Where Are We Stuck?

Using Analytics to Keep Cash Flowing

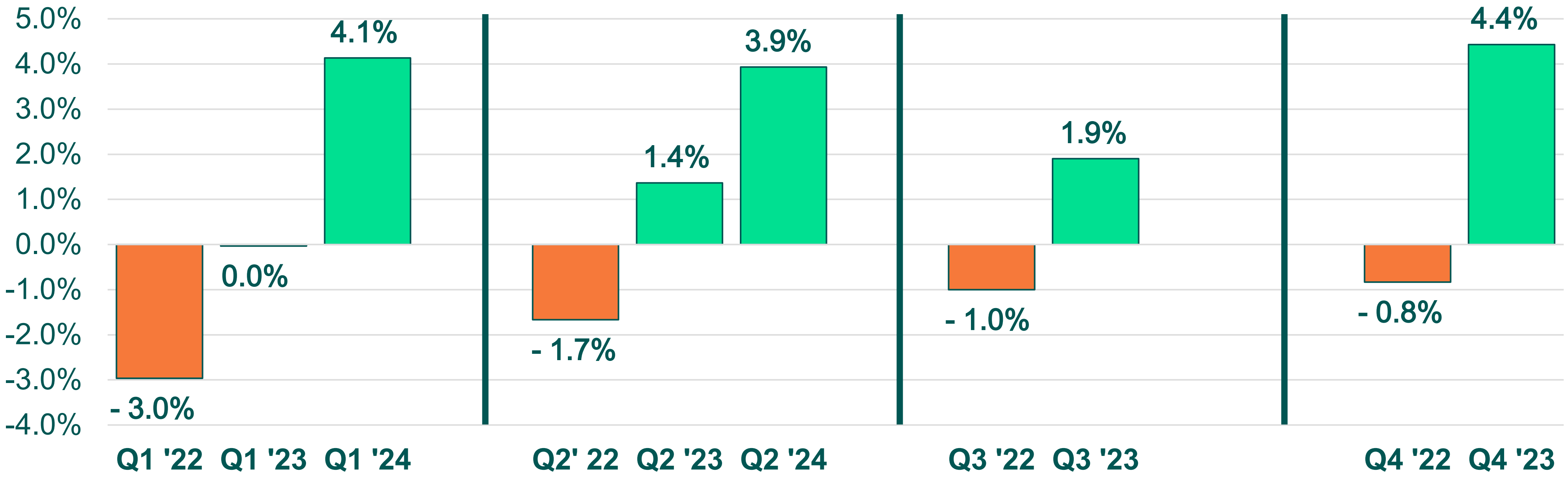
September 9, 2024

Market Dynamics

Recovery…

Operating Margin Recovery – by QTR

Hospital Operating Margin by QTR (KH Index)



https://www.kaufmanhall.com/insights-reports/national-hospital-flash-report

Kaufman Hall:

While financial performance looks solid on the surface, a closer examination of the data shows a greater divide between high- and low-performing hospitals…

Forty percent of hospitals in the United States are losing money…

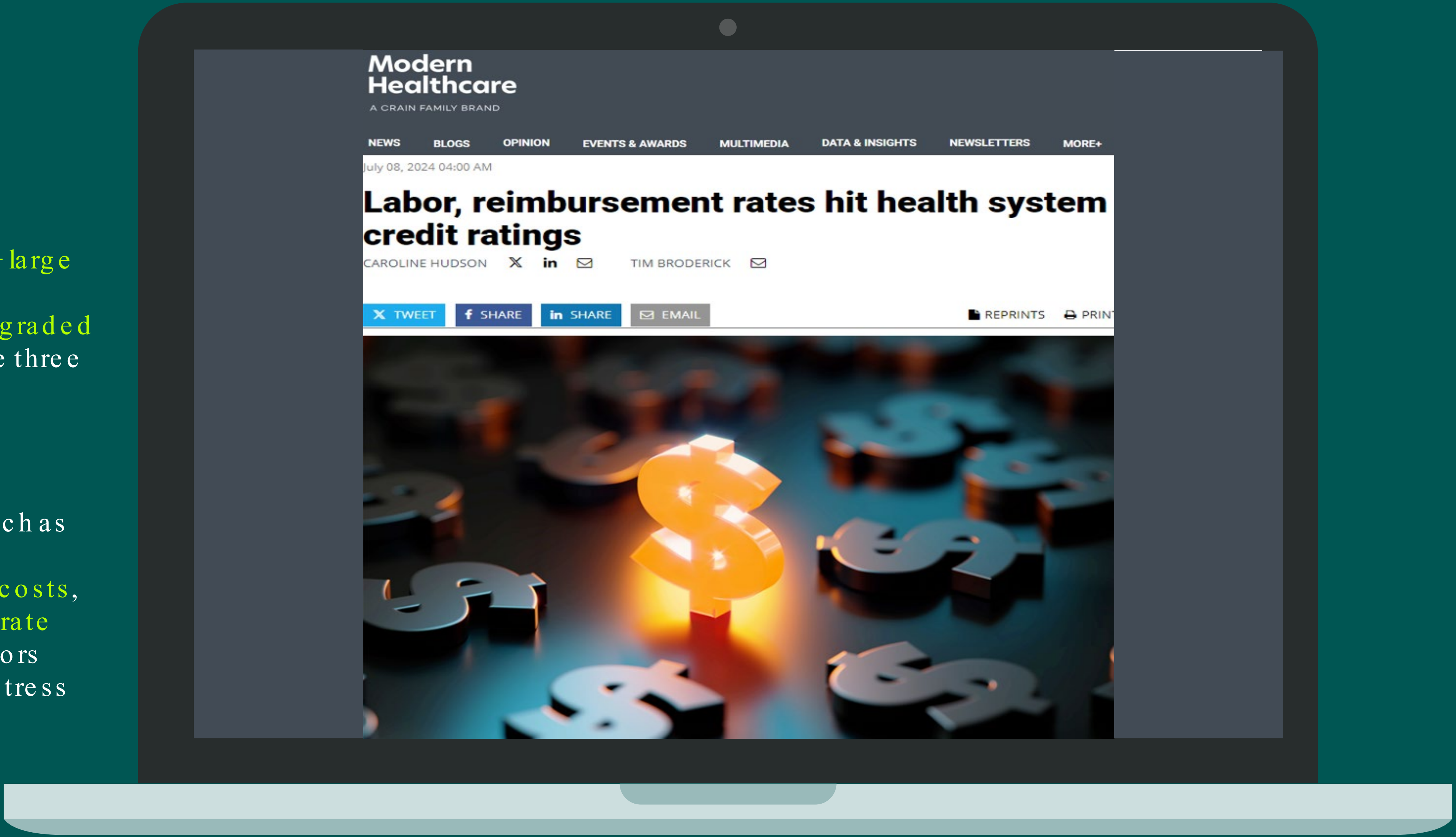
Organizations who have weathered the challenges of the last few years have adopted a wide range of proactive and growth-related strategies, including improving discharge transitions and a building a larger outpatient footprint.

– Erik Swanson, senior vice president of Data and Analytics, Kaufman Hall

https://www.kaufmanhall.com/news/hospital-and-health-system-financial-performance-improves-outlook-uneven

Revenues are up, but expenses are still outpacing:

- Through Q2 '24, **30+ large hospitals and health systems were downgraded** by at least one of the three largest credit rating agencies
- The agencies noted challenges such as inflated expenses, including **high labor costs**, and **reimbursement rate negotiations** as factors leading to financial stress

