ARTICLE

EMPLOYED PROVIDER NETWORKS

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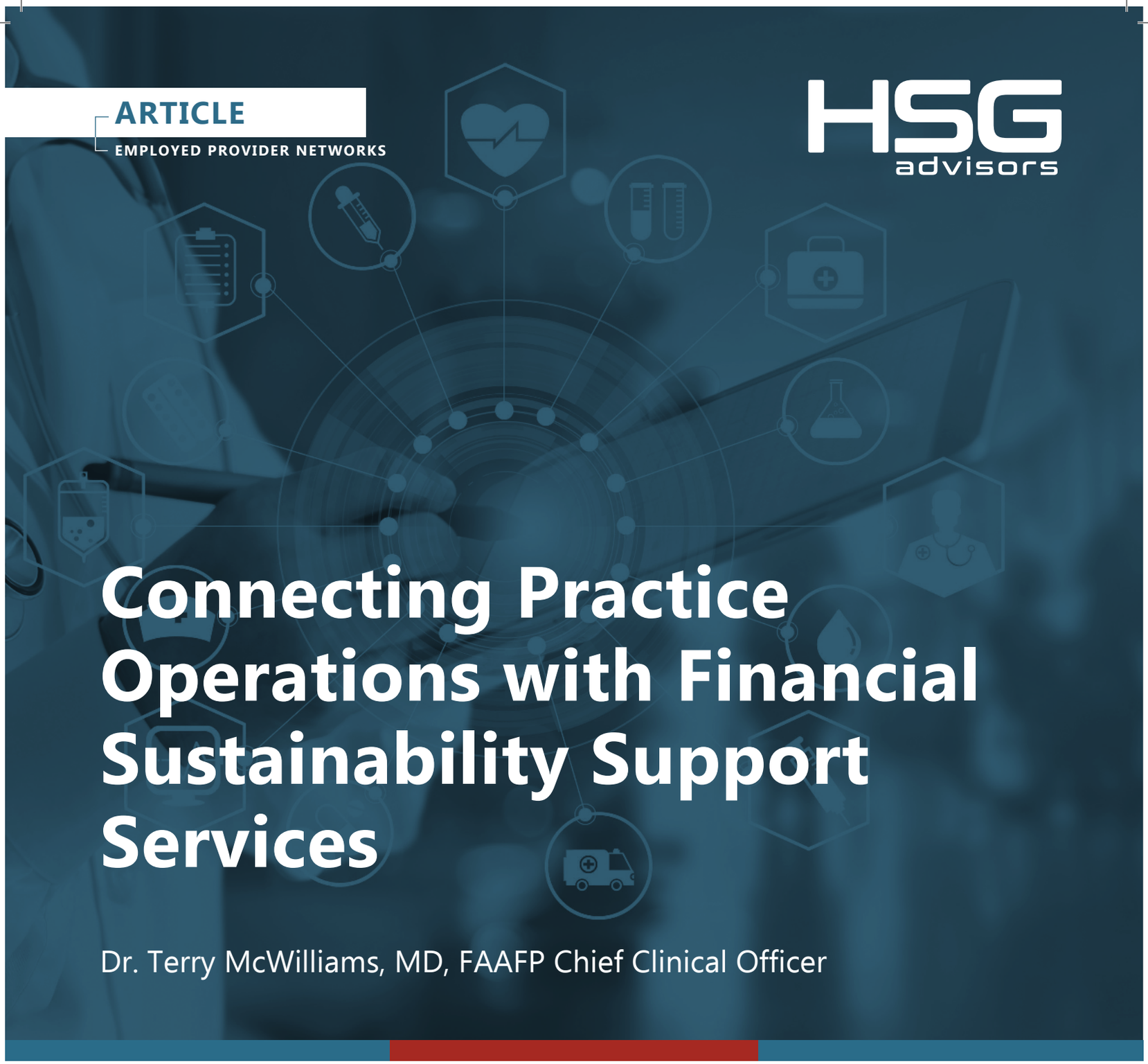

Connecting Practice Operations with Financial Sustainability Support Services

Dr. Terry McWilliams, MD, FAAFP Chief Clinical Officer

Effective, efficient practice operations require well-defined relationships, clear expectations, transparent communications, and mutual accountability. Employed networks, and their parent health systems, tend to focus on improving the operations management side of the organizational structure so practices run smoothly—and physicians and staff complain less. Not uncommonly, employed networks, and their parent health systems, overlook or undervalue the dedicated support services side of the organizational structure—particularly if support is provided through shared services arrangements.

While disconnectedness is an unfortunate occurrence regardless of support service area, two crucial areas that directly affect network financial sustainability and long-term viability are **revenue cycle** and **payor contracting**. Direct, meaningful interactions with both are critical to network success. Unfortunately, both areas tend to be disconnected from operations management—to the detriment of network performance.

