CHANGE HEALTHCARE

Revenue Cycle and Transaction Service Vendors RFQ

Proposal for
Client

Software and Analytics | Network Solutions | Technology-enabled Services

PROPRIETARY AND CONFIDENTIAL PROPOSAL

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Executive Summary

CLIENT is evaluating its existing portfolio of revenue cycle applications and transaction service vendors with a goal of consolidating its business with a few, Epic-experienced providers. Specifically, you want a vendor who is aligned with your mission and vision, and who can integrate Epic with your clinical, revenue cycle, and ancillary enterprise system solution to enhance automation. The competitively-priced solution should deliver new Epic functionality for patient access and claims and remittance management services to accelerate revenue. Criteria for the single source vendor includes delivery of:

- Environmentally-responsible healthcare that advances your mission
- End-to-end scope of functionality that delivers quality and cost savings
- Deep Epic integration that enhances automation and CLIENT value

We are uniquely positioned to consolidate CLIENT's hospital and physician revenue cycle management solutions into a single platform that seamlessly interfaces with Epic. Since 2003, we have been CLIENT Affiliated Practice's trusted Revenue Cycle Management services partner and are providing Business Intelligence Performance reporting to enhance operations. **To date, we have achieved a net collection rate of 99.68% and a reduction in AR over 120 days to only 4.5%.**

We recommend CLIENT build on your current investment and ROI to include **the Clearance Patient Access Suite (Clearance) including Clearance Enhanced Eligibility, Assurance Reimbursement Management™ (Assurance), Acuity Revenue Cycle Analytics™ (Acuity), Payment Automation, and SmartPay™ with Print Statements. Together the applications can streamline and automate the day-to-day business of healthcare, so CLIENT can focus on what you do best- delivering compassionate, quality care to the economically underserved.**

Environmentally-Responsible Healthcare that Advances Your Mission

Our goal is to help CLIENT prudently steward your revenue cycle and resources from start to finish to bring greater value to the community you serve. No other vendor can offer you a larger portfolio that aligns with CLIENT's mission of lowering costs and inspiring a better healthcare system to help you care for the needs of the poor, vulnerable, and marginalized.

Change Healthcare invests broadly in environmentally-responsible technology that is transforming a healthcare system burdened by paper to one that is enabled by automated solutions that reduce cost while advancing efficiency and quality care. You can count on us to champion innovation, integrity, and our Epic experience to help CLIENT improve lives and the health of your community. **Our solutions can be customized to CLIENT's charity policies to expand care access for the underserved and improve the patient experience.**

Our Intelligent Healthcare Network™ is the largest in the nation, and the first with block chain providing greater trust and accountability. The network manages high volumes of real-time

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eligibility and claims transactions through our EHNAC-certified clearinghouse connecting to 2,600 payers (for claims processing), 1,300 payers (for eligibility and benefits verification), and 5,500 hospitals/health systems including 800,000 clinicians. Last year, we processed 4+ billion financial transactions valued at more than $2 trillion. **Our national footprint and superior connectivity means we can help turn CLIENT's data and industry benchmarks into visionary plans that improve processes, profitability, and patient reach.**

As leaders in healthcare technology, we believe it is our social responsibility to collaborate with our clients to test, adopt, and refine new infrastructure and technologies, including artificial intelligence (AI), that makes healthcare more patient-centric. **AI is expected to create $150 billion in annual savings for the U.S. healthcare economy freeing CLIENT's resources to fuel your mission of providing accessible, quality care for all.** As such, we have more than 50 data scientists and developers dedicated to AI and have invested over $4M in the last 18 months to build an internal Center of Excellence (CoE) with Automated Intelligence in revenue cycle. Our investments extend the reach of emerging technologies across healthcare, supporting a healthy ecosystem of competitive applications.