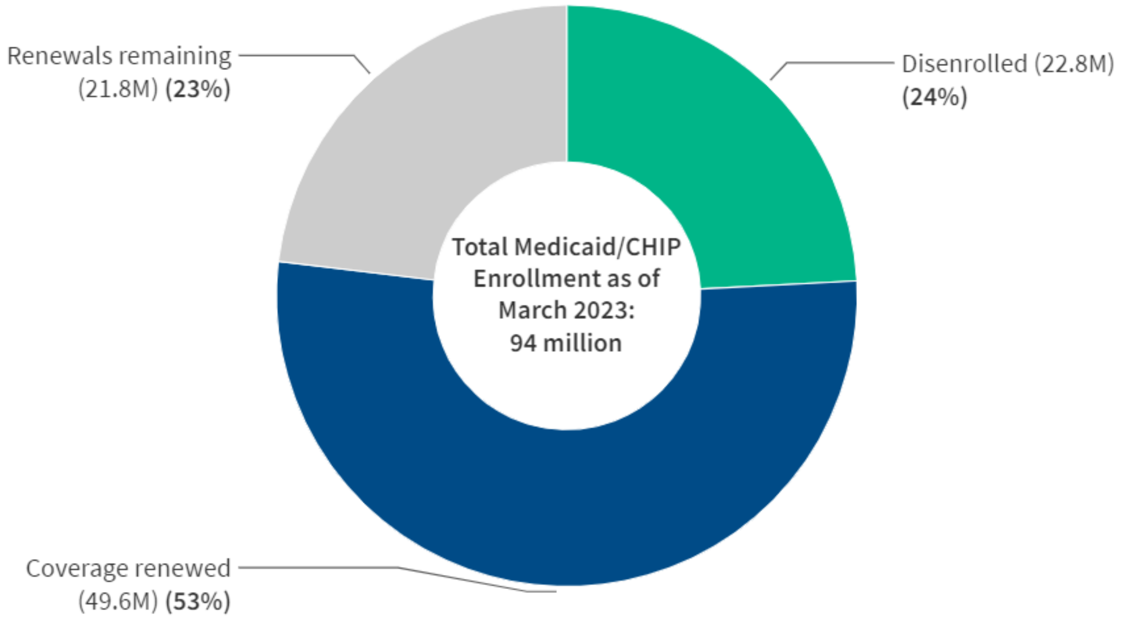


https://www.modernhealthcare.com/finance/hospital-credit-ratings-moodys-fitch-sp-global-2024

Medicaid Redetermination Status

As of June 4, 2024, States Have Reported Renewal Outcomes for Roughly Three-Quarters of People Who Were Enrolled in Medicaid/CHIP Prior to the Start of the Unwinding

Cumulative Medicaid renewal outcomes reported as a share of March 2023 Medicaid/CHIP enrollment:



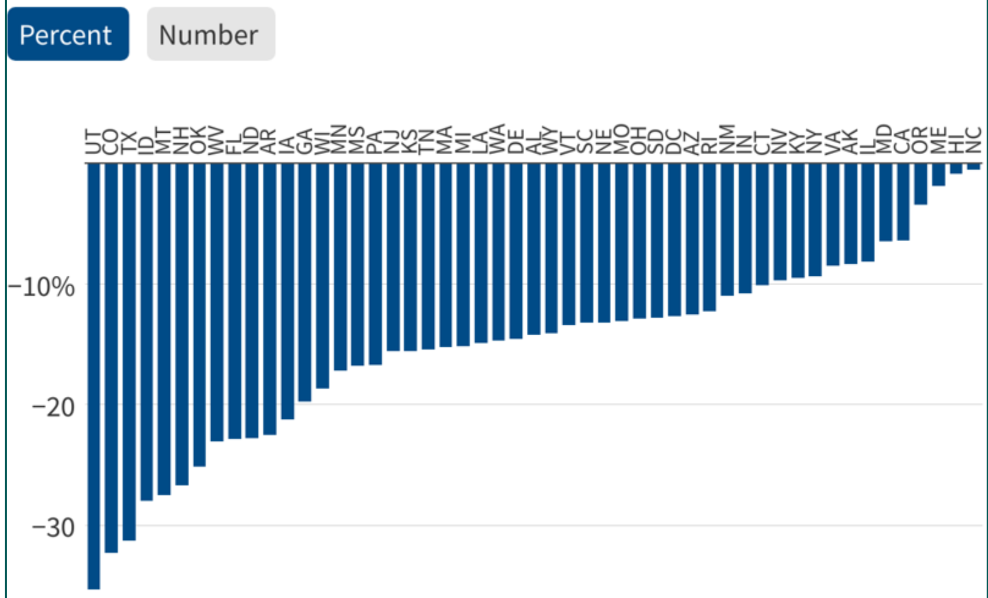
Note: Based on the most recent state-reported unwinding data available from state websites and CMS reports. Time periods differ by state. Baseline enrollment based on March 2023 Medicaid/CHIP Performance Indicator Data from CMS and excludes enrollees with partial benefits, though states may include partial benefit enrollees in their unwinding data. Some states' baseline month for enrollment was in February or April, rather than March 2023. The data source for one state (MA) does not include the number of people renewed at time of reporting.

Source: KFF Analysis of State Unwinding Dashboards and Monthly Reports to CMS. CMS Performance Indicator Data (March 2023 Medicaid/CHIP Enrollment). • Get the data • Download PNG

KFF

Net Medicaid Enrollment Declines Range From 35.3% in Utah to 0.5% in North Carolina

Based on the cumulative change in Medicaid/CHIP enrollment from baseline enrollment in 2023 through the most current time period available



Note: Time periods and data sources vary by state. Baseline enrollment is enrollment in the month before a state resumed disenrollments and varies by state. Data are taken from state websites or CMS Performance Indicator Data, depending on which is most current and complete.

Source: KFF Analysis of Medicaid enrollment data from state websites and CMS, as of June 4, 2024, Medicaid & CHIP: Monthly Application and Eligibility Reports

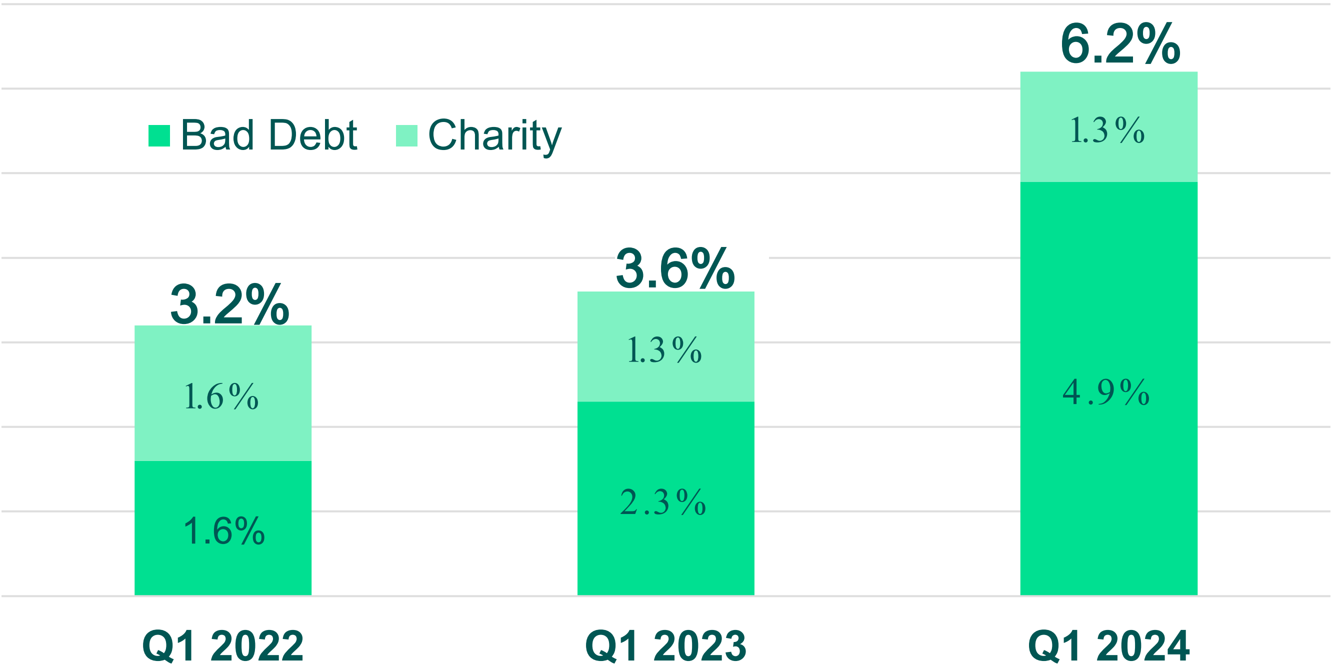
KFF

Medicaid Redetermination Status

Impacts to Provider Market:

- Majority of hospital margins are in low single digits
- 2-3% NPR represents $500K to $30M depending on size of hospital/system
- Providers will look to aggressively manage source(s) of bad debt:
    - Uninsured / unknown coverage
    - Transition bad debt to charity
    - Payer accountability tools (Prior Auth, Denials, Contract Mgr.)

