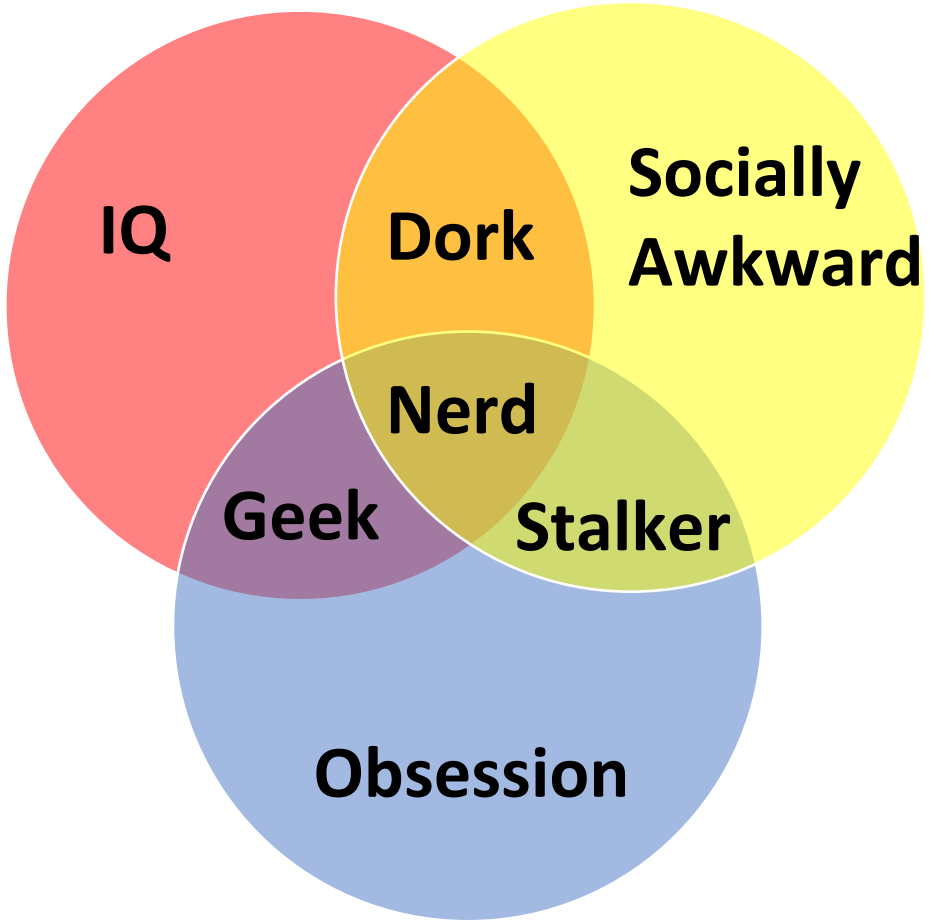
HYVE HEALTH

Payer Accountability Through Data….Not Stories

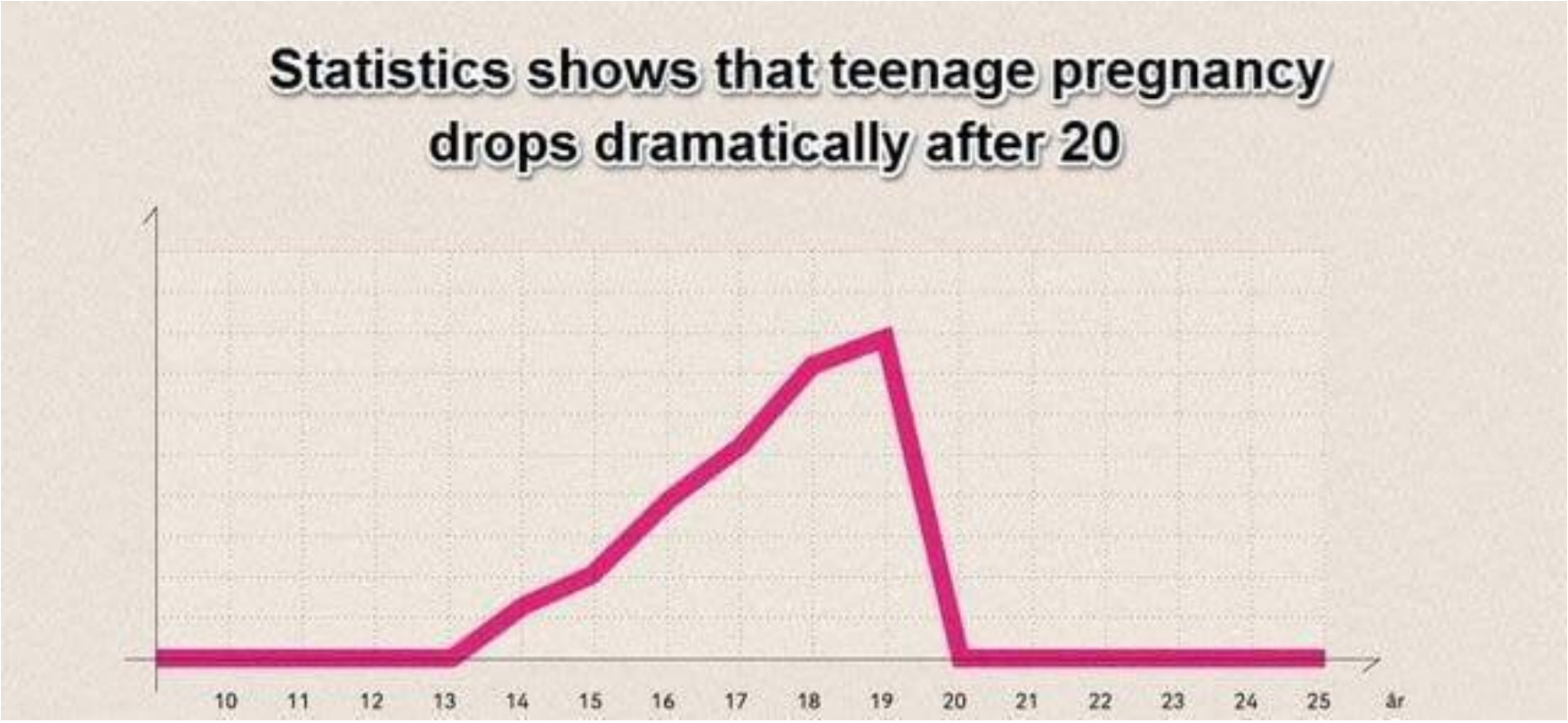
Travis Gentry, Hyve Health
Alyssa Keefe, Keefe Policy Insights

KPI
KEEFE POLICY INSIGHTS

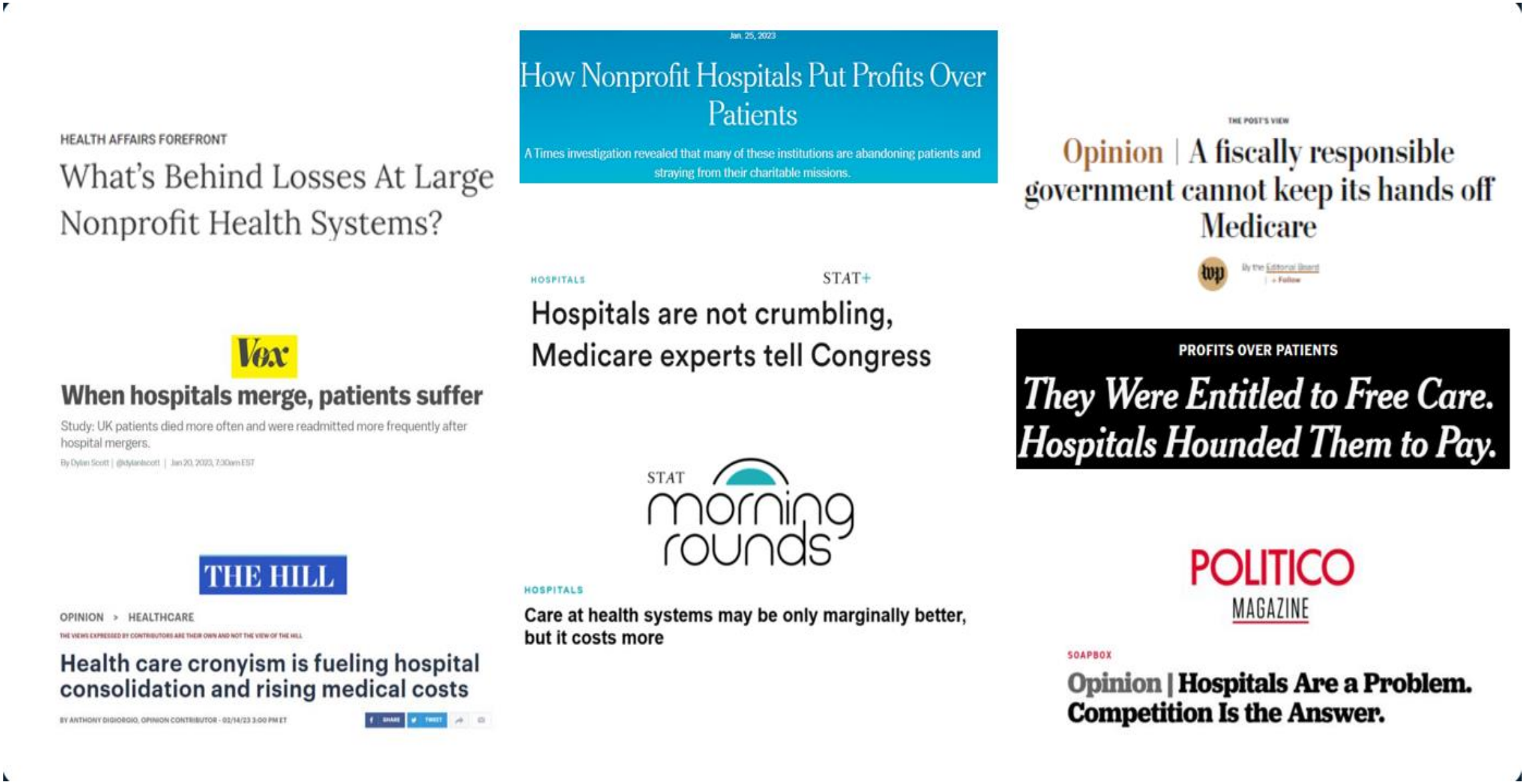
Nerd vs Geek by Don McMillan



Statistics can be misleading by Don McMillan



Headwinds: A Challenging Public Narrative



KFF Health News

Bill of the Month

Send Us Your Medical Bills

State Legislatures Turn Attention to Citizens' Crushing Medical Debt

Several states have pending measures to tackle Americans' medical debt and the impact it has on their lives.

By State Net Capitol Journal | February 12, 2024

Adversaries Actively Engaged in Promoting the Negative Hospital/Health System Narratives

Arnold Ventures

PATIENT RIGHTS ADVOCATE.ORG

BECKER'S HOSPITAL REVIEW

Healthcare provider organizations' greatest political advantage? Local presence

Isaac Squyres, partner at Jarrard - Wednesday, September 11th, 2024

It was no surprise when the Journal of the American Medical Association published research last month that found "trust in physicians and hospitals [had] decreased substantially…from 71.5% in April 2020 to 40.1% in January 2024."

The fact is, people believe provider organizations are not focused on what they are supposed to do: take care of people. In one of our firm's recent consumer surveys, 69% of adults said they believed hospitals, in general, are more concerned with "making money" than caring for patients, up a disturbing 16 points from just a year prior. Additionally, 64% said they support increased regulation of hospitals.

The stark difference between the public's perception of the healthcare industry at large and their view of local caregivers reflects a simple political truism: People trust who they know.

https://www.beckershospitalreview.com/hospital-management-administration/healthcare-provider-organizations-greatest-political-advantage-local-presence.html

Reality Check: Most Hospitals Are Struggling

The current situation is not sustainable.

Adequate reimbursement is crucial to provide access to patients, maintain and upgrade equipment and facilities, improve technology, and expand services according to community needs.

Soaring cost inflation. Insurance contracts are locked in with rates that have not kept up with inflation.

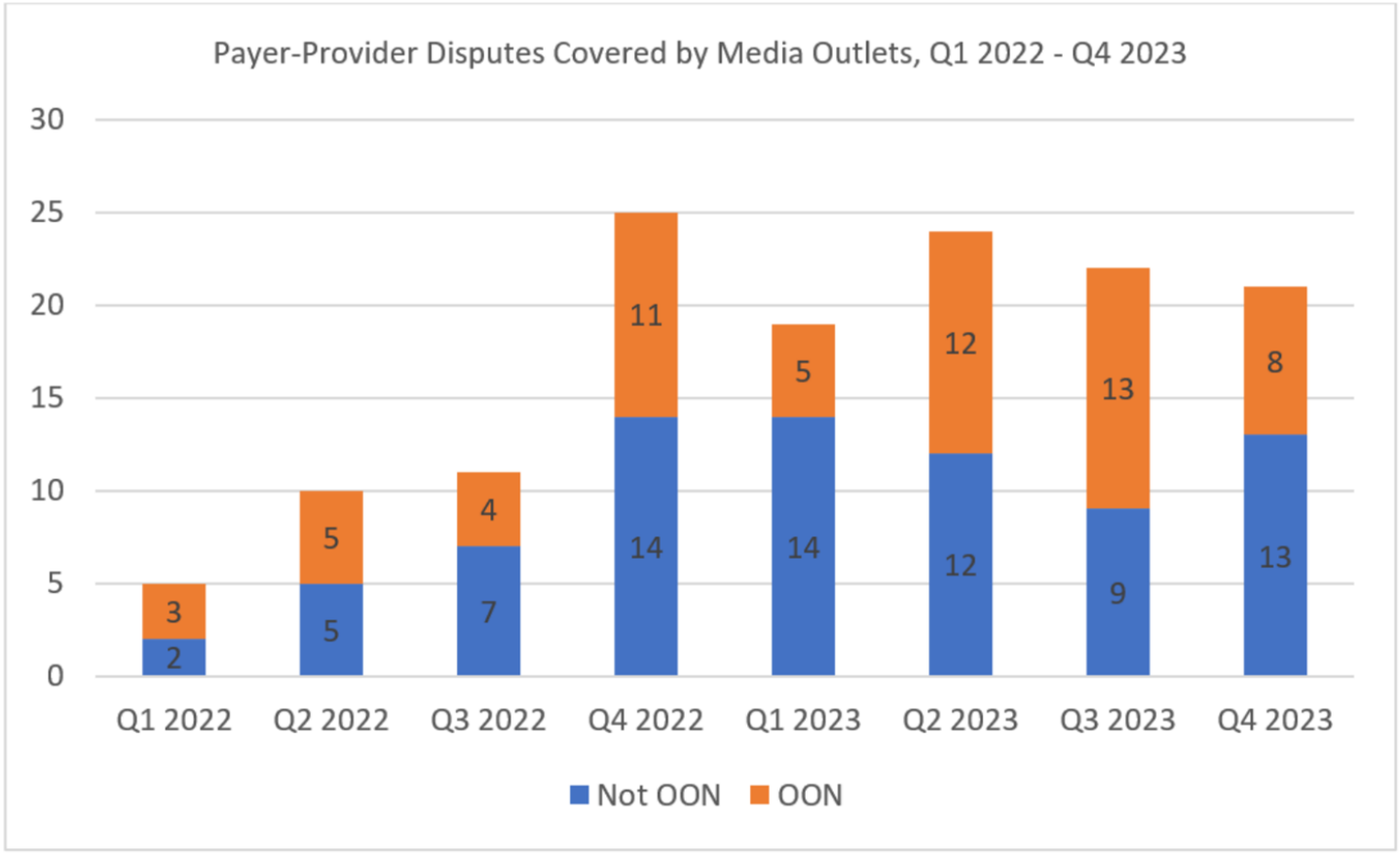
Under-funded government reimbursement. Reimbursement for serving patients with government insurance is significantly less than what it cost to provide care.

