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The Digitalization Rhapsody: Enabling Clean Claims Through Digital Means

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Introduction

A day after Janice[1] was discharged from the hospital, her five-day old baby became unresponsive, prompting her husband to call emergency services. The baby was admitted to Children's Hospital where they discovered that he was seizing. The baby was treated, monitored, and released after a hospital stay of a few days. Janice's insurance program required her to register any newborn baby within 30 days of birth. Because the seizures occurred just after her hospital discharge, she had not yet submitted the insurance registration form to her employer; however, as soon as the baby was released, she immediately submitted the required forms, well within the required timeframe. Fast forward a few weeks, and Janice received a denial from her insurance company for the claim for the baby's care (almost US$50,000) citing lack of preauthorization as the reason for denial. (Source: Whattoexpect.com)

While Janice's US$50,000 hospital bill came as a shock to her, the incident had impact beyond Janice. The insurance company's image takes a beating when stories like Janice's are publicized. Beyond the image issue, the cost of processing and re-processing claims, not to mention time spent on the telephone explaining denial reasons to members and health systems, can have significant impact on health insurers when spread across their entire member population.

And healthcare providers are not immune from impact, as they also bear the brunt of administrative expenses and potentially additional medical cost. Further, if a member is unable to pay the denied amount, the provider's costs may be compounded by collection expenses, potentially legal expenses, and ultimately possibly writing off the bad debt.

Unfortunately for all stakeholders, Janice's experience is not unique. Healthcare blogs, forums, and review websites are flooded with stories of claims denials for seemingly minor issues involving registration errors and incorrect information or lack of training. For both payers and providers, losses caused by incorrect claims run into the billions on top of administrative and brand value impacts.

While incorrect claims cannot be eliminated completely, the question remains: can they be minimized for the benefit of all involved? This viewpoint explores how digital transformation can reduce incorrect claims, including:

1. The impact of incorrect claims on payers, providers, and members
2. Drivers of incorrect claims
3. How instances of incorrect claims can be reduced
4. The benefits for stakeholders of adopting a digitally transformative approach

1 Name changed to protect patient confidentiality

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How incorrect claims impact payers, providers, and members

"Kicking the cat": the downstream effects of seemingly unrelated events

The motivational speaker Zig Ziglar had a story he liked to tell called "Kicking the Cat." Essentially, it was a narrative about a businessman who was pulled over and ticketed for speeding one morning. His reaction to that incident led him to treat a subordinate badly, which led to the subordinate treating the secretary badly, which led to the secretary yelling at her son, which resulted in the son kicking of the family cat. (Source: Zelis)

The story demonstrates how seemingly unrelated events can have downstream effects. Imagine the number of things that have to go right for a health care claim to be correct and approved. The ultimate success of a claim's approval depends on many upstream processes; failure at any stage results in claims denial, impacting provider, the payer, and the patient. And that impact is not limited to financial losses but includes administrative and efficiency losses, time delays, goodwill losses, and many others.

Take the example of delayed payments stemming from claims denials. On the provider side, payment delays significantly impact hospital revenue cycle – Crowe Horwath estimates that an average of 15-16 days are added to payment times for denied clams versus claims that have not been denied. On the payer side, claims processing, denial, re-processing, and then final denial or acceptance is a significant administrative burden. For patients, the entire claim denial scenario is a nightmare to say the least.

Adding to the complexity is the fact that claims denial is only one potential scenario – a submitted claim can also be suspended or only partially paid, leaving space for multiple downstream effects. The table below offers a brief analysis of impact in such scenarios.

EXHIBIT 1

How incorrect claims can impact payers and providers

Source: Everest Group (2019)

Positive impact — Negative impact

Situation	Impact on payers	Impact on providers
Claim accepted	Best case scenario	Best case scenario
Claim denied	• Best case scenario, if it is permanently denied • Additional administrative burden if it is resubmitted • Loss of member goodwill	• Loss of revenue • Loss of patient goodwill • Additional administrative burden in determining reason for claim denial • Time dedicated to follow-up with the patient for direct pay for the amount submitted • Inconsistent A/R cycle
Claim partially accepted	Loss of member goodwill	• Additional administrative burden in determining reason for partial payment • Time dedicated to follow-up with the patient for direct pay for the amount submitted • Loss of patient goodwill
Claim suspended	Increased claim processing time	Additional administrative burden to submit more information

