Optimizing Revenue Cycle Performance

PRACTICE IMPROVEMENT CONFERENCE
Michigan Chapter Meeting HFMA/ACHE
Saginaw Valley State University

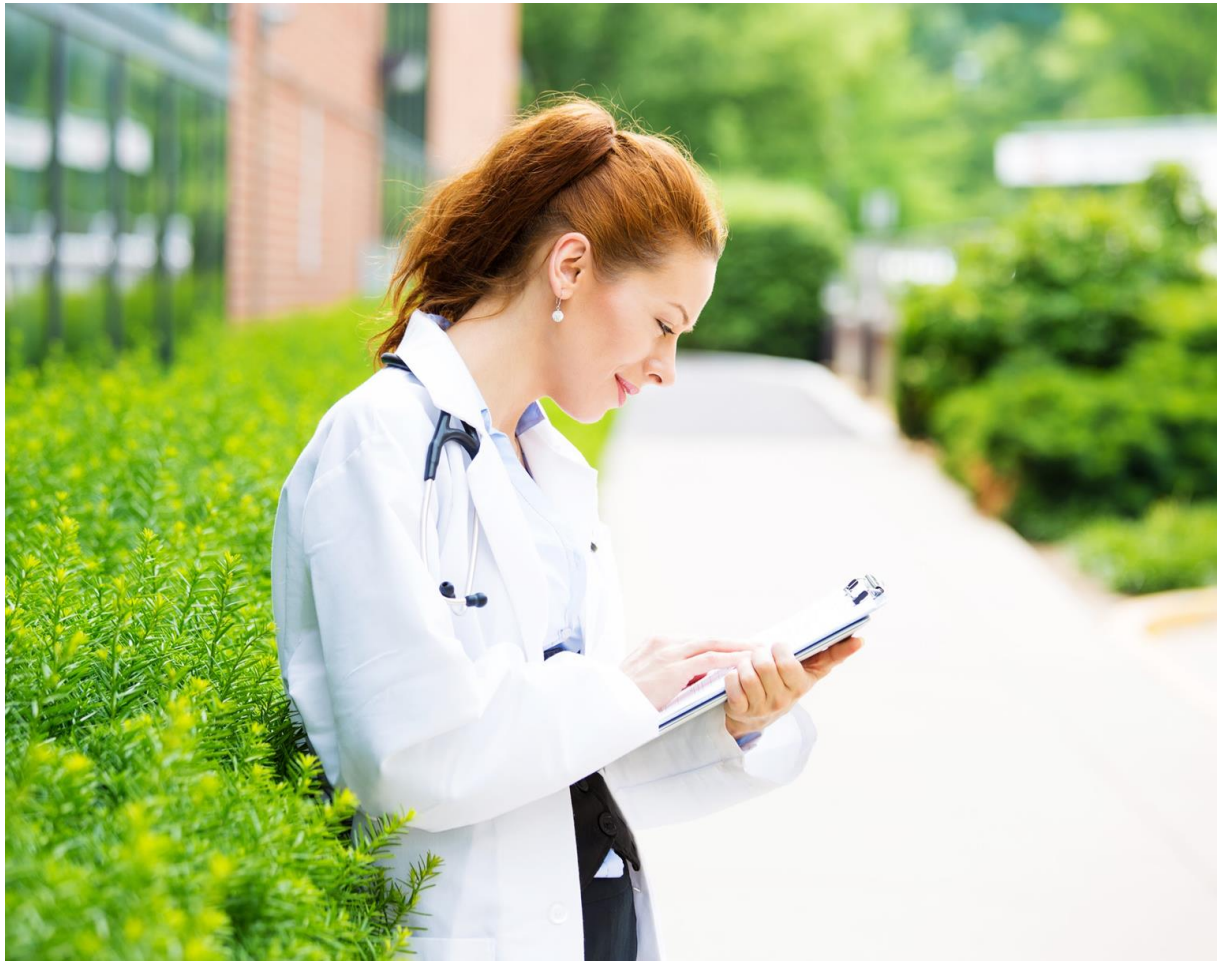
Maureen Clancy, MBA, FACHE, CPC
SVP Revenue Cycle – Privia Health
April 19, 2018

950 North Glebe Road, #4000
Arlington, VA 22203
Phone: 571.336.8850

Web: priviamedical.com
Twitter: @priviahealth
Blog: priviahealth.com/blog

AGENDA

- Introduction to Privia
- Managing for success
  - Front, Middle, Back
  - Key Performance Metrics
- MAP Award Criteria & Process
- Q & A



Introduction– Privia Health

Dr. Suzanne Wittig, Pulmonary Medical Associates of Northern Virginia

Privia Health is a national, high-performance physician organization that partners with payers, and layers in technology and population health management programs to *improve outcomes and reduce costs*.

