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Lola Butcher

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Payer access to EHR data improves cash flow

Lola Butcher

Sharp Healthcare has a "presumptive approval" for level-of-care authorization requests, speeding up the entire revenue cycle process.

Frustrated by the extra staff time required to appeal level-of-care requests that were denied but approved after the appeal process, Sharp HealthCare tried a new approach: granting payers real-time access to members' electronic health record (EHR) data. This allows the payer to check the record to determine whether the case meets medical necessity for inpatient status.

The experiment started with a single payer. "We immediately saw a reduction of denials," says Gerilynn Sevenikar, vice president-hospital revenue cycle, for the San Diego-based health system.

The new process means that Sharp staff no longer spend time gathering and submitting clinical information to justify a level-of-care authorization request. Rather, Sharp enjoys "presumptive approval" for requests, and the entire revenue cycle is sped up. Accounts receivable greater than 90 days for this payer dropped from more than 35 percent of claims to less than 10 percent.

Best of all, the work—on both payer and provider side—associated with denials, appeals and approvals-after-appeal is eliminated. "On occasion, the payer reaches out for clarification but these calls are infrequent," Sevenikar says. "As long as the case meets medical necessity for inpatient status, we never hear from the payer."

The Problem

Sharp sought to streamline the concurrent review process, whereby it seeks payer authorization for a patient to be treated as an inpatient versus observation status or for the appropriate level of care, such as medical/surgical versus intensive care unit.

Several payers, particularly Medicaid managed care plans, were routinely denying requests, prompting Sharp to submit additional clinical information to support an appeal. More than 90 percent of cases appealed were eventually approved.

"It was evident that there was a lot of rework for both the provider and the payer," Sevenikar says.

At a meeting with one payer, Sharp presented data showing that more than 90 percent of initial denials were eventually approved.

The Solution

To address the problem, Sharp sought to obtain "presumptive approval" for its level-of-care decisions by providing payers real-time direct access to the information they needed to approve.

"The thought was that if we open the EHR, then the paradigm has flipped," she says. "Instead of an admission being presumptively denied pending an approval, the (clinical) information is readily available and should result in a presumptive authorization."

At a meeting with one payer, Sharp presented data showing that more than 90 percent of initial denials were eventually approved. Sevenikar's team also discussed the administrative and financial burden associated with appealing denials. They proposed the following actions:

> Provide the payer with real-time access to a limited set of HIPAA-compliant EHR data.

- Ask the payer to agree that Sharp's level-of-care decisions would have "presumptive authorization" unless the payer notified Sharp of intent to deny.
- Require that if the payer issued an intent to deny, the payer would allow peer review (always clinician-to-clinician; physician-to-physician, if necessary) to discuss the clinical status of the health plan member.

Sharp Healthcare sets the following parameters for payer access to EHR data:

- The record is open 12 hours after the patient is admitted.
- The payer is provided a specific call line for clarification questions or to discuss the possibility of a denial.
- The payer agrees to Sharp's "presumptive approval" language.
- The payer has access only to the information that would have been provided by request previously; access to social work notes, for example, is not granted.
- The record closes 30 days post-discharge.
- The payer can only see information related to the member's current visit.

After a successful trial with the initial payer, Sharp has extended EHR access to other payers. As part of this innovation, Sharp collaborates with payers to identify other data about their members that they would like to receive on a daily basis. These have included the following information:

- The admit list of the payer's members from the previous day
- Daily census report
- Prior-day discharges
- Emergency department encounters with discharge summaries
- Daily list of observation patients

Lessons Learned

EHR access does not work well with all payers. After one payer was granted access to member data, members of its utilization management team started calling Sharp with requests to change patient status from "inpatient" to "observation."

"The frequency of the requests became notable, and it became clear that they were focused on payment reductions versus proper payment for care provided," Sevenikar says. "We quickly removed their access and are still in discussions regarding the conditions of access."

