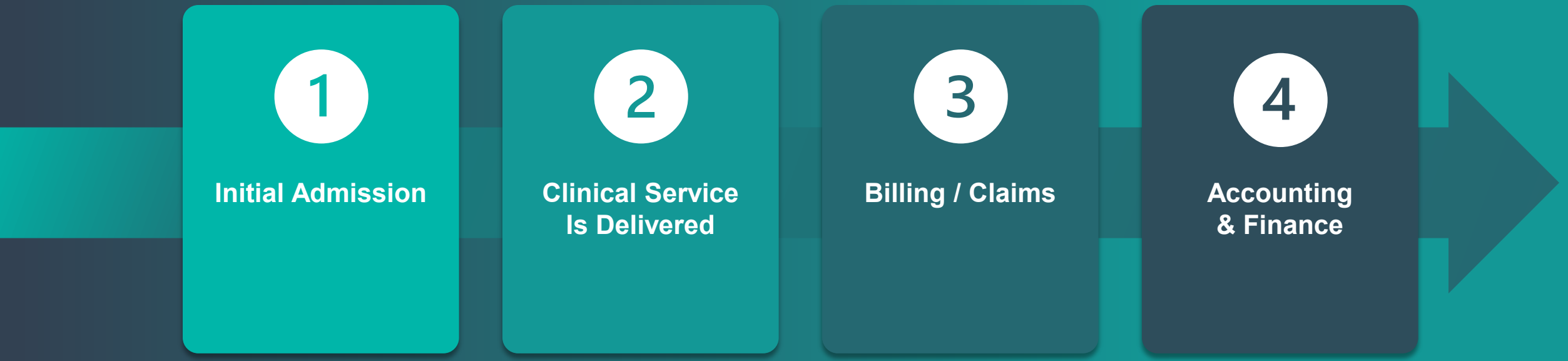
- With modern technology and AI and analytics, RCM is increasingly tech-driven requiring leadership to select tools, fund implementation, redesign workflows, and manage workforce restructuring
- Many organizations are switching to more tech-enables solutions and requires decision-making

Leaders Enable Data-Driven Continuous Improvement

- Leadership must lean in on the data and intervene to identify issues to keep the process moving

Leadership Connects RCM To Patient Experience & Brand

- RCM is part of the customers journey and requires leadership to help guide the strategic positioning and experience



Phases Of RCM

1

Initial Admission

Will We Get Paid For Providing The Service?

- Does the person have coverage?
- Is the clinical program in the network/contracted able to receive payment for the service?
- Is the service one that the clinical program performs?
- Are there clinicians who are licensed or privileged to provide that service?
- What processes must be completed prior to service delivery?
- Authorization from the payer is part of this initial workflow.

1

Initial Admission

Hurdles To Collections

- Work is often done by three or four people who may not know each other.
- Reporting comes through three or four departments that may not have similar priorities.
- Collaborative work often needs done in one or two days.
- The work is done in two or more locations and often by job descriptions with the highest turn over and least job training.
- Most fatal errors to billing occur before the consumer is seen.

1

Initial Admission

Developing An Effective RCM Team Requires A Heavy Lift To Bring Together Key Staff Who Have Previously Been Siloed

Five Key Values

1. No one and no department is at fault. Poor communication and poor workflows are the culprit.
2. Everyone owns the targets and goals. We succeed or fail as a group.
3. Be driven by the data rather than by anecdotal references.
4. Errors do not frequently occur in a single person's domain. They occur in the communication and handoff phases which will require the most attention. Items are “lost in the cracks.”
5. Automation is the first answer to suggest for any problem.

Phase Two: Clinical Service Is Delivered

Before the service is delivered…

1

Is the service covered?

2

Am I privileged to provide this service independently or do I need a co-signer?

3

Does my note clearly state:

- What service I provided
- The clinical rationale for the service
- The link with the treatment plan
- The activities that took place in the appointment
- The plan for the next session

4

Is my note completed within 24 hours of delivery?

5

If needed, is my note sent to co-signer?

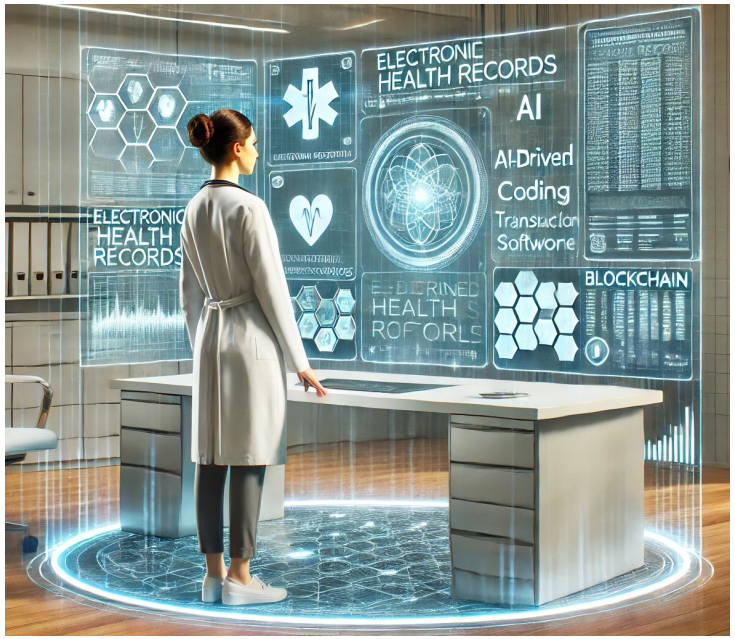
Is my signature on the note?

3

Billing / Claims

Everything That Can Be Automated Should Be

- Since the implementation of approved standards like the 837, 835, 270, etc. workflow automation has grown explosively.
- There are industry-standards for automated insurance verification, automated inquiry, automated posting and many other features.



