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2024 Revenue Cycle Rollercoaster

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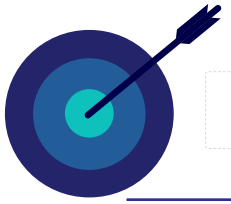
May 16th, 2024

Agenda



Learning objectives

Industry Landscape and Denials, Denials, Denials!

Patient Access Optimization

Automation and GenAI- What’s all the buzz!

Key takeaways

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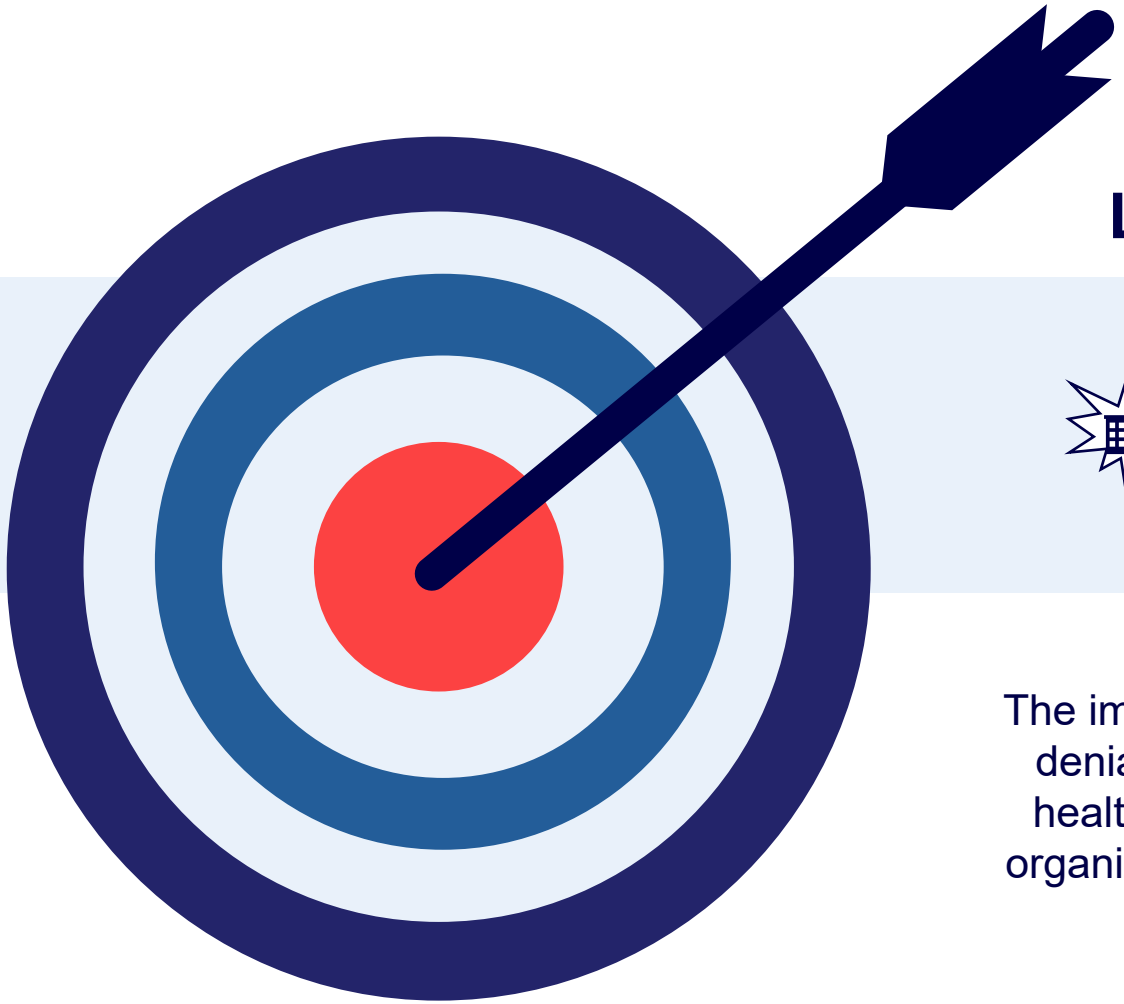

Learning Objectives

The impact of denials on healthcare organizations

Why prioritizing patient access drives positive outcomes

How GenAI and automation will change RCM

Benefits of improving denials, focusing on patients and implementing AI

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Industry Landscape and RCM Denials

Questions – Please Scan QR Code to Submit Answers

1. What percent of initial claims are payers denying, on average?
   a) 12%
   b) 6%
   c) 21%

2. What percent of denials received are being appealed and resubmitted, on average?
   a) 80%
   b) 30%
   c) 10%

RCM redefined: 2023 trends & 2024 forecast

In 2023, the RCM industry underwent a digital transformation. Healthcare providers increasingly adopted **automated RCM systems**, leveraging advanced technologies such as **AI** and **machine learning** to **streamline billing processes**.

Technology

- According to Bain & Company and KLAS, nearly **80% of healthcare providers prioritized** investment in **RCM technology.**
- **Denials management** and **underpayment recovery** were high focus areas.

Staffing Shortages

- A 2023 HFMA survey found **nearly half of finance** leaders (48%) **reported billing errors in their revenue cycle**, likely **due to staffing shortages**.
- **63%** of healthcare organizations report leveraging **outsourced RCM services**.

Reduce Costs

- A 2023 Cost of Caring report highlighted cost increases across multiple areas in healthcare. **Labor expenses** saw a **257% rise between 2019** and **2022**.
- **78%** of those surveyed reported rising **administrative costs** due to claim backlogs.

Ineffective Collaboration

- **Experian Health** found a **10-15% rise in claim denials**, with stricter payer **authorization** rules a **major culprit**.
- Providers blame **manual processes** for delays and wasted resources.

2024 is anticipated to witness a monumental shift towards **data-driven decision-making processes** in RCM. Healthcare organizations are projected to **leverage advanced analytics** to drive informed strategies, optimize revenue, minimize denials, and improve the patient experience.

How AI & automation are reshaping healthcare revenue

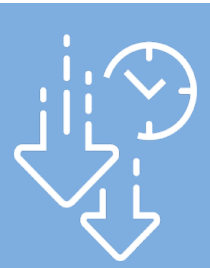
The ever-changing world of revenue cycle optimization demands continuous learning for specialists and managers. Embracing the latest trends lets you optimize processes, leading to smoother patient experiences, higher revenue, and lower costs.

Improve Patient Experience

Nearly **90%** of patients **want estimates** before service, but surveys show that **only 30%** receive them[1].

Optimize Revenue

Advances in **automation** and **machine learning** are being deployed in the denials management space to help health systems identify the root causes of underpayments and denials, and to automate the appeals process.



Minimize Denials

41% of **denials** are due to **frontend errors,** of which **22% are eligibility-related**[1]. Eligibility technologies tackle this issue using automation to identify patient insurance coverage, preventing revenue loss at the start.

Data-Driven Decisions

Data empowers healthcare providers to pinpoint revenue leaks. By analyzing data, they can identify areas where money is lost due to coding errors, underused services, or incomplete documentation.

[1] https://www.mdclarity.com/blog/revenue-cycle-management-trends

Industry Landscape – Healthcare Denials

90% of a Health System's Missed Revenue Opportunity comes from DENIALS

As many as 60% of returned claims are never resubmitted[3]

Cost of denials increased 67% from January 2021 to August 2022[4]

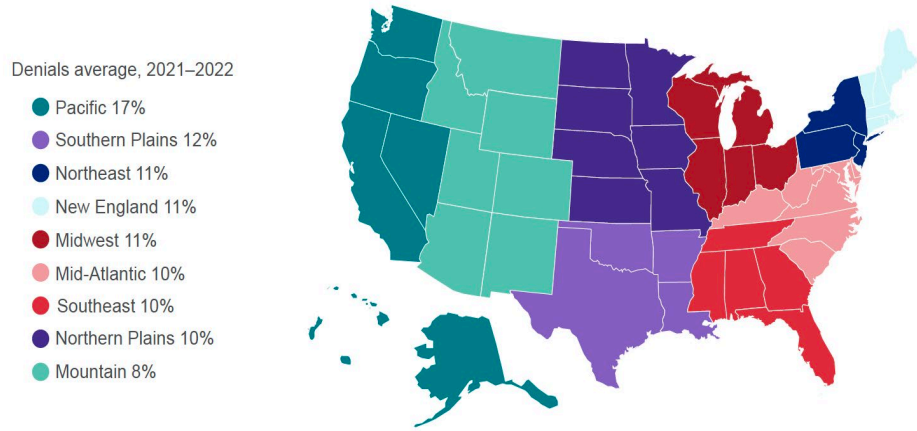
12% of claims denied upon initial submission in 2022[1]

Highest denial rates nationally in the **Pacific** and Southern Plains

Average denial rate is up 3% since 2016[1]

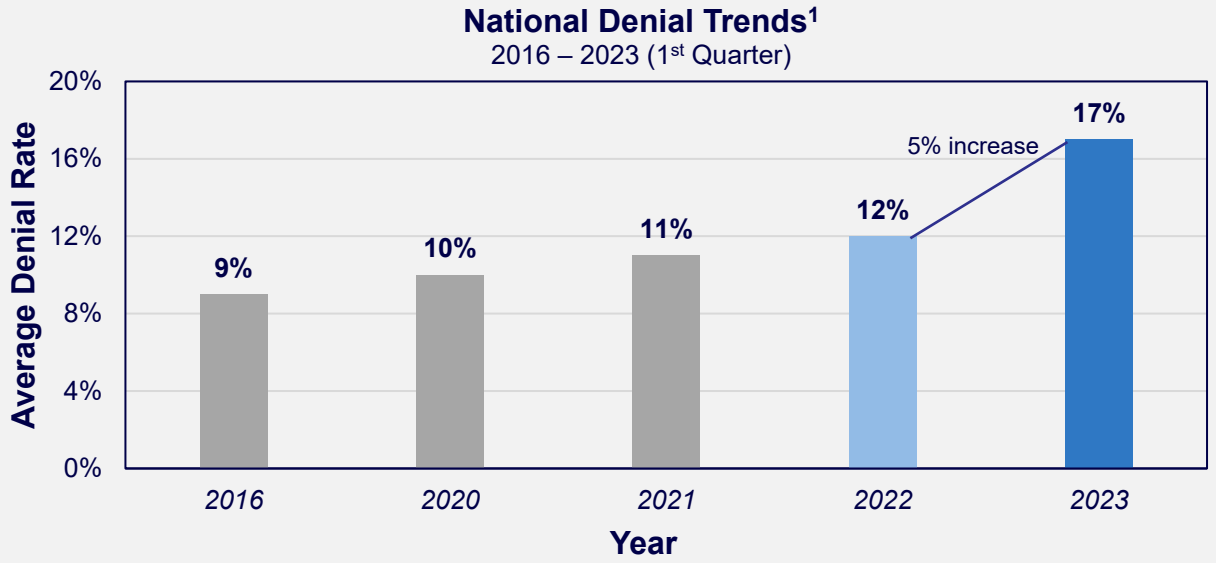
Denial rates largely vary by region

The highest denial rates nationally are in the Pacific and the Southern Plains.



