AAIHDS:
Fall Managed Care Forum

Improving Operational Performance in a Managed Care Environment

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Presentation Objectives

- To identify and analyze relative strengths and weaknesses of hospital operations pertaining to managed care information
- To identify opportunities for process standardization to increase operating efficiency and minimize billing delays/denials
- To develop protocols for monitoring the flow of managed care information
- To describe the role of physicians in the hospital's revenue cycle and present strategies to involve physicians in improving revenue cycle efficiency
- To improve management reporting and evaluation of operational performance
- To encourage appropriate information sharing among those departments impacted by the hospital's managed care operations

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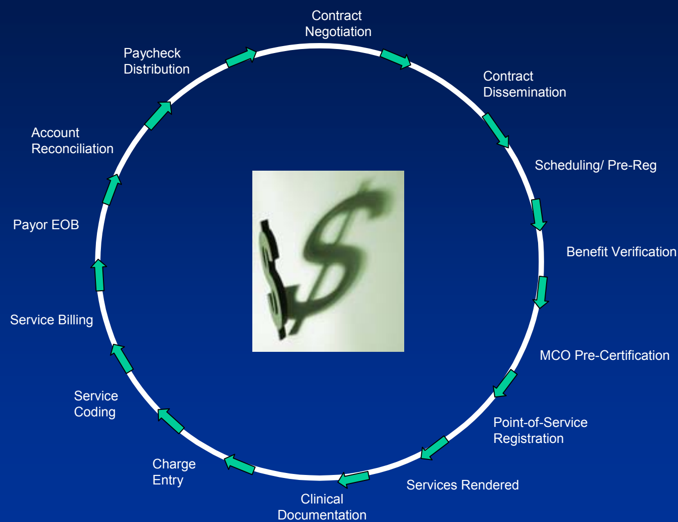

Strategies Used by MCOs to Reduce Hospital Expenditures

- Step-down care
- Utilization management
- Service carve-outs
- Risk transfer
- Health promotion
- Disease management
- Aggressive claim review/denials
- Managed care contract obligations

Result: Loss of revenue and impeded cash flow

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Reasons for Claim Denials (Partial List)

- Member not eligible
- Not a covered service
- Failure to obtain authorization
- Expired authorization
- Not medically necessary
- Delay in treatment
- Inappropriate level of care
- Untimely filing of claim
- Procedure does not match diagnosis
- HACs and POA conditions

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Managerial "Postures"

- Reactive
- Adaptive
- ***Proactive***

Prevention is the best strategy to maximize the revenue cycle.

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Burdensome Managed Care Contract Obligations

Language included in contracts and provider manuals has a direct effect upon key department operations; therefore, contracts/abstracts must be routed to appropriate parties (prior to and after contract execution) so that they may adjust their processes to conform with managed care contractual obligations or suggest contract modifications during contract negotiations/re-negotiations.

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Provider and Payor Operational Weaknesses

Typical **provider** weaknesses:

- Poor inter-departmental communication
- Slow response to web-based tools
- No centralized managed care function
- Costly medical supplies (e.g., defibrillators) are not tracked separately
- Limited tracking of product-line and contract performance
- Weak mechanisms to identify “silent discounting”
- Inability to hold payors accountable for late payments
- Limited ability to follow-up on open accounts and to track claims denials
- Limited ability to collect “self-pay” accounts
- Limited ability to control physician behavior

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Provider and Payor Operational Weaknesses (Continued)

Typical **payor** weaknesses:

- Limited claim payment systems
- Poor response to pre-authorization requests
- Poor communication of alternative level of care criteria
- Limited ability to control physician behavior
- Many still pay the physician when the hospital is denied
- UM system is not always integrated with the claim payment system

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Other Factors Influencing Revenue Maximization

- Automated proration
- Billing for implantables
- Billing for new technology
- Tracking of outpatient claims (including ER)
- Proper billing for Medicare/Medicaid managed care
- Front-end financial counseling and cash collection

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A Proactive Multidisciplinary Approach (Managed Care Functional Matrix)

Departments whose processes are affected by managed care obligations and whose processes impact the revenue cycle include:

- Registration areas
- Nursing case management
- Social services
- Medical staff
- Medical records
- Patient accounts
- Finance
- Quality/utilization management
- Management information systems
- Managed care (if present)

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Functional Managed Care Matrix

Functions	Senior Management	Managed Care	UM/QA	Nursing/Case Management	Social Services	Medical Records	Behavioral Health	Finance	Patient Registration	Patient Accounts	Information Systems	Medical Staff/IPA
Managed Care Policy Development												
Strategic Policy	X	XX						X				X
Financial Policy	X	X						XX				X
Managed Care Contracting												
Contract Negotiation		XX						X				X
Contract Administration		XX	X	X	X	X		X	X	X	X	X
Pre-Authorizations												
Internal			X						XX			X
External			X						XX			X
Eligibility/Insurance Verification									XX	X		
Patient Care			X	X			X					XX
Concurrent Review												
Chart Reviews				XX			X					
Physician Review			XX									
MCO Interface				XX			X					
Continued Stay Requests			X	XX			X					
Concurrent Coding				XX		X	X					
Clinical Pathways												
Development			X	XX	X		X				X	X
Administration			X	XX	X		X				X	
Monitoring and Compliance			X	XX	X		X					X
Discharge Planning			X	XX			X					X

