OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

CAH Finance and Operations Webinars

April 20, 2023
Ensuring Long Term Success Today: 2023 Revenue Cycle Strategies

The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.

The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being

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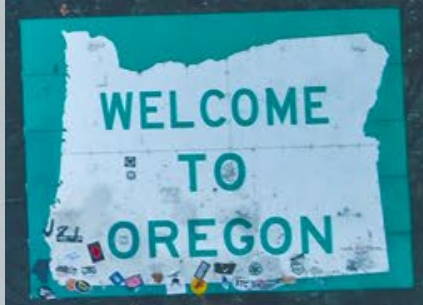
Webinar Logistics

- Audio muted and video off for all attendees.
- Select to populate the ··· to populate the chat feature on the bottom right of your screen. Please use either the chat function or raise your hand on the bottom of your screen to ask your question live.
- Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/resources-and-technical-assistance-cahs.



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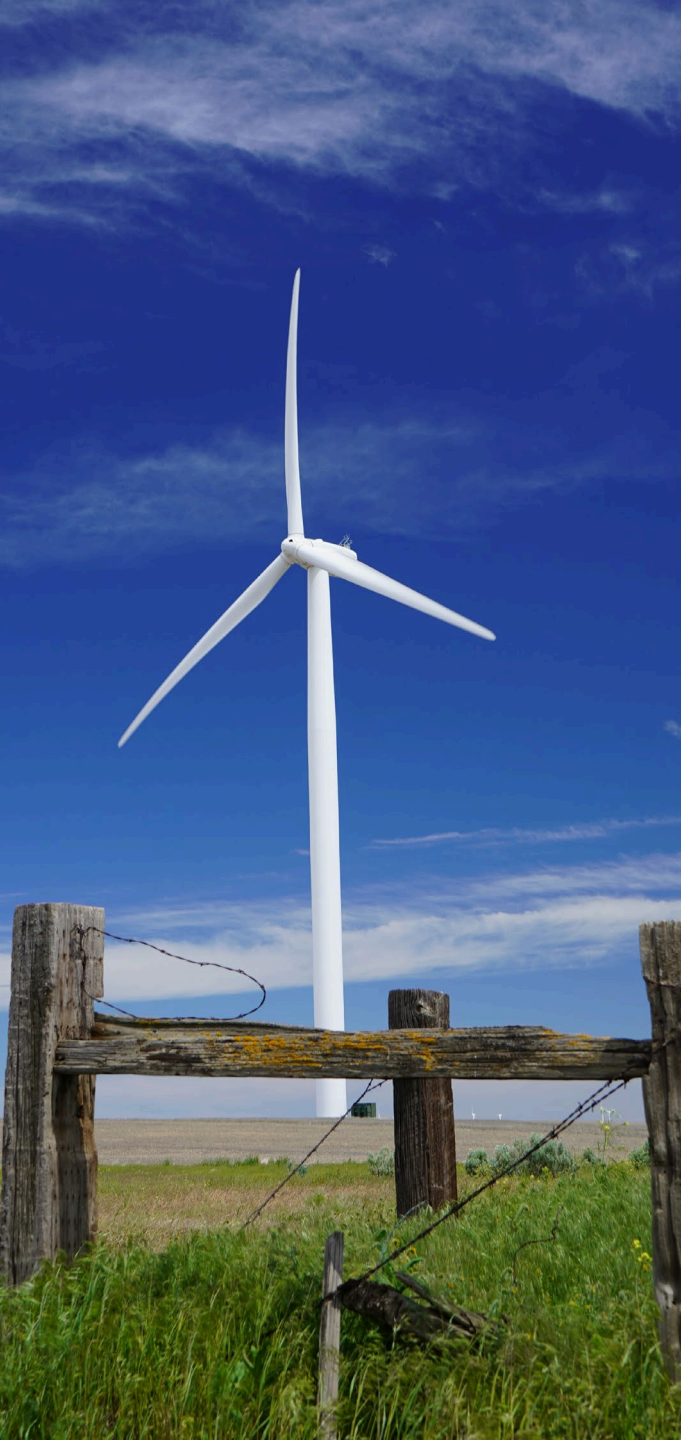

