Reimagining Patient Access

Artificial intelligence at the epicenter of coordinated benefits management.

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Today’s Presenter

“Fig” has over 20 years of experience in the healthcare and information management spaces, having worked with a broad range of hospitals, providers, payers, and government agencies on transformational projects.

His extensive background in EDI created a passion for developing low/no touch process automation through the use of data and applied analytics, and his career path is a natural progression of that desire for innovation.

Before Experian, Fig was the Chief Operating Officer of Wave HDC, a healthcare technology start-up where he managed an agile, innovative product portfolio that integrated Eligibility, Demographics, Discovery, MBI and COB ‘curators’ to simplify the revenue cycle process. Previous to Wave, he led the Sales & Business Development group at Change Healthcare.

Modernization of RCM

Improved POS Automation is the primary driver.

<2014

Providers seek basic integrated eligibility functions with EMR, HIS systems

- Oracle, Epic begin to integrate real-time eligibility functionality
- Meditech and other HIS systems follow

2019

Basic chaining automation a primary theme for Medicaid HMO and Medicare

- Epic and other EHR systems begin to offer provider-administered native chaining functions
- Disparity and inefficiency rule due to staffing and limitations

2020-2024

HIS systems invest in automated filing order logic to assist claim generation

- Basic logic to file flagged primary from system followed by auto-attaching primary EOB with secondary payer claim
- Limited logic to reorder payers on claims with departmental logic overrides (e.g. ESRD claims file to Medicare)

TODAY

Most providers have capabilities, but COB and Eligibility Denials at a all time high

- Volumes of denials outpace ability to hire & train Registration and Billing specialists
- Payers deploy vendors and sophisticated analytics to proactively deny claims; provider technologies moderately stagnated as “good enough” with a focus on reactive staffing

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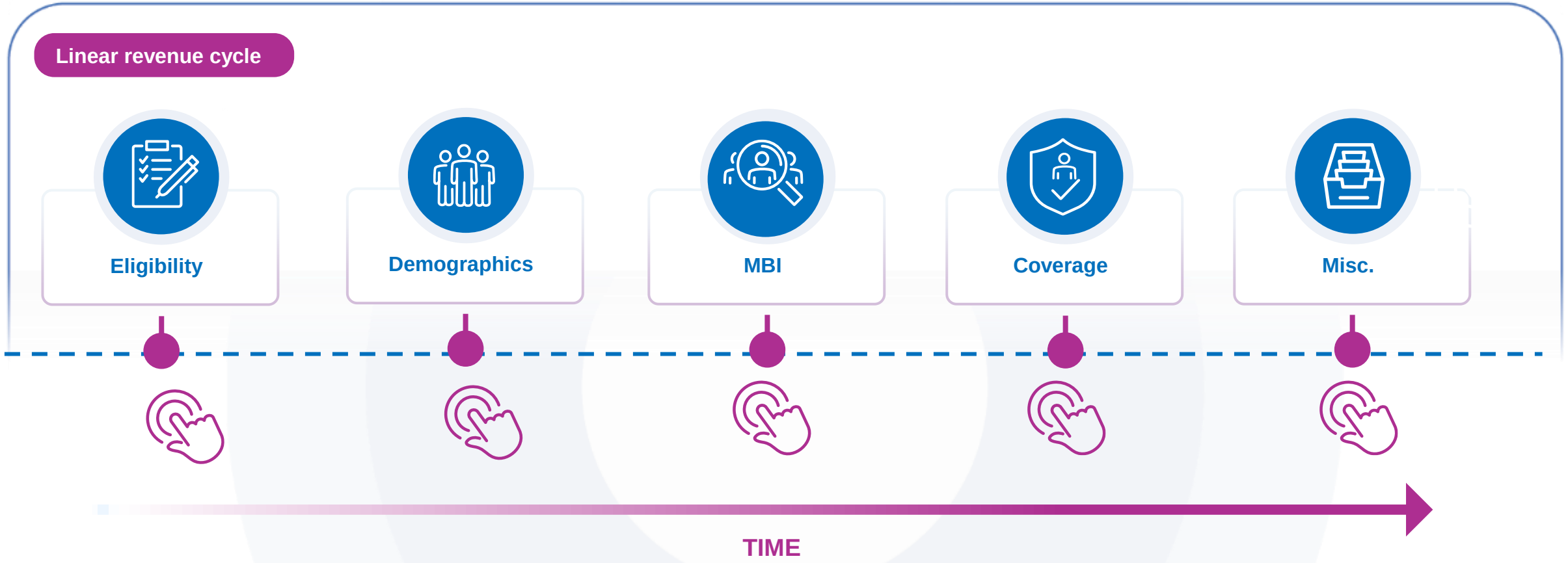
Legacy 1:1 rev cycle – Multi-step Investigation



Measuring the Problem: Case Studies

Case Study 1: Retrospective Denial Analysis

SCOPE

- **12-month retrospective review** of all initial denials for primary payer claims inclusive of HB and PB claims.

