THE CONSUMER INFLUENCE IN HEALTHCARE: PATIENT ACCESS ANALYTICS STRATEGIES TO DRIVE REVENUE INTEGRITY
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
Assessing your Data Landscape

analytical framework
A Framework to Optimally Deploy Data

Data Resources

Transformation

Information Delivery
Options are Abundant so Focus is Imperative

Data Resources
- Claim/Remit
- Benchmarks
- EMR/clinical
- Demographic
- Public
- Geo-location

Transformation Methods
- Reports/alerts/trending
- Embedded dashboards
- Natural Language Processing
- Machine Learning/Al
- Big Data tech

Information Delivery
- Financial management
- Patient Safety & Quality
- Supply Chain
- Staff productivity
- Population Health
- Value-based Payment
- Access to Care
- Patient Satisfaction
- Consumerism
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: 2016: “4 basic health insurance terms 96% of Americans don’t understand”, PolicyGenius, Nov. 2016
Payers & Providers Share some Consumer Engagement Objectives

**TOP GOALS OR OBJECTIVES BEHIND IMPLEMENTING SOLUTIONS**

**PROVIDERS**

1. **Improving (patient/member) satisfaction**: 45%
2. **Increasing market share (patient volume/members)**: 45%
3. **Reducing Costs**: 38%
   - **Increasing (admissions/member) retention**: 32%
   - **Improving brand loyalty**: 21%
   - **Moving toward value-based [care/reimbursement]**: 20%
   - **Improving Member outcomes**: 0%

**PAYERS**

1. **Improving Member outcomes**: 33%
2. **Increasing market share (patient volume/members)**: 36%
3. **Reducing Costs**: 30%
   - **Increasing (admissions/member) retention**: 26%
   - **Improving brand loyalty**: 11%
   - **Moving toward value-based [care/reimbursement]**: 24%

**ORC INTERNATIONAL**

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

<table>
<thead>
<tr>
<th>Provider Top 3 Metrics</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Patient satisfaction</td>
<td>73%</td>
</tr>
<tr>
<td>Re-admission rates</td>
<td>56%</td>
</tr>
<tr>
<td>Operating margins</td>
<td>48%</td>
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</table>

<table>
<thead>
<tr>
<th>Payer Top 3 Metrics</th>
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<tbody>
<tr>
<td>Member retention</td>
<td>56%</td>
</tr>
<tr>
<td>Member satisfaction scores</td>
<td>55%</td>
</tr>
<tr>
<td>Member outcomes</td>
<td>52%</td>
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</tbody>
</table>
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.
Consumer Perceived Improvement varies across Segments

**Change in Health Plan Consumer Experience Over Last 18-24 Months**

- Millennials are more likely to see improvement (51%)
- Medicare Advantage (57%) and Individual Insurance (39%) saw more improvement

<table>
<thead>
<tr>
<th>Yes, see an improvement</th>
<th>No, has gotten worse</th>
<th>See no difference</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>19%</td>
<td>21%</td>
<td>51%</td>
<td>9%</td>
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**Change in Health Provider Consumer Experience Over Last 18-24 Months**

- Millennials more likely to see improvement (28%)
- Original Medicare (74%) more likely to see no difference

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<tr>
<td>20%</td>
<td>18%</td>
<td>54%</td>
<td>8%</td>
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</table>
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.
- 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%).
Building Patient Revenue Integrity
managing data to drive reimbursement and collections effectiveness
Denials: An Obstacle to Timely and Complete Reimbursement

$3 Trillion in Claims Submitted

$262 Billion
9% of Claims Denied

$4.9 Million Per Hospital
3.3% Net Patient Revenue

Source: Change Healthcare, 2017
Revenue cycle has multiple paths to success

Initial Denial Rate by Process Area

Source: Change Healthcare Pulse Perspective Revenue Cycle Report
Patient Access is foundation for denial prevention

Denial Causes

Patient Access Denials

- All Other Causes: 52.8%
- Patient Access: 47.2%
- Authorization/Pre-Certification: 24.51%
- Registration/Eligibility: 22.91%
- Service Not Covered: 52.57%

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

2018 Change Healthcare Revenue Cycle Index

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL
California Versus National Denial Metrics

National - Denial Reasons

- Registration / Eligibility: 21%
- Duplicate Claim / Service: 18%
- Missing or Invalid Claim: 13%
- Authorization / Pre-...: 10%
- Service not covered: 9%
- Medical Documentation...: 8%
- Medical Necessity: 6%
- Other: 6%
- Medical Coding: 4%
- Untimely Filing: 3%
- Provider Eligibility: 0.6%
- Avoidable Care: 0.5%

California Hospitals - Denial Reasons

- Registration / Eligibility: 55%
- Duplicate Claim / Service: 11%
- Medical Documentation...: 8%
- Service not covered: 5%
- Medical Necessity: 5%
- Missing or Invalid Claim: 5%
- Authorization / Pre-...: 5%
- Untimely Filing: 2%
- Other: 2%
- Medical Coding: 2%
- Provider Eligibility: 0.0%
- Avoidable Care: 0.0%

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

Where are denials originating?
• Patient Access and Registration
• Insufficient Documentation
• Coding/Billing Errors
• Payer Behavior
• Utilization/Case Management

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

1. Root Cause Determination

2. Prioritization
Eligibility process issues causing denials

Source: Acuity Revenue Cycle Analytics™
## Authorization denials root cause versus checks

### Auth obtained from wrong payer
- [AETNA]
- [Auth obtained from wrong payer]

### No screening found
- [AETNA]
- [No screening found]

### Auth not Obtained
- [AETNA]
- [Auth not Obtained]

### Auth # not on claim
- [AETNA]
- [Auth # not on claim]

### Auth expired
- [AETNA]
- [Auth expired]

### Performed different procedure than Authorized
- [AETNA]
- [Performed different procedure than Authorized]

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### Patient Access data

### Claim & Remit data

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**Source:** Acuity Revenue Cycle Analytics™
Connecting teams and financial outcomes
Patient experience is simple but not easy

- Did we set patient expectations? $210 Estimated Patient Access
- Did we collect effectively? $20 Collected at Point of Service Finance
- Did we create patient follow up problems? $180 Patient Responsibility (Explanation of Benefits) Billing Office

Answer Lives in:
Connecting teams and financial outcomes
Unified reporting

Are estimates high or low?

How much is team collecting against the opportunity?

Thousands

Jan | Feb | Mar | Apr

- Patient Estimate
- Actual Remit OOP
- POS Collection
- Total Patient Collection

PROPRIETARY & CONFIDENTIAL
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
Q&A

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