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25th Annual Revenue Cycle Conference
Tailgates, Touchdowns, & Revenue Cycle Championships!
It's time……to Reignite!

THREE FULCRUM POINTS OF PROVIDER-PAYER COLLABORATION IMPACTING HEALTHCARE OUTCOMES

Krithika Srivats, Sagility Health
Edison Bond, St. John's Episcopal Hospital
Dan Hillman, Sagility Health

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Krithika Srivats, MSOTR, Sr. Vice President, Clinical Practice, has been a thought leader in the health care industry deeply supporting innovation in care delivery. She has over 25 years experience supporting patient care. She has also vast experience working on Payer processes for over 15 years. She leads the medical management practice for Sagility Health and directs all automation and analytics development for improving the overturn rates. She has been a speaker in several healthcare conferences and has published thought leadership articles in collaborative care, automation, predictive analytics to improve home-based aging etc. Her deep experience in healthcare resonates in her podcasts and other published articles.

Edison Bond, Jr., MPH, MDiv, DMin, CPXP, Chief Patient Experience Officer, Episcopal Health Services, St. John's Episcopal Hospital, Far Rockaway, New York. He has over 30 years of healthcare experience working in public and private academic medical centers and acute care hospitals. He has been a speaker in several healthcare conferences and has a proven track record in leading the successful cultural transformation for enhancing the patient experience and employee engagement.

Dan Hillman, Vice President, Revenue Cycle Strategy has been supporting automation efforts for over 10 years in the healthcare financial operations. Dan has been part of the evolution of technology in the healthcare finance operations specifically in the application of intelligent automation within healthcare financial operations. He has been a speaker at the HFMA regional and local conferences and has authored articles on reducing the cost of collections and strategies for applying intelligent automation in RCM. His most recent published article is in the February 2020 issue of the HFM magazine.

THREE FULCRUM POINTS OF PATIENT-PROVIDER-PAYER COLLABORATION IMPACTING HEALTHCARE OUTCOMES

- Prior Authorization
- Human Connections & Patient Experience
- Claims and Clinical Denials
- Q & A

TOP ISSUES AFFECTING THE HEALTHCARE INDUSTRY

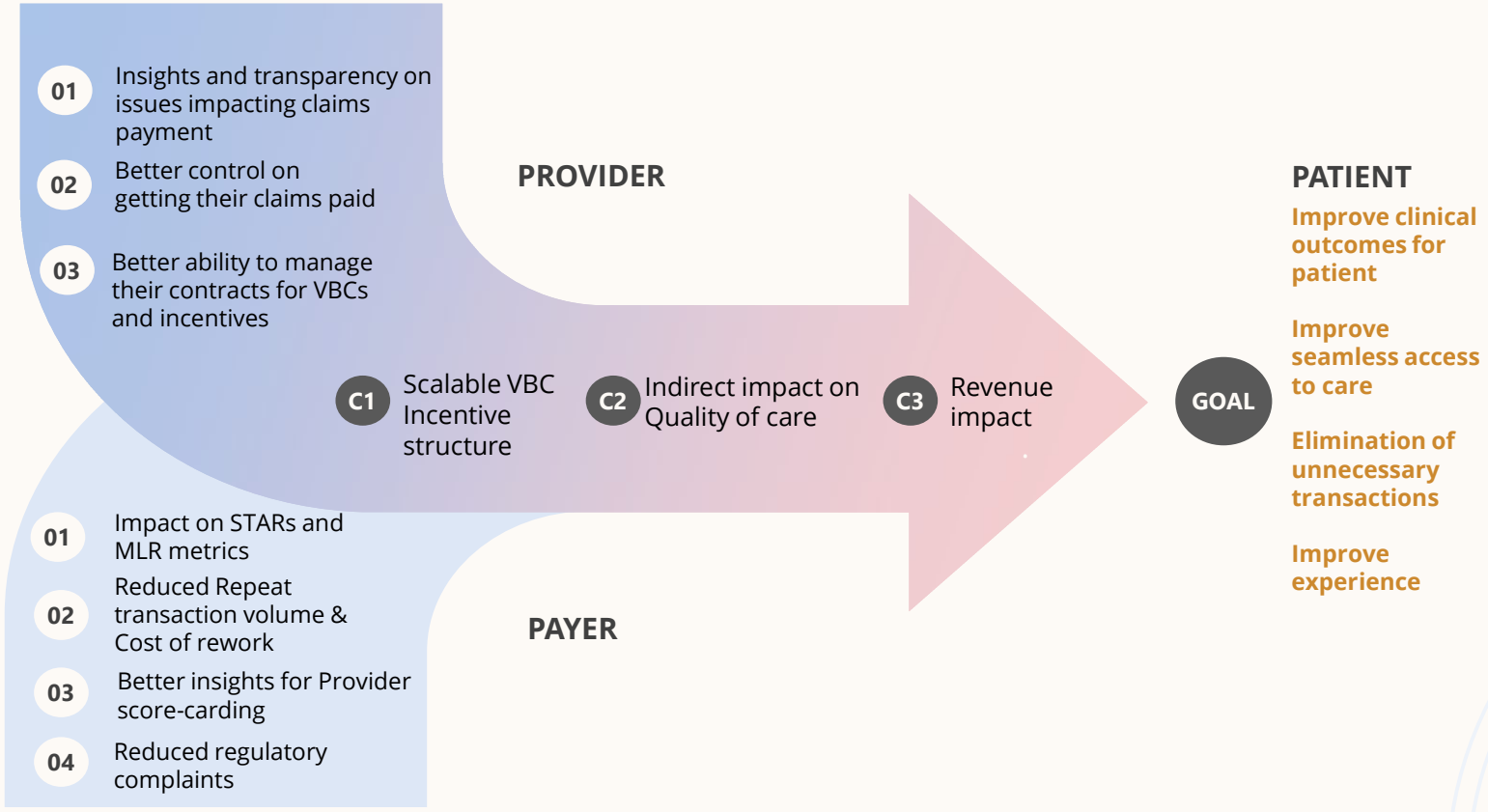
as a result of siloed systems between Payers and Providers

