Penn Medicine

hollis cobb

MULTI-TIERED APPROACH TO ELIMINATING PRIOR AUTHORIZATION DENIALS, IMPROVING CASH FLOW AND CUSTOMER SERVICE

Introduction

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Penn Medicine

Penn Medicine Overview

Hospital of the University of Pennsylvania

Beds: 789
Admissions: 34,653
Inpat Surgeries: 13,272
Outpat Surgeries: 11,662
ER Visits: 61,250

Annually recognized as one of the nation's best hospitals by U.S.News & World Report in its Honor Roll of best hospitals.

Pennsylvania Hospital

Beds: 496
Admissions: 19.601
Inpat Surgeries: 7,073
Outpat Surgeries: 14,664
ER Visits: 35,299

Nation's first hospital (co-founded by Benjamin Franklin in 1751), with many expert clinical programs, including the Women's Cardiovascular Center, orthopaedics, and maternity.

Penn Presbyterian Medical Center

Beds: 331
Admissions: 15,388
Inpat Surgeries: 8,076
Outpat Surgeries: 9,458935
ER Visits: 46,336

Level 1 Trauma Center consistently recognized for delivering superior patient safety and high-quality care and as a center of excellence for cardiac surgery, cardiac care, orthopaedics, and ophthalmology.

Penn Medicine Overview

The Chester County Hospital

Beds: 257
Admissions: 13,521
Inpat Surgeries: 3,517
Outpat Surgeries: 4,936
ER Visits: 44,959

Joined Penn Medicine in 2013 and provides cardiovascular services, oncology, radiation oncology and maternal health services to Chester County and the surrounding area.

Lancaster General Health

Beds: 630
Admissions: 35,282
Inpat Surgeries: 12,657
Outpat Surgeries: 16,977
ER Visits: 69,251

Joined Penn Medicine in 2015 Lancaster General includes Lancaster General Hospital, the Women & Babies Hospital and a network of more than 60 outpatient facilities and physician practices.

Princeton HealthCare System

Beds: 355
Admissions: 49,136
Inpat Surgeries: 3,212
Outpat Surgeries: 9,578
ER Visits: 48,740

Joined Penn Medicine in 2018 Princeton HealthCare System, includes the University Medical Center of Princeton at Plainsboro and was named one of the Top Performers on key Quality Measures in the US among 405 hospitals nationwide being recognized in 2010.

Penn Medicine Overview

Penn Medicine Profile

Patient Care	Statistic
Licensed Beds	2932
Physicians	5351
Admissions	145,913
Outpatient Visits	4,183,730
ED Visits	304,614
Births	16,160
Home Care Visits	330,000
Employees	35,273

History of Authorizations at Penn Medicine

- Identified the need to centralize Authorizations at Hospital of University of Pennsylvania post Epic Go Live
  - 2 of 3 downtown hospitals previously migrated to centralized model
  - Authorization denials were a significant issue but cancellations an even bigger issue