After a successful trial with an initial payer, Sharp has extended EHR access to other payers. As part of this innovation, Sharp collaborates with payers to identify other data about their members that they would like to receive on a daily basis.

An unexpected side effect of the new process: an uptick in audits for DRG validation. Because Sharp has high-quality coding, this has not resulted in any takebacks, and Sevenikar already has an idea on how to address the issue. "Our next area of opportunity will be to open the record for post-discharge clinical review," she says.

Sharing patient/member data in this way requires trust between payer and provider and can only happen if both parties agree on how information will be used, Sevenikar says.

"As we increase transparency with patients, we need to be confident enough to increase transparency with our payers," she says. "If we can agree that our primary interest is the care delivery to their member and our patient and that our overarching desire is to reduce expenses that do not directly contribute to the clinical care, then the area of denial management becomes fertile ground for process improvement." •

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Why don't more patients use transparency tools?

Laura Ramos Hegwer

Only 13% of consumers seek out-of-pocket cost information.

For years, price transparency tools have been available from employers and health plans, as well as through public initiatives. Yet only a small percentage of consumers use these tools. A *Health Affairs* study found that 13% of consumers sought information on out-of-pocket costs and just 3% compared provider costs before receiving care.

Why is utilization so low? The lack of consumer incentives to use the tools is the primary reason, says Sally Rodriguez, chief of staff and director of products at the Health Care Cost Institute, Washington, D.C., a not-for-profit research institute that tracks healthcare spending.

"The insured consumer has no incentive to use many transparency tools. They may be saving money for their health plans, but that money doesn't transfer to them," Rodriguez says. When shopping for healthcare, consumers tend to be focused on factors like quality or location. "Other factors are more important than cost because they are not going to feel an impact if they choose a lower-cost provider."

To spur consumer interest in using these tools, some health plans are experimenting with financial incentives that reward members if they choose lower-cost providers, Rodriguez says. For example, Blue Cross and Blue Shield of North Carolina, Durham, N.C., is offering financial rewards ranging from $50 to $500 to members who choose lower-cost, in-network providers. The rewards are available for approximately 100 eligible procedures.

Getting the Word Out

Another reason consumers may be slow to use price transparency tools is that they

don't know they exist, Rodriguez says. She recommends building awareness by increasing promotion of these resources. "[Consumers] need healthcare information that is relevant to their lives, and if plans are making cost a bigger part of their outreach, that could help," she says.

Rodriguez also believes that making price transparency tools more relevant would likely lead to widespread adoption. For example, some early tools did not account for members' health plans but offered average procedure costs. Today, more sophisticated tools allow users to understand what they are likely to pay based on their benefits.

Price transparency tools also could be made more relevant by including quality data, allowing users to make the most informed healthcare decisions. "The best tools incorporate quality information so people are getting a holistic picture of their options, rather than just being told which one costs more or less," she says.

Aligning the Stakeholders

Looking ahead, Rodriguez says, "There is momentum, but the stakeholders need to be aligned to create strong tools and incentives for people to use price transparency to lower healthcare costs." Among these stakeholders are providers, health plans, policy makers and patients.

Rodriguez believes providers, in particular, will face greater demands to improve price transparency and offer cost estimates. For example, the Centers for Medicare & Medicaid Services issued a rule earlier this year requiring hospitals to make standard charges available to the public.

But when it comes to shifting consumer behavior, the most important factor may be creating better incentives, Rodriguez says. "The consumer has to be empowered and have a reason to care about this," she says. •

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Chargemaster reviews promote outpatient revenue integrity

Caroline DeLaCruz

Be aware of seven outpatient account factors that may impact accuracy and payment.

Question

We are experiencing increased denials and loss of revenue as a result of chargemaster issues related to outpatient services coding. What steps can we take to identify the issues and clean up the chargemaster?

