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Implementing a modern managed care environment inside your organization

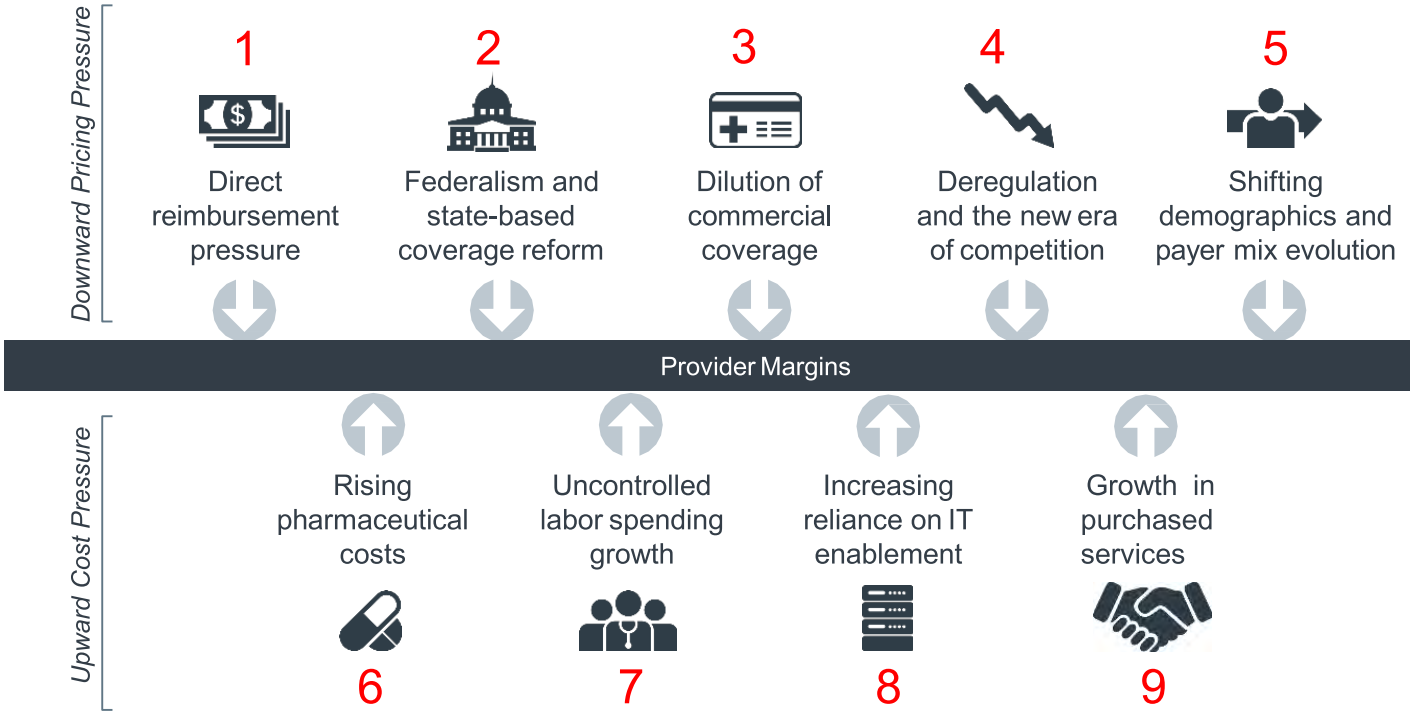
November 6, 2018

Learning objectives

- Establish a definition of what success looks like to help set expectations with leadership
- Recommend approaches on leveraging analytics with processes around the new payment mechanisms to maximize reimbursement
- Reference case studies providing you with concrete examples of organizations that have successfully deployed these strategies and achieved improved financial outcomes

Nine structural forces compressing provider margins

Advisory Board



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What is Payer Performance Management (PPM)?

A collection of tools and processes developed with the primary goal to help healthcare provider organizations maximize the level of reimbursement from all third-party insurance companies, including Value Based Care options.