https://www.changehealthcare.com/insights/denials-index

Increasing denials rates have substantial impacts across the country

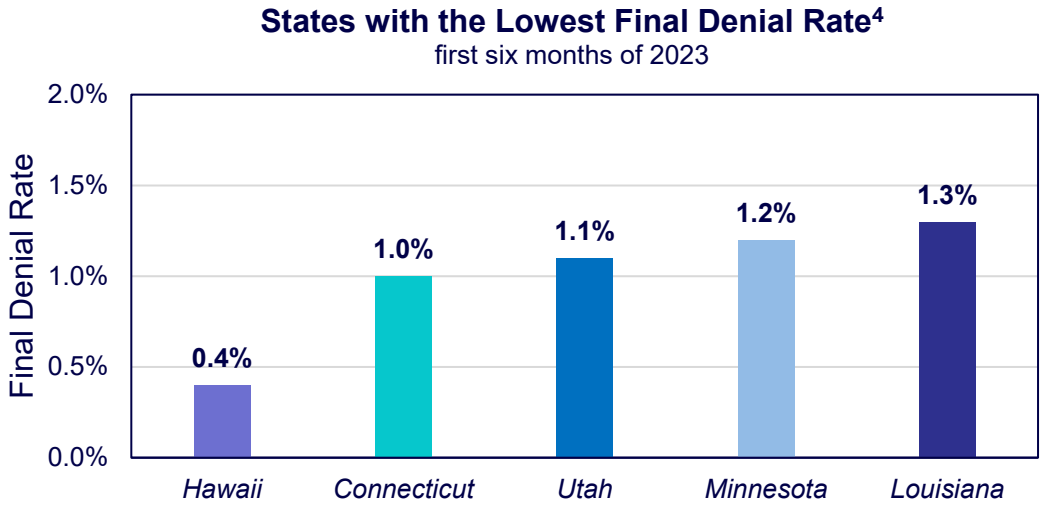


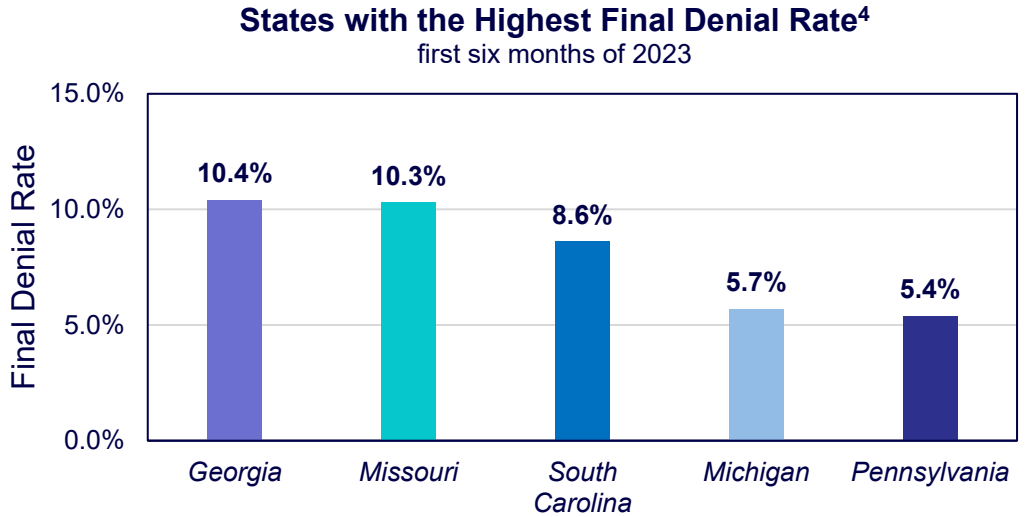
The Problem: Increasing denials = lost revenue opportunities

Average denial rate is up 5% since 2022 according to RevCycleIntelligence[2]

43% of providers say denials management is their top priority[3]

22% of providers lose over **$500K** in annual revenue due to denials, while **10% lose $2M**[3]



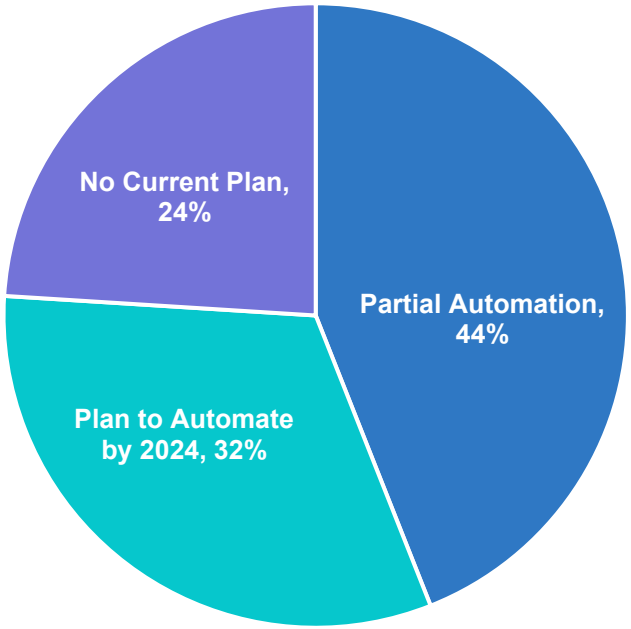


"…this data helps us zero in on the states where payors consistently refused to pay claims…"

[1] https://www.changehealthcare.com/insights/denials-index
[2] https://revcycleintelligence.com/news/patient-access-registration-errors-lead-to-most-claim-denials
[3] https://revcycleintelligence.com/news/claim-denials-pose-expensive-problem-for-providers
[4] https://www.crowe.com/news/crowe-report-ranks-the-best-and-worst-states-for-healthcare-claims-payment

Automation of the denial management process across the revenue cycle can improve efficiency and cut costs

Revenue Cycle Leaders on Automation Plans[1]



62% of providers don't automate any part of denials management[1]

Cycle Times and Cost

- On average, providers conduct three rounds of reviews with payers, and each review takes 45-60 days, which puts pressure on a provider's cash flow[2]
- Claim **denials cost** an average of **$43.84 to fight** with an **additional $13.29** per claim to account for **labor costs**[3]

Outcomes

- Nearly **15%** of medical **claims** submitted to private payers for reimbursement are **initially denied**[3]
- Despite the initial claim denial rate, **over half** of the claims rejected by private payers at first were paid to the provider[3]
- **Delays** in reimbursement led to almost **14%** of all health system claims being **past due** for remittance[3]

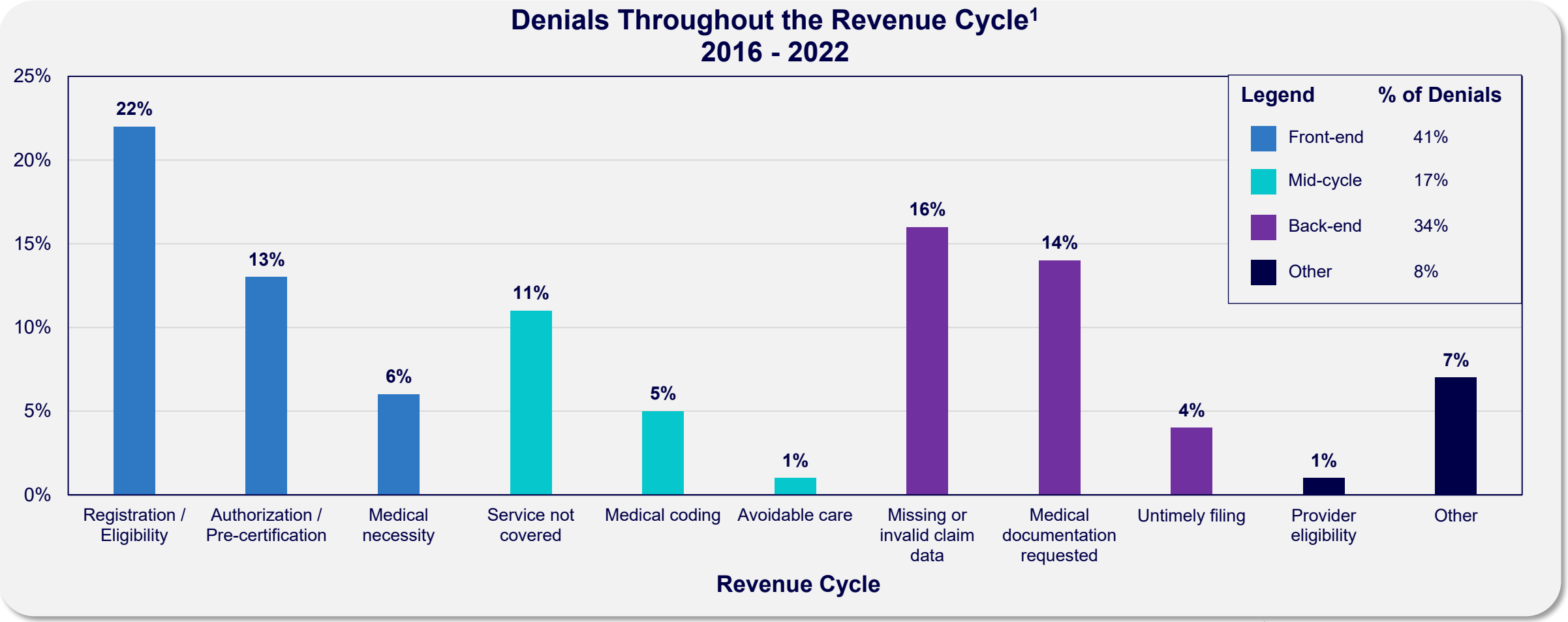
Patient Satisfaction

- Denials have been linked to lower patient satisfaction Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores even after the claim was ultimately paid[3]

[1] https://revcycleintelligence.com/news/62-of-hospitals-dont-automate-any-part-of-denials-management
[2] https://revcycleintelligence.com/news/claim-denials-pose-expensive-problem-for-providers#:~:text=Dig%20Deeper&text=More%20than%20one%20in%20five,over%20%242%20million%20in%20losses.
[3] https://revcycleintelligence.com/news/private-payers-initially-deny-nearly-15-of-medical-claims