Current financial state. Many hospitals are operating on very thin or negative margins. Loss of coverage for millions of Medicaid enrollees has increased number of uninsured contributing to higher uncompensated care.

Administrative burdens from payers. Increasing costs to providers for obtaining prior authorization, appealing claims as well as the entire billing and reimbursement processes.

[1] Beckers Healthcare

Contract Disputes are Going Public, Risking Reputation, Putting Patients in the Middle



Souce: FTI Consulting, 2023

of Tennessee

Health Action Network
Connecting Advocates. Changing Healthcare.

Tell CommonSpirit to stop using Coloradans as a cash cow to support out-of-state hospitals!

12 On Your Side

Messy Bon Secours-Anthem dispute threatens to disrupt care for thousands of Virginians on Medicare

Going on Offense

COALITION TO STRENGTHEN AMERICA'S HEALTHCARE
PROTECTING 24/7 CARE

FIERCE Healthcare

Providers | Health Tech | Payers | Regulatory | Finance | Special Reports | Fierce 50

SPECIAL REPORT: The Fierce 50 of 2024 >

PAYERS

California Hospital Association sues Anthem Blue Cross over discharge delays

Financial Management

Health systems' hard line on insurers pays off

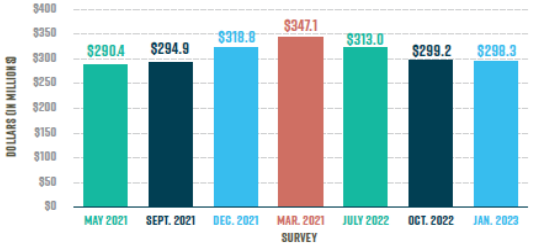
Alan Condon - Wednesday, May 22nd, 2024

New Hampshire Hospitals' Report on Anthem Performance

May 2021 – January 2023

In early 2021, the New Hampshire Hospital Association (NHHA) heard frustrations from several member hospitals concerning Anthem, the largest commercial payor in the state. The complaints came from varying departments within hospitals on topics including outstanding Accounts Receivable (AR), company policies, and customer service. In response, NHHA conducted quarterly surveys from May 2021 to January 2023 to gather more information; the results paint a picture of universal dissatisfaction with Anthem's practices, procedures, and overall performance.

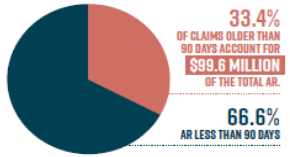
TOTAL ANTHEM OUTSTANDING ACCOUNTS RECEIVABLE



In January 2023, hospitals reported a total outstanding AR[1] of $298.3 million, well over the $290.4 million reported in the initial survey conducted in May 2021.

AGING AR

Days in accounts receivable is a key performance indicator of financial health in the healthcare industry. Anthem's high percentage of aged claims is a cause for concern for the hospitals.



33.4% OF CLAIMS OLDER THAN 90 DAYS ACCOUNT FOR $99.6 MILLION OF THE TOTAL AR.

66.6% AR LESS THAN 90 DAYS

EVIDENCE OF SYSTEMIC FAILURES

Over the past year and a half, hospitals reported evidence of multiple systemic failures at Anthem[2]:

Correctly enrolled providers dropped unexpectedly from the hospital's network with no communication from Anthem about the issue.

Contradictory information on prior authorization requirements leading to many inappropriately denied claims.

Customer service issues including hours long wait times, frequently transferred or dropped calls, customer service representative poorly trained and inability to reach a supervisor to escalate claims.

Insufficient issues tracking systems require hospitals to track claims issues separately for quality assurance, with many issues known to Anthem remaining unresolved for years.

The Problems

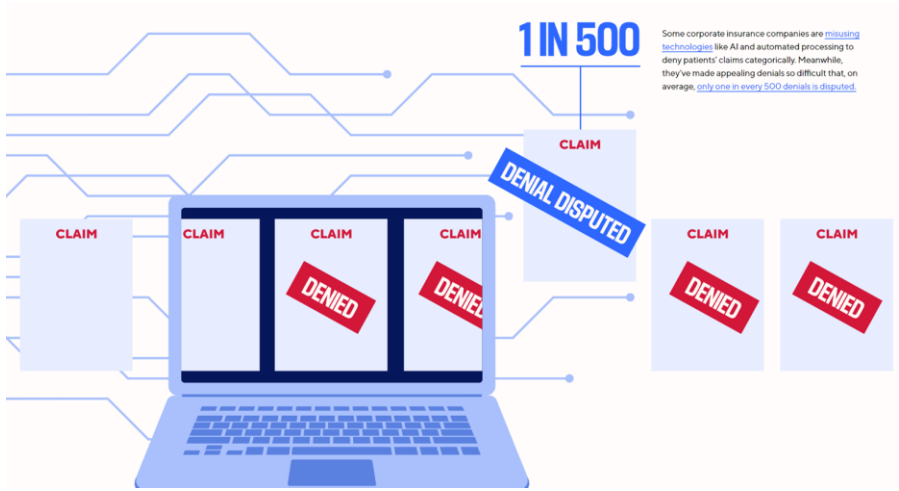
Health plan utilization management and other business practices are:

- Burning out clinicians;
- Delaying or denying patient access to medically appropriate care;
- Creating excess administrative costs and burden for providers; and
- **Driving up the cost of care and diverting increased resources to health plans bottom lines.**

The Messages

Health plan practices hurt **patients**

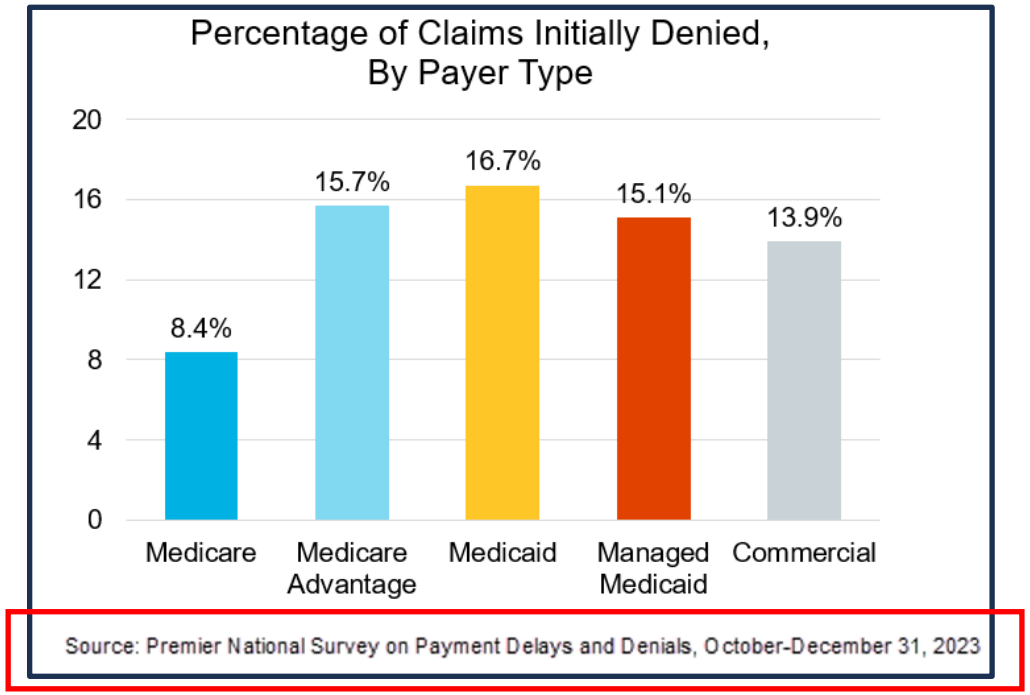
- Reimbursement denials are **coverage denials**
- Administrative delays are **care delays**
- Administrative costs are ultimately **patient costs**



The Current State: How we tell our story publicly

March 21, 2024

Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims



Methodology

Premier conducted a voluntary, national survey of member hospitals and health systems from October 10-December 31, 2023. Respondents represented 516 hospitals across 36 states, accounting for 52,123 acute care beds. Respondents were asked to consider all claims from January 1, 2022 to December 31, 2022. Findings are presented as averages, weighted by acute bed capacity of the respondent. Respondents ranged from a small 12-bed critical access hospital to large, multi-state health systems. A copy of the survey questions can be found here.

Source: Premiere Blog. https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

PREMIER

Premier is collecting data to inform our advocacy on behalf of members experien payment denials and delays by health plans. We are interested in learning more abo and administrative burdens that providers face when appealing or pursuing denials/d payment. Understanding the severity of the issue amongst our members will h development of a data-driven advocacy strategy in Washington DC.

For the purposes of the survey, please consider the time period from January 1, 202 31, 2022.

Please answer the following questions, to the best of your knowledge, by November completion, please email the completed PDF document to Mason Mason_Ingram@premierinc.com. Should your organizational policies require that y information in a different format, or via protected means, please contact Mason and work with you to meet your organization's needs.

Ideally, the survey should be completed by the Finance or Revenue Cycle Mana Responses to the survey will be aggregated and anonymized.

Should you have any questions regarding the survey, please contact Mas Mason_Ingram@premierinc.com.

1. During the period from January 1, 2022 to December 31, 2022, what volume of you claims were subject to pre-service approvals (e.g., prior authorization) by health pla enter a percentage (0-100) in the text boxes for each insurance type.

Insurance Product	% of Claims Requiring Prior Auth
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

2. During the period from January 1, 2022 to December 31, 2022, what percentage o submitted to payers were denied? Please enter a percentage (0-100) in the text b insurance type.

Insurance Product	Initial Claim Denial %
Medicare	
Managed Medicare	
Medicaid	
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Managed Care and Other Commercial	
Marketplace Exchanges	

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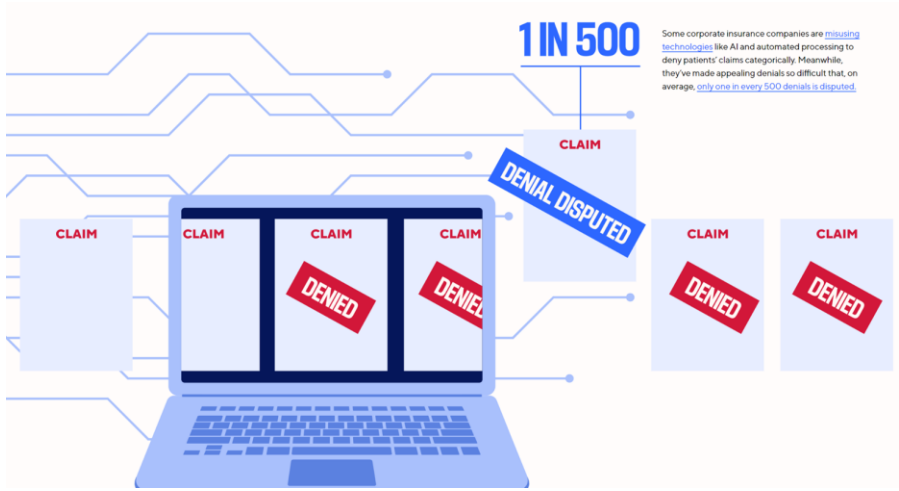


Articulating the Message: Key Local Audiences

Internal Audiences

- What should I know that I don't know?
- What are the areas of vulnerability and risk or opportunity?
- What is my story?
- Conduct your own opposition research, and address vulnerabilities.
- Monitor state regulatory and legislative changes.

Your Community and Large Employers

- Continue tell your story about the important role you play in your community (24/7 access to care etc.) .
- Be clear with patients and your community what you billing and collections practices are and make sure they are working as they should.
- Talk to your large employers and community leaders about your challenges.

Policy Makers (Local, State and Federal)

- Educate policy makers about health care financing (CHANGE event provides opportunity for education)
- Leverage your data with others to articulate the story of the challenges with health plan behavior.
- Use information to develop strategies to protect reputation during contract negotiations or periods when you may be out of network.

