Revenue Cycle Roadmap

Prepare your practice for value-based success

By Sreeram Mantha

A modern medical practice has many moving pieces. Health IT adoption, clinical quality reporting, and the rise of consumerism in health care bring unprecedented levels of complexity to the practice setting. As the industry pivots to value-based care, many practice leadership teams are fighting to maintain independence as a profitable business amid rising costs and decreasing reimbursement rates.

How do practice leaders and administrators with limited time and resources implement a strategy to improve revenue cycle performance while continuing to deliver high-quality patient care?

For many practices, the day-to-day management of patient throughput leaves little time to stop and evaluate opportunities to bring efficiency to existing processes and procedures. However, investment in an honest internal review can have a major impact on your practice's bottom line. Methodical analysis of current processes and how they work together illuminates cracks in handoffs that result in revenue leaks. Knowledge of key performance indicators (KPIs) enables administrative teams to make educated decisions on how to implement best practices—some of which may be new to the practice—that plug those leaks and pave the way for revenue cycle optimization.

Stabilize and Optimize

Stabilizing and optimizing revenue cycle processes to ensure the practice isn't leaving money on the table is a fundamental yet often overlooked element of any practice strategy. By tracking meaningful performance metrics and using analytical tools to transform data into actionable information, your team can begin making strategic improvements to operational areas that will have the greatest positive impact on revenue and outcomes.

Start by taking a probing look at the foundation of existing billing operations. Weigh financial KPIs against established industry benchmarks to reveal underperformance in coding, claims filing, billing, and collections. Your goal is to keep KPIs on par with or better than industry standards. Executives should closely monitor the financial KPIs and their corresponding industry benchmarks as shown in Table 1.

Industry benchmarks enable peer comparison through quantitative, metric-driven performance tracking. This comparative analysis arms administrators with operational insight into areas most in need of attention to drive an informed improvement strategy.

Use the last six months of practice data to establish a baseline of revenue cycle performance in these areas. When establishing baselines, bear in mind that inclusion or exclusion of various case types may influence calculations for certain KPIs. For example, will rejected claims be included in claim denial rate formulas? The decision to include or exclude bad debt claims or payment plan accounts can similarly skew accounts receivable (AR)-related KPI calculations.

Track KPI performance at least monthly to begin with. This allows leadership to identify and intervene in failing performance areas early. Conduct a root cause analysis in areas of underperformance to understand month-to-month variations. When possible and where applicable, monitor KPI variation at the individual clinician level, at the aggregate practice level, and by payer for a granular view of potential problem areas.

Table 1

Financial KPIs and Corresponding Industry Benchmarks

Financial Metric	Definition	Industry Standard Benchmark
Denial Rate	% of total claims denied of total claims submitted	5–10%
Days in Accounts Receivable (AR)	Average number of days to collect payments due	30–0 days
% of AR > 120 Days	% of AR on books > 120 days from date of service	≤ 25%
Gross Collection Rate (GCR)	Total payments as % of total submitted charges	35–40%
Net Collection Rate (NCR)	Net payments minus contractual adjustments as % of total submitted charges	≥ 95%
First Pass/Clean Claim Rate	% of claims accepted on first submission out of total claims submitted	90–5%
Charge Lag Days	Average number of days between date of service and charge entry	≤ 7 days

Variable Factors

Practices can see deviation from industry standard benchmarks for a variety of reasons, some of which may be out of your control. Specialty, location, resources, and payer partners all influence financial KPIs. For example, subspecialties such as interventional cardiology or pediatric neurology typically field high-dollar surgical procedures that require prior authorization work. As a result, these specialties often experience high denial rates. Practices located in inner cities with large Medicaid patient volumes might anticipate low gross and net collection rates due to diminished patient propensity to pay.

Paper-based practices generally underperform compared to those using a practice management system (PMS) or electronic health record (EHR). Paper superbills typically take long process times and are susceptible to error. Thus, charge lag days are often high in these environments. This can lead to payment posting delays and denials, which have big impacts on cash flow. If claims are not processed correctly within a given payer's timely filing criteria, money may be left uncollected.

Turnaround times also vary from payer to payer. Some payers may be slower in processing, adjudicating, and reimbursing claims than others. While this is not a rejection or denial, it does lead to a decrease in cash flow and a high number of days in AR. Administrators who notice this occurring should engage the payer or plan's representative to discuss the situation. Understanding these outside influences is important in setting realistic performance improvement goals within the practice.

