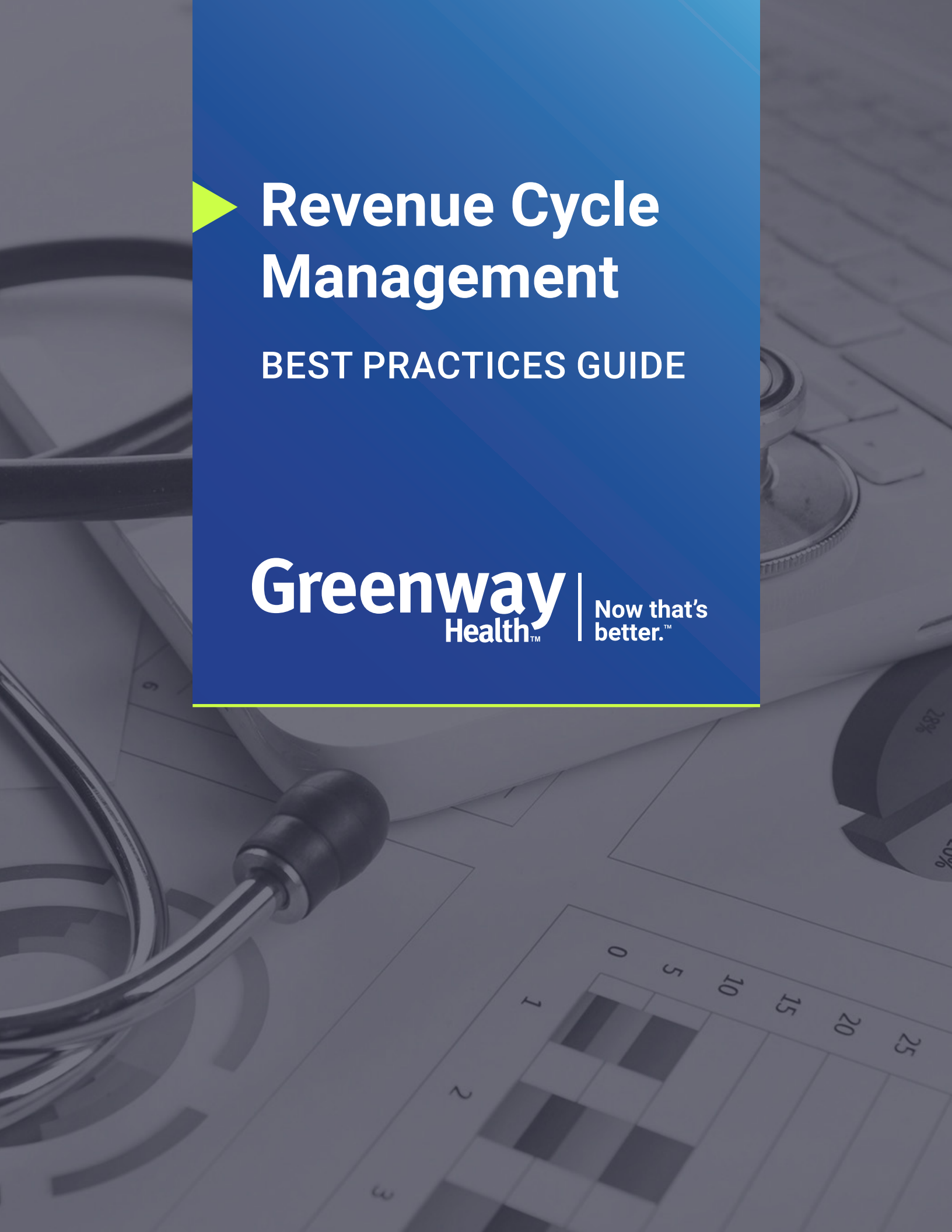
Revenue Cycle Management

BEST PRACTICES GUIDE



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Financial STABILITY for the future of healthcare.

Revenue Cycle Management

Our Greenway Revenue Services team is highly skilled in understanding a wide array of specialty-specific billing, and is well-versed with the nuances of billing for specialties such as OB-GYN, primary care, cardiology, pediatrics, and orthopedics, as well as community health centers and multi-specialty organizations. We offer the tools and training practices need to:

- **Track claims data**
- **Ensure accurate and timely claims submission**
- **Boost collection rates**
- **Optimize billing practices**

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We’re HERE
to navigate
your path
together.

Introduction

The critical role of effective revenue cycle management (RCM) is unprecedented in healthcare. As multiple regulatory initiatives converge with existing demand for faster billing cycles and cost containment, provider organizations face a perfect storm of clinical and financial challenges.

For many practices, the struggle to collect patient responsibility balances extends throughout the practice. At the front desk, knowledge gaps can limit staff members' ability to collect monies owed, while in the back office, lack of follow-up can leave revenue on the table. Inaccurate coding and the more severe problem of rejected or denied claims can cause payment delays affecting the bottom line.

