

HOST PREP GUIDE

Setting Up a Revenue Cycle Engine for Success

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HCRS | Certified

Not audience slides. This is a host-facing brief to shape the arc, keep the conversation practical, and create a clean bridge into HCRS certification.

The core thesis

Revenue cycle success is an operating system, not a billing task.

A clean claim is usually won or lost before the claim is ever submitted.

What the audience should understand by the end

- Billing is the final checkpoint, not the whole revenue cycle.
- Revenue leakage usually starts with weak intake, eligibility, authorization, EVV, documentation, or payer setup.
- An agency needs controls, rhythm, ownership, and trained judgment—not just software.
- HCRS exists to build the person-level competency behind that engine.



**ENGINE
MINDSET**

The revenue cycle engine

A practical map Miriam can keep in front of her during the conversation.



Every stage asks the same practical thing: can this claim be paid cleanly for this member, service, payer, and date?

Julio's anchor line

“You do not fix revenue cycle at claim submission. You fix it by controlling the inputs before billing.”

The hidden failure pattern

Most agencies do not have a revenue problem first. They have a control problem.

REACTIVE PATTERN

- Claim is denied, then someone chases it.
- Payer issue becomes a vendor ticket.
- Owner discovers cash problems late.
- Rules live in one person's memory.
- The same preventable errors repeat.

ENGINE PATTERN

- Exceptions are caught before billing.
- HOLD and READY are explicit states.
- Denials feed process improvement.
- Ownership is visible by stage.
- The system survives staff turnover.

Podcast movement

Move from symptom chasing → control design → trained operator judgment.

Conversation arc: start with the problem

The opening should feel practical, not promotional.

Opening frame

Home care agencies often call it a billing problem only after revenue is already stuck.

- Define revenue cycle engine in plain language.
- Separate billing activity from revenue operations.
- Show why Medicaid HCBS/LTSS creates special complexity.
- Make the pain recognizable: denials, delayed cash, vendor dependence, and key-person risk.
- Do not open with HCRS; open with the operating gap HCRS was built to solve.

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PROBLEM
FRAME

Conversation arc: build the clean claim upstream

The strongest middle section is a walk-through of what must be true before billing.

- Eligibility** — Member active for the dates of service; payer and program match.
- Authorization** — Units, date span, service code, limits, and MCO lane are controlled.
- EVV / visit** — Visits reconcile cleanly to the service actually billed.
- Documentation** — Record supports the service, time, and care delivered.
- Payer setup** — Provider, contract, portal, clearinghouse, and claim path are right.
- Code / modifier** — Billing format matches payer rules and state program requirements.

If these controls live only in someone's head, the agency does not have an engine. It has a dependency.

Conversation arc: add rhythm, ownership, and metrics

The engine has to be managed on a cadence, or it degrades.

Daily

- Exception queue
- Eligibility holds
- EVV mismatches
- Missing documentation
- Payer edits

Weekly

- Denial patterns
- A/R aging by payer
- Stuck claims
- Recovery work
- Training needs

Monthly

- Trend review
- Policy/payer changes
- Control updates
- Staff coverage
- Revenue at risk

Useful metrics to mention

clean-claim rate • denial rate • A/R by payer • recovery time • revenue at risk • preventable error categories

What breaks as agencies scale

The weak spots are survivable at low volume, then expensive at scale.

More payers	Different edits, portals, authorization behavior, and denial patterns.
More states	Different program authority, waiver language, MCO lanes, aggregators, and enrollment rules.
More staff	More handoffs, more variation, and more places for tribal knowledge to fail.
More vendors	More tools and tickets, but not necessarily more internal judgment.
More volume	Small error rates become large cash-flow consequences.

Scale exposes the system.

Not just the biller.

The natural bridge to HCRS

HCRS is the competency system behind the revenue cycle engine.

Software can route the work. A trained operator has to know what is right, what is wrong, and what to hold.

- National Core** — Common revenue operations foundation across Medicaid home care.
- State Module** — State-specific authority, payer lanes, claim paths, volatility, and operating risks.
- Applied Work** — Scenario-based exercises that force judgment, not memorization.
- Certification** — A visible standard for the person responsible for the engine.

**HCRS
Certified**

Position HCRS as the practical answer to a capability gap, not as another training product.

CLOSING POSITION

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The practical next step

- 1 Map the engine** Where does revenue get stuck before billing?
- 2 Identify the failure points** Eligibility, authorization, EVV, documentation, payer setup, claim path, or remittance learning.
- 3 Put trained ownership against it** Someone has to know the rules, operate the controls, and improve the system.
- 4 Use HCRS to build that capability** National core + state module + applied work + certification.

Clean close: “HCRS exists so agencies are not relying on tribal knowledge, vendor tickets, or after-the-fact denial chasing to protect Medicaid revenue.”