



THE CONSUMER INFLUENCE IN HEALTHCARE: *PATIENT ACCESS ANALYTICS STRATEGIES TO DRIVE REVENUE INTEGRITY*

August 28, 2018

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Presenter



Jason Williams, MBA, MEM
VP, Analytics & Growth Strategy
jason.williams@changehealthcare.com

Discussion Points

- △ **Assessing your data landscape** – Analytical framework
- △ **Improving the Patient Experience** – Survey data, engaging consumers
- △ **Building Patient Revenue Integrity and Efficiency** – Industry metrics, managing data to drive reimbursement and collections effectiveness

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Assessing your Data Landscape

analytical framework

A Framework to Optimally Deploy Data

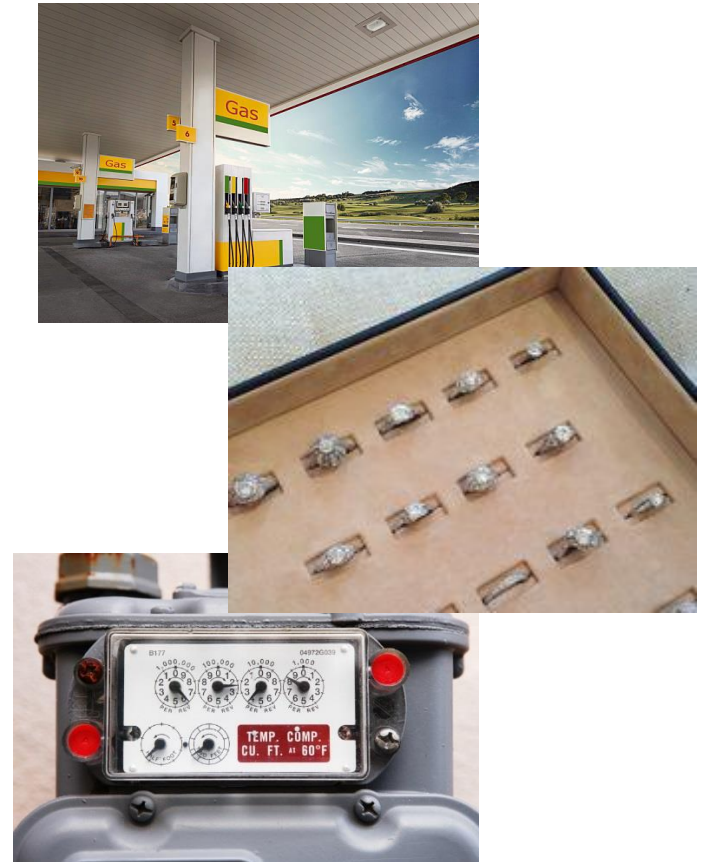