Analytics Translated to Key Advocacy Messages for Target Audiences (Examples)

Access to Care: Commercial health plans are restricting patients' access to medically necessary care.	• Denials by Types of Service by Payor: Be able to track implementation of health plan "clinical guidelines" that are not consistent with standard practice • Denials by Payer: Payers are normalized by standardized groups across hospitals. • Denials by Denial Category: Denials are normalized by standardized denial categories.
Insurers Are Siphoning Off Critical Health System Resources:	• Rate of unpaid claims and how that has changed over time • Time to remit and how that has changed over time • How much is sitting in AR and how old
NSA: Qualifying Payment Amounts	• This data could calculate and provide transparency to the QPA

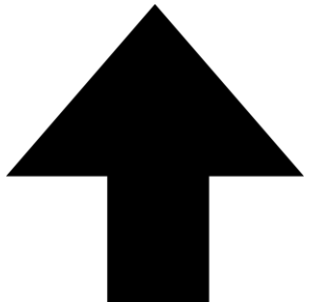
Providing multiple years of data enables hospitals to show a trend of increasingly challenging health plan practices that impact patient care and provider financial stability. Data shared on an ongoing basis will allow us to refresh payor "scorecards" without surveying hospitals (as done currently in many states).

State and National Advocacy Strategies

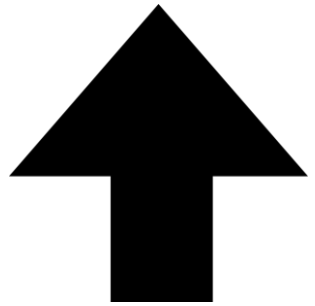
Legislative (State and Federal)

Regulatory/Administrative (State and Federal)

Legal



State and National Benchmarking Data Regarding Health Plan Practices and Impact on Patients and Providers (Vitality Payor Scorecard)

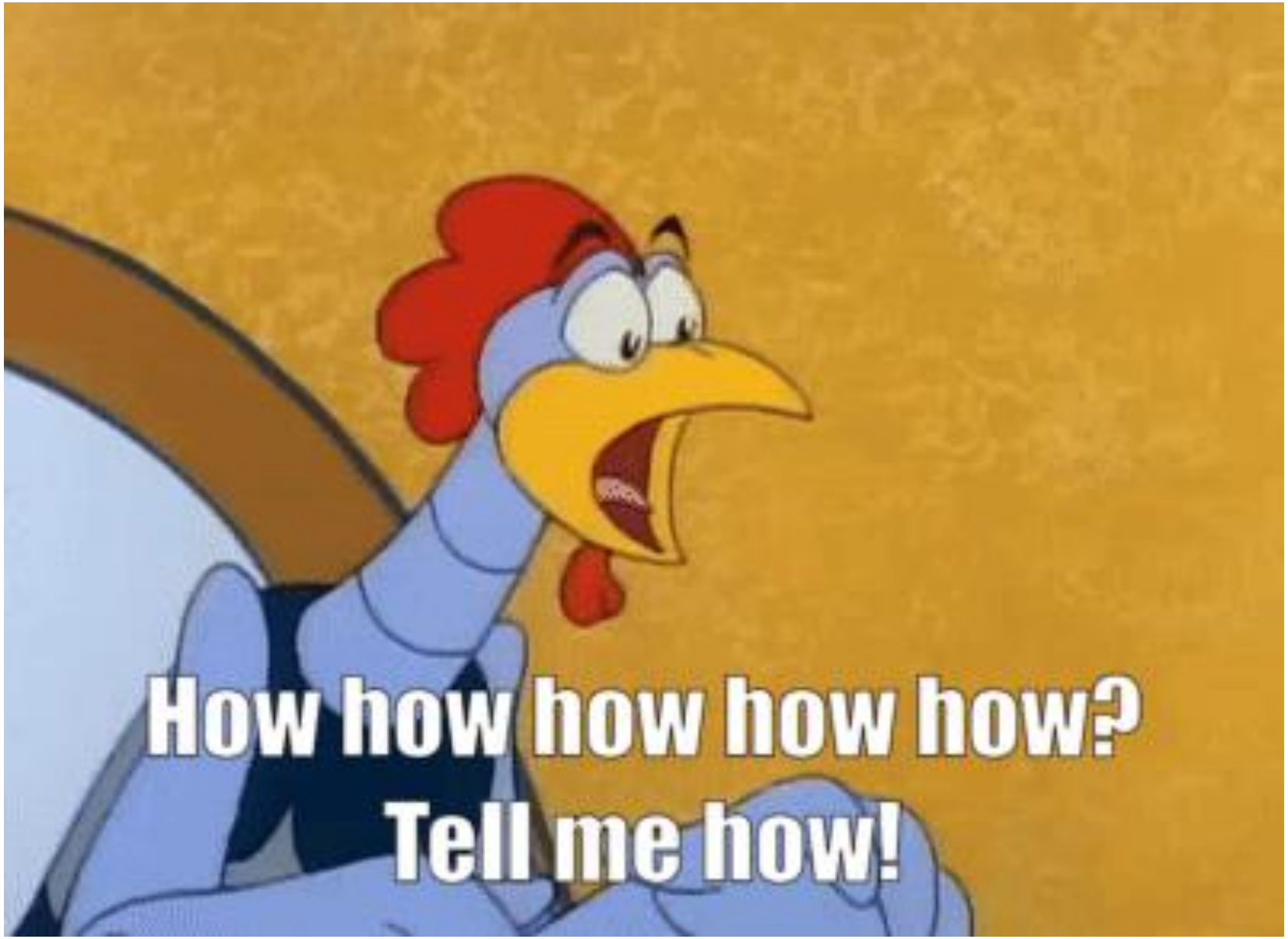


Communications

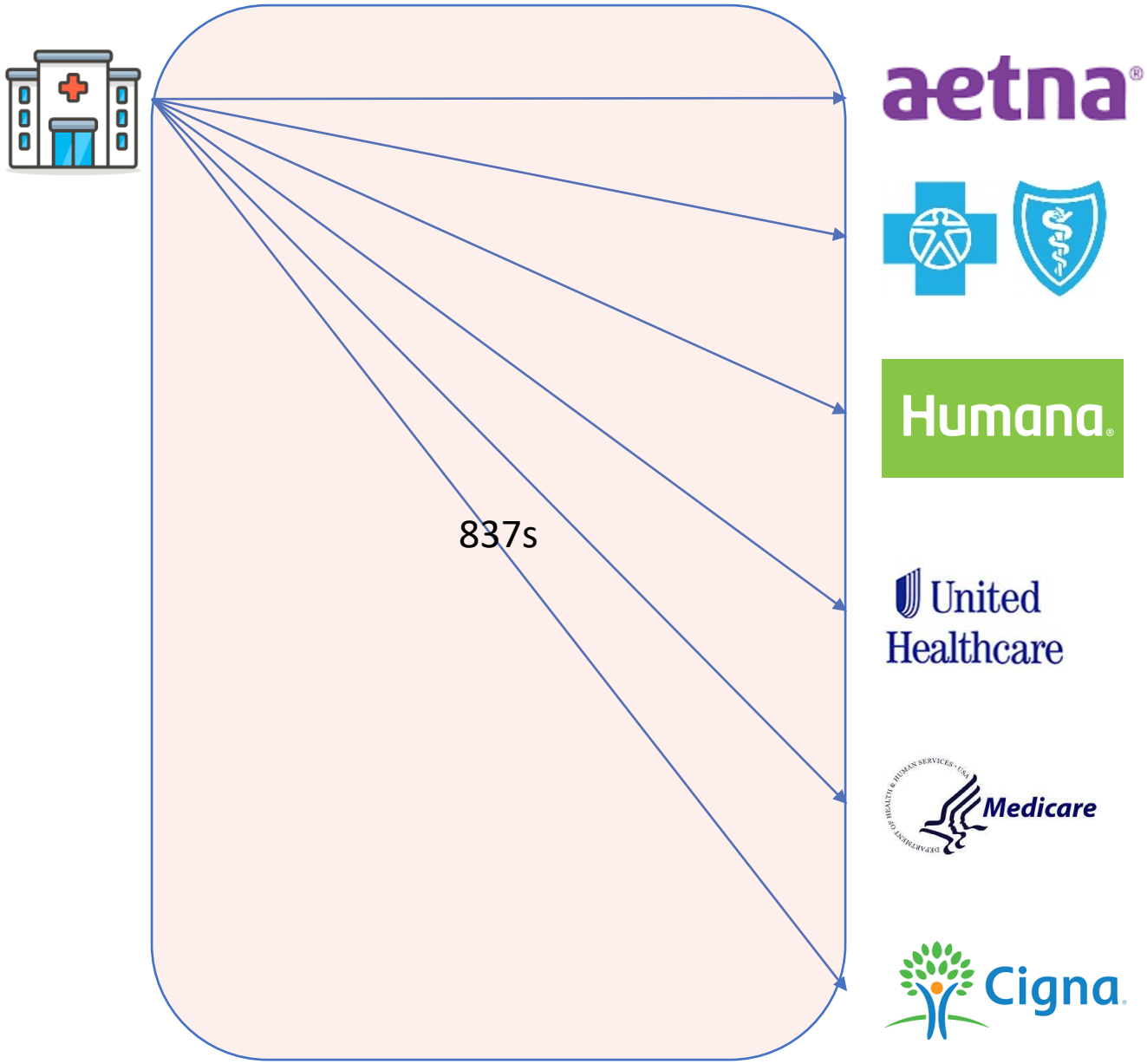
Patient Stories and Clinician Spokespeople

ECHO CHAMBER

Standardized Proof Points Needed


How how how how how?
Tell me how!

