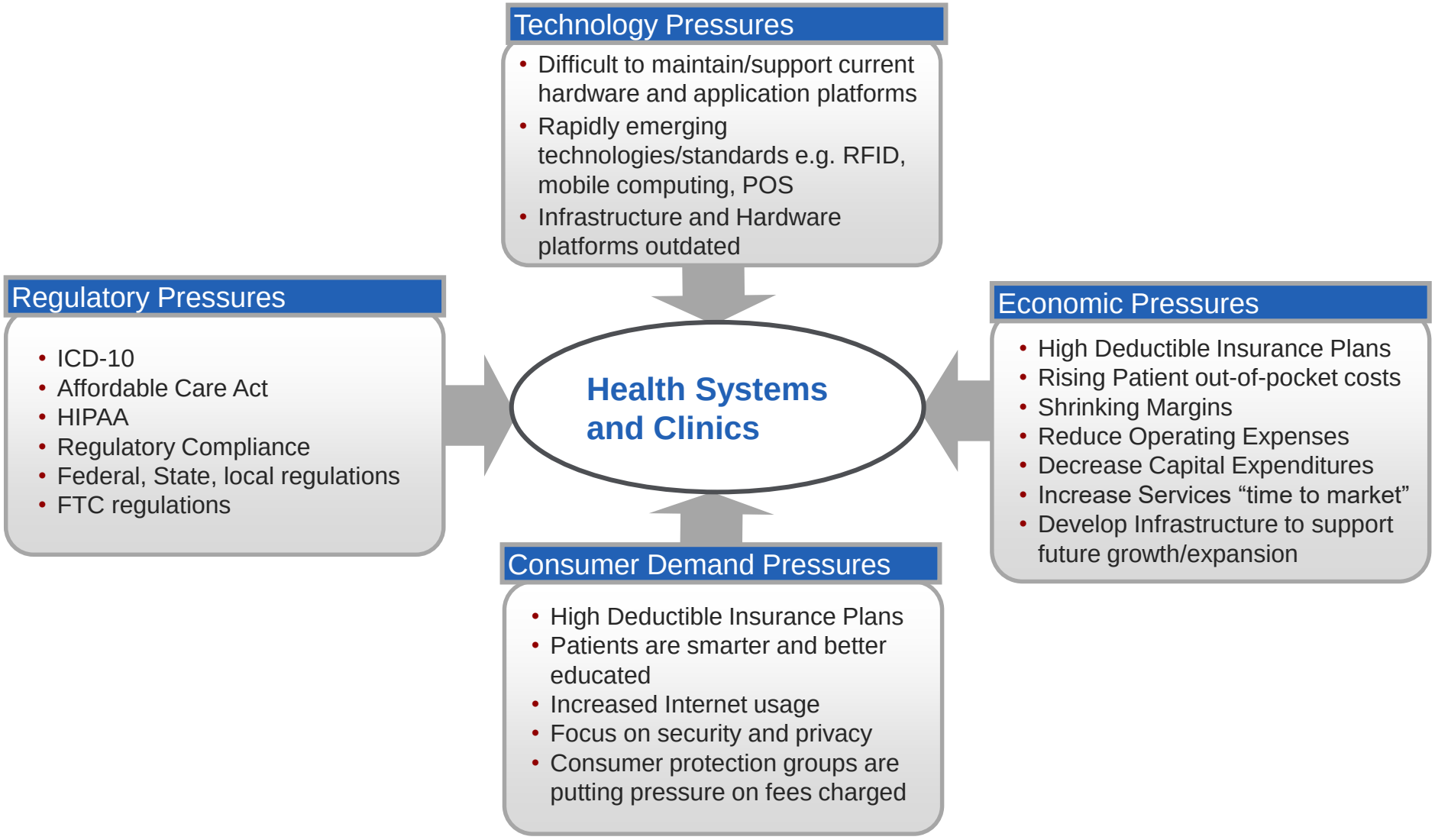
Availity®

STOP WAITING DAYS
GET ANSWERS IN MINUTES

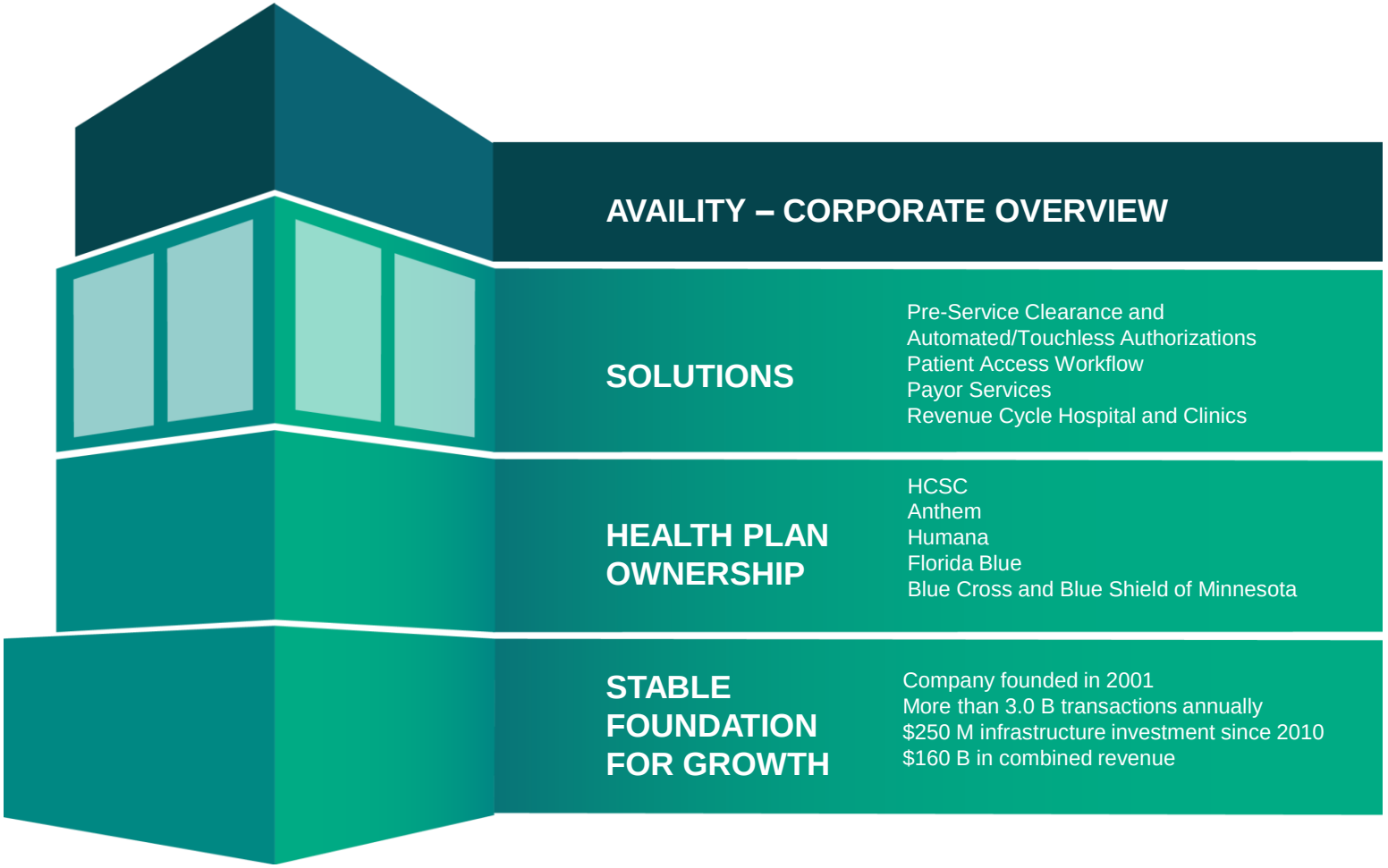
Automation of the pre-authorization process

better information. better insights. better outcomes.