Characteristics of a modern PPM program

Sophisticated Contract Modeling/ Rate setting capabilities

Underpayment identification and Robotic Process Automation refiling

Lost Charge and DRG Anomaly identification

Up-to-date denial trending integration

Advanced Payer Performance Scorecard

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Recommendations on how to develop (or enhance) a Payer Performance Management (PPM) program

Sophisticated contract modeling / Rate setting

- Review and analyze current contracted rates, benchmark rates against industry market data and develop max reimbursement models
- Identify opportunities to improve reimbursement rates across service lines, including the introduction of VBC terms
- Enables hospitals to strategically evaluate overall contract performance and assess the potential financial impact of new service lines
- Focus on ROI and annual net revenue improvement through a detailed contracting strategy

Rate modeling

Yearly Increases	ABC Payer
Year 1	15%
Year 2	13%
Year 3	12%

Payer Name	Total Actual Payments	Total Expected Payments	Actual as a % of Expected	2018 Medicare Reimbursement	Expected Payments as a % of 2018 Medicare Reimbursement
ABC Payer	$3,783,232	$4,173,231	91%	$3,672,951	114%

	Yearly Adjustments (Total Expected Payments) based on % of Medicare			
Payer Name	Year 1	Year 2	Year 3	Adjusted % of 2018 Medicare Rates
ABC Payer	$4,799,216	$5,423,114	$6,073,887	151%

Revenue Change Y/Y	$625,985	$623,898	$650,774

Additional Expected Revenue
$1,900,656

- Methodology to determine annual increases in revenue are based on previous twelve months payments across IP/OP service lines
- Expected revenue increases are payer specific
- Focus is on multi-year agreements with annual COLA's

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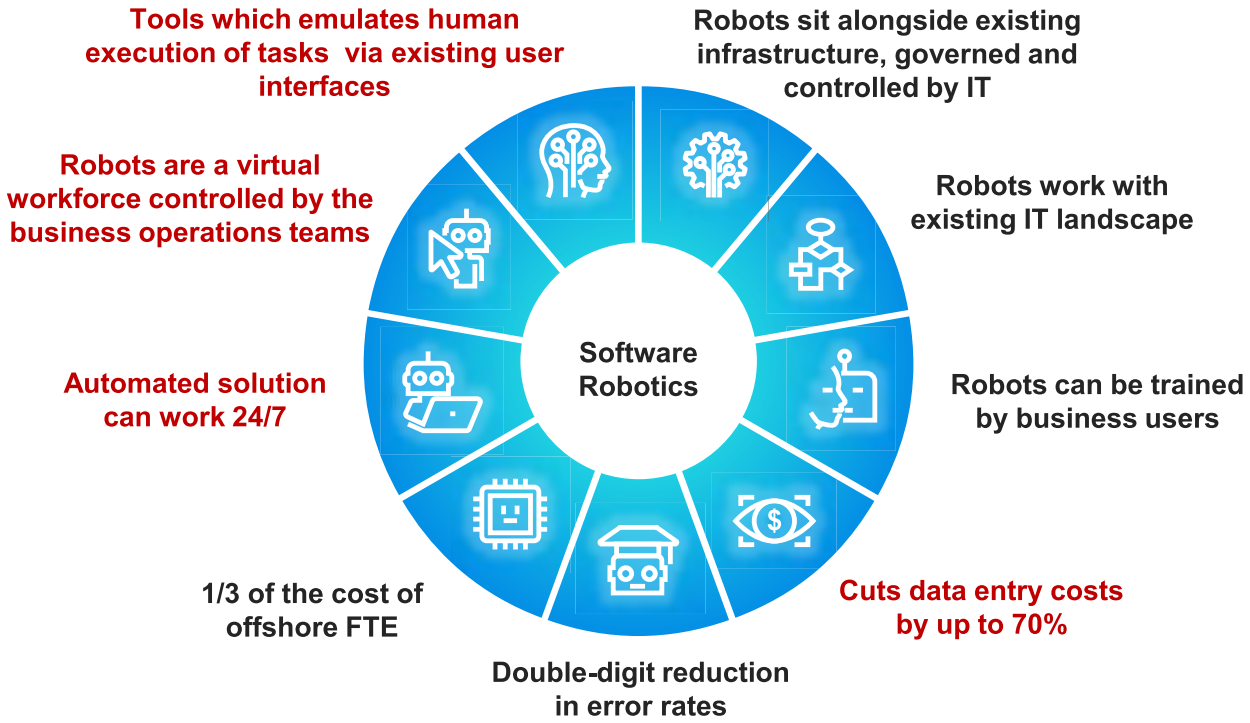
Underpayment identification leveraging Robotic Process Automation