Bad Debt and Charity 2022-2024



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CBO: Shift in payer mix and rise in uninsured anticipated

Projected health insurance coverage for people younger than age 65, by calendar year, 2022–33

	Actual, 2022[a]	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Population under age 65	271	271	271	271	271	271	271	271	271	272	272	273
Employment-based coverage	157	155	155	155	156	157	157	157	158	158	158	159
Medicaid and CHIP[b]												
Blind and disabled in Medicaid	8	8	7	7	7	8	8	8	8	8	8	8
Children in Medicaid	35	35	32	31	31	30	30	30	30	30	31	32
Adults made eligible for Medicaid by the ACA	17	17	15	14	14	14	14	14	14	15	15	15
Adults otherwise eligible for Medicaid	16	16	13	12	12	12	12	12	12	13	13	13
CHIP	7	7	7	7	7	7	7	7	7	7	6	5
Subtotal, Medicaid and CHIP	84	83	74	71	71	71	71	71	71	72	72	72
Nongroup coverage												
Marketplace[c]												
Subsidized	12	14	16	17	12	11	11	11	11	11	11	11
Unsubsidized	1	1	1	1	2	2	2	2	2	2	2	2
Subtotal	13	15	17	18	15	13	13	13	13	13	13	13
Off-Marketplace	3	3	4	4	5	5	5	5	5	5	5	5
Subtotal, nongroup coverage	17	19	21	22	20	18	18	18	18	18	18	18
Basic Health Program[d]	1	1	1	1	1	1	1	1	1	1	1	1
Medicare[e]	7	7	7	7	7	7	7	7	7	7	7	7
Other coverage[f]	3	3	3	3	3	3	3	3	3	3	3	3
Uninsured[g]	24	23	25	26	27	28	28	28	28	28	28	28
People with multiple sources of coverage	22	20	15	14	14	14	14	14	14	14	14	14
Insured people	247	248	246	245	243	243	243	243	243	244	245	245
Uninsurance rate (%)												
Including all US residents	8.7	8.3	9.3	9.7	10.1	10.4	10.4	10.4	10.2	10.2	10.1	10.1
Excluding noncitizens not lawfully present	6.8	6.4	7.3	7.7	8.2	8.6	8.5	8.5	8.4	8.3	8.3	8.2

ESI "flat" (0 M)

Medicaid DOWN (9M)

HBE UP (2M)

Uninsured UP (2M)

Insured DOWN (2M)

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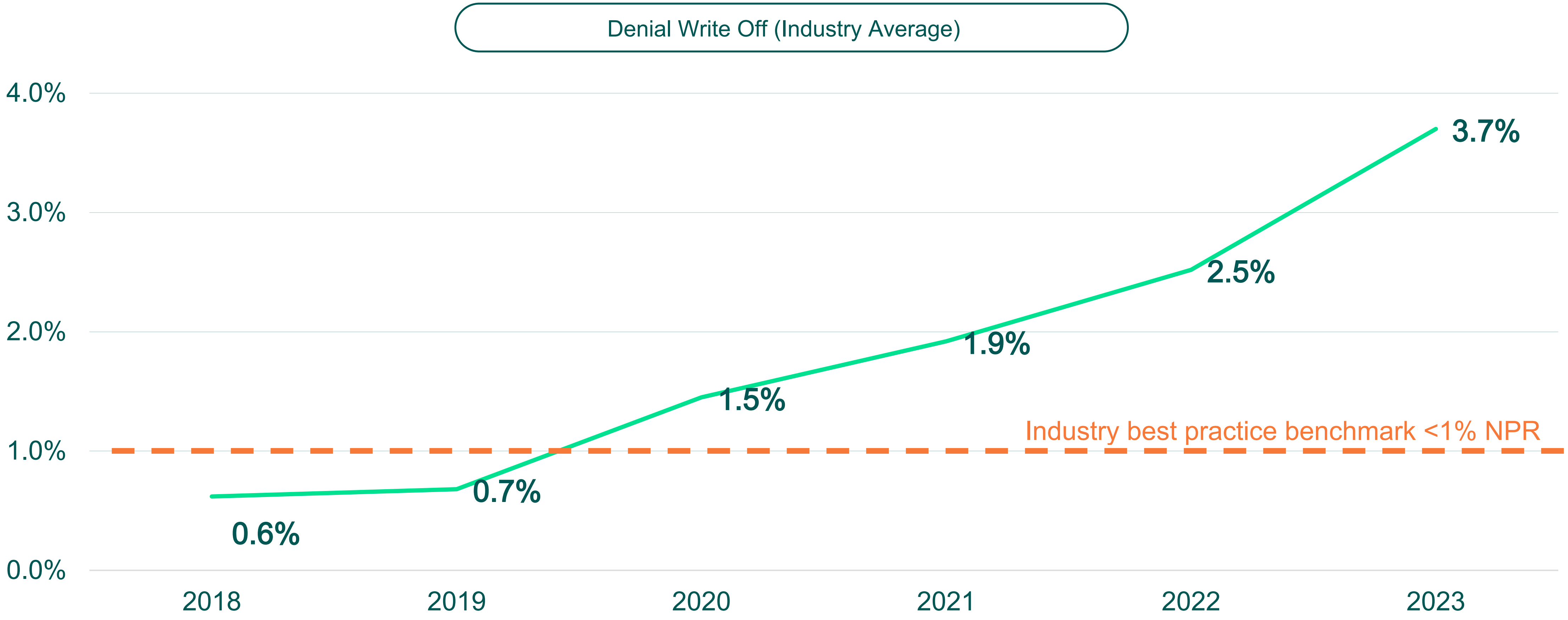
https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2023.00325

Denials are 3X Since 2018



Source data: Clarivate 2023: https://clarivate.com/products/healthcare-business-insights

Patient Experience


REWE
STOP

Why is it So Hard for Consumers to Pay for Healthcare?

Care and Payment are Not Equal

≠

Business Issues

Patient

Common patient complaints [1]

- Scheduling difficulties
- Disagreements with staff
- Feeling unheard
- Insufficient time with the doctor
- Long wait times
- Confusion with insurance and billing

Top patient priorities for healthcare payments [2]:

- 60% want affordable payment options
- 58% need clear communication
- 55% seek transparency on out-of-pocket costs

Demand for digital solutions

- 84% want digital access to insurance and billing info
- 80% prefer digital communication channels at least part-time
- 49% desire digital check-in before appointments
- 44% interested in digital engagement with providers pre-visit, during, and post-visit

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Healthcare consumers are expecting their experiences with providers to mirror those in the retail/consumer space.

Especially as patients take on more financial responsibility under high-deductible health plans.

1
2
3
4
5
6

McKinsey quarterly survey

52%

of consumers would pay from
$200 to $500 or more up front
if an estimate was provided
at the point of care

74%

of insured consumers indicated that they
are both able and willing to pay their
out-of-pocket medical expenses
up to $1,000 per year
(90% up to $500/yr.)

SOURCE: JPM Key trends in healthcare patient payments

Impacts to Revenue Cycle

Patient Access in the Dark

Due to outdated the deployment of disparate solutions, health systems and practices are burdened with:

- Lack of visibility into performance and results
- Inability to identify loss and areas to increase net revenue
- Unable to access data in a timely manner to isolate root causes and take corrective action

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Business Issues

Health Systems

Data accuracy

- Inaccurate patient registration data
- Outdated patient contact information

Insurance and billing

- Insurance claim denials
- Compliance challenges

Revenue and collections

- Inability to provide accurate patient estimates
- Need for upfront point-of-service collections

Operational inefficiencies

- Paper-based admission notifications
- Order management inefficiencies

Charity care

- Determining eligibility

Staffing issues

- Staff retention/recruiting

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Patient Access Challenges

Healthcare is bogged by Denials, Resources, Collections, Errors & Regulations

$4.9 million in losses
Significant annual financial impact per hospital due to denials

50% of claim denials could be prevented
Staff often lack the time and resources to get it right the first time

Only 50% - 70% of patient balances collected
Providers typically collect just 50-70% of patient balances after a visit

46% registration error rate
Registration professionals collect 70% of billing data, yet the average error rate is 46%

70% struggle with compliance
Over 70% of providers find achieving compliance to be a significant burden

$8.6 billion per year in missed revenue
Attributable to claim denials and high administrative costs

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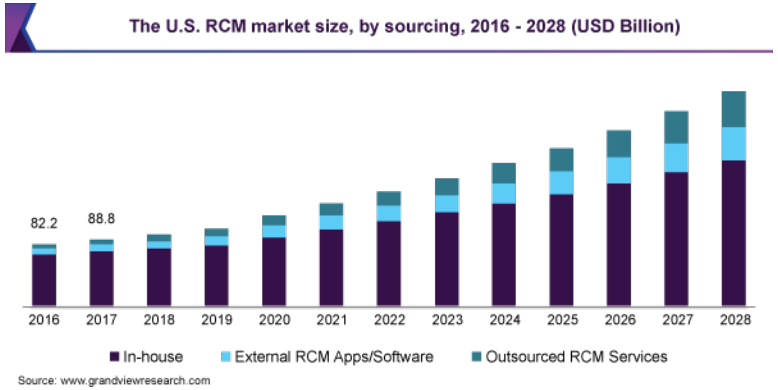
RCM technology market has responded with mixed results