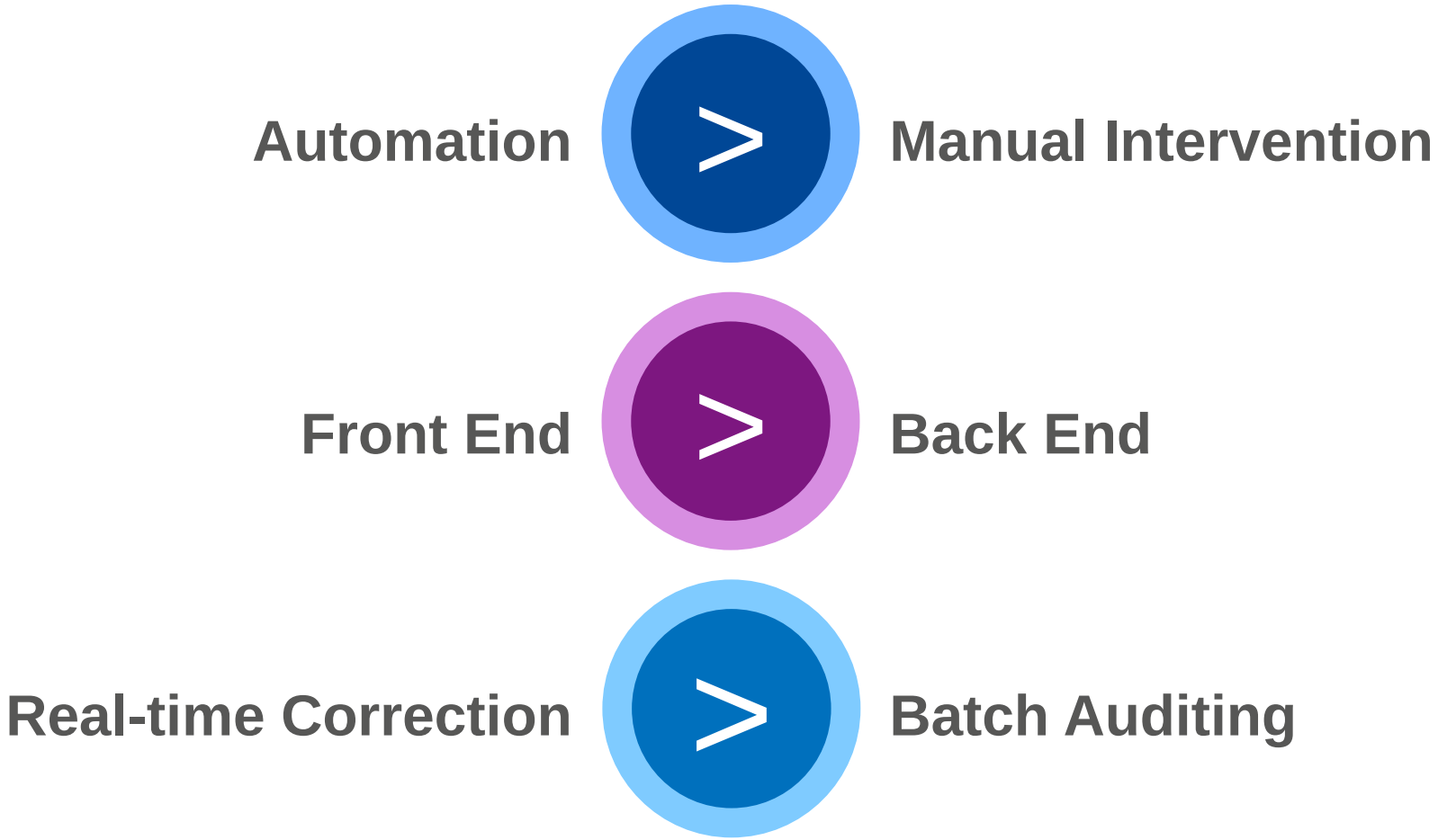
FINDINGS

- For most providers **11-18% initial denials are for coverage** related issues. Ratios can be skewed by other issues like claim or enrollment\credentialling issues.
- **53% of denials were COB-related** (22/109)
  - Medicaid and Medicare payers overrepresented, even with query chaining in place.
- **25% of denials were eligibility-related** (27/26)
  - Over representation of known termed coverages were found in the data.
- **~20% of denials were timely filing** (excludes timely appeal) related
  - Majority related to other categories, such as COB denials being finally corrected, but past timely filing when routed to the correct payer.

