RED RIVER SHOWDOWN

2016

SEPTEMBER 30, 2016
“THE FAST AND THE FURIOUS”
REVENUE CYCLE - 3.0

(A.K.A.)

THE REVENUE CYCLE
OF
THE FUTURE
INDUSTRY ANALYSIS

82% of people say price is the most important factor when making a healthcare purchasing decision*

The costliest 1% of patients in the US consume 20% of the nation’s healthcare*

11-20% of Americans think healthcare is affordable*

Percentage of covered workers enrolled in a plan with a deductible of $1000 or more is on the rise* (i.e., 46.0%)

43% of patients in fair or poor health found medical treatment unaffordable**

In 2015 25% of employers are only offering high deductible plans**

Source: *Price Waterhouse Copper HRI Consumer Survey 2014
Source: **Money Matters Billing and Payment For A New Health Economy
REVENUE CYCLE OF THE FUTURE

• Three Greatest Sources of Revenue Leakage or Lost Yield
  • Patient Access
  • Guarantor Obligations / Collections
  • Denials Management
Reallocation processing to the front-end will result in cost reductions and increased yield.
REVENUE CYCLE OF THE FUTURE

Medical Informatics
• Revenue Cycle becomes the technology-driven, data repository
• Source for consumer-centered care and care coordination programs

Consumer-Focused
• Revenue cycle will move from rules-based to behavior-based processing
• Create personalized plans that emphasize quality and affordability

Value-Based Reimbursement
• Systems must support dual-track processing for reimbursements / claims
• Evolution towards “fee-for-value”

Retail Model
• Move towards a “cash and carry” model where payment is received in advance
• Opportunity for “peer-to-peer” lending

Clinical Revenue Integrity
• Focus on coding and documentation
• Basis for establishing reimbursement and risk adjustment factor score

Greater Collaboration
• Sharing across the continuum of care to improve outcomes and reduce costs
• Partner of the clinical department
PROVIDERS ARE FACING A PERFECT STORM

Massive Shift to FFV with Inadequate Tools or Information
Commercial payers and CMS both committing to significant FFV targets over the next 3 years
Providers tracking upwards of 100 quality measures, primarily via spreadsheets
Accurate coding/HCC capture is essential

Cost-Shifting to the Consumer
Approaching $650 billion in annual patient responsibility
Increased bad debt expense.
Providers must increase yields just to maintain current revenue.

Consumerism is Changing the Game and the Necessary Tools to Play
Patient experience; mobile; transparency tools; patient payment options… All critical to maintain patient volume

Administrative Requirements Reaching a Breaking Point
Greater usage of pre-authorizations, referrals, etc., to control utilization of services
Increase need of data concerning predictive analytics in a team based care environment

Massive Productivity Challenges
Projected to result in 40% productivity loss in coding operations
Significant impact to cost-to-collect metrics and denial rates

Pressure to Consolidate or Become Employed
Limited options to achieve necessary scale, manage risk and make necessary technology purchases
OVERARCHING THEMES

• We must simplify the health care consumption experience
• Consumers will pay more for healthcare
• Providers will have to collect payments directly from the patients
• Employer sponsored health insurance will evolve to only high deductible plans with the end game being “defined contribution”
• We must significantly take down the cost structure – not bend the cost curve.
Approximately $1,800 Today
# Vaginal Delivery

**Total Fair Price:** $9,802

## Fair Price Fee Details

### Hospital Services

**Fee Details:**
Price is for a 2 day admission for mother and baby. More days charged at $1,800 per day for mother and $335 per day for baby.

**Fee:**
$5,393

**Pricing Agreement:**
[Printable Detailed Pricing Agreement](#)

### Physician Services

**Fee Details:**
Physician fee for procedure and routine postoperative care. Vaginal delivery of a baby

**Fee:**
$2,922

**Pricing Agreement:**
[Printable Detailed Pricing Agreement](#)

### Anesthesia

**Fee Details:**
Price is for an average surgery time of 4 hours and 45 minutes. Prices may go up or down based upon the actual surgical time required.

**Fee:**
$1,487

**Pricing Agreement:**
[Printable Detailed Pricing Agreement](#)
Figure 3-1.

National Spending for Health Care, 2014

Total health care spending amounted to $2.9 trillion in calendar year 2014, about half of which was private spending. The federal government subsidizes a substantial part of that private spending, primarily through the tax exclusion for employment-based health insurance.