End-to-End Scope of Functionality that Delivers Quality and Cost Savings

Our interoperable, end-to-end revenue cycle products and artificial intelligence (AI)-driven automation **deliver more value with less effort. Change Healthcare RCM solutions offer unlimited rules and edits to customize your patient access and billing processes to align with Federal Poverty Level and CLIENT charity policies**. The technology minimizes manual processes, reduces FTE spend, increases productivity, accelerates cash flow, and reduces bad debt so you can allocate more dollars to those in need in your community.

With the Change Healthcare portfolio, CLIENT achieves cost savings and improves the patient experience and access to care at every point in the revenue cycle beginning with registration. **Clearance helps CLIENT confirm coverage for patients who have it, find charity and financial assistance for those who do not, estimate self-pay responsibility, and manage expectations to broaden your reach and reduce risk.** The solution empowers CLIENT staff to recognize patients who are unable to pay and automatically enrolls them in charity, Medicaid or other financial assistance. **Using customized online charity and financial aid screening and enrollment processes within the normal Epic registration workflow, Clearance offers proper charity classification, helping CLIENT avoid unnecessary collection efforts, and helps reduce avoidable bad debt.**

When bundled with **Clearance Enhanced Eligibility**, it leaves no stone unturned to locate previously unbilled commercial, government, and MVA, insurance available for self-pay, bad-debt, and charity accounts. The application interfaces with **Assurance** to perform real-time clean claims submission (up to 99.7% are accepted upon first-submission) to manage and eliminate denials. All of our solutions are layered with AI analytics that are further mined by **Acuity** to provide out-of-the box operational efficiency reporting to drive strategic direction. Lastly, **Payment Automation, and SmartPay and Print statements** can improve the management of CLIENT's self-payments (patient portal and IVR), and

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allow your staff to take any form of payment anytime, anywhere across your enterprise so you get more, faster.

Deep Epic Integration that Enhances Automation and CLIENT Value

Our comprehensive, cloud-based, high-performance revenue cycle solutions successfully integrate value-based models into your existing Epic to meet all your requirements. As your current RCM services partner, we understand your business systems and technology and can leverage our knowledge to drive the adoption of new products and services at CLIENT.

Through a strong and lasting relationship with Epic that spans more than a decade, we have successfully developed integration for more than 400 Epic clients. **Our in-house Epic consultants can work with CLIENT to innovate new functionality and seamless integration for scalable efficiencies**. Our cloud-based solutions enhance Epic capabilities by creating user-friendly, intelligent workflows to help CLIENT return accurate patient data, speed payment velocity, reduce patient wait times, and enhance patient satisfaction**. Lastly, our solutions are customized for CLIENT to optimize Epic platforms and drive transparency by layering in our Acuity analytics to improve revenue cycle performance.**

We support Epic's standard integration services and are actively working with Epic to pioneer additional joint services that improve revenue cycle efficiency, reporting, and market performance. Just as our technology and that of Epic are integrated, our people collaborate as a single team to provide you with a singular, successful solution and implementation experience. The powerful alliance includes custom project team planning, implementation management, and outlining and testing of best practice set up and processes.

Proven Partner in Revenue Cycle Excellence

You can count on Change Healthcare to help you develop fresh ways to create savings and better steward your resources while improving your community benefit programs, charity care, and the patient experience. We can seamlessly integrate with your existing Epic technology and provide innovation in AI-automation to deliver scalable, environmentally-responsible efficiency. **As your strategic partner for the past 16 years, *we are confident* we can deliver a relationship that evolves with your needs and is aligned with your vision to improve lives and the health of your community.**

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Section 1: Solution Descriptions

PLEASE NOTE: While Clearance and Assurance workflow screens are portrayed in our proposal, many Epic clients choose not to use our screens in this manner. You have the option to only use the integration of our applications and the subsequent results that are sent to Epic.

Our goal is to provide CLIENT with a cost-saving technology and single vendor solution for your entire enterprise and revenue cycle that helps you better steward resources. Our one-stop-shop suite of solutions integrates with Epic to automate your billing and patient access processes from start to finish so you spend less time on the business of healthcare and more time caring for patients.