PRIVIA HEALTH

We've Come Together to Fix our Broken Healthcare System

18%
GDP spent on healthcare (and growing)

$3T+
Spent annually on healthcare (2x other countries)

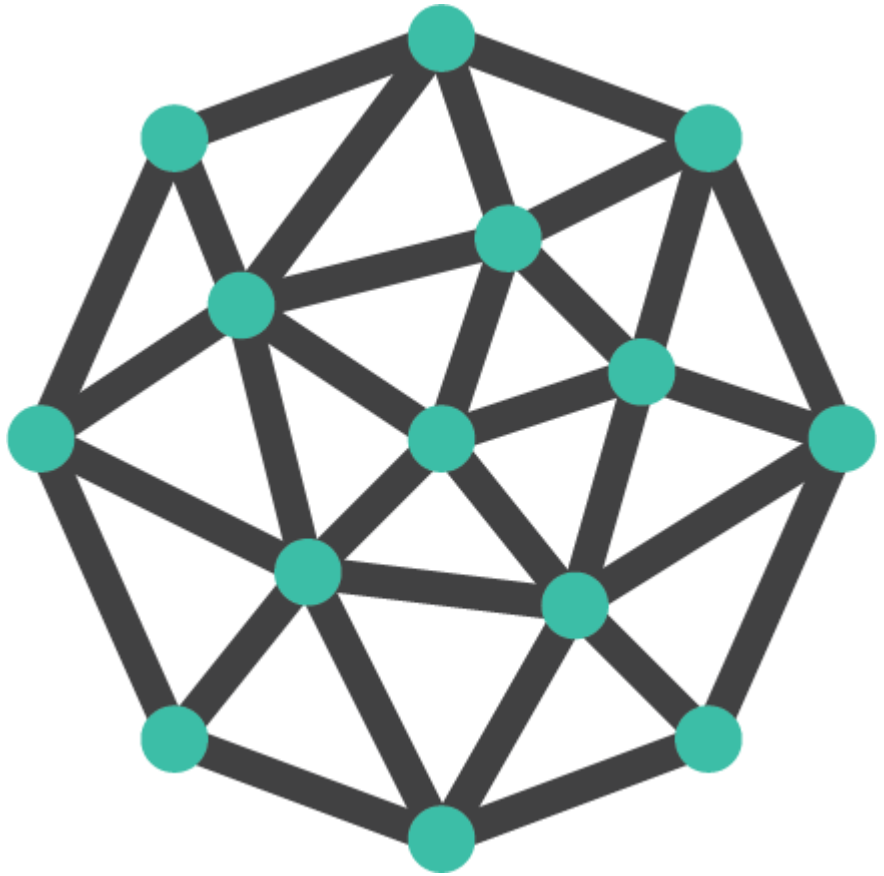
$765B
wasted annually on unnecessary services (25%)

Increased spending ≠ improved outcomes or access

PRIVIA HEALTH

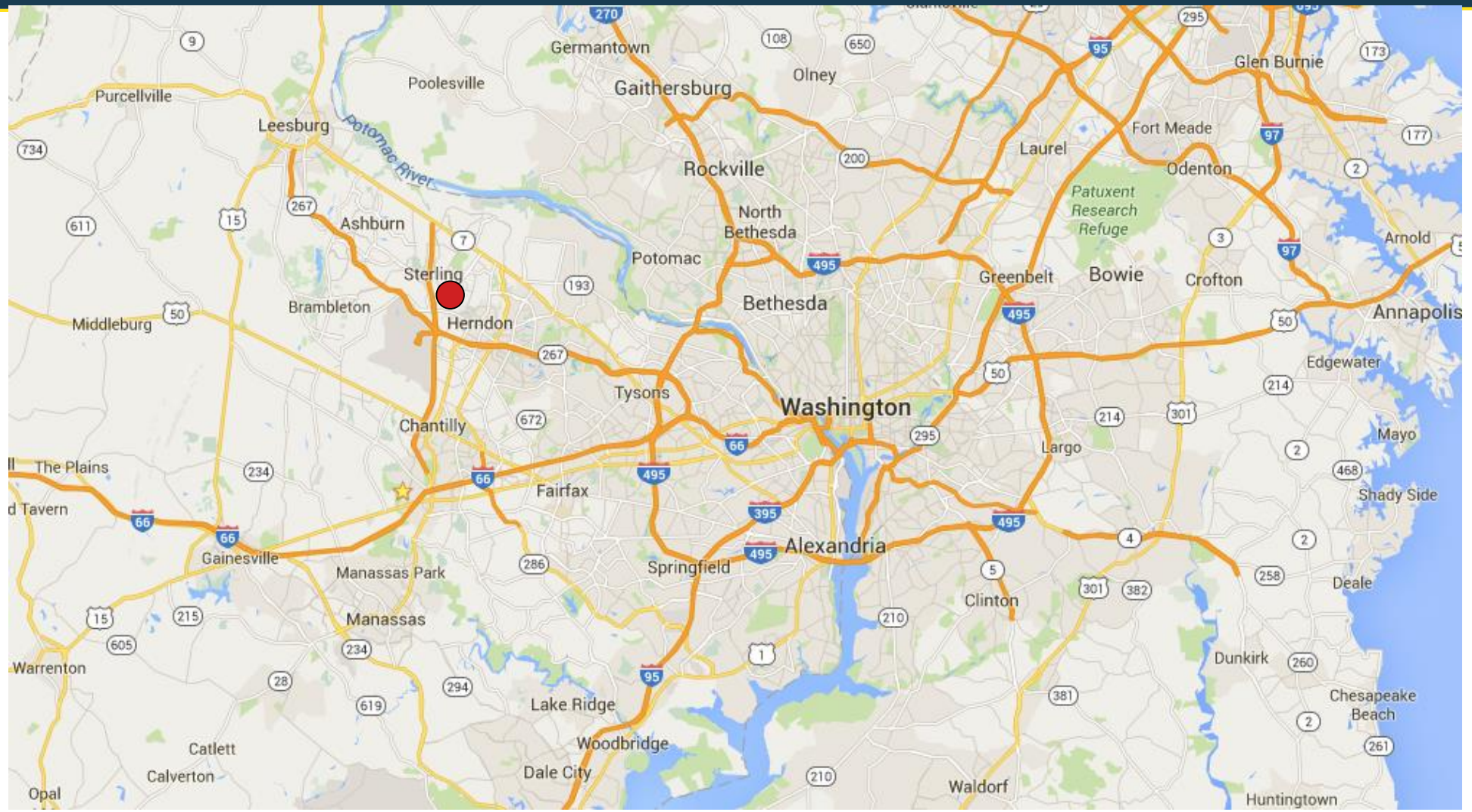
We are building the “machine” around private practice …