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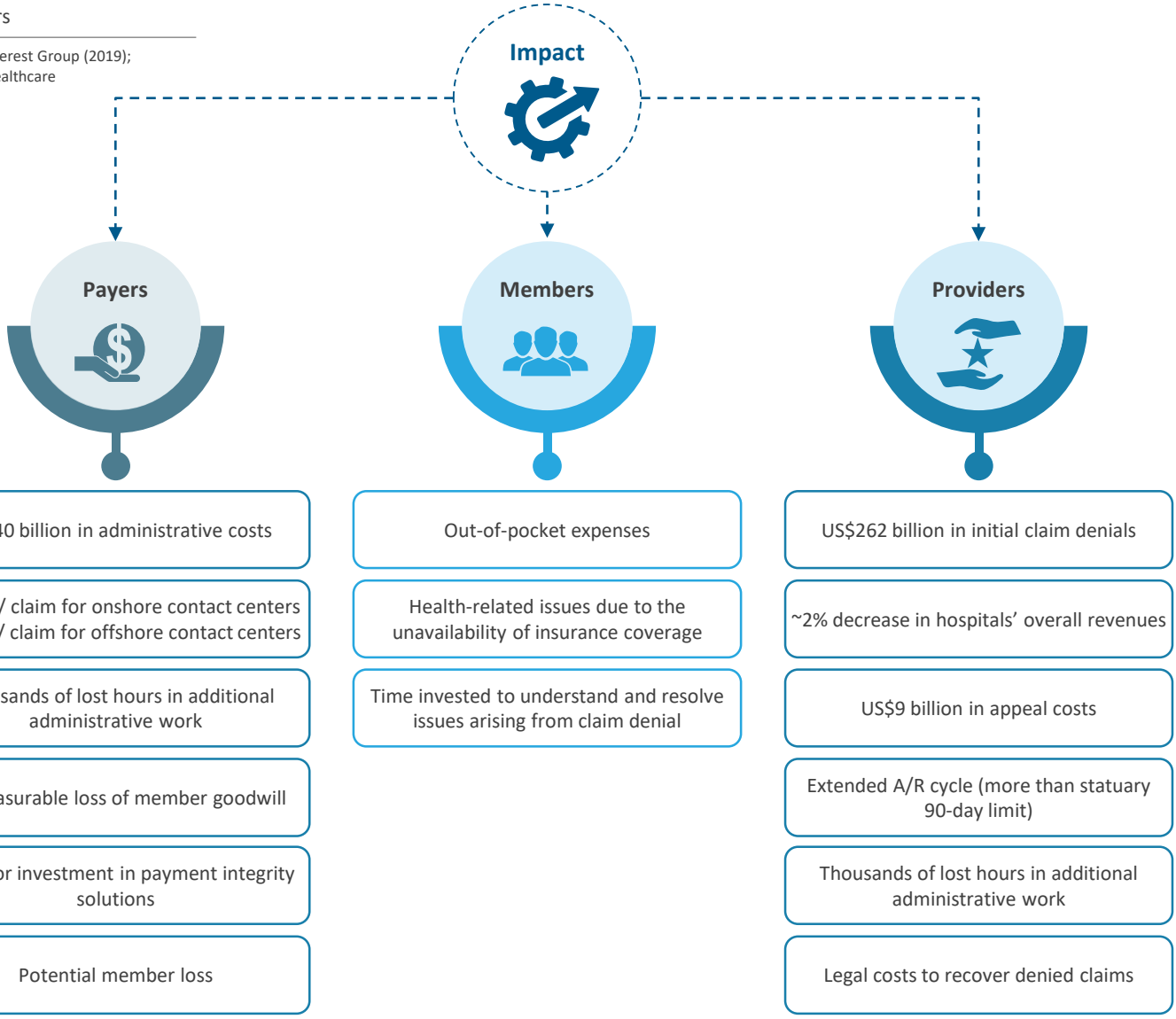
The quantitative impact of incorrect claims on healthcare payers, healthcare providers, and members

Exhibit 1 outlined the impact of incorrect claims on payers and providers. The exhibit below offers financial figures, where possible.