Data Resources



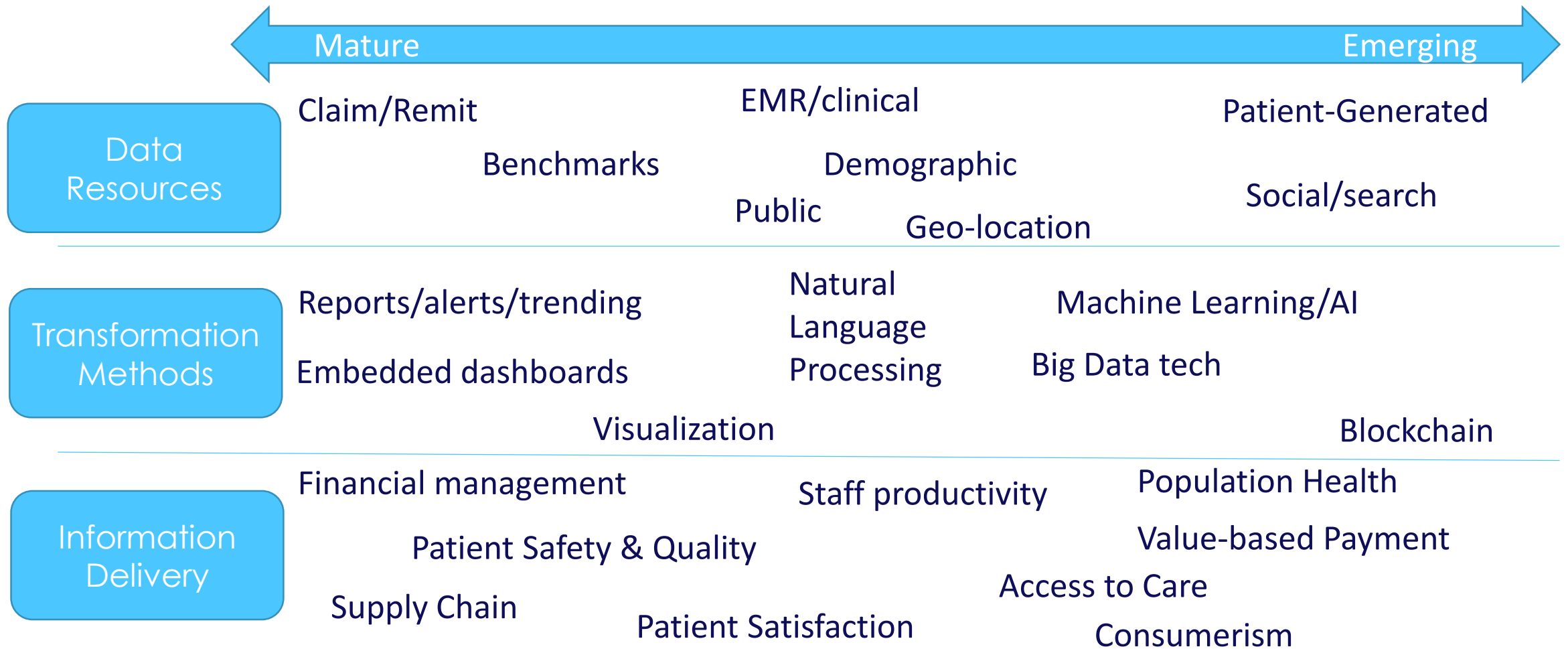
Transformation



Information Delivery



Options are Abundant so Focus is Imperative

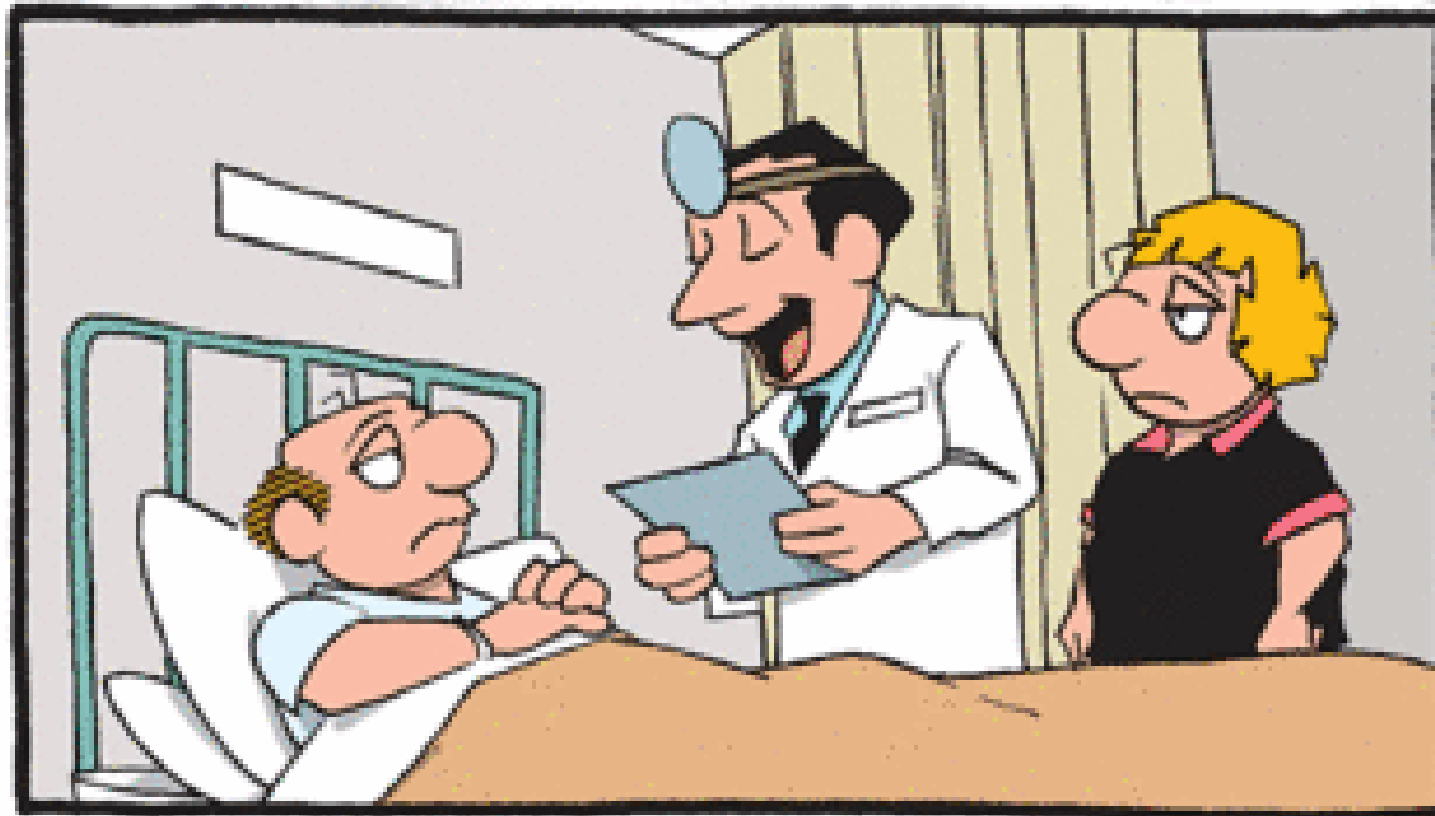


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Improving the Patient Experience

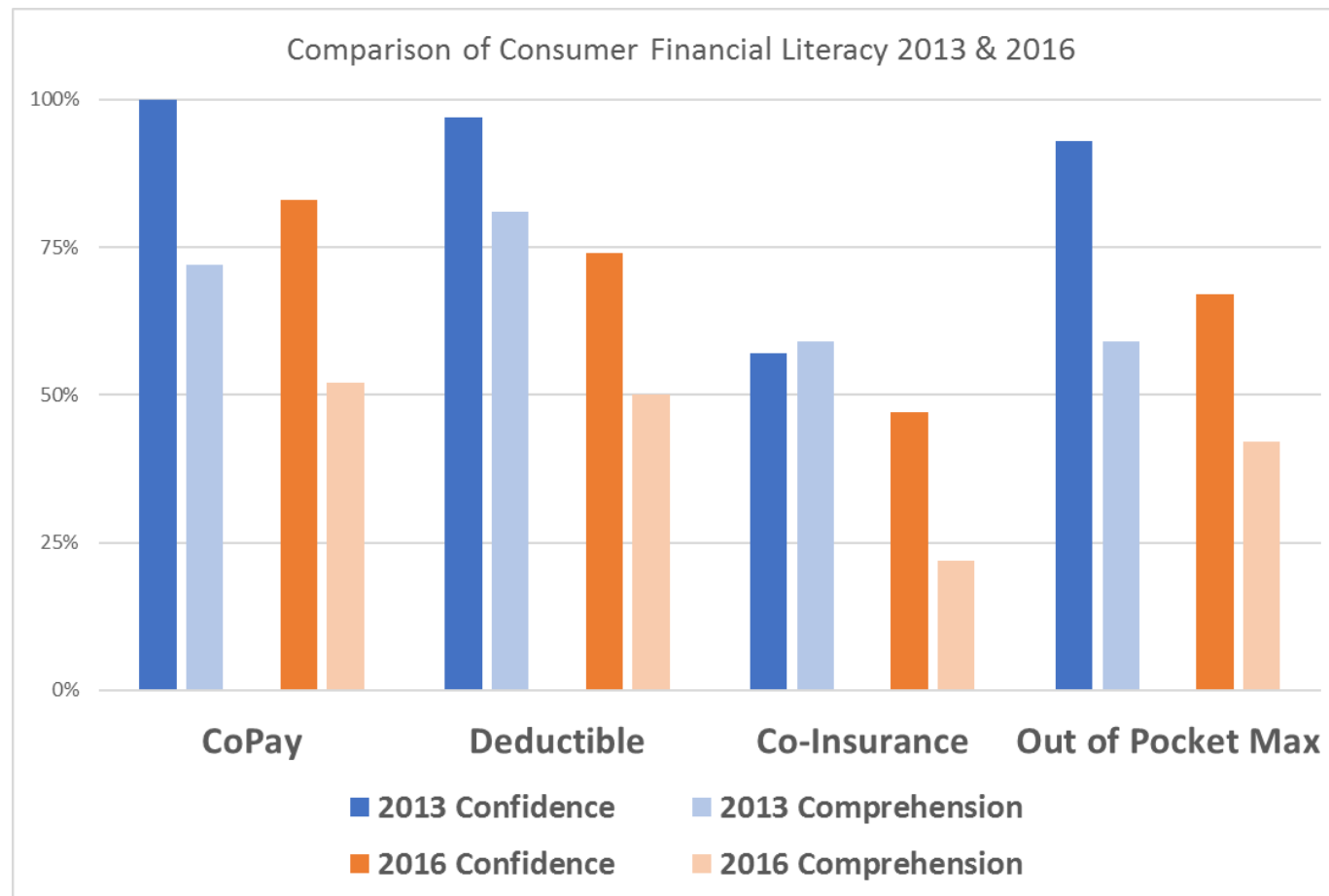
consumer engagement results

Healthcare Experience in the Mainstream



**"THE TESTS WERE INCONCLUSIVE, BUT THE ESTIMATE
ON YOUR BILL IS RIGHT ON TARGET."**

Consumer Confusion Trending Negatively



Source: 2013: "Consumers Misunderstanding of Health Insurance", Journal of Health Economics & Washington Post, August 2013
Source: 2016: "4 basic health insurance terms 96% of Americans don't understand", PolicyGenius, Nov. 2016

