Patient Access—Referrals, Scheduling, and Authorizations

Front-End Revenue Cycle, Stopping Groundhog Day

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October 21, 2024

Presenter

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Learning Objectives

- Understand Groundhog Day.
- Identify how Patient Access can be like Groundhog Day.
- Character refresher.
- Review people, process, and technology challenges.
- Recommendations for improvement.
- Learn about the future trajectory of the industry.

Setting the Stage

What is Groundhog Day?

On this day, according to tradition, people watch the behavior of a groundhog to find out what the weather will be like for the next six weeks.

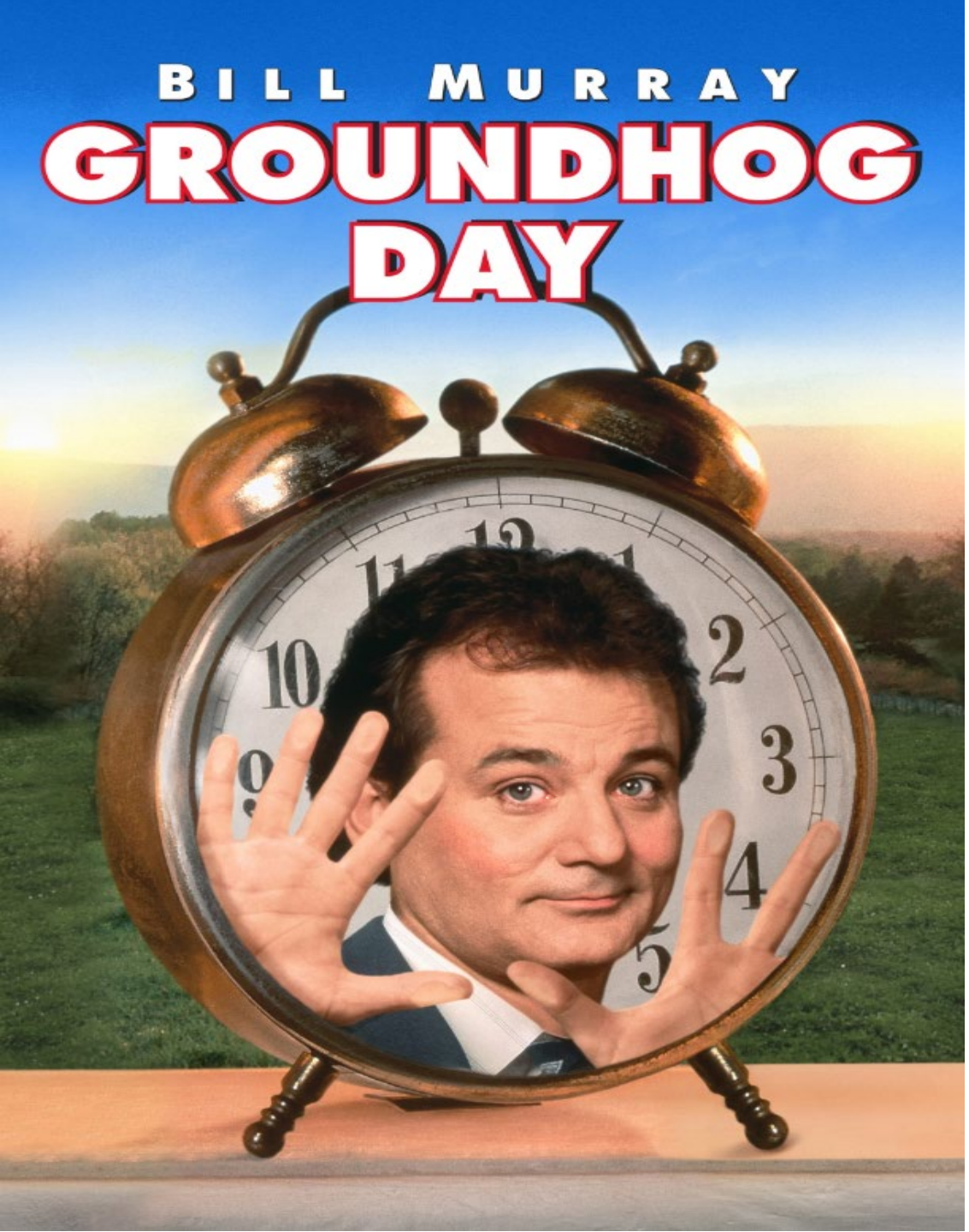
If the groundhog sees its shadow as it emerges from its burrow, there will be six more weeks of wintery weather. However, if it does not see its shadow, the weather will be mild and springlike.