Impact Grouping	Denial Volume	Denial Rate	Dollars
Coverage Related	**353,600**	**11.68%**	**$ 261,295,957**
COB	187,143	52.93%	$ 124,586,750
Eligibility	89,997	25.45%	$ 75,834,121
Timely Filing	76,460	21.62%	$ 60,875,086
Other	**2,674,184**	**88.32%**	**$ 2,637,111,417**
Edits	591,830	22.13%	$ 588,090,307
Coverage	478,767	17.90%	$ 280,738,878
Duplicate Claim	377,783	14.13%	$ 337,523,352
Coding	262,669	9.82%	$ 246,090,356
Adjustment	217,147	8.12%	$ 253,922,964
Recovery	200,632	7.50%	$ 182,557,294
Authorization	176,314	6.59%	$ 342,814,586
Documentation	169,685	6.35%	$ 271,851,827

Demonstrating a Path Forward

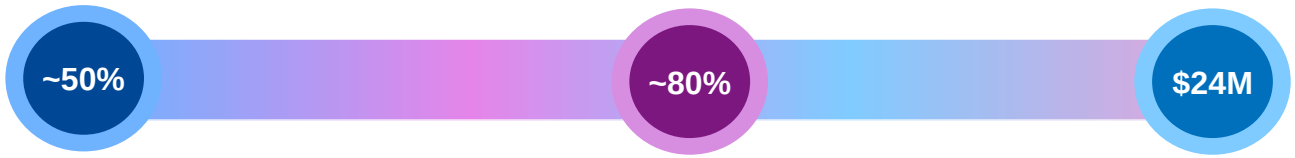
RCM Modernization Rules



Case Study 2: Provider Denial Audit Findings

Denial Outcome	Volume	Percentage	Charges $	Charges %
COB	**7,067**	**76.31%**	**$35,024,052**	**75.28%**
No Primary Change	4,132	58.47%	$17,897,645	51.10%
Payer Change	2,935	41.53%	$17,126,407	48.90%
Demographic	**98**	**1.06%**	**$491,170**	**1.06%**
No Primary Change	39	39.80%	$130,737	26.62%
Payer Change	59	60.20%	$360,433	73.38%
Eligibility	**1,831**	**19.77%**	**$9,501,418**	**20.42%**
No Primary Change	744	40.63%	$4,387,909	46.18%
Payer Change	1,087	59.37%	$5,113,509	53.82%
Timely Filing	**265**	**2.86%**	**$1,506,928**	**3.24%**
No Primary Change	205	77.36%	$1,022,692	67.87%
Payer Change	60	22.64%	$484,236	32.13%
Grand Total	**9,261**	**100.00%**	**$46,523,568**	**100.00%**

~40% of denials could have been resolved at point of registration had HIS system had technology to automate correction.



% of actual denials identified as requiring a payer change that the system was able to provide the correction

% of the correction predate the DOS and would be corrected at registration / scheduling via automation

Total dollars in automated correction and allows staff to focus on research and correction of the remaining claims