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Billing / Claims

Before Creating The Claim Form

Are the notes signed by a clinician with the required qualification?

Are the service codes and diagnosis codes matching?

Are there quality problems with documentation that will cause the claim to reject?

3

Billing / Claims

After The Claim Is Sent

Is the 837 file completed correctly?

- Rejection errors, not accepted at all

Does the claim get accepted at first submission?

- Pass the first edits

Is this a claim that requires coordination of benefits?

- Claim paid completely
- Is there a self-pay portion in the expected revenue?

Is the correct contract allowance applied to the expected revenue?

4

Accounting & Finance

Collections

Accounts receivable follow-up and collection is the biggest problem for most organizations. Many do not follow-through on a regular basis.

The optimal scenario is that your staff can account for the status of all claims that have aged 60 days since the last bill date.

4

Accounting & Finance

Remittance Received

If claim is paid, then payment is applied to the correct patient account.

If claim is denied, then it is reviewed to determine if corrections can be made and the claim resubmitted

If claim is denied for coordination, then claim to the primary insurer is created

If claim is denied for lack of authorization, then it goes to a report for analysis

4

Accounting & Finance

Processes Are Needed For:

- Missing appeals
- Collection of co-payment/co-insurance
  - Determining when to forgive patient self-pay amount
- Closing accounts when determination is made
- Applying monies for uncompensated care against patient accounts or in total

Best Practices

Industry Performance Standards

- 45 days or less for about 60% of expected collections.
- 60 days for 25% of uncollected receivables.
- 90 days or more for 15% (bills that need to be coordinated, etc.)
- Completely uncollectible (bad debt should be <5% of total)

Goals For A/R

All A/R payments are posted in a timely manner:

- Completed posting within 72 hours of receipt.
- All deposits entered within 24 hours of receipt.

Things to do:

- Batch control systems for deposits and all correspondence.
- Enter data QA for payment distribution.
- Report daily for all remittance received that is not yet posted to an account.
- Handle all communication from payers within 2 days.
- Balance billing (if required) within 2 days of 1st remittance.
- Approve and write bad debt off A/R as soon as a claim has been identified as un-collectable.

Examples Of Reports

Aged Trial Balance Summary

- This report is usually in 30-day aging buckets by payer or payer category. It quickly allows you to identify “blips” in the collection process.

Billing Edit Summary

- This report details the claims that have been held from billing by the EHR for billing related reasons.

Claim Denial Report

- These are the claims that have been denied by payers.

Bad Debt Write-Off Report

- This report details the year-to-date bad debt write-offs by reason.

Undistributed Payment Report

- This report details the accounts receivable payments that have been received but not yet posted to open claims.

Aged Trial Balance By Payer In 30-Day Buckets

- Aging by date of service allows overall A/R analysis.
- Aging by most recent bill date allows you to find claims with no activity.

Aged Trial Balance Detail

- Run by payer or payer category for all claims over 60 days from date of service.
- The goal should be to follow-up on all these claims—obtaining a claim status from the payer, fixing problems, rebilling, balance-billing, etc.

Collection Percentage Reports

- This is the percentage of the net A/R collected in a given time period.
- It is routinely run sorted by service month and payer so you can track collection success over time.
- The collection rate targets should be 95% for ambulatory services and 98% for bed-based services.

Discussion

Revealing RCM Vulnerabilities

1. Do you know the following metrics?
   - Time to bill from date of service delivery
   - Days in A/R
   - Percentage unpaid over 120 days
2. Do you know the denial rates by payor, program, and service?
3. Do you have a process to deal with the output of those rates? Is someone responsible for modifying the results of those rates?
4. Can your clearinghouse tell you the number of claims that were clean on first billing? Percentage paid after some correction?
5. Do you track productivity strictly? Are most or all staff meeting goals?
6. If you have a program that you know loses money, but that acts as a front door (or public relations requirement for your organization), do you have a numeric value of referrals/new clients that they should generate to cover the assumptions?

Assessment Scoring

Did you answer "No" to three or more of the questions to the left?

If you did, it is time to take a closer look at where your organization stands and how your RCM is performing.

Ensure your organization has full visibility into whether it is being paid for the services it provides.

Glossary

Glossary / Dictionary

- **Accounts Receivable (A/R):** The process that sorts and counts all money earned and expected.
- **Administrative Services Organization (ASO):** The company that handles Medicaid behavioral health claims by state contract (does not apply in every state).
- **Authorization:** The process by which a payer approves that a covered member can receive a service, could be based on medical necessity, benefit plan.
- **Bad Debt/Uncollectable:** Money earned but not received, even after all efforts are made to collect.
- **Benefit Plan:** The list of services that a member can receive.
- **Claims File (837):** A national standard for an electronic file, or a paper form, that payers require providers to submit to get paid.
- **Client:** A person who receives services.
- **Contract Allowance:** The amount of money that a payer agrees to pay to a provider for a service.
- **Credentialing:** The process by which a payer confirms that a provider in its network is who they proport to be.
- **Eligibility:** The status of coverage by a payer related to a member's insurance coverage.
- **Member:** The insurance company's word for a person who has their insurance.
- **Net Revenue Collection:** The amount of money received as a difference from what was expected.
- **Payer:** The entity that is responsible for payment for services delivered.
- **Privileging:** The process by which the provider organization determines the scope of work for clinicians within their organization.
- **Productivity:** The amount of time within a specified period that a clinician completes revenue producing services.
- **Provider/Clinician:** Individual who provides services to a client.
- **Revenue:** Money earned by providing services.
- **Timeliness of Documentation:** The time between a service being delivered and the charge being received by billing.

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