- Lack of transparency in data sharing between Payer, Providers
- Siloed systems and technology
- Lack of seamless processes and workflows

Resulting in:

- Delay in care for patients
- Increased waste from unnecessary repeated transactions (multiple procedures, unnecessary rework in operations, unnecessary burden on patients and providers, etc.)

WHAT'S IN IT FOR PROVIDER, PAYER, AND PATIENT



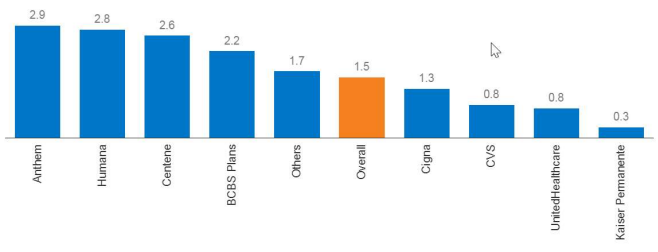
PRIOR AUTHORIZATION

KAISER FAMILY FOUNDATION STUDY OF PRIOR AUTHORIZATIONS IN MEDICARE ADVANTAGE BY HEALTH PLAN

Figure 1

Prior Authorization Requests Are More Common Among Certain Medicare Advantage Firms

Requests for prior authorization of services per Medicare Advantage enrollee in 2021



NOTE: Excludes requests that were withdrawn or dismissed. Anthem BCBS plans are not included in the analysis because of data quality issues.
SOURCE: Technical Specifications Public Use File of Contract Year (CY) 2021 Part C and D Reporting Requirements • PNG

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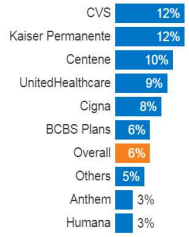
2 million denials in total

Figure 2

Firms Denied Between 3% and 12% of Prior Authorization Requests

Adverse and partially favorable determinations as a share of all prior authorization determinations in 2021



NOTE: Denied requests include determinations that were partially favorable or adverse. Anthem BCBS plans are not included in the analysis because of data quality issues.
SOURCE: Technical Specifications Public Use File of Contract Year (CY) 2021 Part C and D Reporting Requirements Data • PNG

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35 million prior authorization requests for 23 million MA members

INEFFICIENCIES – PRIOR AUTHORIZATION

- **Negative impact on care**
  - **87% negative** or somewhat negative impact on **patient clinical outcomes** is reported by physicians.[1]
  - **72% of patients abandon treatment** or somewhat abandon treatment due to prior authorization delays.[1]
- **Unnecessary cost and Provider burden**
  - Impacting provider's time- estimated 21 min per prior auth
  - Impacting provider's cost-~$11-14 per prior auth
  - **93%** of physicians reported delay in care due to prior authorizations in a recent Colorado study.
  - **1 in 10** prior authorizations are appealed
  - **82%** of appeals result in being fully or partially overturned[2]
- **Inefficiencies for the Payer**
  - **60% of denials** are because prior authorizations are not completed
  - **30%** of waste resulting from unnecessary procedures[3]

[1] Prior-Authorization-Survey-Results-FINAL.ashx (aans.org)
[2] Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021 | KFF
[3] Waste in the US Health Care System: Estimated Costs and Potential for Savings - PubMed (nih.gov)

SILOED PROVIDER JOURNEY

	Provider onboarding & Contracting	Care quality	Prior Authorization	Claims payment	Support & Navigation
Other Impact	• Access to care issues for members	• MLR impact • HEDIS and STAR rating impact	• Unnecessary procedures causing increase in MLR		• Repeat transaction process inefficiency
Claims Impact	• Rework from recredentialling or credentialling delays • Claims rework resulting form inaccurate provider data		• Variance in prior authorization services between approved and billed • Unauthorized services resulting in claims rework & retrospective reviews	• Delayed claims resulting in LCIP • Appeals from denied claims • Payment integrity issues	

COLLABORATIVE PAYER-PROVIDER PROCESSES-PRIOR AUTHORIZATION

- Process automation for reduced burden of transaction and AI
- Collaborative Peer-to-Peer process – to reduce unnecessary care
- AI, electronic outreach, and Avatar engagement with patient- to improve care outcomes

[1] Prior-Authorization-Survey-Results-FINAL.ashx (aans.org)