Total Health Care Spending: $2.9 Trillion

<table>
<thead>
<tr>
<th>Public Spending: $1.4 Trillion, or 48 Percent</th>
<th>Private Spending: $1.5 Trillion, or 52 Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>$619 Billion Medicare*</td>
<td>$991 Billion Payments by Private Health Insurers</td>
</tr>
<tr>
<td>$509 Billion Medicaid and CHIP*</td>
<td>$330 Billion Consumers’ Out-of-Pocket Spending</td>
</tr>
<tr>
<td>$243 Billion Other Government Spending</td>
<td>$186 Billion Other</td>
</tr>
</tbody>
</table>

22% | 18% | 8% | 34% | 11% | 6%

Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services.

CHIP = Children’s Health Insurance Program.
a. Refers to gross spending for Medicare, which does not account for offsetting receipts that are credited to the program. Those offsetting receipts are mostly premium payments made by beneficiaries to the government.
b. Includes federal and state spending.
WHAT DO CONSUMER’S VALUE?

Data shows how most of healthcare’s inflation has resulted from increased administrative spending.

*2300% increase in U.S. healthcare spending per capita between 1970-2009

Source: Health Care Costs: A Primer, The Henry J. Kaiser Family Foundation
Federal Spending on the Major Health Care Programs, by Category

Percentage of Gross Domestic Product

The projected rise in federal spending for the major health care programs results from the aging of the population and the expectation that health care costs per person will continue to grow more quickly than potential GDP per person.

Source: Congressional Budget Office.

The extended baseline generally reflects current law, following CBO’s 10-year baseline budget projections through 2026 and then extending most of the concepts underlying those baseline projections for the rest of the long-term projection period.

Potential GDP is the maximum sustainable output of the economy.

CHIP = Children’s Health Insurance Program; GDP = gross domestic product.

a. “Marketplace Subsidies” refers to outlays to subsidize health insurance purchased through the marketplaces established under the Affordable Care Act, as well as spending to subsidize insurance provided through the Basic Health Program and spending to stabilize premiums for insurance purchased by individuals and small employers.

b. Refers to net spending for Medicare, which accounts for offsetting receipts that are credited to the program. Those offsetting receipts are mostly premium payments made by beneficiaries to the government.
140M Consumers
Supply Side Push
• ACO / PCMH / Pop Health
• Value Based Reimbursement
• Continued consolidation
• Patients should value quality the way we define it.

175M Customers
Demand Side Pull
• Employer shift to CDHP then DC
• Increased economic exposure
• Innovation in delivery and focus producing solutions that consumers want
• Fracturing the health care consumption marketplace
• New players (i.e., Walmart)
# Revenue Cycle – The New World of Reimbursements

By 2018, 50% of Medicare Payments will be based on value-based payment models

By 2018, 95% of all Medicare Fee-for-Service payments will contain a quality component

## Utilizing Four Main Programs:
- Medicare Shared Savings Program
- Bundled Payments
- Primary Care Medical Homes
- Value-Based Purchasing Programs

## Five Common Features:
- Clinical Integration
- Team-Based Care
- Financial Risk
- Self-Governance
- Physician Leadership
<table>
<thead>
<tr>
<th>Procedure/Surgery</th>
<th>Cost</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior Cruciate Ligament Repair</td>
<td>$6,790.00</td>
<td>REQUEST A SPECIALIST</td>
</tr>
<tr>
<td>Anterior Cruciate Ligament Repair with Allograft</td>
<td>$9,790.00</td>
<td>REQUEST A SPECIALIST</td>
</tr>
<tr>
<td>Chondroplasty</td>
<td>$3,740.00</td>
<td>REQUEST A SPECIALIST</td>
</tr>
<tr>
<td>Complete Synovectomy</td>
<td>$3,740.00</td>
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</tr>
<tr>
<td>Med &amp; Lateral Meniscoectomy</td>
<td>$3,740.00</td>
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</tr>
<tr>
<td>Medial Collateral Ligament</td>
<td>$6,160.00</td>
<td>REQUEST A SPECIALIST</td>
</tr>
<tr>
<td>Posterior Cruciate Ligament Repair</td>
<td>$6,990.00</td>
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<tr>
<td>Tibial Tubercle Osteotomy</td>
<td>$6,270.00</td>
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</table>
## ACA IMPACT