Case Study 2: Provider *Retro* Denial Audit Findings

Denial Outcome	Volume	Percentage	Charges $	Charges %
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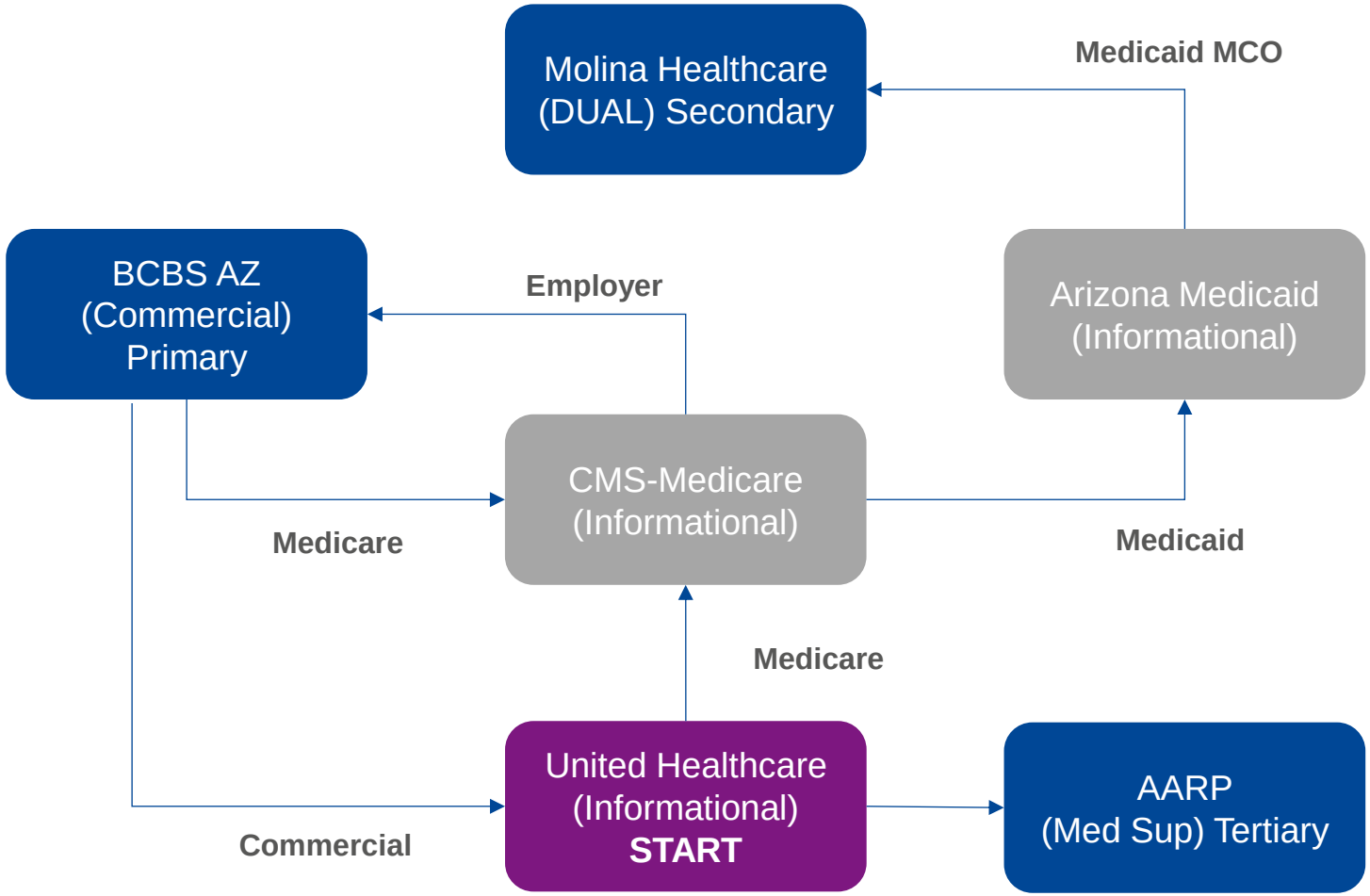
COB DENIAL FINDINGS

- ~50% of COB (22/109) denials had clear and present indications of **other primary payer coverage**, with ~80% of those coverages verifiable at the time of service with automation
- Medicaid HMO misses indicate existing “established” **query chaining** is outdated or poorly maintained
- Missed Commercial and Medicare primary coverages present significant **revenue risk** while being a smaller portion of the total volume
- Majority of Commercial primary for Medicaid were **valid but undetected**, and ~20% were outdated\invalid TPL record

ELIGIBILITY DENIAL FINDINGS

- ~95% of Eligibility (26/27) denials had **clear and present indications of the coverage on file was terminated at the time eligibility** was originally run, but where the reg workflow or user did not remove the invalid coverage
- ~5% of Eligibility denials were a function of **retro termination**
- **Unidentified terminations = missed opportunity** to take corrected action at time of service, leading to denials, additional labor and lost revenue (missed auth\pre-collect)
- **~60% of termed coverage patient episode would have returned corrected** at time of service via Discovery