RCM vendor-fest

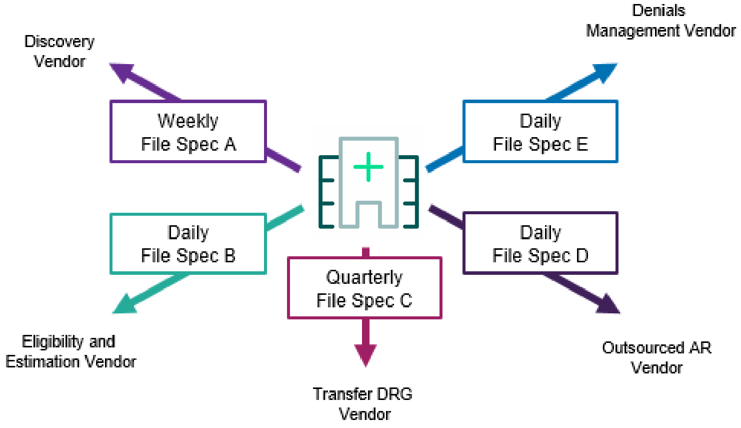


Disparate results

69% of Hospitals Use Multiple Vendors for Revenue Cycle Management

Most hospitals use their EHR system and at least one other vendor solution for revenue cycle management, but using multiple solutions led to claim denials issues.

Vendor cost / maintenance



The “frankencycle”

Common concerns from RCM leadership

- What is outside my core EHR and why?
- What RCM technology is in place today?
- What is my total cost of ownership?
- Has the yield from the solutions improved?
- What are the IT and data connections?
- What is my strategic path to RCM excellence?
- Where can automate or leverage predictive analytics?
- How many vendors do I need?

- RCM vendor performance has been **difficult** to measure, **expensive** to maintain, and **duplicative** in offerings

- Hospitals are closely evaluating third party relationships – looking to **consolidate** or **eliminate**

Best Practices

Patient Financial Clearance

Area of Interest Survey 2024 Results

87 Respondents
CFO, CRO, VP RCM, Director
> $500M/ 150 Beds

Objective: Identify top strategic and departmental goals, supporting initiatives, and planned investments by stakeholder

Respondents most likely to have planned investments in…

Patient Access Technology

Stakeholder

- VPs/Directors of Patient Access
- VPs/Directors of Patient Experience
- CFOs/CROs/VPs/Directors of RCM

Primary AOI

- Increase Revenue
- Increase Patient Satisfaction

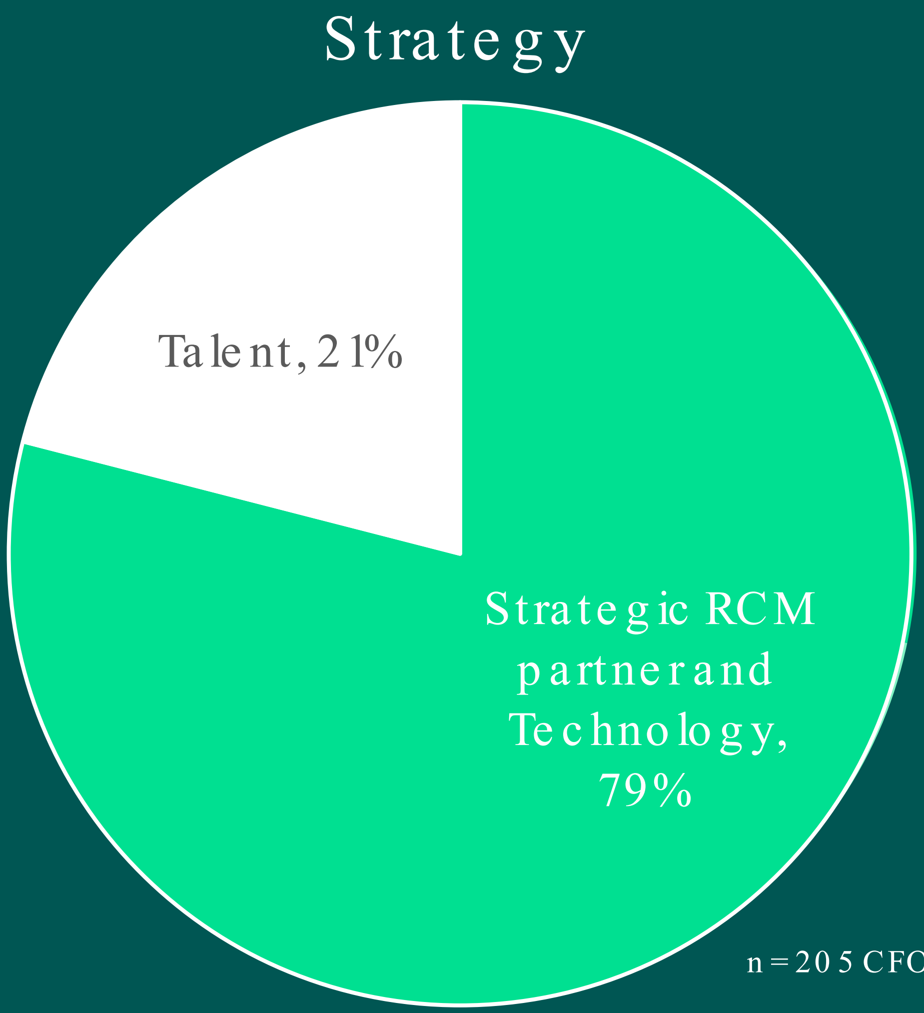
Key Initiatives *that align to Patient Access:*

Increase Revenue
- Reduce denials
- Improve the prior authorization process
- Improve patient payment experience
- Increase CDI impact
- Improve POS collections

Improve Patient Satisfaction
- Improve the scheduling experience
- Improve the patient experience
- Improve payment estimation accuracy
- Expand EHR portal capabilities

Approaches to enhancing revenue management

Strategic focus



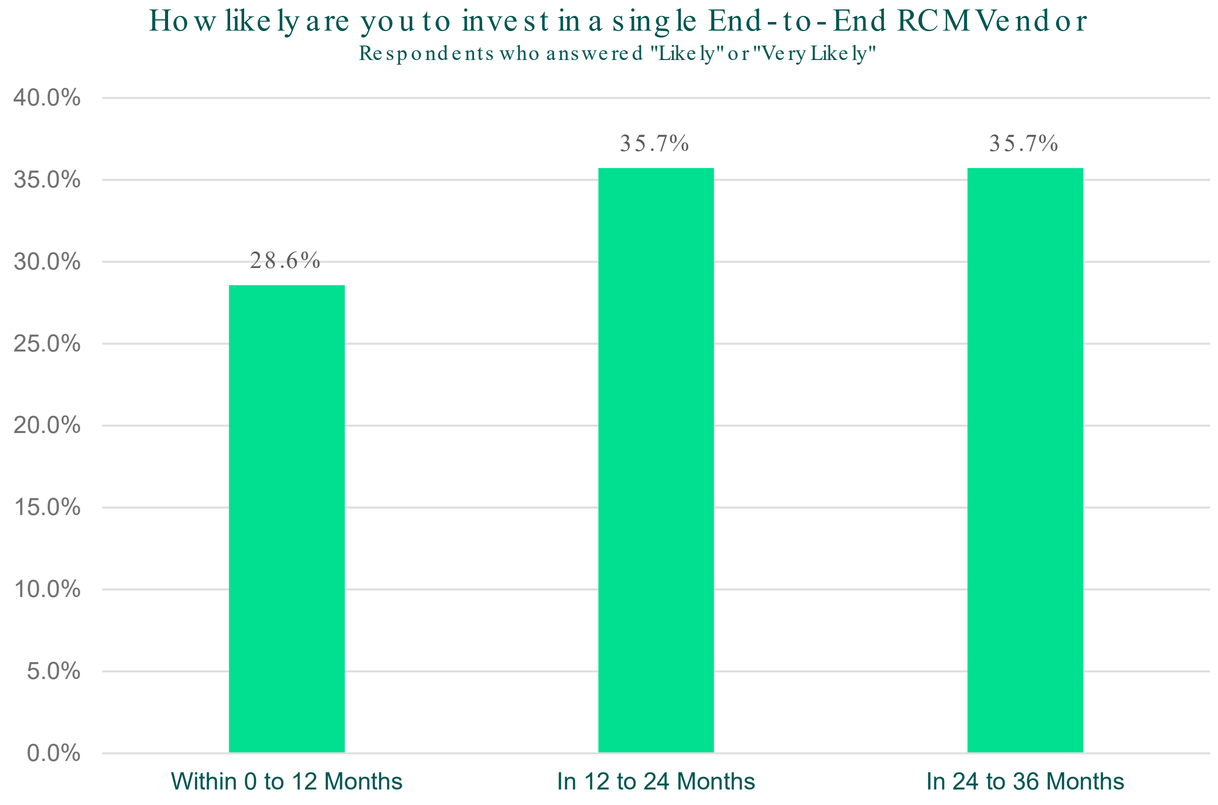
n = 205 CFOs and vice presidents of revenue cycle

https://akasa.com/press/filling-the-gaps/
https://www.hcinnovationgroup.com/finance-revenue-cycle/revenue-cycle-management/news/21272867/survey-cfos-rcm-vps-facing-severe-cost-staffingshortage-challenges

Almost 2/3 of healthcare finance leaders will invest in a single vendor Revenue Management Platform within 12 - 24 months.

