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*

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

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 and 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
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
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 to manage revenue

Cost-Shifting to the Consumer
Approaching $650 billion in annual patient responsibility at low collection rates
Mix shift toward patient revenue will increase 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; telehealth; 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

FFV
Administrative
Patient Pay
Coding
Consolidation
Consumerism
PROVIDER STRATEGY: REVENUE OPTIMIZATION

ACHIEVE FOUR OBJECTIVES

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

THREE PRODUCT SUITES

- Payment Plans
  - Patient Statements & Collections
  - Guarantor A/R Management

THREE CONCEPTS

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

THREE CONCEPTS

- Core Claim Mgmt / Scrubber
- Denial / Contract Management
- Coding / Clinical Advisory Services
FOUR KEY STRATEGIES

I. 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

II. Reduce Operating Expenses
- Capital Constraints
- Reduced Productivity (e.g., ICD’10)
- Increased Automation and Reduce “Cost-of-Rework”

III. Incremental Net Revenue Enhancement
- Eliminate Revenue “Leakage”
- Health System Revenue Leakage 3.0% - 5.0% annually
- Revenue Leakage vs. Revenue Preservation

IV. Enhance Patient Experience
- Pre-Service Clearance
- Retail Model
- Comprehensive Transparency
SHIFTING FOCUS TO PRE-SERVICE CLEARANCE

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

- Propensity-to-Pay
- Automated Authorizations & Referrals
- Address Verification & Improvement
- SSN# Verification
- Red Flag Alerts
- Pre-Registration and Registration
- Automated Insurance Verification (primary & secondary)
- Benefit Verification by Individual Plan
- Network Status (patient and provider)
- Frequency Edits
- Search for Missing/Incorrect Insurance
- 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
Reallocating processing to the front-end will result in cost reductions and increased yield.
**SOLUTION OVERVIEW – PATIENT ACCESS**

**AUTOMATED WORKFLOW PROCESS**

- **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

- **Payers**
  - 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
AUTOMATED WORKFLOW SOLUTION

EXTERNAL DATA SOURCES
- Third-party payers
- 200,000+ public data sources

CLIENT INTERNAL DATA SOURCES
- Payer contracts
- Charge master (CDM)
- Charity/discount policies

FULLY-INTEGRATED SAAS-BASED SOLUTION
- Insurance Eligibility
- Medical Necessity
- Identity Verification
- Propensity-to-Pay
- Charge Estimate
- Estimated Patient Portion

INTERNAL DATA SOURCES
- Custom Patient Script

EXTERNAL DATA SOURCES
- POS Cash
- Improved Process Control
- HCAHPS

Reporting, Analytics, and QA edits – all in Real-time
HOW WE GOT THERE

$200 million in growth investments since 2010

- **INFRASTRUCTURE**
  - $50 million over 4 years
  - Built on a foundation with world-class scale, security, reliability and flexibility

- **SOLUTIONS**
  - $100 million over 5 years
  - Broad range of solutions built on a single, integrated platform

- **INTELLIGENCE**
  - $20 million over 3 years
  - Optimized for risk adjustment as an initial priority focus

- **TRANSACTIONS/DATA**
  - $30 million over 5 years
  - Enabled by a powerful suite of intelligence capabilities
THE ARIES INTELLIGENCE PLATFORM

EVOLUTION OF TECHNOLOGY AND CAPABILITIES THAT POWER AVAILITY

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
    - Address Verification and Improvement
    - SSN Search and Verification
    - Segmentation and Scoring
    - Red Flag Alerts
  - Insurance and Benefit Verification (e.g., primary and secondary)
  - Out-of-Network Benefit Verification
  - Provider 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 and demographic verification)
- 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)