Upcoming CAH Operation and Finance Webinars

May 11, 12 p.m. - 1:00 p.m.
CAH Reimbursement Heuristic: Using Medicare Cost Report to Reveal Opportunities

June 8, 12 p.m. - 1:00 p.m.
10 CAH Revenue Cycle Priorities: What to Review Immediately

July 13, 12 p.m. - 1:00 p.m.
The Post-Acute Care Lever: Hospital Swing Beds

Aug. 3, 12 p.m. - 1:00 p.m.
How to Build Revenue: Front-End Competencies

Aug. 31, 12 p.m. – 1:00 p.m.
The No Surprises Act: Revenue Protections and Transactional Compliance

Sept. 14, 12 p.m. – 1:00 p.m.
Fund Your Mission: Practice Steps to Move from Volume to Value

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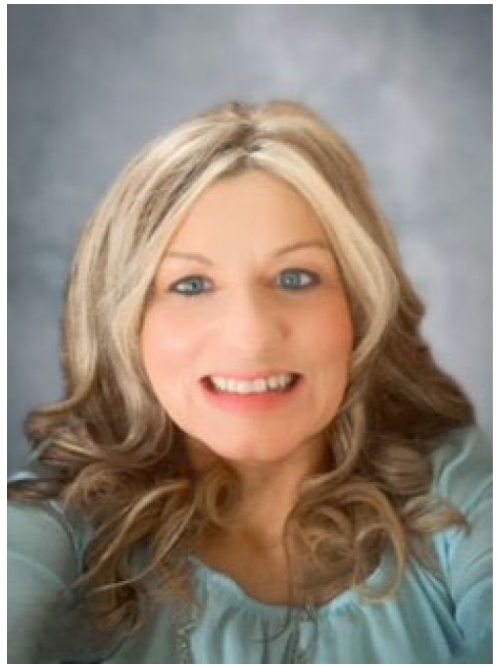


Carrie Bova has over 15 years of experience managing revenue cycle operations. Carrie is an expert in optimizing revenue cycle operations and improving cash flow in rural healthcare organizations. She has a proven record of accomplishment of increasing revenue cycle efficiencies, reducing expenses, establishing compliance, and developing growth strategies in a constantly evolving industry. Prior to joining Wintergreen, Carrie worked for multiple rural organizations. Carrie was instrumental in successfully turning one rural hospital that she worked for over ten years into a Critical Access Hospital Top 100 organization.

Ensuring Long Term Success
2023 Revenue Cycle Strategies

April 20, 2023

WINTERGREEN

Agenda

Prioritize Retention

- Enhance the Patient Experience
- Enhance Ease of Use
- Establish Virtual and Telehealth Options

Identify Opportunity

- Align with National Health Initiatives
- Existing Opportunities
- Growth Opportunities

Revenue Optimization and Integrity

- Enhanced Charge Capture
- Monitoring Payment Expectations and Variance
- Limiting Risk

2023 Priorities Industry Standard

Organizations have been inundated with content associated with industry trending priorities such as inflationary pressures, increased payor denials, data and analytics and leveraging artificial intelligence. All of these priorities have value and should be included in your review and strategic planning for the future.

The intent of this presentation is to identify some key areas of focus that will help you to achieve those priorities but also focus on healthcare trending as it relates to how you can prepare and optiize now to stabilize current and future state.

Prioritize Patient Retention

Retention

Patient Retention should be one of the top priorities for Healthcare organizations. An increasing and growing market of retail healthcare threatens patient retention, yet patient retention can create and provide stable revenue streams. Often existing patients are loyal and provide repeat business.