Answer

The rise in outpatient services provided at various outpatient locations adds to the complexity of revenue integrity challenges. Proper outpatient coding, documentation and charges are increasingly important to reduce and prevent denials as well as ensure accurate reporting and payment.

Knowing the seven likely factors related to outpatient account challenges and what three strategies to implement for chargemaster integrity is key to a thorough review of the chargemaster.

7 outpatient account issues to know

Be aware of these seven outpatient account factors during chargemaster review:

1. Coding errors and documentation gaps such as missing CPT codes and the ability to show medical necessity
2. Hard-coded codes, assigned by the chargemaster that are not visible or available during soft coding
3. Inadequate or missing charge-validation processes
4. Outdated or invalid chargemaster
5. Lack of process to assign correct and applicable modifiers
6. Timeliness of charge entry
7. Absence of internal charge reconciliation process within ancillary departments

Chargemaster review and maintenance avoids denials

Denial management requires a thorough chargemaster review to understand what is causing denials, followed by ongoing maintenance to avoid future potential issues. Department managers must carefully evaluate their department codes related to the chargemaster to make sure the designated codes are being used properly. Ensuring accurate CPT/HCPCS codes is the main concern in a chargemaster review. Because these codes are hard coded in the chargemaster for most ancillary departments, an annual review for new, revised and deleted codes is critical to ensure proper payment.

HCPCS codes are updated quarterly and yearly. For quarterly HCPCS updates, ancillary departments should review new, revised and deleted codes, and verify current usage in their department chargemaster and update changes. Failure to regularly update codes increases the likelihood of using outdated codes and increased denials.

For example, during a recent chargemaster review, it was determined several outdated codes were still being used, and there was no chargemaster coordinator or other individual solely responsible for monitoring the chargemaster additions or deletions. Using outdated codes resulted in billing edit/claim denials and shifted responsibility for addressing the issue to another department.

To prevent similar issues, which negatively affect both revenue capture and the patient experience, it's important to have well thought-out strategies in place.

3 strategies to ensure chargemaster integrity

As an integral part of chargemaster maintenance, consider the following three strategies to help ensure chargemaster integrity.

1. *Conduct onsite interviews with individuals from each department.* Along with the chargemaster review, interview each person from each department listed on the chargemaster. Go through their processes, understand their workflows, discuss pain points and explore solutions.

2. *Create a charge capture reconciliation process.* Using a report of all cases completed the previous day, review all charges. Assigning this task to someone in each department ensures the most thorough review. For each unit that has a service and service line, check each patient's documentation to match charges with treatments/procedures.

3. *Establish best practices to proactively identify issues.* Maintain the chargemaster routinely, develop a payment integrity program and appoint a chargemaster coordinator and team to oversee the maintenance process. Department managers should review individual department charges at least every three to six months for any updates within their services.

Additional best practices include the following:

> Meet with key departments to understand how they bill/charge for goods and services.

> Establish or refine your internal process for staff to submit additions, deletions and changes to the chargemaster.

> Educate staff on chargemaster changes and ensure there is financial executive leadership involvement prior to making any changes to the chargemaster.

> Review any/all paper charge tickets against the chargemaster.

> Constantly monitor edits and denials to determine if they trace back to the chargemaster.

Chargemaster review and maintenance will help eliminate denials by ensuring all codes, supplies and revenue codes are up to date and accurate. Addressing pre-billing edits related to hard-coded claims can ensure correct coding and appropriate payment. And, the good news is that chargemaster clean-up projects deliver immediate results. However, organizations must continually track outcomes and performance. Revenue integrity requires rigorous oversight of chargemaster integrity. ■

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is manager Comprehensive Outpatient Revenue for Integrity Services at Pena4, Inc.

8 KPIs for measuring Medicaid eligibility and advocacy

Marie Hinds

Before evaluating data, make sure you are comparing apples to apples.

We've all heard the saying, "You can't manage what you can't measure." When evaluating Medicaid eligibility and enrollment performance, there are many considerations for assessing internal eligibility staff or eligibility vendors using key performance indicators (KPIs).