- Woodchuck
- Groundpig
- Whistlepig
- Thickwood Badger

[Groundhog Day Movie Trailer 1993 - TV Spot (youtube.com)]

Why Can Patient Access Team Members Feel Like They're Living in Their Own Groundhog Day Movie?

Bad Patient Access workflows cause Patient Access Team Members to encounter the same frustrating situations ***over and over again***.



Is Your Patient Access Department Experiencing Symptoms of Groundhog Day Syndrome (GDS)?

Who in here has experienced symptoms of Groundhog Day Syndrome (GDS) at some point in their career?

Character Refresher

The Main Characters

Scheduling

Refers to the process of coordinating appointments, procedures, and other healthcare-related activities for patients.

Referrals

Refers to recommendations, typically made by PCPs, for patients to see specialists for specific medical care.

Authorizations

Refers to the process used by insurance companies to determine whether they will cover the costs of specific medical services or procedures before they are provided to patients.

- Referrals (Insurance).
- Orders (Medical Services or Procedures).

Referral Types

Provider

Refers to recommendations made by healthcare providers (commonly PCPs) to specialists in order for patients to receive specialized care.

Helps to ensure patients receive appropriate and coordinated care.

Insurance

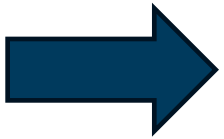
Formal requests from PCPs to patients' insurance companies, seeking approval (authorization) for patients to see specialists.

HMO & POS insurance types commonly require Insurance Referrals.