- Conduct analytics to determine payment discrepancies between actual payments and contract payment terms
- Use of Robotic Process Automation to extract contract language to support underpayment claim and auto file with payer for increased reimbursement
- Can also use RPA to assist on the follow-up of the underpayment submission
- Underpayment information/data can be leveraged in scheduled contract renegotiations with payers with the goal of increasing rates across appropriate service lines

Characteristics of Robotic Process Automation (RPA)



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Underpayment identification and Robotic Process Automation refiling

Leveraging Automation

- Use automation and contract rules to identify underpaid accounts
- Use RPA to identify specific contract language to support additional reimbursement and then refile claim

Reduce Time for Reimbursement

- By using RPA, lag days for additional reimbursement can be drastically reduced
- By using automation, the volume of underpayments reviewed and then rebilled is improved significantly
- RPA can also perform follow-up tasks to better understand payment timing

Higher Success Rates

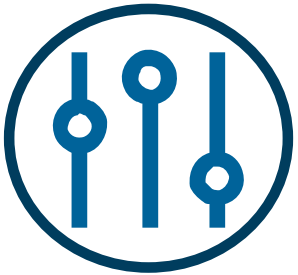
- Drive higher reimbursement with low cost threshold
- Improve recovery rates due to specific contract language and remove human error rates

Improve Reporting Capabilities

- RPA allows for improved granularity of data
- This improved data will drive advanced conversations with the respective payer and assist in contract negotiations

Lost Charge and DRG Anomaly identification

- Perform a detailed assessment of the Charge Description Master (CDM) to determine charge capture opportunities
- Develop sophisticated charge reconciliation processes to ensure proper charging
- Deploy user friendly, but robust charge capture tools that do more than basic charge discrepancies and consider outside validation of documentation services
- Use similar analytic engines to identify potential incorrect DRG assignments (up or down) and validate in the medical record
- Use DRG Anomaly identification to ensure services provided and documentation match the billed DRG for appropriate reimbursement and better understand payer utilization