- “Physician practice management & population health”
- ***Built for purpose*** to manage risk
- Patient centered & physician governed
- Built for ***scale***
- “Keeping doctors in private practice”



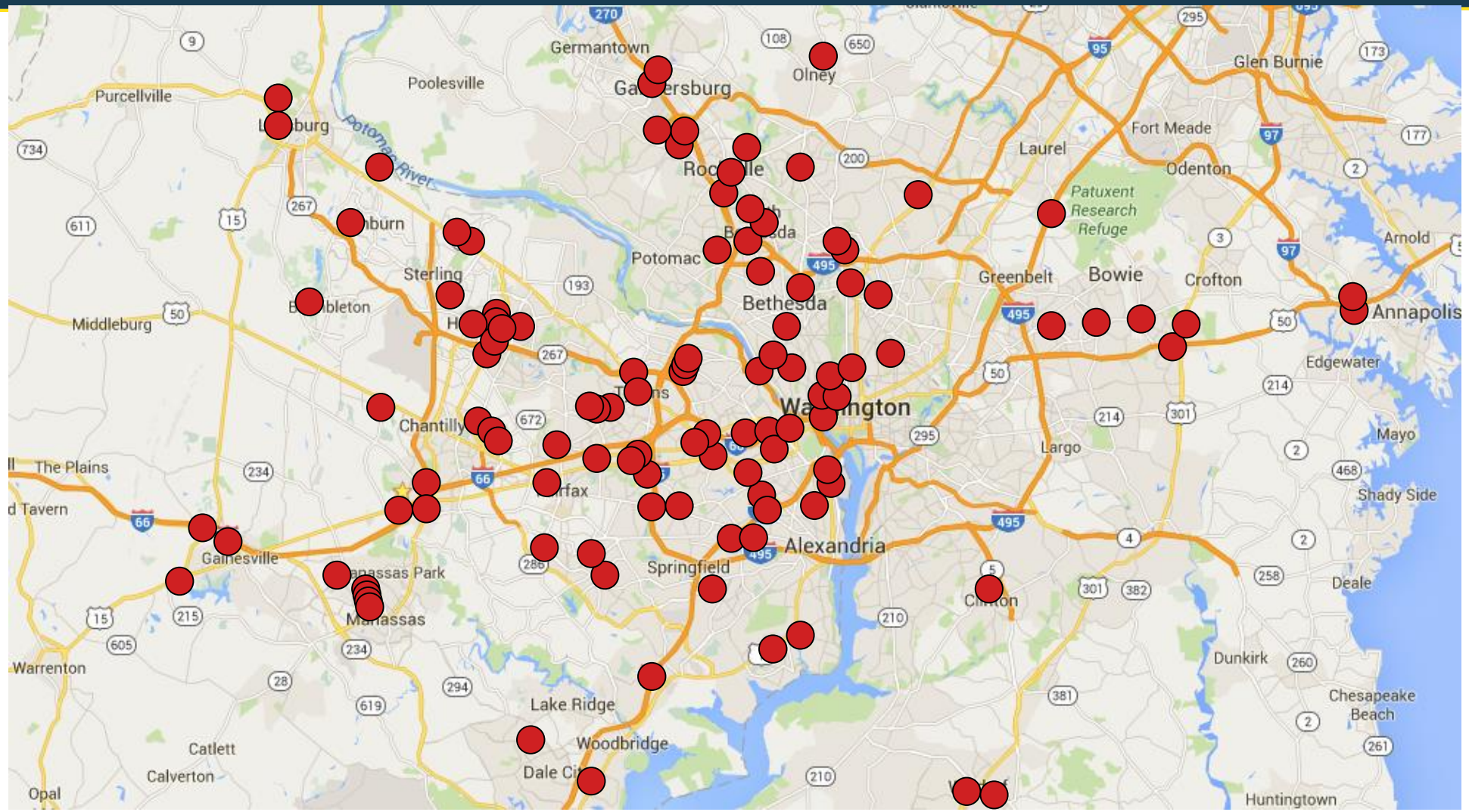
PRIVIA HEALTH

PMG – Mid Atlantic: Locations in January **2014**



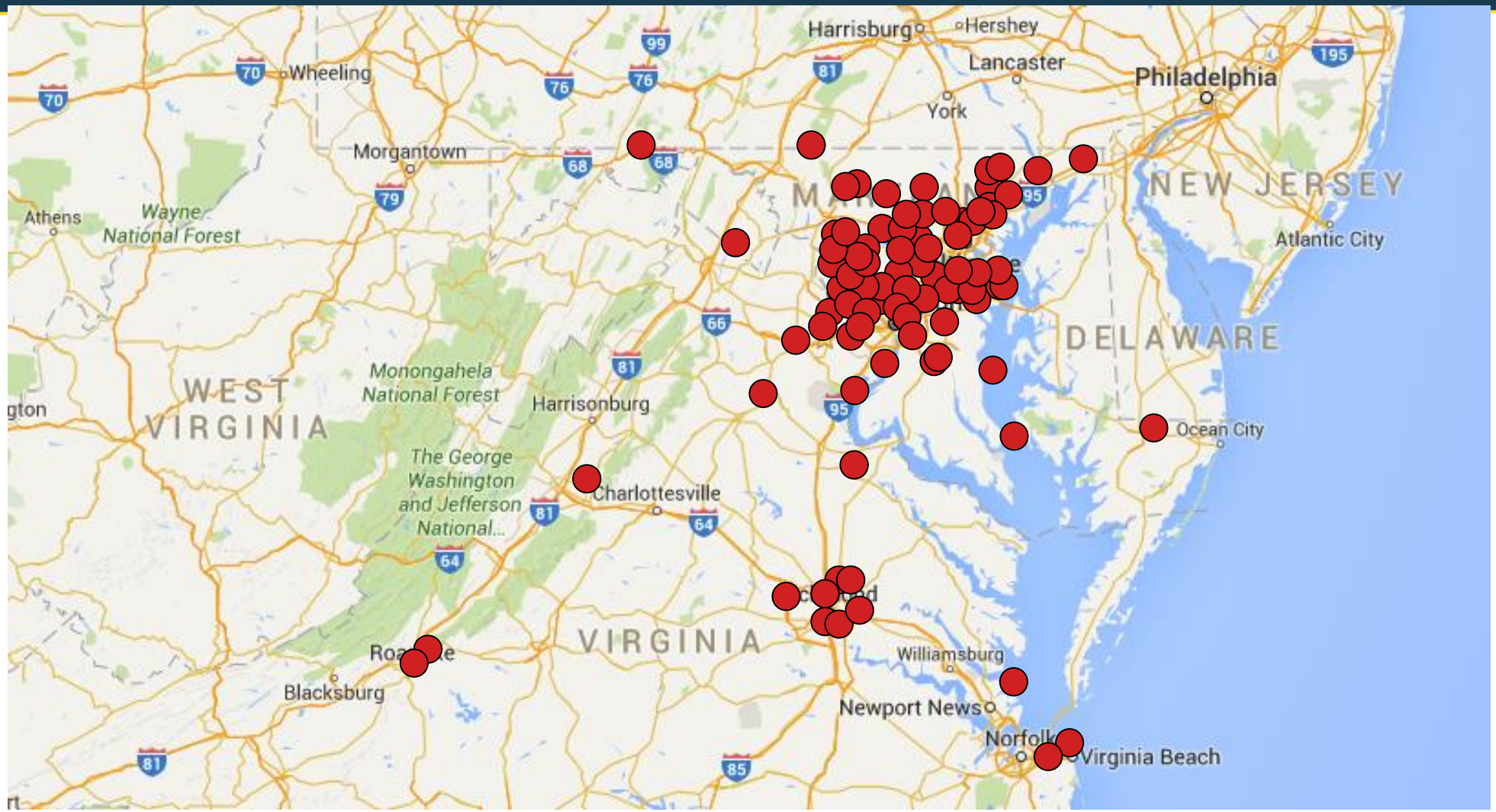
PRIVIA HEALTH

PMG – Mid Atlantic: Washington DC Metro region



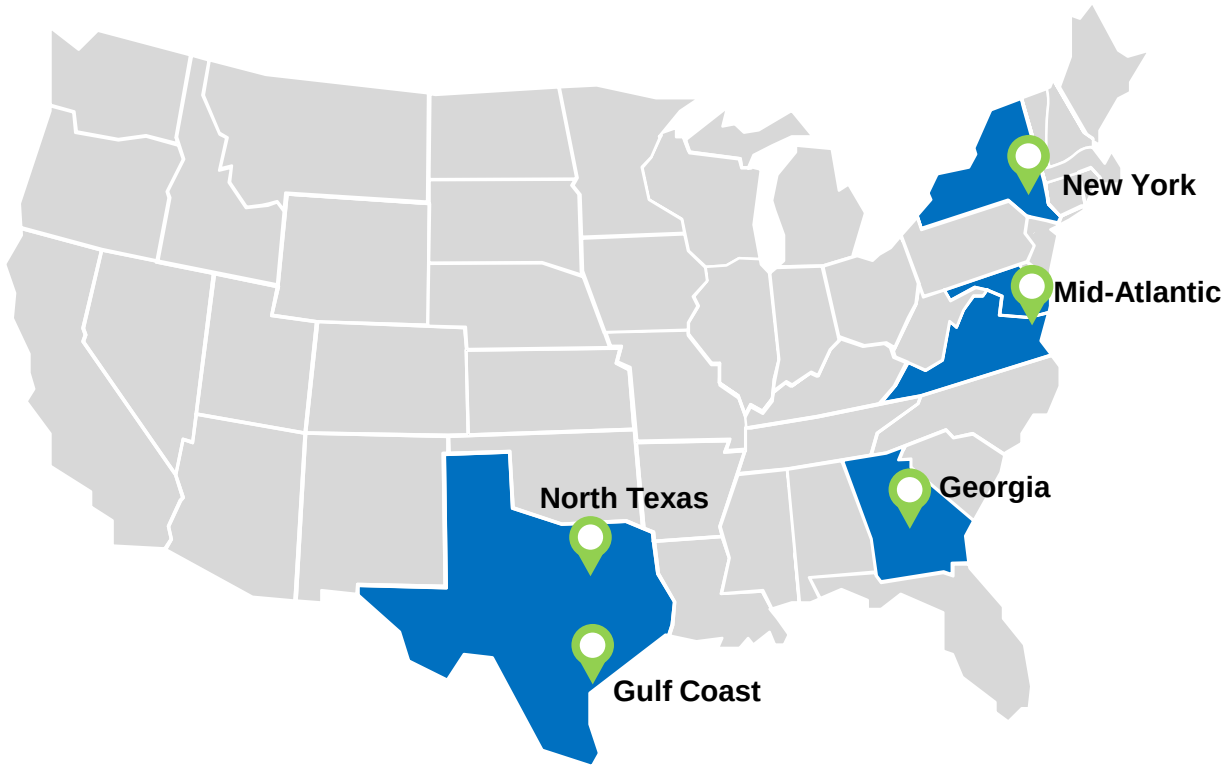
PRIVIA HEALTH

PMG – Mid Atlantic: Locations Across DC, VA, MD



PRIVIA HEALTH

PMG: The Country's Fastest Growing Independent Physician Network



~2,000

Privia Medical Group Providers

4M+

Unique Patients Seen Last 24 Months

$2B+

Medical Spend Managed Under Risk Programs

PRIVIA HEALTH

How We Manage Revenue Cycle

- Co-sourced model - “You Do, We Do, They Do”
  - Benefits / Limitations
- Account Management (Performance Management Team)