Inspiring better healthcare systems, not only means creating technology to help our clients become better stewards of their resources, but it means fostering collaboration. Working with your assigned Change Healthcare project team and Epic implementation experts, we can collaborate to create a stronger, better coordinated, and more efficient CLIENT healthcare system that enables **better patient care, expanded access for the underserved, choice, and outcomes at scale.**

While the point of care delivery is the most visible measure of quality and value, we are a healthcare technology solutions company that uniquely champions the improvement of all the points before, after and in-between care episodes.

Our solutions can provide CLIENT with new functionality at every patient touch point within your revenue cycle to improve patient engagement, expand access and enrollment in charitable programs, perform self-pay coverage discovery, increase revenue performance (managing and eliminating denials), streamline payment management (automation, online, and IVR), and enhance operational efficiency (reporting operational and financial performance).

The collection of technology and services span the revenue cycle continuum (shown in Figure 1) to minimize manual processes, increase staff productivity, accelerate cash flow, and reduce A/R days and bad debt to free resources to fuel your mission. Finally, we can provide CLIENT with strategic insight where improvements might be most favorable across your enterprise.

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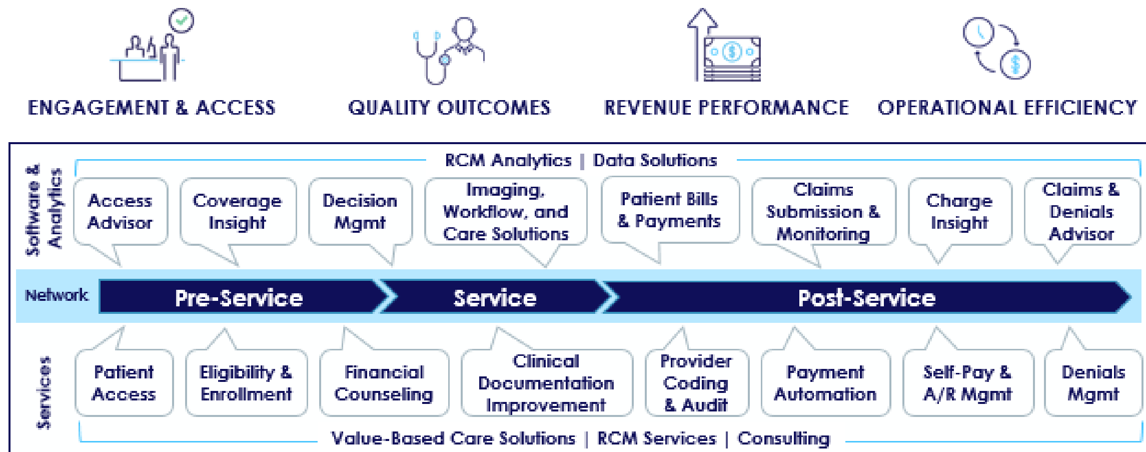

Figure 1. Change Healthcare paperless solutions provide end-to-end scope of functionality that delivers quality and cost savings across your enterprise.

The following are descriptions of Change Healthcare portfolio solutions that will be most beneficial to CLIENT as you explore a single-vendor for your revenue cycle across your enterprise.

A. Patient Access Solutions

The Clearance Patient Access suite gives you clear vision within Epic Prelude and Cadence to help CLIENT confirm coverage for patients who have it, find and enroll patients in charity and financial assistance who do not, estimate self-pay responsibility, and manage expectations to broaden your reach and reduce risk. CLIENT frontline staff can easily recognize patients who should be evaluated for charity, Medicaid or other financial assistance using online charity screening. The screening tool is customized to CLIENT's charitable policies and provides interview processes that can be seamlessly incorporated into your current patient registration and pre-registration workflows.

With Epic integration, staff can quickly determine a patient's ability to pay for healthcare, verify insurance coverage, validate patient identity, and identify patients for charity assistance. For patients who can pay, the system enables the creation of a credible bill estimate, and guides your staff through the collection of appropriate payment based on existing provider collection policy. If a patient is unable to pay for part of or all of their healthcare expenses, Clearance identifies all available financial assistance options and initiates enrollment. It enables the eligibility process to take place within minutes – prior to or at the time of service –reducing the cost to collect, minimizing bad debt, and accelerating cash collections for CLIENT.