The **revenue cycle** starts with a patient's initial contact with the office and continues until the resulting encounter claim is paid. Although the revenue cycle has many facets, it tends to be embodied in the professional services billing functions, which are often contained in a **centralized billing office (CBO)**.

The critical nature of the relationship between the CBO and operations management is manifested by the estimated 80% of claim denials attributed to the practice front end rather than the CBO back end—areas such as scheduling and check-in processes, prior authorization completion and accuracy, referral management, and encounter documentation. Identifying and correcting business and clinical processes to enhance co-pay and co-insurance collections, minimize claims denial rates, maximize revenue, and generate clean claims on the first attempt are paramount for success.

The opportunities for interfaces between these areas are numerous. The most imperative involves including revenue cycle leadership in employed network operations meetings—regardless of where these individuals reside in the health system organizational structure. This degree of functional integration is critical to maximizing mutual understanding and effectiveness. Participating in operations discussions permit real-time input in discussions and action planning which streamlines processes and avoids rework. It also affords an opportunity to ensure that workload is being proactively and accurately captured, and all patient interactions that are billable events are recognized, pursued, and secured.

Another key, desirable CBO and operations interface lies within the coding and documentation functions. Regular interactions and feedback to providers and staff maximize patient care revenue realization. For providers who are tasked with coding their own encounters, initial education followed by regular educational feedback through a formal coding audit program potentiates the adult learning process and reaps a significant return on investment.

For providers who are not tasked with coding their own encounters, their documentation of the care rendered is foundational to the coding process—a factor that may not be fully recognized by the providers. When providers receive regular feedback about their actual medical record entries and the impact their documentation has on encounter coding, clinical documentation predictably improves and ensures a more accurate capture of the care rendered and the effort expended. Connecting these dots is pivotal for maximizing professional services revenue and provider wRVU credit generated from the submitted claims.

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Additionally, timely claims submissions require timely completion of the clinical documentation. Claims cannot be submitted until the encounter document is completed, signed (authenticated), closed, and part of the legal medical record. Timely accounts receivable performance promotes a goal of submitting a clean claim within 3-5 business days of a patient encounter. This requires the encounter note to be completed within 2 business days—an expectation that should be explicitly delineated through a formal chart completion policy.[1]

The revenue cycle benefits from working closely with operations management to create and execute practical chart completion incentives. One mechanism is establishing a chart completion policy that sets clear expectations, including palpable consequences for noncompliance. A complimentary mechanism is incorporating a chart completion metric in the provider compensation model that awards overachievement. Using a combination of these mechanisms creates a carrot-and-stick approach that can very effectively achieve the desired outcomes.

Finally, timely third-party payor enrollment and initial credentialing is a critical step in determining effective start dates for newly recruited providers. Intimately involving third-party credentialing staff in the new providers' administrative onboarding process is crucial for establishing and achieving a realistic start date. Regular status updates and ongoing operations management support of these processes tend to be critical for new providers to take the process seriously and comply with requests for information required to successfully complete the process. Failure to do so can result in a delayed start (and a disgruntled new hire—because it is never their fault) or in an on-time start but no revenues generated for the services rendered and expenses incurred. Once credentialed, all payors require periodic updates – many of which require ongoing provider involvement and compliance—which the operations team can help manage.

Connecting operations management with payor contracting is often not considered—or is, at best, an afterthought. Historically, employed networks felt powerless in this area, as they were completely disconnected from the process and the staff. Payor contracts happened somewhere else in the organization and often favored lucrative acute care services rather than, or to the disadvantage of, office-based professional services. The networks felt that they just had to deal with the consequences. This relationship must be different—especially as risk contracting continues to assume increasing prominence in most markets.

The **value-based "pay-for-performance"** elements of payor contracts are often all about the employed networks. The connection between payor contracting and operations management needs to be bidirectional to affect the best outcomes. Payor contracting needs to understand the capabilities of the network and parameters that comport with reasonable performance expectations. The network needs to understand the value-based metrics, targets, and payor expectations to maximize performance and revenue. Disconnects do not allow either to happen—and the network "flounders," revenues are not realized, and financial performance suffers.

Connections between employed network operations management and payor contracting should not merely be information flow, i.e., these are the metrics and targets. The interface should be a functional integration with regular interactions so both truly understand the other and know each other's elements well. Payor contracting should designate dedicated individuals to deal with the office-based contract metrics and collect end-user feedback to be used in conversations with payors.

This feedback may include effective communication of the administrative burden of prior authorizations and other direct patient/member concerns – information that may be used to negotiate different future contract terms or processes. This designated resource should also be involved in employed network operations meetings for direct information exchange and input in discussions and decision-making. This functional integration can occur regardless of where payor contracting resides in the health system's organizational structure. This best practice predicts mutually beneficial, enhanced performances—and maximum professional services revenue generation.

Effective relationships are crucial to employed network success. Cultivating enhanced relationships between operations management, revenue cycle functions, and payor contracting will reap rewards across the system—and enhance employed network viability.

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REFERENCES

[1] HSG article re: Chart Completion Policy

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