Develop Strategies for the following:

Minimum Service Costs

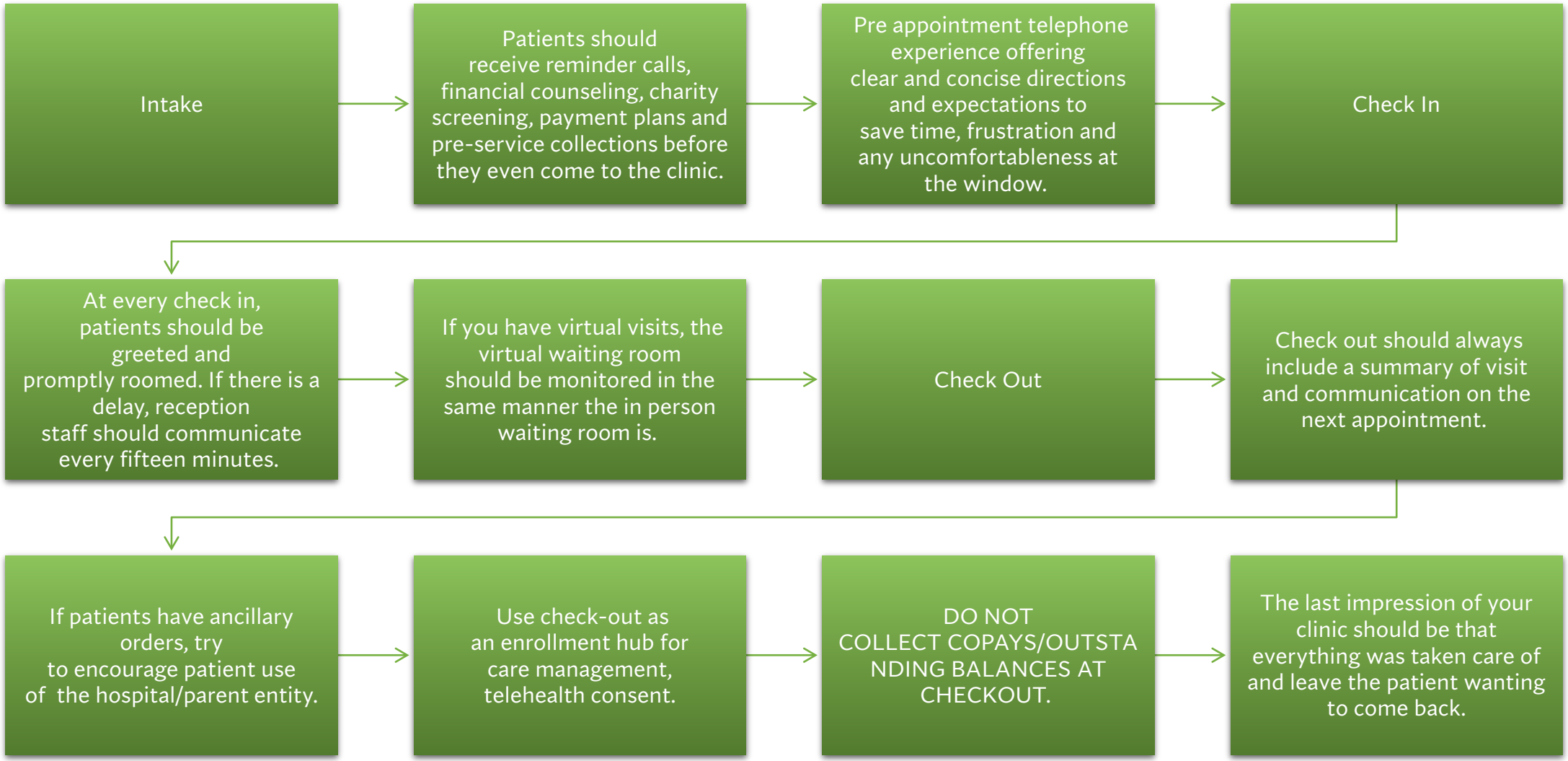
Enhanced Image and Reputation

Improved Quality and Financial Performance

Improved Patient Relations

- Evaluate patient costs and payment options- Are you passing too much cost on to your patients?
- Are patient financing options available?
- Do you offer prompt pay discounts and financial counseling?
- Do you offer underinsured charity?
- Are patient's preregistered with minimal wait times?
- Is your office/staff inviting and accommodating?
- Ae your practitioners consistent and do your patients trust them?
- Do you offer extended business hours? Increase office hour availability for clinic and business office.

Patient Experience



Reception/Patient Facing Staff

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Building Front End Competencies and ensure that all patient facing staff are knowledgeable and courteous. Your front-end staff are your only face to face encounter with the patient and the impression here is what makes or breaks your clinic.