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Clearance also offers propensity to pay scoring that classifies a patient's ability and willingness to pay their bill and helps your staff conduct meaningful conversations with patients their medical responsibility. **Using online charity and financial aid screening and enrollment processes within the normal registration workflow, Clearance offers proper charity classification, avoiding unnecessary collection efforts, and helps reduce avoidable bad debt.**

Clearance integrates with Epic RTE and drives eligibility and benefit verification so you can enhance Epic workflow, reduce registration errors and collect cash as early in the revenue cycle as possible. It eliminates registration errors by returning eligibility and verification results within seconds so registrars can correct errors in real time while the patient is still with them. Staff can quickly determine patient financial responsibility so you collect earlier in the process, reduce denials, and enhance patient satisfaction. It provides unlimited real-time payer portal eligibility and benefits verification with notice of admission for a flat fee and offers you automated pre-authorization screening and verification, and medical necessity, all within the Epic workflow. It performs quality checks on 100% of registrations for patient data accuracy, validates patient ID and demographics with fraud alerts, and estimates of patients' medical expense responsibility. Modules within the suite includes Verifier, Address Validation with Fraud Alerts, Estimator, Advocate, and Propensity to Pay.

> With Clearance, Health First has achieved a 30% reduction in bad debt and write-offs, and Munson Healthcare is performing transactions up to 20 times faster.

The value of Clearance begins with quality assurance audits on 100% of patient registrations for data accuracy and identifying errors at registration during patient interaction before they negatively affect your cash flow and other revenue cycle processes. The system automates many of the manual functions performed so you can increase the efficiency of your upfront quality assurance process by improving the productivity and accuracy of this review. The solution helps CLIENT accelerate reimbursement and optimize revenue from registration through point-of-service collections (shown in Figure X) for faster reimbursement downstream the solution.

> Clearance solutions empower CLIENT to identify sources of payment, manage self-pay and collect accurate data needed for timely reimbursement.

It confirms coverage and manages patient expectations to improve engagement, access to care, and reduces self-pay risk (as shown in Figure 2). Tightly integrated workflow tools integrate with Epic to deliver clean patient data, real time eligibility and benefit verification, pre-

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authorization and medical necessity validation, notice of admission, patient bill estimation, charity enrollment, propensity to pay, address validation with fraud alerts, and patient access analytics. Please see **Attachment** A for Change Healthcare Solution Brochures.

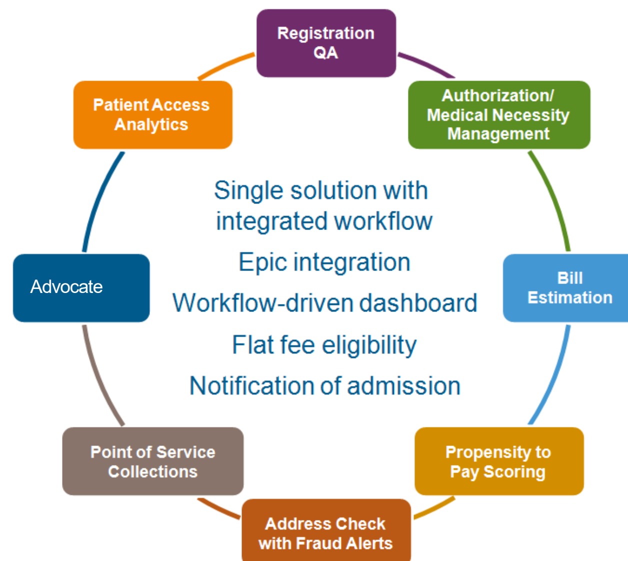

Figure 2. Clearance suite of solutions reduces the administrative costs of reworks and denials to increase ROI.