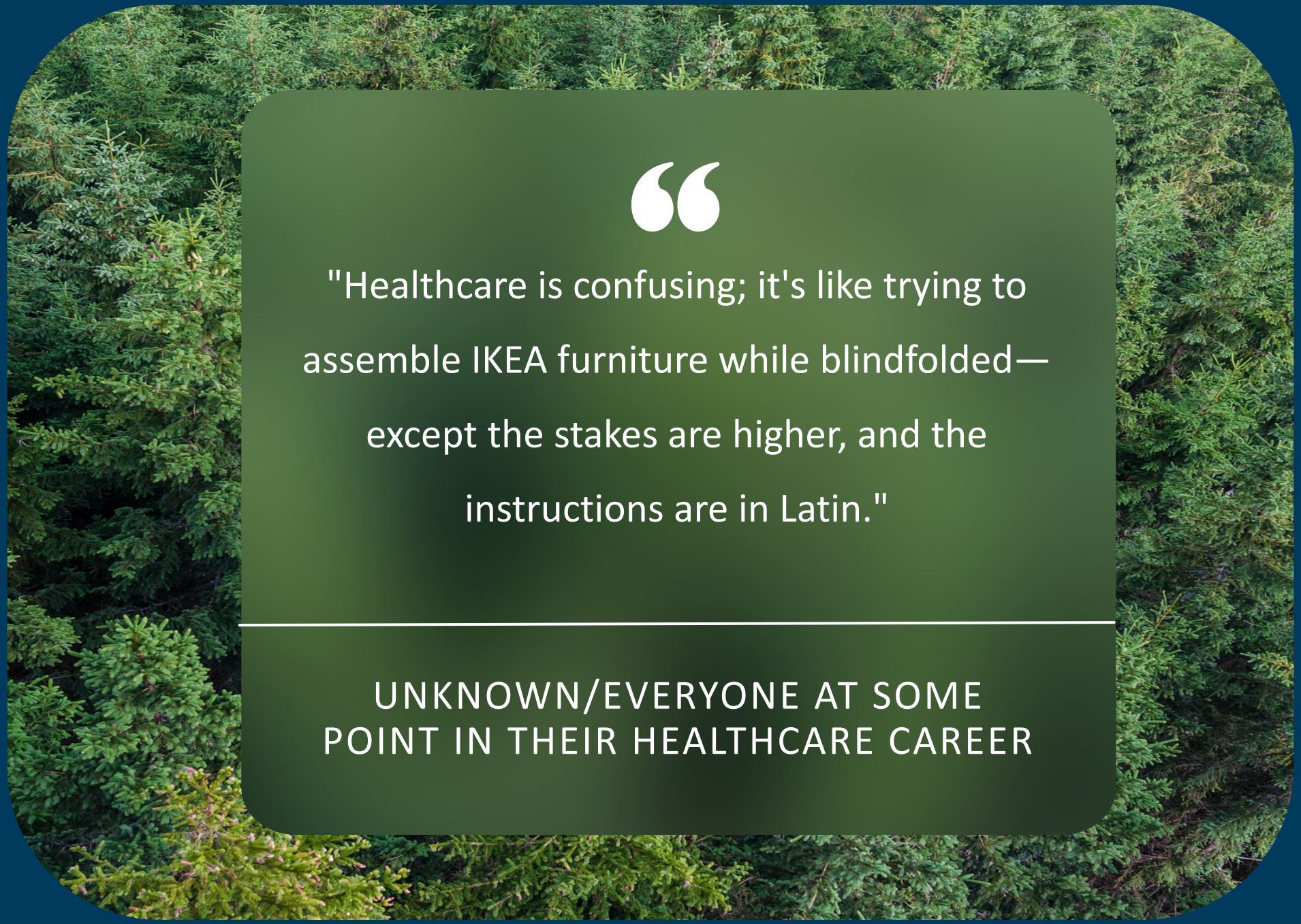
Authorizations

Some healthcare providers place orders to request specific services, which require insurance authorizations to ensure coverage before they can be carried out.

Each insurance company establishes its coverage policies, dictating which services, treatments, and procedures are covered under its plans.



High-Cost Procedures	Transplants Knee & Hip Replacements
Diagnostic Imaging	MRIs PET Scans
Prescriptions	Cosmetic (Propecia for Hair Growth)
Mental Health and Substance Abuse Services	Inpatient Treatment Programs