Payers & Providers Share some Consumer Engagement Objectives



PROVIDERS



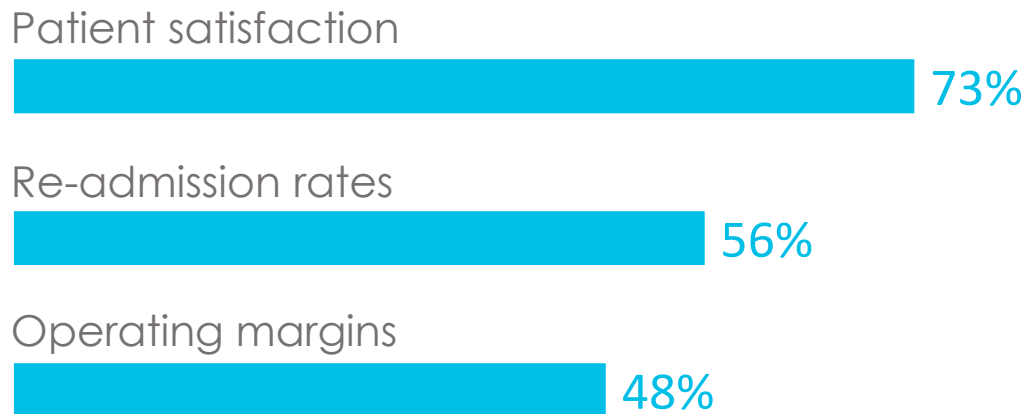
PAYERS



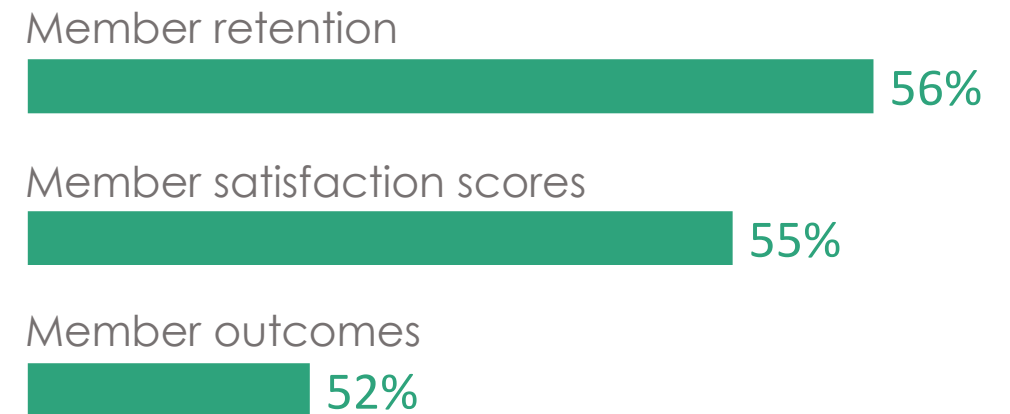
Providers & Payers Both See Consumer Satisfaction As Primary Success Metric of Engagement



Provider Top 3 Metrics

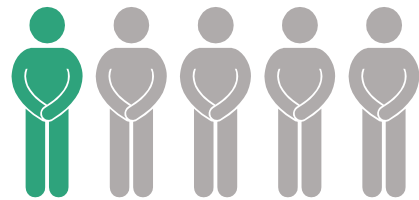


Payer Top 3 Metrics



Despite Significant Investment in Consumer Engagement, Consumer Experience with Payers & Providers Hasn't Improved

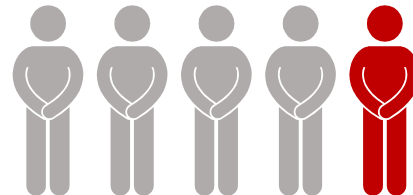
I'M FEELING UNDERWHELMED...



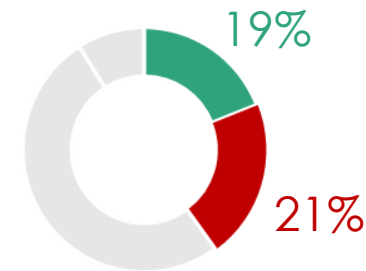
ONLY A FIFTH

of consumers felt their experience with the providers and health plans **improved**.

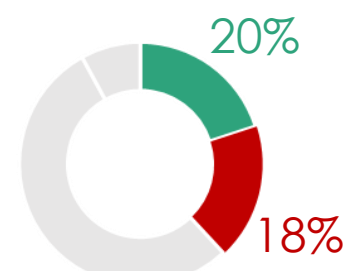
About the same think things actually got **worse**.



PAYERS



PROVIDERS



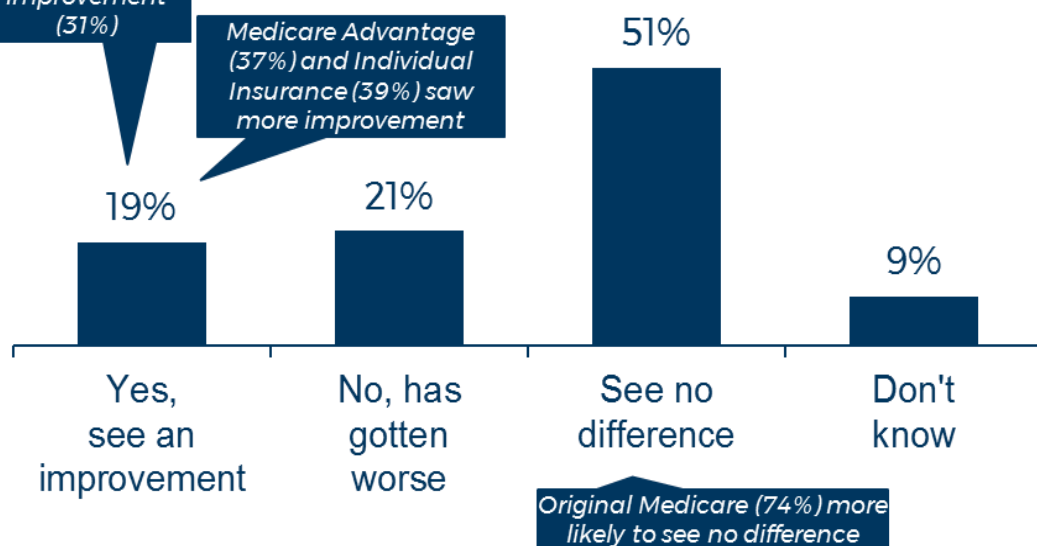
Consumer Perceived Improvement varies across Segments



CHANGE IN HEALTH PLAN CONSUMER EXPERIENCE OVER LAST 18-24 MONTHS

Millennials are more likely to see improvement (31%)

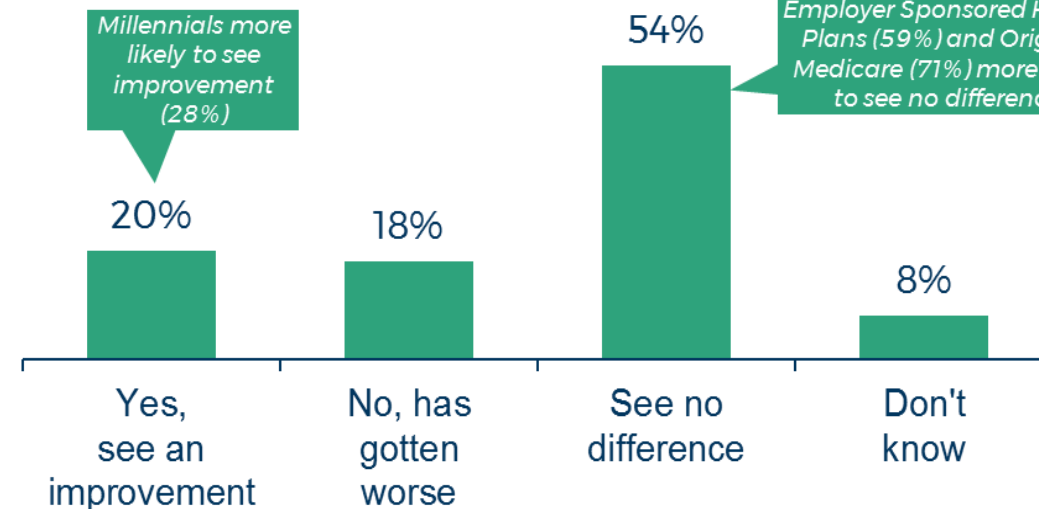
Medicare Advantage (37%) and Individual Insurance (39%) saw more improvement



CHANGE IN HEALTH PROVIDER CONSUMER EXPERIENCE OVER LAST 18-24 MONTHS

Millennials more likely to see improvement (28%)

Employer Sponsored Health Plans (59%) and Original Medicare (71%) more likely to see no difference



Consumer Perceived Improvement varies across Segments

PERCEIVED IMPROVEMENT IN HEALTH SERVICES OVER LAST 18-24 MONTHS

Millennials more likely to see an improvement across ALL services.