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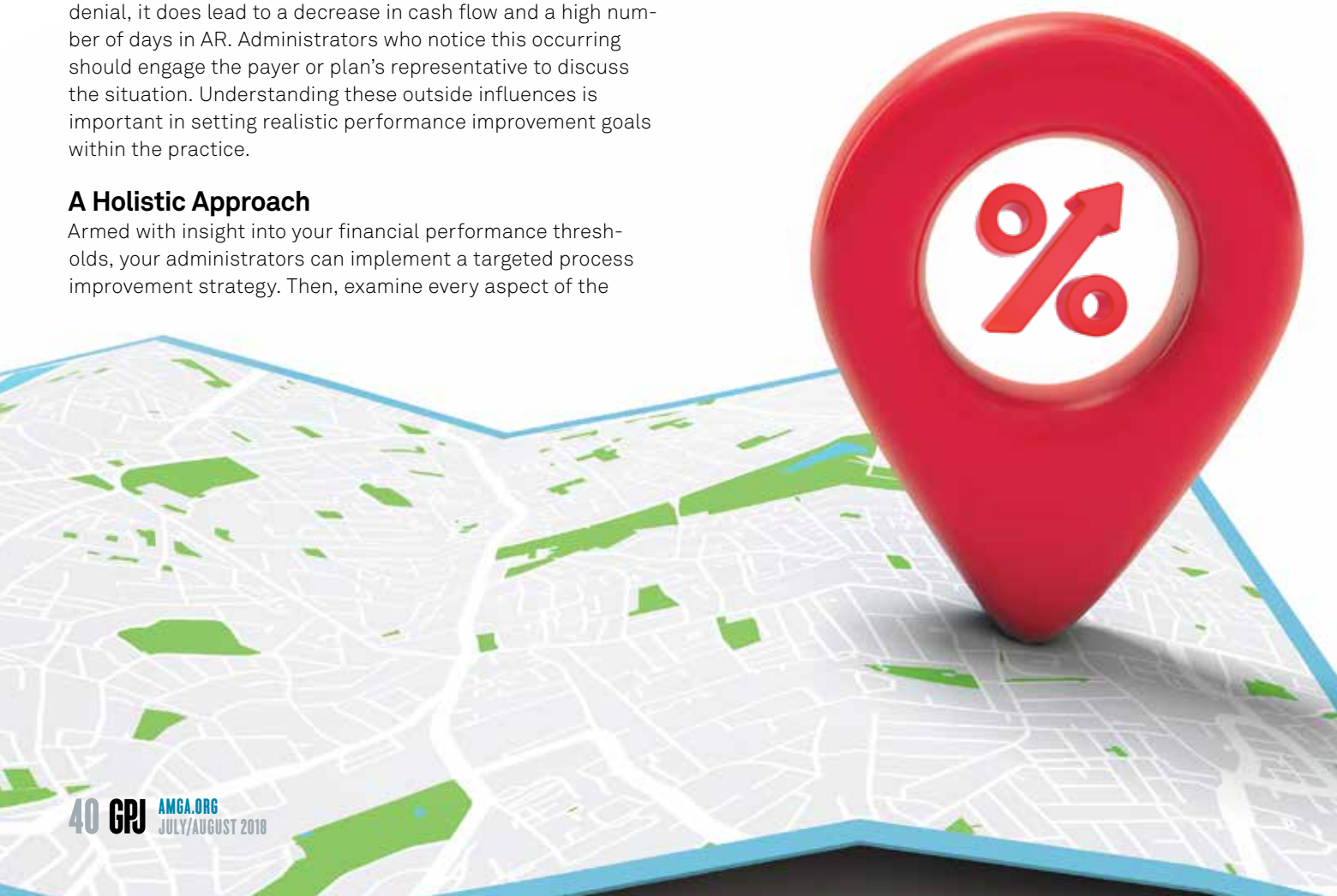
A Holistic Approach

Armed with insight into your financial performance thresholds, your administrators can implement a targeted process improvement strategy. Then, examine every aspect of the current billing process, focusing on the weakest performance areas first. Renewed emphasis on streamlining the following processes can increase your revenue starting today.