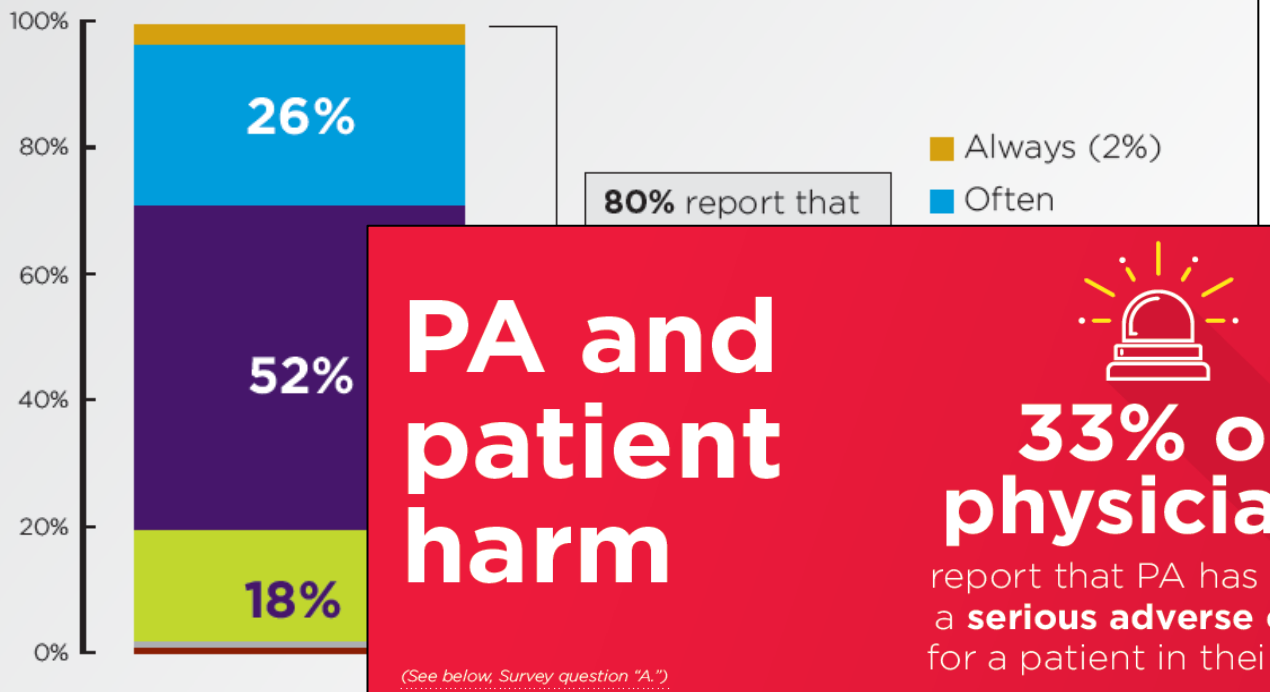
"Healthcare is confusing; it's like trying to assemble IKEA furniture while blindfolded—except the stakes are higher, and the instructions are in Latin."

UNKNOWN/EVERYONE AT SOME POINT IN THEIR HEALTHCARE CAREER

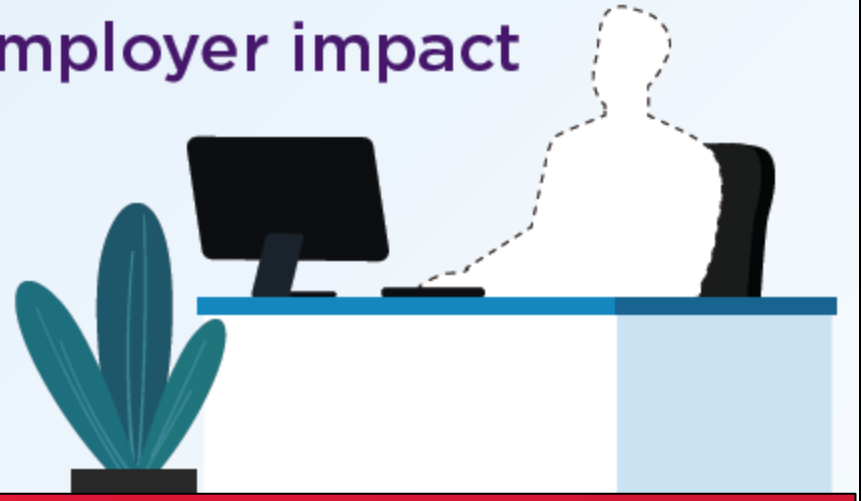
Prior Authorization Physician Survey (AMA)

Abandoned treatment associated with PA

Q: How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?



Employer impact



PA and patient harm

33% of physicians report that PA has led to a **serious adverse event** for a patient in their care.

(See below, Survey question "A.")

25% of physicians report that PA has led to a patient's hospitalization.

19% of physicians report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage.

