Insurance-Attributed Avoidable Days in Transitions of Care

A Roadmap to Reduction of Excess Acute Inpatient Days

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It’s a cruel joke. It feels like Groundhog Day. I’m a seasoned case management director; however, at this moment I feel defeated. Why is this happening to me? I’ve done everything in my power to move this patient to a skilled nursing facility (SNF). I’ve reduced length of stay (LOS) by almost a full day since the beginning of the year when I took over this position. I have the respect of my staff, peers, the physicians, and the C-suite. I round twice daily on my units to support my staff, which is precisely why I feel helpless trying to advocate for this patient right now.

I’m attending multidisciplinary rounds (MDRs) on the step-down unit. The patient we are discussing has been stable for discharge—to an SNF she selected off the list her insurance provider supplied—for two days now. She was right on track to discharge within the parameters of the Geometric Mean Length of Stay (GMLOS) without any complications from her procedure. The authorization request was submitted the day prior to anticipated discharge with all the required documentation, and yet, with her head lowered, my case manager apologetically mumbles to the assembled team that we are still waiting on prior authorization from the insurance company. The patient in the next bed had four episodes of diarrhea last night, a C-Diff is pending, and now this patient spiked a temp last night and is complaining of loose stools. I’m starting to regret my career choices. This trend is relatively new and getting worse year over year.
Abstract and Business Case

Does this sound like your case management director? Has your institution put a price on the cost of an avoidable inpatient day? Most of our clients have determined $500 to $1,200 as a conservative average cost to cover nursing care, room, and pharmacy charges, not including professional fees.

Are you tracking insurance avoidable days and attributing them correctly? What is your current process of analysis, escalation and resolution? In the absence of quality and patient satisfaction issues, which inherently occur as a result of medically unnecessary hospital days, what is your financial loss on an annual basis? Are insurance delays a daily issue contributing to LOS inflation?

BRG industry experts would suggest that it is at least a seven-figure problem at your facility. We have developed a solution and a process to stop the hemorrhage that is occurring that is rooted in payer process inefficiency and the payer’s strategy for profitability.

Avoidable Days by Payer - Prior Auth SNF

![Avoidable Days by Payer - Prior Auth SNF](image)

Problem Statement

Fewer than twenty years ago, Medicare was the only Diagnosis Related Group (DRG) payer, and most commercial contracts were payed at a per diem rate depending on level of care. Insurance companies were motivated to move the patient through the continuum of care so they could incur less expense. The utilization review nurses at the health plan, at one time, had intimate knowledge of their members through daily interaction with the hospital case managers, even assisting with discharge planning in many cases. It’s curious that once the health plans converted to DRG methodology for reimbursement, they also put in play contractual language that allowed up to three business days to approve discharge resources. That grace period, where they queue up thousands of prior authorization (PA) requests from hospitals across the nation and provide limited internal resources to review them, created a delay that is more than half of the DRG GMILOS for which you are being reimbursed.

The shift from FFS (Fee for Service) Medicare to MA (Medicare Advantage) has created an extra step for PA approval, adding days to the tail end of the patient experience. The delays in rehabilitative care and increased risk for an adverse event in your facility can be avoided in your FFS Medicare population, since Medicare trusts your providers, therapists, and case managers to screen for medical necessity throughout the course of treatment.
Meanwhile, it costs the MA plans nothing to delay the processing and reviewing of medical records to approve a discharge to SNF and prolongs additional payments they will have to make to the SNF they are contracted with. How many of your patients decondition even further as a result of delayed rehabilitative services that are necessary for their recovery and wellbeing?

**Why?** According to a recent article in Modern Healthcare:

CEOs for the eight largest publicly traded insurers saw total compensation climb 14.4% in 2018. Nearly all of the largest publicly traded health insurance companies gave their CEOs a pay raise in 2018. That includes UnitedHealth Group, whose CEO David Wichmann's total compensation reached $18.1 million. Health insurer CEO compensation and company profits are topics fueling discussions about moving the U.S. healthcare system to a single-payer model to provide universal coverage to all Americans. Combined, the CEOs of the eight largest publicly traded insurance companies—including pharmacy behemoth CVS, which acquired insurer Aetna—made $143.5 million in total compensation in 2018, up 14.4%. Meanwhile, those same companies recorded a combined $21.9 billion in profits in 2018 on revenue of $718 billion.1

Could the short answer be revenue margins? Have the health plans tripled their professional staff over the years to handle medical necessity reviews for prior authorization, or are they not incentivized to process these faster? Have they purposefully found a contractual loophole and created an environment to increase their profits at your expense? What did they offer you? A few extra dollars over Medicare on the Relative Weight of the DRG?