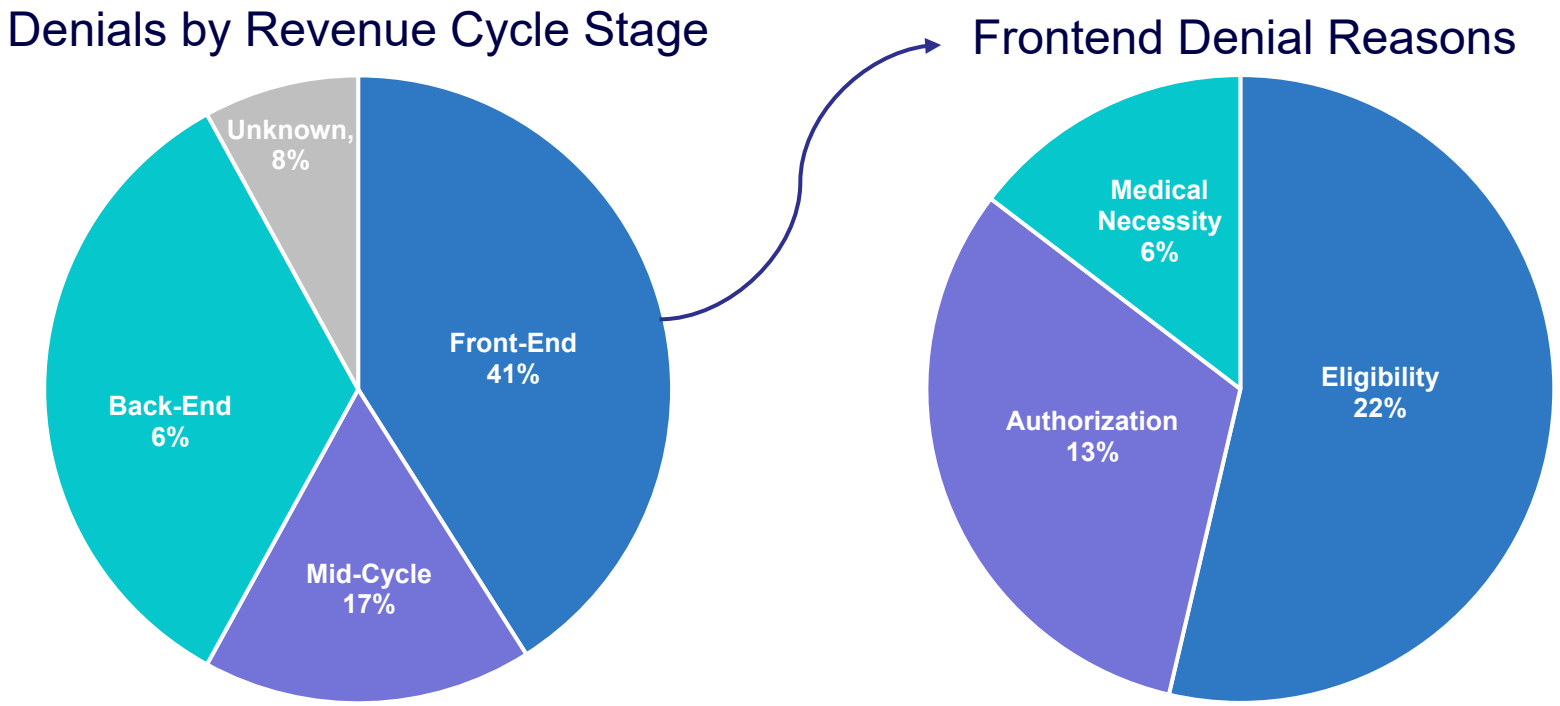
Understanding the distribution of denials across the revenue cycle is critical to reducing the cost of denials management

Providers **spend about $19.7B annually** reviewing claim denials, when **$10.6B is wasted** over claims that should have been paid at the time of submission[2]



[1] https://www.changehealthcare.com/insights/denials-index
[2] https://revcycleintelligence.com/news/private-payers-initially-deny-nearly-15-of-medical-claims

It is critical to have efficient workflows for data accuracy, insurance verification, and authorizations to better manage denials



350 chief medical officers surveyed in 2023 said **errors in patient registration** was in the **top 5 reasons** for denials[3]

Missing or incorrect patient information was also a **top 5** reason for **frontend denials**

54% of providers reported **phone** as the most common **method to obtain a prior authorization**

According to a 2024 survey **36% Medicare Advantage participants** waited over a month for care due to **prior authorization**

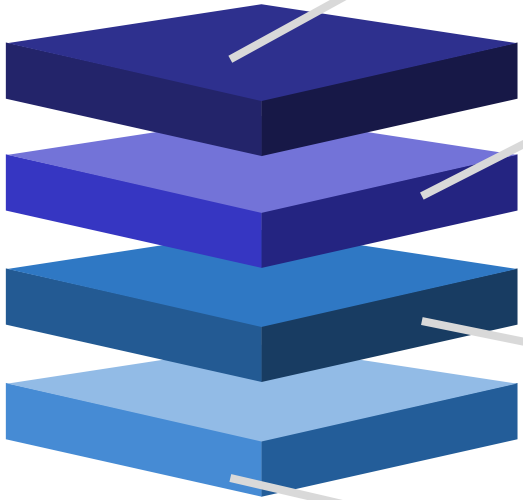
AMA Prior Authorization Survey Update | AMA (ama-assn.org)
How to Optimize the RCM Process - AAPC Knowledge Center
[3] News: Nearly half of providers have seen denial rates increase in 2023, survey shows | ACDIS

Map the battleground to prepare for the next battle…

COMPREHENSIVE REVIEWS

- Process & Policies
- Data
- Process Mapping
- Applications
- People

FUNCTIONAL REVIEWS



- Denial Reason Study
- Patient Access Operations
- Coding Validation Review
- Billing Validation Review

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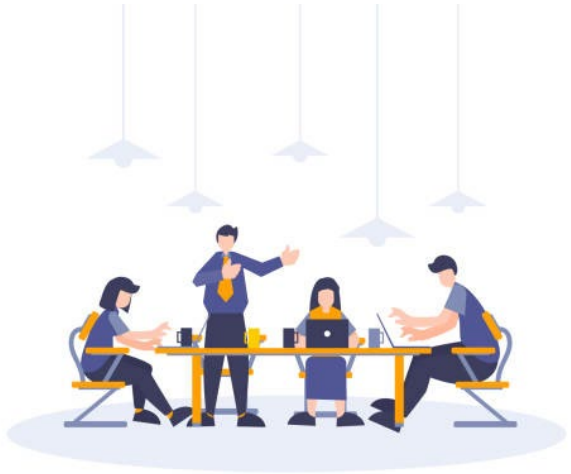
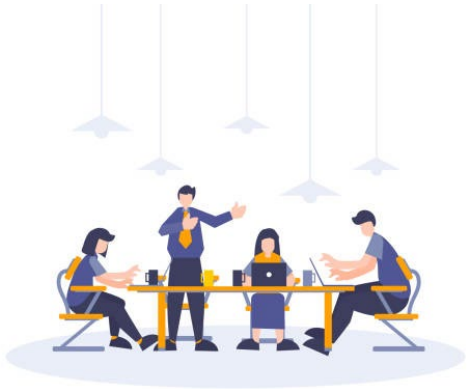
Recruit more resources for battle…

Current-state → **Future-state**



Team



Team
(existing)

+

Expert Support
(third parties, new SMEs hired)

Technology
(automation, cloud, etc.)

Denials management is complex and requires investment in additional support such as industry expertise and technology to gather revenue

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Just like battle wounds, providers are bleeding revenue from denials, but that can change!

According to HFMA, out of $3 trillion in total claims submitted by healthcare organizations –

$262B

are denied annually

This translates to nearly **$5,000,000 per provider**

If healthcare organizations set (and reach) a target of **capturing 60% of denials**, the result, nationally, would be:

$157B

captured annually

OR

$3,000,000 per provider

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Implementing Impactful KPIs

AR over 90 Days

- Hospitals should be less than 20% and Physicians should be less than 10%.
- Have analytics that provides aging by admit and discharge date, and by payer
- Heat maps are helpful with showing you where you are reducing the inventory and where it is increasing by payer aging buckets
- Denial reports by denial type and payer by aging month over month are critical. Create an action plan to focus on the buckets that are increasing which could be putting staff focus on those buckets or working with your provider rep and/or payer to escalate denial issues.

Clean claim rate should be 95% or higher

- Divide the total of claims received by the payer and the total number of claims submitted to the payer
- Tracking and monitoring rejections daily.
- Verify eligibility prior to services being rendered
- Look at edits by payer to see potential bridge routines you can implement. This will decrease the amount of touches it takes to resolve the accounts.

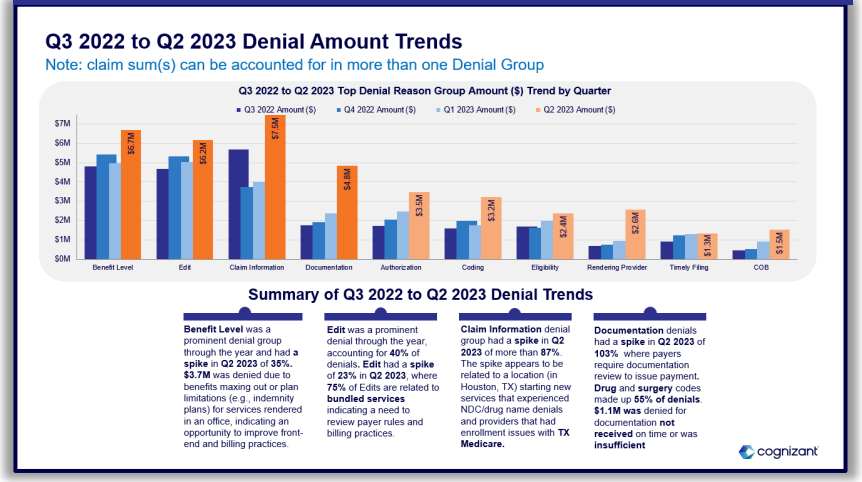
Avoidable Write Offs should be less than 3%

- Track avoidable write offs monthly.
- Run reports to determine by payer and adjustment reason why you are adjusting the claim.
- There are many reasons you could be adjusting such as no authorization, incorrect insurance was billed, coding, timely filing, etc.
- Quantify denials by each area and meet with each department to share what type of adjustments are occurring and putting together an action plan to prevent them.