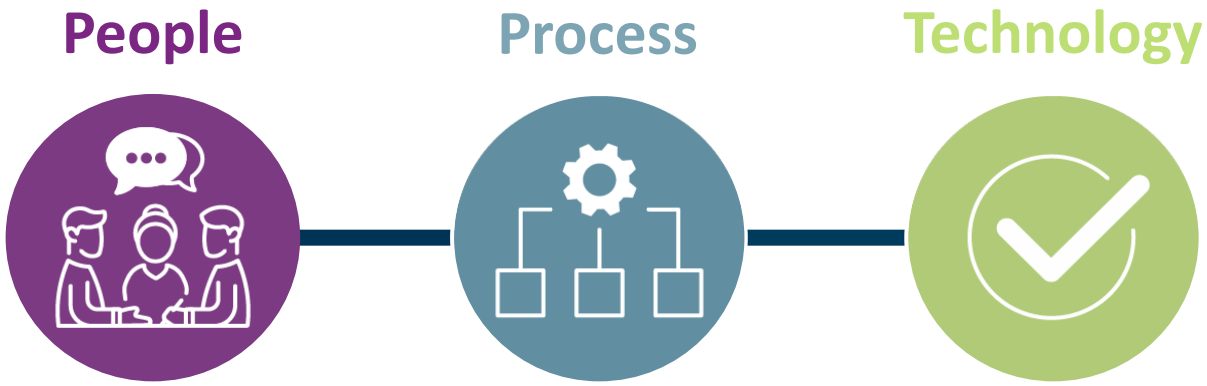
9% of physicians report that PA has led to a patient's disability/ permanent bodily damage, congenital anomaly/birth defect or death.

*From AMA (2022)

