



APPEALS AND GRIEVANCES: Automate the Process to Improve Member Satisfaction and Your Bottom Line

TABLE OF CONTENTS

- 1 The appeals and grievances process can lead to improved member satisfaction and increased profitability.
- 1 The best evidence of the advantage of increased appeals and grievances automation can be seen in the places they matter most: member satisfaction and the bottom line.
- 2 Streamline Communications
- 2 Simplify File Management
- 2 Save Time
- 4 Minimize Risk
- 5 About SunGard
- 5 SunGard iWorks Healthcare
- 5 Partnering

THE APPEALS AND GRIEVANCES PROCESS CAN LEAD TO IMPROVED MEMBER SATISFACTION AND INCREASED PROFITABILITY.

The appeals and grievances process is regulated, scrutinized and monitored. Guidelines with state Departments of Insurance (DOI) are contingent upon swift dispatch and effective management. The Centers for Medicare and Medicaid Services (CMS) include very specific language regarding timely response, escalation, prioritization, tracking and reporting.

With so much riding on this process – including significant fines and penalties for non-compliance – payers are finding that process efficiencies are a must. Fortunately, the appeals and grievances process lends itself to automation. And automation leads to improved efficiency; which then leads to better member satisfaction levels and improved profit margins.

Automating the appeals and grievances process enables payers to:

- **Streamline communications:** Guide coordinators automatically through communication procedures with members and providers by employing best-practice-based correspondence templates, while gaining visibility into the entire correspondence process. Miscommunication is reduced or avoided.
- **Simplify file management:** Enable supporting documents such as signature forms, physician reports and other material information to be automatically detected upon arrival and attached to the rest of the case documentation. Document misplacement is avoided.
- **Save time:** Minimize human-intensive elements of the process by streamlining routing for expedited cases, aligning the right people with the right tasks, integrating disparate systems to pull and push information for a cohesive view and easily populating complainant information into the core administration system. Reduce inefficiencies associated with manual entry.
- **Minimize risk:** Manage compliance proactively through an automated approach that provides a detailed, long-term record for every case. An aging calendar also enables continual monitoring of milestones and deadlines. Remain compliant.

With requirements varying by product line and applicable laws and industry standards changing often, additional efficiencies continue to be necessary – and increased automation is key. Further automating the appeals and grievances process helps rapidly resolve cases, decrease operational costs, reduce errors and demonstrate compliance – all of which contribute to greater efficiencies and ultimately, increased member satisfaction and higher profit margins.

THE BEST EVIDENCE OF THE ADVANTAGE OF INCREASED APPEALS AND GRIEVANCES AUTOMATION CAN BE SEEN IN THE PLACES THEY MATTER MOST: MEMBER SATISFACTION AND THE BOTTOM LINE.

Member satisfaction and the bottom line – the two go hand in hand and are completely dependent upon a comprehensive positive customer experience. Though minimizing the number of appeals or grievances filed is the ultimate aim, efficiency – accelerating resolution and facilitating consistency, is the first step.

Appeals and grievances automation can be realized with integrated technologies for document and business process management and business activity monitoring. Automating the process enables payers to streamline communications, simplify file management, save time and minimize risk. What's more, insurers can successfully use technology to ensure regulatory compliance and improve overall member satisfaction.

“EFFICIENCIES LEAD TO INCREASED MEMBER SATISFACTION AND PROFITABILITY”

STREAMLINE COMMUNICATIONS

To ensure process visibility for complainants, state and federal regulations stipulate certain appeals and grievances notifications to be initiated within specific timeframes from when a milestone is achieved. Each such notification must meet appropriate internal legal and compliance standards before it is sent. The constraint is that similar but different content still needs to be reviewed, which can, in turn, jeopardize crucial time frames.

With the right technology, insurers can use best-practice-based correspondence templates that help guide coordinators through communication procedures with members and providers. These templates ensure uniformity of language and message while minimizing the effort and time associated with manually written communications. Traditional correspondence items – request-for-signature forms, reminders, about-to-close letters, determination letters and others – can be standardized in terms of content and internal creation procedures. Automation can also provide visibility into the whole correspondence process via real-time tracking of communications, documents and resolution time frames.

SIMPLIFY FILE MANAGEMENT

Appeals and grievances are initiated in a variety of ways, including electronic formats and paper. After that, however, a myriad of supporting data – originated within the payer or from external sources – must be received, routed, associated, evaluated and processed. But no matter which of the many forms that additional information takes, it must be quickly and easily absorbed into the overall case file.