- **Credentialing and enrollment.** When leadership teams set up a new practice, one of the first things they must tackle is credentialing and enrollment for every physician and eligible provider with each insurance plan they accept, for each facility they practice in. Unfortunately, after initial setup, many practices tend to forget about it. If changes are made—for example, a new clinician is added, they now practice in a different location, or the payer itself changes some detail—things don't line up, and your reimbursements can be frozen, sometimes for months. Dedicated in-house or outsourced credentialing expertise and support helps keep these items from slipping through the cracks.
- **Eligibility verification.** Validating up-to-date patient information is crucial to the revenue cycle process and making sure the practice gets paid. For some patient populations, like Medicaid-centric groups, best practices may warrant a patient data review at every visit. With Medicaid beneficiaries, for example, there is an increased chance for members' managed care plans to shift from month to month. Perhaps



a patient that was on Health First last month shifts to MetroPlus this month, where eligibility and coverage details may vary. Practice leaders should ensure that front-office staff are well versed in the intricacies of comprehensive eligibility verification. Insurance verification technology resources might also support these efforts.

- **Prior authorizations.** Confirming that procedures have the appropriate authorizations in place is another crucial aspect of effective revenue capture. Verify prior authorizations with payers early during patient engagement to avoid the risk of denial on the back-end. Many practices prioritize this as an element of front-end patient intake to make sure approvals are in place before procedures are carried out.
- **Coding and compliance.** To determine if clinicians are over-coding or under-coding, conduct routine coding audits to compare accuracy to like-providers. Coding specificity has a direct impact on hierarchical condition category (HCC) coding, which factors into reimbursement determinations. Thorough documentation of all patient risk conditions ensures that you receive adequate resources to support patient care. Your leadership teams should regularly educate clinicians and staff on clinical documentation requirements and common denial culprits to help guard against recurring problems.
- **Collections.** With the advent of high-deductible health plans (HDHPs), patient copays and deductibles are an increasing percentage of revenue flow. As HDHPs become commonplace, payment responsibility resides with the patient, prompting practices to move collection processes to the front end of the payment cycle to ensure payment capture. Ask patients to confirm payment responsibility during scheduling and appointment confirmation, as well as at intake, to ensure you receive payment for services rendered. This introduces opportunities to arrange payment plans early in the billing process to increase chances of remittance.
- **Contracts.** Analyze contracts and scrutinize payer reimbursements every six to 12 months to ensure revenue due to the practice is collected. Reach out proactively to commercial payers to evaluate any value- and risk-based contracts you may qualify for to take advantage of plan- and state-based incentive programs that may not be advertised. Note that internal KPI knowledgeability can inform payer contract negotiations, which is increasingly important to evaluating shared-risk arrangements under value-based care.

Institutionalize Success

Improved revenue cycle processes decrease collection costs and improve financial KPI averages to help accelerate cash flow. Streamlined workflows also support reduced staff stress and turnover, which impact patient satisfaction and loyalty—all of which directly or indirectly impact the bottom line. Keep the following focus areas in mind to institute a comprehensive and successful revenue cycle management (RCM) program.

- **Real-time insight.** Do whatever is within your means to establish daily tracking of KPIs to keep a pulse on RCM performance. Early identification of and intervention in issues help to avoid remittance interruptions. Share this insight with team members to elevate individual performance.
- **Process optimization.** To optimize RCM processing, include EHR and other technical resource customization to support workflow efficiency. Doing so opens bandwidth for additional patient scheduling, which might include carving out room to adopt additional preventive wellness measures that generate financial incentives.
- **Expertise.** Many practices struggle to establish an internal knowledge base on things like compliance and reimbursement issues. Dedicate resources to keeping internal candidates up to speed on RCM best practices or identify a reliable outsourcing partner to secure external expertise.
- **Convenience.** In the increasingly consumer-oriented field of health care, patient convenience is paramount to remaining competitive. Make it easy for patients to do business with you by offering online scheduling and bill pay services.
- **Practice culture.** Leadership sets the tone for a practice culture of continuous improvement. Routinely review financial and other KPIs with staff stakeholders to help drive personal buy-in. Hold recurring educational sessions to keep team members up-to-date on the latest best practices and corporate goals.

Evolve to Keep Pace

Financial KPIs tell the story of your value proposition and differentiation to health plans and new and existing patients alike. Advanced financial analytics—ideally with real-time data insight, alert mechanisms, and easy-to-interpret dashboards—enable practice RCM teams to quickly note downward trends and take action to intervene. Investing in revenue cycle optimization efforts today, before layering in quality payment program initiatives, ensures that future plans are built on a solid foundation.

In an era of rapid change and a dizzying mixture of regulation and competition, providers must routinely determine where inefficiencies are occurring that plague profitability and sustainability. Only through a thoughtful diagnostic evaluation process can you implement changes that maximize time, staff, and other resources so your practice can operate at peak efficiency to achieve desired results today and in the future. The old ways of operating a successful healthcare business must evolve to keep pace. GPJ

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