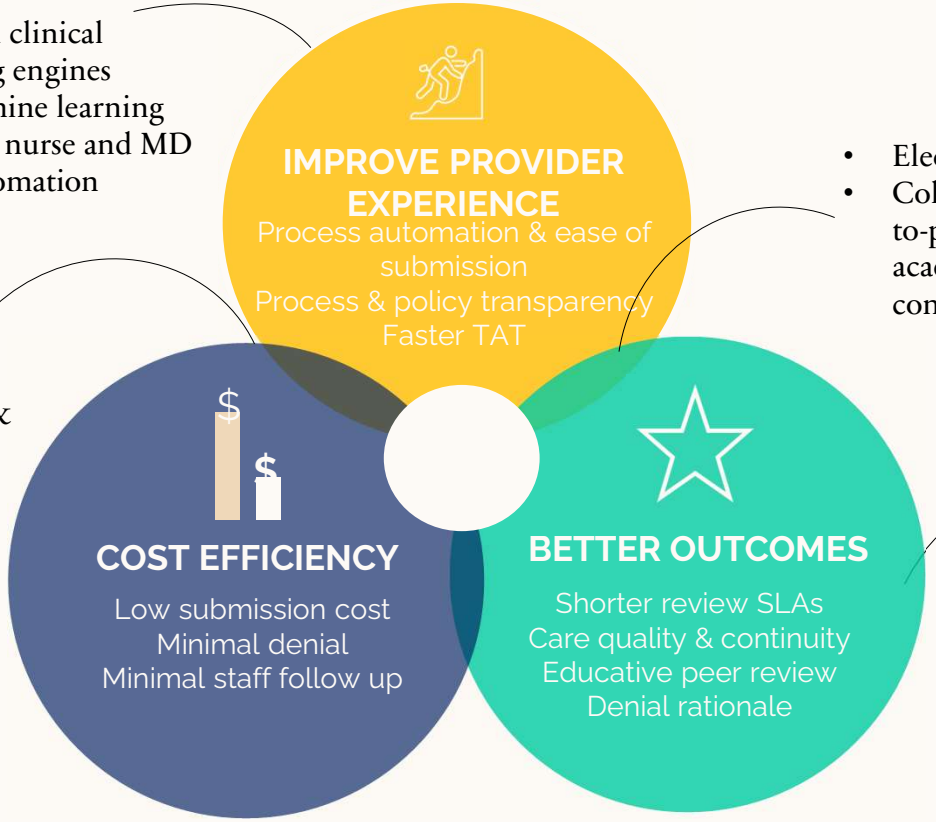
EXAMPLES OF HOW THE THREE LEVERS COME TOGETHER

- Automated clinical decisioning engines
- Large machine learning models led nurse and MD review automation

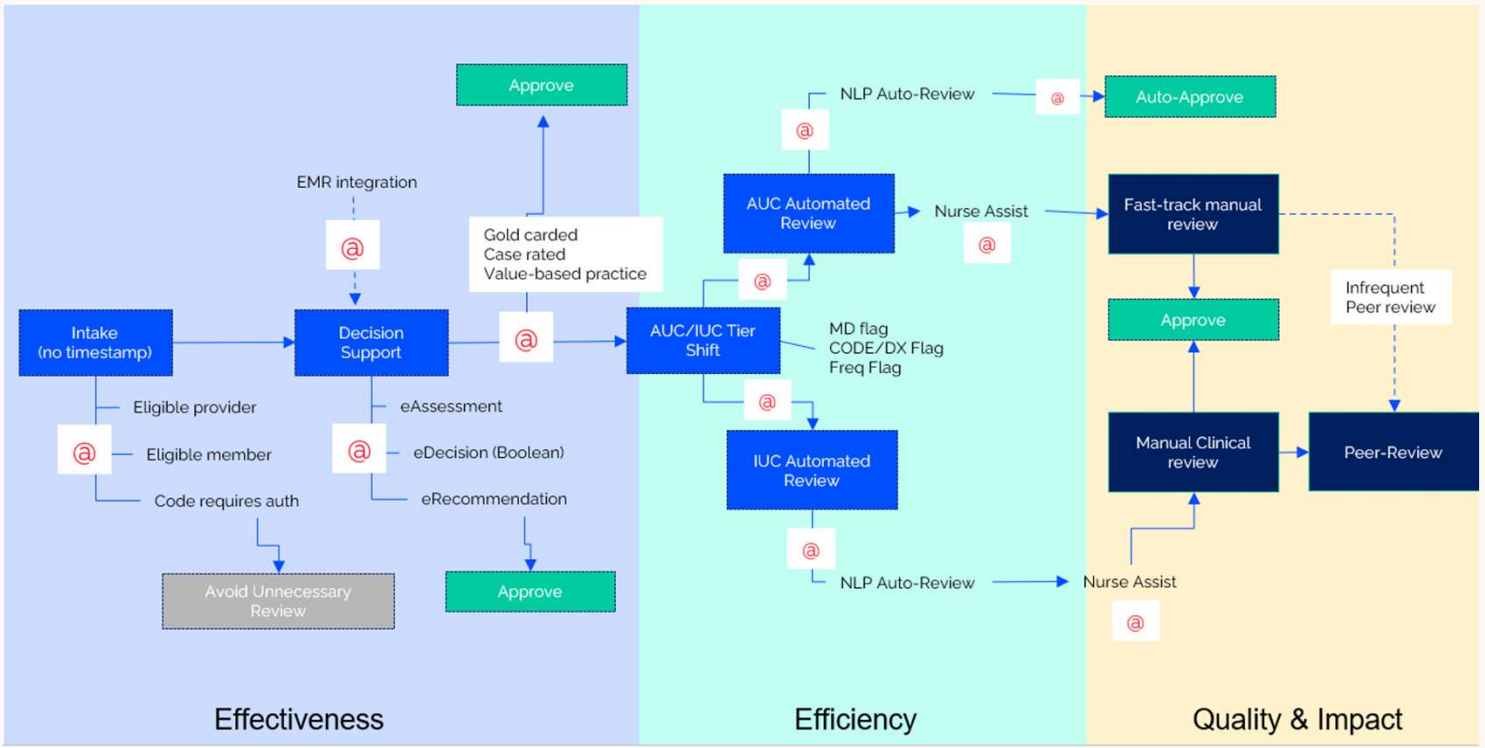
- Electronic assessments
- Collaborative, educative peer-to-peer discussions using academic care pathways and consultative approach