Timely revenue cycle processes are essential to future success and positioning, especially given the rise of high-deductible health plans (HDHPs) and the increasing number of patients responsible for their healthcare costs. Practices must embrace new RCM models and best practices to improve patient collections.

This guide educates provider organizations about the evolving challenges of RCM and teaches best practices for improving revenue collections. Providers and administrators will learn how to train staff and apply processes to promote revenue collection and improve overall financial health. To better equip providers and administrators with the tools they need to navigate today's reimbursement landscape, we will also introduce Greenway Revenue Services, an RCM partnership that involves every practice function — from the front desk to the back office — to help manage revenue cycle from initial patient encounter to collection and beyond.

Revenue cycle management is at the HEART of what we do.

What is RCM?

In simple terms, RCM refers to the steps that healthcare organizations must take to receive payment for services rendered. Historically viewed as a straightforward back-office function, RCM involves every aspect of a practice.

A complete RCM strategy has three main functions:

1. Revenue generation: A practice's survival and sustainability depend on its ability to generate revenue. By reducing gaps in scheduling, and by taking a proactive approach to capturing patient information and copays up front, a practice can achieve this goal.

2. Revenue capture: Once a patient is called from the waiting room, the clinical encounter begins, and it continues until the patient leaves the appointment. The activity that occurs between the two events must be thoroughly recorded. Accurate and complete documentation of services rendered, and proper coding of those services, is required for a practice to receive the highest level of payment.

3. Revenue collection: In general terms, back office billing functions enable a practice to collect revenue and round out the RCM cycle. Included in this category are functions associated with billing, posting, and collection of payments. Practices should regard it as the last step of the RCM process.

How Does RCM Differ from Traditional Billing?

Within many fee-for-service care delivery models, billing traditionally was characterized by functions performed in the back office. It was not viewed as a shared responsibility between front office, back office, and clinical staff. Today, billing strategies have evolved within provider organizations to reflect RCM models that align with value-based care and proactively address payment. For example, clinically driven RCM would involve eligibility checks before a patient arrives.

But it's not just about financial aspects. Clinically driven RCM takes a proactive approach to patient health. It includes outreach to remind patients when it's time for annual visits, as well as to let them know about services and procedures that can help them manage chronic conditions such as diabetes and high blood pressure.

As the shift from fee-for-service to value-based care continues, the revenue cycle increasingly depends on complete and accurate documentation of patient information, beginning at the point of registration and extending through the clinical documentation process. One single gap in data can significantly detract from revenue streams.

For instance, if front office staff is unable to get all the patient information required for payment or fails to check for eligibility, it can cause significant billing delays or irreversible claim denials. Lack of proactive outreach up front can force back office staff to spend valuable time correcting rather than engaging in timely follow up with payers.

What is RCM?

The reality is that only a fraction of problematic claims is ever resolved. Greenway Health research finds that only 62% of practices review delinquent claims and only 59% of secondary claims are filed due to back-office time constraints.

These four common mistakes can hinder billing performance:

1. Not focusing on process: Billing glitches originate in many areas of practice operations, especially during times of peak scheduling. When patients are coming in and out, key information may be miscommunicated, overlooked, or even lost. Billing processes must be standardized and optimized as a "cycle" that is clinically driven and embraced by all staff.

2. Neglecting critical information: Many documents move through a practice. While managing all the critical information contained in these documents may seem overwhelming, providers must embrace this task to optimize revenue opportunities. For instance, when organizations understand the nuances of payer contracts, they are in a better position to fully leverage payment and negotiations. Equally important is staying on top of edit reports, explanation of benefits forms and other claims issues, and making sure denied claims are reworked and resubmitted as needed.

3. Failing to follow up: Provider organizations employ many strategies to improve collections, including appeals, tracers, collections letters, and payment plans. While these tactics are a good first step, many fall short due to a lack of follow-up. Often, by the time a practice realizes a patient or payer has not responded, it's too late to collect the money owed.

4. Drowning in detail: Details are important, but when billing practices become all about minutiae, organizations can neglect the bigger-picture revenue opportunities. For example, if practices look for trends, such as repeated claims denials for the same services or claims that are denied for registration errors, processes can be reworked to eliminate the potential for those errors to occur in the future.

KEY TAKEAWAY:

Practices should not make the mistake of believing revenue cycle management only applies to the back office. Front office, back office, and clinical staff all play an important role in bringing in revenue.

86-90% of denials are potentially preventable[1].

[1]https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/

What is RCM?

How Can a Practice Measure Financial Health?

Before it can implement an effective RCM strategy, a practice must understand its current financial health. Practices can leverage several best practice metrics to make this determination.

DAYS IN ACCOUNTS RECEIVABLE

The days in accounts receivable (A/R) measurement represents the average length of time it takes for a claim to be paid based on average daily charge volume. As suggested by Medical Group Management Association (MGMA), days in A/R should be fewer than 40 days and preferably in the 30- to 35- day range.