Front end staff should be well trained to understand insurance plans and patient's certificate of coverage and coordination of benefits.

Pre-Appointment processes help to achieve financial counseling and set patient expectations. This can also ensure compliance as Good Faith Estimates and Charity Screening can occur pre appointment.

Educate and Automate to ensure patients are not inconvenienced and have options.

Establish routine intake and checkout process that focus on efficiency and getting the next appointment. Retaining the patient for another vist and ensuring that the patient is left with the impression that they are well cared for.

If a patient has Ancillary orders, identify a process post appointment/check out to follow up with the patient in 48/72 hours. Use scripting to drive the patient to your parent entity if applicable. Fun fact, nearly 30% of ordered testing is never received of the patient due to non compliance.

Evaluate annual exams/well visits that occurred 366 days ago, should you not have a full schedule and get patients engaged and coming in to the office. If a patient presents for acute reasons, schedule the annual exam at the check out process if not already scheduled.

Provide feedback surveys to track and analyze patient experiences from the patient perspective.

Identify Opportunity

Preventative Services – The Need and Initiatives

Healthy People 2030 | health.gov

Healthy People 2030 focuses on increasing preventive care for people of all ages. Healthy People 2030 focuses on five key factors

Health Disparities

Health Equity

Health Literacy

Well Being

Social Determinants of Health

Preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes have been implemented and continue to evolve to assist and influence more people to access these critical services.

Rural Healthcare has an opportunity to develop a proactive, not reactive approach and despite multiple initiatives has struggled to effectively manage.

Rural America also has great potential to benefit from these opportunities.

Opportunities – Current State

Evaluate identification of service offerings that address Leading Health Indicators and Priorities. Align you service delivery with the goals established by the initiatives.

Health Conditions	Health Behaviors	Population
Arthritis Blood disorders Cancer Chronic kidney disease Chronic pain Dementia Diabetes Heart disease and stroke Infectious disease Mental health and mental disorders Oral conditions Osteoporosis Obesity Pregnancy and childbirth Respiratory disease Sensory or communication disorders Sexually transmitted infections	Child and adolescent development Drug and alcohol use Family planning Nutrition and healthy eating Physical activity Preventative care Sleep Tobacco use Vaccination Violence prevention	Adolescents Children Infants LGBT Older adults People with disabilities Women Workforce

Alignment with Indicators

Industry and payment methodologies are aligning with health indicators. Whole person care, quality, and improved outcomes are of significant priority. Transition to quality payment delivery is expected and recent studies from HHS indicate that some initiatives have not delivered desired results. Evaluating how you provide care now to protect your payments later is critical to success and preparedness for the future.

Children	Adolecent	Adult
Obesity G0447 – Behavioral Health Counseling Obesity generates $15-$35 per patient G0473 - Behavioral Health Counseling Obesity Group – Improves Resource utilization and volumes. Generates $10-$15 per patient in group. Groups must be 2-10 patients. 30 minutes Both codes are paid by both Medicare and Medicaid. ICD Codes: E66.9, E66.01, Z71.3,E66.09 **Dental Care** 99188 Application Fluoride Varnish– generates $10-$15 per patient. ICD Codes: Z00.121, Z13.84, Z29.3, Z91.841, Z91.842, Z91.849 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes. Generates $20-$25 per patient ICD Codes: Numerous	G0442 **Annual alcohol misuse screening**, 5 to 15 minutes Generates $8-$20 per patient ICD Codes: Z13.89, Z13.39 G0444 **Depression/Anxiety screening** and timely preventative care (leads to BH integration)Generates $8-$20 per patient ICD Code: Z13.31 **Substance Use Screening** and timely preventative care (leads to BH integration) **Sexually Transmitted Infection Screenings** (i.e. HIV, Syphilis, Gonorrhea, Chlamydia)- multiple codes and dx to support. Generates ancillary lab revenue. G0445 – STI counseling 99406 **Tobacco Counseling** – 3 to 10 minutes. Generates $10-$20 per patient. ICD Code: F17.210 ***In addition to codes listed under child.***	**AAA Screen** $100 **Cardiovascular Screen** $20-$40 **Diabetic Screening** **Medical Nutrition Therapy** **Mammograms** $100 **Bone Mass Measurements** $120-$140 **Colorectal Cancer Screenings**$140-$160 **Prostate Cancer Screening**$170-$200 **Glaucoma Screening** $40-$60 **IBT for Cardiovascular Disease** $25-$45 ***In addition to all codes listed for Children (excluding Dental) and adolescent.***

Opportunities – Future State

Doing the math….

