Agenda

- Overview of The Revenue Cycle
- CCH Revenue Cycle Journey, Successes & Challenges
- Cerner Patient Accounting Project Status
  - Project Governance & Structure
  - Project Critical Path
  - Metrics Review
- Patient Access Status - People, Process, Technology
- Time of Service Status - People, Process, Technology
- Post-Service Status - People, Process, Technology
- Next Steps & Discussion
Overview of The Revenue Cycle
Overview of the Revenue Cycle

- The Healthcare Financial Management Association (HFMA) defines a revenue cycle as “All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.”

- The Revenue Cycle begins with Medical Record / Encounter creation, and ends with Collection / Write-off.

- **3 Critical Divisions** of the Revenue Cycle:
  - **Pre-service** - patient is scheduled and pre-registered for service. The encounter record is generated, and the patient, guarantor, and insurance information is obtained and/or updated as required.
  - **Time-of-service** - for scheduled patients, a final account review is completed prior to the patient’s arrival.
  - **Post-service** - coding claims are prepared and submission payment processing and balance billing is done.
CCH Revenue Cycle Journey, Successes & Challenges
Revenue Cycle Lookback

2008
- MedAssets ‘Rev. Cycle Reengineering’
- IL-Rev. Cycle Cert.
- CPA Kick-Off
- Professional Building (PB) Opened

2009
- Invision Optimization
- Revenue Cycle Initiatives
- CountyWide ERP Implementation (STEP) - IBM

2010
- Lawson ERP Start (ACS) 1/10
- Oak Forest CBO Established 1/12
- Invision Consolidation
- Illinois Early Access CMS 1115 Waiver

2011
- Lawson ERP Live (ACS) 12/12
- Medical Business Associates ‘Charge Capture’
- Medical Business Associates ‘Rev. Cycle’
- öffentlicher Consulting Group

2012
- HMA Corporate Operations Improvement 01/16
- E. Akpan CFO 12/15
- ESM Cleanup LIVE

2013
- Illinois Early Access CMS 1115 Waiver
- CountyCare Establish 7/14
- HMA Corporate Operations Improvement 01/16

2014
- Lawson ERP Live (ACS) 12/12
- Medical Business Associates ‘Charge Capture’
- E. Akpan CFO 12/15
- HMA Corporate Operations Improvement 01/16

2015
- E. Akpan CFO 12/15
- HMA Corporate Operations Improvement 01/16
- Revenue Cycle Initiatives

2016
- E. Akpan CFO 12/15
- HMA Corporate Operations Improvement 01/16
- Revenue Cycle Initiatives

2017
- E. Akpan CFO 12/15
- HMA Corporate Operations Improvement 01/16
- Revenue Cycle Initiatives

2018
- E. Akpan CFO 12/15
- HMA Corporate Operations Improvement 01/16
- Revenue Cycle Initiatives

2019
- E. Akpan CFO 12/15
- HMA Corporate Operations Improvement 01/16
- Revenue Cycle Initiatives

2020
- E. Akpan CFO 12/15
- HMA Corporate Operations Improvement 01/16
- Revenue Cycle Initiatives
The Journey - Successes & Challenges

- Consistent year-over-year growth in gross charges capture a 3% growth to $1.74B in FY2019 from $1.69B in FY2018

- Consistent year-over-year growth in cash collections a 7% growth to $409M in FY2019 from $383M in FY2018

- Sustained growth in Case Mix Index by an average of 6% in FY2019 vs FY2018

- Ongoing Improvements in Initial Claims Denials

- Sustained Improvements in “Allowances for Bad Debt” and bad debt write-offs in FY2018 vs. FY2017 a trend likely to sustain in FY2019 audited reports
Cerner Patient Accounting Project Status
Committee Details & Objectives

Information Technology Steering Committee
• **Committee Chair** – CIO
• **Objective** - Interdisciplinary Executive representation across all IT projects.

Executive Steering Committee
• **Committee Chair** - CIO & CFO
• **Objective** - Executive oversight of Revenue Cycle Program.