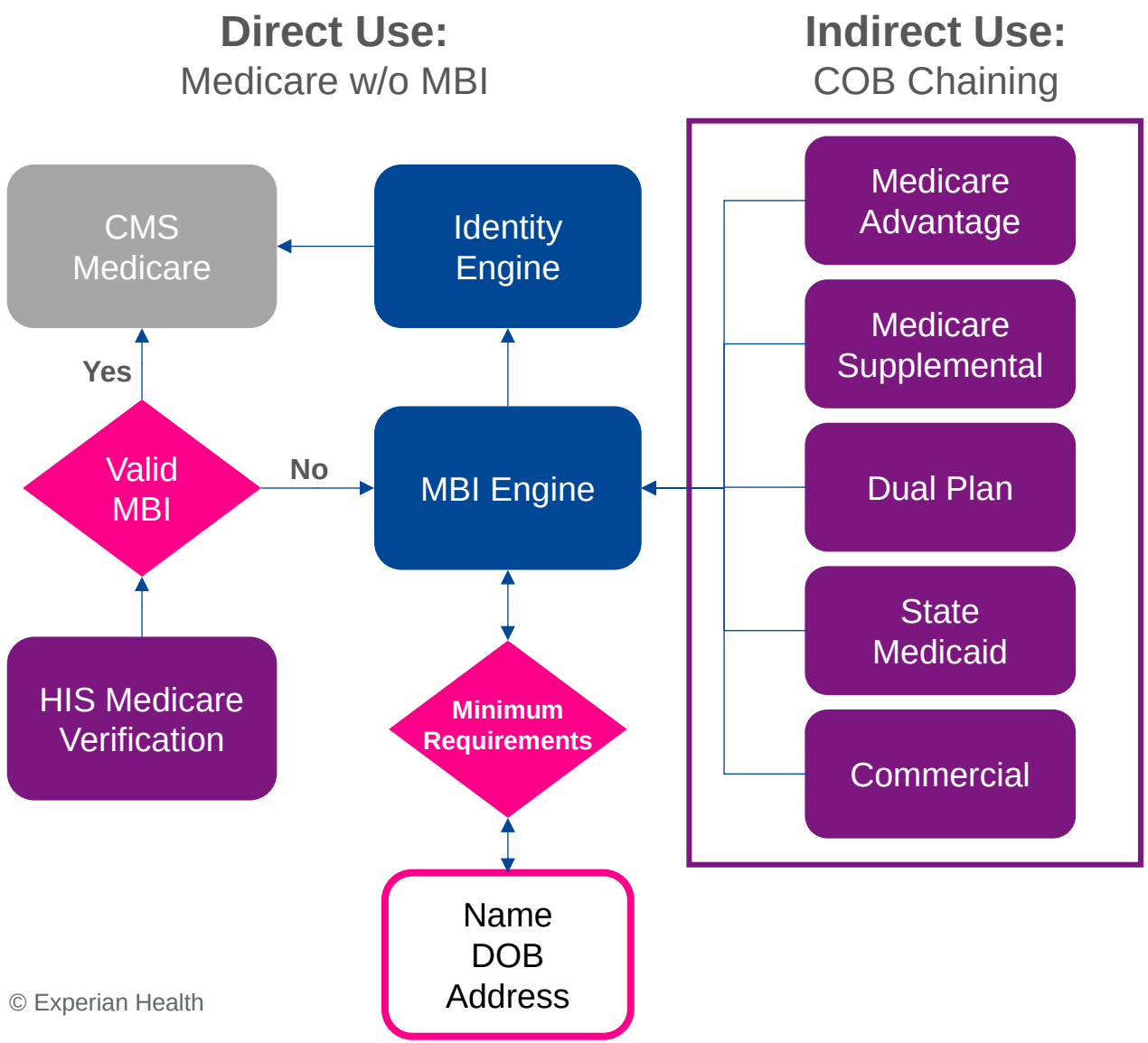
Real-time eligibility with MBI & COB automation



Data and technology as the solution

- Conduct real-time identity confidence scoring to maintain compliance and PHI controls
- Processes each payer response
- Triggers transactions to other payers using Coverage Curator engine
- Labels Primary, Secondary, Tertiary and informational coverages
- Transmits full payer 271s directly