OUR INDUSTRY IS UNDER PRESSURE



FLEXIBILITY TO PROVIDE STRATEGIC SOLUTIONS



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 nations 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**

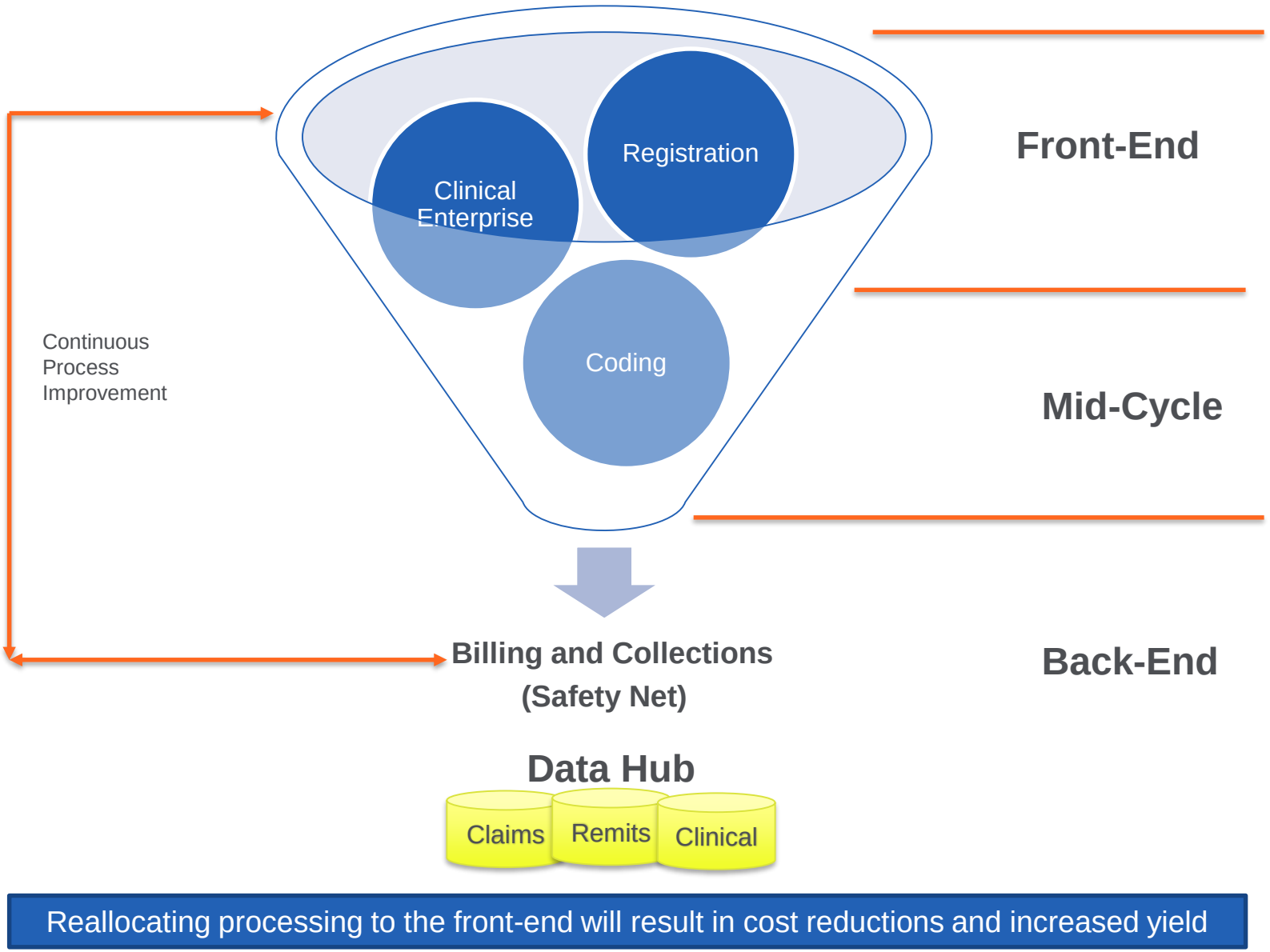
In 2015 25% of employers are only offering high deductible plans**

*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**

REVENUE CYCLE MANAGEMENT



Reallocating processing to the front-end will result in cost reductions and increased yield

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.