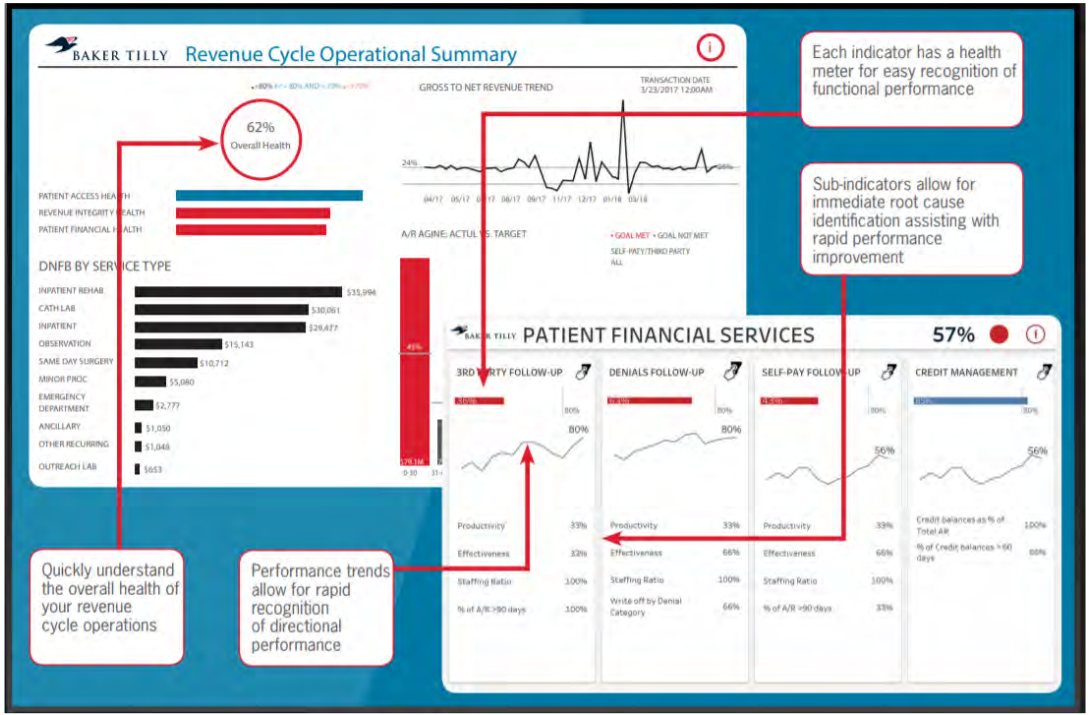


Up-to-date Denial trending integration

- 1 in 7 claims is denied and 3 times more costly to process for providers
- Use actual 835 remittance files to evaluate Rejection and Denial trends by payer as they contain more information than what is posted to the host
- Integrating real-time denial performance supports the identification denial trends that can be used in future contract negotiations in order to limit or remove denied claims
- Denial trending integration should support:
  - Ability to quickly analyze and diagnose denial ‘Root Cause’ Issues
  - Ability to implement action plans to resolve common issues
  - Ability to segregate and address avoidable denial populations

Up-to-date Denial trending integration

- Denial trending integration should leverage 835 remittance data and not only what is posted to the host system
- By utilizing 835 data, you get the whole picture of payer reimbursement trends, including those areas that require rework and slow payments



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Improved payer analytics

Preventative maintenance for payer performance

- Break down the critical activities of the entire contract management process
- Understand the differences between organizational issues and payer performance issues

Core function approach

- Built with “what-if” capabilities to model various scenarios
- Utilize visual analysis for pattern recognition

Key Benefits

- Improved visibility and a discovery approach for understanding payer performance
- Identification of negative performance earlier in the operational lifecycle
- Assists in the discovery of root cause issues developing practical improvement initiatives

Advanced payer performance scorecard

- Allows for real-time analysis of performance of managed care agreements by benchmarking desired metrics
- Potentially provides leverage with payers during a renegotiation by quickly identifying key drivers that are negatively impacting reimbursement
- A scorecard can support a risk readiness assessment by capturing payer mix, utilization trends, and CMI profiling

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Advanced payer performance scorecard
Example

Hospital Managed Care Scorecard

Select Payer: **United Health Care**

Measurement	Target	Owner	Apr-18	CY 2017	YTD 2018	Overall Commercial
Days in A/R	50-60 Days		51	50	54	49
Receivables > 120 Days	< 10%		16%	16%	14%	14%
Patient Bad Debt	1.5%-2.5%		1.7%	1.7%	1.8%	1.9%
Clean Claims Payment Rate Per Contract Terms	90%-95%		93%	96%	94%	90%
Payment Accuracy Rate	90%-95%		93%	93%	93%	93%
Average Reimbursement Per Visit (OP)			$2,401	$2,421	$2,421	$1,213
Average Reimbursement Per Visit (IP)			$21,402	$21,601	$21,601	$15,709
Chargemaster Benchmark Review Against Payer Fee Schedule	2-3x Medicare		3.77	3.21	3.50	2.34
Payer Mix				Results		
Denials - Initial	< 10% Initial		7%	6%	7%	9%
Denials - Final	2% Final		3%	3%	3%	4%
Average Interventions Per Account			1.21	13.50	12.77	11.42
Claims Appeal Response Time (days)			8.30	8.50	8.40	7.56