How are you currently measuring your eligibility and enrollment success? Clearly defining KPIs for your leadership to track progress or to report where challenges are cropping up are instrumental in building a successful eligibility program.

When you're ready to take a hard look at your eligibility performance, or if you merely need help deciphering the Medicaid eligibility reports that hit your inbox, these recommendations may be helpful.

Comparable data

Before evaluating data, make sure you are comparing apples to apples. When you're reviewing monthly operating reports, you need to know the story behind the numbers you see so you can pay attention to the right metrics. Knowing how certain activities are counted isn't just to measure ratios but also to determine whether you should be paying a vendor for a conversion.

For example, if you have an account registered as self-pay but is later covered by commercial insurance, you may not expect a vendor to count that as a conversion. However, some vendors will consider it a conversion, which is why it's important to set clear expectations, so everyone is on the same page when discussing KPIs.

KPI checklist

While nomenclatures may vary, here are example metrics you should be generating internally or receiving from a vendor on a monthly basis:

Analyzing KPIs reveals information about trends and enables you to paint a narrative of the "why" behind what's happening.

1. Application numbers. How many patients have applications for Medicaid or other programs completed?
2. Conversion rates. How many applications were approved versus the number of patients that were screened?
3. Denial breakdowns. What are the patterns behind denials? What are some of the underlying issues?
4. Days from referral to application submission. How swiftly is the team working to enroll patients?
5. Days from application submission to approval. How successfully and rapidly are those applications being approved?
6. Screening percentages. What percentage of accounts have been screened?
7. Volume of placements. How many patients have been enrolled? How many reimbursable accounts?
8. Gross placement dollars. What is the total amount of dollars being collected from enrollment in Medicaid, Supplemental Security Income or other programs?

Uncovering room for opportunity

Data alone is insufficient. Analyzing KPIs reveals information about trends and enables you to paint a narrative of the "why" behind what's happening.

If you are not routinely evaluating your Medicaid eligibility and advocacy performance, and your organization is seeing high self-pay accounts receivable balances, that should be a huge warning sign that operations need to be refined. Analyzing metrics may lead to ask the following questions:

- > Have there been staffing changes?
- > Is staff productivity not keeping pace?
- > Why are screening rates down?
- > What is the turnaround time for applications, and why are there delays?
- > What are the reasons for denials?
- > Are there any environmental changes that are impacting your organization?

If you set up a reoccurring KPI review process, you can identify problems that need attention and expect a plan for remediation. If your current vendor isn't providing these plans or you don't have the resources to do it yourself, you should seek a vendor who can deliver the people, process and platform to drive success.

What does success look like?

Industry benchmarks don't necessarily exist. So much will vary based on your state and the type of patient population you serve. Vendors that have experience with organizations similar to yours in terms of size or scale and serve your state will be in a better position to set expectations for what you can expect to accomplish. •

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Should utilization review report to patient care or revenue cycle?

Erin Murphy

Experiences from small facilities and large suggest there is not just one answer.

There is no one-size-fits-all answer to where the utilization review function should report, according to CFOs on the HFMA Forums listserv. Whether healthcare finance leaders are considering a single employee or a team, a small hospital or a major health system, they have options.

Asking for small-scale advice

"In our small facility with a census of 10 to 12, our utilization review position currently reports to our patient care department. We are looking to change this approach to have our utilization review position — an employee who deals with inpatients, observation, swing bed stays and criteria, and insurance needs — report to our patient financial services manager in the revenue cycle department," explained Steve Alger, CFO of Lakes Regional Healthcare, Sioux Falls, South Dakota.

Several peers on the forum had made the very same move. "We had a similar experience moving utilization review under revenue cycle several years ago, and it has produced much more successful results," noted Michael L. Taylor, vice president, revenue cycle management, Cincinnati Children's Hospital Medical Center.