  - RCM Support / Integration
- Revenue Management
  - Market orientation
- Key Objective process
- KPIs

Optimal processes at each part of the Rev Cycle

Front End

- Accuracy of registration
- Pre-certification / prior authorization
- Insurance Verification
- TOS Payment collection
- Prior balance collection
- Card on file

Middle

- Complete and accurate documentation
- Orders, tests submitted, reviewed
- Procedure and Diagnosis Coding
- Risk Adjustment / Quality review
- Timely Charge Capture
- Scrub edits resolved

Back End

- Timely Denial management
- Appeals
- Payment posting
- Statements – frequency, timing
- Self Pay follow up
- Aged AR Management
- Collections

Front end

Think: On Stage – Off Stage

- Highest and best trained staff
- Patient access
- Patient friendly communications (award)
- Card on file
- Expectation setting
- Rewarding front desk staff (bonus structure)
- Having the right system (eligibility, pre-certs)

HFMA MAP METRICS

- POS Cash Collection Rate
- % Schedule Occupied
- Cash collections as a % of Adjusted Net Patient Service Revenue

- Dashboard Metrics
  - Registration accuracy
  - Card on file rate
  - Copay collection rate
  - SP AR – amount of prior balance, coinsurance, deductible collected at TOS

Middle

Keys: Accuracy, Completeness, Timeliness

- Charge capture
- Accurate coding
- Audits & Education
- Scrub Edits – resolve immediately

- Dashboard Metrics
  - Charge lag
  - Coding compliance / accuracy
  - Clean claim rate
  - Scrub and Front end denials

HFMA MAP METRICS

- Charge Lag Days
- Denial Percentage

Back end

In a perfect world there would be no Back End of RCM

- Denial management
- Analytics
- Payer meetings / relationships
- Education – full circle (back to the people who made the errors)