HIS Clinical Advisory Counsel
• **Committee Chair** - CMIO
• **Objective** - Clinician only, bidirectional collaboration of IT based initiatives.

Revenue Cycle Action Team
• **Committee Chair** - Finance Project Manager & Financial Alignment Executive
• **Objective** - Execute system-wide revenue cycle initiatives and drive optimization by identifying where opportunities exist, determining best practice, and driving to implement standard process for hospital, outpatient clinics and physician groups.
<table>
<thead>
<tr>
<th>Metric</th>
<th>*HFMA Benchmark</th>
<th>Actual</th>
<th>CCH Target</th>
<th>Description</th>
<th>Current Status</th>
<th>Future Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Collection</td>
<td>N/A</td>
<td>$34.5M</td>
<td>$37M</td>
<td>Gross amount of cash Collected Monthly from CCH Services transmitted to payers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Receivable &gt; 90 Days as a % of</td>
<td>&lt;20%</td>
<td>47%</td>
<td>40%</td>
<td>Accounts Receivable (AR) is the gross dollar amount of patient accounts that have been billed (transmitted) to the payer but not yet paid. (Unpaid Patient bills Transmitted to the payer 90 or more days/Total number of Unpaid patient bills transmitted to the payer=Accounts Receivable% &gt;90 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billed AR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNFB Days</td>
<td>7 Days</td>
<td>8 Days</td>
<td>5 Days</td>
<td>Discharged not Final Billed (DNFB) is a term used to define unbilled accounts where the patient has been discharged and the account is either not coded, or pending charges, service documentation or claim holds to be released into the final billed receivable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or $26.4M</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Late Charges</td>
<td>&lt;2%</td>
<td>12%</td>
<td>7%</td>
<td>CCH has a target to transmit bills to the payer within 5-7 days after the patient’s last service date. Bills transmitted after 5 days are late. (Charges with postdate&gt; than 5 days from the last service date/ Total Gross Charges)= Late Charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total AR to date</td>
<td>Not Applicable</td>
<td>$421.9M</td>
<td>Not Applicable</td>
<td>Accounts Receivable (AR) is the gross amount of patient accounts that have been billed (transmitted) to the payer but not yet paid are classified as receivable.</td>
<td>Not Applicable</td>
<td>TBD</td>
</tr>
<tr>
<td>Accounts Receivable Days (AR Days)</td>
<td>&lt;40 Days</td>
<td>88 Days</td>
<td>60 – 65</td>
<td>The average length of time, in days, that patient accounts are outstanding: billed to the Payer but not yet paid. (Net A/R/ Average Daily Net Patient Service Revenue)=Net A/R Days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>60 Days(non HFMA)</td>
<td>-</td>
<td>60 Days</td>
<td>The number of days that an organization can continue to pay its operating expenses, given the amount of cash available.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Source Healthcare Financial Management Association (HFMA) Key Hospital Statistics and Ratio Margins
Patient Access Status - People, Process, Technology
Pre-Service In Perspective

Engaged Consumer
Ease of Access
Improved Consumer Service
Improved Quality

Engaged Patient
Coordination of Care
Coordinated Financial & Clinical Care
Compliant Clinical Documentation

Satisfied Customer
Appropriate Payment
Effective & Efficient Account Resolution
Decreased Cost to Collect
## The Revenue Cycle Program: **Scheduling**

<table>
<thead>
<tr>
<th>Function</th>
<th>Problem</th>
</tr>
</thead>
</table>
| Patient scheduling ensures appropriate reimbursement and/or significant resource coordination, such as reserving rooms and/or equipment, ordering devices or supplies, and ensuring that professional staff, such as physicians, nurses, and/or technicians are available. Patient Access are ‘First line billers’. | • Lack of Standardization  
• Lack of Accountability  
• Limited Patient Contact!  
• Limited Patient data collection due to established roles and responsibilities  
• Improper system usage - duplicate patients, overbooking. |