ACA IMPACT

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

Source: Kaiser Family Foundation

FUTURE STATE OF ACA

Target Area	2016	2017	2018
Uninsured Rate	10%	9%	4%
Under Insured (Deductible / Co-Pay over $2,500)	43%	49%	52%
Medicaid Recipient	16%	18%	20%
Healthcare Exchange	11%	13%	15%
Platinum	4%	4%	5%
Gold	13%	15%	17%
Silver	67%	69%	70%
Bronze	16%	12%	8%

Source: Kaiser Family Foundation

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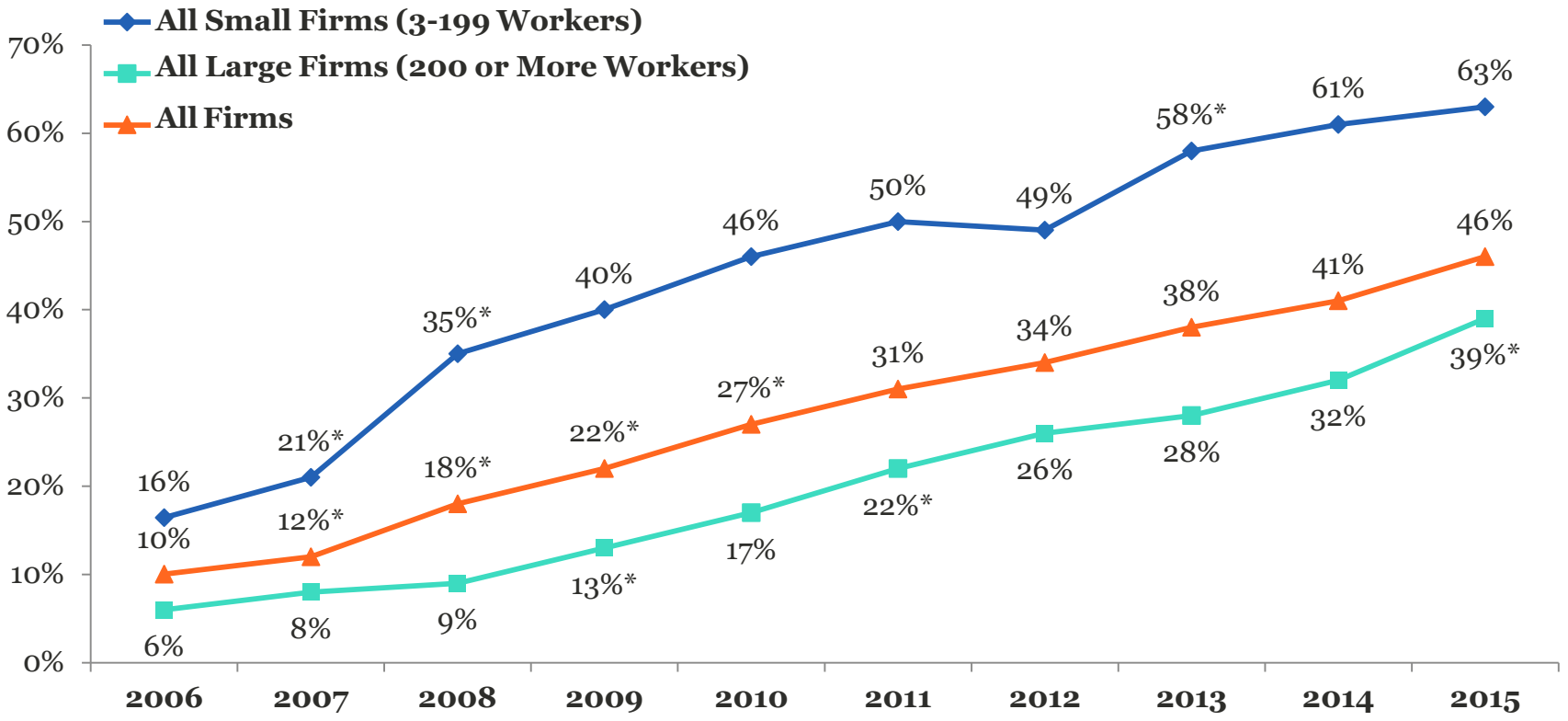
PERCENTAGE OF COVERED WORKERS ENROLLED IN A PLAN WITH A GENERAL ANNUAL DEDUCTIBLE OF $1,000 OR MORE FOR SINGLE COVERAGE, BY FIRM SIZE, 2006-2015



* 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 deductible s 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