With a proper combination of process and content management technologies, supporting documents such as signature forms, physician reports and other material information can be automatically detected upon arrival and attached to the rest of the case documentation for review. Automated systems can also help minimize the enormous burden traditionally involved in case construction and maintenance by replacing paper document handling, routing and storage with digital capture that offers post time stamps, file location data, and integration with core administration systems.

SAVE TIME

Many benefits can be derived from the use of rules-based workflows to help ensure the appeals and grievances process is conducted consistently and in a timely manner – in other words, advancing the case with minimal human intervention. These pre-defined rules are automated, flexible and cover the majority of data collection and case tracking tasks. As such, payers can realize additional return on their appeals and grievances automation investment by leveraging the technology to help minimize the more human-intensive elements of the overall process.

An appeal is waiting for a signature form before it can proceed. After the standardized letter requesting the form has been sent, the automated system begins to wait for a signature form with a matching case and member number corresponding to the appeal in process. When the form arrives, it enters into the system as any other incoming document by scanning, faxing, email or other method. The system is already looking for the document with the matching data; within seconds of receipt, it automatically attaches it to the appeal and advances the appeal to the next stage of review. On the other hand, if the form takes too long to arrive, the system advances the case to the next step of escalation or closure depending upon the pre-configured rules and process design.

- **Decrease member resolution time frames; meet mandated time lines.** When time frames close in, manual solutions often result in “walking the case around” the organization to achieve quick resolution. While this works for the occasional individual case on an infrequent basis, it is overall inefficient for staff members, and therefore, may lead to more appeals or grievances approaching time limits. With an automated tracking system, each case is continually tracked by the system as it progresses, and automated alerts and notifications eliminate the need for staff to maintain and

monitor status data. Regardless of history, cases can be independently tracked without human effort to maintain a status list. Staff members are notified of areas requiring attention instead of exerting valuable effort to monitor cases without issues or manually transferring cases – which can lead to mishandling.

- **Streamline routing for expedited cases.** Expedited processes can be used to provide an abbreviated version of the standard (non-expedited) flow. These expedited flows have all the alerting, reporting and staff efficiency advantages of the non-expedited versions. For example, an expedited flow may have a higher priority in the work queue and be routed more quickly through the process than a non-expedited case. A phone call or other real-time activity may be assigned to replace the usual letter exchange which introduces wait periods and escalations not desirable in expedited situations.
- **Align the right people with the right tasks.** At each stage of processing, the system can return a case to a specific staff member who worked on it in any previous stage. This allows supervisors and analysts to automate the selection of the best person for each processing activity. In some cases, such as when supporting documentation has just arrived, it is best to return the case to the individual who last worked on it to take advantage of recent memory and knowledge. In other cases, based upon how the case is proceeding, it may be better to return it to the originator, a supervisor or another individual from a precise point in its lifecycle to render judgment. Finally, there are times when there are no particular constraints, and the case should simply flow to the next available person possessing the appropriate skills. The system can make any and all of these determinations quickly and without any human involvement beyond the initial institution of rules.
- **Provide a cohesive view of information to aid in better decision making.** In many organizations there are a plethora of systems that may be aligned with functional areas and/or specific tasks. These systems in concert with a skilled person behind the helm provide all the relevant information to work the appeal or grievance however the penalty is in the time needed to gather the information and the skilled person to know exactly which system to obtain what information. With the ability to integrate these disparate systems and pull and push information from many systems into a single view aids in speed to process the appeal or grievance and the ability to have those skilled workers dedicate their skills on resolving the matter versus knowing the ins and out of systems.
- **Effortlessly populate complainant information into the core administration system.** Each appeal or grievance has information that may need to be sent to the core administration system for complete recordkeeping and compliance purposes. Manually re-keying this information is time consuming and prone to error. By tracking appeals and grievances on an electronic form with integration to the core administration system, the data can be transferred in one action and with complete accuracy. In most cases, extensive case form details can be shared with the host in a matter of seconds, eliminating the need for retyping or later correction of basic case information in the administration system.

A Medicaid appeal is within three days of delayed processing. Emails and other notifications are automatically sent to appropriate personnel to alert them of the problem. Staff members review the case from their desks and take the appropriate action which, in turn, causes the system to automatically advance the case to the next stage.

A commercial appeal requires that a letter be sent indicating the appeal is being closed if there has been no response to a request for information within forty days. No one has to repeatedly check the case status to decide when the letter should be sent; the system creates a task when the designated time arrives.