Individual Insurance more likely to see ease of getting info from website (20%) worsen

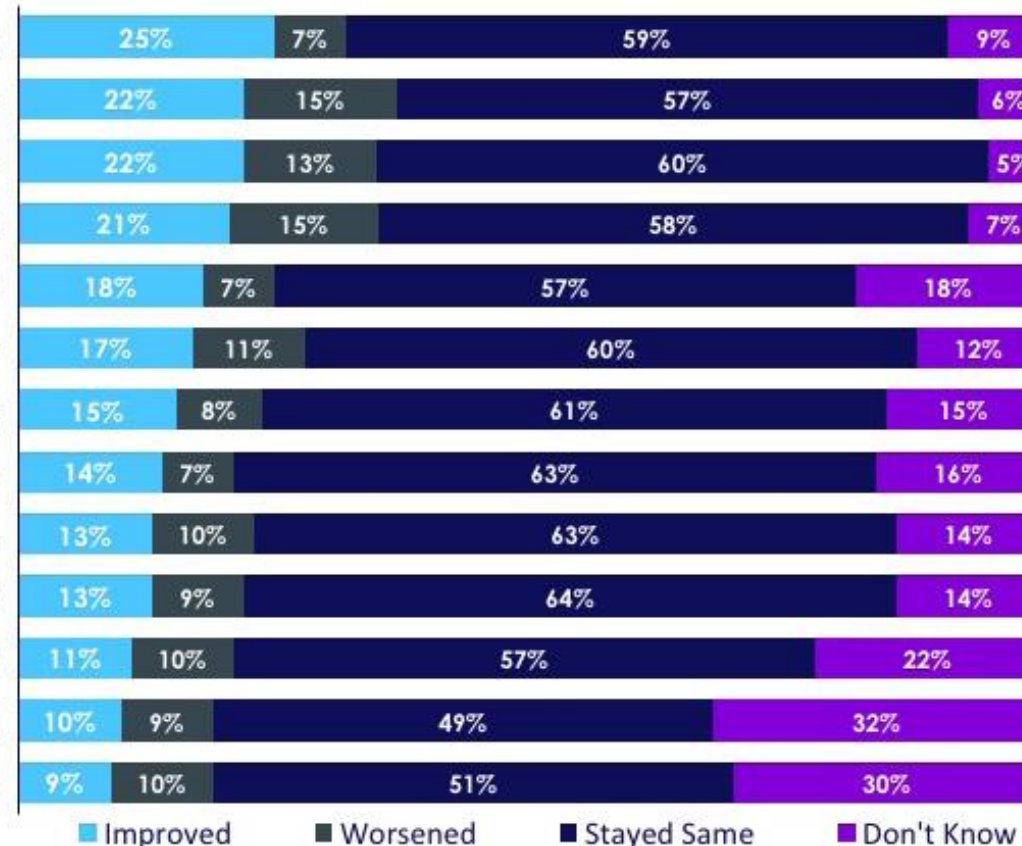
Individual Insurance more likely to see improvement in understanding bills (25%)

Public Exchange more likely to see understanding bills worsen (18%)

Individual Insurance more likely to see cost info before service (22%) worsen

Individual Insurance more likely to see improvement in financial assistance (32%)

Improving health
Ease of getting appointment
Time with doctor
Time in waiting room
Easily getting information on website
Access/authorization for treatment
Accurate information on available providers
Understanding bill/answering questions
Understandable bills after service
Correct bill for services
Cost information before service
Financial assistance provided
Comparing healthcare costs

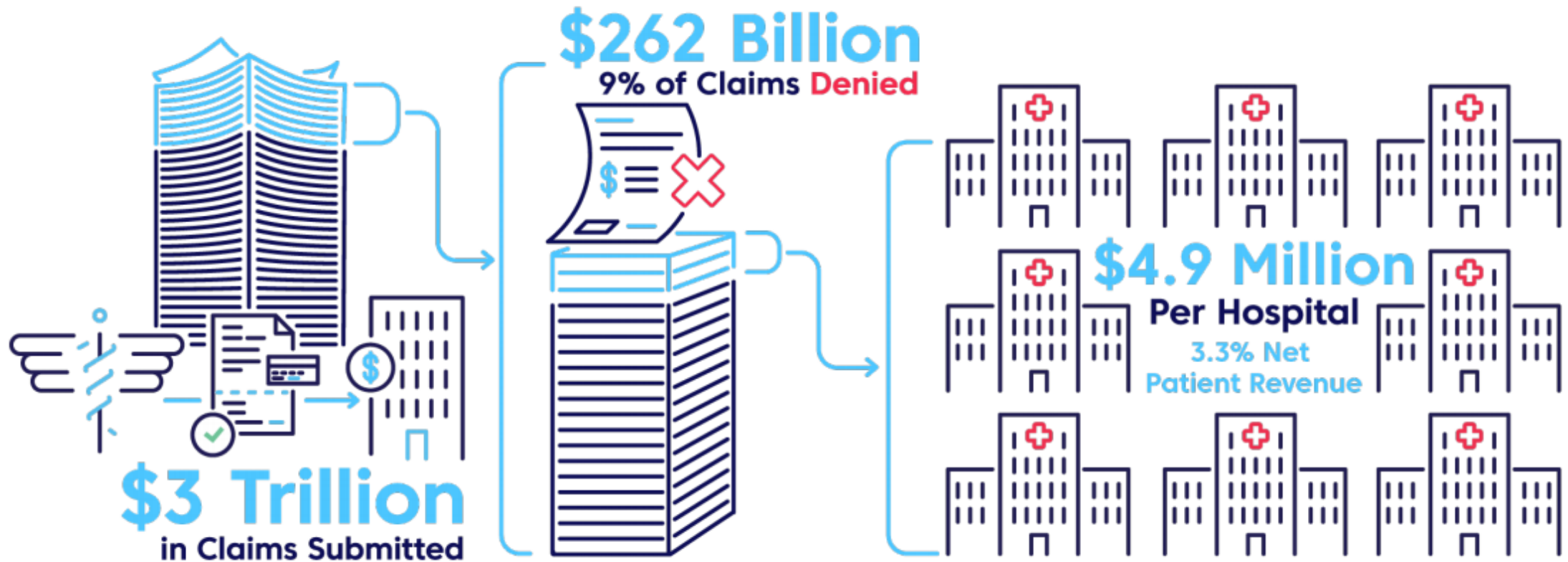


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Building Patient Revenue Integrity

managing data to drive reimbursement and collections effectiveness

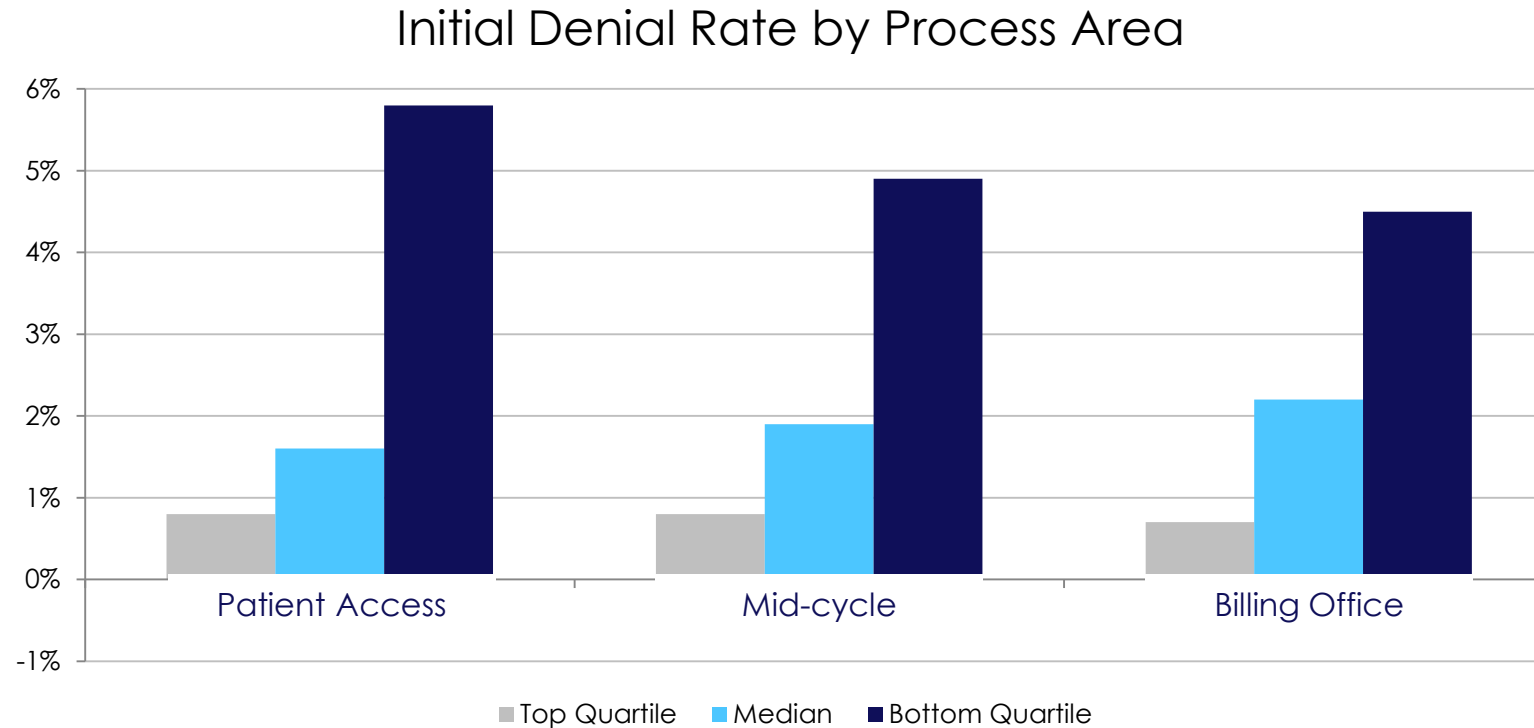
Denials: An Obstacle to Timely and Complete Reimbursement