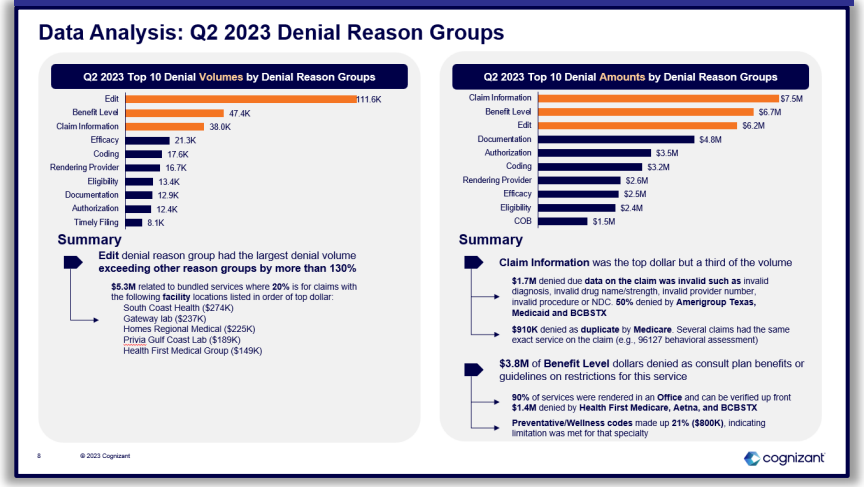
Assess your opponent's fighting patterns…

What denial data should you be assessing? Know where your organization falls in comparison to national averages

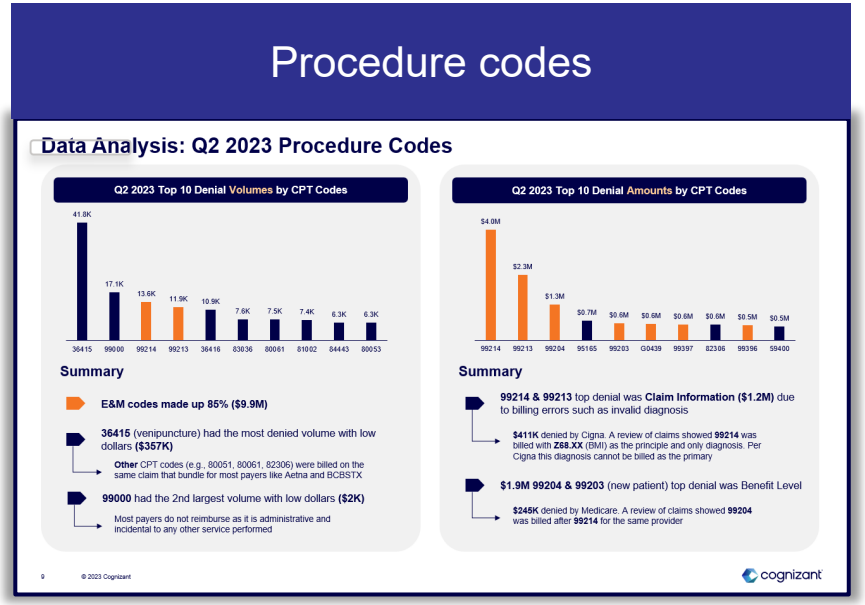
Volumes and amounts **over time** (MoM, QoQ, YoY, etc.)



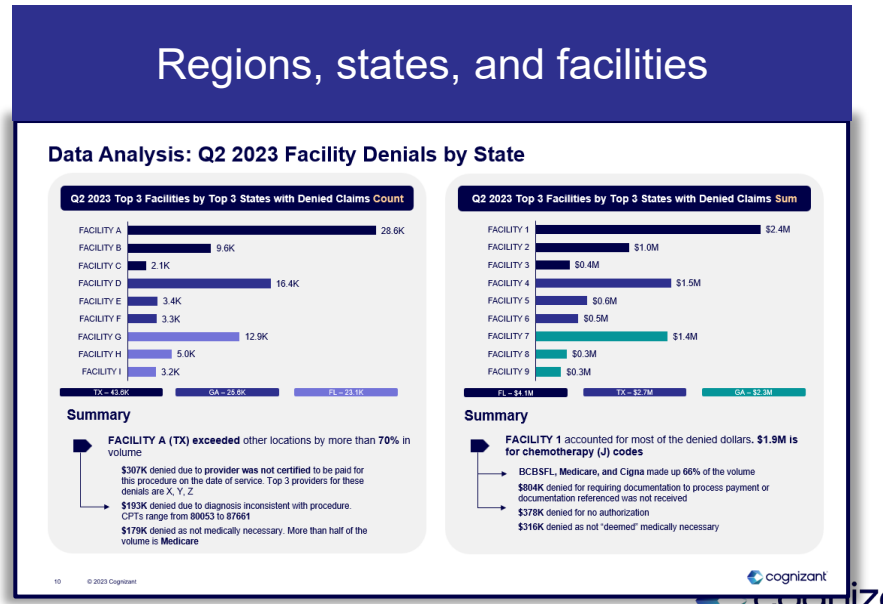
Reason groups and codes



Procedure codes



Regions, states, and facilities



Patient Access Optimization

Questions – Please Scan QR Code to Submit Answers

Patient Access Questions

1. Globally, more people own a mobile phone than a toothbrush.
    a) True
    b) False

2. What dollar amount constitutes an "expensive medical bill"?
    a) $0-199
    b) $199-$999
    c) $1K- 3K
    d) >3K

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Impacts of First Impression

The first impression can make or break the trust patients have with a provider. Therefore, providers must gain trust early which provides immense benefit for both patient and provider across the care continuum.

Build Trust

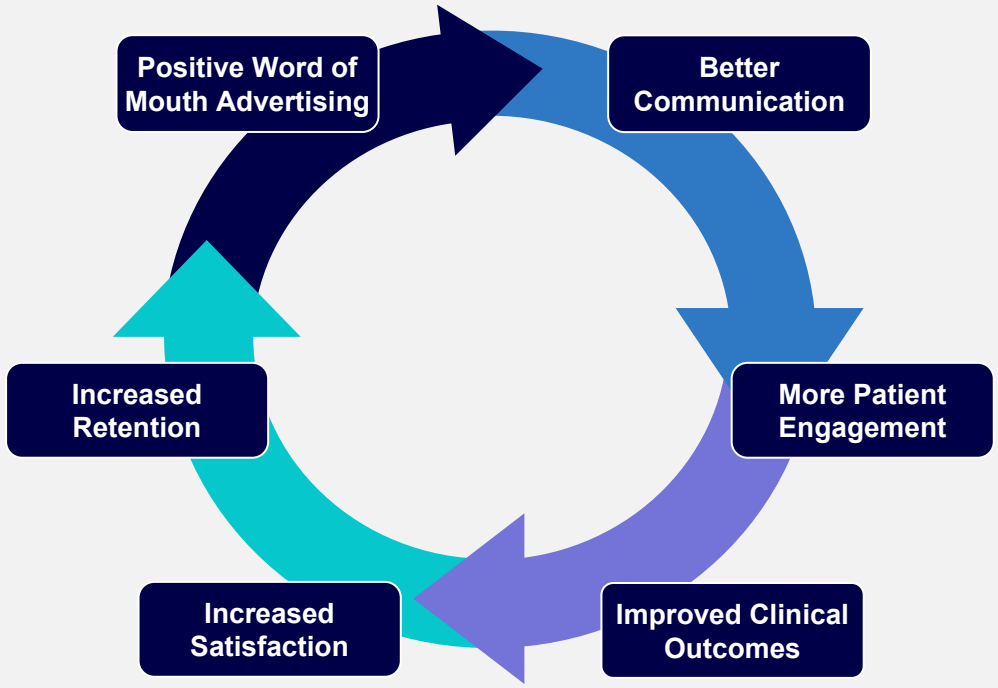
50% of patient's state that a bad digital interaction with a provider ruins their entire experience[1]

Drive Loyalty

80% of patients prefer digital options and would switch to providers with digital convenience[2]

Reduce Denials

41% of denials stem from front-end errors and inefficiencies[3]



[1] DeliverHealth 2022 digital front door
[2] Businesswire 2021
[3] The Change Healthcare 2022 revenue cycle denials index

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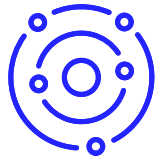
What Are Patients Asking For?

According to patients, they want increasing control over their healthcare experience. Access should be convenient, transparent and enable patients to be part of the process.

Accurate Pre-Care Estimates

Payment Plans

Digital Payment Options
(mobile, portal, etc.)

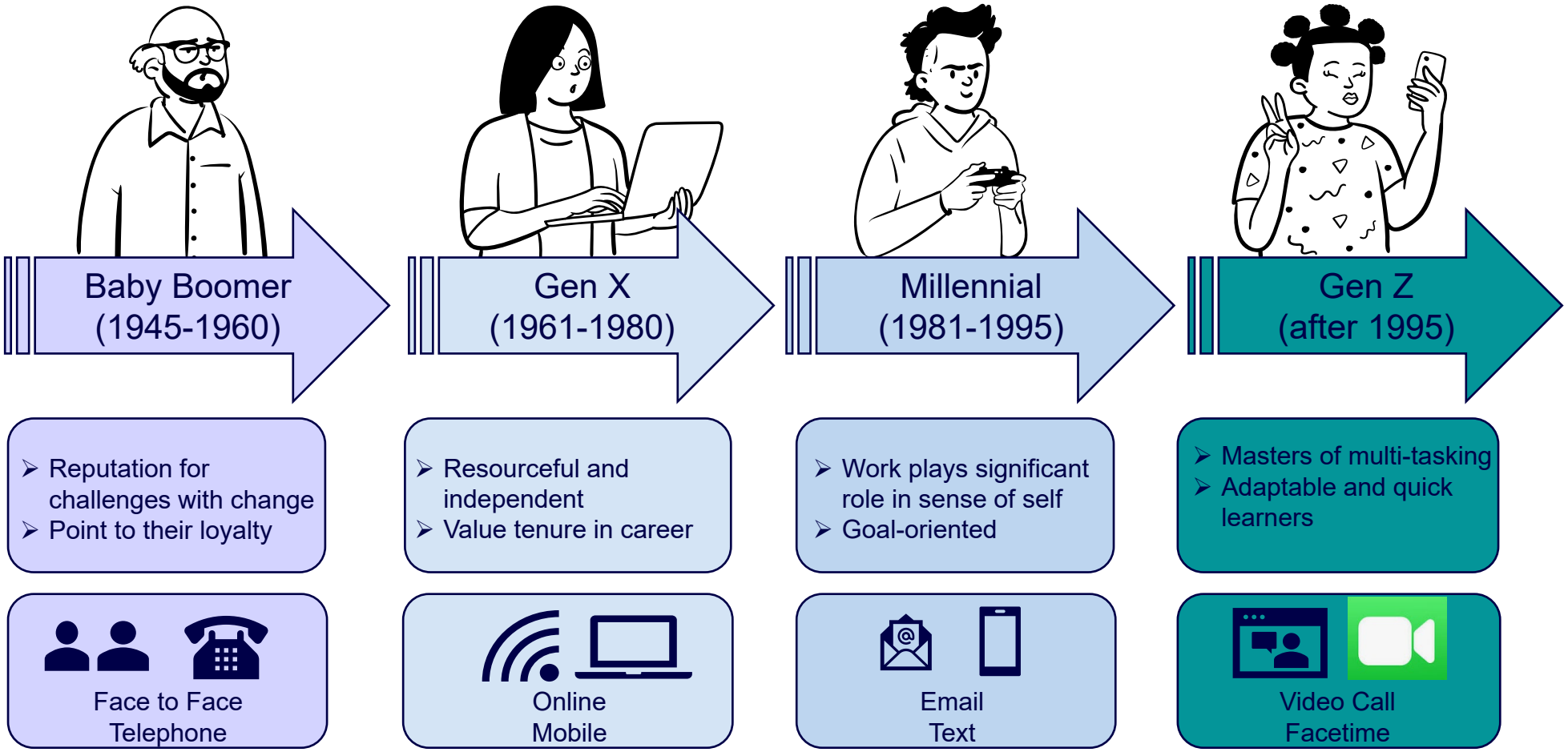


Multi-purpose Portal Access

Mobile Access and Communications

As the next generation of healthcare consumers enters the market, there is a shift to consumers who have technology tied to convenience in their daily lives.
They will expect these capabilities to be standard in their experience.