EXHIBIT 2

Impact of incorrect claims on payers, members, and providers

Source: Everest Group (2019); Change Healthcare



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Why incorrect claims happen?

The total number of denied insurance claims is debatable; however, some industry experts put the number up to 30% of the total claims filed every year. Denial rates are essentially identical for commercial and government payers, indicating the prevalent nature of the problem.

The payer side

The causes of claims denials are widespread – both on the payer and provider side. For payers, some of the key issues driving wrongful denials include lack of uniform data collection standards, discrete and fragmented systems that do not talk to each other, excessive reliance on humans for even transactional work, and use of legacy platforms.

A review of the lifecycle of a medical claim helps to illuminate where things can go wrong.

EXHIBIT 3

The medical claims lifecycle and possible causes of claim denials

Source: RevCycle Intelligence

Step	Processes involved	Possible causes of claim denial
Data entry	• Submission of claim through manual or electronic medium • Validation of the provider's contract, the member's benefit plan, and the reference code information • Other information to be validated includes member eligibility, provider eligibility, provider contract eligibility, diagnosis codes, reference data, etc.	• Member ineligibility • Provider ineligibility • Wrong procedure or diagnosis codes • Provider contract ineligibility • Non-conformance of BPA rules • Pre-authorization issues
Editing	• Claim is edited against business rules • Claim can be passed, denied, or suspended	• Detection of third-party liability • Incorrect coding
Pricing	• Calculation of final payment amount according to prior authorization rates • Claims requiring manual pricing enter suspended claims phase	• Prior authorization issues • Incorrect provider contracts loaded or contracts misinterpreted
Audit	Cross checking of service data against prior claims by the same member	• Duplicate services • Service conflicts • Limitation on services
Disposition	• Claim is paid, suspended, or denied • Suspended claims undergo further review	• Suspended claims can be denied due to: – Non-compliance – Timelines – Errors
Reimbursement	Distribution of payment to providers	

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As discussed above, a significant proportion of incorrect claims arise from discrete systems and manual processing. Some of the other key factors that contribute to the challenge of incorrect claims include:

Lack of uniform data collection standards

Payers, employers, and insurance companies collect health policy enrollment data in multiple formats – paper-based forms, excel-based forms, and custom 834 forms. The result of this unstructured data collection is an increased possibility of error, which only adds cost on top of the expense of standardizing the data.

Fragmented systems

Payers use multiple core administration platforms in addition to other platforms for processes such as health plan enrollment, policy administration, and care management. A vast majority of these platforms operate in siloes.

Lack of process optimization

Many payers have core administration platforms for claims processing; however, other processes such as enrollment and care management are primarily people-driven.

Legacy systems

Many payers' core administration platforms are archaic with no ability to effectively integrate with other systems.

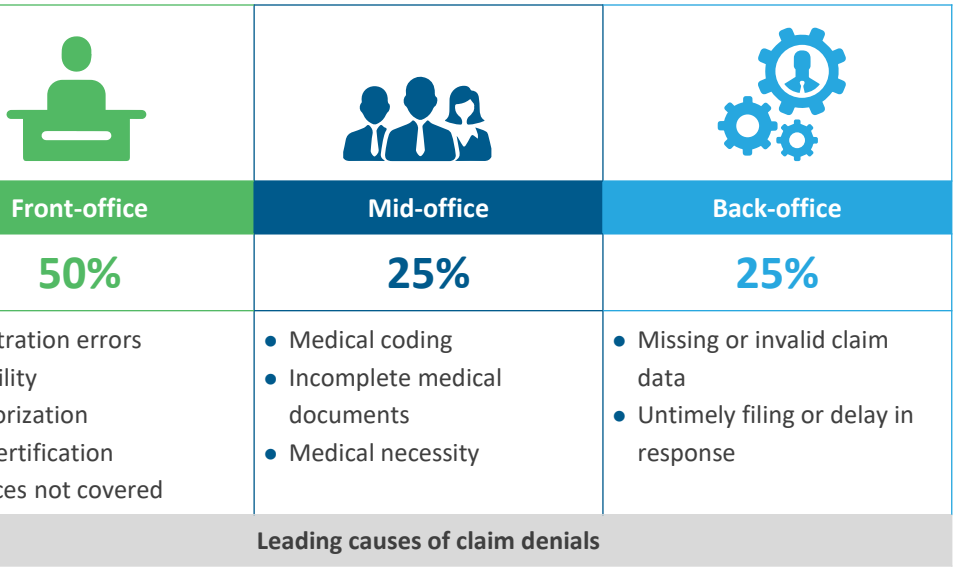
Are providers doing better?