<table>
<thead>
<tr>
<th>Process</th>
<th>People</th>
<th>Technology</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Org. structure alignment with Industry Best Practice - scheduling functions across the Health System.</td>
<td>Mary Sajdak / Ekerete Akpan</td>
<td>Scheduling Clerks (Ward Clerks) in Central Scheduling, at all hospital-based clinics, at ambulatory/remote clinics.</td>
<td>n/a</td>
</tr>
<tr>
<td>Job role expansion to mirror Industry best practice including collection of patient demographic and financial data at point of scheduling.</td>
<td>Mary Sajdak / Ekerete Akpan</td>
<td>Scheduling Clerks (Ward Clerks) in Central Scheduling, at all hospital-based clinics, at ambulatory/remote clinics.</td>
<td>n/a</td>
</tr>
<tr>
<td>System-wide process standardization, with checkpoints and accountability structure.</td>
<td>Dr. Robert Sumter</td>
<td>Scheduling Clerks (Ward Clerks) in Central Scheduling, at all hospital-based clinics, at ambulatory/remote clinics.</td>
<td>Cerner Scheduling Appointment Type Cleanup (primary &amp; specialty care)</td>
</tr>
<tr>
<td>Process improvement during patient scheduling (i.e. CCH does not adequately contact patient during scheduling process to confirm appointment).</td>
<td></td>
<td>Scheduling Clerks (Ward Clerks) in Central Scheduling.</td>
<td>Luma Health Patient Reminder System</td>
</tr>
</tbody>
</table>
The Revenue Cycle Program: **Scheduling**

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</table>
| Patient scheduling ensures appropriate reimbursement and/or significant  | • Lack of Standardization
| resource coordination, such as reserving rooms and/or equipment, ordering  | • Lack of Accountability
| devices or supplies, and ensuring that professional staff, such as physicians, | • Limited Patient data collection due to established roles and responsibilities
| nurses, and/or technicians are available. Patient Access are ‘First line billers’. | • Improper system usage - duplicate patients, overbooking.             |

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</thead>
<tbody>
<tr>
<td>Process improvement to reschedule patients with insufficient financial</td>
<td>Scheduling Clerks (Ward Clerks) in Central Scheduling, at all hospital-based clinics, at ambulatory/remote clinics.</td>
<td>Cerner Discern Analytics Reports (identifying patients prior to arrival), Revenue Integrity</td>
<td>CCH must create a policy and procedure to incorporate into pre-service activity. CCH has drafted a policy.</td>
</tr>
<tr>
<td>verification/certification prior to visit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process improvement to provide Advance Beneficiary Notice during</td>
<td>Scheduling Clerks (Ward Clerks) in Central Scheduling, at all hospital-based clinics, at ambulatory/remote clinics.</td>
<td>Cerner Medical Necessity</td>
<td>CCH must create a policy and procedure to incorporate into pre-service activity.</td>
</tr>
<tr>
<td>pre-service activity, ensuring Medicare patient aware of non-covered service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proper patient identification at point of scheduling to avoid duplicate record creation (i.e. search existing person record through model system usage).</td>
<td>Scheduling Clerks HIM</td>
<td>Cerner Enterprise Master Patient Index Cleanup, Scheduling Flex Forms</td>
<td>6M people records removed, in agreement with HIM, Compliance, &amp; Legal.</td>
</tr>
<tr>
<td>Patient self scheduling via online portal.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## The Revenue Cycle Program: **Pre-Registration**

### Function

Pre-Registration is a pre-service activity meant to collect, validate, or complete information such as Insurance Verification, MSP screening, Medical Necessity check, managed care requirement resolution, and financial education & assistance resolution. Target of 98% pre-registration rate. Patient Access are ‘First line billers’.

### Problem

- Limited staff
- Due to poor data collection upstream, inability to always complete full pre-registration.