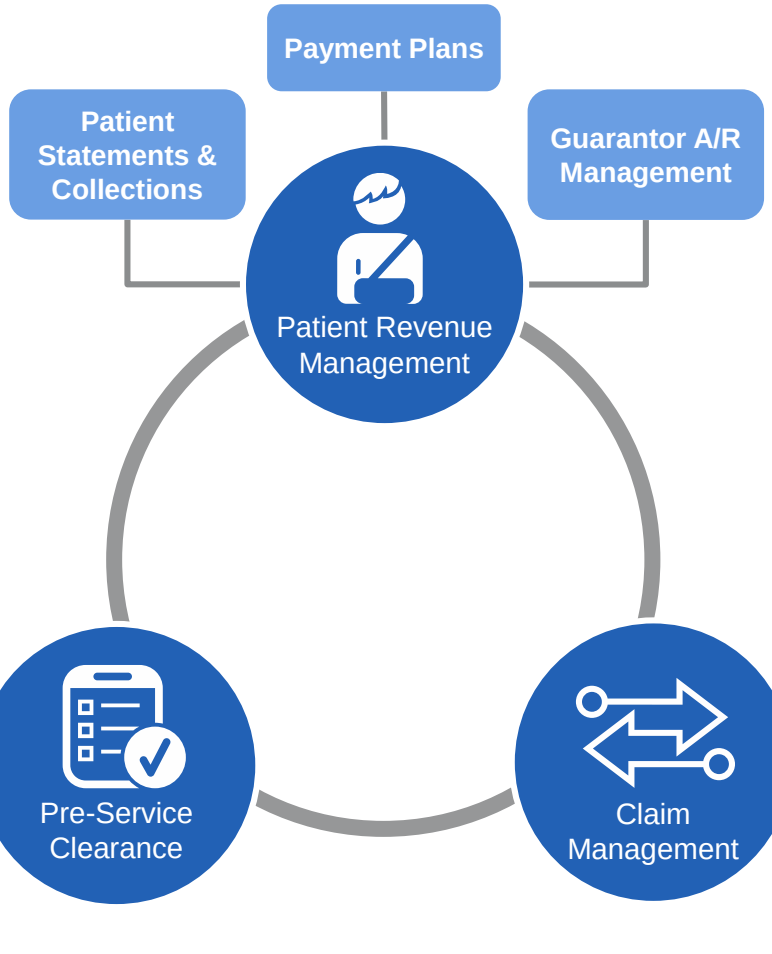
- Median household income in the United States is approximately $53,000 suggesting that when out-of-pocket expenses exceed $2,600 guarantor collections become extremely difficult