Note: XX indicates lead responsibility (i.e., accountable departments)

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Functional Managed Care Matrix (Continued)

Functions	Senior Management	Managed Care	UM/QA	Nursing/Case Management	Social Services	Medical Records	Behavioral Health	Finance	Patient Registration	Patient Accounts	Information Systems	Medical Staff/IPA
Discharge Placement					XX		X					X
Retrospective Review												
Chart Reviews			XX			X	X					
Physician Review			XX									X
MCO Interface			XX				X					
Patient Billing/Accounting						X			X	XX	X	
Government Claim Appeals			XX	X		X	X			X		X
Commercial Claim Appeals			XX	X		X	X			X		X
Management Reporting		X	X	X		X		X		X	XX	
Physician Feedback/Education		X	XX	X							X	X
Physician Credentialing		X	X									XX
Regulatory Compliance	XX	X	X					X		X	X	X
Performance Monitoring & Control												
Program Performance	X	X					X					
MCO Contract Performance			X				X	XX		X	X	X
Quality Improvement Interface	X		XX	X			X				X	X

Note: XX indicates lead responsibility (i.e., accountable departments)

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Key Assessment Points

- Training
- Managed care contract administration
- Policies and procedures
- Level of automation
- Management reports/exception reports
- Inter-departmental linkages
- Staffing

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Staffing Recap – by Account Volume

Average FTEs involved in the receivables management function .... 29 FTEs (national average)

Business office (exclude admissions/registrations) .... 1 FTE for every 3,371 open accounts

Inpatient accounts .... 1 FTE for every 199 accounts

Outpatient accounts .... 1 FTE for every 1,729 accounts

Emergency room accounts… 1 FTE for every 408 emergency room accounts

Billers .... 1 FTE for every 3,340 claims billed per month

Collectors .... 1 FTE for every 9,708 accounts

Report on Fourth Quarter 2007, HARA Volume XXII, Number 1

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Registration: Inpatient, Outpatient, Emergency, Ambulatory Surgery

- Mechanisms for assuring accuracy and completeness of information
- Data entry error tracking and control
- Pre-authorization procedures
- Compliance with managed care notification requirements
- Referral documentation procedures
- Triage mechanisms
- Insurance verification
- Financial counseling/cash collections
- Pre-visit registration

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Nursing Case Management (if integrated with Utilization Management)

- Coordination of managed care concurrent and retrospective review activities
- Coordination concerning medical necessity disputes
- Identification and resolution of treatment delays
- Use and implementation of clinical pathways
- Resource consumption oversight
- Discharge planning
- Notice of non-coverage

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Social Services

- Specification of goal lengths-of-stay
- Discharge placement and coordination
- Consistency of discharge protocols
- Monitoring of post-discharge services
- Extended stay for social reasons

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Medical Staff/Medical Affairs Physician's Role in the Revenue Cycle

Physicians are drivers of a hospital's revenue cycle

- Admissions and inpatient services
- Utilization of outpatient services
- Work with hospital in planning/implementing new services/ technology
- Can take away utilization (e.g., ambulatory surgery redirected to ambulatory surgery centers and physician offices)

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Medical Staff/Medical Affairs Physician's Role in the Revenue Cycle (Continued)

Physicians need to work with hospitals to maximize revenue through:

- OR and service scheduling
- Following hospital admission criteria
- Preauthorization/authorization of admissions and services
- Concurrent review, as needed
- Timely inpatient consults, testing
- Discharge planning

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Medical Staff/Medical Affairs Physician's Role in the Revenue Cycle (Continued)

Physicians need to work with hospitals to maximize revenue through:

- Length-of-stay
- Denial management
- Denial appeals, as needed
- Timely chart completion
- Documentation

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Medical Staff/Medical Affairs Physician's Role in the Revenue Cycle (Continued)

Hospital strategies to involve physicians in improving revenue cycle efficiency

- Physician education regarding hospital revenue cycle (QA Committee)
- Communication and education for physician's office staff
- Physician representation in revenue cycle committee, inpatient denials committee (i.e., Medical Director participation, at a minimum)
- Feedback to physicians

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Revenue Cycle
Specific Recommendations for Physicians

- Request payor information during scheduling
- Confirm eligibility and payor requirements for scheduled patients
- Collect patient financial responsibility at registration/ time of service
- Review and update chargemaster annually
- Track and manage A/R; formalize write-off policy
- Confirm payments, follow-up on underpayments; appeal denials
- Renegotiate payors' rates annually

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Medical Records

- Processing/prioritizing of requests for medical records
- Chart tracking mechanisms
- Discharged Not Final Billed
- Coding accuracy controls
- Interface with MCOs
- Physician education

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Patient Accounts

- Tracking of denied/delayed payments by payor, reasons, product, hospital service area
- Integration of authorization numbers into billing process
- Third-party requests for information
- Billing cycle “bottlenecks” (bill holds)
- Managed care payment reconciliations
- Charge capture process
- Claim edits/submission (feedback to registration)
- Payment posting
- Account worklists

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Patient Accounts
What’s In the Accounts Receivable?