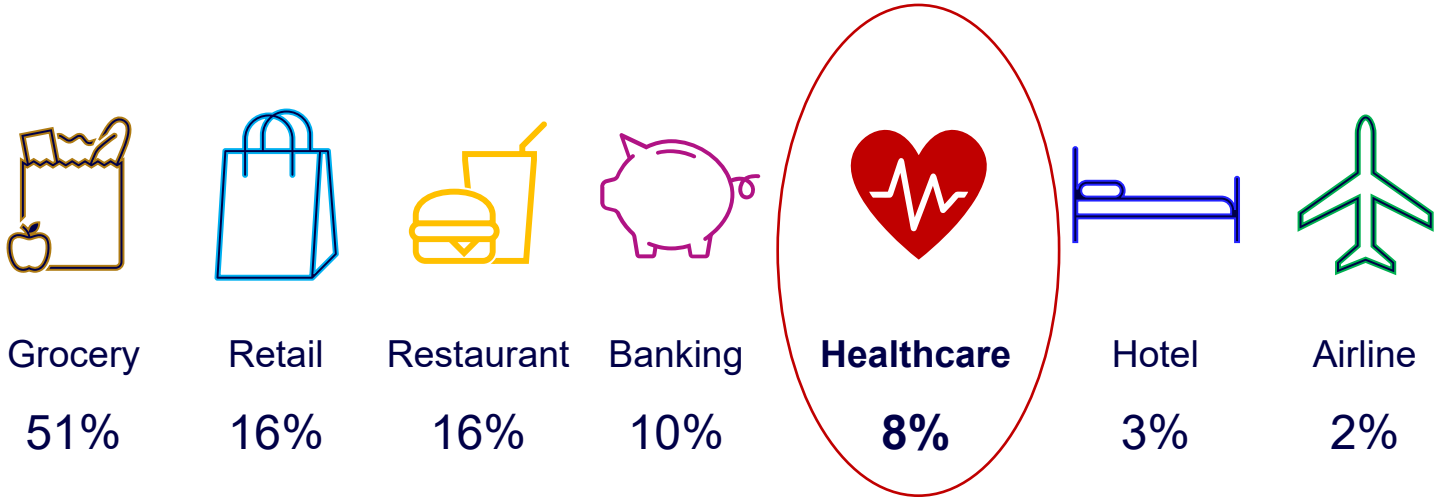
Understand Your Audience



Are Providers In Line With Patient Perceptions?

When asked if they feel they provide adequate information about medical bills to patients, 96% of providers answered “yes”.

“Considering your recent experiences across all payments, please rank the industry category by how EASY it is to make payments.”



Grocery	Retail	Restaurant	Banking	**Healthcare**	Hotel	Airline
51%	16%	16%	10%	**8%**	3%	2%

[1] RUS Bank Survey healthcare-payments-report-USB.pdf

Patient Access Features

Patient Engagement

Patient-facing portal that allows patients to self-serve registration and other financial clearance tasks on their own timeline. Communication via text, email, phone/IVR.

Preservice Payments

Estimate based on patient's insurance coverage that meets requirements for Price Transparency. Embedded full-featured payment options that are equivalent to the payment portal experience.

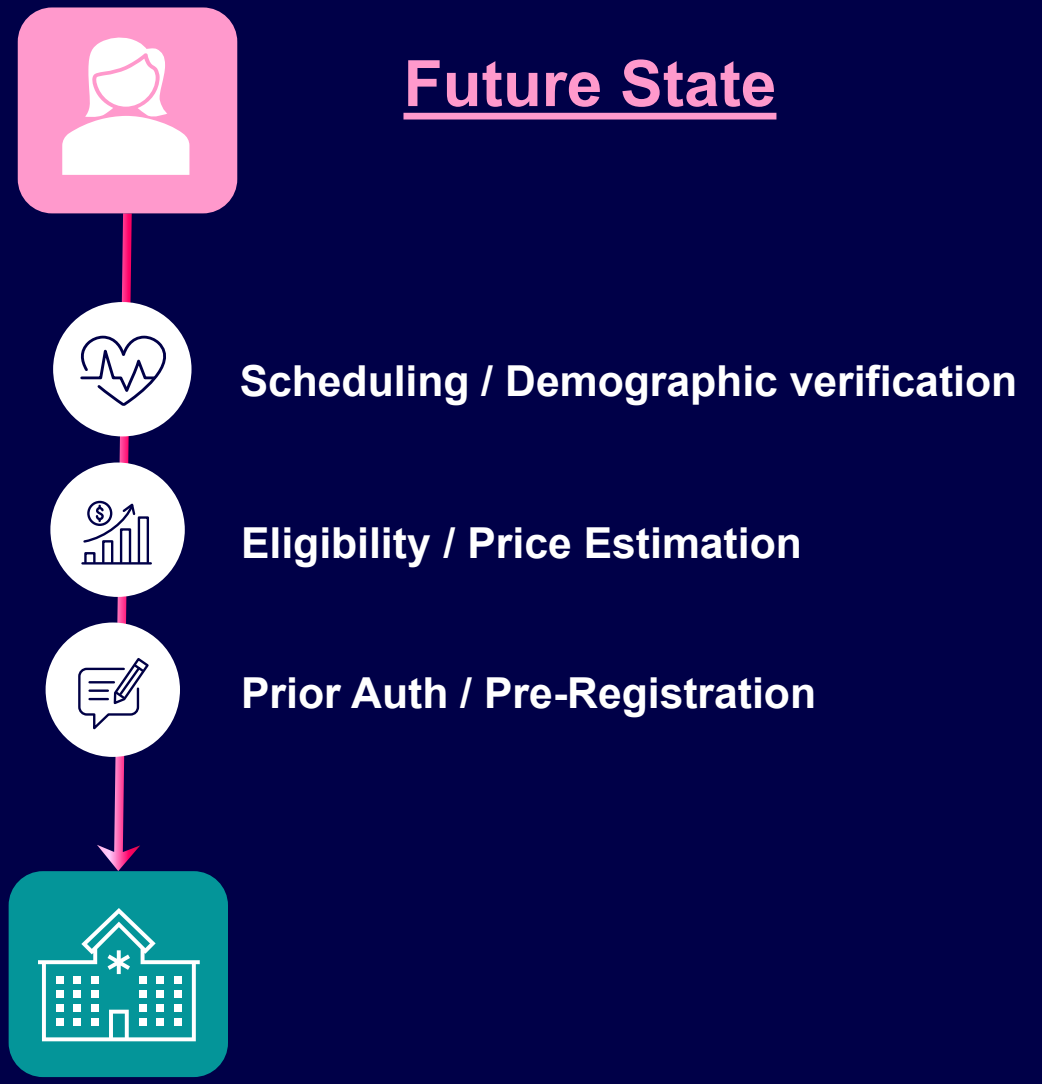
Registrar Workflow

Workflow-oriented registrar tool focused on preservice financial clearance to include interfaces and EHR integration.

Pinpointing Areas of Inefficiency

Current State

Future State



How Do We Measure Patient Access Success?

Financial impact for providers

- **Reduces** claim denials and rebills
- **Reduces** bad debt and days in AR
- **Improves** cash flow
- **Improves** registration data quality

Improved experience for patient

- **Often** first contact with the patient
- **Opportunity to** reduce sticker shock
- **Opportunity to** ease the intake process
- **Opportunity to** offer flexible payment options

Financial Impact for Provider

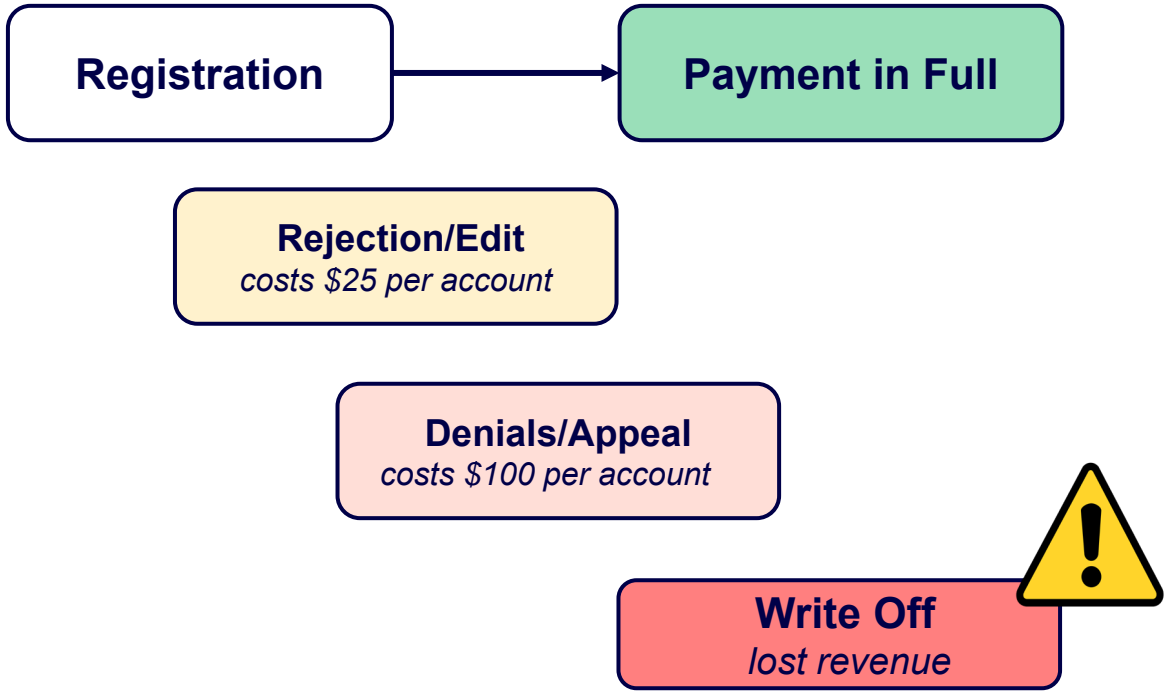
Communicating costs before the procedure to increase the chance of payment from

30% to 70%

Increase in pre-service patient collections at point of service by

10%

The farther inaccurate or incomplete information goes into the rev cycle, the higher the cost & time to collect and the lower the value of the dollar.



