CFO REVENUE CYCLE MANAGEMENT TRAINING

This training is designed for those who have some knowledge and context of the Community Health Center program and the revenue cycle management issues that are a daily reality. Typically someone should have a minimum of 6 months experience in order to get the most out of the training, but all are welcome. The more experienced attendees will be challenged to reconsider things they believe they know about revenue cycle management. Frequently we manage as we were taught and may not have had the time to challenge existing processes. As we enter into a "New Era of Accountability", revenue management and compliance are at the forefront of organization sustainability. We will address current revenue cycle topics in a practical, but detailed manner and put them in context with the current compliance environment.

DAY ONE

Opening Session: "Strategically managing the revenue cycle" (2.5 hours)

A Federally Qualified Health Center (FQHC) is typically engaged in the business of providing medical, dental and other social services to medically underserved populations. As a community health center (CHC), FQHCs receive funding to cover a portion of its cost to provide care to the uninsured and underinsured populations. However, the majority of its operating revenues are generated by billing and collecting from third parties and patients. Improved patient revenue cycle (the "revenue cycle") performance will be important for the long-term financial success of any CHC.

In today's fiscal environment, CHCs are seeking ways to improve functions that impact the revenue cycle to ensure funds are available now and in the future to fulfill the CHC's mission. In this section we will focus on managing one of if not the most significant revenue stream to the organization. We will discuss how CHC Management can develop and implement organizational changes to improve and sustain fiscal health, conduct a careful analysis of current CHC operations in comparison to available benchmarks and accepted industry best practices and understand the importance of operating an effective revenue cycle as if every employee of the CHC is a member of the billing department. Additionally, we will discuss how a working knowledge of net patient service revenue (NPSR) payer mix is critical to understanding and managing this revenue stream. We will define each payer source of revenue and discuss strategies to maximize revenue from each. We will also present a simple excel spreadsheet tool that can be used to track and predict revenue outcomes for each payer type and provide insight into possible problem areas.

Second Session: "Organizational structure considerations for effective billing and collections" (1.5 hours)

The key objective of the billing function is to ensure a process exists that fosters claim submission in a timely and accurate manner and it meets federal, state and other billing guidelines. Delays or errors in the initial billing process, or in following up on unpaid claims, can lead to cash flow delays and account balance write-offs. CHCs typically have a central billing office (CBO) which is responsible for claim submission and follow-up on unpaid accounts. We will delve into various structures, organization and staffing levels within a CBO which are key to strong effective billing and collections practices.

Third Session: "Patient revenue accounting and reporting" (1 hour)

In this section we will discuss the important aspects of accounting and reporting NPSR. We will discuss the selection of the practice management system (PMS) used to track revenue activity as well as the important elements of proper set up and use of the system. We will also discuss the general ledger (GL) accounting for revenue and how to properly integrate this with the PMS. Then we will wrap up this section with a discussion regarding the reporting of data related to the NPSR. Tools presented for this section includes an example journal entry cross walk from the PMS data to the GL and an example financial dash board.

Fourth Session: "Revenue cycle key performance indicators (KPIs)" (1.5 hours)

Key performance indicators (KPIs) are quantifiable measurements used to reflect the critical success factors of an organization. KPIs allow performance to be compared to established benchmarks, a reference point or standard as a basis for performance assessment. We will provide tools and discussion to assist with calculating vital KPIs, evaluate trends, both negative and positive and how this information is valuable when used to facilitate decisions toward continued improvement.

Fifth Session: "Medicare and Medicaid Overview" (1.5 hours)

In this section we will dive deep into current and future FQHC Medicare and Medicaid theory. Significant known and unknown potential changes are on the horizon for both of these key payer sources of revenues. We will review the current Medicare and Medicaid reimbursement methods and then examine in depth the new Medicare proposed rule and possible Medicaid changes on the horizon.

SECOND DAY

Opening Session: "FQHC Medicare and Medicaid Cost Reporting" (3 hours)

This section includes an overview of cost reporting theory followed by a detail look at each schedule in the Medicare cost report. We will also look at the Medicaid cost reporting requirements (if any). We will also address some best practices and make some recommendations for how to avoid common mistakes in the process. This is not a formal "how-to" regarding completing the cost report. The goal is help you improve the process in place and take things that have been learned previously in the training and integrate the concepts into your process.

Second Session: "FQHC Medicare billing and compliance" (2 hours)

Understanding the complexities of the Medicare program is a challenge for many CHCs and the risk associated with potential noncompliance is real in today's environment. This interactive discussion will provide a management level perspective on billing nuances and regulations related to this program and address questions attendees pose to clarify correctness of current processes within individual organizations.

Third Session: "Charge structure development, analysis and related information" (1 hour)

A CHC's charge structure or fee schedule is one of the most neglected but yet important tools in the health center. We will provide pointers on considerations for development, regulatory guidance and a detailed checklist of step-by-step items to incorporate when analyzing or updating your charge structure.

Fourth Session: "Evaluating third party payer contracts" (1 hour)

Health Centers deal with a variety of insurance and managed care organizations. To survive financially, a CHC must understand and engage in the insurance contracting process. We will discuss essentials in the contracting process, review a sample contract and provide a checklist of items for consideration in this important process.