The answer, unfortunately, is no. Providers are equally, if not more, at fault for incorrect claims leading to claim denials, as the following exhibit indicates.

EXHIBIT 4

Denial causes by front-, mid-, and back-office processes

Source: Everest Group (2019); Change Healthcare



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As with payers, the biggest problems for healthcare providers are discrete systems and processes, and very low penetration of automation solutions even for transactional work, as well as the fact that many healthcare providers are unsuccessful in integrating various point analytics and automation solutions because they have no long-term approach or strategy to do so.

While many healthcare providers are making significant investment in EHR platforms, with many targeting an end-to-end EHR-RCM integration to make claims processing faster, cleaner, and leaner; however, lack of interoperability is emerging as a key hindrance to their efforts.

Healthcare providers need to integrate discrete point solutions with platforms (EHR, RCM, etc.) that are interoperable to improve their chances of decreasing denial rates.

How instances of incorrect claims can be reduced?

A large health insurer improved its appeals workflow by employing a business process automation solution, achieving several benefits, including 20-30% cost reduction per appeal and ~100% accuracy in auto-classifying appeals.

A U.S.-based top ten healthcare payer reduced claims processing costs by 30-40% by leveraging a digital platform for claims submission.

These two use cases indicate how digital solutions can help payers to improve the entire claims management process; however, realizing these results requires a long-term strategy and a step-by-step overhaul of claims management, from the people, process, and especially technology perspectives. Spending without a strategy can result in short-term gains but will be detrimental to payers' financial health in the long term.

For example, an end-to-end RCM+EHR platform provided by many large vendors seem ideal to address a majority of claims and other related problems of healthcare providers; however, these platforms are costly, suited for large volumes of work, and take time to reach breakeven. For small or even mid-sized health networks or hospitals, investing in such a platform can be a significant financial strain. Hence, it is vital for payers and providers to evaluate existing solutions in the context of their needs before investing.

Below we outline some examples of solutions and their potential benefits.

Electronic Data Capture (EDC)

Whether collecting member data (during policy enrollment), provider data, medical records, or claims data, digitalization enables stakeholders to check (as well as validate) information such as eligibility, coverage, and claim denial reasons much more easily than traditional collection processes. Results include faster, leaner, more efficient claims management processes with lower probability of dirty data or incorrect claims.

Automation and analytics point solutions

Processes such as policy enrollment, front-end contact center, eligibility check, medical coding, and claims processing and adjudication can be partially or fully automated through various automation solutions available in the market. EDC combined with automation and analytics can significantly reduce many avoidable errors that lead to claim denials.

Platform harmonization

A majority of the payers have multiple platforms (core administration or otherwise) for the same operations. Investment in a unified platform can not only improve efficiency but accuracy as well. However, it is a very costly solution.

Payer-provider collaboration and education

Janice's case (described in the introduction) could have been resolved easily if the provider and the payer were synchronized on coverage for emergency procedures. The case study explains the (intentional or unintentional) lack of effective collaboration and education between payers and the providers.