Providers' Perspective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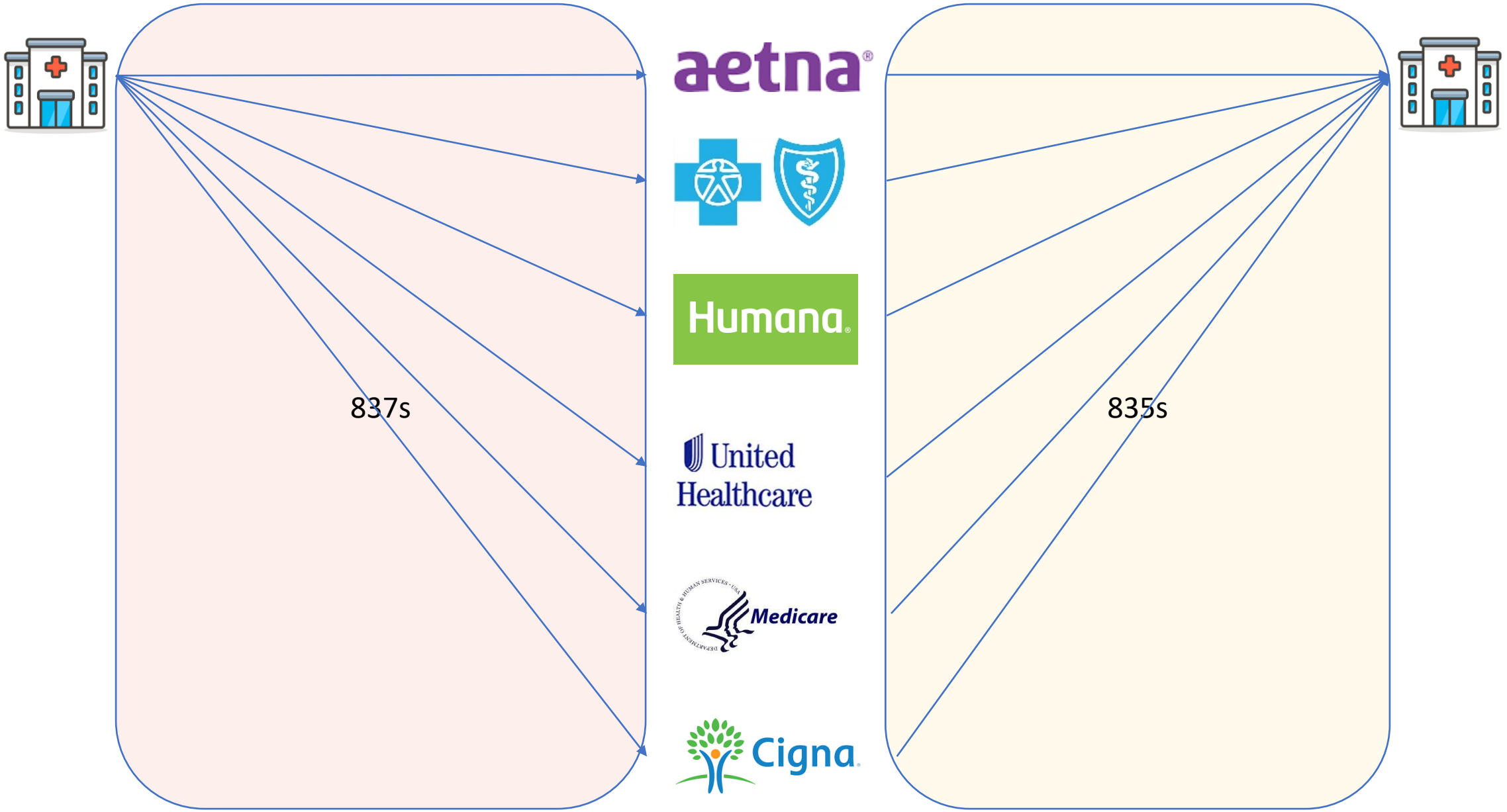
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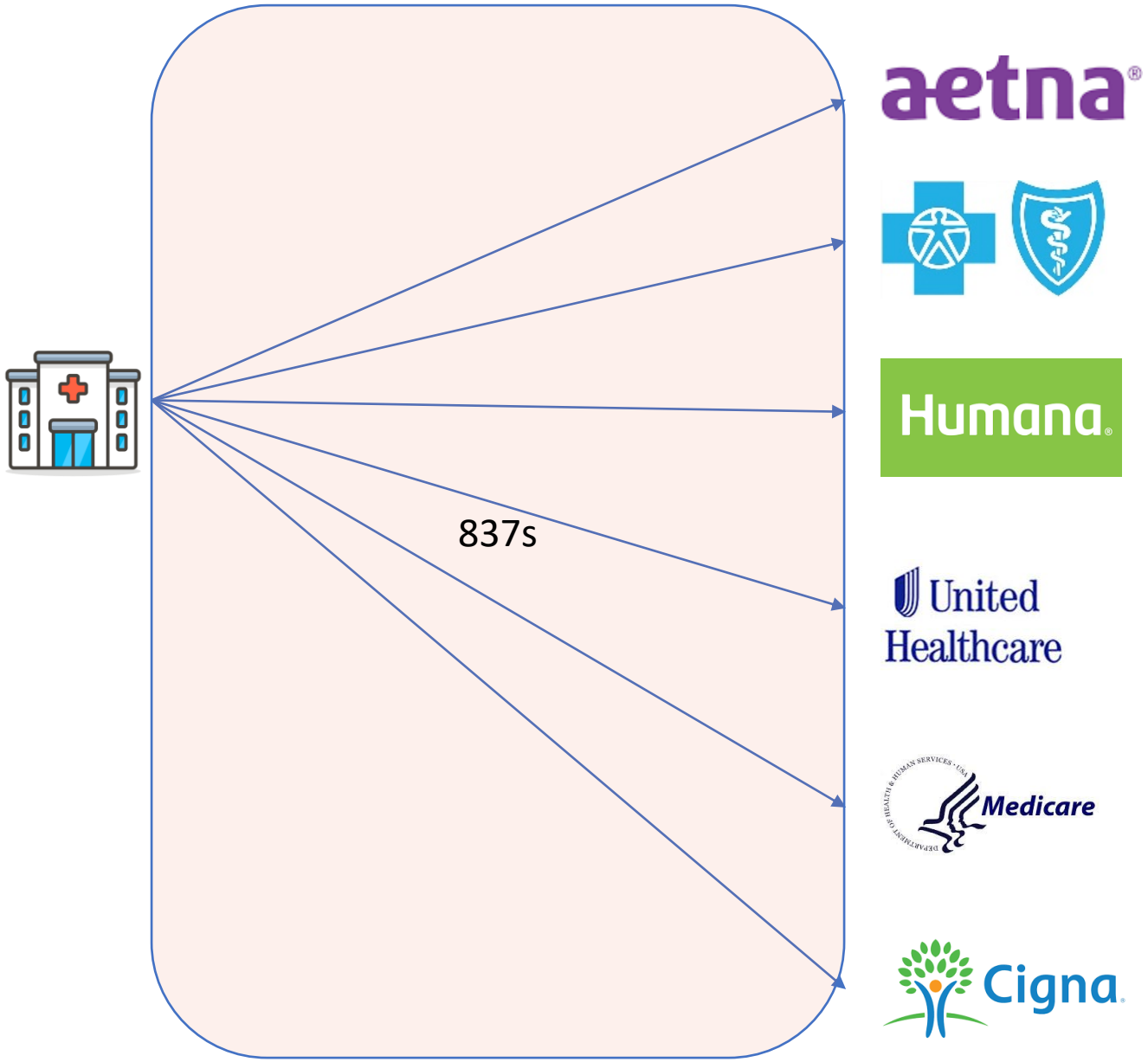
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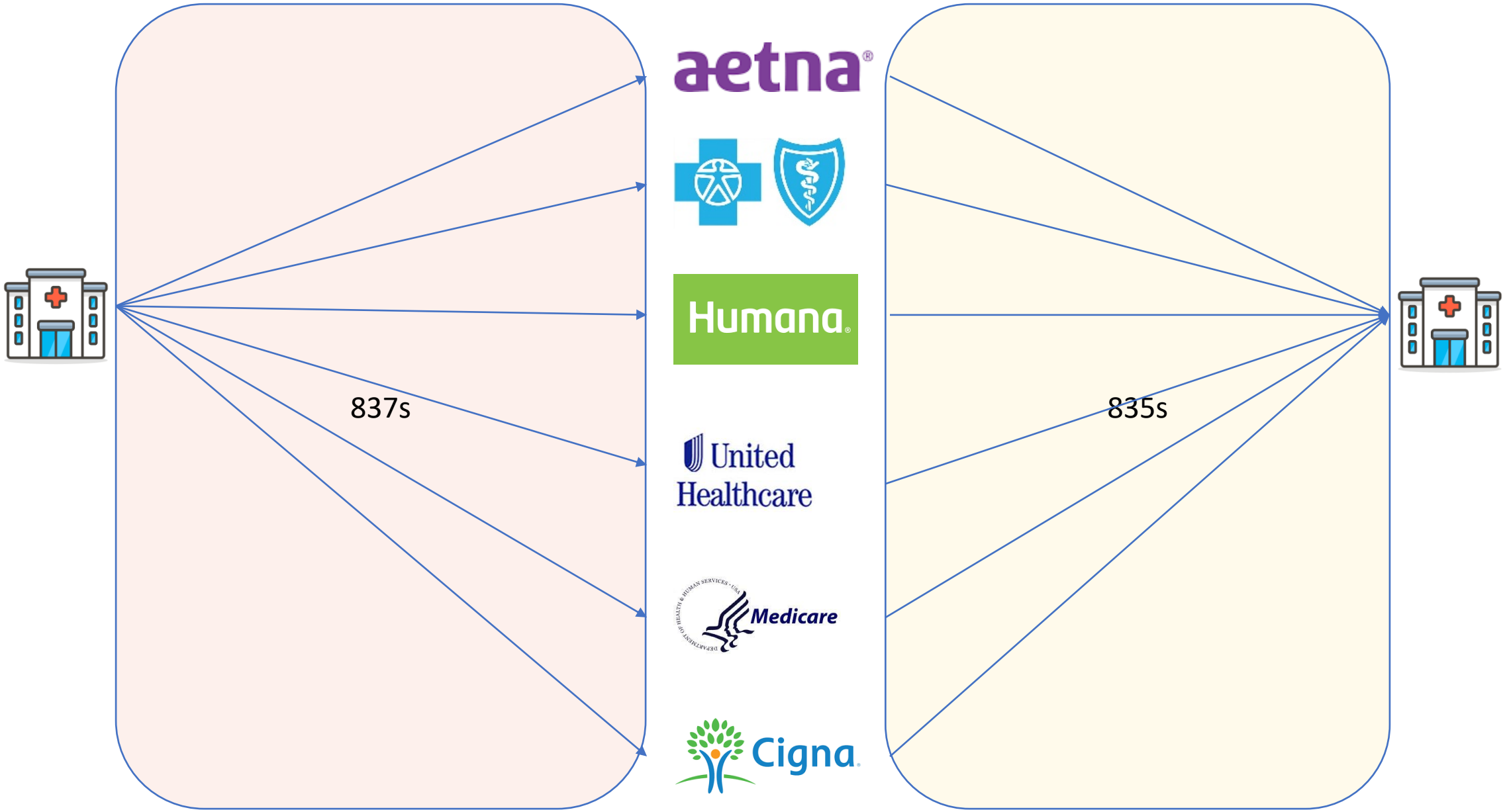
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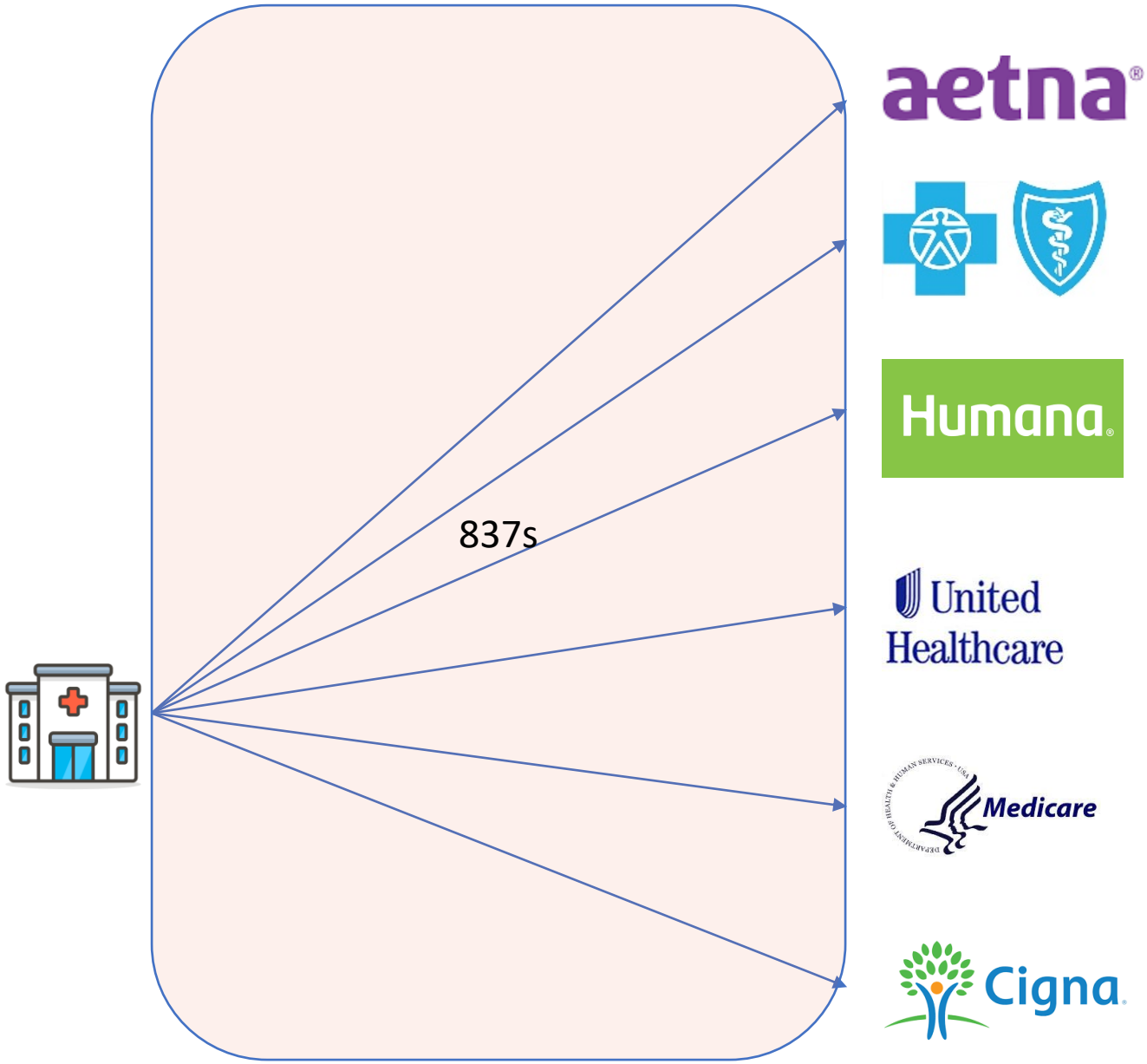