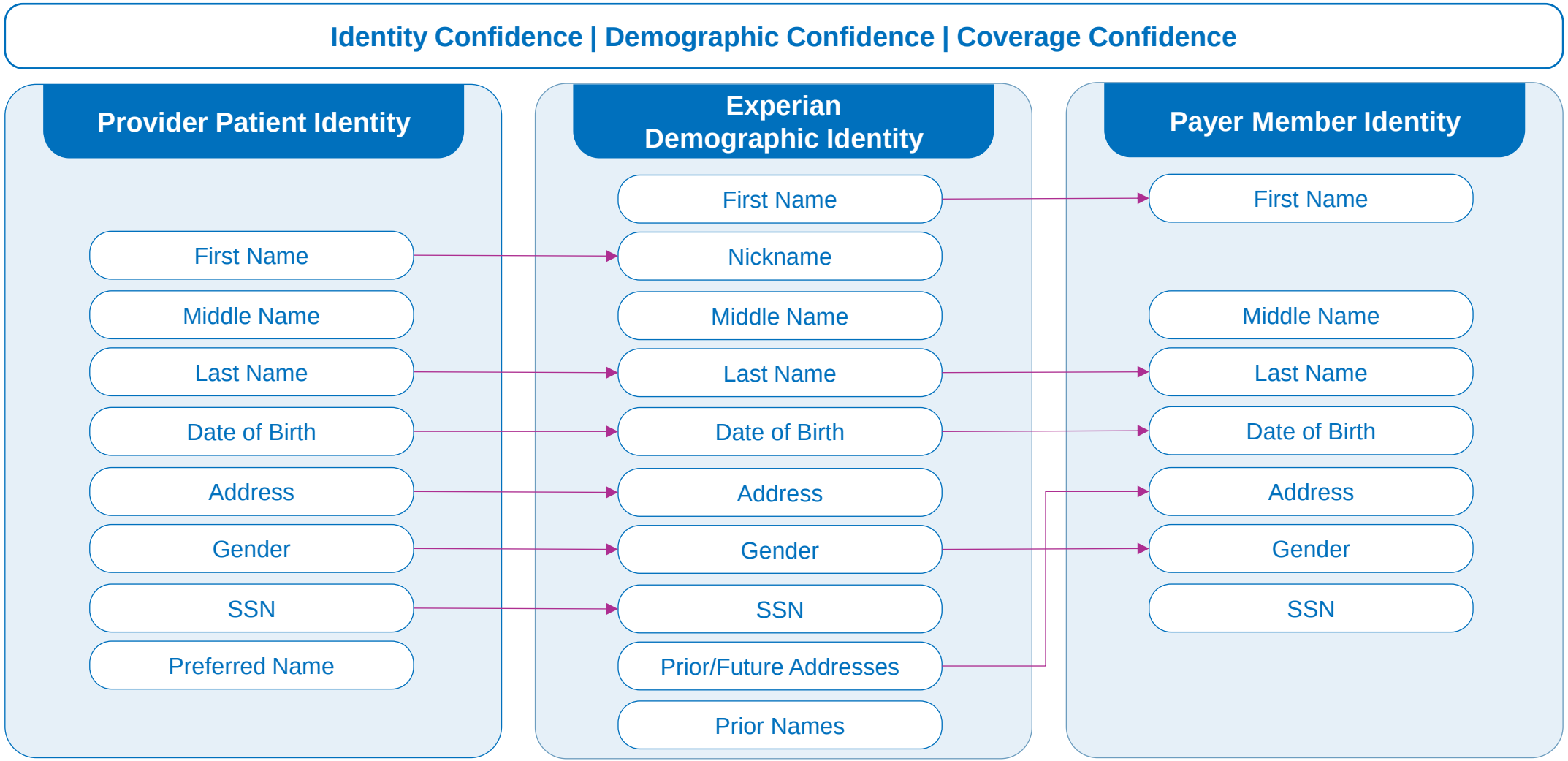
Real-time Eligibility with MBI Curation



Transparent MBI Correction

- Medicare requires valid MBI to verify benefits
- Designed for transparency – mimics traditional Medicare eligibility transactions
- Verifies Medicare when patients can't or won't provide MBI
- No MBI/SSN needed to verify Medicare benefits - patient name, DOB, and address only
- Locates MBIs and verifies coverage for 85-90% of patients without SSN, on average
- Also used indirectly within PAC's COB Curator engine to chain from other payers to Medicare as a means of fully investigating all COB leads
- All benefit details returned come directly from Medicare in real-time; may also trigger additional other payer investigations via the COB Curator engine

Confidence Scoring on All Transactions for Automated Post Back



Data Without Automation

Case Study 3: Provider Line-Item Denial Audit Findings

COB DENIAL FINDINGS

- ~60% of COB denials **never had eligibility verification performed** on the episode due to eligibility reuse rules in HIS resulting in missed correction opportunities.