<table>
<thead>
<tr>
<th>TARGET AREA</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured Rate</td>
<td>41%</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>Under Insured (Deductible / Co-Pay over $2,500)</td>
<td>22%</td>
<td>29%</td>
<td>43%</td>
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<tr>
<td>Medicaid Recipient</td>
<td>10%</td>
<td>13%</td>
<td>16%</td>
</tr>
<tr>
<td>Healthcare Exchange</td>
<td>NA</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Platinum</td>
<td>NA</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Gold</td>
<td>NA</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>Silver</td>
<td>NA</td>
<td>60%</td>
<td>65%</td>
</tr>
<tr>
<td>Bronze</td>
<td>NA</td>
<td>21%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Source: [Kaiser Family Foundation](https://www.kff.org/health-reform/interactive/aca-impact-2015/)
## FUTURE STATE OF ACA

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<td>Silver</td>
<td>67%</td>
<td>69%</td>
<td>70%</td>
</tr>
<tr>
<td>Bronze</td>
<td>16%</td>
<td>12%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation
PERCENTAGE OF COVERED WORKERS ENROLLED IN A PLAN WITH A GENERAL ANNUAL DEDUCTIBLE OF $1,000 OR MORE FOR SINGLE COVERAGE, BY FIRM SIZE, 2006-2015

* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs,
HOW MUCH IS TOO MUCH?

- Patients are unlikely to pay medical bills that are greater than 5.0% of household income, per The Advisory Board.

- Median household income in the United States is approximately $53,000 suggesting that when out-of-pocket expenses exceed $2,600 guarantor collections become extremely difficult.
PROVIDER STRATEGY: REVENUE OPTIMIZATION

THREE PRODUCT SUITES

ACHIEVE FOUR OBJECTIVES
- Enhance the Patient Experience
- Increase Yield
- Cost Containment
- Incremental Net Revenue Enhancement

THREE CONCEPTS
- Better Manage the Insurance $
- Tackle the Problem of Patient Collections
- Accomplish Both by Focusing on the Front End

THREE PRODUCT SUITES

- Payment Plans
- Guarantor A/R Management
- Patient Statements & Collections
- Pre-Service Clearance
- Authorizations
- Core Claim Mgmt / Scrubber
- Denial / Contract Management
- Coding / Clinical Advisory Services
FOUR KEY STRATEGIES

I. Enhance Patient Experience
   • Pre-Service Clearance
   • Retail Model
   • Comprehensive Transparency

II. Increase Yield
   • Increase Insurance “Yield” (e.g., 88.0% - 99.0%)
   • Guarantor Recoveries (e.g., 38.0% to 70.0%)
   • Enhanced Denials and Contract Management Services

III. Cost Containment
   • Capital Constraints
   • Reduced Productivity (e.g., ICD’10)
   • Increased Automation and Reduce “Cost-of-Rework”

IV. Incremental Net Revenue Enhancement
   • Eliminate Revenue “Leakage”
   • Health System Revenue Leakage 3.0% - 5.0% annually
   • Revenue Leakage vs. Revenue Preservation
What it means...

• Shifting the revenue cycle processes’ focus from “post-service” and “point-of-service” to “pre-service”

• Performing all administrative functions associated with a scheduled appointment for a patient prior to the patient arriving for his/her service

• Creating a “one stop shop” patient service call center in order to facilitate the patient experience

• Leveraging technology, particularly mobile, to engage the patient prior to the visit
Why it’s important…

- Roughly 45% of denials are due to patient access issues
- Only 40-60% of post-service patient responsibility is never collected
- Expectation that this individual program/function would increase yield by approximately 3% to 4%
- Tackles consumerism and patient experience head-on. Separates the patient clinical encounter from the financial clearance process in order for the visit to the provider to be purely clinically related
- Allows for the conversion of the revenue cycle to a “clinically driven, retail model”
- Provides for the horizontal integration of functionality across the revenue cycle, which will improve efficiencies, reduce the number of errors, and streamline the back-end process while enhancing the patient experience
- Provides a mechanism to manage increased volume, due to the evolution of the market to a decentralized ambulatory or outpatient care model
PATIENT SERVICES + CLINICAL REVENUE INTEGRITY + A/R MANAGEMENT

PRE-SERVICE CLEARANCE
PERFORM ALL ADMINISTRATIVE FUNCTIONS PRIOR TO THE PATIENT ENCOUNTER

- POS Standalone & Automated Batch Processing
- Registration Quality Assurance (RQA)
- Online Patient Payments
- Automated Workflow
- Dual Eligibility Review
- Medicaid Eligibility Screening
- Presumptive Charity Care
- Coordination of Benefits
- Patient Out-of-Pocket Estimates
- Medical Necessity Checking
- Search for Missing/Incorrect Insurance
- Frequency Edits
- Red Flag Alerts
- Network Status (patient and provider)
- Benefit Verification by Individual Plan
- Automated Insurance Verification (primary & secondary)
- Pre-Registration and Registration
- Address Verification & Improvement
- SSN# Verification
- Automated Authorizations & Referrals
- Propensity-to-Pay
SOLUTION OVERVIEW – PATIENT ACCESS
AUTOMATED WORKFLOW PROCESS