VBC metric examples

- Number of covered lives by population (e.g. payer, gender, age group)
- Monthly and YTD revenue received for covered lives by population (e.g. payer, gender, age group)
- Monthly and year-to-date medical expenses for top 10 diagnoses (e.g. payer, gender, age group)
- Total charges, costs and payments
- Actual performance vs HEDIS and other quality measures
- LOS by physician (e.g. payer, gender, age group, top 10 diagnoses)
- Post surgical infection rate (e.g. payer, gender, age group, top 10 diagnoses)
- 30 day readmission rates by physician (e.g. payer, gender, age group, top 10 diagnoses)
- Number of non-emergent patients seen in the ER (e.g. payer, gender, age group, top 10 diagnoses)

VBC metric examples

- Specialty referral rates for primary care physicians (e.g. independent and employed, Family Practice and Internal Medicine, top 10 diagnoses)
- Number of recurring patients in ER (e.g. payer, gender, age group, top 10 diagnoses)
- Tracking of discharge destination (e.g. by type of service, by top 10 diagnoses, payer and gender)
- Number of patient engagement encounters per quarter
- Patient satisfaction by payer type, patient type, gender, age group (e.g. by health care, health plan, service provider/location)
- Number of inpatient and outpatient surgeries (e.g. payer, gender, age group, top 10 diagnoses)
- Colorectal cancer screening and survival rate
- Hemoglobin A1C > 9% (those with diabetes)

PPM case study

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Case study

Baker Tilly identified $97.1M in revenue pick-up over three years for a large hospital system through an extensive analysis of their managed care agreements.

Challenge

- Baker Tilly was engaged by senior management to conduct an extensive analysis of the top five commercial and top two Medicaid managed care agreements
- The primary analysis included benchmarking reimbursements across both hospital (inpatient & outpatient) and physician service lines and comparing those rates to market reimbursement ranges
- Baker Tilly performed a detailed review of current contract language
- The timeframe of the engagement was very tight due to several pending payer renegotiations

Case study

Baker Tilly identified $97.1M in revenue pick-up over three years for a large hospital system through an extensive analysis of their managed care agreements.

Approach

- The benchmarking analysis of the seven payer contracts indicated the hospital's agreements were under-valued compared to other like institutions
- The analysis revealed the client's inpatient and emergency room rates were well below market allowable as well as several physician service lines
- Our recommendations and modeling brought these service lines to or above market rates
- Baker Tilly also provided detailed recommendations for improving contract language to further protect the organization from revenue leakage

Case study

Baker Tilly identified $97.1M in revenue pick-up over three years for a large hospital system through an extensive analysis of their managed care agreements.

Impact

- Our independent contract benchmarking analysis allowed our client to have more leverage at the negotiating table with contracted payers
- Changes to payer contractual language were made to focus on cost savings and revenue improvement opportunities such as:
  - Pre-authorization waivers
  - Claim denial caps
  - Elimination of certain trailer billing requirements
- The provider was given a more predictable revenue forecast

Case study

Baker Tilly identified $97.1M in revenue pick-up over three years for a large hospital system through an extensive analysis of their managed care agreements.

Impact

	Inpatient	Outpatient	Physician	Total
Tier 1 payers	13.3%	4.8%	7.1%	25.2%
Tier 2 payers	5.6%	3.0%	3.7%	12.3%

***29.7%** growth in commercial revenue over three (3) years across five (5) contracted payers*

What can I do?

What can you do to take advantage of these tools and techniques to optimize your employee effectiveness?

1. Perform an assessment of current Revenue Cycle operations and technology. ***You can't get to an improved position if you don't know where you are.***

2. Develop a PPM report card of performance using technology / tools to collect accurate and actionable data.

3. **TAKE ACTION:** The worst thing you can do is nothing. If there are real opportunities to make improvements, then those opportunities should be pursued.

Disclosure

The information provided here is of a general nature and is not intended to address the specific circumstances of any individual or entity. In specific circumstances, the services of a professional should be sought.

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