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Improved Experience for Patient

41% Of patients who did not get an estimate prior to care said the final cost was more than expected

72% of patients are confused by their explanation of benefits

70% of patients are confused by their medical bills

While healthcare providers may not be able to lower their cost of care, here are some examples of what they **can achieve** with our battle tactics:

- Improve price clarity and transparency
- Decrease billing mistakes
- Make patient payments more accessible and easier to manage

1 Report 2023: The State of Patient Access | Experian Health
2. Patient Engagement HIT.

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Automation and GenAI 101

Questions – Please Scan QR Code to Submit Answers

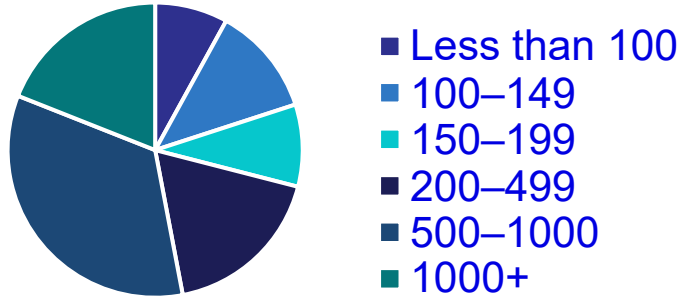
AI Implementation in Healthcare

1. What is the **largest** barrier to providers implementing AI in their organization?
    a) Uncertain ROI
    b) Data Privacy and Security Concerns
    c) Limited Budget and Expert Resources
2. Where are **MOST** providers on their automation journey today?
    a) Not Started
    b) 1-2 Functions Automated
    c) 3+ Functions Automated

2023 Healthcare Provider Automation Survey: Methodology

- 300 hospital and health system executives
- Questions covered attitudes toward, investment in, and use of automation and generative AI
- Broad range of organization types and sizes
- Divided into 3 cohorts:

Organization Size
(by employee count)



120 C-Suite
CEO, COO, CFO

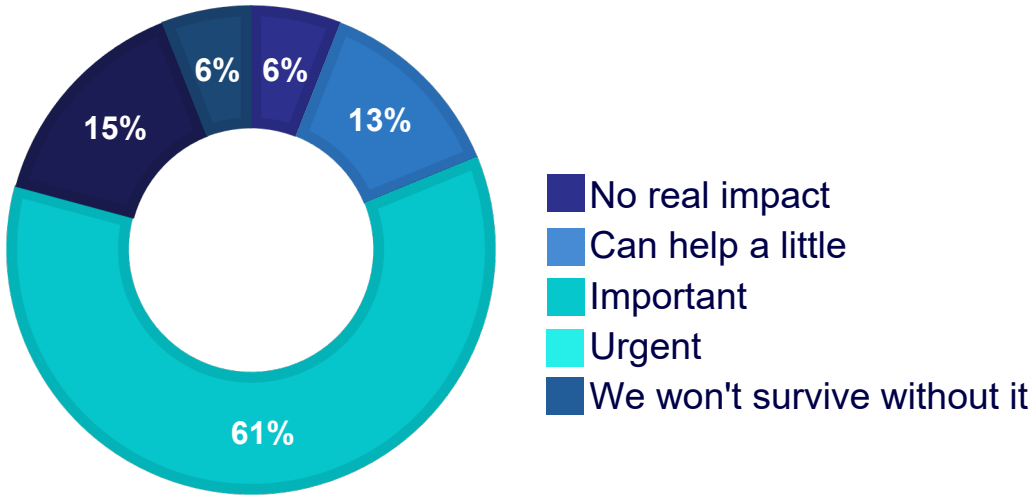
80 IT
CIO, VP IT,
VP Automation

100 Business Leaders
CNO, CMO, VP of:

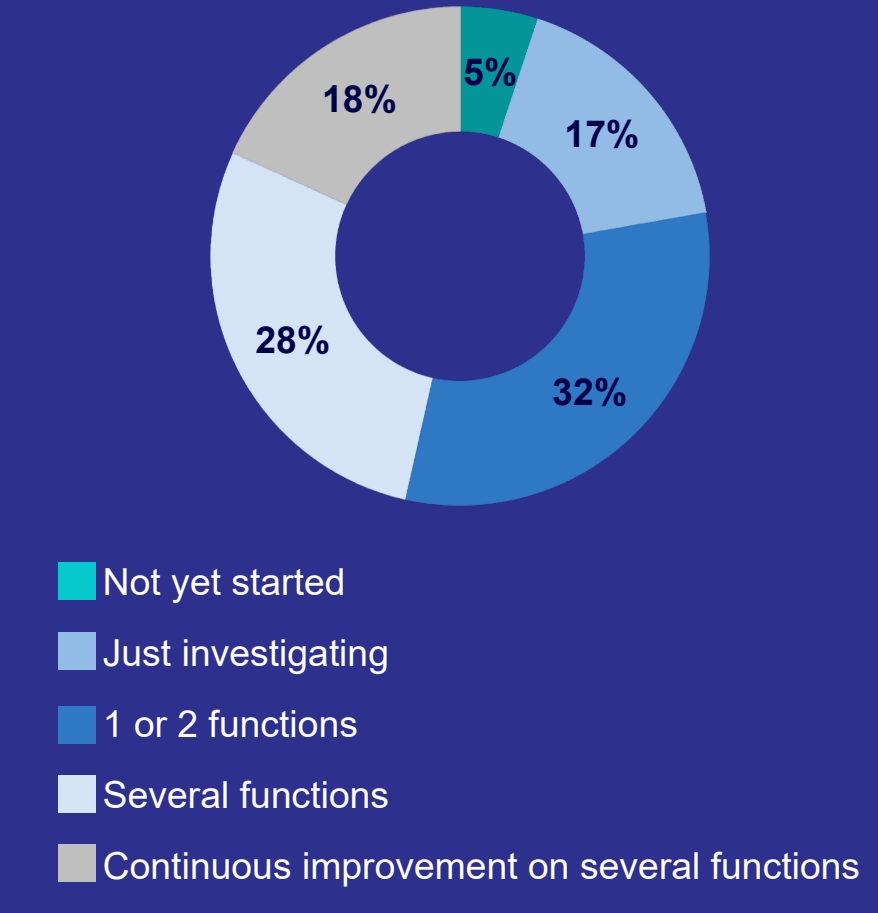
Accounting
Care Delivery
Care Mgmt
Claims
Clinical Ops
Collections
Contracting
Finance
HR
Patient Access
Patient Financial Services
Rev Cycle
Supply Chain

Key finding: Automation is vital to a providers' future, but they haven't dived in yet.

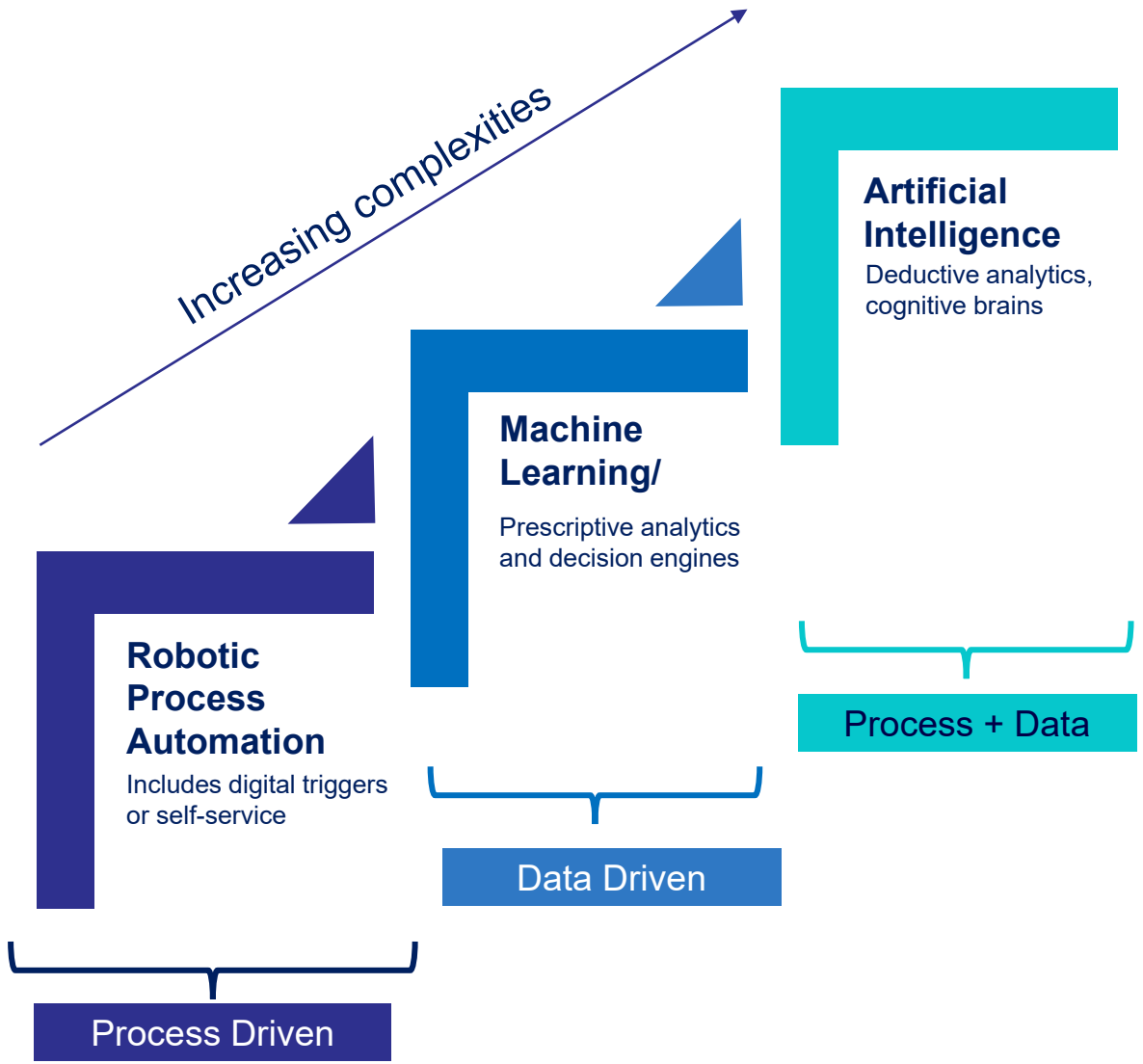
How important is automation to your future?