Problem Identification

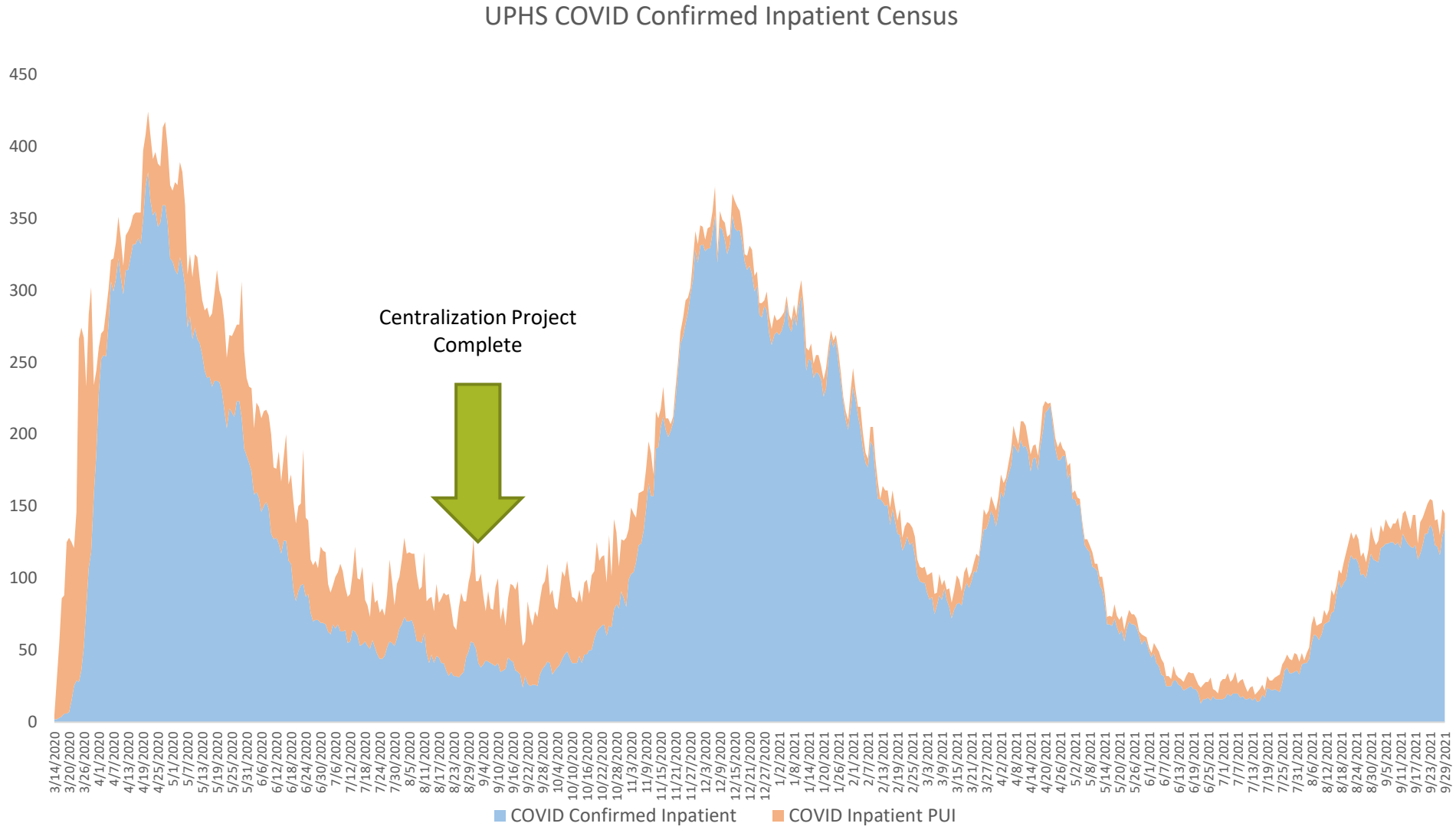
- Practices (not the hospital) were responsible for Authorizations

- Financial Clearance of hospital procedures traditionally inconsistent
  - Surgery Schedulers/Administrative Assistants rather than a specific job role
  - Competing responsibilities

- Decentralized reporting structure
  - Lack of accountability
  - No training program/education tools

- No payor performance tracking

History of Authorizations at Penn Medicine



History of Authorizations at Penn Medicine

Centralized (2020 Pre-Pandemic) → Centralized (2020 – 2021 Pandemic) → Centralized (2021 – Post Pandemic ?)

- Efforts to centralize took place pre-Covid/ early Covid setting us up nicely to transition into a work from home environment
- Catalyst for a full shift to work from home environment

Problem Identification

- **Radiology and Gastroenterology – High Volume = High Impact**
  - **History of Gastroenterology**
    - Less than 1 day out in Financial Clearance
    - Reported up through clinical department with no hospital accountability
    - Department was not working from a Patient Workqueue (WQ); previously the department focused financial clearance efforts through the use of the Department Appointment Report (DAR)
    - High number of cases scheduled within 24-48 hours that required Pre-Authorization
    - Led to high impact for post procedure Retro Authorization processes
    - Increased denial activity due to no Authorization, no referral, inactive insurance, and PAR coverage issues

Problem Identification

- **History of Radiology**
  - Less than 1 day out in Financial Clearance
  - Each hospital entity had their own WQ
  - High rate of same day rescheduled cancellations
  - High turnover
  - Poor morale/culture
  - Inconsistent tracking of denials/cancellations