Electronic submission & omnichannel access

AI and avatars to provide continuous care support



AUTOMATION LEVERS



COLLABORATIVE PEER-TO-PEER

Engaging Peer-to-Peer review, when needed, benefits provider, payer and ultimately the patient during the prior authorization process –

- Boosts transparency
- Improves care collaboration and access to different services
- Encourages more effective coordination and timely care for the patient
- Identifies necessity for care and the level setting of that care
- Reduces misuse of services
- Promotes high quality and safe patient care

IMPROVED CARE OUTCOMES

Using automation and electronic outreach improves patient engagement, compliance and healthcare outcomes.

- Automated triggers throughout the workflow speeds up the notifications and requests for additional information.
- Electronic communications and follow up allows for simplified and accurate information exchange.
- Patient interaction with Avatars improves care outcomes
  - Follow up for patient compliance
  - Reinforces treatment recommendations
  - Improves patient outcomes and compliance

PAYER-PROVIDER SYNERGY EXAMPLE

OBJECTIVE

- Resolve the unworked and aging cases: 80% of cases have either been unworked or aging for 31+ days without required details to resolve.

SOLUTION

- Creation of required templates to accommodate data inputs from Provider group and details required from Payer to resolve the A/R case.
- SFTP site to transfer files containing PHI data.
- Created standard operating procedures and workflows to support offline case completion – following required documentation process in both CRM and agreed template
- Identification of required staff to handle case inflow and off the phone time schedule to optimize occupancy and line adherence.

BENEFITS

- Productivity of 7 cases per hour with 97% compliance with turnaround time.
- Of the case received, **87% were successfully completed** of which 96% were cases that were either unworked or aging for 31+ days.
- **98% first touch resolution**.
- **86% decrease in calls to the contact center** in the first month post-implementation.
- Paved the way in establishing **Provider Mailbox** to increase Provider participation and pool.

RE-ENGINEERING TO REDUCE CLINICAL ESCALATIONS EXAMPLE

OBJECTIVE

- Reengineer utilization management and prior authorization processes as a result of multiple hand-offs affecting provider and member experience.

SOLUTION

Process Improvements

- Medicare Triage. Select skilled coordinators assist with PAR Research lessening non-par and administrative review for both nurses and MDs.
- DME Auto Approvals. Per CMS PHE Declaration, certain DME codes can be auto-approved decreasing pends for no-par providers.
- Interim Nurse Approval Process. MDs partnered with Nurses to determine interim process of modalities or case types that can be approved without MD Route.

BENEFITS

- Achieved **65% improvement** on our Pend-to-MD % from 30% in 2018 to 10.52% in 2021. In 2023 it has maintained at 10%.
- Approval rate increased from 75% in 2020 to **78% in 2021**.
- Improved Inter-rater reliability test of **97.26% in 2021 from 91.82% in 2019**.

AUTOMATION REDUCES TURNAROUND TIME EXAMPLE

OBJECTIVE

- Clinical intakes posing challenge to track a case due to multiple channels of receipt.
- Inability to allocate case by missing information; skill/provider and expertise.
- Accounts, procedures and codes that are restricted for Sagility and need to be routed.

SOLUTION

- Image analytics to extract data from multiple templates.
- 5 factor hierarchy created (restricted accounts, restricted codes, State and jurisdiction, Matrix partners and missing information) for automated case allocation.
- Care routing algorithm that determines the most likely case type and raise fallback if uncategorized.
- Workflow and BI enabled dashboard for better insight and better case management.

BENEFITS

- Automated inventory count and faster **identification of non-standard** cases by **28%.**
- Prioritization of non-standard cases **enabling >80%** of non-standard cases being handled within **3 days**.
- **Higher productivity** thus reduced cost.
- Efficient operations management and reporting for **continuous improvement** and agile resources allocation.