### Process

<table>
<thead>
<tr>
<th>Process</th>
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<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Verification through Batch Eligibility workflow, ensuring member status active with payor.</td>
<td>Ekerete Akpan / Mary Sajdak</td>
<td>Dr. Robert Sumter</td>
<td>Project in design &amp; build phase, targeted go-live of 3/31.</td>
</tr>
<tr>
<td>Determination &amp; communication of patient out-of-pocket liability including deductibles, co-pays, and co-insurance.</td>
<td>Pre-Registration Clerks</td>
<td>Cerner Premium Eligibility</td>
<td>Project in design &amp; build phase, targeted go-live of 3/31. Process will need to be determined to review how patient liability will be calculated and payment will be collected - integrated discussion with time-of-service collection.</td>
</tr>
<tr>
<td>Staffing analysis and expansion of Pre-Registration team scope.</td>
<td>Pre-Registration Clerks</td>
<td></td>
<td>Slotting activity, not yet in progress.</td>
</tr>
<tr>
<td>Process Improvement to handle Out-of-Network patients, determining financial liability and routing to Financial Counseling for non-essential care.</td>
<td>Pre-Registration Clerks Financial Counseling Registration Clerks (Clerk V) Integrated Care - Managed Care</td>
<td>n/a</td>
<td>Identified Out-of-Network volumes, drafted Out-of-Network policy. Will review process, communicate and educate for addressing patients with Out-of-Network coverage. Will work with Managed Care group to evaluate contracting with payors.</td>
</tr>
</tbody>
</table>
The Revenue Cycle Program: **Pre-Certification (Authorization)**

<table>
<thead>
<tr>
<th>Process</th>
<th>People</th>
<th>Technology</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orders-to-scheduling &amp; proper Pre-Registration (Phase 1 &amp; Phase 2)</td>
<td>Ordering Physicians</td>
<td>Cerner Registration (specific conversation) / Prior Authorization Worklist</td>
<td>Streamlining work effort for Prior Authorization team, ensuring proper upstream processes necessary. Phase 1 &amp; 2 includes Sleep Lab, Rehab, Cardiology, Radiology.</td>
</tr>
<tr>
<td></td>
<td>Scheduling Clerks (Ward Clerks) Per-Registration Team Managed Care Prior Auth</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Managed Care Prior Auth</td>
<td>Prior Authorization Worklist / CAMM</td>
<td>Providing CAMM to Prior Auth team, will evaluate workflow for Payors requiring image as part of submitted data.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Engaging Cerner for an Oncology based gap analysis of existing PowerPlans and integration with Orders-to-scheduling.</td>
</tr>
<tr>
<td>Orders-to-scheduling &amp; proper Pre-Registration (Phase 3)</td>
<td>Ordering Physicians</td>
<td>Cerner Registration (specific conversation) / Prior Authorization Worklist / Cerner Oncology PowerPlans</td>
<td>Project slotted. Phase 4 includes Pain.</td>
</tr>
<tr>
<td></td>
<td>Scheduling Clerks (Ward Clerks) Per-Registration Team Managed Care Prior Auth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orders-to-scheduling &amp; proper Pre-Registration (Phase 4)</td>
<td>Ordering Physicians</td>
<td>Cerner Registration (specific conversation) / Prior Authorization Worklist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scheduling Clerks (Ward Clerks) Per-Registration Team Managed Care Prior Auth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pre-certification is a pre-service activity in which a dedicated team (normally clinical in function) works with Managed care plans to ensure there are agreements and those agreements (payer specific criteria for treatment) have are satisfied.

- Limited staff
- Lengthy & complex requirements to complete Prior Authorization
- Deficits in upstream data collection often require

Function
- Problem

<table>
<thead>
<tr>
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<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Claudia Fegan / Mary Sajdak</td>
<td>Dr. Fegan / Ekerete Akpan / Mary Sajdak</td>
<td>Dr. Robert Sumter</td>
<td></td>
</tr>
</tbody>
</table>

Orders-to-scheduling & proper Pre-Registration (Phase 1 & Phase 2) will ensure all required patient financial data is captured for prior auth req's.

Ophth. & OMFS Image viewing access for Prior Auth submission.

Orders-to-scheduling & proper Pre-Registration (Phase 3) will ensure all required patient financial data is captured for prior auth req's.