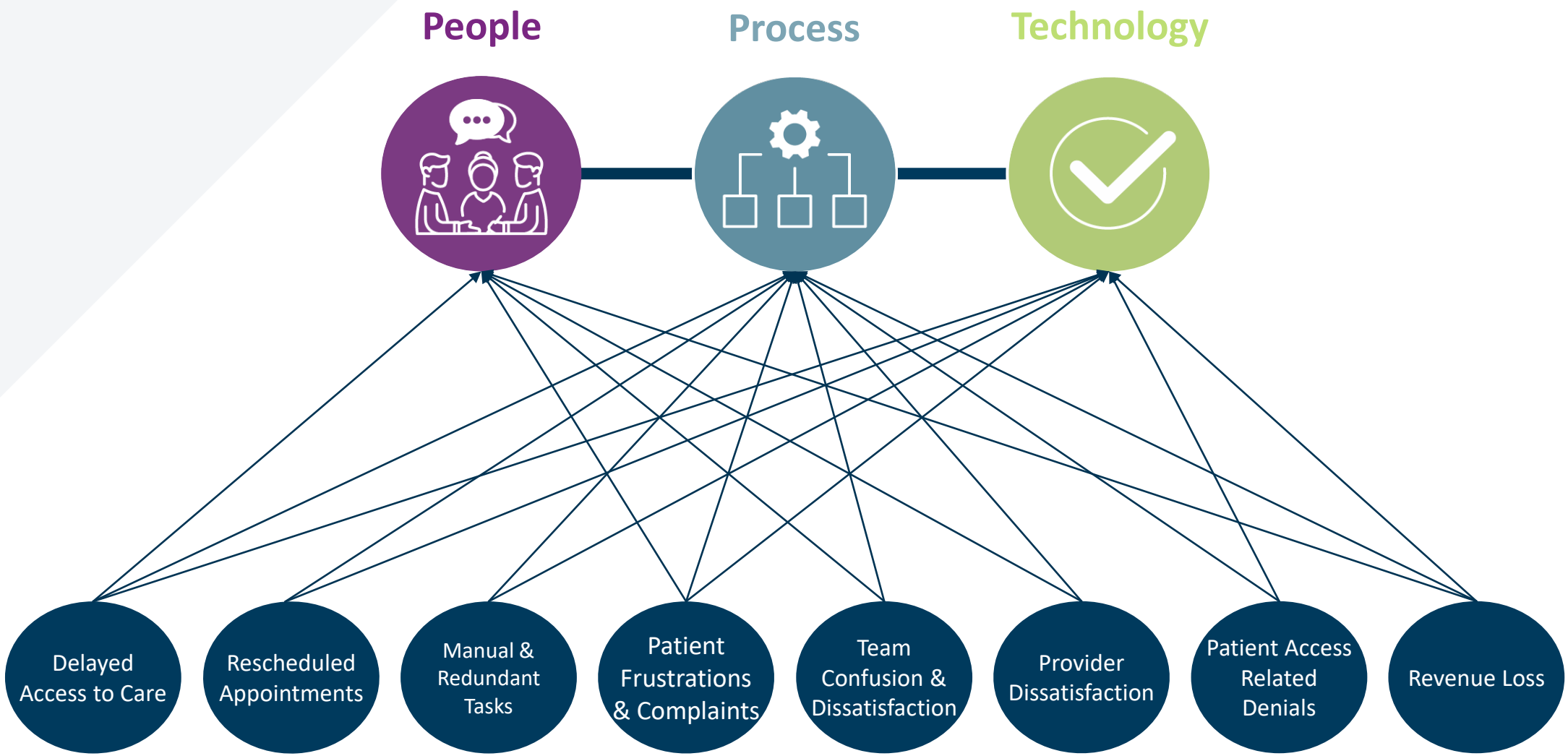
Starting at the Finish Line

Starting at the Finish Line: Our Primary Goal

Deliver timely, top-notch care that facilitates patient well-being, while ensuring that healthcare systems receive fair compensation.



The Interconnectedness of People, Process, and Technology



Patient Access Challenges: **People**, Process, and Technology

- **Lack of Standardized Training**: Inadequate onboarding and continuing education on workflows hinder team members' ability to perform their roles accurately and confidently. *Not understanding the 'why.' Generalized EHR training vs. workflow-specific training. Being 'thrown into the deep end.'*
- **Undefined Roles & Responsibilities:** Multiple job descriptions for the same role create confusion and uncertainty regarding team members' ownership of workflow components. *Who should be completing insurance verification? Who is responsible for obtaining authorization?*
- **Lack of Leadership Support:** Insufficient guidance and empowerment from Patient Access Leadership results in decreased team morale, confidence, and engagement. *Team members feel uncomfortable asking questions, making suggestions, or adopting optimized workflows due to the fear of making mistakes.*
- **Poor Communication:** Work is often done in silos, lacking interdepartmental communication pathways, which leads to errors and unstandardized approaches. *Department changes requiring Access Center build updates (e.g., decision trees).*
- **Resistance to Change**: Team members resist adopting optimized workflows, hindering efforts to improve efficiency and patients' access to care. *"If this gets implemented, I will quit!" or "That's going to take too long to do!"*

Patient Access Challenges: People, **Process**, and Technology

- **Antiquated Foundational Workflow Designs:** Workflows are largely reactive, not proactive, and <u>inconsistently</u> include:
  - **A Living Workflow Design Document:** Living process maps (Visio) illustrating a Patient Access Department's current state workflows. *Majority do not know their true current state. Perception vs. reality (e.g., running insurance verification, reading vs. asking).*
  - **Schegistration:** Not collecting and/or verifying patient demographic, guarantor, and insurance information at the time of scheduling. *Trusting that a patient's insurance information can be verified/updated at check-in, only for the patient not to bring their insurance card.*
  - **Insurance Verification:** Failing to run insurance verification and review response statuses and benefit details. *Undefined insurance verification response statuses workflow (i.e., active, inactive, or unresponsive).*
- **Manual Referral and Authorization Workflows:**
  - **Bypassing Insurance Determinants:** Not determining if the patient's insurance even requires authorization before spending time attempting to obtain authorization. *Waste of time and reduces capacity.*
  - **Missing Required Information:** Attempting to obtain or validate authorization without first ensuring all of the required details are in place. *Insurance details, diagnosis codes, CPT codes, and NPI numbers.*
  - **Validation of External Orders:** Blindly trusting the accuracy of incoming orders from external providers (i.e., does not require authorization). *Trust but verify.*
  - **Scheduling:** Scheduling before determining, validating, or obtaining authorization. Scheduling too soon/not far enough out. *Not one size fits all. Both can be successfully implemented.*