HUMAN CONNECTIONS & PATIENT EXPERIENCE


Everything is
the Patient
Experience

https://youtu.be/pIGzPsfnpoc?si=3rqY74CEwZf7cacU

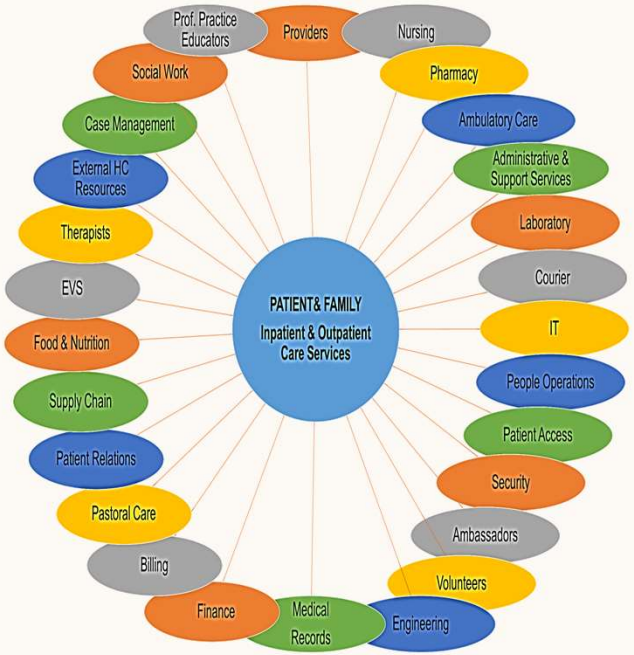
HUMAN CONNECTIONS PATIENT EXPERIENCE

THE BERYL INSTITUTE

Patient Experience Defined:

The sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care.

- The Beryl Institute



MAKING MEANINGFUL CONNECTIONS USING ESSENTIAL BEHAVIORS

Connect with me

- Recognize me as ME
- Use the name I want to be called
- Know me when I come in
- Recall prior visits
- Go beyond the medical issue at hand
- Take an interest in me
- Take an interest in my family
- Be aware of me as a whole person
- See the big picture of my life
- Make me feel like you understand me
- Follow up on something I've said about my personal life

Listen to me

- Listen, and act on what you hear
- Listen
- Make eye contact
- Pay attention
- Never interrupt
- Be fully present

Partner with me

- Tailor care & communication to me
- Focus on the patient point-of-view
- Focus on where I am (health/life)
- Take my concerns seriously
- Treat me as an equal
- Get to root of problem/concern
- Admit if don't know something
- Be patient with me
- Nudge me to be responsible for my care
- Write things down for me
- Speak in terms I understand
- Protect my dignity
- Be accessible to me
- Follow up
- Call me with results and explanations

TRANSFORMING PATIENT EXPERIENCE THROUGH REVENUE CYCLE

Tech meets Touch

- PX is not limited to clinical care
- Encompasses full spectrum of a patient's interaction with a health system
- PX shift to Consumerism

Creating Patient-Centric Experience

1. Digital Service Integration
2. Process Automation
3. Data Models and Advanced Data Science
4. Demand-based Team Schedules


TOGETHER...
WE ARE THE
PATIENT
EXPERIENCE

CLAIMS & CLINICAL DENIALS

Latest Trends & Solutions

LATEST IN CLINICAL DENIALS

Patient Access, Registration Errors Lead to Most Claim Denials

Revenue Cycle Leaders Spend the Most Time on Denials Management

Claim Denial Rates as High as 80% for Some Marketplace Payers

62% of Hospitals Don't Automate Any Part of Denials Management

Generative AI's Potential Shines on Revenue Cycle Management

~20-22% increase in clinical denials each year (commercial)

Medicare Advantage denials jump **56%**

LATEST IN CLINICAL DENIALS

90% of healthcare system's missed revenue opportunities comes from denials

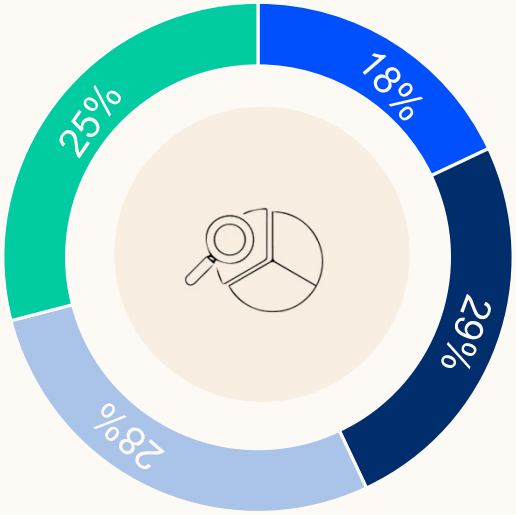
Claims Reimbursement Speed, Denial Rate Tied to Location

Providers in Louisiana, Oregon, and New Mexico receive claims reimbursement faster and more accurately compared to hospitals and practices in other states based on two KPIs: initial denial rate and accounts receivable (A/R) greater than 90 days. Pennsylvania, Indiana, Wisconsin, Iowa, Arizona, Illinois, and Ohio round out the top ten best states based on claims-paying performance by payors to providers