Clearance Verifier is the core component of Clearance and offers **the most innovative eligibility and benefits verification in the industry for a flat fee.** The solution provides CLIENT staff a quick method to verify insurance coverage in real time or through fast-batch processing. It integrates X12, 270/271 eligibility responses within your existing Epic workflow, allowing staff to set up work queues and take advantage of alerts that help them work efficiently.

Integration with Epic permits CLIENT to:

- Harness the power of Clearance 1,300 plus payer connections by going directly to payer web portals for eligibility information.
- Leverage an Epic-normalized 271 to simplify RTE data mapping, drive alerts, and enhance workflows directly in your Epic system.
- Support a healthier bottom line with automatic submission of self-pay patients to state Medicaid plans or other appropriate healthcare management organizations (HMOs).

The solution extends the value of Medicaid and Medicare inquiries with auto-submission and data returns to Epic. It also identifies and automatically submits to secondary or replacement plans in the government payer's eligibility response.

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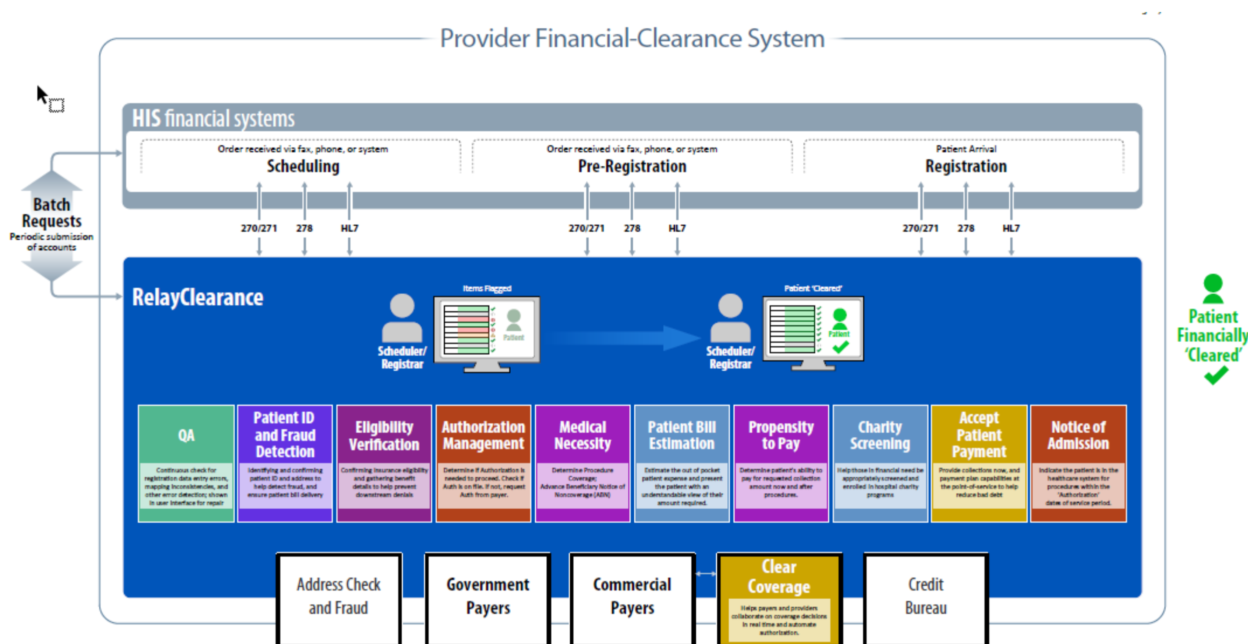
Sophisticated pre-service exception work listing within your Epic work queues reduces the FTE hours required to complete tasks (as shown in Figure 3). **Staff can also effectively identify missed coverage and properly reclassify self-pay with timely fast-batch eligibility checks.**



Caption 3. Clearance integrates with Epic fast-batch processing to automate the business of healthcare so you can focus on delivery of compassionate care.

Clearance Enhanced Eligibility (also known as Coverage Insight) helps CLIENT convert uncollected self-pay and open balance accounts with previously-unbilled insurance coverage into new revenue. It uses advanced analytics to systematically and intelligently screen all patients, service types, and balance levels to identify missed Medicaid, Medicare, and insurance to recover lost revenue. CLIENT is only billed if lost revenue is recovered.