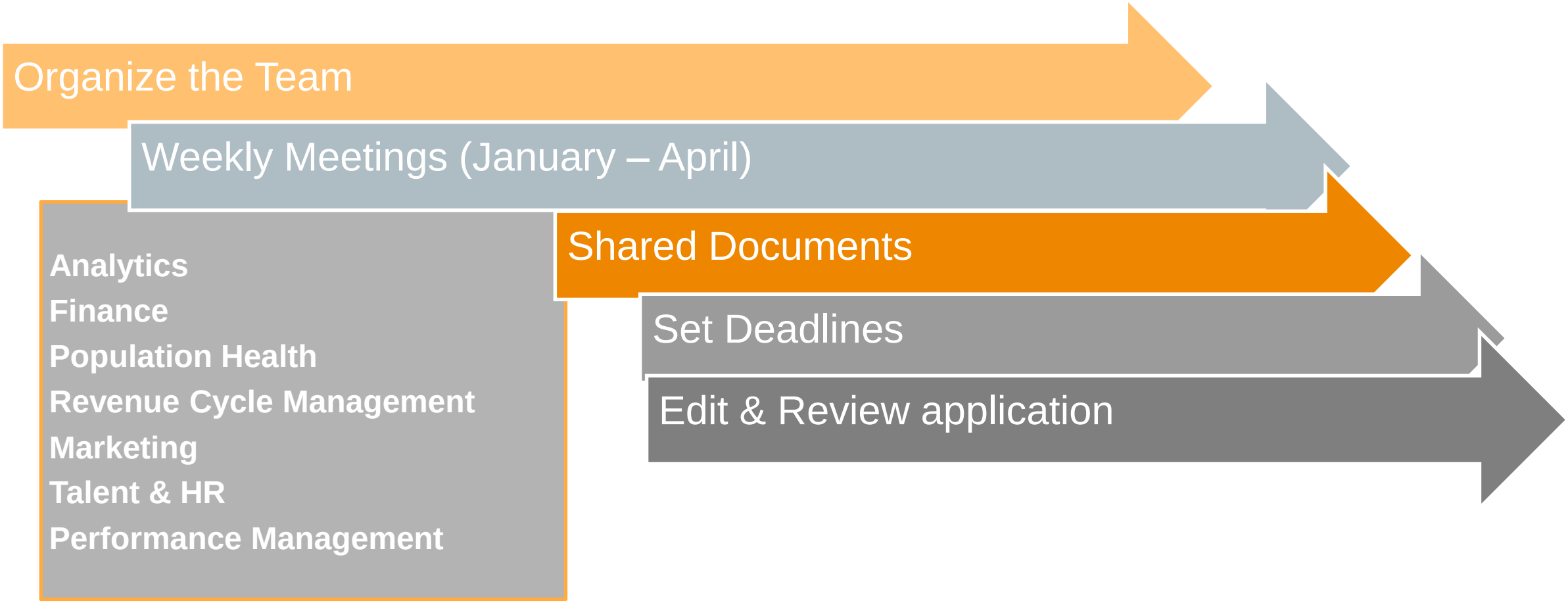
- Dashboard Metrics
  - Back end denial rate
  - Bad debt
  - Collection recovery
  - Underpayments
  - Down coding analysis and correction rates
  - Appeal success rate
  - AR aging

HFMA MAP METRICS

- Net Days in Accounts Receivable
- Aged AR as a % of Billed AR >90 days

HFMA MAP Award

The Process



PRIVIA HEALTH

MAP AWARD APPLICATION

Phase I

- Demographics
  - Number of providers by type
  - ACO details – attribution, number of and type of contracts
  - Number of Locations
  - Payer Mix
- Data
  - Key Metrics
  - Data files attached
  - Audited financial data

Phase II

Narrative portion

- Invitation only
- Essay and Multiple Choice

Interview

- Senior leaders of HFMA
- Senior leaders of your organization
- Fact checking, clarification

Patient Financial Communication Best Practice Adopter

- Required for Hospitals and IDNs
- Optional for Physician Practice applicants (highly suggested)
- 3 year term
- Self reported data and narratives
- See Healthcare Dollars and Sense

MAP Award Metrics – Physician Practices

Category	Metric			Metric	HFMA Winners Median	Formula
Audited / Financial Data	Net Patient Service A/R	A	-->	Net Days in Accounts Receivable (A/R)	29.40	= A / (B / 365)
	Net Patient Service Revenue	B				
Cash Data	Total Self-Pay Cash Collected	C	-->	Point-of-Service (POS) Cash Collection	50.90%	= D / C
	Total POS Cash Collected	D				
	Total Patient Service Cash Collected	E	-->	Cash Collections as Percentage of Adjusted Net Patient Service Revenue	102.70%	= E / B
A/R Data	Total Billed A/R	F	-->	Aged A/R as Percentage of Billed A/R 90 Days and Greater	16.00%	= G / F
	A/R Dollars Aged 90 Days or Greater	G				
Scheduling Data	Number of Patient Hours Occupied	H	-->	Percentage of Patient Schedule Occupied	86.70%	= H / I
	Number of Patient Hours Available	I				
Physician Practice System Data	Count of CPT Units Denied	J	-->	Denial Percentage	3.10%	= J / L
	Count of CPT Units Billed	K				
	Count of CPT Units Remitted	L				
	Service-to-Revenue Lag Days	M	-->	Charge Lag Days	2.50	= M / K

Net Days in Accounts Receivable

$$\frac{\textbf{Net Patient Service A/R (Balance Sheet)}}{\textbf{Average Daily Net Patient Service Revenue (Income Statement)}}$$

Purpose: Trending indicator of overall AR performance

Value: Indicates revenue cycle efficiency

DEFINITIONS

Net A/R: is the net patient receivable on the balance sheet. It is net of credit balances, contractual allowances for third party payers, discounts for charity care and allowances for uncollectible accounts.

Average Daily Net Patient Service Revenue: Most recent 3 month daily average of total net patient service revenue (NPSR).