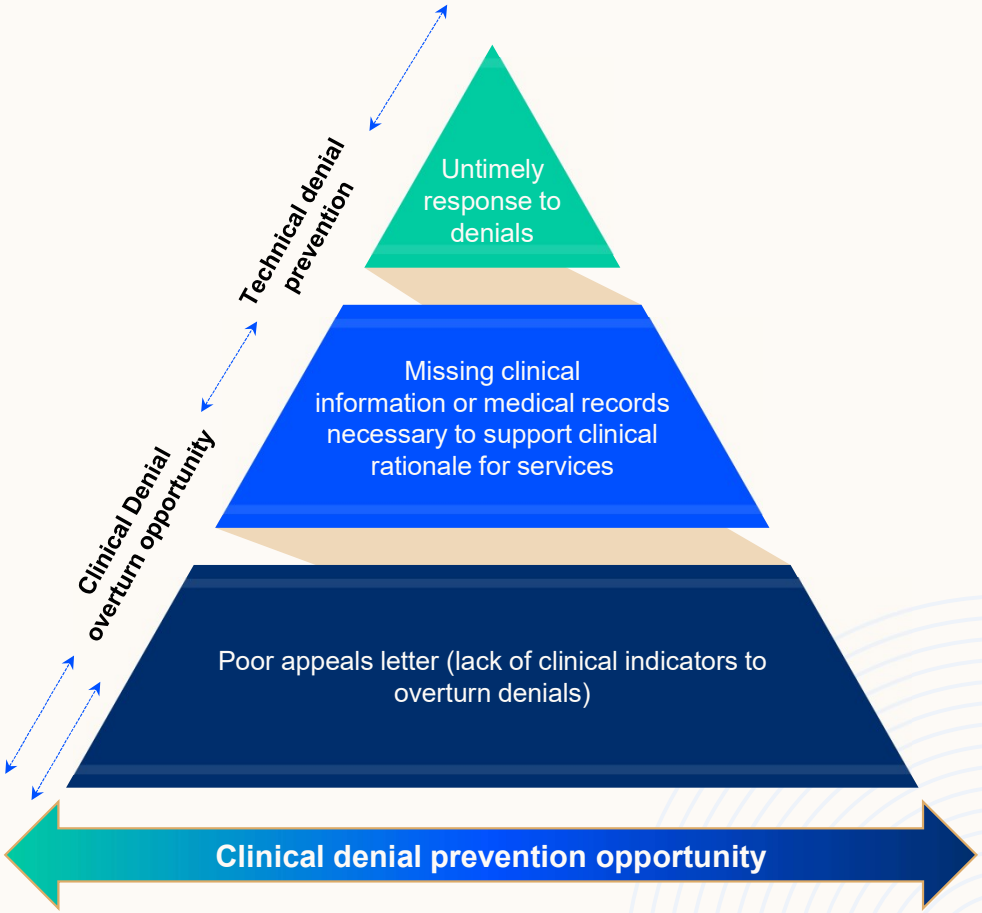
$262 Billion is denied across healthcare organizations

$5 Million denied per provider

POOR OVERTURN RATES

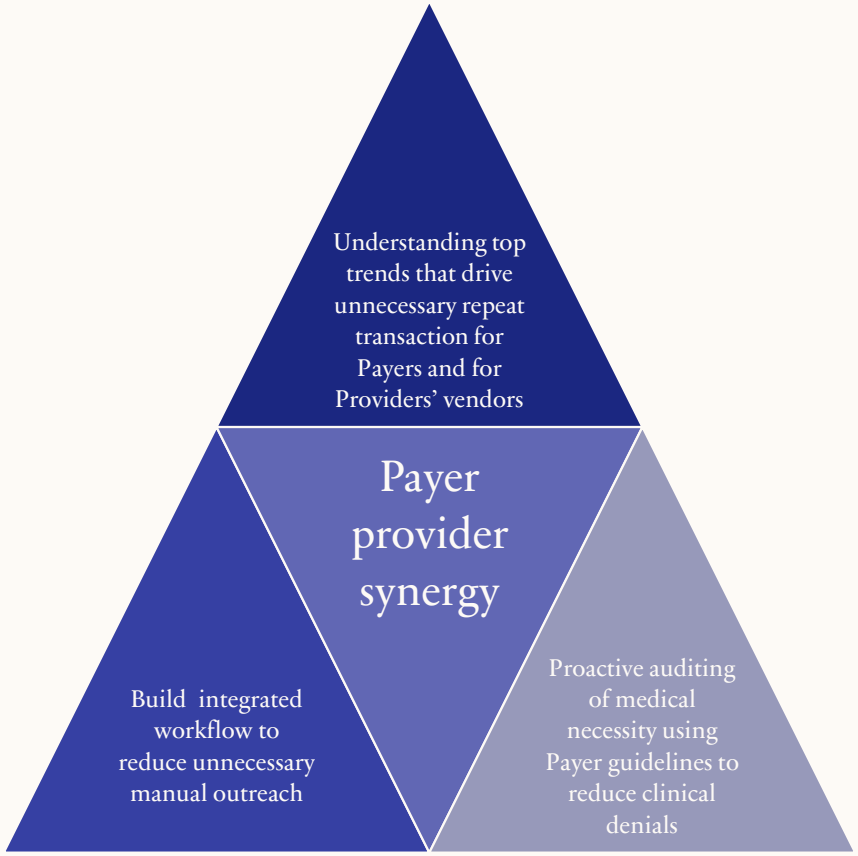


- Disparate Payer process
- Insufficient resource allocation
- Process breakdown between Revenue cycle and clinical teams
- Poor insights and trend analytics



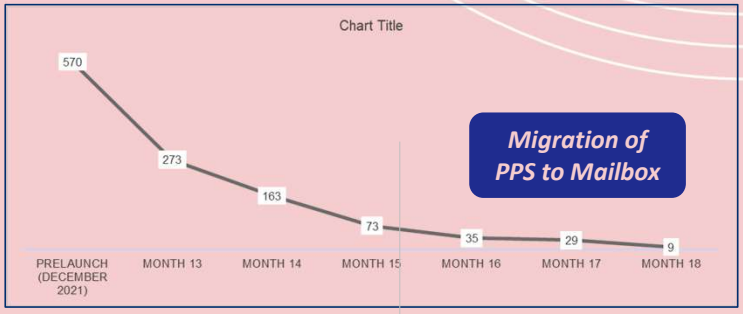
RESULTS:

Payer and Provider Alternate Channels & Results

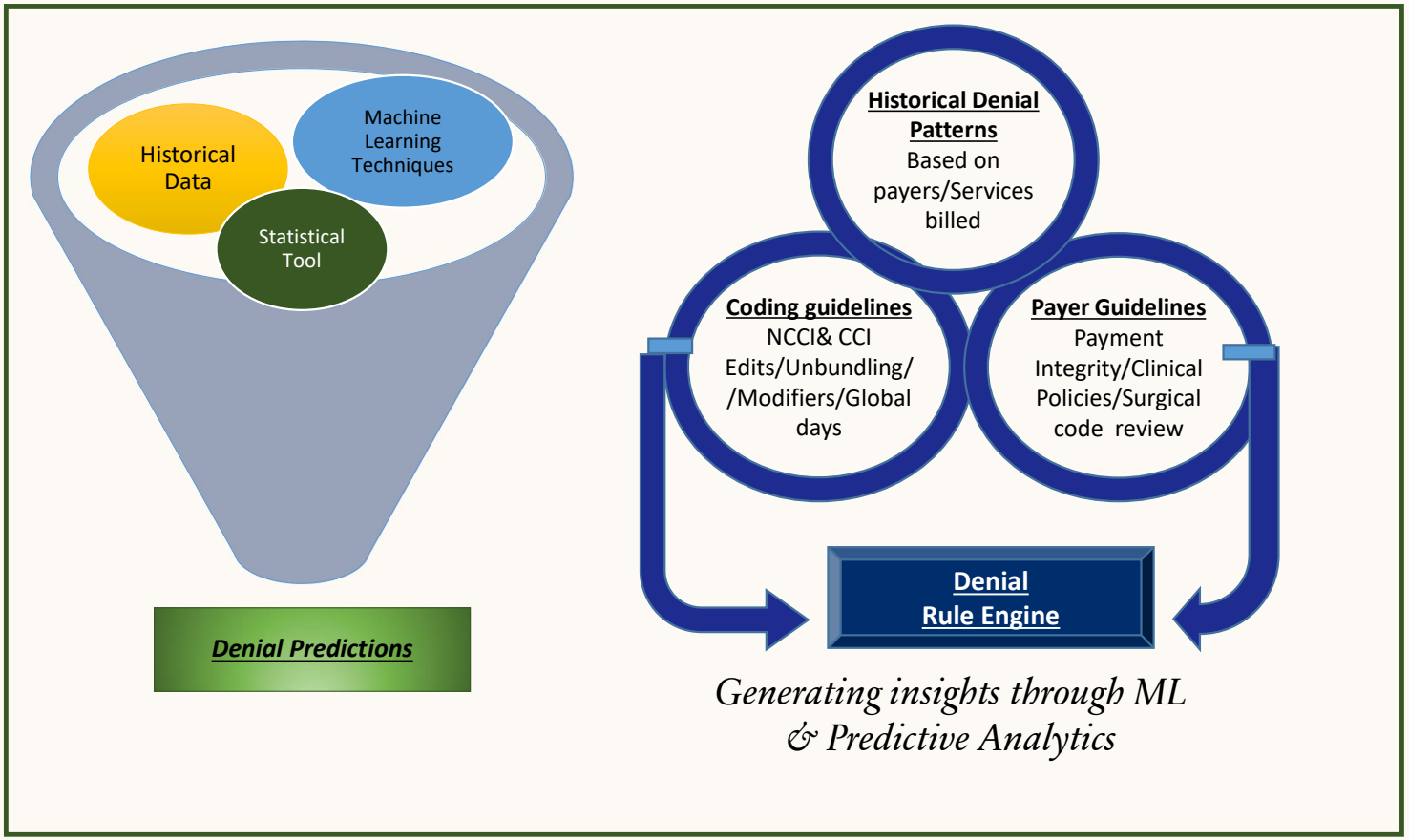


98% reduction in repeat transactions

Average monthly calls reduction



ROLE OF ANALYTICS IN CLINICAL DENIALS PROGRAM



Faster Cash collection
Reduce incorrect Technical denials

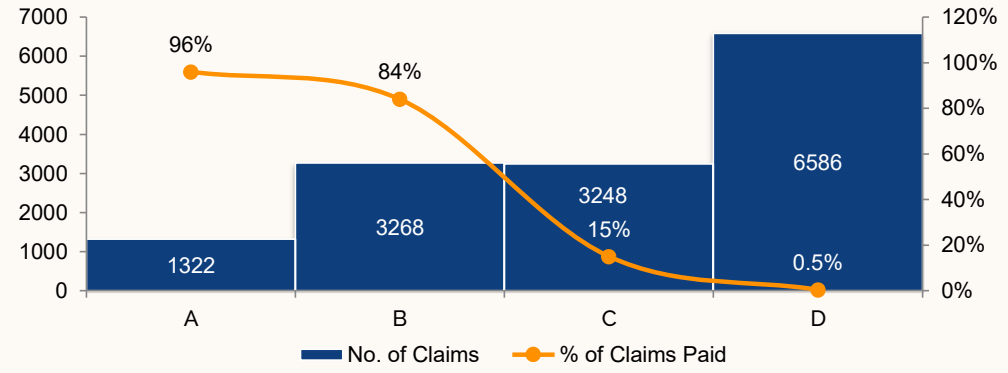
P-Models
P2D & P2OT

Predictive models on propensity to overturn denials based on Payer type, denial type, trends in clinical documentation integrity by provider and clinical criteria