When **Eligibility** was confirmed to have been run:

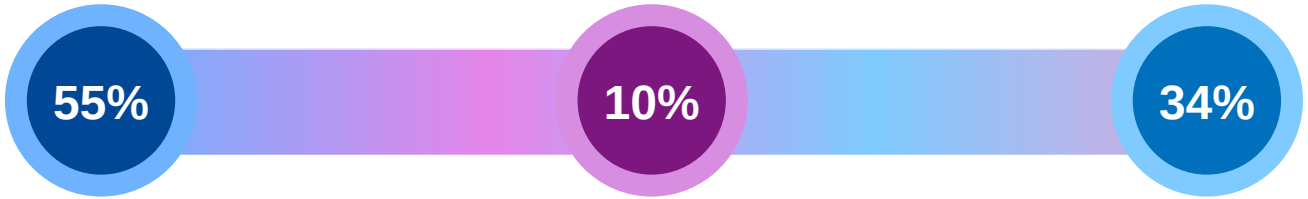
- 35% of the time Payers appear to have been **using outdated TPL records** (e.g. Coverage not active for DOS).
- 30% of **COB denials were avoidable had chaining rules been kept up to date**. Lack of staffing, data focus and curation automation leads to outdated query chaining automation.
- ~30% of **COB denials were avoidable as the correction information was delivered** to HIS, but **lack of automation** (e.g. termination\auto creation\Filing order) and human error (e.g. User did not follow process).
- Retro changes in states accounted for only 2.5% of issues but was **highly prevalent with specific payers**.

Category	HB	PB	Grand Total
Eligibility Not Run	63.75%	46.67%	62.34%
Invalid\Outdate Payer TPL Record	13.15%	13.33%	13.16%
Missing Chain	11.95%	4.44%	11.33%
Failed to Add New Payer	5.78%	28.89%	7.68%
Failed to Term Policy	2.79%	0.00%	2.56%
Unable to Locate Primary Coverage	1.20%	0.00%	1.10%
Retro Change\Term\Activation	0.60%	4.44%	0.91%
Filing Order	0.60%	0.00%	0.55%
Retry Problem	0.20%	2.22%	0.37%

Category	HB	PB	Grand Total
Invalid\Outdate Payer TPL Record	36.26%	25.00%	34.95%
Missing Chain	32.97%	8.33%	30.10%
Failed to Add New Payer	15.93%	54.17%	20.39%
Failed to Term Policy	7.69%	0.00%	6.80%
Unable to Locate Primary Coverage	3.30%	0.00%	2.91%
Retro Change\Term\Activation	1.65%	8.33%	2.43%
Filing Order	1.65%	0.00%	1.46%
Retry Problem	0.55%	4.17%	0.97%

Case Study 4: Eligibility Line-Item Denial Audit Findings

Category	HB	PB	Grand Total
Failed to Term Policy	48.89%	58.82%	51.61%
Retro Change\Term\Activation	42.22%	11.76%	33.87%
Invalid\Outdate Payer TPL Record	8.89%	11.76%	9.68%
Failed to Add New Payer	0.00%	17.65%	4.84%



- **% of COB denials were avoidable as the correction information was in the HIS, but missed action resulted in the denial**
- Most accounts were termed / not valid for DOS and HIS system requires manual termination of coverage.
- Some accounts had both termed coverage and corrected primary known at TOS but payer change was not performed.

- **% of claims that appear to have been using outdated TPL records (e.g. Coverage not active for DOS)**
- Interesting trend in payer behavior with certain payers demonstrating an increase invalid\outdated TPL rate than others.
- Potential data and process issues by the payer causing measurable harm to patient and providers.

- **% of claims were a casualty of retro changes in coverage impacting HB claims disproportionately.**
- Employer plans from major carriers were highest risk of post service retro termination.
- Medicaid HMO termination (flip to FFS) was the second largest risk for retro termination.

Known Automation Limitations

Automated Coverage Termination

Uniformly, most HIS systems require manual termination of a policy even when a coverages response clearly indicates the coverage is termed. Automated action can be built, but HIS systems do not support this out of the box.

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Filing Order Automation

Even when coverages are updated in the HIS, filing order for claims are very limited or manual only. This leads to incorrect claim filing, compliance risk and revenue loss\delay. There is a lack of awareness of this issue.

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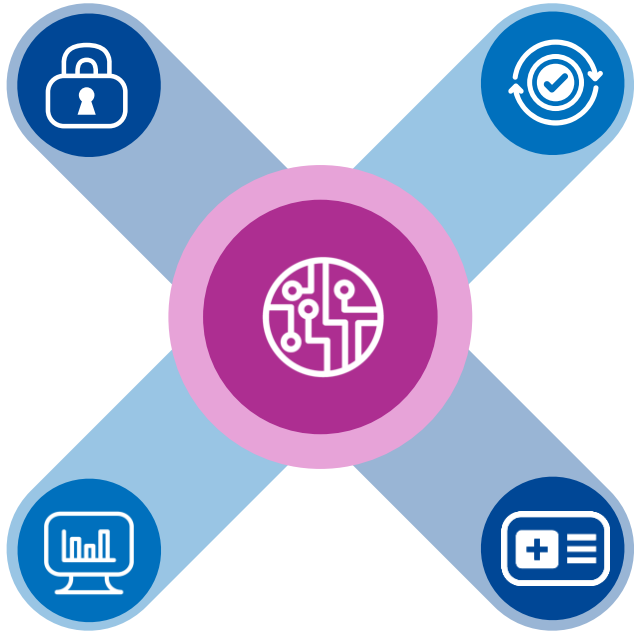