If you had 100 Medicare members and 65% of them were enrolled in Care Management of some sort, your organization would generate an additional $5066.10 per month, $60,793.20 annually. If you do not currently have Care Management, evaluate the expense versus the benefit and determine if a vendor support could be helpful. The 20 minutes per month is a cumulative total and can be a combination of several provider types.

Care Management Services
Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.

Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. (these services include the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team)

Medicare pays Chronic Care Management (CCM), Principal Care Management (PCM), CPM, and general Behavioral Health Integration (BHI) services provided as of January 1, 2023, at the average of the national non-facility physician fee schedule payment rate for CPT codes 99490, 99487, 99484, 99491, 99424, and 99426 when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.
G0511 is billed and generates $77.94 per member for each 20 minutes of monthly care management.

Opportunities – Future State Behavioral Health Integration

"Access to services promoting behavioral health, wellness, and whole-person care is key to helping people achieve the best health possible," says CMS Administrator Chiquita Brooks-LaSure in a press release. "The Physician Fee Schedule final rule ensures that the people we serve will experience coordinated care and that they have access to prevention and treatment services for substance use, mental health services, crisis intervention, and pain care."

In light of the current needs among Medicare beneficiaries for improved access to behavioral health services, CMS has considered regulatory revisions that may help to reduce existing barriers and make greater use of the services of behavioral health professionals, such as licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs). Therefore, CMS is finalizing the proposal to add an exception to the direct supervision requirement under our "incident to" regulation at 42 CFR 410.26 to allow behavioral health services to be provided under the general supervision of a physician or non-physician practitioner (NPP), rather than under direct supervision, when these services or supplies are furnished by auxiliary personnel, such as LPCs and LMFTs, incident to the services of a physician (or NPP).

The new provision adds an exception to the direct supervision requirements under the "incident to" regulation. It allows auxiliary personnel such as licensed professional counselors to provide services under the general supervision, rather than direct supervision, of a physician or non-physician practitioner (NPP) when these services are incident to the services of a physician or NPP.

According to CMS, the final rule also clarifies that any service primarily for the diagnosis and treatment of a mental health or substance use disorder can be provided by auxiliary personnel under the general supervision of a physician or NPP who is authorized to furnish and bill for services provided incident to their own professional services.

This rule will expand access to licensed professional counselors and marriage and family therapists for Medicare beneficiaries beginning Jan. 1, 2023.

CMS is also clarifying that any service furnished primarily for the diagnosis and treatment of a mental health or substance use disorder can be furnished by auxiliary personnel under the general supervision of a physician or NPP who is authorized to furnish and bill for services provided incident to their own professional services. CMS believes that this change will facilitate access and extend the reach of behavioral health services. Finally, CMS indicated in the final rule that we intend to address payment for new codes that describe caregiver behavioral management training in CY 2024 rulemaking.

RHC's are instrumental in both access and monitoring this care and have a very marketable strategy as patients can have one visit and achieve medical and behavioral treatment, studies have shown that this engages and promotes utilization of behavioral health services.

Revenue Optimization and Integrity

Revenue Integrity

Revenue integrity in health care ensures that all encounters between patients and providers/qualified health care staff convert into claim payments. It is important to use systems and procedures that focus on compliance
and optimal compensation.

There are several factors in health care and workflows that influence revenue management including pricing, charge capture, contracts, workflows and compliance.