1) Accurate Estimates based on Patient's Plan and Historical payments

2) Instant Response by Payers for Eligibility & Benefits

3) Patient Registration Staff equipped to collect “appropriate” POS Cash from Patient

4) “Notice of Admission” to the Payer

Physicians
- Eligibility & benefits
- Care gaps
- Authorizations/referrals
- Attachments
- Summaries
- Claims
- Remittances
- Payments

Hospitals
- Admission/discharge notifications
- Lab/test results
- Eligibility & benefits
- Care gaps
- Authorizations
- Attachments
- Claims
- Remittances
- Payments

Payors

- "Notice of Admission" to the Payer
THE INTELLIGENCE PLATFORM

EVOlUTION OF TECHNOLOGY AND CAPABILITIES
THat POWER THE PROVIDER

Broad range of solutions built on a single, integrated platform

Optimized for risk adjustment as an initial priority focus

Enabled by a powerful suite of intelligence capabilities

Built on a foundation with world-class scale, security, reliability and flexibility
COMPETITIVE DIFFERENTIATION

• Investing in pre-service automation and services to simultaneously impact insurance and patient revenue yields

• Leveraging OHP/payer data and networks in the pre-service program and the digital clipboard

• Using a service model leveraging payer relationships to bridge the gap to full automation of authorizations, referrals and orders

• Leveraging automation, patient engagement and payer data to empower a unique comprehensive guarantor A/R management offering
PRE-SERVICE CLEARANCE FUNCTIONALITY

• Standalone Point-of-Service Processing

• Automated Batch Processing

  • Propensity-To-Pay
    o Address Verification and Improvement
    o SSN Search and Verification
    o Segmentation and Scoring
    o Red Flag Alerts
  • Insurance and Benefit Verification (e.g., primary and secondary)
  • Benefit Verification at the Service Type Level
  • Out-of-Network Benefit Verification
  • Provider and Patient Network Status
  • Cascading (e.g., incorrect, missing, uninsured, inactive primary/secondary insurance)
  • Advanced Search Algorithms
  • Coordination of Benefits (e.g., age, dialysis, MSP, Birthday Rule)
  • Dual Eligibility Determination
  • Membership Lists
Automated Authorization Management

- An automated process to submit, obtain and manage the authorization process
- Complete Authorization Rules Engine by Payor
- Approximately 80% of the Process – Automated
- Automated Follow-Up
- Reconciliation of Authorizations
- Workflow Driven
- HIPAA Compliant
- Comprehensive Pre-Service Clearance Automated Batch Processing (e.g., including eligibility, benefits and demographic verification)
- Medical Necessity
- Frequency Edits / Limitations
- Embedded Management Analytics to Allow Reviews by Individual Physician, Practice, and Department by Service (e.g., Procedure) Performed by Payor.
• Calculation of “Out-of-Pocket” Estimates
  • Provider based clinics (e.g., two bills, two out-of-pocket amounts and two deductibles)
  • Calculate the value of two commercial insurances
  • “Combined” out-of-pocket amount for recurring accounts
  • Frequency edits or benefit limitations related to services provided or the corresponding utilization limits (e.g., archive search or payor data)
  • Interpretation of modifiers and reduced reimbursement
  • Government payors as secondary payors are not taken into account (e.g., prime paid more)
  • Contract Management System
  • Historical Charges
  • Ability to email or fax the out-of-pocket estimate to the patient
PRE-SERVICE CLEARANCE FUNCTIONALITY (CONTINUED)

- Comprehensive Guarantor A/R Management Services Functionality
  - Provider based clinics (e.g., two bills, two out-of-pocket amounts and two deductibles)
  - Propensity-to-Pay
  - Address Verification and Improvement
  - SSN # Verification
  - Red Flag Alerts
  - Early-Out Program (e.g., pre-collection)
  - Patient Statements (e.g., paper and electronic)
  - Bad Debt Collection Agency Program
  - Second Placement Agency
  - No Interest Patient Payment Plans
  - Medical Eligibility (e.g., comprehensive sources)
  - Alternate Funding Programs
  - Patient Advocacy and Navigation
  - Automated Presumptive Charity Care
  - Liens/Accidents/Para Legal
  - Collection Optimization Program (e.g., management of third party vendors)