Where are you in the automation journey?



Scaling Automation to Artificial Intelligence



Artificial Intelligence: The ability for a computer to perform tasks that normally require human intelligence. RCM uses to analyze trends and patterns helping to optimize revenue collection and minimize revenue leakage.

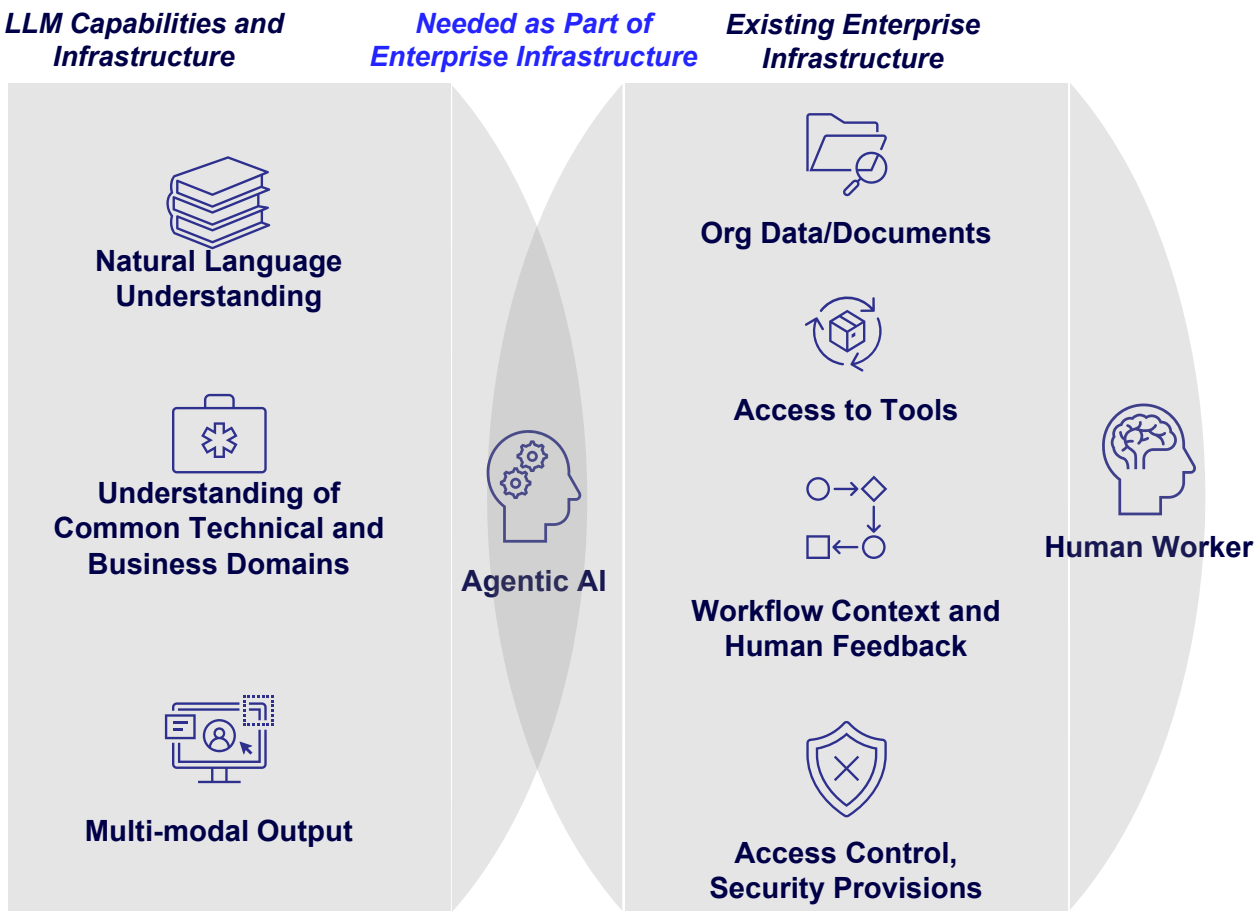
Generative to Agentic AI/Cognitive Agents: Agentic AI would bridge the gap between generative AI and human knowledge worker workflow by applying its skills on enterprise data and documents in a manner that integrates within a knowledge user workflow.

Machine Learning: Showing a large volume of data to a machine so that it can make predictions or classify data. RCM uses in denial prediction, AR prioritization, discharge planning.

Robotic Process Automation: Process driven; Labor-intensive, repetitive activities (e.g. keystroke simulator). RCM uses in data entry/transcription, Claim Status, document attach.

From Generative to Agentic AI/Cognitive Agents – to create the future of work

Agentic AI would bridge the gap between generative AI and human knowledge worker workflow by applying its skills on enterprise data and documents in a manner that integrates within a knowledge user workflow.



Illustrative Areas

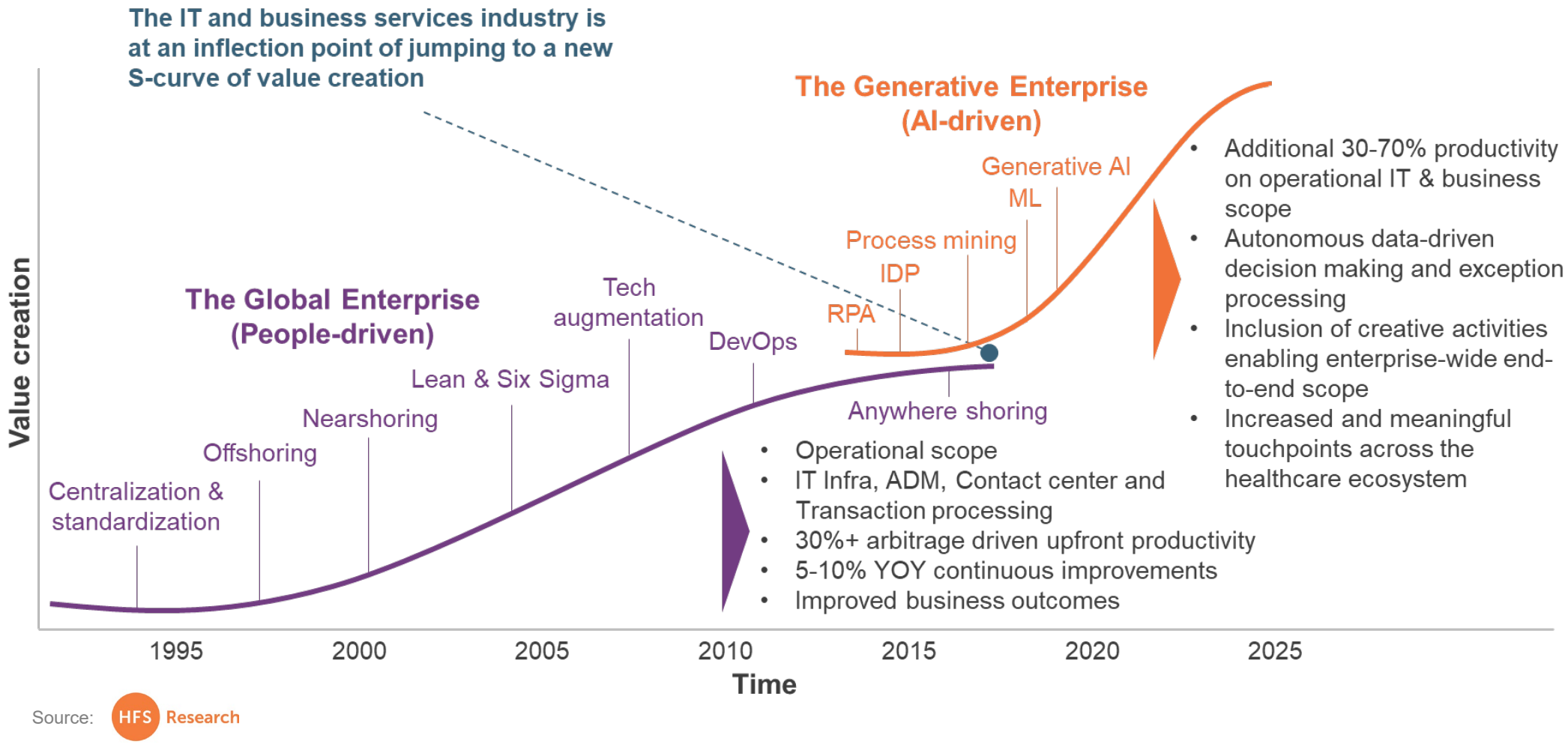
RCM

- Analyze contract and find out areas of optimization based on my service volume
- Analyze current orders needing prior authorizations, determine risk of payer rejections and show me the gaps in clinical justification based on my data
- Analyze revenue leakage and recommend areas of patient outreach

Care Management

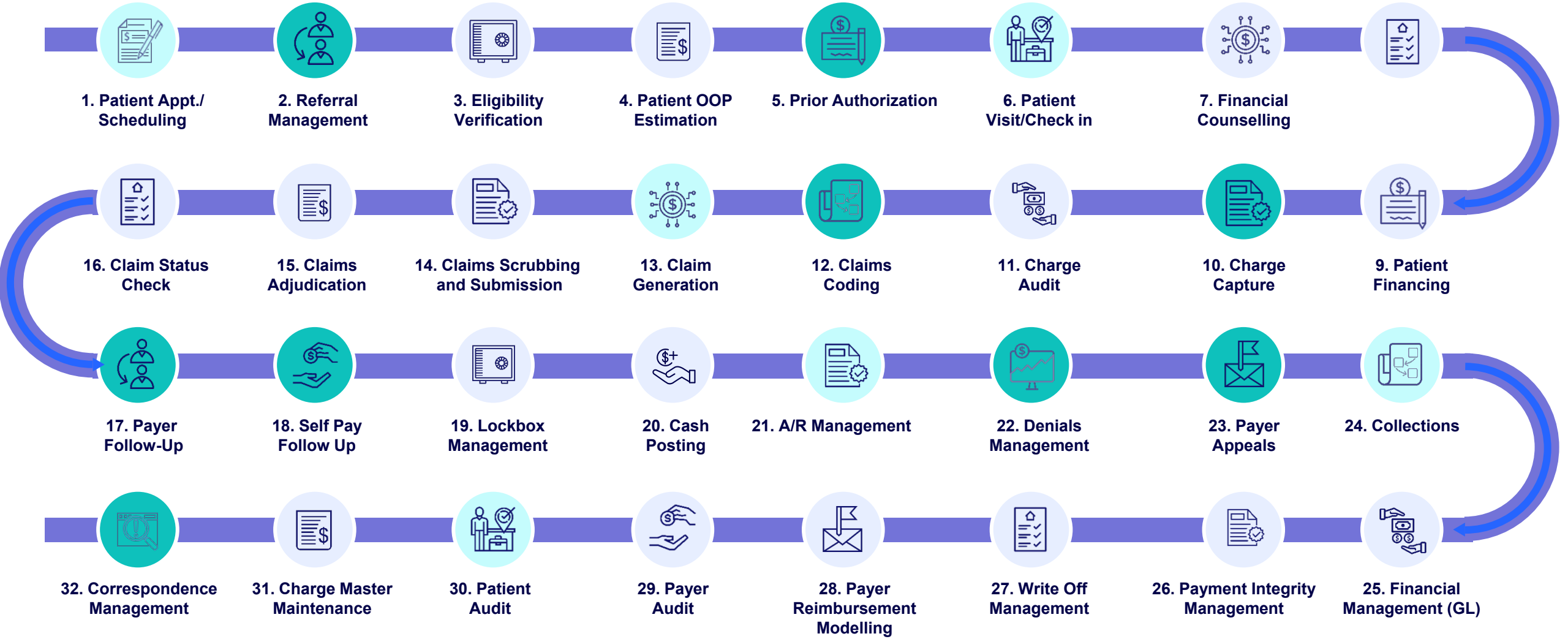
- Determine which patients need to be reached out to close gaps in care. Create, review and send out personalized communications
- Analyze new clinical research and show me differences with current care management pathways