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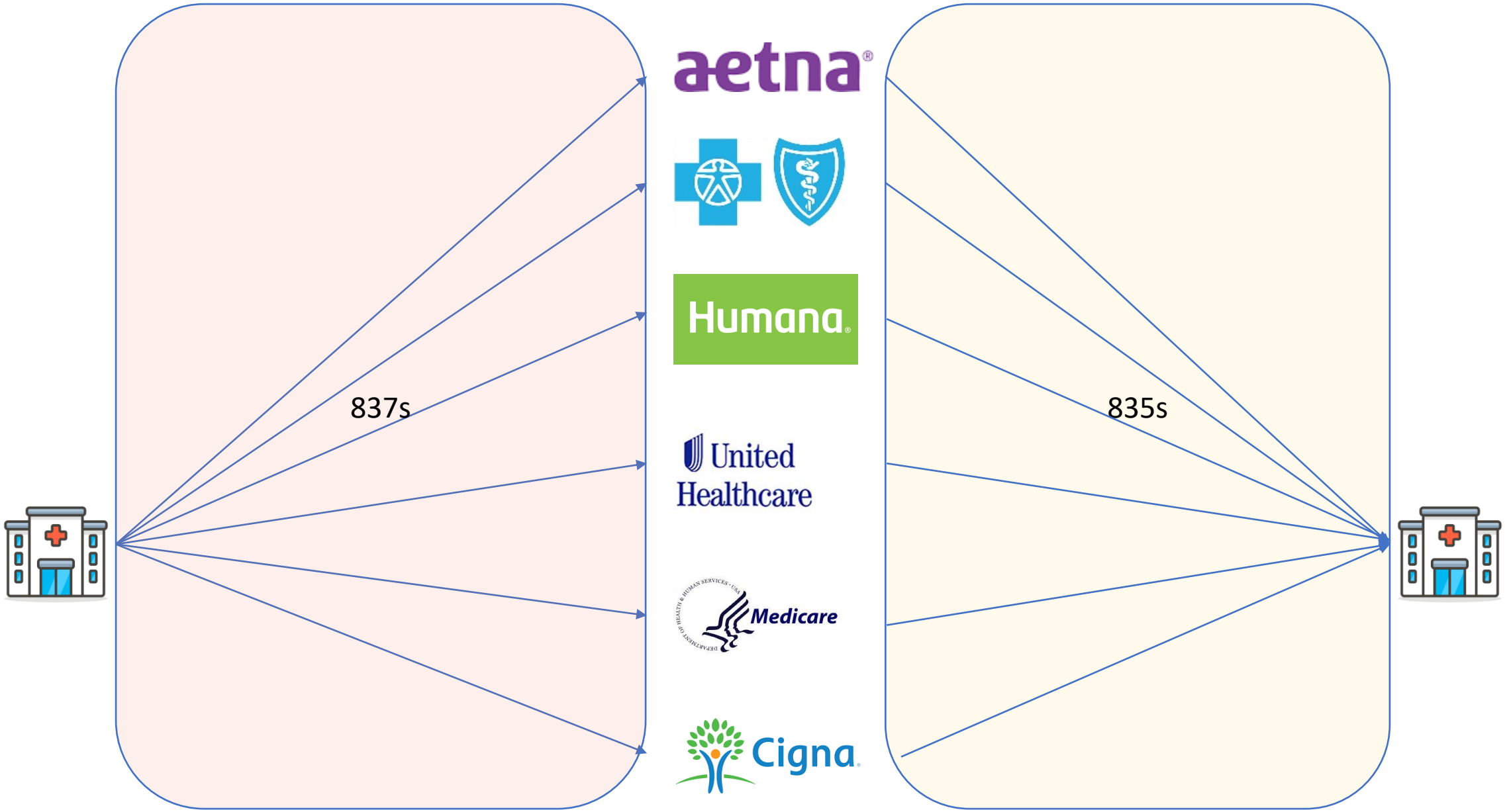
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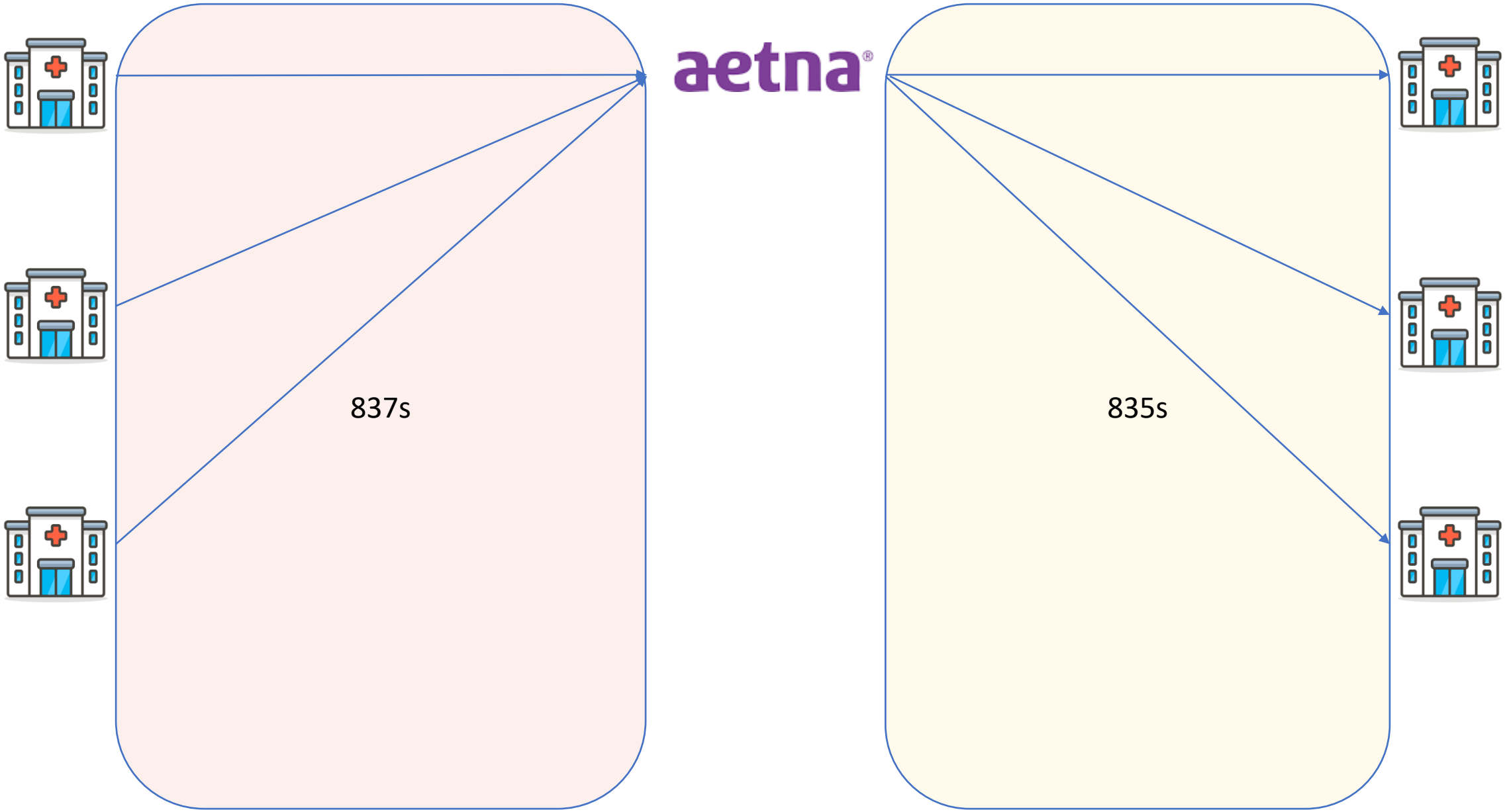
Payers' Perspective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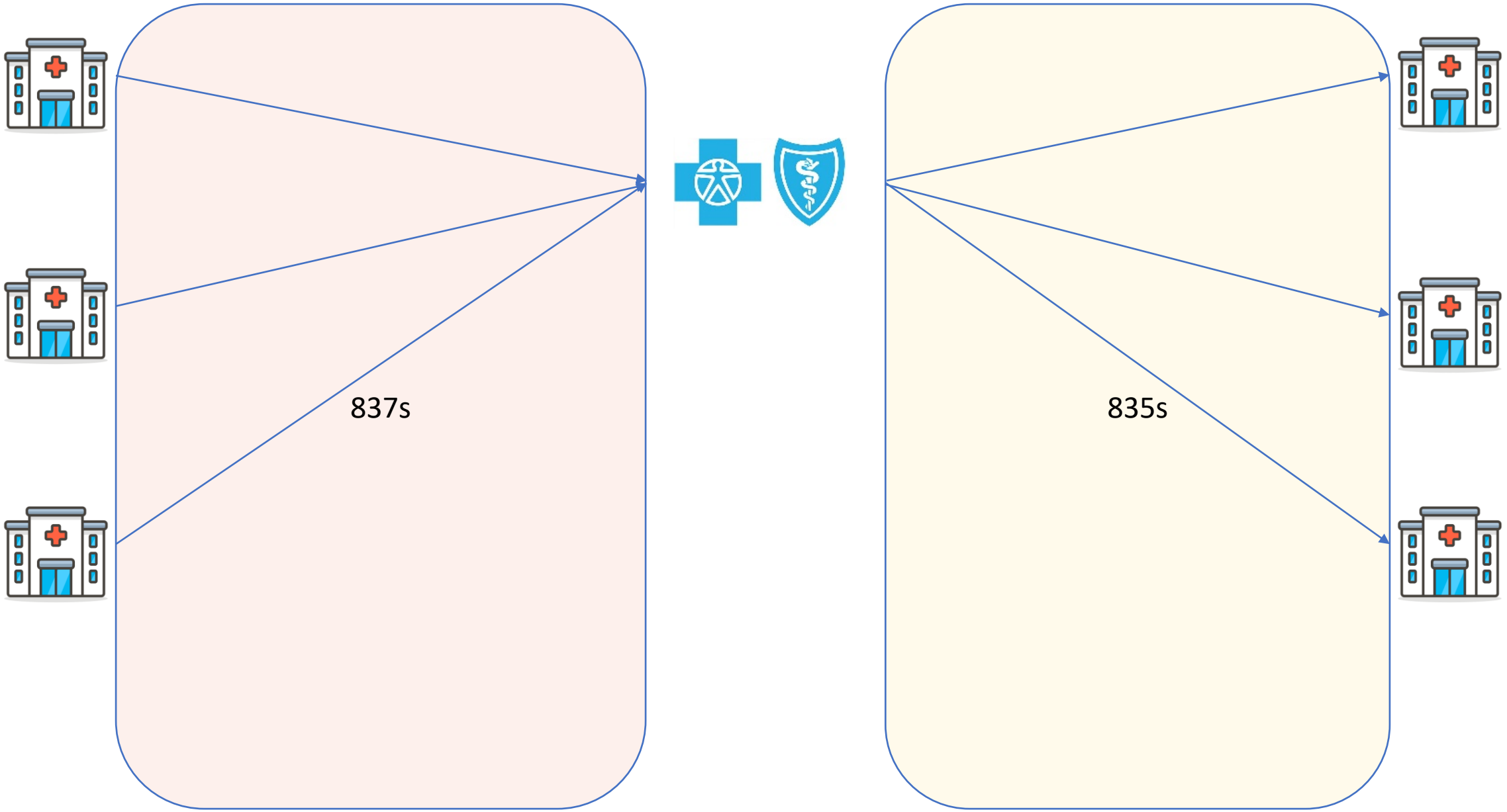
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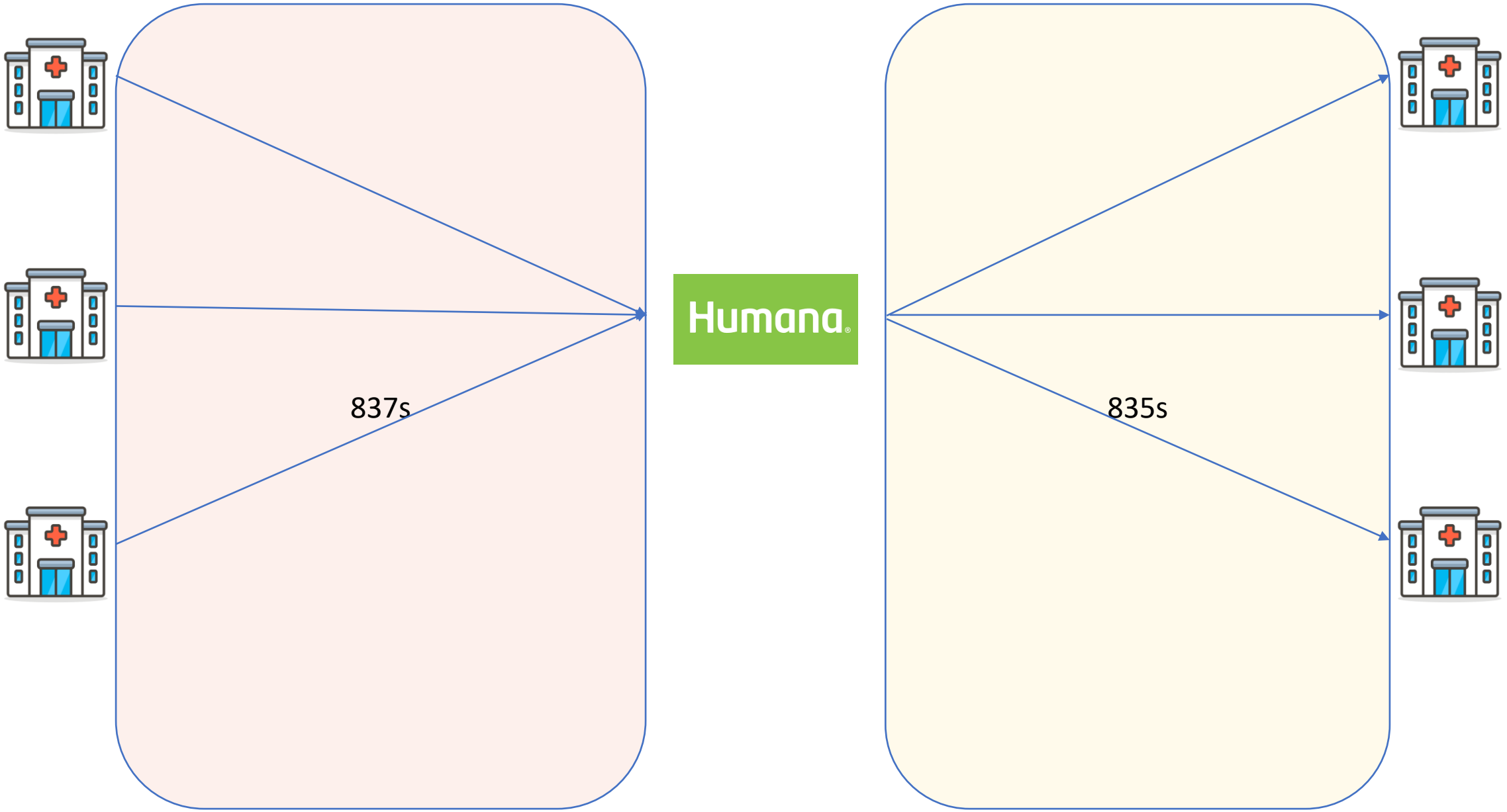