Common factors that contribute to longer days in A/R include:

- Increased rejections and/or denials
- Incorrect coding
- Credentialing issues
- Incorrect posting process
- Incorrect appeals process

GREENWAY REVENUE SERVICES IN ACTION:

Greenway Revenue Services helps practices decrease their days in A/R and improve collections.

Experienced RCM teams help you meet the timely filing limit and reach out to the payers in advance, reducing the instance of outstanding claims.

By handling A/R management, the team does the heavy lifting for you. Our professionals are experts in both the ambulatory product and your billing processes. They offer extensive experience managing |payments with insurance carriers. Greenway Revenue Services helps you by:

- **Conducting regular insurance follow-up**
- **Scrubbing claims to ensure that your practice is paid as quickly as possible on the highest percentage of visits**
- **Preventing delays in cash collections through seamless integration of the solutions and services**

What is RCM?

WHY SHOULD PRACTICES USE GROSS CALCULATIONS TO CALCULATE FINANCIAL METRICS?

Measurements that include all charges tend to be arbitrary not reflective of reimbursements a practice can receive.

Internal Greenway Health research found that 79% of providers are dealing with 10 or more payers. This makes it difficult – if not nearly impossible – for practices to track and manage all fee schedules effectively. For this reason, practices often set their own fees high enough to ensure the greatest capture of revenue while recognizing that real-world reimbursement from any given payer will be lower than what is reflected on the provider fee schedule. The metric that really matters is the net collection rate because it reflects the reimbursement a practice can actually receive. The total days in A/R based on gross charges is always lower than total days in A/R based on gross collections. As such, practices should avoid using this metric. It will result in skewed, unrealistic expectations.

WHY ARE DAYS IN A/R IMPORTANT?

When money is tied up with payers, practices lose momentum with cash flow as well as opportunities to invest and earn interest. Therefore, maintaining a low days in A/R metric benefits a provider organization.

In addition, organizations often have to meet timely filing limits — deadlines established by insurance carriers that require claims to be filed within a certain period from the date of service. Once this deadline has passed, it is often difficult to receive any payment for services rendered. For this reason, these deadlines are more favorable to insurance carriers than providers.

Commercial carriers often require claims to be filed within 90 days of the date of service. Although that timeframe may seem ample, it can be challenging for a busy practice without a solid RCM strategy that addresses days in A/R.

KLAPPER & DELUCA PULMONARY ASSOCIATES CASE STUDY

After implementing Greenway Revenue Services, Klapper & DeLuca Pulmonary Associates was able to support a newly appointed Office Manager. Their Revenue Cycle Manager with Greenway Revenue Services partnered closely with the Office Manager to work on claims processing, submission management, insurance follow-up, and payment posting.

"I feel comfortable with my Greenway Revenue Services team because they always offer to help me when it is needed. Our Revenue Cycle Manager has been there whenever help is needed."

— *Shirley Rodriguez*, Billing Manager, Klapper & DeLuca Pulmonary Associates

What is RCM?

GREENWAY REVENUE SERVICES IN ACTION:

Greenway Revenue Services examines clean claims metrics and denial trends across an entire organization and our customers. By analyzing this data, our experts can:

- Teach best practices to the front office staff to ensure correct and updated patient information on claims.
- Make sure the practice always verifies patient eligibility before the patient arrives.
- Look over the claims to make sure staff members follow payer-specific coding guidelines and correct modifier usage.
- Make sure the correct medical documentation is attached to claims.
- Quickly apply findings from one customer to another, scaling knowledge transfer.

Clean Claims Ratio

Also known as the first-pass ratio, the clean claims ratio is the percent of claims that are paid at first submission. A clean claim is the goal of any billing process. It has never been rejected, does not have a preventable denial, has not been filed more than once, and contains no errors. According to industry standards, a practice should strive for a 95% clean claims rate.

Understanding the clean claims ratio is important because the time a provider organization spends reworking denials can be substantial. Staff must review the original claim, identify the reasons for the denial, and then rework the entire claim for resubmission.

Once completed, the claim cycle must be restarted, delaying receipt of monies. In addition, some claims denied on first pass are never paid.

As claims are denied over time, the billing staff needs to analyze where breakdowns occur, identify trends, and implement new processes that will improve the outlook. Otherwise, a provider organization will continue to perpetuate its mistakes, reimbursements will fall short, and the entire organization will suffer.

KEY TAKEAWAY:

Only 59% of secondary claims are filed.

12% of practices never update their payer fee schedules.

What is RCM?