Source: Change Healthcare, 2017

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Revenue cycle has multiple paths to success

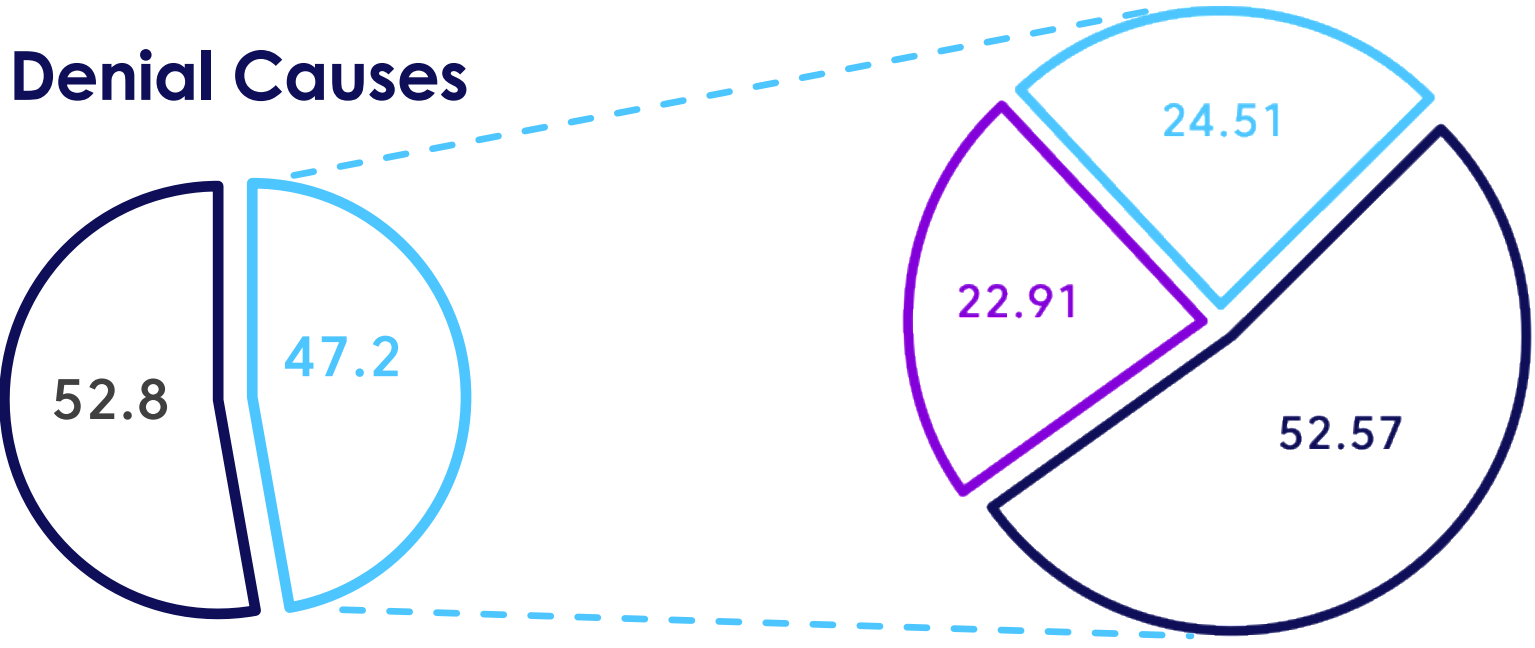


Source: Change Healthcare Pulse Perspective Revenue Cycle Report

Patient Access is foundation for denial prevention

Patient Access Denials

Denial Causes



Translates into a **\$3.2 million write-off** for average hospital after appeals

■ All Other Causes

■ Patient Access

■ Authorization/Pre-Certification

■ Registration/Eligibility

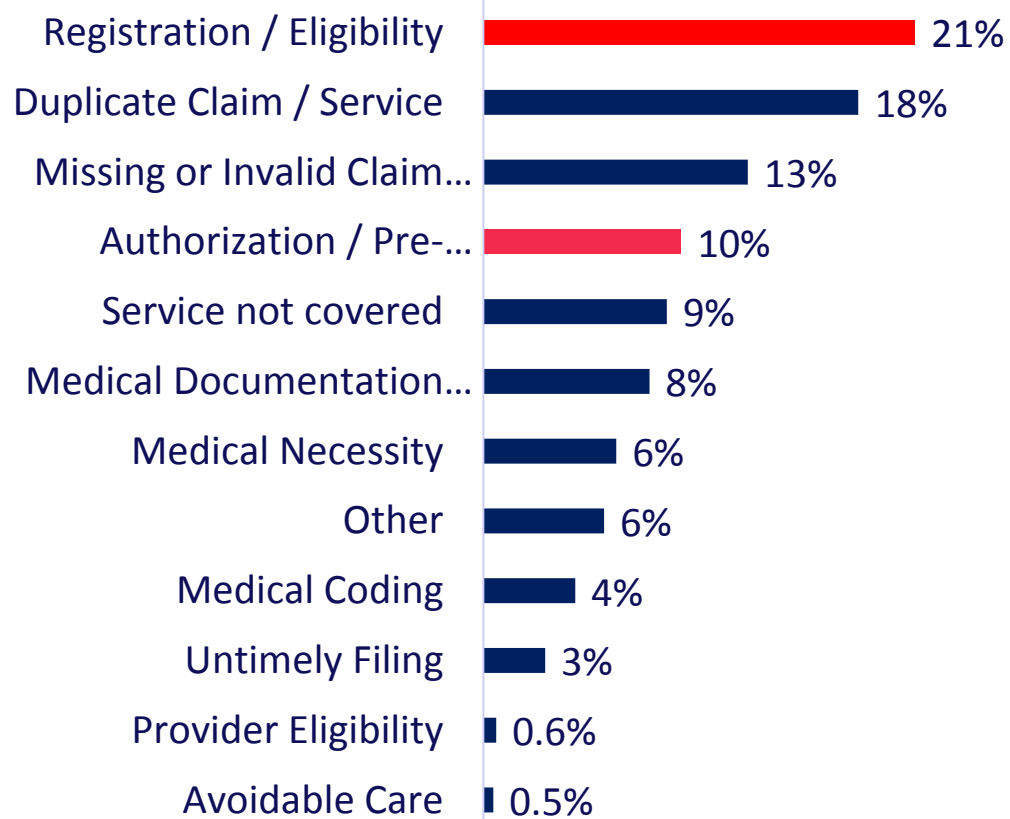
■ Service Not Covered

2018 Change Healthcare Revenue Cycle Index

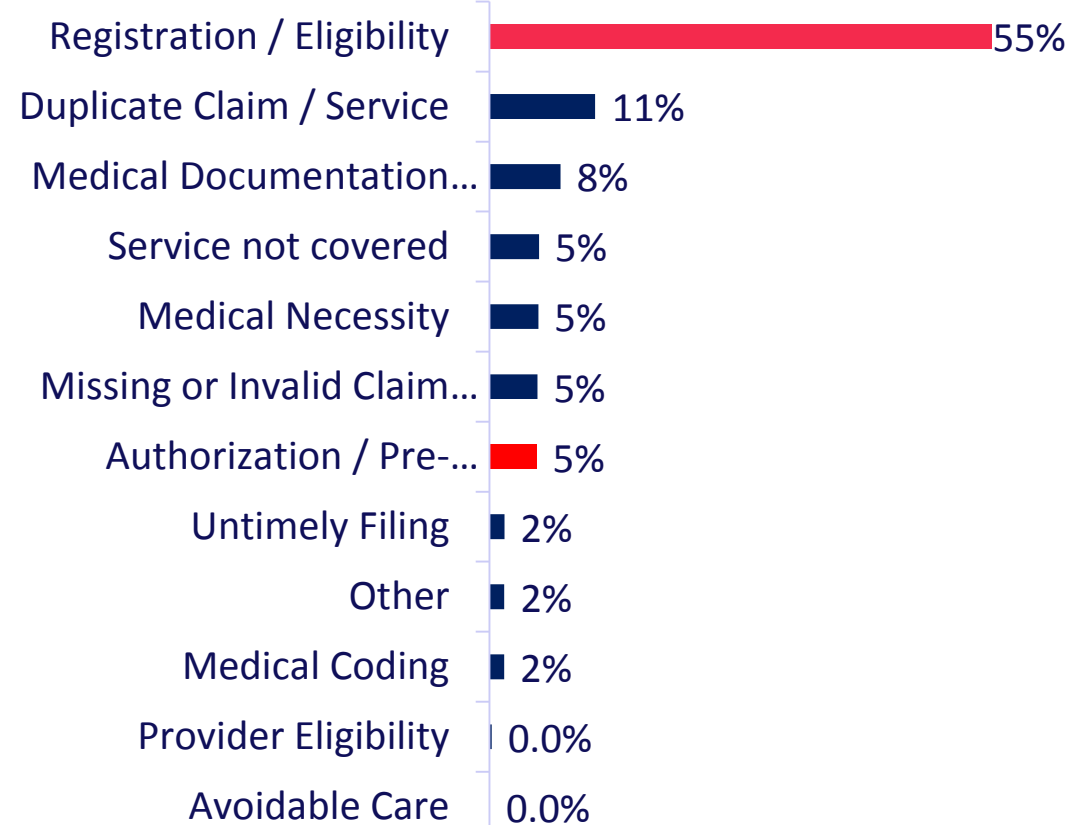
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California Versus National Denial Metrics

National - Denial Reasons

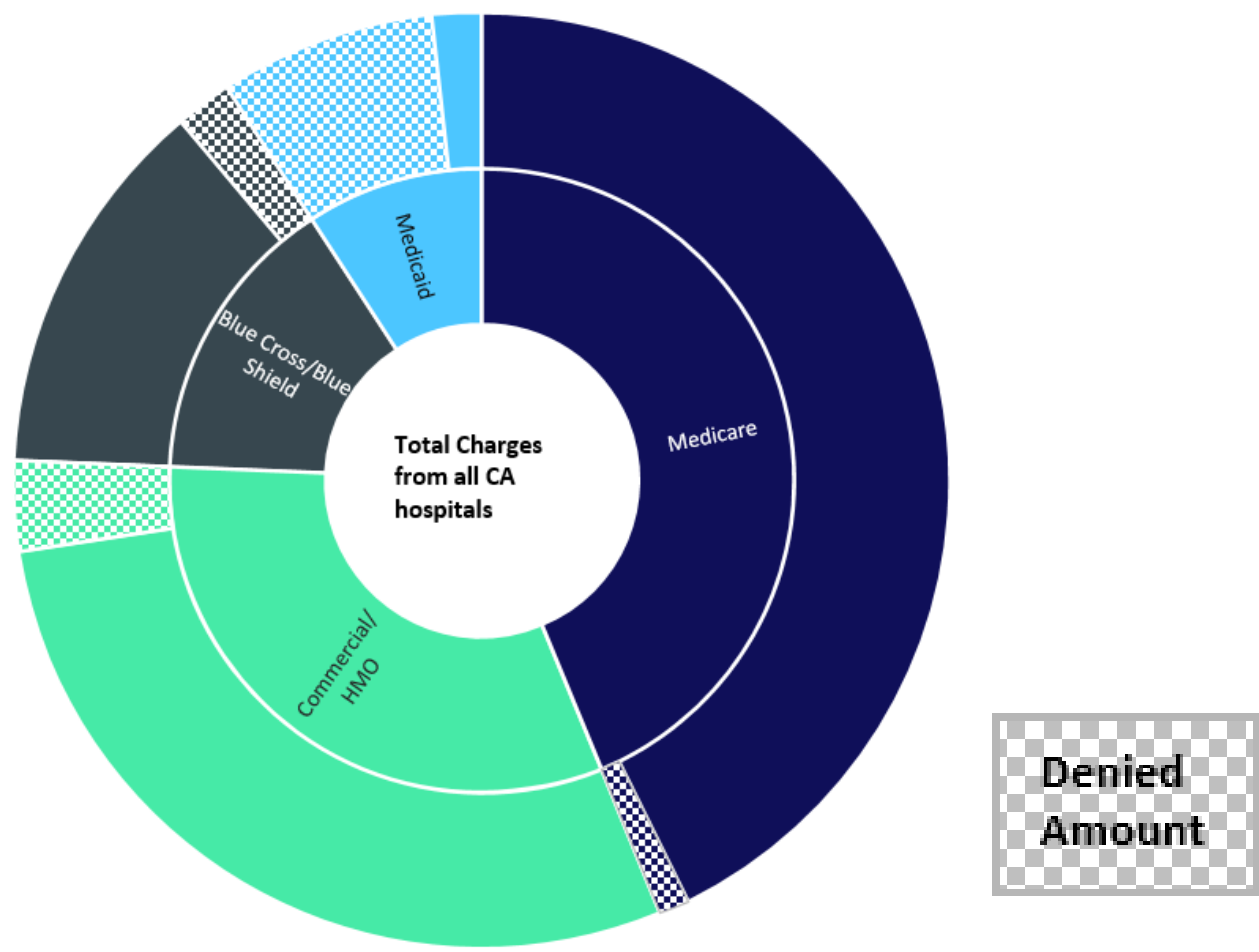


California Hospitals - Denial Reasons



Source: Change Healthcare, 2018 sample of CA hospitals using charged dollars

California Varies Significantly in Denial Rates across Payer Types



Source: Change Healthcare, 2018 sample of CA hospitals using charged dollars

The Seven Critical Components of a Denials Prevention and Management Program

- △ Determining patient coverage
- △ Validating registration data
- △ Obtaining prior authorization, when necessary
- △ Accessing timely and thorough claim edits
- △ Gaining early visibility into claims headed for trouble
- △ Managing the appeals process efficiently
- △ Interpreting analytical insights to inform strategic process changes

The First Steps in Denials Prevention - Analysis

1. Root Cause Determination



Where are denials originating?