The shift to End-to-End has begun:

- 29 percent of healthcare financial executives expect to make investments in the next 12 months.
- More significant short-term investment plans can be found in pockets, such as with large IDNs.



Source: FinThrive AlphaSights CFO Survey

Rethinking revenue management in the healthcare ecosystem

Less complexity by consolidating vendors

Reduced level of IT work

Improved data security

Improved cost-efficiencies

Higher ROI from solution synergy

Best-in-breed solutions

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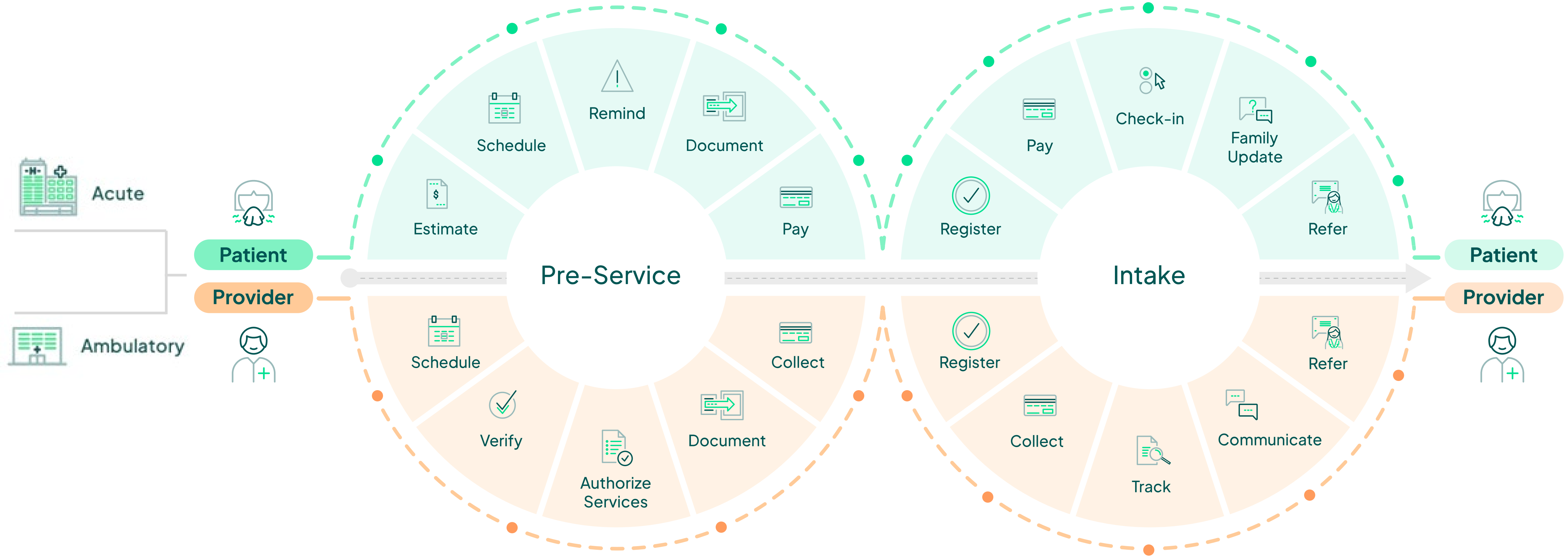
Improve Patient Convenience with Seamless Integration

Patient Access Technology



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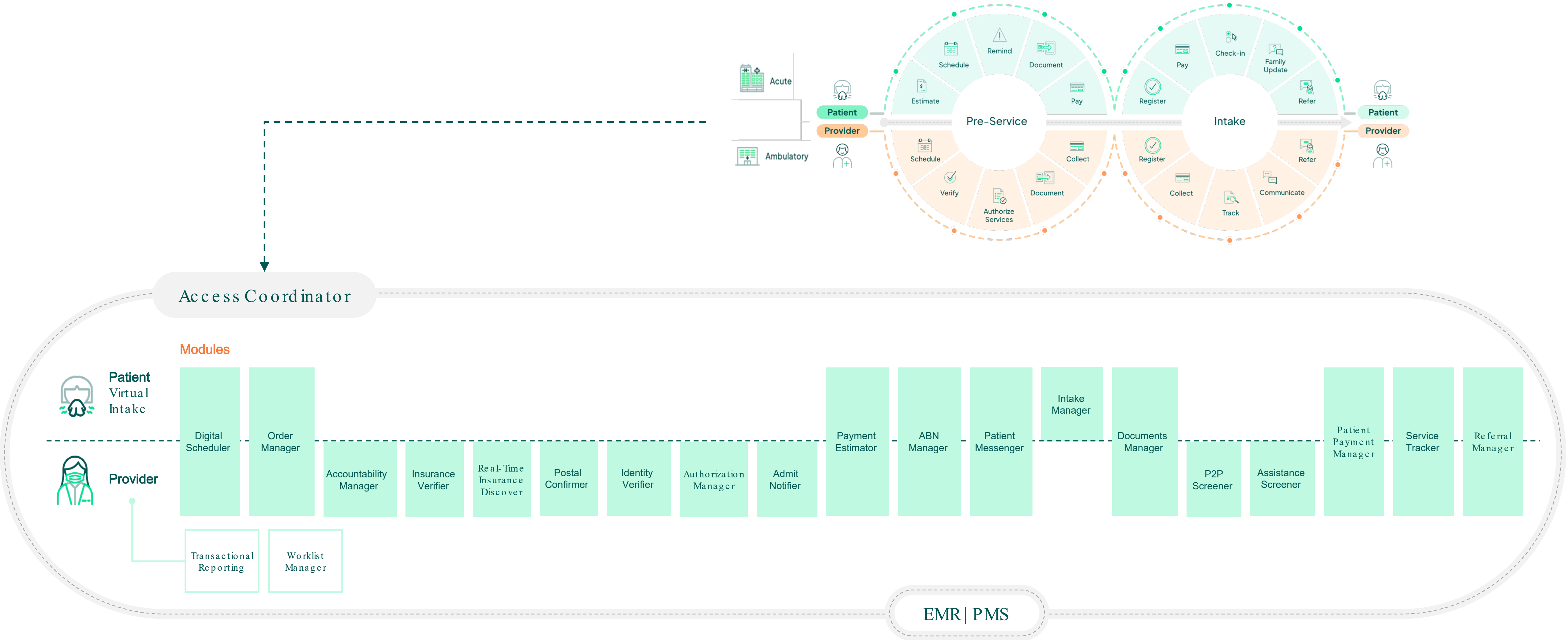
A Holistic Patient Access Experience



Checklists/Gates:

Eligibility

- Insured/Self Pay
- 270/271 EMR
- 3rd party

Verification

- Benefits
- Auth/Referral/ Notification
- Med nec

Estimation

- Matrix
- Estimator
- P2P
- FPL

Collection

- Preservice
- POS
- Payment Plans
- Loans/Credit

✓ Proceed/document

✗ Stop/escalate

End-to-End Insurance Verifier & Discovery

Real-time Verification & Insurance Discovery at POS

24-hr coverage discovery that keeps your billing timely

Correct case manager + Assign correct primary payer + Reduce recoupments

Post-service coverage discovery

Reduce bad debt

Quick Registration	Full Registration	Charge Capture	Bill Claim
Point Of Registration	Time-of-Service	Pre-Final Bill	Post-Final Bill
Front Office			Back Office