PROVIDER STRATEGY: REVENUE OPTIMIZATION

ACHIEVE FOUR OBJECTIVES

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

THREE PRODUCT SUITES



THREE CONCEPTS

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

SHIFTING FOCUS TO PRE-SERVICE CLEARANCE

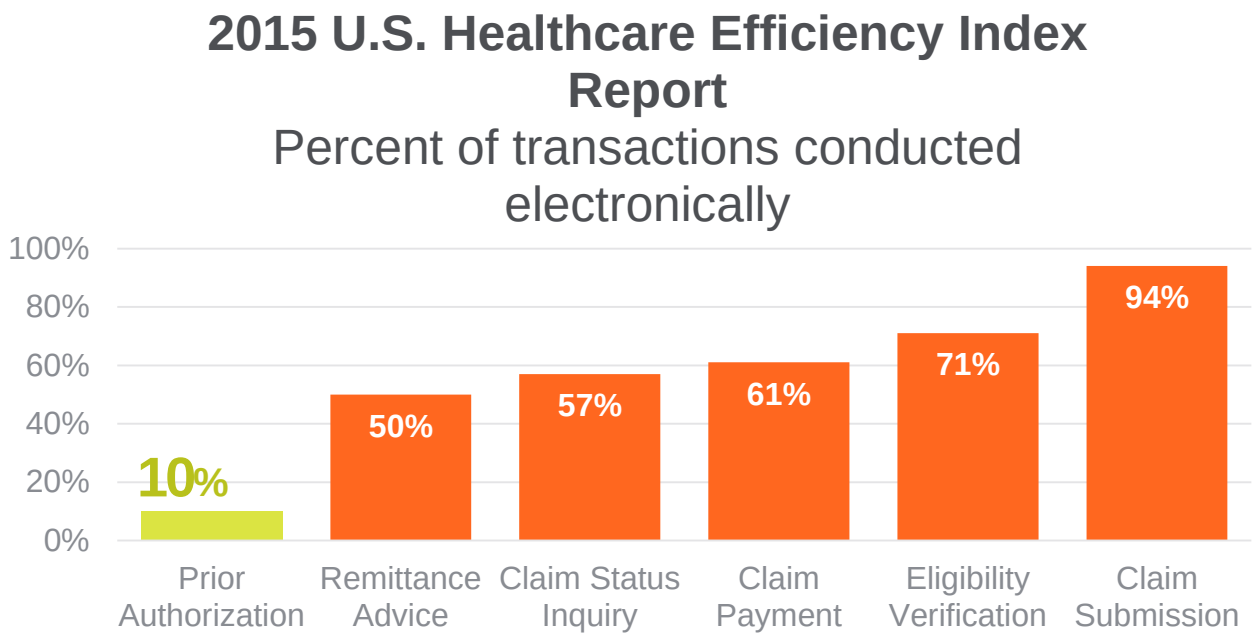
Why it's important…

- Roughly 45% of denials are due to patient access issues
- Only 40-60% of post-service patient responsibility is ever collected
- Only 25-30% of self-pay is ever collected after 90 days from service
- Expectation that Pre-Service Clearance programs would increase yield (cash) by approximately 3% to 4% of Net Patient Revenue (NPR)
- 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

PRE-SERVICE CLEARANCE

PERFORM ALL ADMINISTRATIVE FUNCTIONS PRIOR TO THE PATIENT ENCOUNTER

PRE-AUTHORIZATIONS HAVE THE LOWEST RATE OF AUTOMATION



$8 Billion

Potential industry-wide savings for electronic adoption of these six transactions

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OBTAINING PRE-SERVICE AUTHORIZATIONS IS A HUGE CHALLENGE FOR ALL HEALTH SYSTEMS

- Current state of the Authorizations
  - Utilizes manual processes between payer
  - Staff can only process 15-25 Authorizations per day per representative
  - Team spends 20 to 40 minutes on the phone per Authorization
  - Denials impact lost revenue - higher than appropriate/expected denial rates due to manual processes
  - Missed opportunities for reimbursement on procedures on a regular basis
  - No good mechanism for adjustments to authorizations from changes in services rendered
- Patient and provider dissatisfaction
  - Long wait for required procedure
  - Unexpected Denials from missing or none obtained Authorizations
  - No Authorization needed initially …. Then Payer “changes their mind”
- Employee dissatisfaction
  - Tedious, time-consuming tasks
  - Unnecessary Denials after all the hard work up front on the phone

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THE PROCESS NOW TAKES MINUTES, NOT DAYS

Step 1:
Determine if the authorization is required

- Automatically checks for **CPT-specific** eligibility and benefits and determines whether a prior authorization is required. If a prior authorization is not required, it immediately notifies the pre-cert team members.
- Delivers CPT specific co-pay information, ensuring accurate point-of-service collections
- Medical Necessity Checking