Staffing Analysis

- Performed comprehensive staffing evaluation to determine external need

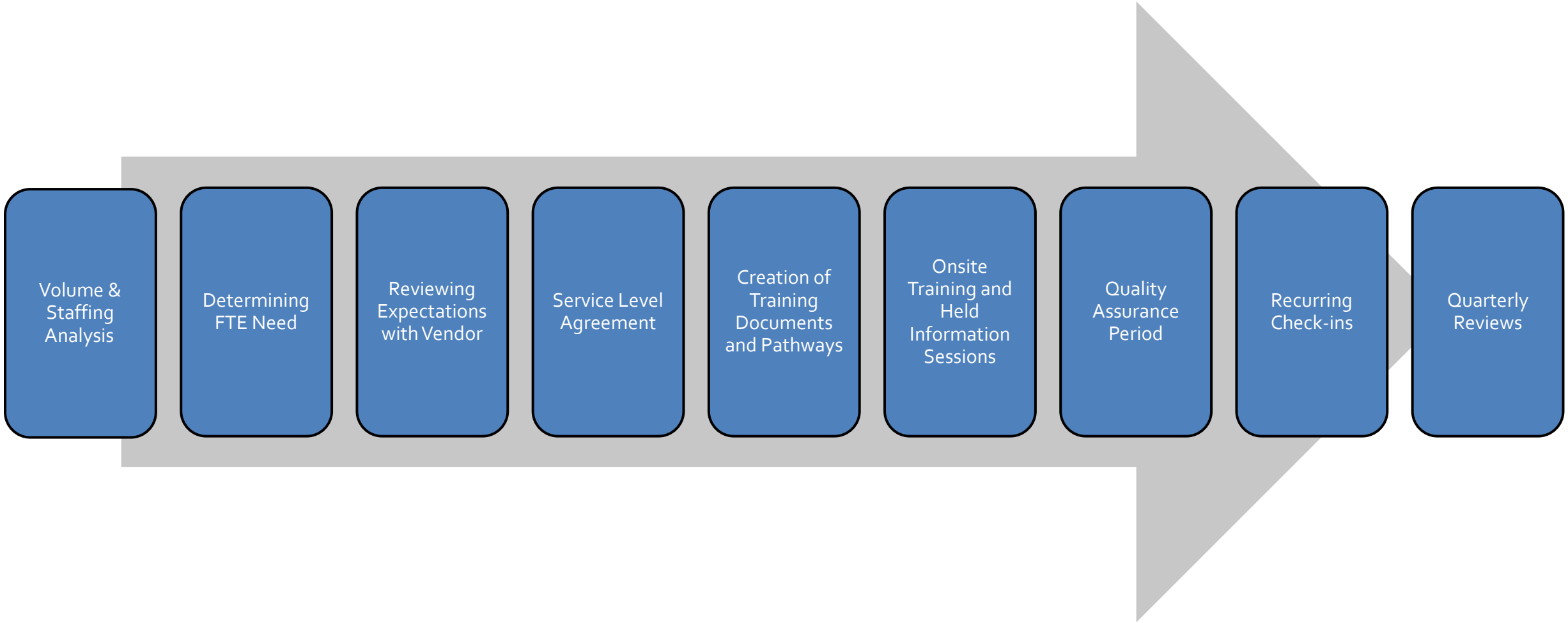
- Gastroenterology:
  - 3 FTEs from Hollis Cobb
  - 1 FTE from Penn Medicine

- Radiology:
  - 2 FTEs from Hollis Cobb

	Current State					Future State
Group	Number of Staff	Staff Utilization (%)	Total Cases	Cases Per Day	Cases Per FTE Per Day	Required FTEs (cases per FTE per day: 20)
Gastroenterology	2	100%	18,939	71.7	35.9	3.6
Surgery	4	70%	14,758	55.9	14.0	2.8
Radiology	2	65%	6,868	26.0	13.0	1.3
Cardiology	1	100%	5,552	21.0	21.0	1.1
OTO	4	16%	3,364	12.7	3.2	0.6
OB/GYN	8	7%	2,922	11.1	1.4	0.6
Neurosurgery	9	4%	1,883	7.1	0.8	0.4
Pulmonary	1	34%	1,814	6.9	6.9	0.3
OFMS	2	5%	504	1.9	1.0	0.1
Neurology	1	5%	282	1.1	1.1	0.1
Orthopedics	1	3%	182	0.7	0.7	0.0
Rad Onc	2	0%	37	0.1	0.1	0.0
Sub-total	**37**	**29%**	**57,105**	**216.3**	**5.8**	**10.8**
		16	3569.0625	13.51917614		0.675958807
Other						
Oncology			1,451	5.5		0.3
Other			171	0.6		0.0
Medicine			142	0.5		0.0
Emergency			151	0.6		0.0
Hospitalist			103	0.4		0.0
Transplant			339	1.3		0.1
Grand Total			**59,462**	**225.2**		**11.3**