USING THE CLEAN CLAIMS MEASUREMENT

A practice files 1,000 claims per month and maintains a 90% clean claims ratio. Of the claims filed, 91% are paid without any further action, and 9% required rework. With this knowledge, a practice can:

- **Determine staffing needs:** If a practice needs to rework 100 claims a month, it can use the average number of claims a full-time employee can work a day (usually 50) to determine the number of employees needed. This calculation may factor in the number of touches a claim requires during rework. These could include entering the rejection or denial, calling the payer for details, researching coding mistakes, refiling the claim, or posting another denial.
- **Measure costs:** If the average cost of rework is $25 per claim and 100 claims a month require rework, it costs a practice an average of $2,500 a month to work unclean claims. In addition to an employee's hourly rate, a practice should factor in overhead costs such as benefits (30% of salary), facilities, hardware, and electronic filing fees. directly associated with unclean claims.

MONONGAHELA VALLEY ASSOCIATION CASE STUDY

By leveraging Greenway Revenue Services, the 14-provider Federally Qualified Health Center (FQHC) received support where they needed it most:

- Filling in training gaps
- Navigating government regulations
- Communicating coding and other changes proactively
- Discovering programs that practices are eligible to participate in
- Working with auditor groups to help practice complete grant funding reconcilement reports
- Optimizing system set-up to complement funding requirements

"They help me quite often when I'm looking for a way to add a code or change, or if the way something is adjusted off. They take the initiative so I can work on other things, which is great."

— *Michelle Cook*, Business Office Supervisor/RCM, Monongahela Valley Association

What is RCM?

GREENWAY REVENUE SERVICES IN ACTION:

Greenway Revenue Services improves net collections ratios for provider organizations by finding errors and omissions that result in denials, unreimbursed visits, and other uncaptured revenue opportunities. Greenway Revenue Services teams will go over a monthly reporting package that allows practices to monitor financial health and identify root causes for collections issues. Our experts will also conduct monthly calls to develop and reinforce best practices that ensure your long-term success.

NET COLLECTIONS RATIO

The net collections ratio is the percentage of total potential reimbursement collected out of the total allowed amount. Denial rates, unreimbursed visits, and other factors affect the net collections ratio. According to MGMA, 50% to 65% of denials are never worked and attribute this statistic to the lack of time or knowledge and negatively impacts this measurement of financial health.

The net collections ratio is important because it represents the efficiency of the revenue cycle and, ultimately, success with collections. Consider that an important component of net collections is bad debt and the ability to specifically manage patient collections. In most scenarios, the percentage of patient net collections is lower than payer net collections.

Patient deductibles are on the rise. As the number of HDHPs continues to increase, practices need to become more skilled and proactive in collections because it is harder to collect money owed by a patient.

PERCENTAGE OF CLAIMS BELOW 60 DAYS

Practices track the percentage of claims below 60 days for many of the same reasons they track days in A/R. Management of this metric — an important aspect of A/R management — recognizes that a dollar received today is more valuable than a dollar received in the future.

The aging of A/R is calculated by viewing an aged trial balance (ATB), which is a summary of all receivables by age and by percentage of total. For example, if an account has been outstanding for 34 days, it is part of the “31-60 day” category. Each category includes all accounts that have aged for a particular period of time and are typically categorized as 0-30 days, 31-60 days, 61-90 days, 91-120 days, and more than 120 days. To arrive at the percentage of claims below 60 days, the total dollar amount of each category is tabulated along with the percentage of total accounts receivable outstanding.

STREAMLINE your practice for RCM efficiency.

No Longer Just Back Office

Gone are the days when billing was contained in the back office. While roles in a practice used to be segregated, today all staff must engage for a complete RCM strategy. All staff be cognizant of how they contribute to the bottom line.

Front Office Responsibility

RCM begins with the first staff and patient encounter, which should occur before a patient enters the office by having front desk staff collect insurance information before the visit. Many practices are addressing the need to proactively obtain payment information by requiring insurance information before an appointment is scheduled.

Once information is obtained, front office staff must then confirm a patient's eligibility before an appointment. That way, the front desk can reconcile any inconsistencies in advance of treatment and billing. Queries regarding primary and secondary coverage should also be made, as a practice can leave money on the table if it only files claims for primary insurance.

According to Greenway Health market surveys, practices only file 59% of secondary claims. During this time of declining reimbursements and rising costs, practices cannot afford to ignore sources of revenue.

Appointment reminders are another critical part of the RCM equation and should be handled by the front desk, whether through automated text messages or actual phone calls. If a patient does not show up for an appointment, the practice loses revenue for the missed appointment and the opportunity to generate revenue by filling the opening.

If possible, the practice should collect the demographic and medical information before the patient comes in. This makes the registration process more efficient. Gathering the information at the office can eat into the appointment time. Practices can accomplish this task using online patient portals, or they can email a registration packet ahead of an appointment, requesting that patients fill out forms before they arrive.

After an appointment is scheduled, needed information is gathered, and the patient arrives, the front desk is responsible for collecting the copay. While practices engage various strategies for collecting this revenue, the task should be completed before the patient leaves the office.

Collecting small copays after a patient has left is a tedious, cumbersome task that many practices view as a waste of time. However, it can add up to significant revenue over time.