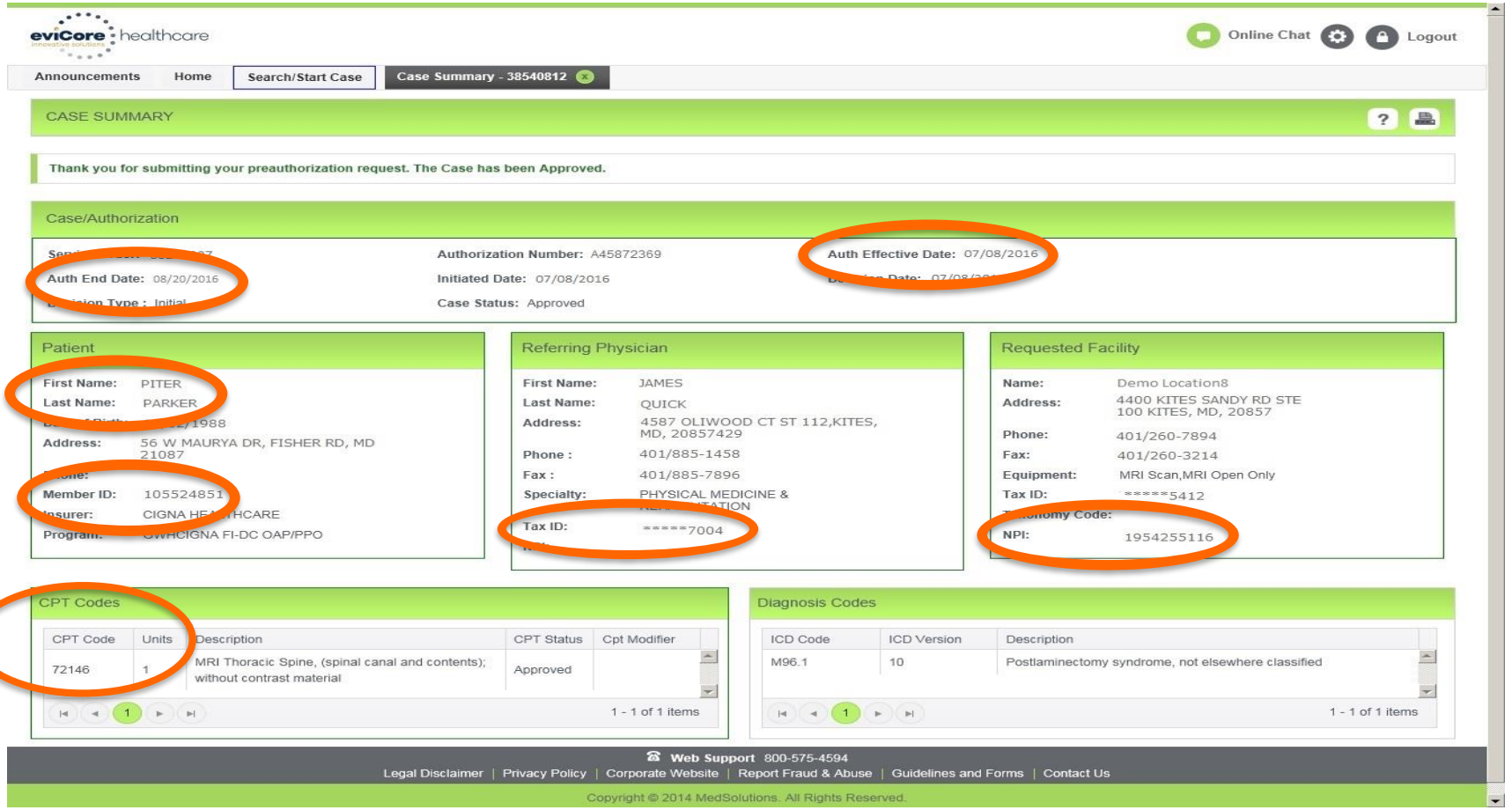
Step 2:
Obtain the Authorization

- Submits the authorization request in real-time.
- If a prior authorization cannot be obtained automatically, Automated Solution helps the pre-cert team members answer clinical questions by automating the remaining steps required to obtain a prior authorization.