Patient Access Challenges: People, Process, and **Technology**

- **Multiple EHRs Used:** Creates duplicative work and increases the likelihood of patient demographic, guarantor, and insurance-related errors since there isn't a single source of truth. *Appointments are scheduled in Allscripts, but duplicate appointments must also be created in CPSI so that patients can check-in. Unsure of where to find secured authorization numbers.*
- **Underutilization of EHR Functionalities:** Existing EHR functionalities are not being leveraged or were not built correctly to streamline scheduling, referral, and authorization workflows. *EHR implementations were built based on the client's antiquated foundational workflows. Not leveraging decision trees. Provider templates (visit type lengths, blocks).*
- **Not Utilizing Bots or AI to Automate Authorization Workflows:** Manually reaching out to each payor to initiate and track the authorization process, which results in significant delays, often compounded by incorrect phone numbers and dead ends in communication. *Takes 40+ minutes to get through to a payor.*
- **Not Utilizing a Collaboration Platform:** Without a collaboration platform (i.e., Microsoft Teams), Patient Access Departments face communication and documentation (e.g., standard operating procedures) issues, which perpetuates disjointed workflows. *NDrive folders containing 5,000+ outdated documents, voicemails that are full, and emails that get lost.*

Breaking the Cycle: A Functional Cure for GDS

Breaking the Cycle: A Functional Cure for GDS

<u>Technology</u>:

1. **One EHR**: Phase out unnecessary EHRs lacking purpose; work towards a single source of truth.
2. **Optimize Existing EHR Functionalities:** Ensure your EHR build reflects best practice workflows. Consider implementing decision trees and reviewing provider templates to optimize scheduling and increase patients' access to care.
3. **Leverage Bots or AI to Automate Authorization Workflows:** Utilize bots or AI to determine when authorizations are required, facilitate and track submissions, and retrieve payor authorization responses.
4. **Leverage Provider Portals & Centralized Platforms:** Ensure Patient Access Team Members have access to:
   - Review coverage and benefit detail responses.
   - Determine if authorization is required.
   - Validate authorization details.
   - Efficiently enter, track, and search for authorization submissions.
5. **Utilize a Collaboration Platform:** Consider implementing a collaborating platform like Microsoft Teams to provide team members with a centralized location for easy communication and documentation storage (e.g., SOPs), ensuring consistent workflows.

The Second Act: The Tides Are Turning

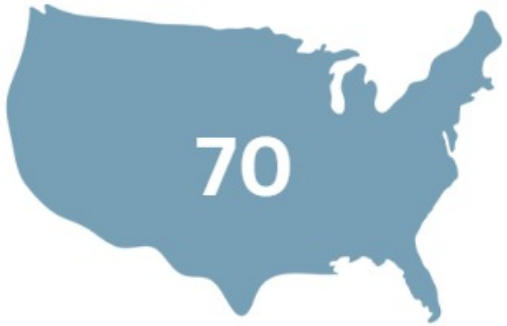
The Turning Tides

Centers for Medicare and Medicaid Services (CMS) Finalized New Regulations

- Starting in 2026, Medicare Advantage Plans and State Medicaid must respond to non-urgent authorization requests within seven days and to urgent requests within 72 hours.