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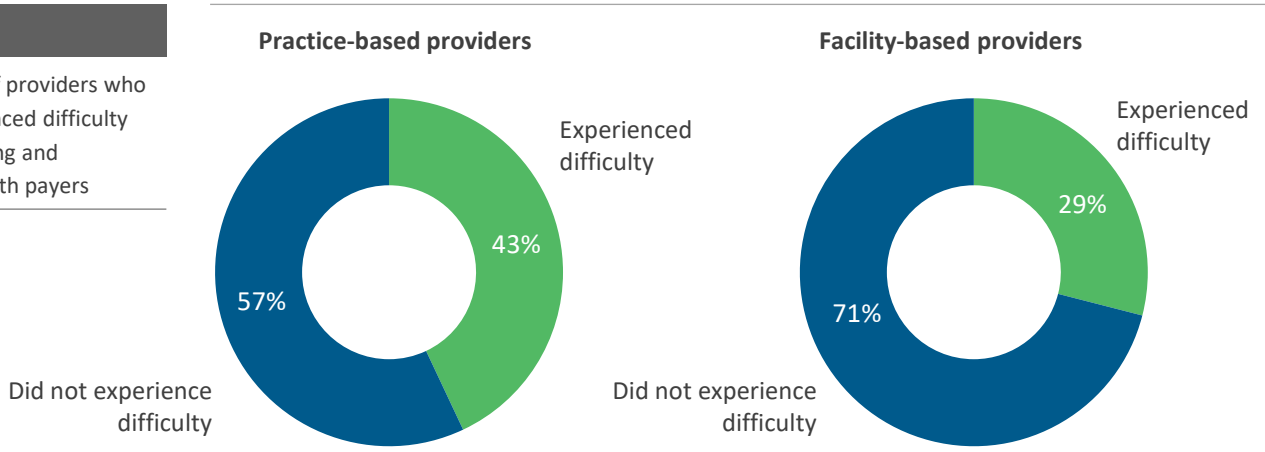
EXHIBIT 5

Percentage of providers who have experienced difficulty communicating and interacting with payers

Source: Availity



ROI analysis of available solutions

Earlier we discussed how different solutions – alone or in conjugation with each other – can help payers and providers to improve the claims management process. However, there is always an associated cost with any solution, so it is important to understand the pros and cons of each solution before investing in it. Exhibit 6 offers an ROI analysis of all the solutions we discussed earlier to understand which are better for what type of buyers.

EXHIBIT 6

ROI analysis of solutions for claims management

Source: Everest Group (2019)

Very high | High | Medium | Low | Very low

Solution	Investment required	Cost benefits	Quality improvement
Electronic data capture	◑	◑	◑
Automation and analytics point solutions	◑	◕	◕
End-to-end platforms	●	●	●
Payer-provider collaboration and education	◔	◑	◑
Closed-loop feedback system	◔	◑	◕

As the table above indicates, end-to-end platforms and solutions that can help in integration and interoperability have the highest cost benefits and impact on quality. However, they are expensive, and so not fit for buyers that have financial constraints. Another key aspect to understand is that electronic data capture in siloes has little benefit; however, it enables automation and analytics solutions to work effectively.

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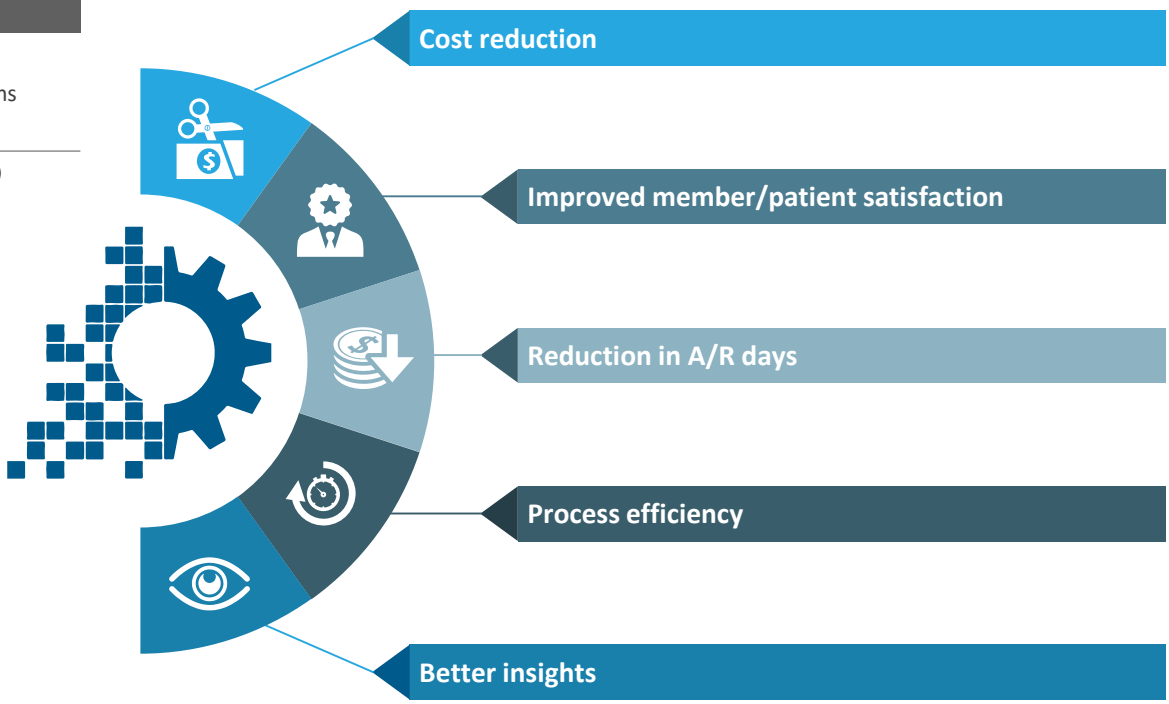
Benefits of digital transformation for stakeholders