Rapidly Determine…

Identity verification

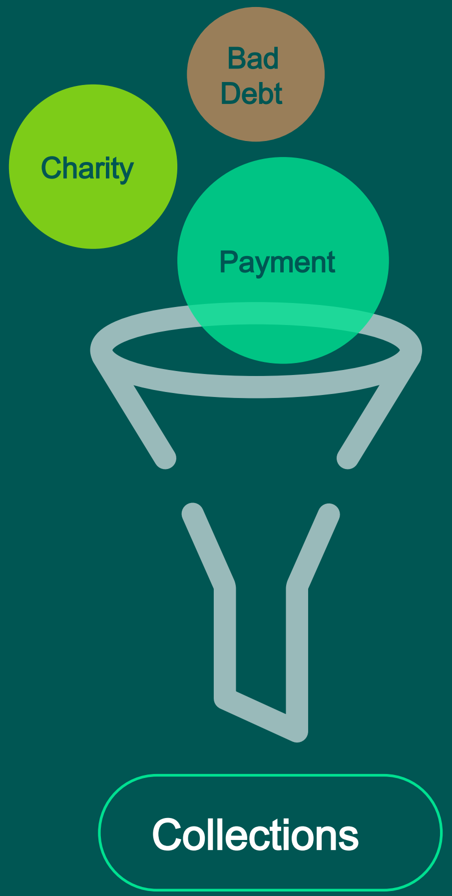
- Prevent fraud
- Reduce reject mail

Presumptive charity

- Balance bad debt portfolio
- Re- class as charity

Propensity to pay

- Prioritize high balance accounts
- Increase POS collections and cash flow
- Help patients truly in need and collect from those who can pay



Identity Verification – Data Return

Status Message	What Does It Mean?
Red Flags	A trigger occurred on a patient file that may signal potential identity theft, such as a SSN used in a death benefit or a fraud victim alert.
Investigate Warnings	There are alerts or warnings on the patient's credit file that require further investigation, such as a SSN not issued prior to 2011, but they are not serious enough to be flagged as Red Flags.
Verify Demographics	There are demographic discrepancies between the patient input and returned data, but there are no credit alerts or warnings associated with the patient's file.
No Record Found	There is no credit history for the patient, such as a minor or person located outside the U.S.
Accurate	There are no demographic discrepancies or alerts on the patient's file.

Identity Verification Metrics

Recover more money with complete and accurate patient identity and contact information

Account Number	Last Name	Returned Last Name	SSN	Returned SSN	Address	Returned Address	Identity Verification Status	Warning Message
D0 40 21840	SMITH	Miller		97865432		156 Main Street	Accurate	
D0 40 08755	SMITH	Smith	12345678	97865432	157 MAIN STREET	157 Main Street	Accurate	
D0 40 05289	SMITH	Smith	12345678	97865432	208 MAIN STREET	208 Main Street	Accurate	
D0 40 22243	SMITH	Smith	12345678	97865432	210 MAIN STREET	210 Main Street	Accurate	
D0 40 1						treet	Investigate Warnings	INPUT SUBJECT ADDRESS DOES NOT MATCH FILE ADDRESS
D0 40 (						treet	Investigate Warnings	INPUT SUBJECT SSN DOES NOT MATCH FILE SSN
2377849	SMITH	Smith	12345678	97865432	158 MAIN STREET	158 Main Street	Investigate Warnings	Address Has Been Reported More Than Once
D0 40 10453	SMITH	Smith		97865432		179 Main Street	Investigate Warnings	INPUT SUBJECT SURNAME DOES NOT MATCH FILE SURNAME
D0 40 21461	SMITH	Smith		97865432	203 MAIN STREET	203 Main Street	Investigate Warnings	INPUT SUBJECT SSN DOES NOT MATCH FILE SSN
D0 40 05534	SMITH	Smith	12345678	97865432	205 MAIN STREET	205 Main Street	Investigate Warnings	INPUT SUBJECT ADDRESS DOES NOT MATCH FILE ADDRESS
D0 40 (						Street	Red Flags	***Red Flag Alert***Address Has Been Reported Misused and Requires Further Investigation
D0 40 1						et	Red Flags	***Red Flag Alert***Address Is A Restaurant /Bar/Night Club
D0 40 (						in Street	Red Flags	***Red Flag Alert***Address Is A Hotel/Motel Or Temporary Residence

There are alerts or warnings on the patient's credit header file that require further investigation, but they are not serious enough to be flagged as Red Flags

- A trigger occurred on a patient file that may signal potential identity theft
- Provider should follow-up and seek further information
- Built-in alerts help fulfill the FTC Red Flag Rule requirements

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Charity Assistance – Data Return

Metric	What Does It Mean?
Federal Poverty Level (FPL) %	Helps determine the patient’s financial situation relative to the federal government’s standard for poverty.
Estimated Household Income	The monthly estimate is determined by analyzing individual level credit characteristics from a consumer’s credit file.
Estimated Household Size	The estimate is determined by analyzing individual level credit characteristics from a consumer’s credit file.
Financial Aid Status	Compares Financial Aid metrics against end - user defined thresholds and returns a status message, such as Meets Charity Guidelines.

Charity Screening Stratification

Segment accounts for presumptive charity care using credit and community-based models

Hospital Charges	Account Number	Min. Monthly HH Income	Family Size	Percent of Federal Poverty Level (FPL)	Financial Aid Status	Hit	FPL Model
$525.00	D04007296	$1,100	2	85.11%	Complete FA App / PE Charity	Y	comm-based
$188.65	[illegible]	[illegible]	[illegible]	[illegible]	Complete FA App / PE Charity	Y	comm-based
$400.00	D04008992	[illegible]	2	[illegible]	Complete FA App / PE Charity	Y	credit-based
$597.00	D04000053	$1,700	4	86.62%	Complete FA App / PE Charity	Y	credit-based
$440.91	D04003583	$2,333	2	180.53%	Needs-Based Discounting	Y	credit-based
$3,403.10	D04006259	$1,710	1	178.59%	Needs-Based Discounting	Y	comm-based
$277.27	D04021577	$1,823	1	190.43%	Needs-Based Discounting	Y	credit-based
$1,300.00	D04013397	$4,790	4	244.08%	Discount to Sliding Scale	Y	credit-based
$76.71	[illegible]	[illegible]	[illegible]	[illegible]	Discount to Sliding Scale	Y	credit-based
$35.80	D04008210	$2,943	2	227.72%	Discount to Sliding Scale	Y	credit-based
$122.61	D04011388	$8,373	4	426.67%	Pursue Payment Arrangement	Y	credit-based
$175.50	[illegible]	[illegible]	[illegible]	[illegible]	Pursue Payment Arrangement	Y	credit-based
$75.00	D04007387	$5,803	2	449%	Pursue Payment Arrangement	Y	credit-based

Determine presumptive charity care based on FPL%

Configure FPL ranges and status message according to your provider customers' financial assistance policy

Use credit-based and/or community-based models to help financially assess patients

Likelihood of payment – Data Return

Metric	What Does It Mean?
Available Credit	Displays the amount of revolving credit available on credit cards that can be used to pay for patient responsibility amounts.
New Account Score	Determines the likelihood that a Patient will pay a **new** healthcare bill
Recovery Score	Determines the likelihood of collecting on an **existing** healthcare bill
Propensity to Pay Status	Compares Propensity to Pay metrics against end-user defined thresholds and returns a status message, such as Collect in Full, or Refer to Bad Debt.

Payment Indicators: Point-of-Service

Determine the optimal payment workflow for accounts

Account Number	Available Credit	New Account Score	Active Bankruptcy	Propensity to Pay Status
D04010931	$14,954	840	NO	Collect in full at time of service
				Collect in full at time of service
				Collect in full at time of service
D04004034	$30,207	674	NO	Collect in full at time of service
D04006259	$8,065	663	NO	Offer discounts / payment plan
D04022243	$8,100	662	NO	Offer discounts / payment plan
D04003681	$2,721	663	NO	Offer discounts / payment plan
D04005683	$3,091	606	NO	Offer discounts / payment plan
D04008974	$3,601	502	YES	Offer discounts / payment plan
D04019111	$12	478	NO	Screen for Medicaid / Charity
D04006047	$0	458	NO	Screen for Medicaid / Charity
D04006681	$47	492	YES	Screen for Medicaid / Charity
D04004359	$0	437	NO	Screen for Medicaid / Charity

Configure Propensity to Pay status messages according to your provider customers' collection policies

Payment Indicators: Post-Service

Focus resources on the most collectable accounts

Hospital Charges	Account Number	Available Credit	Recovery Score	Has Mortgage	Collection Status
$1,100.00	D040 10931	$14,954	640	YES	High Propensity to Pay: send to automated dialer
$175.50	D0400 1745	$39,817	632	YES	High Propensity to Pay: send to automated dialer
$1[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	High Propensity to Pay: send to automated dialer
$[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	High Propensity to Pay: send to automated dialer
$3,403.10	D0400 6259	$8,065	662	NO	Moderate Propensity to Pay: send to early-out collection agency
$101.00	D0400 3681	$2,721	663	YES	Moderate Propensity to Pay: send to early-out collection agency
$74.70	D0400 5683	$3,091	708	YES	Moderate Propensity to Pay: send to early-out collection agency
$50.00	D0400 7573	$100	634	YES	Moderate Propensity to Pay: send to early-out collection agency
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Moderate Propensity to Pay: send to early-out collection agency
$525.00	D0400 7296	$0	597	NO	Moderate Propensity to Pay: send to early-out collection agency
$8,480.85	D040 19111	$0	478	NO	Seek State or Local Funding
$600.00	D0400 6047	$0	458	NO	Seek State or Local Funding
$150.00	D0400 6681	$0	492	NO	Seek State or Local Funding
$1,200.00	2377849	$0	437	NO	Seek State or Local Funding

Determine likelihood of collections based on customizable thresholds for propensity to pay, such as available credit information and credit score ranges

Configure propensity to pay status messages according to your provider customers' follow-up strategies

“What” Does Analytics Support?