- Patient Access and Registration
- Insufficient Documentation
- Coding/Billing Errors
- Payer Behavior
- Utilization/Case Management

2. Prioritization



- Which has the greatest impact?
 - A certain physician
 - A particular service line
 - A specific payer
 - A certain type of code
 - Process redesign in both the clinical and revenue cycle areas of opportunity

Eligibility process issues causing denials

Patient Access

Eligibility Denials

Claim Level Denial Details

Payment Date From: 3/1/2014 To: 4/30/2014

Last Data Refresh: 04/30/14

Report Run Date: 05/23/14 10:12:32 AM

ACME GENERAL HEALTH

Payer	Eligibility Status at Release	Denial Category	Denial Adj. Group	Denial Adj. Code	Denial Adjustment Description	Total Patient Count	Denial Adj. Amount
Cignify Health	INELIGIBLE	Registration					
Cignify Health	INELIGIBLE	Registration					
OC Net Care	INELIGIBLE	Registration					
OC Net Care	INELIGIBLE	Registration					
OC Net Care	INELIGIBLE	Registration					
OC Net Care	INELIGIBLE	Registration					

Patient Access

Eligibility Denials
Claim Level Denial Details

Page 1 of 1

Payment Date From: 3/1/2014 To: 4/30/2014

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ACME GENERAL HEALTH

Payer	Eligibility Status at Release	Denial Category	Denial Adj. Group	Denial Adj. Code	Denial Adjustment Description	Total Patient Count	Denial Adj. Amount
Cignify Health	ELIGIBLE	Registration / Eligibility	CO	119	Benefit maximum for this time period or occurrence has been reached.	6	\$1,288.00
Cignify Health	ELIGIBLE	Registration / Eligibility	OA	119	Benefit maximum for this time period or occurrence has been reached.	5	\$1,638.64
Cignify Health	ELIGIBLE	Registration / Eligibility	OA	22	This care may be covered by another payer per coordination of benefits.	378	\$70,602.20
Cignify Health	ELIGIBLE	Registration / Eligibility	OA	26	Expenses incurred prior to coverage.	6	\$108,257.40
Cignify Health	ELIGIBLE	Registration / Eligibility	OA	27	Expenses incurred after coverage terminated.	15	\$132,204.60
Cignify Health	ELIGIBLE	Registration / Eligibility	OA	31	Patient cannot be identified as our insured.	1	\$6,034.60
Cignify Health	ELIGIBLE	Registration / Eligibility	OA	B5	Coverage/program guidelines were not met or were exceeded.	88	\$280,729.00

Source: Acuity Revenue Cycle Analytics™

Authorization denials root cause versus checks

<div> <div>Auth obtained from wrong payer</div> <div>No screening found</div> <div>Auth not Obtained</div> <div>Auth # not on claim</div> <div>Auth expired</div> <div>Performed different procedure than Authorized</div> </div> <div> Authorization Denials vs. Check Denied Claim Auth Comparison - Detail Payment Date From: 12/1/2016 To: 12/31/2016 Page 1 of 1 Last Data Refresh: 12/09/16 Report Run Date: 02/27/17 03:48:32 PM </div>													
Claim Payer	Clearance Payer	Auth Status	Auth #	Claim Auth #	Auth Effective Dates	Service Dates	Auth Procedure Code in Check	Actual Procedure Code on Claim	Patient Control #	Adj. Group	Adj. Code	Adj. Description	Denied Claim Amount
AETNA	Quick Care	Approved	A32817434	A32817434	11/23/16 - 11/23/16	11/23/16 - 11/23/16	87972	87972	22-4522-00000	PL	197	Pre-certification/authorization/notification absent.	\$95.00
AETNA		Not Matched			-	11/23/16 - 11/23/16		93015	22-4522-00000	CO	197	Pre-certification/authorization/notification absent.	\$1,782.00
AETNA	AETNA	Unable To Process Authorization			-	11/23/16 - 11/23/16	97003	97003	22-4522-00000	CO	197	Pre-certification/authorization/notification absent.	\$2,281.15
BUCKEYE COMMUNITY HEALTH - OHIO	BUCKEYE COMMUNITY	Approved	B67852		10/24/16	10/24/16 - 10/24/16	78599	78599	22-4522-00000	CO	197	Pre-certification/authorization/notification absent.	\$7,024.90
BUCKEYE COMMUNITY HEALTH - OHIO	BUCKEYE COMMUNITY	Approved	C32817	C32817	11/1/16 - 11/6/16	11/1/16 - 11/1/16	35475	35475	22-4522-00000	CO	197	Pre-certification/authorization/notification absent.	\$11.37
BUCKEYE COMMUNITY HEALTH - OHIO	BUCKEYE COMMUNITY	Approved	D3946	D3946	11/16/16 - 11/16/16	11/16/16 - 11/16/16	70540	72141	22-4522-00000	CO	197	Pre-certification/authorization/notification absent.	\$24.98