With HDHPs on the rise, front desk staff members need to be better trained and equipped to discuss money with patients. Many staff have not had to engage in discussions related to money under fee-for-service arrangements and may not be adequately trained to discuss finances with patients. Therefore, strategies for education will need to be deployed.

No Longer Just Back Office

Front desk staff need to be prepared to discuss the costs of each treatment and procedure to educate patients regarding their fees. Practice executives will also need to identify parameters for turning patients away. Questions that may need to be answered include:

- Will the practice see patients who do not have insurance?
- Will the practice see patients who cannot pay their copay at the time of service?
- Will the practice see patients who owe money from past visits?
- Does it matter how much a patient owes?

A good RCM vendor will provide consultation and education for front desk staff. If a vendor sees some way that the front desk is inefficient, it will step in and give advice. RCM vendors monitor to ensure these best practices are happening.

Clinician Responsibility

Traditionally, many clinicians have felt their primary responsibility is treating and helping patients — not generating revenue. Unfortunately, in a time of declining reimbursements and rising costs, it is no longer possible for the clinician to be ignorant of finances. ICD-10 coding rules and value-based reimbursement requirements make it necessary for clinicians to be cognizant of documentation practices to ensure they capture all details of the care they provide.

A top-rated RCM vendor will share best practices with the office and can also suggest different codes if they believe the physician is undercharging for services. Greenway Revenue Services teams track the performance of all staff in a practice and make suggestions on ways they can improve.

GREENWAY REVENUE SERVICES INCLUDE:

- System alerts that prompt patient payment upon check-in
- Best practices training to ensure accurate policy ID and referral entry and upfront payment collections
- Copay systems tables for accurate collections

No Longer Just Back Office

Integrated Clearinghouse

The role of the clearinghouse is to provide an interface for claims management. Clearinghouses receive claims from a practice management system by an interface and move that information to the appropriate payers, both government and commercial.

In the role of facilitating claims processing, clearinghouses may receive information containing nonstandard elements in a nonstandard format and move that information into a format that will be acceptable to the payer intended to pay the claim.

The reverse may also be true: Standard transactions received by the clearinghouse may be put into a nonstandard format for the receiving organization.

Not all clearinghouses are alike. Some clearinghouses have high claims acceptance rates and good editing processes with short time frames for reviewing claims for billing conflicts. Clearinghouses should provide the medical practice with ease in viewing, editing, correcting, and submitting claims.

Greenway Health owns its own clearinghouse that's integrated into the practice management system. Therefore, our RCM team has visibility into claim statuses and responses from payers, as well as boasts a 99% first-pass acceptance rate.

KEY TAKEAWAY:

Front office staff play a significant role in patient collections. The front office staff should understand that their role contributes to practice revenue and take that responsibility seriously. Their role in patient collections will increase further as the industry experiences a rise in HDHPs.

Clinicians can no longer deny their role in generating revenue. They need to be cognizant of documentation practices and capture all details of care.

GREENWAY REVENUE SERVICES INCLUDE:

- Optimized tables to improve data capture
- Guidance and education to ensure compliance with payer documentation requirements
- E&M coding tools to ensure you can bill at the highest clinically appropriate level for each visit

No Longer Just Back Office

Patient Responsibility

With the rise in HDHPs, patients are gaining more responsibility for their bills. Practices need to be more diligent in focusing on patient payments. There are six best practices to improve patient collections:

1. **Gather** patient insurance and contact information before patients arrive for an appointment. Staff should be prepared to collect complete and current insurance and contact information when a patient calls to make an appointment. Patients can be given the option of mailing or emailing information.

2. **Verify** insurance eligibility and identify any amounts due from patients prior to patient visits. Prior to a patient's appointment, provider organizations should check with payers to verify coverage and clarify payer rules.

3. **Collect** copays and other patient-responsible balances at the front desk when the patient checks in. The best time to collect payment from patients is when you can do so face to face. Practices need to develop and communicate clear policies to patients, enforce them routinely, and consider the option of rescheduling non-emergency appointments if the requirement is not met.

4. **Offer** multiple payment methods. Make the process of paying a bill easy through flexible options that include cash, check, or credit/debit card. This practice will increase the likelihood of collecting amounts due while the patient is in the office and can streamline overall billing processes.

5. **Offer** payment plans and track them. For procedures that extend beyond the health savings account, or for uninsured patients, establish plans that let patients pay over time, and train staff on how to communicate these options to patients effectively and track them properly.

6. **Make** follow-up part of the routine. Perseverance is key to maximizing collections for patients who don't make timely payments, yet many offices don't routinely call patients who have outstanding balances. Develop a routine, proactive timeline for initiating phone contact, and create a script for staff to follow.

(Print this out as a reference for improving patient collection)

No Longer Just Back Office

DID YOU KNOW?