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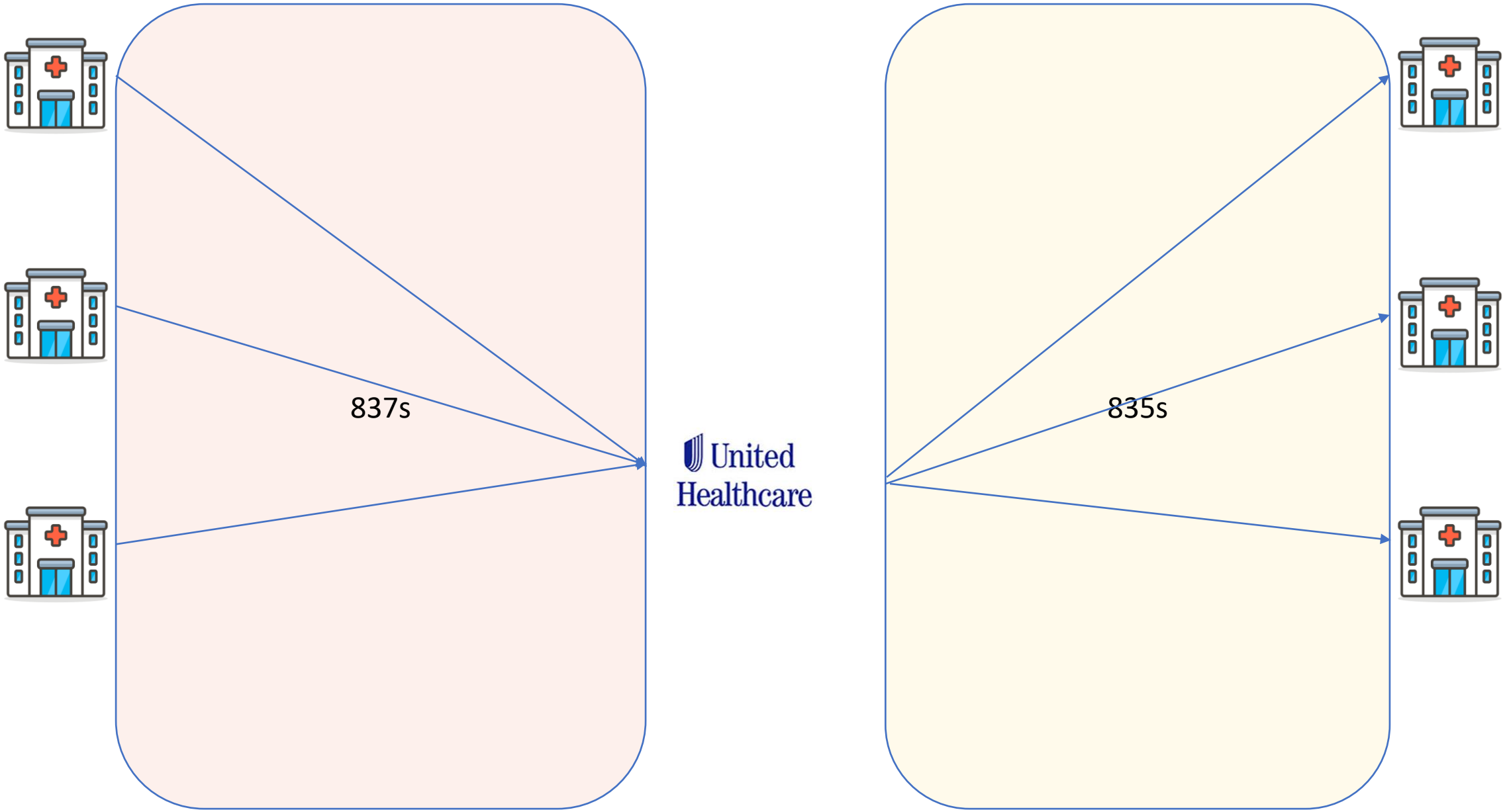
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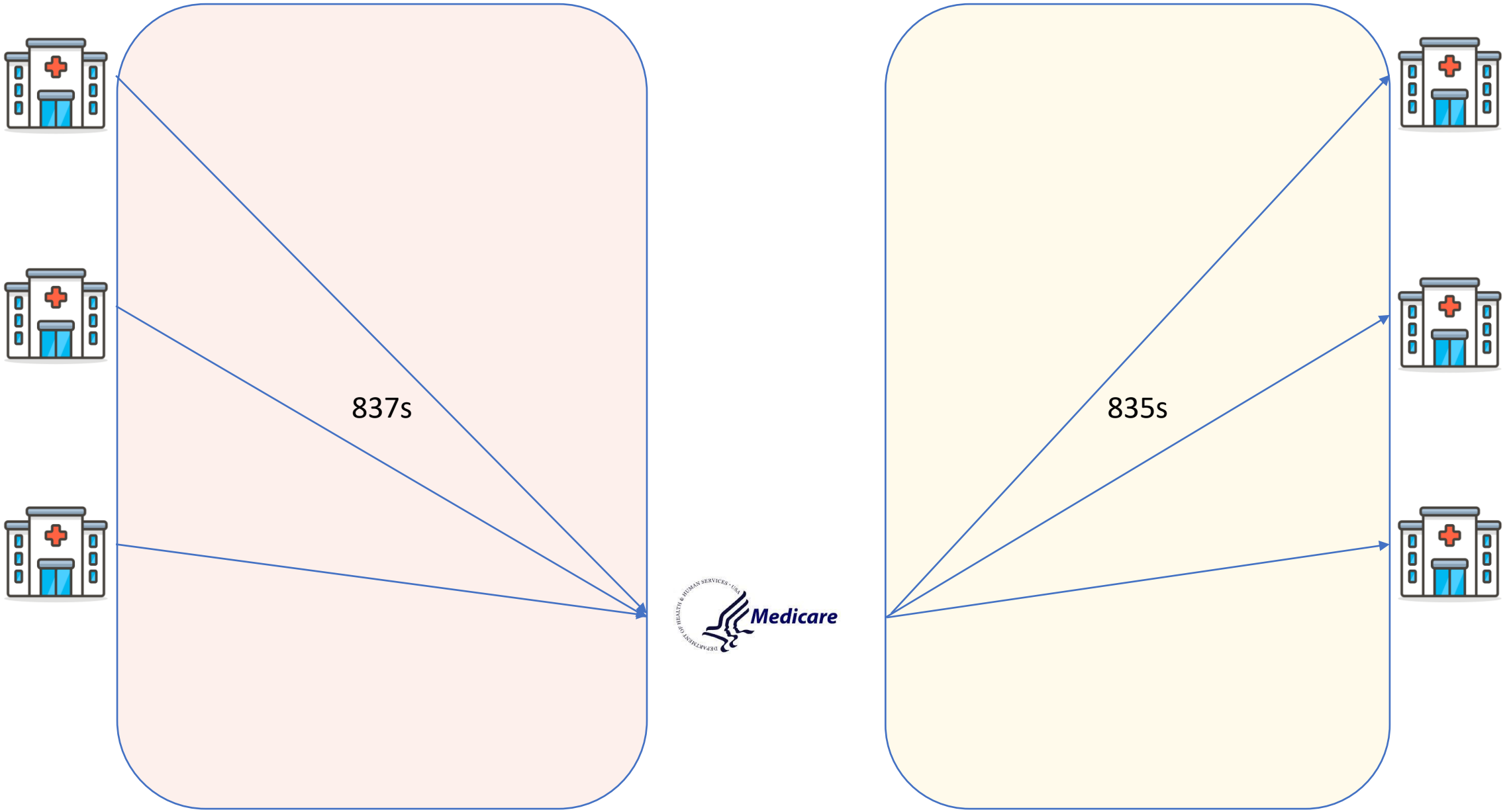
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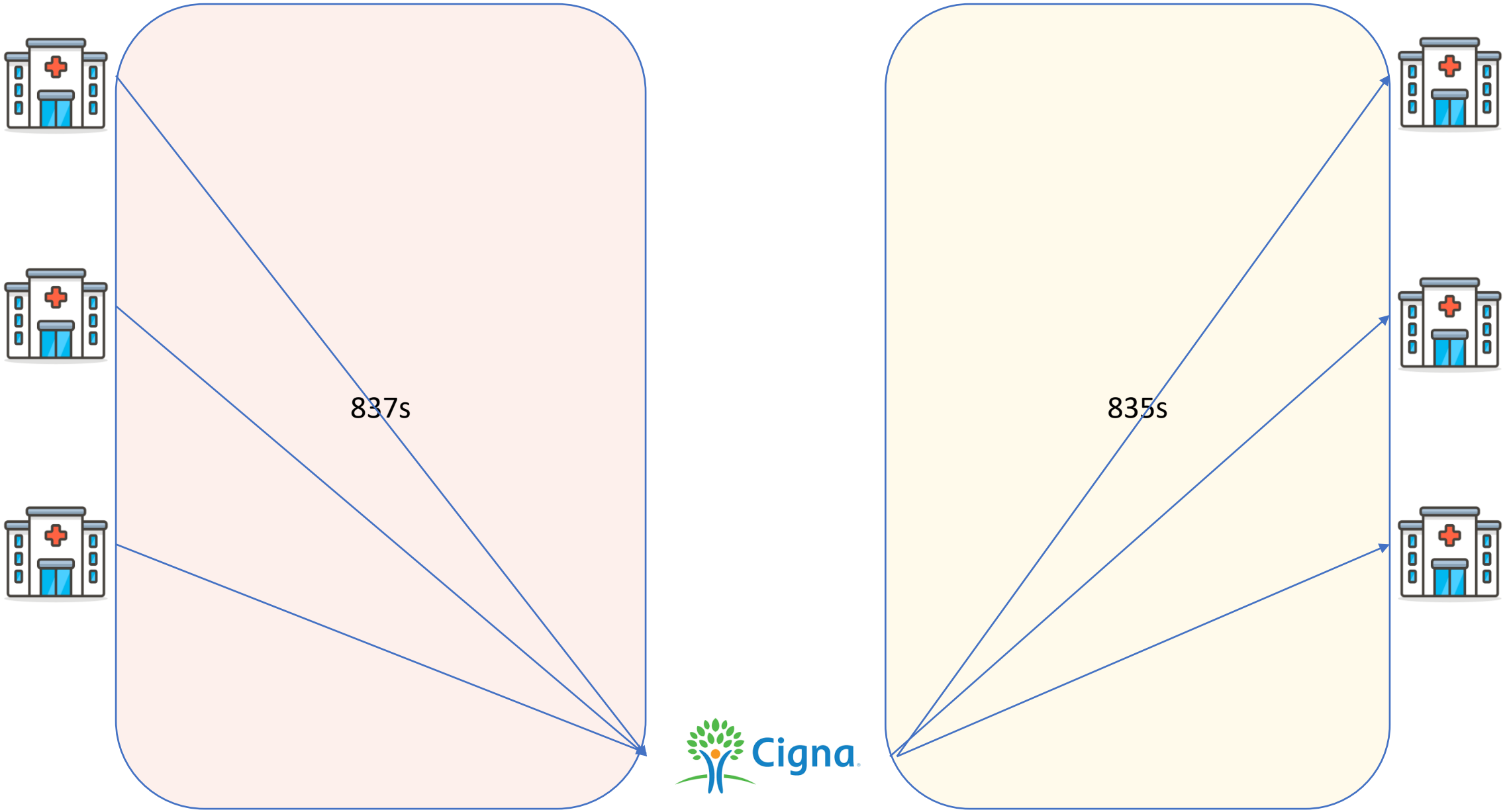
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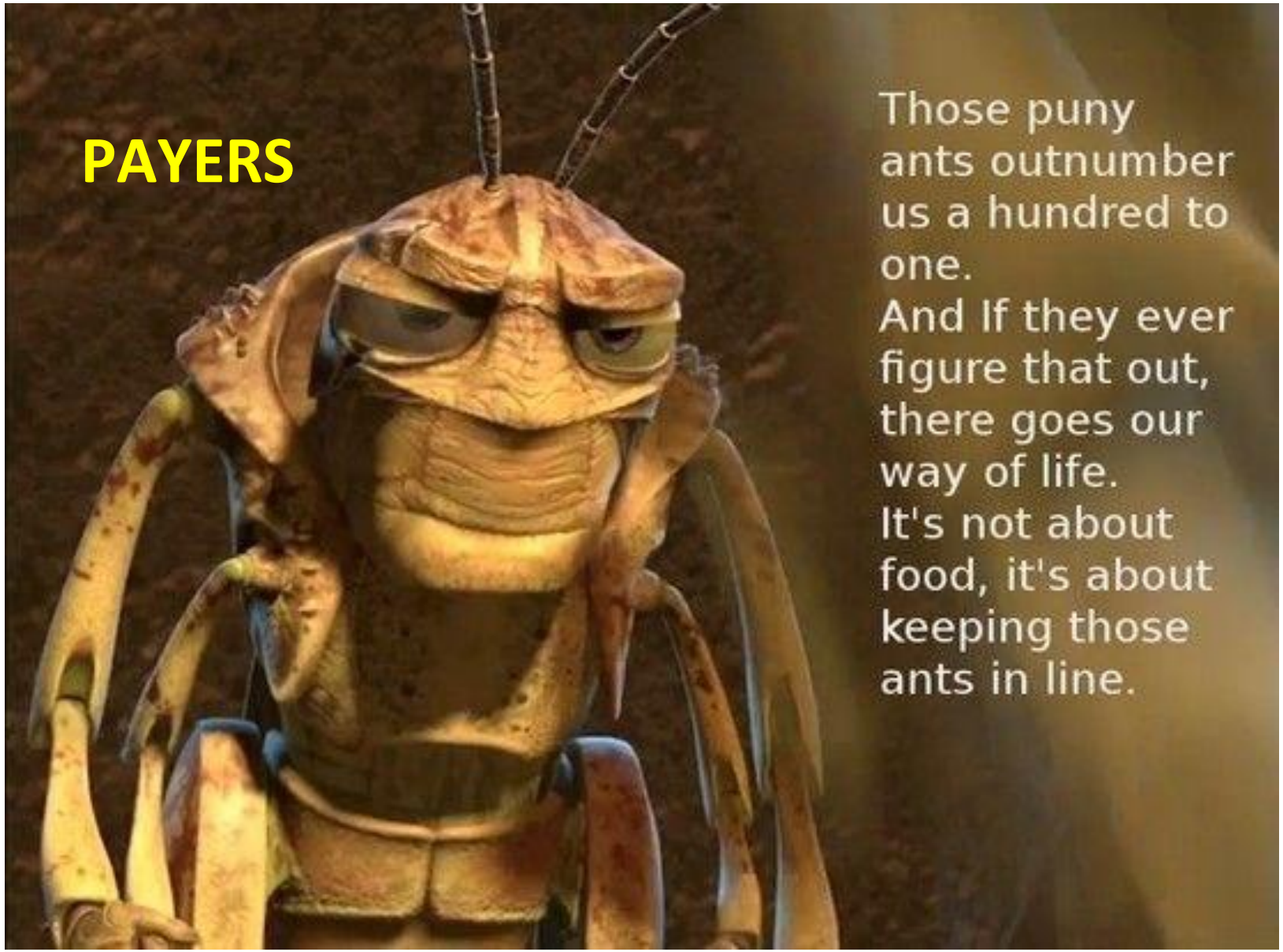
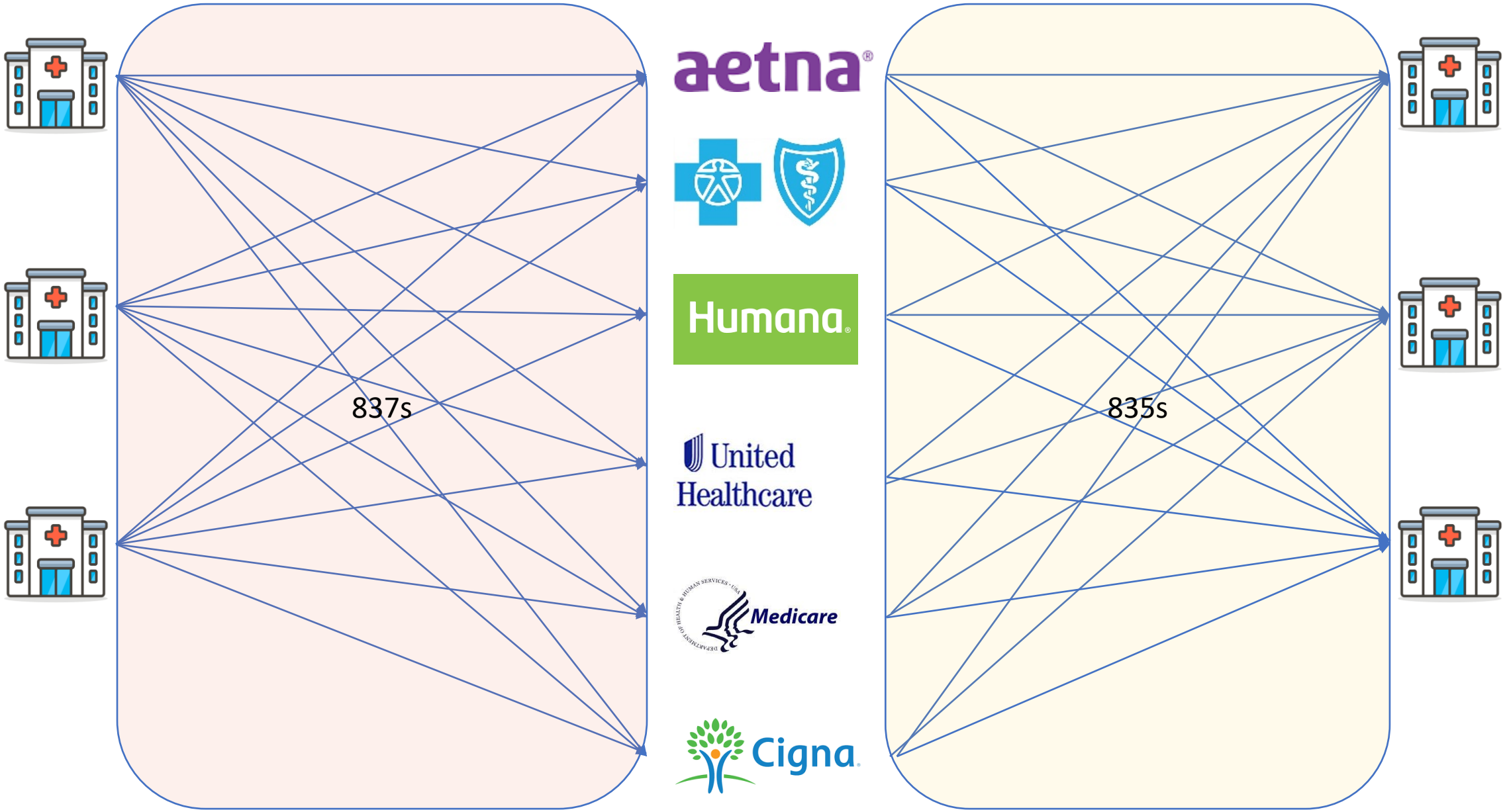