Notice of Admission (NOA) **is also a valuable feature of Clearance Verifier at no additional cost.** It integrates directly into your Epic workflow and automates NOA to payers like UnitedHealthcare, BC/BS, Aetna, and Molina (and others as required and available) within 24 hours to keep you compliant. Payers are informed that a patient has been admitted to an acute care, skilled nursing, or acute rehabilitation facility using a modified X12 278 transaction in Clearance.

#1 KLAS-Rated Clearance QA works to virtually eliminate registration errors by identifying errors in real time before registration is complete through integrated monitoring. With Clearance QA, CLIENT can add value to your current QA processes, by alerting staff to potential registration errors as they occur allowing them to verify the information while the patient is still with them. This helps decrease claim errors and creates time limits on the required corrections, resulting in

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improved productivity, reduced FTE hours needed to perform QA and better patient satisfaction scores.

It is the only automated solution on the market with custom business rules to audit 100% of registrations to virtually eliminate errors at registration. With Clearance QA, CLIENT can increase point of service collections, and reduce denials and claim rejections. The solution:

- Produces up to 99+% clean claims
- Increases point of service collections
- Eliminates the need for additional FTEs to perform QA processes
- Keeps your cash flow constant with fewer A/R days
- Creates registrar report cards that help improve staff productivity

CLIENT registrars can view and correct errors on the front-end while the patient is still in front of them *and prior to services being rendered.*

Clearance QA offers hundreds of standard and configurable business rules that give CLIENT the flexibility to define error-checking specific to your business needs (including hard stops for missing data). For example, the Business Rule logic or the Demographic Address checker in Clearance QA activates pop-up error messages for fields containing errors and omissions (shown in Figure 4). This allows registrars to process registrations with more accuracy because they won't overlook fields that are in error or have been omitted.

QA [202001] Eligible

Account:	Medical Record:	Patient:	Patient Type:	Reg Date:
83962168	970291151	FERRELL, CAMILLE	Emergency	11/6/2013

Field Name	Field Value	Rule Error	Severity
Account	0041061330	[Medical Record] Duplicate Medical Record #8829849118 found on Account: 32137631303	Error
		Eligibility(Plan 1) Eligible	Error
1 Ins Plan Code	BPO	Eligibility(Plan 1) Insured has other provider BLUE CROSS OUT OF ST. Please add the insurance.	Error
1 Ins Policy Number	J867E53N09Y	Eligibility(Plan 1) Policy number should be ""DJ867E53N09Y"".	Error
Patient Name	KENT, MARTHA	Eligibility(Plan 1) Dependent full name must be "KENT, CLARK".	Error
Patient Name	KENT, MARTHA	[Red Flags] Unable to verify name, address, SSN/TIN and phone	Error
Patient SSN	857005309	[Red Flags] The input SSN is invalid	Error
Patient DOB	10/16/1981	[Patient ID+] Unable to verify date-of-birth	Error
Patient State		[997] (Patient Address is required AND Patient City is required AND Patient Zip is required AND Patient State is required)	Error
3 Ins Plan Code	99999, SEINFELD ,JOSHUA	[2284] (ATN-MDNAME cannot contain '99999')	Error

Figure 4. The solution allows users to easily view registration errors, duplicate records, data inaccuracies, and red flag rules.