Source: Acuity Revenue Cycle Analytics™

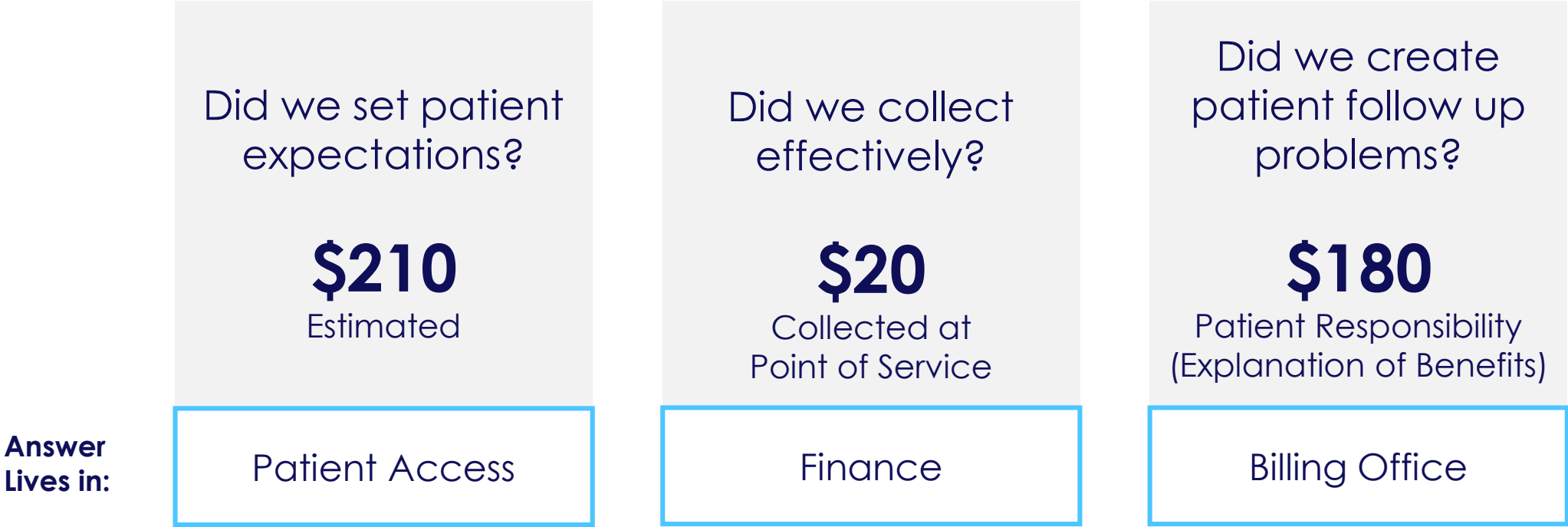
Patient Access data

Claim & Remit data

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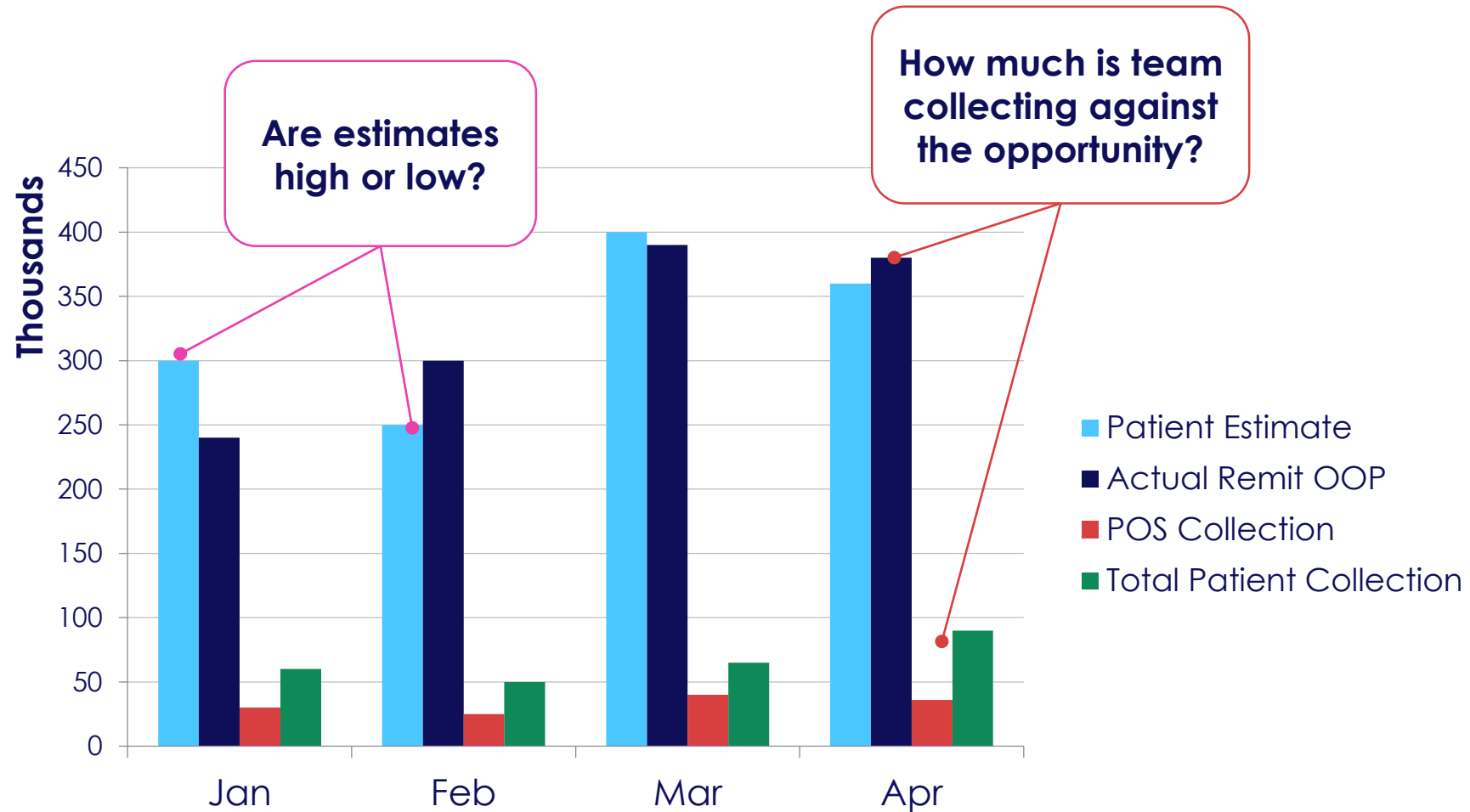
Connecting teams and financial outcomes

Patient experience is simple but not easy



Connecting teams and financial outcomes

Unified reporting



Key Takeaways



△ Foster fact-based analytic culture

- Assess data for areas of opportunity then focus distribution of data; repeat on a recurring basis

△ Monitor consumer segments

- Cater to preferences and maximize engagement and satisfaction with the healthcare experience

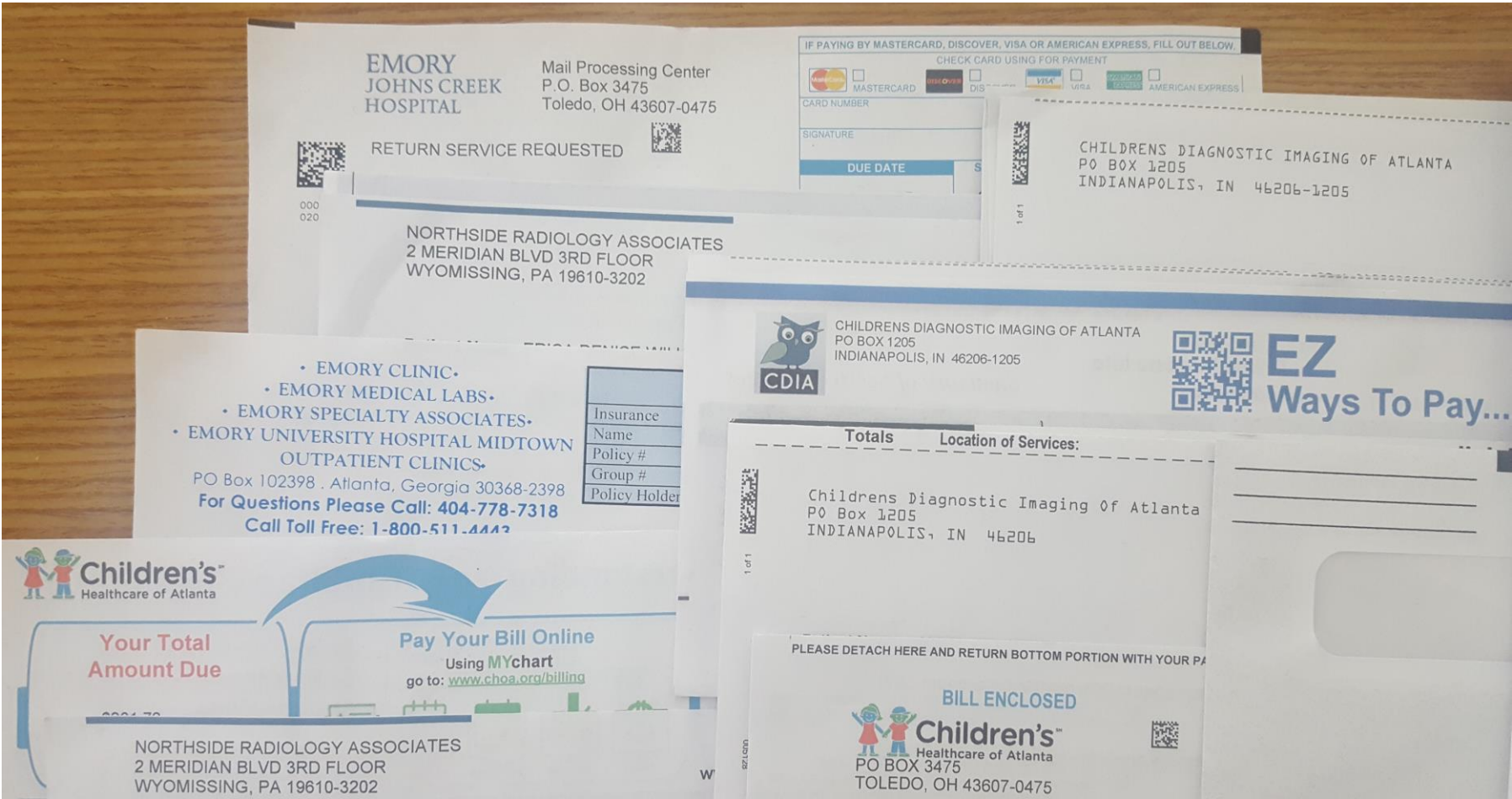
△ Revenue cycle is a “village”

- Connect and distribute data across departments to maximize patient revenue

The healthcare experience



Also the healthcare experience



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Q&A

Jason Williams, MBA, MEM
VP, Analytics & Growth Strategy
jason.williams@changehealthcare.com

To download the white paper
<http://ConsumerEngagementStudy.com>