The generative enterprise inspires a new S-curve of value creation that could motivate true ecosystem collaboration



Source: HFS Research

Generative AI in RCM Value Chain



Automation Potential — High — Medium — Low

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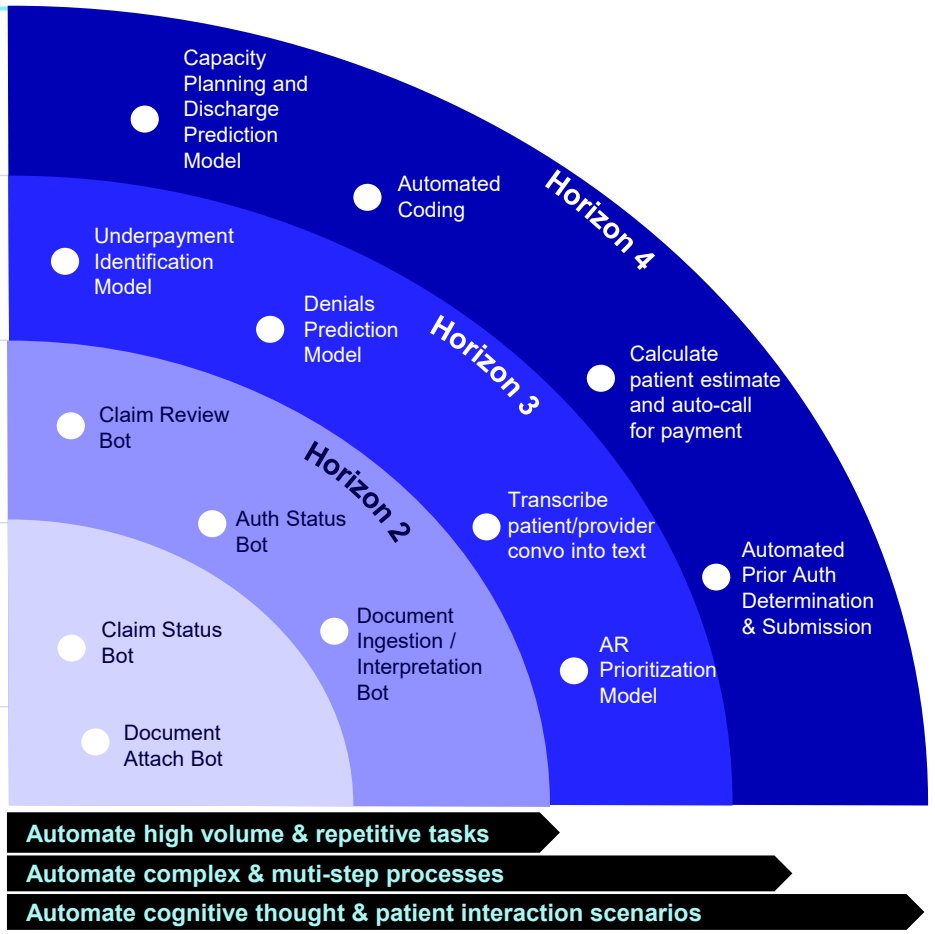
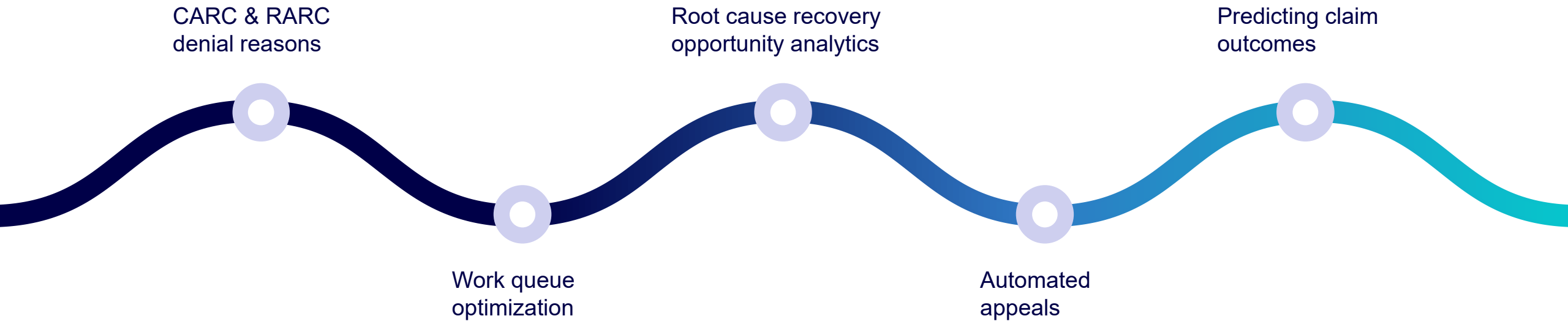
RCM Automation Transformation Journey

Complexity and Outcome Maturity

Outcome	Automation Acceleration
Process Transformation / Automation	All facets of AI are leveraged to fully replace process or augment it to peak performance
Elevate knowledge workers	Predictive analytics and machine learning models bring new levels of insight
Increase worker productivity	Bots find and transcribe relevant data required for the process
Replace repetitive manual tasks	Bots complete manual process



Evolution of Denial Management Technology



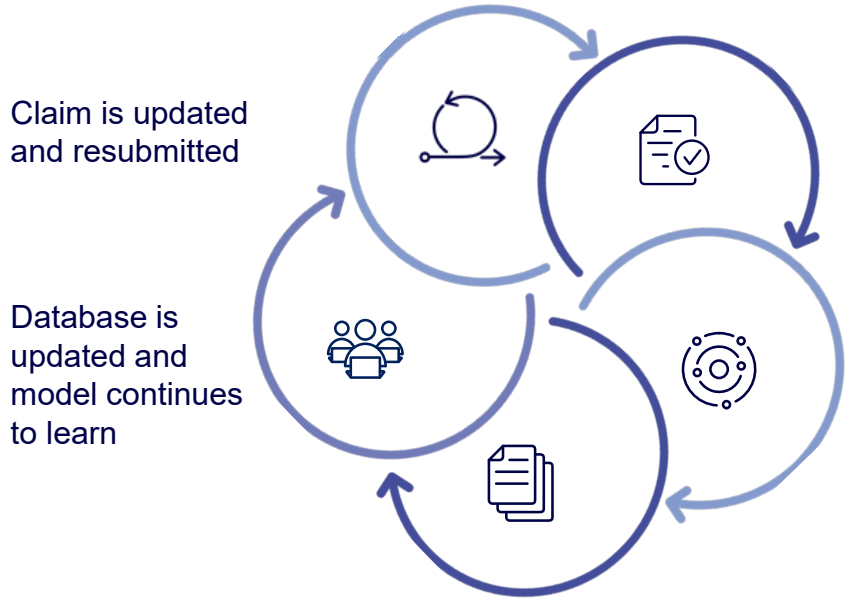
PREVENTION - Cognizant proprietary denial prediction model

Proprietary machine learning models

100m+ claims and remit database

Integrated within customer's existing workflow

Model able to predict and prevent over 30% of denials before submission



Key Takeaways

Proceed thoughtfully…

Technology is key, however, laying technology on top of a broken system will only lead to more complexities

What you should know to reduce your denials

01

Data, data, data!

It’s critical to understand your data and where denials are coming from. What are the root causes? You cannot fix what you don’t understand.

02

What are denials costing you?

Often healthcare providers don’t address the root cause because they think it costs too much to do so, but they fail to assess whether they’re losing more money from not investing in a solution.

03

Understand your audience

Determine the best way to communicate and engage with your patients, using data and historical payment methods. This understanding will yield higher satisfaction and increased revenue.

04

Bring the pieces together

Analyze the data, cost to collect, and remediations to ensure you’re reaching to the right outcomes. Determining and targeting set KPIs will yield your desired ROI.

05

Technology is essential, however…

Laying enhanced technology over a fragmented RCM system will only lead to more complexities. Approach implementation with the mindset of people, process and technology.

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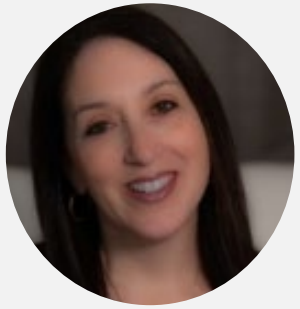
Thank you

Our Team



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Cheryl is an executive-level revenue cycle leader with over 30 years of rich experience in end-to-end revenue cycle solutions, who consistently helps to increase reimbursement by improving front-end operations, collection rates, deficiency management, ICD-10 and CPT coding, and ethical and compliant approaches to healthcare revenue cycle management. Cheryl is a results focused executive driven by her deep knowledge of laws, regulations, and credentialing requirements. Prior to joining Cognizant, Cheryl served in various leadership capacities as Vice President of Revenue Cycle and a 20-year business owner of a revenue cycle company.

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Maryann Sears is a Senior Service Leader for Cognizant and is responsible for development, expansion, and operation of Patient Access Solutions. Prior to joining Cognizant, she served in various Patient Access leadership roles. She has 15 years of Patient Access experience from scheduling, financial clearance and pre-registration, to arrival and check-in, and financial counseling. She has supported large hospital systems as well as hospital-based physician groups and physician practices. Maryann is focused on improving operations and outcomes by focusing on the patient's experience and engagement with the revenue cycle.

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