Complex business rules and logic are created in the backdrop of the fields to provide a comprehensive accountability for errors. Weighted value can be placed on fields of higher importance (i.e., those that directly affect the billing process), which ensures registrar compliance. **All rules integration and upgrades to Clearance QA are included at no additional cost.**

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Clearance Address Validation with Fraud Alerts offers CLIENT the ability to verify all patient demographic data prior to service, **helping you improve downstream processes and reduce administrative back-office costs for correcting errors**. The solution indicates if there are any "identity issues" with the patient and **provides the ability to present the response within Epic, indicating any data mismatches to reduce potential medical fraud and identity theft (as shown in Figure 5).**

The solution integrates directly into your Epic workflow and accurately verifies all patient demographic data, spots potential fraud, flags discrepancies and automatically alerts staff to correct errors prior to service (shown in Figure 4). Staff can easily see and address "identity issues" in real time with the patient still in front of them to improve quality assurance, coverage discovery, and collections. Alternative addresses and telephone numbers are automatically indicated for any data mismatches such as:

- Invalid SSN
- Deceased SSN
- SSN issued prior to birth
- SSN associated with a different person
- Invalid addresses
- Disconnected phones (cell and landline)

	HIS	Subscriber Eligibility	PatientID	Propensity-to-Pay	Accepted
Guarantor First Name:	STUART	Stuart	STUART	STUART	STUART
Guarantor Last Name:	WOODASTER	Woodaster	WWOODASTER	WWOODASTER	WOODASTER
Guarantor Address:	4578 PETREL LN	4578 Petrel Ln	4578 PETREL LN	4578 PETREL LN	123 Linn St
Guarantor Address 2:					
Guarantor City:	GLENDALE HEIGHTS	Glendale Heights	GLENDALE HEIGHTS	GLENDALE HEIGHTS	GLENDALE HEIGI
Guarantor State:	IL	IL	IL	IL	ILLINOIS
Member Id:	123456789	123456789			0
Patient First Name:	STUART	Stuart			Stuart
Patient Last Name:	WOODASTER	Woodaster			Woodaster
Date Posted:			02/09/2010	02/09/2010	

[Show Detail Credit Report]

Save Accepted Values | Cancel

Actions

Indicators

Alerts
RISK INDICATOR - Unable to verify SSN/TIN
RISK INDICATOR - Unable to verify phone number

Figure 5. Clearance Address Validation with Fraud Alerts notifies users to potential mis-keys that are often mistaken for fraudulent data.

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Clearance Estimator works within Epic to calculate an accurate estimate of a patient's medical bill responsibility (as shown in Figure 6) leading to greater patient satisfaction and revenue predictability. **The solution adds value to CLIENT's providers and hospitals to better manage rising patient self-pay risk by calculating a credible, defensible estimate of a patient's financial responsibility.**

It evaluates all key data components like provider charges and historical data, patient benefits, and payer contracts to calculate a more creditable estimate than just historical claims data alone. It guides non-clinical users through the process of identifying the services the patient is likely to receive by expanding on the information provided by physicians to determine the appropriate procedure codes. Commonly used codes can be added to the system, and a list of the most common procedures at the physician and facility levels is presented. Clearance Estimator then analyzes the provider's specific contract, applies the patient's benefit information and completes an out-of-pocket estimate (Figure X). It helps keep the cash flowing at CLIENT by calculating pre-service bill estimates for patients that help set financial responsibility expectations prior to service delivery.

Figure 6. Estimator calculates pre-service bill estimates for patients that help set financial responsibility expectations.

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Clearance Advocate empowers CLIENT frontline staff to recognize patients who are unable to pay and should be evaluated for charity, Medicaid or other financial assistance using online charity screening interview processes that can be seamlessly incorporated into your current Epic patient registration and pre-registration workflows. The tool helps you reduce risk and staff can build Medicaid eligibility enrollment and take e-signatures in real time.

It can also be used to support financial aid counselors' more detailed financial assistance patient interactions. **CLIENT can configure screening questions in Advocate based on Federal Poverty Level and CLIENT business rules. Worklists are then routed/assigned to financial counselors, billing customer service, etc., based on the output from the Advocate screening process.** Your staff can also build Medicaid eligibility enrollment forms in real time and take e-signature for the form in real time. **Using online charity and financial aid screening and enrollment processes within the normal registration workflow, Advocate offers proper charity classification, avoiding unnecessary collection efforts, and helps reduce avoidable bad debt.**

Clearance Advocate can also be used to complete online Medicaid and other financial assistance enrollment forms (as shown in Figure 7). It stores vital information and pre-populates the financial assistance forms, eliminating redundant data entry and provides completed forms for the patient's signature.