Orders-to-scheduling & proper Pre-Registration (Phase 4) will ensure all required patient financial data is captured for prior auth req's.
Time of Service Status - People, Process, Technology
Time-of-Service In Perspective
The Revenue Cycle Program: **Patient Arrival, Validation & Activation**

<table>
<thead>
<tr>
<th>Function</th>
<th>Problem</th>
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</tr>
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<tbody>
<tr>
<td>Registration is a time-of-service activity and the final checkpoint in which all patient information is captured and confirmed prior to providing service for scheduled patients, and the process to complete full-registration for unscheduled patients.</td>
<td>• Inaccurate data selection, collection &amp; verification of patient information.</td>
<td>• Limited adherence to required financial collection.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process</th>
<th>People</th>
<th>Technology</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ekerete Akpan</td>
<td>Ekerete Akpan</td>
<td>Dr. Robert Sumter</td>
<td>Process and people not yet addressed, waiting on org. structure alignment and associated contractual discussions.</td>
</tr>
</tbody>
</table>

- **Org. structure alignment** with Industry Best Practice - scheduling functions across the Health System report to Finance.
- **System-wide process standardization**, with checkpoints and accountability structure.
- **Registration Process standardization** across entire health system with checkpoints and accountability structure.
- **Patient check-in & verification at time of arrival** via self check-in, biometric tools.

- **Registration Clerks** (Clerk V) in acute setting, all hospital-based clinics, and ambulatory/remote clinics.
- **Registration Clerks** (Clerk V) in acute setting, all hospital-based clinics, and ambulatory/remote clinics.
- **Registration Clerks** (Clerk V) in acute setting, all hospital-based clinics, and ambulatory/remote clinics.
- **Registration Clerks** (Clerk V) in acute setting, all hospital-based clinics, and ambulatory/remote clinics.

- **Cerner Patient ID in Banner Bar**
- **Patient Kiosk Expansion & Imprivata Palm Vein Scanner**

- n/a
- n/a
- Live at Core, scheduled rollout across system wide clinics.
- Awaiting commitment on policy of patient identification capture and inclusion in patient’s chart. CCH will move forward with capturing Patient Image and posting to Patient Chart. Implementation will need to include education, communication, and process review at check-in.
# The Revenue Cycle Program: **Patient Arrival, Validation & Activation**

## Function

Registration is a time-of-service activity and the final checkpoint in which all patient information is captured and confirmed prior to providing service for scheduled patients, and the process to complete full-registration for unscheduled patients.

<table>
<thead>
<tr>
<th>Function</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration</td>
<td>• Inaccurate data selection, collection &amp; verification of patient information.</td>
</tr>
<tr>
<td></td>
<td>• Limited adherence to required financial collection.</td>
</tr>
</tbody>
</table>

## Process

### People

- Ekerete Akpan
- Ekerete Akpan
- Dr. Robert Sumter

### Technology

- Imprivata Kiosk / Credit Card Processing Vendor

### Status

- Evaluating tools for implementation, and will slot project once vendors selected.

## People

- **Registration Clerks (Clerk V)** in acute setting, all hospital-based clinics, and ambulatory/remote clinics.

## Technology

- Imprivata Kiosk / Credit Card Processing Vendor

## Status

- Evaluating tools for implementation, and will slot project once vendors selected.
The Revenue Cycle Program: **Documentation & Revenue Recognition**