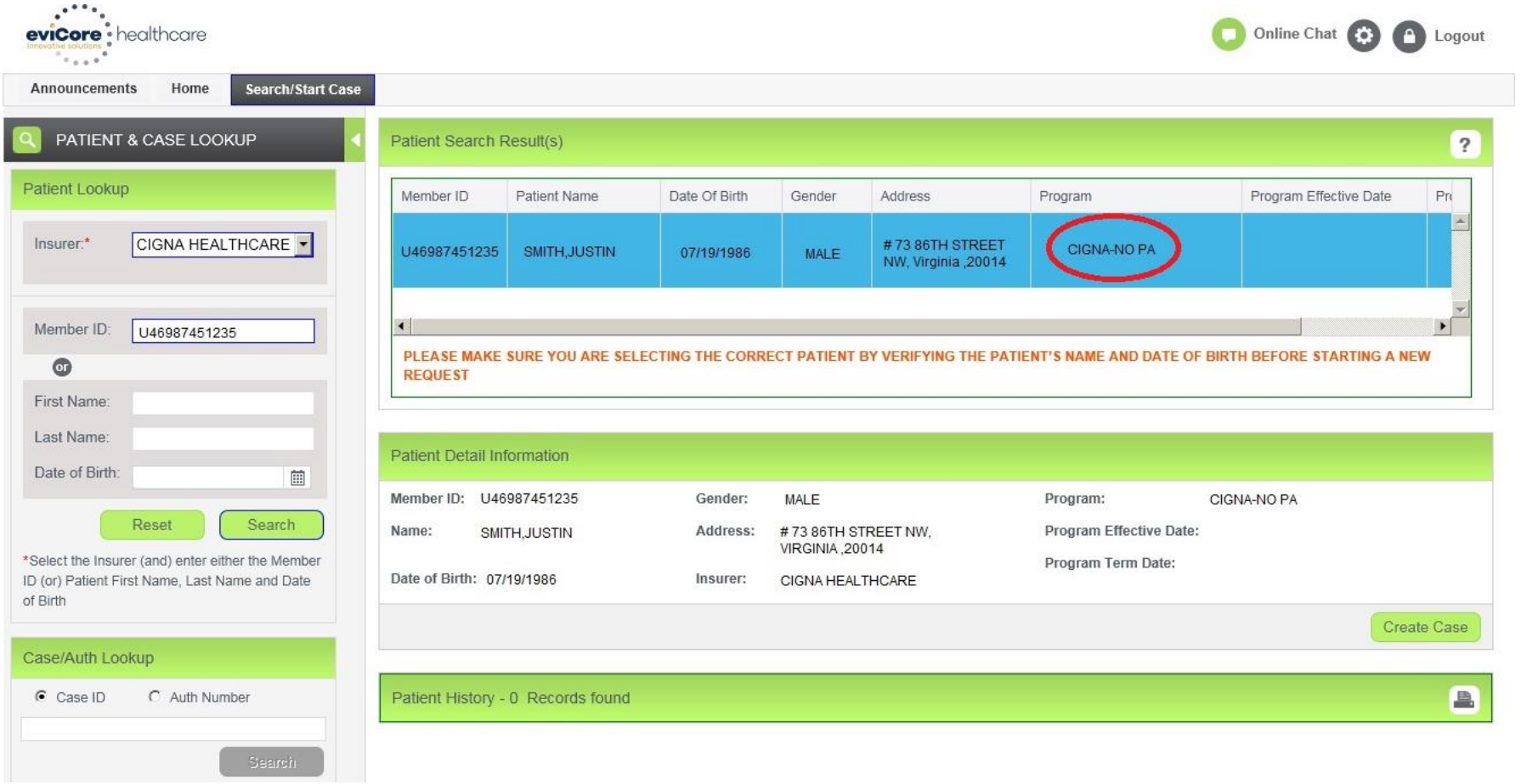
Step 3:
Return authorization number

- Continually checks the payer or RBM websites to find out the latest status of the prior authorization.
- As soon as the prior authorization is obtained, returns the prior authorization approval number, valid dates and an archived screen capture of the authorization details that can be integrated into your core HIS solution (Epic, Cerner, McKesson, Meditech, MedHost) via HL7.
- Documentation can be saved and attached to the medical record for audit purposes.

Automated validation of key data fields to ensure accurate Prior Auths



Screenshot of “Auth not required” stored within AuthPal & sent to client



SOLUTION BENEFITS WITH TOUCHLESS / AUTOMATED PRE-SERVICE AUTHORIZATIONS

- Benefits of Automated Authorizations
  - Automated processes in place for Authorization submission and obtaining approvals – highly efficient
  - Staff productivity increases to the ability to process 90-120 Authorizations per day per representative
  - With the staff able to process 4x authorizations volume, the number of authorization staff can be reduced significantly (if 43 FTEs, should be able to reduce to 13 FTEs) 24-30 FTEs to reallocate
  - Significant reduction in denials
  - Increase in payer payments
  - Eliminate missed opportunities for procedures due to slow authorizations
  - Provides mechanism to produce new Authorizations when there are “changes in service rendered”
  - Controls authorization approvals and proper payment not relying on Physician offices efforts
  - Availity can go-live with manual face sheet entry mode initially, no IT interface required
  - PDF is provided with Authorization approval for long term storage of the approval obtained
  - Availity will pay for side interfaces on behalf of the client when hospital is ready to activate the electronic interfaces to the Authorizations solution for inbound and post-back requirements

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