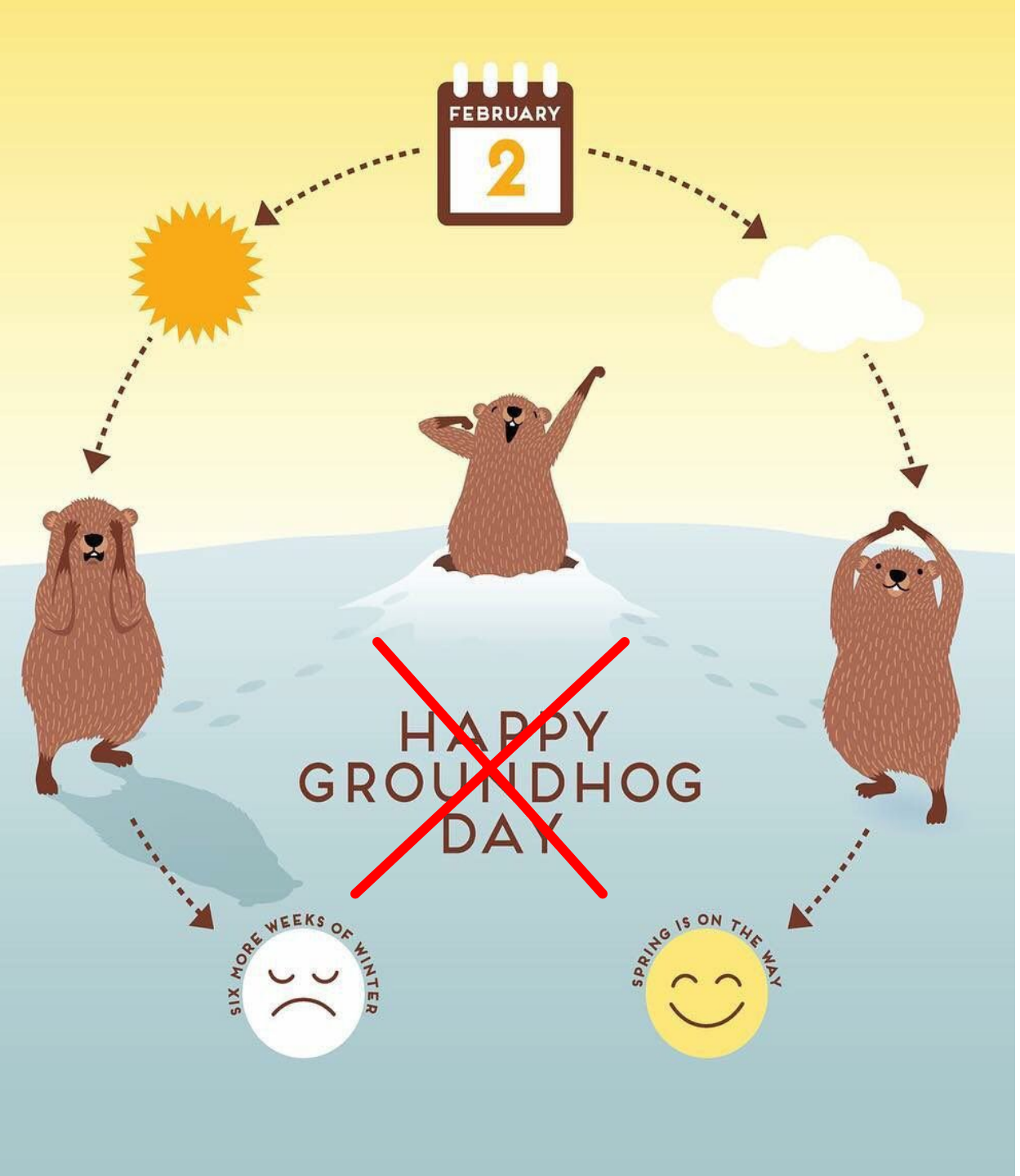
New Jersey Became the Latest State to Tackle Authorizations

- A new law was signed that requires insurance companies to make urgent decisions within 24 hours and routine decisions within 72 hours.



70 Impactful Measures Pending in State Capitals

- According to a National Conference of State Legislatures database, states enacted more than 20 prior authorization bills in 2023.
- The American Medical Association reports about 70 more bills pending in state capitals.



Conclusion: Breaking Free from Groundhog Day

Determine if your Patient Access Department is suffering from GDS.

Pinpoint challenges within your people, process, and technology workflows.

Implement recommendations for low-hanging fruit, plan for long-term solutions, and start having conversations on automation.

Final Thoughts & Questions

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