<table>
<thead>
<tr>
<th>Function</th>
<th>Problem</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Clinical documentation is a time-of-service activity which includes the processes required to accurately capture the services rendered through use of the Electronic Medical Record. Revenue Recognition is triggered through key selection points within the Electronic Medical Record.</td>
<td>• Timely documentation completion. • Complete documentation</td>
<td>Multiphase project beginning at the point of physician order entry - live in Lab, 2/24 in Cardio &amp; Rad, 3/24 in Rehab.</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td><strong>People</strong></td>
<td><strong>Technology</strong></td>
</tr>
<tr>
<td>Order-based Medical Necessity checking and ABN discussion at time of order between Physician and Patient.</td>
<td>Dr. Claudia Fegan / Mary Sajdak</td>
<td>Ordering Physicians</td>
</tr>
<tr>
<td>Clinic Manager roles and responsibilities expansion to include Charge Reconciliation and revenue/cost monitoring.</td>
<td>Dr. Fegan / Ekerete Akpan / Mary Sajdak</td>
<td>Clinic Managers Providers (all physicians)</td>
</tr>
<tr>
<td>Infusion specific data including start &amp; stop time, dose, etc.</td>
<td>Dr. Robert Sumter</td>
<td>Cerner Medical Necessity</td>
</tr>
<tr>
<td>Provider clinical E&amp;M documentation specific to Evaluation and Management for Outpatient Visits.</td>
<td>Ordering Physicians</td>
<td>Revenue Integrity Initiative</td>
</tr>
<tr>
<td></td>
<td>Clinic Managers Providers (all physicians)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cerner Medical Necessity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revenue Integrity Initiative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinic Manager needing to be hired/staffed in order to initiate Pilot project. Executive leadership team authorized kick-off.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>End User Training in progress with targeted go-live on 3/24.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project is currently on hold</td>
<td></td>
</tr>
</tbody>
</table>
### The Revenue Cycle Program: Documentation & Revenue Recognition

**Function**

Clinical documentation is a time-of-service activity which includes the processes required to accurately capture the services rendered through use of the Electronic Medical Record. Revenue Recognition is triggered through key selection points within the Electronic Medical Record.

**Problem**

- Timely documentation completion.
- Complete documentation
- Charge reconciliation processes not in place to support monitoring activity.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Dr. Claudia Fegan / Mary Sajdak</td>
<td>Dr. Fegan / Ekerete Akpan / Mary Sajdak</td>
<td>Dr. Robert Sumter</td>
<td></td>
</tr>
<tr>
<td><strong>Provider clinical surgical documentation</strong> specific to Surgical procedures.</td>
<td>Perioperative Physicians</td>
<td>Surgical CAPD (Vincari)</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Clinical Documentation Improvement</strong> initiative to address Physician doc. deficiencies.</td>
<td>Documenting Providers</td>
<td>Iodine</td>
<td></td>
</tr>
</tbody>
</table>

- Establishing business case to garner project authorization and slotting timeline / resources.
- Continued engagement with Iodine and establishment of CDI department under guise of Health Information Management team.
Post-Service Status - People, Process, Technology
Post-Service In Perspective

Pre-Service

- Insurance Verification
- Pre Registration
- Financial Counseling
- Scheduling
- Pre Certification
- Price Estimation
- Patient Arrival
- Patient Care Delivery
- Financial Clearance
- Validation & Activation

Time-of-Service

- Engaged Patient
- Coordination of Care
- Coordinated Financial & Clinical Care
- Compliant Clinical Documentation
- Cashiering
- Patient Experience
- Standard Work
- Resources
- Culture
- Technology
- People

Post-Service

- Payer Payment Analysis
- Third-Party Follow Up
- Remittance Processing
- Claim Processing
- Case Referral Management
- Collection Agency
- Customer Experience
- Standard Work
- Resources
- Culture
- People

Engaged Consumer
- Ease of Access
- Improved Consumer Service
- Improved Quality

Satisfied Customer
- Appropriate Payment
- Effective & Efficient Account Resolution
- Decreased Cost to Collect
The Revenue Cycle Program: **Claim & Remit Processing, Denials Mgmt**