- NPSR is defined as gross patient service revenue minus contractual allowances, charity care and the provision for doubtful accounts.
- Most recent 3 months is defined as the number of days in the most recent 3 months which includes the month being reported. For example, data submitted for the 3 months ending June would include April (30 days), May (31 days) and June (30 days) for a total of 91 days

Net Days in Accounts Receivable: Include / Exclude criteria

Net Patient Service AR

INCLUDE

- AR outsourced to 3rd party company but not classified as bad debt
- AR related to patient specific 3rd party settlements. A “patient specific settlement” is a payment applied to an individual patient account.

EXCLUDE

- AR related to non patient specific 3rd party settlements. A “non patient specific settlement” is payment that is not applied directly to a patient account. It may appear as a separate, lump sum payment unrelated to a specific account
    - Non patient AR
    - 340 B drug purchasing program revenue if NOT recognized as a patient receivable in the accounting system
    - Any county or state subsidy, tax and match type assessments
    - Capitation and or premium revenue related to value or risk based payer contracts

Net Days in Accounts Receivable: Include / Exclude criteria

Average Daily Net Patient Service Revenue

INCLUDE

- Net patient service revenue

EXCLUDE

- 340 B drug purchasing program revenue if NOT recognized as a patient receivable in the accounting system
- Any county or state subsidy, tax and match type assessment
- Capitation and or premium revenue related to value or risk based payer contracts

Point of Service Cash Collection

Patient POS Payments

Total Self Pay Cash Collected

Purpose: Trending indicator of point of service collection efforts

Value: Indicates potential exposure to bad debt, accelerates cash collections, and can reduce collection costs

DEFINITIONS

Point of Service (POS) payments are defined as patient cash (self-pay cash) collected prior to or at time of service, and up to 7 days after discharge and/or patient cash collected on prior services at the time of a new service (prior balance collections)

Self Pay Cash Collected is the total cash collected for patient responsibility for the reporting month.

Point of Service Cash Collection: Include / Exclude criteria

Point of Service Payments

INCLUDE

- All posted POS payments, including undistributed payments (debit transactions only)
- Cash collected on prior encounters, including cash collected on bad debt accounts at the current service, or pre-service
- Pre service dollars captured in the month payment is posted rather than received (prepayment plans)
- Combined hospital and physician payments, if included in denominator

EXCLUDE

- Refunds; cash refunded to the patient should not be considered
- Routine payment plans unless collected at time of service

Point of Service Cash Collection: Include / Exclude criteria

Self Pay Cash Collected

INCLUDE

- All patient cash collected for the month, reported from patient cash account
- All posted self pay payments, including undistributed payments
- Bad debt recoveries
- Loan payments

EXCLUDE

- None listed

Cash Collection as a percentage of Adjusted Net Patient Service Revenue

$$\frac{\textbf{Total Patient Service Cash Collected (Balance Sheet)}}{\textbf{Average Monthly Net Patient Service Revenue (Income Statement)}}$$

Purpose: Trending indicator of revenue cycle ability to convert net patient services revenue to cash

Value: Indicates fiscal integrity/financial health of the organization

DEFINITIONS

Patient Service Cash Collected is cash collected for the reporting month, net of refunds.

Average Monthly Net Patient Service Revenue is the most recent three-month average of total net patient service revenue (NPSR). NPSR is defined as gross patient service revenue minus contractual allowances, minus charity care provision, then minus the provision for doubtful accounts. Note: Gross patient service revenue does not appear on the audited income statement.

Cash Collection as a percentage of Adjusted NPSR: Include / Exclude criteria

Patient Service Cash Collected

INCLUDE

- All Patient Service payments posted to patient accounts, including undistributed payments
- Bad debt recoveries

EXCLUDE

- Patient related settlements/payments. Examples include capitation, safety net, Medicare DGME, Medicare pass through, Medicaid DSH
- Non-patient cash

Cash Collection as a percentage of Adjusted NPSR*: Include / Exclude criteria

Average Monthly Net Patient Service Revenue

INCLUDE

- Net Patient Service revenue

EXCLUDE

- 340B drug purchasing program revenue if NOT recognized as a patient receivable in the patient accounting system
- Any state of county subsidy, tax and match type assessments
- Capitation and/or premium revenue related to value or risk based payer contracts

**Note: this is the same number as used in the Net Days in AR metric*

PRIVIA HEALTH

Aged AR as a % of Billed AR 90 days and greater

$$\frac{\textbf{Billed A/R > 90 Days}}{\textbf{Total Billed AR}}$$

Purpose: Trending indicator of receivable aging and collectability

Value: Indicates payment delays or revenue cycle's ability to liquidate AR

DEFINITIONS

AR Aged > 90 days:.Total billed AR amount for all payers aged over 90 days from discharge date (DOS)

Total Billed AR: Total billed AR amount for all payers in a reporting month, aged from discharge date (DOS)

Aged AR as a % of Billed AR 90 days and greater

Billed AR > 90 days

INCLUDE

- Only active billed debit balance accounts; “active billed accounts” are only those accounts that are open
- Series accounts / recurring accounts
- Includes accounts outsourced to a third party but not classified as bad debt accounts, as for example, early out accounts and payment plan accounts.