Intelligence

Intelligence

Defined by Merriam-Webster

1. intelligence is the **ability to learn** or understand or to deal with new or trying situations

2. the **ability to apply knowledge** to manipulate one's environment or to think abstractly as measured by objective criteria

What: Intelligence IN Six (6) Core Categories

Patient Access

Account Resolution

Pre-Billing

Financial Management

Claims

Productivity

Five (5) of Six (6) categories align to HFMA MAP Keys; 6th category is for physician productivity

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What: Intelligence IN Six (6) Core Categories
KPI Examples

POS Collections

A/R>90 by Payer

DNFB

Denial Write-off %

Clean Claim Rate

RVUs

Five (5) of Six (6) categories align to HFMA MAP Keys; 6th category is for physician productivity

What: Intelligence **IN** and **ACROSS** Six (6) Core Categories
Platform Effect

POS Collections

A/R>90 by Payer

DNFB

Denial Write-off %

Clean Claim Rate

RVUs

Bringing data from multiple sources together to provide additional context to the data

Top Providers

Productivity + Revenue

Top Payers

Collections + Denials + Underpayments + Mix

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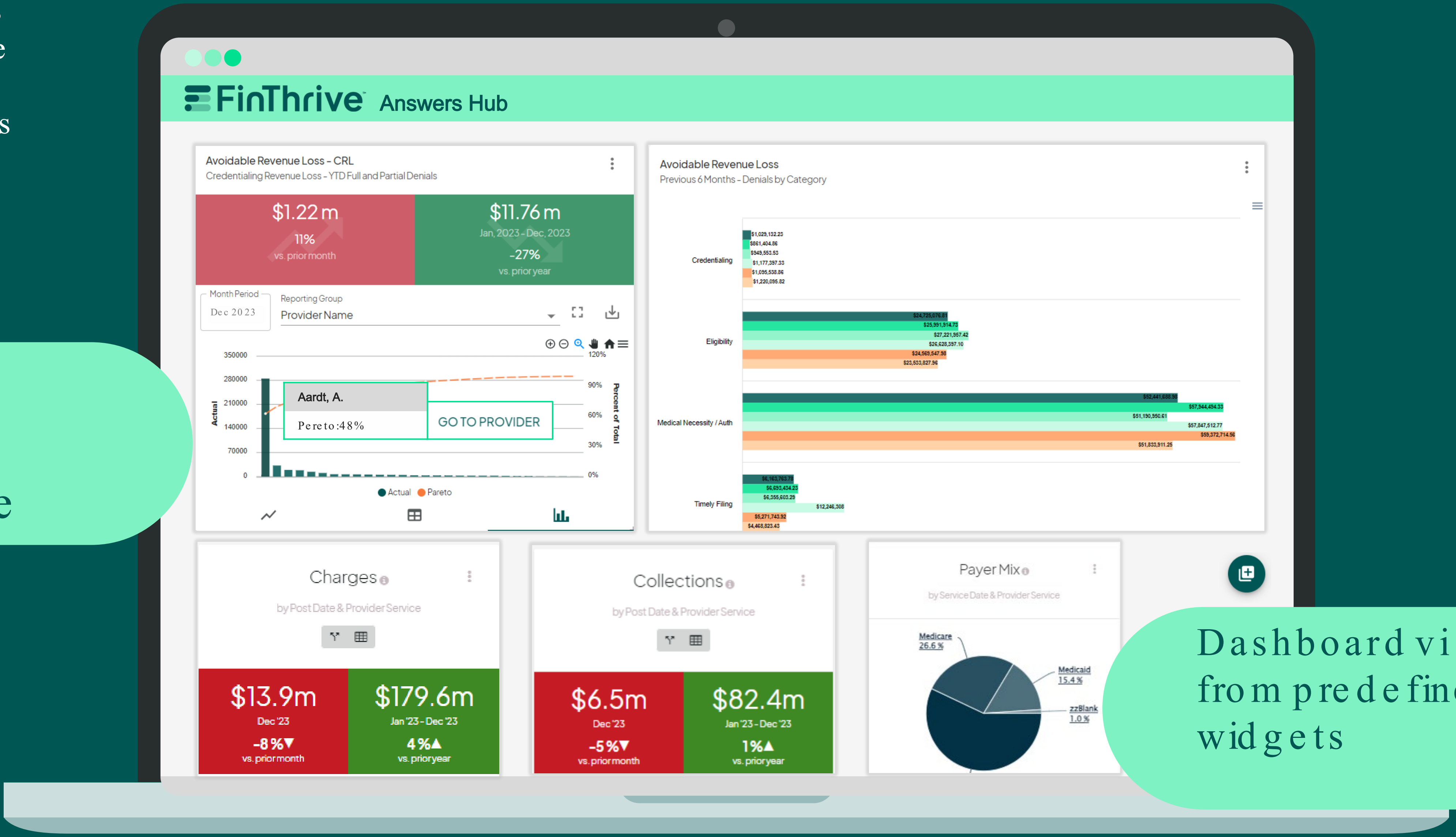
Actionable insights built to answer the most important revenue questions healthcare executives have today

Scorecard revenue performance



Dashboard views from predefined widgets

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Patient Access Technology

Benefits

Enhancing patient and staff experiences for better care and satisfaction

- ✓ Modern scheduling experience
- ✓ Real- time patient communication
- ✓ Streamlined check - in
- ✓ Simplified document management
- ✓ Prevent claim issues and clarify payment responsibilities
- ✓ Quickly verify payer details and ensure faster payment turnaround
- ✓ Simplified patient payments and accelerated cash collection
- ✓ Automated prior authorizations and admission notifications
- ✓ Efficient medical necessity determination
- ✓ Streamlined ability to pay calculations and charity care applications
- ✓ Prevent medical identity theft
- ✓ Enhanced staff efficiency
- ✓ Optimized referral process
- ✓ Improved performance insights

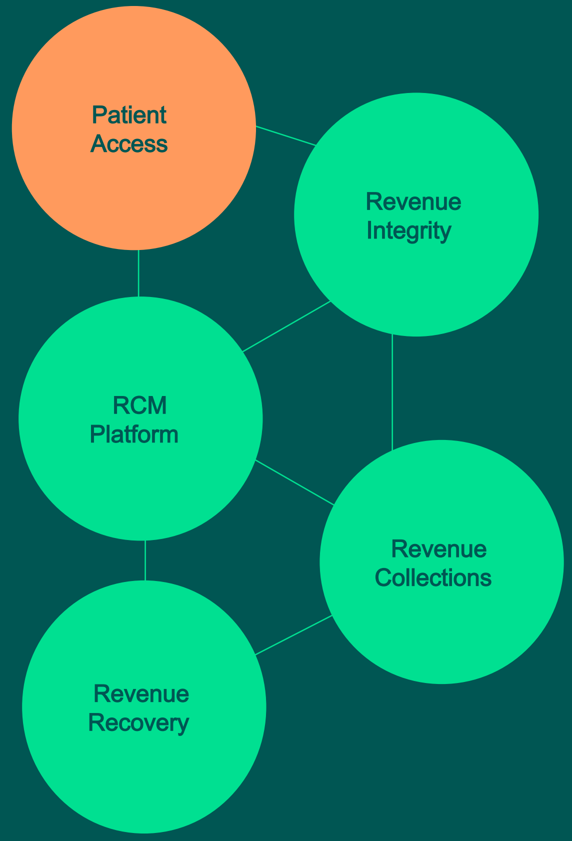
RCM Platform Effect

PATIENT ENGAGEMENT	FinThrive	Vendor 1	Vendor 2
Patient Self-Scheduling	x	x	
Bi-Directional Patient SMS Messaging	x		
Caregiver/Family + SMS Messaging	x		
Automated Appointment Reminders	x	x	
GFE-compliant Patient Estimations	x	x	x
Pre-Visit Digital Patient Payments	x	x	x
Patient Digital Signature Capture	x		
Patient Self-Check In	x	x	
Facility Wayfinding	x		
PATIENT ACCESS	**FinThrive**	**Vendor 1**	**Vendor 2**
Waitlist Management and SMS Wait Times	x		
Patient Identify and Address Verification	x	x	x
Real-Time Eligibility & NOA	x	x	x
Pre-Visit Insurance Discovery	x	x	x
Automated Prior Authorization	x	x	x
Advanced Propensity to Pay	x		x
Charity Screening	x	x	x
Registration QA	x	x	x
Price transparency (shoppable services & MRF)	x	x	