Note: from January 2018 - February 2019; 20 cases per day implies 24 minutes per case at 8 hour FTE capacity
Assumptions: Required FTEs assumes 20 pre-certs per FTE per day, 264 working days in year

Implementation



Process Improvement Design

- Standardized process for Pre-Authorization all through Epic WQs
  - Reconfigured WQs
    - 4 separate WQs: Same Day Next Day, 0-7 days, 8-14 days, and 15-21 days
    - Radiology Specific: consolidated entities into same WQs and separated by high modality and low modality exams
  - Organized and emphasized Pre-Authorization workflow
    - Mapped out workflow for visualization
  - Focused on re-education and re-training the Pre-Authorization process
    - Updated and created training materials in order to help visualize expectations of financial clearance
    - Highlighted any key elements of clinical information or departmental changes

Process Improvement Design

- Creation of Job Tools
  - Service Level Agreements to formalize relationship with practices
    - Scheduling Grid by Payor
  - Productivity Reports
  - Be the VOICE Campaign

Be the VOICE

- Centralized team (with vendor support) is responsible for financially clearing HUP's scheduled elective services utilizing "VOICE" and engaging the department and attending physicians in the 3-2-1 Countdown for untimely Authorization obtainment as outlined in the **Financial Clearance: Scheduled Elective and Inpatient Admissions**

V Verify Eligibility

O Outline Covered Benefits

I Initiate and Obtain Ref/Authorization

C Create Patient Estimate

E Explore Financial Payment Options

3-2-1 COUNTDOWN

At least 72 hours in advance the Precertification Specialist will notify the scheduling department and physician of the lack of authorization

Within 48 hours obtain clinical assessment to determine ability to delay service

By 12 Noon the day before scheduled service recommend cancellation

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Work Level Agreement

Scope

This Work Level Agreement ("WLA"), effective as of February 1, 2020 is by and between the Patient Access Department of the Hospital of the University of Pennsylvania ("HUP") and the Department of Obstetrics and Gynecology.

The Patient Access Department will work closely with the clinical department for the provision of financial clearance services required to support and sustain scheduled elective procedures. Communication, feedback and accountability are critical to ensuring excellent service. In order to measure and monitor acceptable service levels of this relationship, this WLA outlines:

- The services expected from the Patient Access Department and the protocols for working with the Department of Obstetrics and Gynecology including the divisions of Maternal Fetal Medicine, Penn Obstetrics and Gynecology Associates, Reproductive Endocrinology and Infertility, Helen O. Dickens Center, Gynecology and Oncology, Urology Gynecology, [illegible] PEACE during the financial clearance process
- The key performance indicators used to measure the quality of services provided

Patient Access Department Financial Clearance Principles

1. Patients who have met the following criteria are considered financially cleared:
   - Insurance benefits have been verified for 100% coverage and the obtainment of a precertification/authorizations or acceptable payment
   - All necessary demographic and insurance information has been provided to satisfy billing and reporting requirements, and outstanding balances have been reviewed
   - Full communication of expectations has occurred at the earliest possible point within the patient's care/service pathway

2. These results will be achieved by clearing all cases based on the following five financial principles:
   - Verify Eligibility
   - Outline Covered Benefits

SAMPLE

Penn Medicine

   - Initiate and Obtain Authorization
   - Create Patient Estimates
   - Explore Financial Payment Options