MINIMIZE RISK

The appeals and grievances process is a highly scrutinized and regulated function that requires ongoing compliance demonstration for a variety of stakeholders and drivers. As appeals and grievance requirements change over time, one constant in meeting them remains: the ability to accurately and consistently provide the full case history from beginning to end and to reproduce all associated communication. In addition to the historical audit, meeting updated compliance requirements includes the ability to accurately age required milestones or deadlines and prove consistent adherence. Document security poses yet another compliance risk.

An automated appeals and grievances solution centralizes all these elements for different types of reporting. The system can provide a detailed, long-term record that is backed up frequently for every case – past or present. This updated approach is more reliable over time than paper checklists, which may be inconsistently marked, inappropriately transferred, damaged or lost. Inherent in the system is also an aging calendar and continual monitoring of milestones and deadlines. This allows for accurate aging of required milestones or deadlines, providing consistent adherence to updated compliance requirements.

Security is also reinforced as electronic copies of documentation are stored within secured technology. Automated content management features can protect any document or selected sub-types of documents as soon as they become part of an appeal case. When this feature is combined with process management functionality that automatically associates new documents with the appropriate appeal or grievance, unauthorized access is prevented before it can occur.

Automated systems can also streamline the reconciliation portion of the appeals and grievances process by creating a temporary security vault that enables pending cases to be safely and securely stored while the insurer awaits additional information. As new information arrives, in any format, the intelligent document automatically reconciles the vaulted case files with the new information. The auto-reconciliation takes seconds, saving a significant amount of end-to-end case processing time and staff effort. The vault is secured by restricted user access with automated time and staff identification stamps that create an electronic record of when and by whom information was accessed, creating a complete audit trail to help meet HIPAA and other security requirements.

As evidenced within, further automating the appeals and grievances process helps create efficiencies that translate into faster case resolution, decreased costs and reduced errors – all of which contribute to increased member satisfaction and higher profit margins. From case creation through resolution, customizable libraries of best-practice workflows, electronic forms and pre-defined rules can help payers quickly and more effectively manage all aspects of the appeals and grievances process.

As appeals and grievances requirements change over time, one constant in meeting them remains: the ability to accurately and consistently provide the full case history from beginning to end and to reproduce all associated communication.

ABOUT SUNGARD

SunGard is one of the world's leading software and technology services companies. SunGard has more than 20,000 employees and serves 25,000 customers in 70 countries. SunGard provides software and processing solutions for financial services, higher education and the public sector. SunGard also provides disaster recovery services, managed IT services, information availability consulting services and business continuity management software. With annual revenue of about \$5 billion, SunGard is ranked 434 on the Fortune 500 and is the largest privately held business software and IT services company. Look for us wherever the mission is critical. For more information, visit www.sungard.com.

SUNGARD IWORKS HEALTHCARE

SunGard has been helping healthcare payers succeed for more than twenty years. Our award winning Maces and FormWorks solutions are trusted in a wide range of operational areas including Claims, Member/Provider service, Enrollment, Appeals, Authorizations, Contracting, Marketing, Legal and many others. Healthcare payers also depend on SunGard's Financials solutions for comprehensive accounting and reporting to meet the stringent demands of regulators and stakeholders. Our healthcare payer clients cover the spectrum of size and specialty from indemnity to managed care, individual and group products, from fully funded to TPA financial models. With hundreds of implementations in this range of healthcare payers, SunGard compliments core platforms from other vendors and enhances many in-house applications.

The iWorks Solution Suite is used by more than 2,500 customer sites in more than 50 countries. The iWorks suite provides business-focused technology solutions for the insurance industry in each of the following major business lines: life/ health/annuities/pensions, property and casualty and reinsurance.

PARTNERING

Working as a team with both customers and other technology providers pays dividends. Customers obtain more elegant solutions truly tailored to their organization. Technology partners can leverage their particular expertise more effectively. SunGard works with customers of all sizes, including some of the world's largest insurers, all of whom appreciate how technology can power their success. We are also proud to work closely with leading technology providers like Microsoft and HP.

For additional information on SunGard iWorks Healthcare Solutions, please go to www.sungard.com/iworkshealthcare or contact us at iworks.info@sungard.com.

www.sungard.com/iworkshealthcare

SunGard

104 Inverness Center Place
Birmingham, AL 35242
Tel: 205-437-7500
iworks.info@sungard.com

www.sungard.com/iworkshealthcare

©2011 SunGard.

Trademark information: SunGard, the SunGard logo and iWorks are trademarks or registered trademarks of SunGard Data Systems Inc. or its subsidiaries in the U.S. and other countries. All other trade names are trademarks or registered trademarks of their respective holders.