Pricing – Many providers increase pricing to enhance revenue

- While the pricing should reflect accurate charge to cover expenditures and service delivery
- Reimbursement is better managed through analyzing the effectiveness of payor contracts
- In rural health care, we often pass on costs to the patient, rather than expand upon contractual allowances through contract negotiation

Charge Capture – Charge Capture and CDM management and review are ways to ensure that all services being performed are being captured and claimed. Often CDM reviews reveal expired codes

- Use of CPT rather than HCPCS etc.
- The first priority in Revenue Integrity is performing a thorough service review in conjunction with CDM review
- Many Electronic Health Records utilized use superbill templates that are managed by Information Technology and may not coincide with the CDM updates, etc.
- Performing a multi-disciplinary review of services with clinical, finance, and information technology team members present can often lead to identification of gaps and missed charge opportunity

Contracts – Most organizations do not have a formal contract matrix or access to contracts to defend revenue and analyze contract variances

- Even more often, these contracts are not shared with the end users billing the claims to be able to provide a resource and reference to ensure payment accuracy

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Workflow – Many workflows focus on claiming processes but often leave out cash application processes

- Ensure that your system workflow has a uniform cash application process for reporting remittance codes as defined nationally
- Many cash application workflows bundle denied claim lines into contractual adjustments in error
- This can make contract variance analysis and reporting extremely difficult

Compliance – Failure to comply with payor medical policies, federal/state regulations can lead to compliance concerns that result in payment penalties

- Ensure that your organization is evaluating and ensuring billing compliance to ensure revenue received is whole and is not at risk for retraction

Revenue Optimization

Revenue Optimization involves evaluating ways to improve your financial health by finding new/better ways to generate revenue, manage expenses and improve patient outcomes.

Organizations need to pursue new revenue opportunities and sources, often specifically challenging to Rural Organizations given manual workflow processes, lack of software and/or automation and staffing challenges.

Looking for ways to automate workflows and identify process improvements can help overtasked workforce. Evaluating on a granular level the tasks being completed on a daily basis and the effectiveness can be a beneficial review.

Each role in the organization should have an identified daily task workflow and it should be documented.

A "walk in the shoes" by supervisors and management with IT support and involvement can often lead to increased productivity. IT involvement in the review can lead to the investment in appropriate technology or expansion on current software offerings.

Look for investment and/or effectiveness of software for both electronic authorization, eligibility, charge capture and denial management..

Revenue Optimization

Revenue Optimization involves evaluating ways to improve your financial health by finding new/better ways to generate revenue, manage expenses and improve patient outcomes.

Implementing/Optimizing software can streamline and automate allowing staff to focus on denial management and revenue recovery

Evaluate contracts and financial health of service lines. Is your reimbursement for a service cost negative?

- If so, identify immediate amendment needs and reach out to get amendments underway

Service line additions based upon expanded access

- Organizations need to leverage telehealth and behavioral opportunities to increase service delivery and maximize volumes
- Often groups for diabetic management, smoking cessation, and behavioral health can really boost service revenue
- Evaluate group appointments as a source of increased revenue generation

Care Management Services and Population

- Are you providing Care Management Services to have a predictable monthly cash flow?
- Is your organization optimizing enrollment?
- At least 65% of your Medicare population should be enrolled in a Care Management service
- Care Management Services can also help to utilize staff such as respiratory, physical therapy assistants, etc. and allow for cost allocation to your clinic

In an evolving market with new challenges and regulatory pressures, being proactive and focusing on industry trends, strategizing for preparedness/gain and building a proactive strategy to advance performance and readiness will lead to long term success. Maximizing opportunity now can help to improve financial sustainability now and in a future environment.

Questions?

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ORH Announcements

- **2023 Forum on Aging in Rural Oregon**: May 15-17 in Seaside, Ore.
  Registration is open

- **2023 Oregon CAH Quality Workshop:** May 16-17 in Seaside, Ore.
  Registration is open
  Questions? Contact Stacie Rothwell | rothwels@ohsu.edu

- **May 11, 12 p.m. | CAH Reimbursement Heuristic: Using Medicare Cost Report to Reveal Opportunities** (register here)
- Most organizations view the Medicare Cost Report as a tedious administrative task and to many CFOs, a hassle. As a result, CAHs often fail to acknowledge the direct impact the cost report has on CAH reimbursement. This presentation highlights the importance of the Medicare Cost Report, enumerates the Top 10 Most Common Errors and explains how to leverage the cost report as a part of the managerial decision-making process.

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