56% of medical groups reported their time in A/R increased in 2022, often on account of staffing difficulties[1]

Nearly **20%** of healthcare workers have left their jobs since February 2020[2]

52% of medical groups report scheduling or customer service as the top front desk training challenge[3]

There is an expected shortage of **3.2 million** healthcare workers by 2026[4]

1. https://www.mgma.com/data/data-stories/bottom-line-impacts-from-revenue-cycle-staffing-ch 2. https://www.medicaleconomics.com/view/what-the-great-resignation-means-for-healthcare-it 3. https://www.mgma.com/data/data-stories/how%E2%80%99s-it-going-at-your-medical-practice%E2%80%99s-front-de 4. https://www.mercer.us/content/dam/mercer/assets/content-images/north-america/united-states/us-healthcare-news/us-2021-healthcare-labor-market-whitepaper.pdf


FOCUSED on
providing
value for
your patients.

Value-Based Payment Models

What Are Value-Based Programs?

Value-based programs are contracts with payers such as the Center for Medicare and Medicaid Services (CMS) and Aetna that tie reimbursement to the quality of care a practice gives its patients. These payment models are evolving in response to the rising costs of chronic conditions.

Most value-based programs are designed to align with healthcare's "Triple Aim" — improved population health, enhanced patient and provider experience through better quality and satisfaction and reduced per capita cost of healthcare.

How Are Physicians Paid Under These Programs?

Traditionally, physicians have been compensated on a fee-for-service (FFS) basis. Under this model, physicians are compensated for each "widget" of care they sold. In essence — individual procedures, tests and other events generated revenue. Today, payers increasingly use quality and cost measures to adjust physician reimbursement.

The following payment methods are the most common in value-based programs:

PAYMENT TYPE	STAGE OF MEANINGFUL USE
Incentives or penalties	Based on quality and/or cost measures, a physician's FFS reimbursements are adjusted either up or down by a certain percentage.
Care coordination fee	In addition to receiving FFS, physicians collect a set monthly per-patient "care-coordination fee." A care coordination fee is money given to compensate the practice for organizing non-visit patient care activities between the patient, their providers, and any acute care facilities (hospitals) to ensure the patient gets the right care at the right time.
Shared savings	Physicians are reimbursed FFS and a share of the savings, generally up to 50%, generated for the healthcare system through preventative care and population health management. How much savings a practice generates is calculated by measuring cost per patient against national benchmarks set by the payer and then adjusting the rate for quality. If a practice saves the system $1.2 million as measured against its peers, they collect up to $560,000.
Capitated payments (or full risk)	These contracts pay providers a straight fee per patient per month and eliminate FFS entirely. Therefore, if the rate is $100 per month per patient and a practice has 1,000 patients, it will receive $100,000 per month from the payer, regardless of what services are delivered or whether a patient even utilizes the provider.
Blended payments	Many contracts will use a mix of the payment models above. For example, a payer may offer shared savings and a care coordination fee, while still allowing a provider organization to capture FFS reimbursements.

Value-Based Payment Models

How Is Quality Measured?

Within value-based initiatives, quality is measured by using clinical "measures," which are generally fractions that represent performance on a key clinical indicator, such as providing body mass index screenings to patients or the A1C levels of a provider's diabetic patients. In essence, the payer compares clinical performance nationally, sets a performance "mean," and adjusts compensation based on performance against that mean.

Some value-based measures are process based, whereas other measures are outcomes based. Examples of process-based measures include:

- Percentage of adults who had blood pressure screened in the last two years
- Percentage of patients who received a flu vaccination
- Percentage of patients who received depression screening

Examples of outcome-based measures include:

- Percentage of patients discharged from an acute care hospital and readmitted within 30 days
- Percentage of diabetic patients whose blood glucose is uncontrolled (A1C < 8)
- Percentage of patients with high blood pressure whose blood pressure is lower than 140/90

How Is Cost Measured?

Cost is measured by analyzing per-patient/per-month healthcare expenditures and by looking at per-patient/per-month expenditures related to certain chronic conditions, such as coronary artery disease.

How Will Value-Based Models Affect RCM?

Within value-based payment models, it is no longer enough for a practice to document what procedures and services it provides. Now, it is required to track a host of quality measures to be reimbursed.

As physician compensation moves away from FFS and toward shared savings and outcomes-based models, and practices embrace new team-based approaches to care, balancing quality initiatives and revenue processes has become far more complex.

Practices must now track multiple payer contracts and manage quality metrics reporting, requiring additional resource allocation.