Platform Effect

- Payer contracts drive industry leading Patient Estimation accuracy
- Eligibility clearinghouse brings integrated connectivity with majority of payers to facilitate transactional workflows

- Patient estimation used to drive pre-visit personalized, omnichannel patient engagement and payment capture
- Data flow RCM platform analytics drive end-to-end visibility and accountability to outcomes.
- Bi-directional integration with EHR ensures patient updates are reviewed and fed back into source of truth

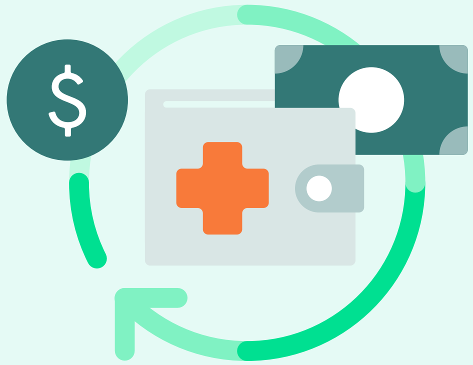


Value Story

Enhancing Patient Access with Technology

Patient Clearance and Accuracy

- 83% accuracy rate identifying insurance (exceeding expectations)
- Immediate insurance validation cut denial response time by 30 - 45 days
- 75% of patients cleared before care
- 93% Accuracy Rate from Estimates
- Eligibility - related denials decreased to almost “0”



Financial Impact

- 50% increase of pre - service payments
- 500% increase of POS payments
- Achieved 4,500% increase in monthly POS collections in 13 months, leading to an 8x ROI in one year
- Up-front collections went from $200 to $10,000+ per month

Efficiency and Appointment Management

- Saved 30 hours per week compared to manual verification with real - time insurance discovery
- 30 - minute decrease in appointment times
- The average billing experience rating is 4.3/5, with self - service plans at 74%, contributing to a significant saving of 102,000 staff hours since 2020 upfront

"These tools provide value for our patients and greatly benefit our staff, improving their efficiency and freeing them to better address patient care."

Nina Dusang

Chief Financial Officer

DCH Health System

Real Results

McCurtain Memorial Hospital Cuts Weekly Verification Time by 30 Hours with Real-Time Insurance Discovery*

Before FinThrive

- Manual data entry process for insurance checks was time-consuming
- Fragmented workflows due to multiple platforms lead to inefficiencies and potential errors
- Processing delays impacted operational efficiency, revenue and patient care

After FinThrive

30	Saved **30 hours per week** compared to manual verifications
83%	Identified insurance coverage with an **83% accuracy rate**, greatly exceeding expectations
30 - 45	Immediate insurance validation, cutting denial response time by **30 - 45 days**

Real-Time Insurance Discover has been a game-changer for us. Before, we were stuck in manual guesswork, wasting time and making errors. Now, verifications are quick, and we can focus more on patient care.

“”

FinThrive

*Case study available

Real Results

AdventHealth's Pre - Service Approach Transforms Healthcare Billing Experience*

Before FinThrive

- Patients are unaware of the costs
- Patients want to know their responsibility
- Patients want estimates online

After FinThrive

64	**64** Patient Net Promoter Score (**3x the average** for healthcare organizations)
↑ 50%	Pre-service payments increased **50%**
90%	Self-service pay rate of **90%**

One of the most important things to the consumer is receiving an estimate of their bill that takes into account their individual insurance coverage and tailors it to their experience.

FinThrive

*Case study available

Final Thoughts

There is no separation between the care experience and the billing experience in the consumer's mind

1

Patient Access and Revenue Cycle leaders should be in close contact with their Marketing and Patient Experience counterparts

2

Set a strong strategy despite technology challenges

3

Consider technology to automate and delight patient financial clearance workflows

The RCM Technology Adoption Model

Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
43% of respondents fall into Stage 1	**33%** of respondents fall into Stage 2	**8%** of respondents fall into Stage 3	**12%** of respondents fall into Stage 4	**4%** of respondents fall into Stage 5

Stage 1

Industry Average Technology Adoption

- 43% of market is currently operating in Stage 1
- Stage 1 is the starting point for most organizations that leverage the RCM TAM.
- Not yet live with 90% of Mission Critical technologies and 50% of High Value Technologies required for Stage 2.

Stage 2

Technology	Area
Eligibility & benefits verification	Patient Access
Patient registration / pre-registration	Patient Access
Medical necessity/ ABN	Patient Access
Charge capture	Mid-Cycle
Chargemaster technology	Mid-Cycle
Discharge planning	Mid-Cycle
Claims manager	Back Office
• Claims edits	Back Office
• Claims clearinghouse	Back Office
• Claims status	Back Office
Paper patient statements	Back Office
Collections management	Back Office
Bad debt collections	Back Office
A/R analytics	Analytics
Claims analytics	Analytics
Collections analytics	Analytics
Coding analytics	Analytics
Patient volume analytics	Analytics

Stage 3

Technology	Area
Referral management	Patient Access
Patient portal/ mobile app	Patient Access
Patient identify and address verification	Patient Access
Pricing transparency (shoppable services + MRFs)	Patient Access
Patient OOP payment estimation	Patient Access
Patient financial clearance	Patient Access
POS payment capture	Patient Access
Charity care evaluation	Patient Access
Clinical documentation integrity (CDI)	Mid-Cycle
Clinical documentation - transcription/ NLP	Mid-Cycle
Utilization Review	Mid-Cycle
Denials management	Back Office
Underpayment recovery	Back Office
Consolidated patient statements	Back Office
Remittance management	Back Office
Complex claims	Back Office
Encounters clearinghouse	Back Office
Contract management	Back Office
Third-party liability	Back Office
Medicare bad debt	Back Office
Call center automation/ IVR	Back Office
Contract analytics	Analytics
Denials analytics	Analytics
Patient access analytics	Analytics

Stage 4

Technology	Area
Patient self-scheduling	Patient Access
Prior authorization/certification	Patient Access
Patient appointment reminders	Patient Access
Pre-visit Propensity to pay	Patient Access
Pre-visit payment plan enrollment	Patient Access
Self-service patient payments (pre-visit)	Patient Access
Registration quality management	Patient Access
Physician CDI/ Coder querying technology	Mid-Cycle
Predictive CDI Worklist prioritization	Mid-Cycle
Post-visit insurance discovery	Back Office
Disproportionate share reporting	Back Office
Transfer DRG	Back Office
Post-visit payment plan enrollment	Back Office
Self-service patient payment (post-visit)	Back Office
Automated remittance matching	Back Office
Data extraction capabilities	Analytics
Drill-down to transaction level capabilities	Analytics
Contract modelling	Analytics
Physician practice operations analytics	Analytics
Uncompensated care analytics	Analytics

Stage 5

Technology	Area
Pre-visit insurance discovery	Patient Access
Prior authorization automation	Patient Access
• Automated determination	Patient Access
• Automated data extraction and submission	Patient Access
• Prior authorization status monitoring	Patient Access
Virtual front desk	Patient Access
Self-triage / care navigation	Patient Access
Clinical documentation - ambient clinical intelligence (ACI)	Mid-Cycle
Computer assisted physician documentation (CAPD)	Mid-Cycle
Computer assisted coding	Mid-Cycle
• ML-based ICD & CPT coding	Mid-Cycle
• ML-based DRG assignment	Mid-Cycle
Case management	Mid-Cycle
• SDOH risk analytics	Mid-Cycle
• SDOH referral management	Mid-Cycle
Predictive denials warnings	Back Office
Automated appeals workflows	Back Office
End-to-End RCM analytics	Analytics
Real-time, near real-time refresh capabilities	Analytics
Patient matching / deduplication capabilities	Analytics
Intelligent denials and underpayment root cause analysis	Analytics

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Key: Mission Critical | High Value

Questions?

FinThrive

Thank you!

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