Another HFMA listserv member noted that when utilization review reported through the patient care department, it was a struggle, but moving the function under revenue cycle was successful. The utilization review team still respects the needs of patient care staff and works closely with physicians and inpatient units, but they are able to focus on utilization review.

Relying on collaboration

A number of experts weighed in with the idea that a variety of reporting structures for utilization review could be successful in a productive work environment. That is, if different areas of the hospital understand each other, communicate and routinely work well together, the specific reporting department is less important.

"I think it is less about the direct reporting relationship and more about achievement of the goals," stated Pat Keel, senior vice president/CFO, St. Jude Children's Research Hospital, Memphis, Tennessee. "However, regardless of where utilization review reports, it needs to at least have a dotted line to revenue cycle, and share the goals as they relate to the revenue cycle."

Reporting lines seem to be less of an issue if there is good communication with the team.

Another HFMA listserv member said that utilization review had always fallen under her organization's chief of nursing. She and her colleagues in revenue cycle have open lines of communication with the team and work closely with them. Reporting lines seem to be less of an issue if there is good communication between the teams.

Choosing the right model

With financial professionals successfully locating utilization review under patient care, revenue cycle and even the chief of nursing, it's clear that the right model depends on the specific organization.

One forum contributor, formerly of the Cleveland Clinic, pointed to the organization's role in ensuring utilization review works as part of a productive whole. "I think there is no perfect place to locate utilization review. I have watched hospitals create programs under finance, administration, operations and even patient experience. Although the reporting arrangement makes a difference in day-to-day management, the organization's governance and strategy for the changing healthcare environment are more important," explained Lyman Sornberger, chief healthcare strategy officer, Lyman Healthcare Solutions, LLC, Cleveland.

"The healthcare system educates employees, promotes the organization's vision and branding, and builds teamwork and appreciation for all of its areas. These efforts support not only utilization review, but also coding, care management and revenue cycle management, all of which have so much overlap now and will have even more in the future." •

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• **figure at a glance** •

Positive patient experiences lead to timely payments

David Shelton

Almost half of patients report difficulties paying their deductibles, which exceed $2,000 for many. Even for insured patients, the costs of annual deductibles, copayments, coinsurance, prescription drugs and treatments not covered by insurance can be staggering. To compound the burden, almost two-thirds of U.S. households have less than $1,000 in savings.

To meet business goals and patients' needs, providers must address payment barriers, including patient lack of awareness about their financial responsibilities and inflexible payment options. Offering a personalized patient financial experience can help people meet their financial obligations and increase timely payments. •

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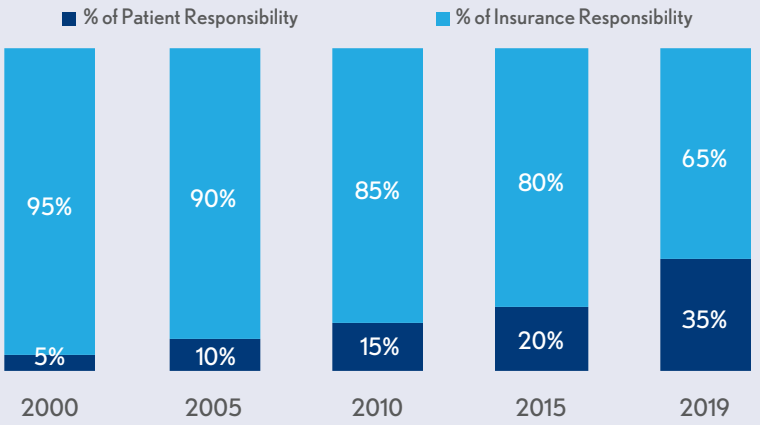
Patient responsibility for medical bills grew by 30% over the last decade

Patient responsibility for medical bills has climbed from 5% in 2000 to 35% in 2019, which has increased the likelihood that providers may not get paid on time, receive the full payment amount or receive any payments at all.



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