Value-Based Payment Models

Specific Value-Based Programs

PROGRAM NAME	PROGRAM DESCRIPTION	PROVIDER REIMBURSEMENT
Accountable Care Organization (ACO)	An ACO is a group of provider organizations that aims to provide highly coordinated care while reducing costs. These organizations usually consist of multiple practices that have allied to participate in ACO programs offered by CMS or private payers. It has 31 different quality measures in four domains: patient/caregiver experience (surveys on the quality of doctor communications, shared decision making, etc.), care coordination/patient safety (medication reconciliation, discharge follow up, etc.), preventative health (BMI screenings, immunizing the population, etc.), and clinical care for at-risk population (A1C levels for diabetics). ACOs measure cost by per patient per month.	Shared savings, adjusted for quality measure performance, and FFS. In private ACOs, payment may be shared savings and FFS or other blended payments.
Patient-centered medical home (PCMH)	A PCMH is a model for individual practices that focuses on providing coordinated and comprehensive care. The National Clinical Quality Association (NCQA) recognizes practices that track specific measures and undergo certain process changes aimed at patient access, care coordination, population health management, continuous improvement, and other elements. Private payers then allow these practices to participate in their PCMH programs.	Care coordination fee plus FFS adjusted for quality measure performance.
Value-based modifier	The value-based modifier adjusts Medicare reimbursement based on quality and cost. Generally, organizations that provide high quality care for a low cost get an incentive, and those who provide low quality care at a high cost receive a penalty. Quality measures are aligned with MIPS. In 2017, it applied to physicians in groups with two or more, as well as physician solo practitioners. In 2018, it includes nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists, as well as physicians.	Incentives and penalties tied to quality and cost performance.
Medicare Advantage	Medicare Advantage is a program where CMS contracts with private payers and pays them capitated payments for Medicare services. The private payers then contract with provider organizations for the delivery of these services. The capitated payments are based on Hierarchical Condition Categories (HCC) codes, which are diagnosis codes that reflect the risk a patient presents. Payers receive more money for higher-risk patients.	Varies, generally FFS and shared savings. Private payers may change FFS reimbursement based on keeping diagnosis codes up to date, so the payer is compensated the right amount.
Comprehensive Primary Care Plus (CPC+)	CPC+, a national advanced primary care medical home model, seeks to improve the quality, access, and efficiency of primary care through multi-payer payment reform and the transformation of care delivery.	Care management fee ranging from $15 to $28 on average, a performance-based incentive payment ranging from $2.50 to $4, as well as payment under the Medicare Physician Fee Schedule.
Chronic Care Management Fee	Practices that have five certain capabilities are permitted to bill CMS once a month per patient for non-visit care management activities, such as medication reconciliation, or monitoring the patient's condition. The five capabilities are 1) use of a certified EHR, 2) maintaining an electronic care plan, 3) ensuring patient access, 4) facilitating transitions of care, and 5) care coordination.	Average $43 per patient per month.

Value-Based Payment Models

Many physicians are discovering that the talent and technology needed to get the job done efficiently and effectively is beyond their current capabilities or will require investment dollars that simply do not exist. In response, many practices are considering the advantages of collaborating with an RCM vendor.

Revenue services vendors have the benefit of working with many practices who participate in value-based payment models, creating economies of scale. A top-rated RCM vendor can help a provider organization navigate the uncertain waters of the value- based climate and ensure revenue is optimized.

KEY TAKEAWAY:

Costs to treat chronic conditions are rising. Value-based programs tie reimbursement to the quality of care a practice provides to its patients instead of using a fee-for-service (FFS) compensation model.

Value-Based Payment Models

DID YOU KNOW?

60.5% of all healthcare payments are tied to some level of quality or value measurement as of 2021[1]

Burnout among providers decreased once practices passed a threshold of **75%** financial investment in VBP models[2]

In a survey by AAFP, **49%** of practices said they are participating in some form of value-based payment[3]

The number of patients receiving care under value based models has increased by **2.3 million** in the last decade[4]

1. https://revcycleintelligence.com/features/unlocking-the-future-of-value-based-care-with-data#:~:text=According%20to%20the%20latest%20data,value%20measurement%20as%20of%202021. 2. https://www.fiercehealthcare.com/providers/increases-value-based-payment-adoption-decreased-family-physician-burnout-aafp-study 3. https://www.agilonhealth.com/news/blog/equipping-physicians-for-vbc/ 4. https://www.beckersasc.com/asc-coding-billing-and-collections/5-stats-to-know-on-value-based-care.html#:~:text=A%202023%20report%20from%20insurer,the%20likelihood%20of%20hospital%20admissions.


A partnership that provides BETTER outcomes.