**Proposed Solution(s)**

BRG professionals can assist in both short- and long-term strategies to reduce the amount of delays attributed to health plans for protracted prior-authorization responses. BRG Revenue Cycle and Case Management experts can analyze your contract language closely for payer bias clauses and supply the necessary elements to prevent delays often caused by boilerplate contracts that put you at risk on a daily basis. By accessing our DRIVETM platform, which includes the ability to drill down into detailed data (see graph above), we review your current avoidable day collection, documentation, and reporting habits and walk you through analysis, escalation, and resolution to reduce your overall LOS.

Accreditation supersedes contract language when there is a potential for patient harm if medically necessary rehabilitative services are delayed. Our team can walk you through the grievance process to ensure your right to a safe and timely discharge for your patients who require urgent rehabilitative services. Our processes ensure enhanced recovery time and increased bed capacity to care for your acutely ill patients.

**Avoidable Days Trends**

![Avoidable Days Trend Graph](source: BRG DRIVETM)

Future Direction and Long-Term Focus

Effective solutions require an institutional culture change. BRG’s on-site support and tools help the client identify, challenge, convince, and manage a small team of Finance and Case Management champions who will campaign for appropriate payer accountability. The payer/hospital relationship has deteriorated from a once-collegial, patient-centric experience. Hospitals have accepted this change with little resistance. Your institution likely has accepted the status quo. To offset financial losses, you have likely looked at other areas to find improvement to support capital growth or to remain relevant in your market (reduction in workforce, cancellation of valuable programs, budget cuts, reduced benefits, etc.). BRG has a long track record of supporting clients through each step of the journey. Your best interest is paramount to our mission.

Results and Conclusion

Do a little research. Quantify your hospital’s avoidable days. Is the data accurate or underreported? Task your CFO to determine the actual cost of a patient day. Include professional fees, nursing labor, room and board, pharmacy, and hospital-acquired conditions expenses. Isolate the days attributed to waiting on prior authorization.

While you are at it, pull and review a few contracts. A handful of Managed Medicare examples will determine how the rest of your commercial contracts are biased toward the payer’s profit and loss margin. Our experience has found that, depending on the hospital size, there may be six to twelve patients in house at any given moment who are lingering because of an inefficient third-party process that leadership may perceive is entirely out of their ability to control. What would your hospital emergency department and post-anesthesia care unit look like if these beds were available? Would you like those beds available to treat your community and generate revenue?

The BRG Care Transitions Team has partnered with dozens of hospitals on long-term implementation engagements to improve throughput and patient flow. As industry experts, we are uniquely qualified to partner with your team and transition the work we perform together into the hands of your staff to ensure sustainable results.

Our vision—to be the health consulting industry’s most trusted and sought-after advisor for pioneering and implementing sustainable solutions—drives every BRG professional to ensure mutual success. Please reach out to one of our managing directors to inquire about a tailored solution for your institution:

About the Authors

JOHN GUTZWILLER, BS, RN

John Gutzwiller, a senior managing consultant with BRG | Prism Healthcare Performance Improvement practice, has more than twenty-six years of nursing leadership experience in emergency departments, case management, health plan medical services, and consulting. His experience in LOS reduction, case, disease and utilization management, transition of care, regulatory statutes, policy development, and data analytics has been instrumental in leading many successful care transition engagements. He is dedicated to appropriate allocation of resources; safe, efficient transition of care, communication; collaboration; time management; and cost analysis. Establishing a culture that supports and promotes education, teamwork, success, and pride are key to his approach when engaging a client.

Before joining BRG, Mr. Gutzwiller worked with a multistate Medicare, Medicaid, and commercial health plan as the senior director of Medical Services. In addition, he held Case Management director positions at multiple healthcare systems, managing LOS to national benchmarks, reducing readmission rates, and ensuring proactive involvement of a multidisciplinary care team. His clinical background is emergency care, where he has been recognized for his leadership, teamwork, proficiency, and customer service skills. His experience in implementing performance improvement initiatives through education, mentorship, and managerial support make him a valuable asset to the BRG team, allowing his executive engagement sponsors and colleagues to achieve or exceed their desired outcomes.

RAMONA ANDERSON, RN, BA, ACM

Ramona Anderson is a managing consultant in the BRG | Prism Healthcare Performance Improvement practice and a Registered Nurse with over twenty-eight years of experience in the healthcare industry. She has a broad range of administrative and clinical skills with proven expertise in utilization and case management, performance improvement, and quality, as well as denials management and revenue cycle. She works closely with department leaders and front-line staff to implement clinical process improvement initiatives, resulting in decreased LOS, improved utilization management of services, and enhanced collaboration amongst the healthcare teams.

Before joining BRG, Ms. Anderson was recognized for developing a new hospital case management program from inception and held progressive leadership positions with multi-site regional management responsibilities at a top ranked nonprofit healthcare leader in Minnesota. She has been instrumental in significant LOS reduction, improved quality star rating, CMS Conditions of Participation compliance, readmission reduction, and medical necessity denials reduction while working with both nonprofit and for-profit health systems.

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