EXCLUDE

- Active billed credit balance accounts; these should be removed from the data. Only if the total account balance is a credit should it be excluded
- Accounts within the charge lag period (not yet billed)
- In-house accounts (inpatient or series (monthly) accounts.

PRIVIA HEALTH

Aged AR as a % of Billed AR 90 days and greater

Total Billed AR

INCLUDE

- Only active billed debit balance accounts; “active billed accounts” are only those accounts that are open
- Series accounts / recurring accounts
- Includes accounts outsourced to a third party but not classified as bad debt accounts, as for example, early out accounts and payment plan accounts.

EXCLUDE

- Active billed credit balance accounts; these should be removed from the data. Only if the total account balance is a credit should it be excluded
- Accounts within the charge lag period (not yet billed)
- In-house accounts (inpatient or series (monthly) accounts.

Percentage of Patient Schedule Occupied

$$\frac{\textbf{Number of Patient Hours Occupied}}{\textbf{Number of Patient Hours Available}}$$

Purpose: Identifies opportunities to maximize schedule utilization and improve practice productivity

Value: Measures available capacity in the patient schedule.

POINTS OF CLARIFICATION

Number of Patient Hours Occupied: Includes filled appointments, unfilled cancellations, and no-shows.

Number of Patient Hours Available: Excludes blocked time. Blocked time is defined as physicians' scheduled hours that are unavailable due to meetings, lunches, and/or administrative functions/

Professional Services Denial Percentage

$$\frac{\text{Total number of CPT codes denied (Accounts receivable system)}}{\text{Total number of CPT Codes Remitted (835 Files and/or Paper Remittance)}}$$

Purpose: Trending indicator of % of claims denied

Value: Indicates the provider's ability to comply with payer requirements and the payers' ability to accurately pay the claim. It is both an efficiency and a quality indicator.

POINTS OF CLARIFICATION

Number of CPT codes denied: Total CPT codes adjudicated monthly. Denials are defined as "actionable denials" – those denials that may be addressed and corrected within the organization and that result in increased reimbursement

Number of CPT codes remitted: Total CPT codes remitted monthly. Remitted CPT codes can be received electronically or through paper process

Professional Services Denial Rate: Include / Exclude criteria

Number of CPT Codes Denied

INCLUDE

- Only payments containing a denial code on the remittance advice
- Both initial claim denials and subsequent appeal denials
- Zero payment and partial payment accounts containing a denial indicator

EXCLUDE

- Denials for plan excluded (non-covered) services
- Denials for patient responsibility
- Denials for duplicate claims
- Shadow / encounter claims

Total Charge Lag Days

$$\frac{\Sigma \text{ days from revenue recognition (posting date) less date of service date (by Charge / CPT code)}}{\Sigma \text{ Charge / CPT codes billed}}$$

Purpose: Trending indicator of charge capture workflow efficiency

Value: Impacts cash flow

POINTS OF CLARIFICATION

Elapsed days between revenue posting date and service date is the number of days between the date of service and the date of revenue recognition (posting) for each charge code on the claim. This is not a total of the charges, but rather a count of the days.

Sum of Charge Codes is the count of the number of charge codes billed, not a summation of the dollars billed.

Phase II

NARRATIVE QUESTIONS

After submitting the initial application for the MAP Award for High Performance in Revenue Cycle, which covers demographics and financial metrics, organizations that qualify to move forward in the process will be asked to submit additional information on performance and best practices.

INTERVIEW

The last portion of the process is to have an interview with the HFMA Leadership and the RCM and Senior Leadership at your organization. HFMA will lead the interview, asking questions to clarify anything they see in the application that needs further explanation or to inquire as to best processes.

Narrative Questions and Interview

Narrative Questions

- Multiple choice and Essay format
- Approximately 20 questions
- Topics
  - Revenue Cycle Staff, Training, onboarding, incentive plans, retention
  - IT and Rev Cycle – interoperability, technology improvements
  - Innovation, Process improvements, Practice Efficiency, Revenue leakage reduction
  - Patient Satisfaction, Patient Friendly Communications, Pricing, Financial Assistance, Compassion

MAP Award Application Tips

- Start now for next year
- Get your data house in order
- Track metrics using HFMA formula
- Make sure you have control of your 835 files, can calculate CPT codes billed *and* remitted
- Review your current processes; Front, Middle and Back
- Most likely in need of improvement: Denials, Timely charge capture and POS cash collections

- Assign responsibility – allows for focus

- Socialize the idea throughout the organization – drum up support and engagement

Other MAP Metrics, not on the MAP Award Application

- **Physician Practice Operating Margin Ratio (Primary and Specialty)**
  - Measures financial performance of a physician entity on an accrual basis
    - ***Net Income from practice operations / Practice operating revenue***

- **Net Income (Loss) per Physician FTE (Primary and Specialty)**
  - Measures financial health on a physician FTE level. Supports the need for strategy development to minimize losses
    - ***Net Income from operations / Number of physician FTEs***

- **Physician Compensation as a Percentage of Net Revenue**
  - Demonstrates an ability to afford physician compensation in relation to the revenue of the enterprise
  - Predicts a reasonableness of physician compensation relative to revenue (direct contribution of a physician)
    - ***Total physician compensation / Total patient service revenue***

THANK YOU….Questions?

PRIVIA HEALTH