Automated Coverage Creation

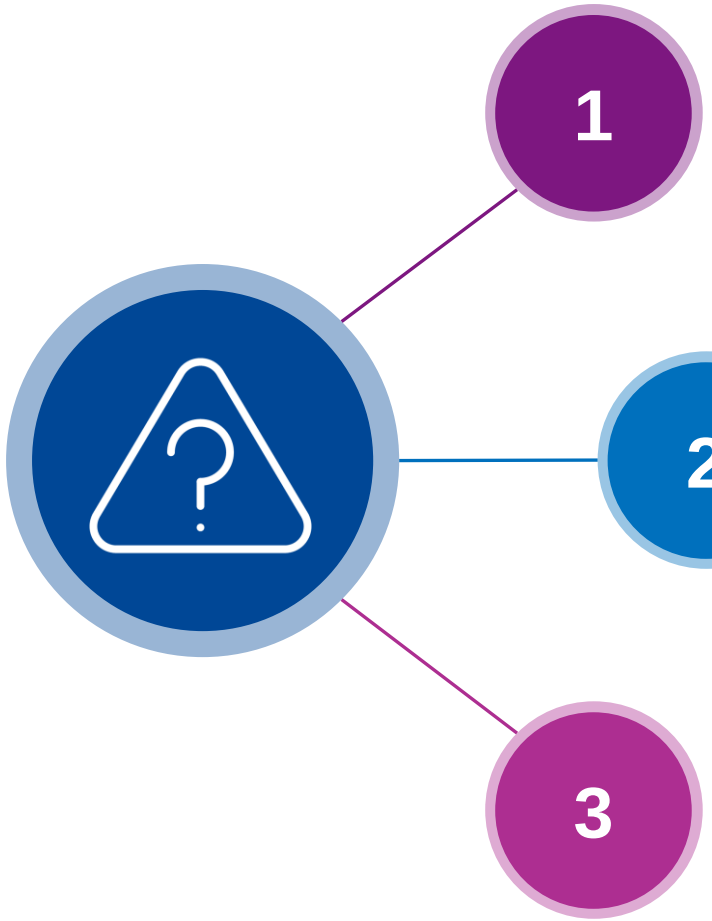
Modern eligibility solutions can return correct\new policy notices via 270/271, but most HIS systems are not natively configured to consume and create the coverage on the episode\account.

Informational Coverage Needs

Most focus is on billable primary/secondary coverages and underlying Medicaid\Medicare coverage are dropped\omitted, but those policies have value (e.g. DSH, 340B, Shadow Claims).

Where Do We Go From Here?

Three Main Problems to Solve



System vendors underinvest in coverage automation, overestimate staff capacity, and avoid integrations that could solve RCM problems.

- More automation is possible via interoperable data standards only if the HIS allows it.
- Competitive mindset of some organizations can result in outsize market control, slows innovation and financially impacts providers.
- Focus on walled garden, hyper dependency reduces innovation and limits means to solve problems.

Payers need to be held accountable for quality, accuracy and ways to make data available to providers.

- Systemically inaccurate data leading to renders services and revenue loss for providers.
- COB records with invalid start\stop dates leads to provider denials.
- Ability to retroactively alter COB records leads to recoupments and denials.

Outdated Transition standards must be updated to enforce standard ways to present data.

- High variability by payer's eligibility systems dramatically over complicates COB processes.
- Lack of mandated retro change date stamps make it difficult to audit changes in information.

Use Your Voice!

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Demand more!

- Talk to your HIS vendors and mandate interoperability on coverage records.
- Pursue clearinghouses whose technology demonstrate problem solving today.
- Ask better questions form all parties… ***Why not now?***

02

Leverage HFMA resources

- Require contracting terms or legislation to hold payers accountable for changed benefits.
- Pursue action when payers retro term coverage after services are rendered.
- Demand payers are accountable for incorrectly denying claims due to bad data.

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Advocate for improved ANSI standards

- Participate in ANSI work groups so your problems are heard.
- Push for more uniform information standard for COB, HMO and other payer notices.
- Drive innovation not just for eligibility but also claims denial workflows.

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