<table>
<thead>
<tr>
<th>Function</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim &amp; remit processing includes all activities required to send a request for payment to a third-party payer for payment of benefits under an insurance policy, and the consequential review &amp; balancing of payor payments. Denials Management includes activity to retro/proactively address claims issues.</td>
<td>• Poor data collection upstream resulting in poor clean claim rate, increased claims edits, and time spent working edits.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
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<tbody>
<tr>
<td>Function</td>
<td>Problem</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process</th>
<th>People</th>
<th>Technology</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ekerete Akpan</td>
<td>Ekerete Akpan</td>
<td>Dr. Robert Sumter</td>
<td></td>
</tr>
<tr>
<td><strong>Claim submission</strong> &amp; residual edits review/work for payor consumption/review and remit.</td>
<td><strong>Patient Financial Services</strong></td>
<td><strong>Artificial Intelligence Claims Processor / Cerner Patient Accounting</strong></td>
<td>Contracting, waiting on Purchasing to contact selected vendor. Cerner will work with AI vendor to determine technical specifics and begin reviewing integration for functional testing.</td>
</tr>
<tr>
<td><strong>Certify Health System for Medicare/Medicaid Behavioral Health services</strong> to grant ability to submit and receive payment for services rendered.</td>
<td><strong>Integrated Care / Managed Care</strong></td>
<td><strong>Behavioral Health Certification</strong></td>
<td>Completed, analyzing collections &amp; denials</td>
</tr>
<tr>
<td><strong>Certify Health System for Public Health Behavioral Health services</strong> to grant ability to submit and receive payment for services rendered.</td>
<td><strong>Integrated Care / Managed Care</strong></td>
<td><strong>Behavioral Health Certification</strong></td>
<td>Completed, analyzing collections &amp; denials</td>
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The Revenue Cycle Program: **Claim & Remit Processing, Denials Mgmt**

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<td>Claim &amp; remit processing includes all activities required to send a request for payment to a third-party payer for payment of benefits under an insurance policy, and the consequential review &amp; balancing of payor payments. Denials Management includes activity to retro/proactively address claims issues.</td>
<td>• Poor data collection upstream resulting in poor clean claim rate, increased claims edits, and time spent working edits.</td>
<td>• RARC / CARC codes providing limited detail</td>
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<td>CountyCare denial analysis to evaluate RARC / CARC codes to address existing edits and denials while implementing proactive measures for future submission.</td>
<td></td>
<td>Evolent (County Care Claims processor) &amp; CCH are analyzing 15,000 denied claims totaling $22 million. 1,600 outpatient accounts valued at $1 Million have been found to overstate A/R as the additional charges <em>will not</em> be reimbursed in these ‘split bill accounts’ since the encounter rate has been paid.</td>
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### Function Breakdown

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<td>Dr. Robert Sumter</td>
<td>CountyCare denial analysis to evaluate RARC / CARC codes to address existing edits and denials while implementing proactive measures for future submission.</td>
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**People**

- **Ekerete Akpan**
- **Dr. Robert Sumter**

**Technology**

- **Invision**
### The Revenue Cycle Program: **Payer Payment Analysis**

**Function**

Payer Payment Analysis includes the ongoing review of payments to manage terms of existing payor agreements while at the same time identifying patient demographics and insurance marketplace for expanding contractual agreements.

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<td>• No Contract Management solution in place today.</td>
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<td></td>
</tr>
<tr>
<td>Managed Care contractual variance monitoring and reporting for identifying short pay.</td>
<td>Managed Care Contract Specialists</td>
<td>Cerner Contract Management</td>
<td>Tested using actual 837/835’s; rate sheets built reflect expected reimbursement amounts, balancing accurately for IL Medicaid/Medicare.</td>
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Next Steps & Discussion
• **Background:** Cook County Health awarded Contract #H18-0042 to [Optum for a Charge Master assessment, a Charge Capture Audit and Charge Master Software](#) that allows for internal review and maintenance of the hospital Corporate Charge Master (facility and professional fees). Maintenance software allows a consistent review of coding and billing elements which are necessary for compliance with Medicare regulations, as well as optimization of revenue and timely reimbursement.

• **Purpose:** Intended to identify charging deficiencies for improved Charge Capture, Revenue Recognition & Increased Reimbursement.

• **Scope:**
  • CDM Assessment - review of CPT/HCPCS, Modifiers, Revenue Codes, Pricing, etc.
  • Charge Capture Audit (Chart to Bill) - audit of 100 claims (20 Inpatient & 80 Outpatient).
  • Enterprise Charger Master Expert (eCME) - software for continued analysis & maintenance.
What to Expect by March 20th

1. Kick-off of Revenue Integrity program
2. Kick-off of Integration with Artificial Intelligence (AI) Claims Processing vendor
3. Medical Necessity Phase 2 Go-Live
4. Prior Authorization Phase 2 Go-Live
5. Premium Eligibility Testing Completed
Questions?