Service and Performance Expectations

1. Staff will access their assigned Patient work queue in EPIC/PennChart daily to obtain the listing [illegible] scheduled elective procedures requiring financial clearance. In the event the assigned staff [illegible] is out of the office on a planned or unplanned absence, the Patient Access department will have [illegible] designated back-up. This information will be included in an out-of-office email and/or [illegible] voicemail.
2. The Patient Access Department and the Department of Obstetrics and Gynecology must adhere to the 3-2-1 Countdown procedure as outlined in the Financial Clearance policy to continually provide service in a timely, efficient and accurate manner.
3. The Patient Access Department will conduct periodic reviews of patient accounts completed. This includes auditing the completion of the key data elements required to financially clear patient accounts and reviewing registration accuracy scores. The key data elements are outlined below:

Auth/Cert Screen		
Precert/Authorization Number	Precert/Authorization Required	Precert/Authorization Status
Date Initiated	Contact Information	Date Received
Authorized From and To	Receiving User	

Benefits Collection Screen	AHIQA
Prepay Collection Amount	Grade Accuracy
Covered Benefits	Error Count
OOP expenses	

4. The Department of Obstetrics and Gynecology, in conjunction with, the Patient Access Department will follow the performance directives detailed in the addendum section of the Service Level Agreement for patient's scheduled services. Terms and Agreement detailed in this Service Level Agreement between the Patient Access Department and the Department of Obstetrics and Gynecology is subjected to change.

Adjustments

Transparency Expansions

Consolidated Appropriations Act

12/27/2020

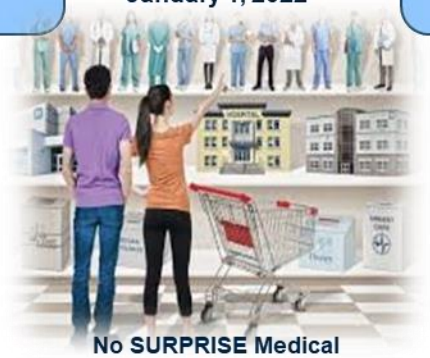
September 30th, 2021 – Final Rule Released

Title I:
No Surprises Act
Out-of-Network Protections

Effective:
January 1, 2022

Title II:
Price Transparency
"3.0"

No Balance Billing



No SURPRISE Medical Bills

Good Faith Estimates Required for **ALL** Scheduled Visits

Adjustments

- Reorient to how do we provide the best service to the patient while maintaining high productivity, compliance and efficiency?
  - The No Surprises Act took effect on January 1, 2022 and provides patients financial protections against surprise medical bills, and prohibits balance billing for certain out-of-network (OON) care
    - Non-Participating Plans
    - Self Pay
  - Standardized approach and commitment to continue to balance bill
  - Goal is to embed estimates into every encounter regardless of payor

Adjustments

- Training on Epic patient estimator
  - One comprehensive estimate to be delivered to patient in advance of service
    - PB
    - HB
- Consideration of automation both for authorizations but also for estimate generation

Ongoing Challenges

- Onboarding/Training
  - Identifying technical issues relating to access and completing prerequisite learning requirements through Schedgistration
  - Comprehending of clinical information
  - Understanding workflow and organization specific to Penn Medicine

- Creating an internal process to support Vendor team
  - Mapping out workflows and templates to help Vendor team appropriately escalate Authorization denials, peer to peer requirements, or patient conversations

Denials

- To some degree, Prior Authorization denials were mitigated by cancelling/rescheduling services if a Prior Authorization was not acquired prior to the date of service
- Penn Medicine Physicians (CPUP) experiences about $28M in denials per month
- Prior Authorization denials represent ~10% of the total denials (down from 11%-12% a year ago)
- Our new Prior Authorization process started with select GI and Radiology practices. Early results are promising
    - GI Prior Authorization denials reduced from 13%-15% range to ~ 11%
    - Radiology Prior Authorization denials reduced from 11%-14% range to below 9%

Advantages

- Quality Assurance YTD is less than 2% overall (1.53%)
- Denial rate is averaging less than 2% (post any P2P/Appeal) and is being worked collectively between the Penn/HC teams
- MTD volume in radiology is trending UPWARD; forecasted to exceed expectations due to Penn/HC collaboratively onboarding/training additional HC staff
- 24 hour follow up on ALL pending cases (radiology specific)

Partnership

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Thank you! Questions?