PAYERS
Those puny ants outnumber us a hundred to one.
And If they ever figure that out, there goes our way of life.
It's not about food, it's about keeping those ants in line.

Hyve's Perspective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Now is the time to change the narrative

- Data is the primary difference between why **payers are winning** and **providers are losing**.
- Payers have been leveraging aggregated provider data against them for years. Providers only have their data, their experience to refute.
- Providers need normalized, national, and state data to go on the offense against payers.
- Peter Drucker: "**You can't manage what do you can't measure."**
- **The time has come for hospitals to unite and hold payers accountable with their collective data.**

Solution: Aggregated, Democratized Data

- **Create the most CREDIBLE data set**
  - Harvest raw 837/835 data from the source.
  - Hospitals are the source.
- **Create the most SECURE data set**
  - PHI from 837/835s is removed at the source.
  - No BAA needed.
- **Create the TIMELIEST data set**
  - Timely data is needed to influence change.
  - 6-18 month old data is not effective for advocacy.
- **Create the SAFEST data set**
  - Hospitals cannot see each other's data.
  - Anonymous.

Why 837/835? What data to harvest?

- **837/Claim**
  - Service Date
  - Diagnosis Codes
  - Procedures
  - Charges
  - Claim Date
  - Claim Filing Indicator

  - NO PHI

- **835/Remit**
  - Remit Date
  - Payer Paid
  - Patient Portion
  - CARCs/RARCs

  - NO PHI

HYVE HEALTH

Glimpse into the possible

What is a good Clean Claim Rate? Prompt Pay?

Hospital	Remits (#)	Paid ($)	Discharge to Claim (days)	Clean Claim (%)	Prompt Pay (days)	Paid Clean ($)	Prompt Pay Cured Denials (days)
	334,404	573,357,727	17.1	85.6%	16.3	445,425,964	82.8
	230,474	445,775,783	14.9	78.2%	16.3	322,810,206	88.8
	179,407	210,028,833	10.7	76.8%	15.6	156,747,765	87.7
	168,369	236,513,317	14.5	77.7%	15.7	171,469,272	81.9
	159,920	300,346,243	13.9	78.1%	15.2	225,006,669	84.4
	153,638	264,720,051	13.1	77.4%	14.9	187,774,500	79.5
	106,864	166,160,185	13.0	73.6%	15.5	129,811,435	89.5
	106,178	131,123,795	9.0	83.0%	15.1	102,209,460	67.2
	99,012	183,159,457	10.7	74.6%	13.0	110,492,514	86.8
	88,124	113,853,636	9.1	80.2%	15.1	83,702,199	67.4
	57,451	114,201,760	10.1	66.3%	15.1	73,327,424	86.6
	42,437	61,243,129	14.0	72.3%	14.2	43,640,738	84.7
	37,683	26,235,438	7.7	79.0%	14.2	18,541,781	60.5
	35,944	27,013,616	8.7	79.6%	12.8	18,506,539	85.1

What is a good Clean Claim Rate? Prompt Pay?

Payer Type	Remits (#)	Paid ($)	Discharge to Claim (days)	Clean Claim (%)	Prompt Pay (days)	.	Paid Clean ($)	Prompt Pay Cured Denials (days)
Medicare FFS	**544,475**	**823,517,302**	**12.3**	**88.7%**	**15.5**		**758,695,983**	**59.1**
Commercial	**492,386**	**1,282,212,913**	**11.0**	**69.2%**	**15.1**		**750,681,310**	**83.6**
Managed Medicaid	**483,133**	**382,354,410**	**11.6**	**67.1%**	**13.9**		**249,025,427**	**81.7**
Medicare Advantage								
[redacted]	167,867	160,678,088	16.0	91.0%	11.1		131,122,292	85.1
[redacted]	132,907	147,586,125	11.5	94.2%	25.2	▲	134,959,988	103.1
[redacted]	56,232	77,702,352	13.2	82.4%	13.2		66,755,786	92.5
[redacted]	20,282	20,826,580	11.5	85.5%	10.3		17,924,743	104.9
[redacted]	13,135	14,268,598	11.4	80.8%	15.2		10,002,388	91.0
[redacted]	267	289,929	8.8	96.6%	24.1		288,081	37.3
[redacted]	48	76,894	14.2	47.9%	26.4		49,717	131.0
[redacted]	2	23,472	13.0					16.0
[redacted]	1	16,463	3.0	100.0%			16,463	
Other	**23,654**	**45,043,544**	**10.0**	**84.2%**	**19.5**		**39,071,499**	**85.2**

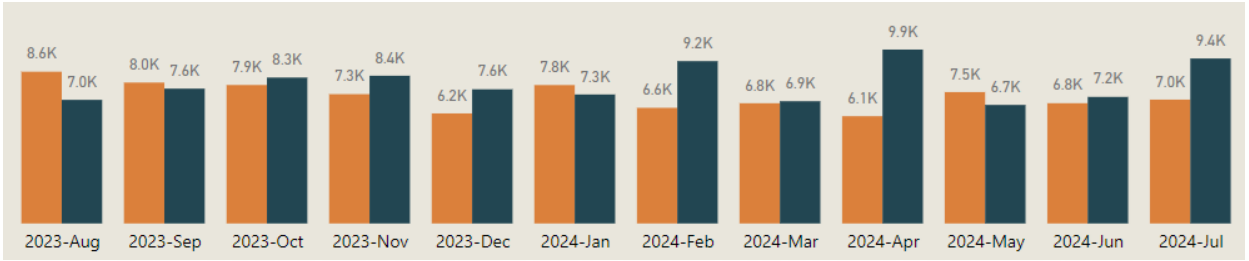
What is a good reimbursement across the state?

Avg Remit Value by Payer by Specialty

Payer	Anesthesia	Auditory	Cancer	Cardiovascular	Dermatology	Digestive	Endocrine	Lymphatic	Medicine	Musculoskeletal	Nervous	OB/GYN
	1,433	3,191	10,830	4,804	3,074	4,352	4,326	6,501	1,971	6,113	4,054	4,619
	1,318	5,895	21,990	6,744	4,818	6,017	7,068	8,856	2,612	10,506	5,914	4,846
	1,660	6,403	28,815	7,920	7,057	7,644	9,145	11,323	2,837	15,954	7,183	6,288
	2,794	8,205	26,052	8,834	9,948	8,859	12,069	8,148	3,170	16,033	10,094	6,729
	643	2,013	8,469	3,860	4,562	4,225	4,639	5,429	2,222	7,467	5,248	10,501
	425	1,450	24,838	3,927	1,781	3,827	2,802	5,400	914	4,096	4,370	3,958
	715	3,318	14,811	3,384	4,049	3,789	5,102	6,130	1,834	7,147	4,559	3,669
	990	1,632		3,945	2,398	2,973	2,558	4,423	998	4,061	3,378	3,231
	638	2,122	22,991	4,340	3,006	3,181	2,941	6,958	1,425	4,826	3,128	3,074
	1,141	5,992		5,003	3,136	4,339	5,702	6,623	2,230	10,931	3,232	5,636
	1,438	3,388		17,054	7,994	10,314	7,479	7,892	7,442	18,649	9,250	7,214
		6,561		183		7,316	13,538		1,196		1,048	
	418	1,294		6,505	4,981	4,783	5,494	6,956	3,519	10,204	5,600	2,260
	1,333	3,492	21,025	6,467	4,989	5,611	6,363	8,259	3,023	9,380	6,039	5,826
		2,405	20,419	4,535	8,323	3,905	9,824	6,589	1,685	7,856	4,655	3,557
											25,747	
Total	**1,194**	**3,874**	**17,657**	**5,511**	**4,294**	**5,012**	**5,438**	**7,387**	**2,209**	**8,290**	**5,154**	**4,754**

Do you have a Lessor Rate or Charge Issue?

Specialty	Remits (#)	Charges ($)	Payer Paid ($)	Patient Responsibility ($)	Clean Claim (%)	Prompt Pay (days)	Full Denial (%)	Avg Payer Paid ($)	Avg Patient Resp ($)	Avg Remit Value ($)	Avg Remit Value NonLRC ($)	Avg Remit Value LRC ($)	Lessor Rate of Charge (%)
Auditory	232	6,305,911	1,891,568	311,006	63.8%	14.6	13.8%	7,807	1,224	9,032	8,855	9,951	18.97%
Respiratory	4,068	188,093,134	51,503,542	7,144,431	63.3%	16.9	16.8%	10,529	1,504	12,033	11,624	15,380	13.86%
Reproductive	1,644	63,862,688	20,740,775	2,074,403	67.9%	16.4	13.6%	10,315	1,121	11,436	11,934	8,625	11.44%
Ocular	78	2,214,874	703,707	69,214	66.7%	19.4	17.9%	8,703	909	9,612	9,610	9,628	10.26%
Lymphatic	66	6,439,183	2,032,669	61,074	72.7%	19.8	15.2%	32,161	1,034	33,195	32,662	37,373	9.09%
OB/GYN	18,722	334,351,265	132,600,157	22,469,926	80.6%	19.8	8.2%	6,023	1,088	7,111	6,919	8,038	8.86%
Endocrine	1,634	58,649,622	17,634,045	2,231,194	72.9%	17.3	13.5%	9,187	1,315	10,503	10,242	12,675	8.81%
Dermatology	958	56,676,071	18,418,752	1,320,798	69.7%	17.8	13.2%	16,447	1,336	17,783	18,075	15,230	8.77%
Urinary	1,880	87,524,707	26,220,375	2,882,745	69.4%	16.9	16.8%	11,613	1,546	13,159	12,746	16,665	8.09%
Cancer	150	10,703,039	3,724,050	134,332	69.3%	15.1	20.0%	23,553	972	24,525	23,358	37,122	6.67%
Pathology	6,508	374,973,609	119,184,220	9,332,101	73.4%	17.8	12.4%	18,131	1,839	19,971	19,074	29,764	5.72%
Nervous	5,712	253,483,772	82,081,424	8,285,045	66.5%	16.0	15.5%	10,644	1,120	11,763	11,534	14,783	5.64%
Digestive	3,870	231,238,904	76,048,647	4,858,975	74.1%	17.7	13.9%	14,306	1,085	15,390	14,806	21,983	5.06%
Transplants	80	48,340,189	11,996,177	51,903	45.0%	25.4	42.5%	147,719	595	148,314	133,267	415,392	5.00%



What is a good Clean Claim Rate? Prompt Pay?
(IP MA Plans)

Specialty	Remits (#)	Paid ($)	Discharge to Claim (days)	Clean Claim (%)	Prompt Pay (days)	.	Paid Clean ($)	Prompt Pay Cured Denials (days)
Pathology	11,012	82,471,480	11.7	86.3%	18.7	▲	75,421,762	98.9
Cardiovascular	8,078	85,350,417	17.5	81.2%	17.9	▲	76,524,905	102.2
Radiology	7,888	5,008,237	36.6	84.9%	13.1		3,931,519	107.2
Medicine	7,206	15,759,766	23.4	82.6%	15.8		12,973,150	96.4
Respiratory	5,028	39,244,056	12.2	79.1%	19.5	▲	35,116,586	84.1
Nervous	4,478	38,014,964	12.9	75.3%	20.3		33,581,567	92.8
Musculoskeletal	3,332	47,474,616	14.3	81.9%	18.3	▲	43,282,846	102.6
Digestive	3,110	27,309,871	12.8	80.8%	17.4	▲	24,973,130	85.3
Urinary	2,808	20,139,516	11.6	76.5%	18.4	▲	18,160,821	87.4
Endocrine	1,648	9,791,016	10.4	75.7%	18.8	▲	9,049,346	105.8
Thoracic	1,262	12,444,207	10.7	80.3%	18.4	▲	10,782,033	105.3
Dermatology	662	6,733,884	12.4	76.1%	18.6	▲	5,975,246	80.5
Reproductive	186	1,311,884	15.0	78.5%	20.3	▲	1,222,770	58.5
Cancer	154	1,988,965	14.7	81.8%	16.9		1,715,557	92.3

What is a good Denials Rate?