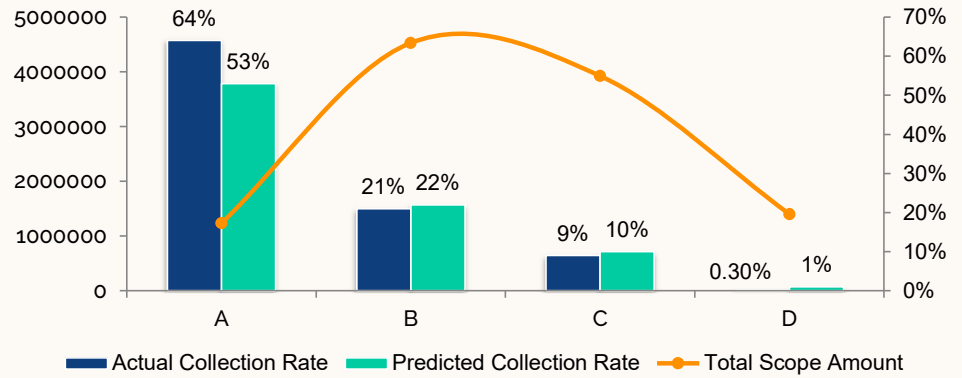
ANALYTICS – PROPENSITY TO PAY MODELS OPTIMIZE DENIAL FOCUS

	Bucket	No. of Claims	Distribution	No. of Claims Paid	% of Claims Paid	Total Scope Amount($)	Predicted Paid($)	Predicted Rate of Collection	Actual Paid($)	Actual Rate of Collection
Collectible	A	1322	9%	1277	96%	1236215	663227	53%	792410	64%
	B	3268	22%	2756	84%	4529208	1003546	22%	954604	21%
Non-collectible	C	3248	22%	497	15%	3926118	418765	10%	365490	9%
	D	6586	45%	30	0.5%	1401644	7730	1%	3937	0.3%

Bucket wise - % of claims paid



Actual vs predicted rate of collection

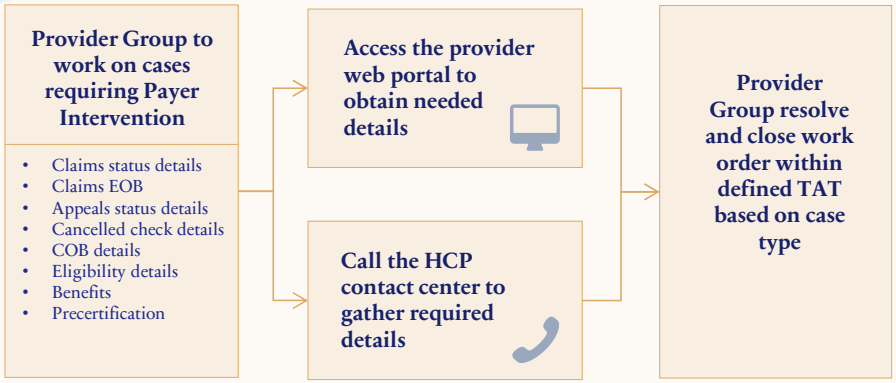


A predictive model that analyses data and recognize patterns

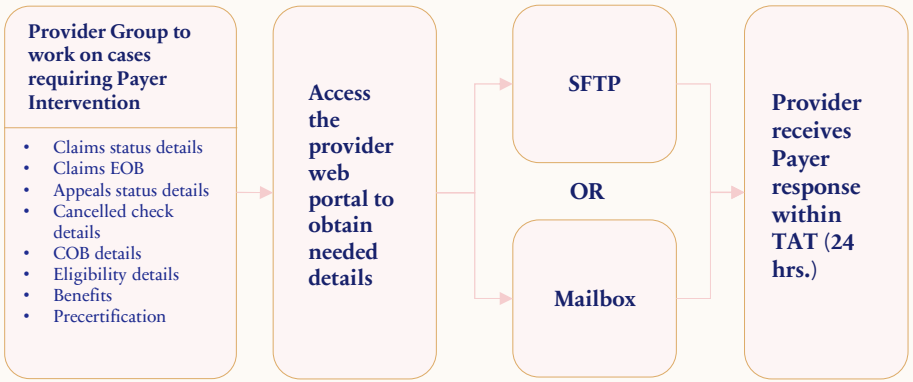
CLAIMS DENIALS - PAYER-PROVIDER SYNERGY

OBJECTIVE: To establish an alternate channel for Provider groups to directly send multiple member accounts or claim details requests by batch

CURRENT PROCESS



IMPROVED PROCESS



IDENTIFIED OPPORTUNITIES:

- 15 min call duration
- Repeat calls
- Case aging prioritization
- Optimize staff Occupancy

POTENTIAL BENEFIT:

- Reduced multiple patient and inquiries calls to the call center
- Reduced Provider effort and improved experience with Aetna cases
- Insights to improve web portal (Availity) functionality and utilization
- Reduced repeat calls - cases are processed and resolved holistically
- Opportunity to manage and optimize staff to work offline during non-critical intervals

Q & A

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THANK YOU!