Digital transformation of claims processing offers a variety of benefits.

EXHIBIT 7

Benefits of digital transformation in claims management

Source: Everest Group (2019)



Cost reduction

Digital transformation in claims processing involves people, process, and technology reengineering. Automation solutions for transactional work, analytics for better insights, and discrete systems integration are some of the facets of digital transformation that result in cost reduction in the long term.

Improved member/patient satisfaction

Customer experience is a key area of concern for payers and providers. A smooth claims processing process not only ensures benefits for payers and providers, but also enhances member/patient stickiness with their plan and doctor.

Reduction in A/R days

For providers, keeping A/R days as low as possible is vital to maintaining a healthy cash flow. Any claim suspension or denial significantly alters the A/R cycle. A digital-led solution approach not only offers better visibility into cashflow but also helps to reduce A/R days.

Process efficiency

Healthcare payers and providers can significantly reduce their claims processing team size by employing automation solutions for processes such as claims submission and auditing.

Better insights

A denial management analytics tool enables providers to check the leading causes of claims denials, which they can act upon to eliminate problem areas.

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Exhibit 8 illustrates how McKesson utilized Exela's proprietary claims solution to deliver automation across the administration of specialty drugs

EXHIBIT 8

A McKesson-Exela case study

Source: Everest Group (2019)

How McKesson revamped administration of specialty drugs

Client details

McKesson is one of the largest providers of pharmaceutical supplies and health information technology (IT) products and services in the United States

Challenges

- Complex claim reimbursement process: Unintegrated technology and unstructured data caused problems with accuracy and efficiency
- Unscalable: Technology platforms that operated in silos limited the ability to service growing demand

Requirements

- To improve the scalability, efficiency, and reliability of the claims management process

Solution

End-to-end administrative support for specialty drugs lifecycle

- Through its proprietary claims solution, Exela helped McKesson to automate and digitize the entire suite of administrative services for specialty drugs
- Exela also helped McKesson to streamline and automate other administrative processes including:
  - Eligibility validation
  - Enrollments processing
  - Benefits verification
  - Claims processing & adjudication
  - Payments: debit card, ACH, check
  - W9 & 1099 processing

Results

Entirely paperless submission of complex claims with improvement across several key metrics:

- Reduced processing time
- Improved accuracy of submitted claims
- Enhanced user experience with seamless connectivity across patients, providers, and payers
- Increased quality and transparency of payments

Conclusion

The Janice case in the introduction showed how the situation arising from the claim denial could have been averted easily if either the preauthorization had been done electronically and the discrepancy highlighted before the treatment, or the payer/provider had informed and educated the member about need to register the infant within 30 days of birth.

Claims management is one of the most transactional processes within the healthcare value chain. Transforming it through the use of digital technologies – such as analytics and automation – is possible; however, the current need is to understand bottlenecks and prepare a long-term strategy to overcome them. Steps such as electronic capture of member data, following standardized rules across the organization (and industry), closer collaboration among stakeholders (payers, providers, etc.), and a continuous feedback mechanisms can enable analytics, automation, and platform-based solutions to work effectively to provide the much-needed benefits.

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About Everest Group

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This study was funded, in part, by Exela Technologies

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