- Charges vs. contracted rates
- Unbilled
  - Claims edits
- Pended
  - Requires additional information
- Denials: Status should be to
  - Appeal
  - Write-off
  - Submit to secondary payor (including self-pay)
- No payment/partial payment
  - Unpaid claims
  - Lower than expected payment
  - Unpaid patient portion

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Finance

- Cost accounting procedures
- Determination of operating margins, cost variances, and other financial performance indicators
- Managed care pricing methodologies
- Charge Description Master (CDM) maintenance

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Quality & Utilization Management

- Coordination of managed care concurrent and retrospective activities
- Coordination concerning all claim disputes (medical necessity and administrative denial)
- Tracking of UM agreement with MCO denials
- Interface with managed care organizations
- Clinical pathways
- Discharge planning
- Concurrent review
- Resource consumption oversight along with nursing case management
- Outsourcing options

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Management Information Systems

- Role in managed care contract management
- Database development and maintenance
- Management report development and production (based on end-user specifications)
- HIPAA compliance
- Systems interface management

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Managed Care

- Managed care education
- Central coordination of contract negotiation/ administration
- Interface with physician delivery system
- Monitoring of overall contract performance
- Ensuring information flow of administrative requirements of MCO agreements
- Tracking of contract issues by HMO for use in contract negotiations/complaint resolution

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Creating Departmental Accountability

- Complete a self assessment
- Develop a prioritized set of recommendations and a concise implementation agenda
- Develop an inter-departmental managed care operations committee to oversee implementation – meet regularly
- Develop accountabilities by department
- Develop/revise policies and procedures by department
- Develop an information management process and system to support departmental accountabilities (Key Performance Indicators)
- Create employee performance incentives with operational standards for employee evaluation

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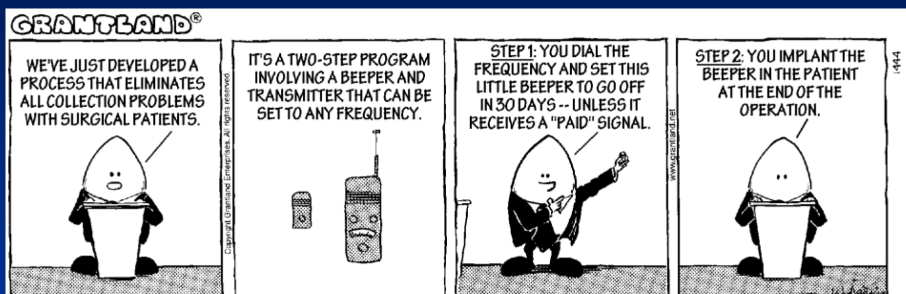

Key Performance Indicators for the Revenue Cycle

Develop indicators by function:

- Scheduling (100% for hi-$ outpatient diagnostics)
- Pre-registration (of scheduled patients ≥ 98%)
- Pre-authorization (100% of required authorizations)
- Financial counseling (collect ≥ 65% of IP self-pay balances prior to discharge)
- Health information management (23-26 IP charts coded per coder per day)
- Third party and guarantor follow-up (bad debt write-offs ≤ 3% of gross revenue)
- Denials (40%-60% overturn rate)

Key Performance Indicators from Healthcare Financial Management Association (HFMA)

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Formulas for Success

Improved Hospital Operations + Tight Contract Language = 1 – 3% Administrative Denials

Improved Hospital Operations + Intense Physician Education + Tight Resource Consumption = 2 – 4% Medical Necessity Denials

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Desired Outcomes: Improved Revenue Streams

- Improved MCO relations
- Improved operational productivity
- Reduced administrative costs associated with managed care contracts
- Improved ATB and cash flow
- Financial information for contract negotiations
- Billing for implantables and new technology
- Reduced claim denials
- Collection of patient OOP liabilities

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Implementation Agenda

- Re-assess your contract portfolio and renegotiate when necessary
- Define the role of the managed care department
- Distribute MCO contract abstracts
- Review and revise, if necessary, registration/patient accounting policies and procedures
- Assess the ongoing role of utilization management

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Implementation Agenda (Continued)

- Strengthen intra- and inter-departmental communication
- Conduct an audit of managed care billing rates and payments
- Assess the feasibility of employee accountability and responsibility
- Conduct formal education programs
- Set financial baselines and track performance

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Enhancing Operations for Revenue Cycle Optimization: *Have We Achieved Our Objectives?*

- Expanded focus from A/R to entire cash conversion cycle
- Identified operational strengths and weaknesses
- Promoted a proactive managerial posture
- Identified factors influencing revenue maximization
- Offered a multidisciplinary matrix to provide structure and foster accountability
- Provided key performance indicators as operational benchmarks
- Offered an implementation agenda – the starting point for operational improvements

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