Greenway Revenue Services

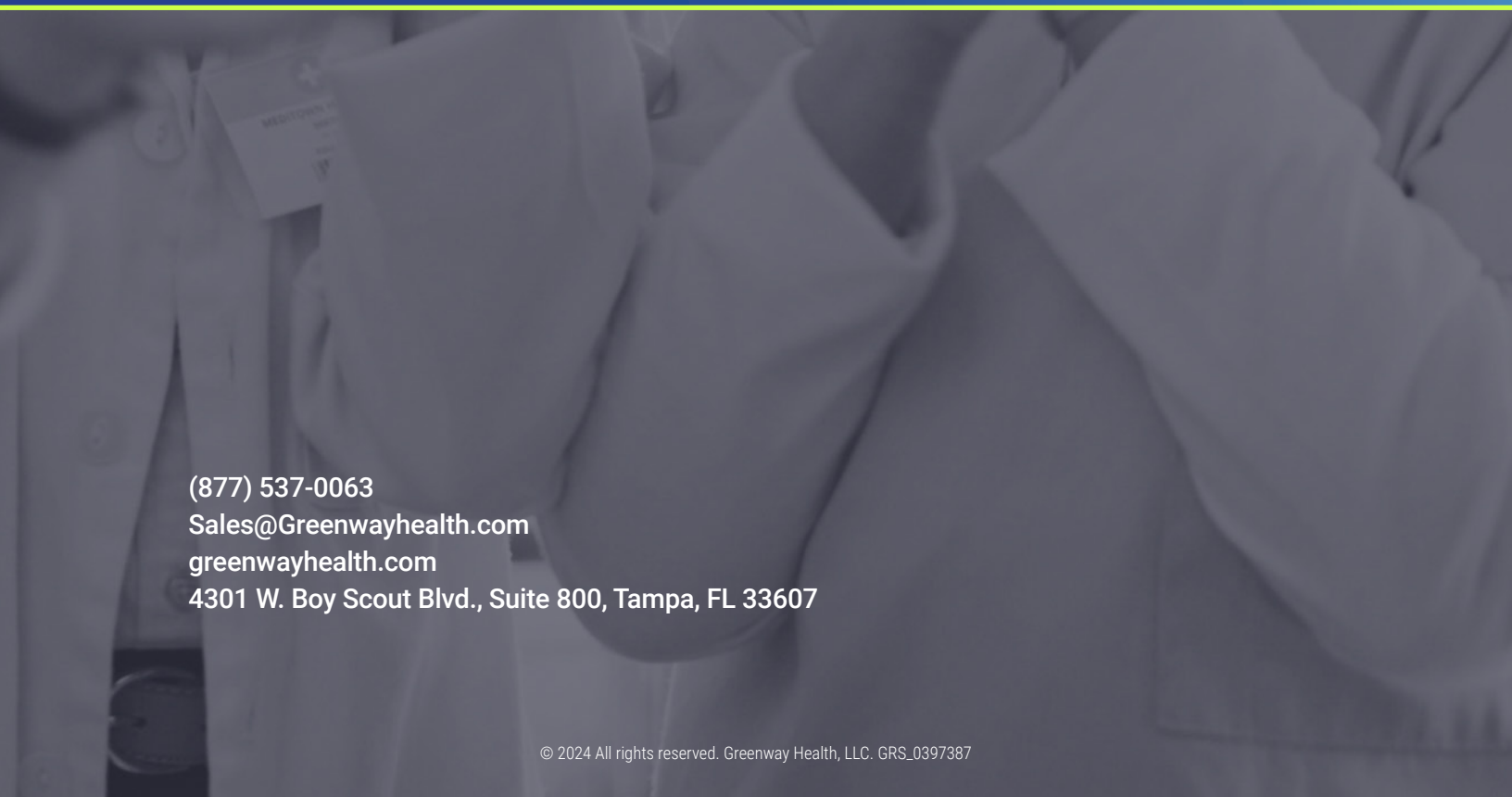
By partnering with Greenway Revenue Services, you can simplify billing, identify new revenue opportunities, and free your staff and providers to focus on patient care. We work with all areas of your practice — front office, clinical, and back office — to help you achieve your financial goals.

BENEFITS OF A GREENWAY REVENUE SERVICES PARTNERSHIP:

- **Collaboration:** Our team integrates with yours, becoming an extension of your practice staff through ongoing communication and transparency through shared technology access. We understand the challenges and billing situations unique to specialties. You will stay on top of your practice financials through weekly and monthly status calls.
- **Experience:** We bring extensive experience both in revenue cycle management and in optimizing billing practice. You will receive continual guidance on best practices, not only for boosting revenue but for improving staff efficiency. We measure key performance indicators and overall financial health on a month-to-month basis to facilitate ongoing improvement.
- **Data analysis:** Data analysis and metric performance are your tools to improve revenue. We examine your practice to identify the causes of revenue cycle frustrations, whether they are codes, internal process issues, or providers. In partnership, we will develop plans to address the issues.
- **A/R follow-up:** Denial management, A/R follow- up, and patient contributions are our expertise. We will work denials and contact payers until we exhaust all options for unpaid claims, plus handle billing queries. By focusing on receiving payments within 30-60 days, you can decrease your days in A/R by an average of 32%.

> *"When partnering with a knowledgeable and dedicated RCM team, you are able to increase your revenue, decrease denials, and focus on other areas of your business."*
>
> — *Kendra Boyd*, Senior Office Manager, Clinical Urology Associates

Greenway Health™ | Now that's better.™



(877) 537-0063
Sales@Greenwayhealth.com
greenwayhealth.com
4301 W. Boy Scout Blvd., Suite 800, Tampa, FL 33607