Hospital	Charges ($)	Full Denial ($)	Cured Denial ($)	Total Remits (#)	Remits by Selected Denial (#)	Full Denial Remits (#)	Full Denial Vol (%)	.	Full Denial Value (%)
	2,831,458,837	126,670,273	57,882,111	334,404	334,404	12,270	3.7%		4.5%
	2,602,877,384	254,162,844	101,925,030	230,474	230,474	15,727	6.8%	▲	9.8%
	2,515,357,470	341,281,204	85,285,428	106,864	106,864	9,333	8.7%	▲	13.6%
	1,830,682,143	164,677,421	58,065,474	159,920	159,920	11,152	7.0%	▲	9.0%
	1,395,689,399	131,863,868	40,341,815	168,369	168,369	11,773	7.0%	▲	9.4%
	1,255,497,284	122,148,405	40,756,556	179,407	179,407	12,830	7.2%	▲	9.7%
	1,146,843,565	73,613,706	33,340,274	99,012	99,012	6,334	6.4%	▲	6.4%
	1,100,850,214	38,044,377	17,600,010	153,638	153,638	6,040	3.9%		3.5%
	769,211,810	40,741,708	16,715,894	106,178	106,178	5,364	5.1%		5.3%
	683,060,046	35,533,055	19,673,288	88,124	88,124	4,213	4.8%		5.2%
	666,700,652	53,629,061	14,130,082	57,451	57,451	4,191	7.3%	▲	8.0%
	321,767,127	10,673,602	4,297,067	42,437	42,437	1,457	3.4%		3.3%
	241,328,620	24,306,908	5,377,195	22,084	22,084	1,734	7.9%	▲	10.1%

What is a good Denials Rate?

Payer Type	Charges ($)	Full Denial ($)	Cured Denial ($)	Total Remits (#)	Remits by Selected Denial (#)	Full Denial Remits (#)	Full Denial Vol (%)	Full Denial Value (%)
Medicare FFS	**6,202,226,297**	**147,867,961**	**107,344,509**	**544,475**	**544,475**	**12,651**	**2.3%**	**2.4%**
Commercial	**4,704,035,040**	**574,380,964**	**153,195,332**	**492,386**	**492,386**	**50,271**	**10.2%**	**12.2%**
Medicare Advantage								
[redacted]	1,572,501,221	136,266,318	99,631,488	167,867	167,867	4,378	2.6%	8.7%
	1,080,735,281	57,826,654	17,951,516	132,907	132,907	3,241	2.4%	5.4%
	668,253,140	97,060,437	24,638,244	56,232	56,232	7,121	12.7%	14.5%
	178,416,556	12,658,980	2,817,232	20,282	20,282	925	4.6%	7.1%
	130,136,408	16,887,987	1,919,926	13,135	13,135	919	7.0%	13.0%
	1,848,307	44,492	2,917	267	267	5	1.9%	2.4%
	632,040	296,119	43,745	48	48	17	35.4%	46.9%
	26,268	42	26,226	2	2	1	50.0%	0.2%
	15,539			1	1			
Managed Medicaid	**3,236,729,177**	**341,834,935**	**80,742,611**	**483,133**	**483,133**	**29,064**	**6.0%**	**10.6%**

What is a good Denials Rate (MA Plans)?

All Patient Types

Specialty	Charges ($)	Full Denial ($)	Cured Denial ($)	Total Remits (#)	Remits by Selected Denial (#)	Full Denial Remits (#)	Full Denial Vol (%)	Full Denial Value (%)
Medicine	2,347,571,547	151,390,637	76,980,576	330,392	330,392	12,654	3.8%	6.4%
Radiology	1,108,164,093	43,897,511	16,115,269	200,384	200,384	6,760	3.4%	4.0%
Pathology	609,011,095	61,376,779	39,705,500	132,770	132,770	4,052	3.1%	10.1%
Cardiovascular	1,058,743,090	110,045,256	53,429,679	47,646	47,646	3,070	6.4%	10.4%
Digestive	380,680,015	37,165,057	14,649,917	16,698	16,698	950	5.7%	9.8%
Nervous	289,934,568	45,934,438	16,649,177	12,294	12,294	1,448	11.8%	15.8%
Musculoskeletal	457,310,350	49,194,398	22,548,351	10,608	10,608	956	9.0%	10.8%

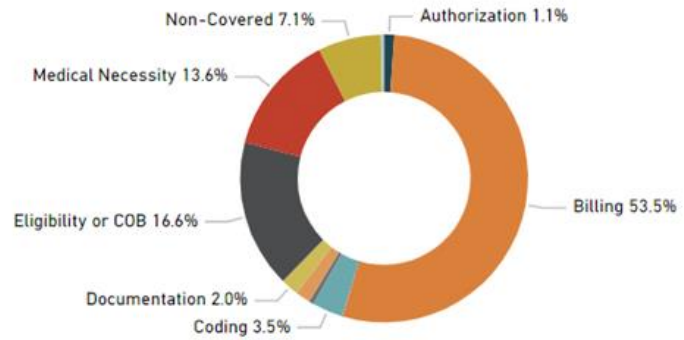
InPatient Types

Specialty	Charges ($)	Full Denial ($)	Cured Denial ($)	Total Remits (#)	Remits by Selected Denial (#)	Full Denial Remits (#)	Full Denial Vol (%)	Full Denial Value (%)
Pathology	526,540,475	58,737,560	39,271,870	11,012	11,012	914	8.3%	11.2%
Cardiovascular	659,381,441	92,927,212	46,248,208	8,078	8,078	1,306	16.2%	14.1%
Radiology	41,935,603	1,840,663	561,295	7,888	7,888	208	2.6%	4.4%
Medicine	112,891,260	22,743,314	9,903,259	7,206	7,206	460	6.4%	20.1%
Respiratory	257,877,403	42,144,250	20,067,972	5,028	5,028	954	19.0%	16.3%
Nervous	235,015,766	42,289,273	14,367,180	4,478	4,478	1,022	22.8%	18.0%
Musculoskeletal	348,808,075	42,282,270	20,307,290	3,332	3,332	554	16.6%	12.1%

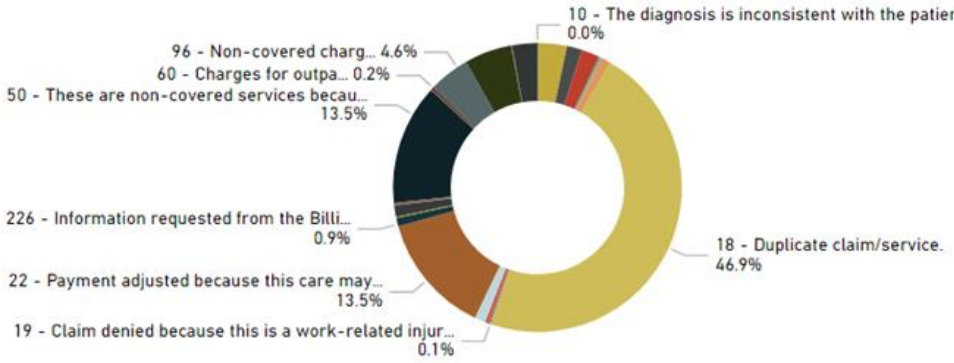
Medicare vs Medicare Advantage

Payer: All | Payer Type: Medicare FFS

Full Denials by Value by Category

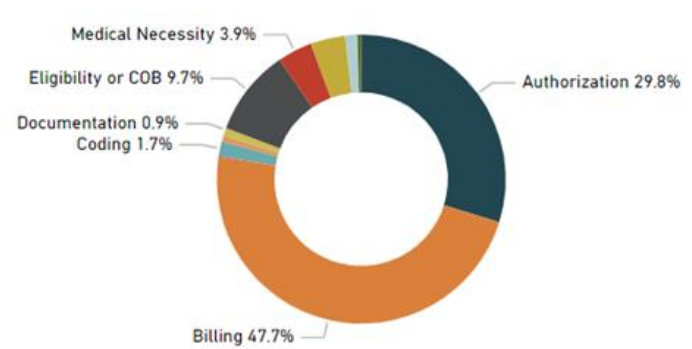


Full Denials by Value by Code

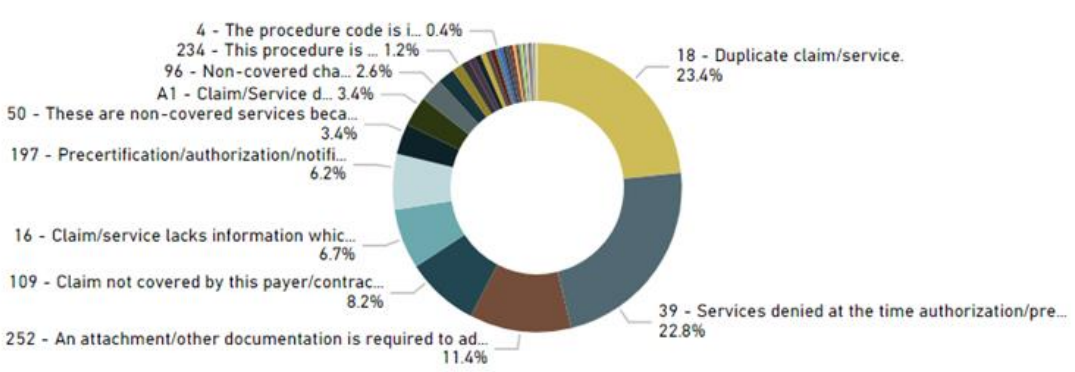


Payer: All | Payer Type: Medicare Advantage

Full Denials by Value by Category



Full Denials by Value by Code



What's coming?

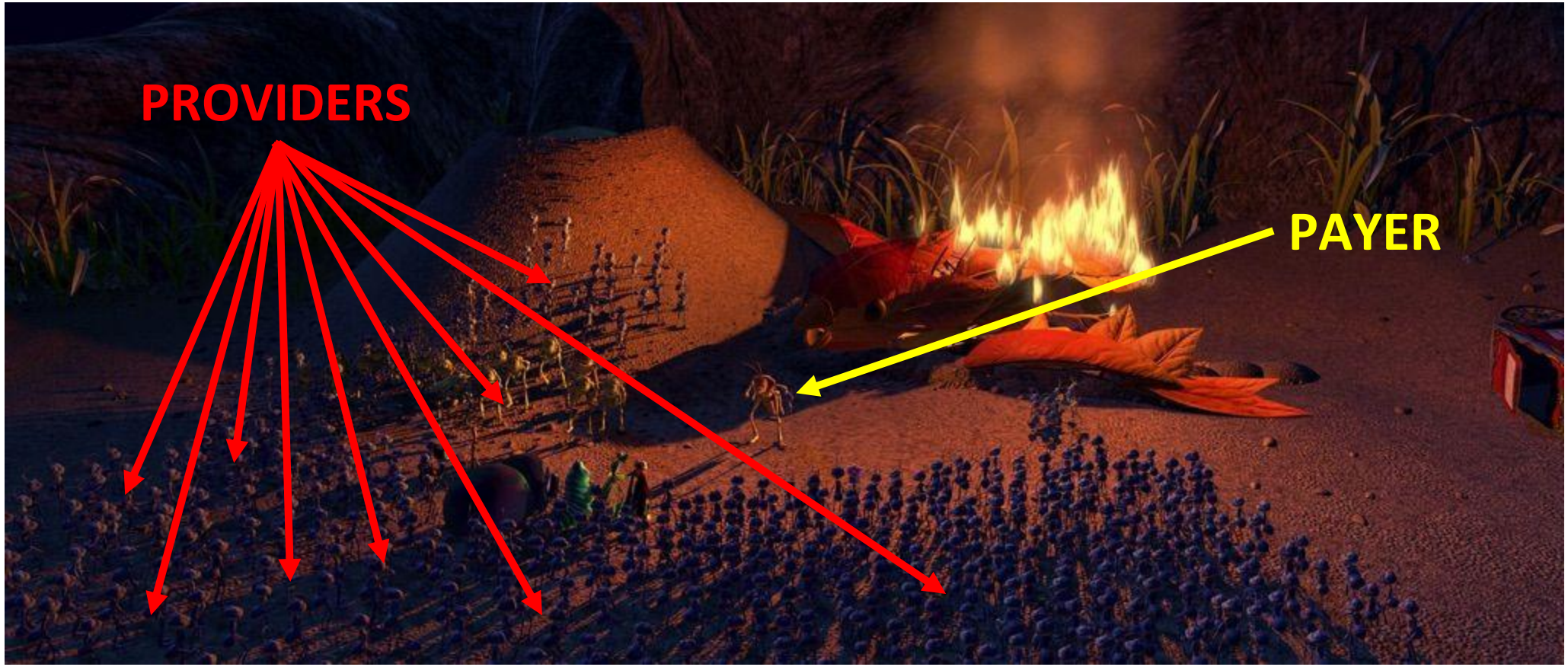
- **Pre-Authorizations**
  - In reviewing 837s, **25% of the claims provided an authorization**
  - What percent of claims with authorization still get denied for No Auth?

- **Downcoding**
  - What percent of claims are being downcoded with:
    - B10 – Allowed amount has been reduced….
    - 186 – Level of Care Adjustment
    - 150 – Payer deems the information submitted does not support this level of service
  - What percent of claims are being downcoded without being told?

SO WHAT? WHAT DO I DO WITH THIS?

- Peter Drucker: “**You can’t manage what do you can’t measure.”**
- National and State Associations need your data for ADVOCACY to help fight the battles. No more “Little Johnny – the payer is being mean”
- Providers need to know what is good vs better. Stop managing based on your data.
- Providers need to know, “is this just me or is everyone?”
- We don’t have the bandwidth…so, are you willing to tell the board that you know there is a problem, but you don’t have the resources to fix it?

This is the opportunity for providers to unite



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