The following graphic depicts a screenshot of the screening assessment and subsequent automated form creation.

Figure 7. The solution gives you the ability to load forms for a variety of financial assistance programs.

With Advocate, you can build out as many forms as are required by your business. The forms are provided to Change Healthcare who program and load them into Advocate. We do all the work for you!

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Your staff can build Medicaid eligibility enrollment forms in real time. Then, they can also take e-signature for the form in real time. **Advocate supports tracking of a patient in the financial assistance process, overall and for individual financial assistance programs**. The fields are configurable based upon your specific business needs.

Clearance Authorization (includes Medical Necessity at no additional charge) connects CLIENT to one of the nation's largest hybrid networks of more than 600 commercial, managed care and government health plans representing nearly 90% of covered lives in the U.S. **It automates 75% of cumbersome manual authorization tasks to save you time and money by automatically determining if an authorization is needed and on file.** It also monitors payers for pending decisions and updates Meditech with the decision creating an audit trail for appeals.

The solution helps staff to rapidly obtain pre-authorizations for commercial payers and medical necessity for Medicare and obtains decisions as soon as they are available. Users are alerted to procedure code and service date discrepancies so proactive outreach to payers and physicians can resolve issues prior to service. On average, manual transactions cost providers and plans $2 more each than automated electronic transactions. With Clearance Authorization, Helen Hayes gains the consistent workflow for managing automatic and manual authorization processes to reduce labor costs and claim denials.

It can help CLIENT manage pre-authorization for commercial payers and medical necessity for Medicare by automating the process within the Epic-based Referral workflow and performing clinical code audits on Medicare outpatient services. It minimizes manual touch points and time-consuming phone calls to help CLIENT better serve patients.

Our authorization screening function enables systematic determination of whether an authorization is required for a given procedure and payer combination. **The screening service houses authorization policies from over 600 payers representing 90%+ of covered lives.** The authorization policy database is routinely updated to ensure actions are taken on the most up to date set of payer policies. Clearance Authorization also determines if an authorization is file with payers and utilization management vendors and monitors for pending decisions. Epic is systematically updated with the authorization decisions (see Figure 8), which creates an audit trail for appeals.

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Figure 8. Clearance Authorization determines if pre-authorization is required and on file with the payer.

Clearance Medical Necessity helps automate Medical Necessity checking as a part of the registration process and performs clinical code auditing for Medicare outpatient services, helping to reduce losses due to Medical Necessity write-offs.

If the Medical Necessity check fails against CMS local or national coverage determination policy the solution immediately generates an Advanced Beneficiary Notification (ABN) form (see Figure X) to secure a patient's acknowledgement of their financial responsibility.

Clearance Medical Necessity helps reduce write-offs due to lack of medical necessity and reduces claims reworks cost by:

- Helping identify non-covered procedures prior to care
- Generating an Advanced Beneficiary Notice (ABN) with expected charges for the patient (see Figure 9)
- Providing extensive, regularly updated content services
- Leveraging routinely updated sets of Local and National Coverage Determination Rules
- Identifying accounts that need follow up
- Supporting electronic signature capture for Topaz devices

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Figure 9. The solution generates a "red" alert identifying that an ABN is required and automatically generates the ABN Form for the user.

Clearance Propensity to Pay (P2P) is an automated predictive modeling tool of Clearance that integrates with your Epic workflow. It can help CLIENT determine a guarantor's ability and inclination to pay their bill and can offer credit scoring on all patients or just certain patient types.

The P2P score combines reliable financial modeling of patient income that plots against the Clearance P2P Score "calculation matrix." One of the four color-coded (easy to understand and visible on the dashboard shown as Figure X) P2P Scores is assigned to the patient (as shown in Figure 10):

- Green is good probability/high income = collect payment
- Blue is low probability/high income = collect payment
- Yellow is good probability/low income = possible financial assistance needed - screening suggested if payment not possible
- Red is low probability/low income = financial assistance screening

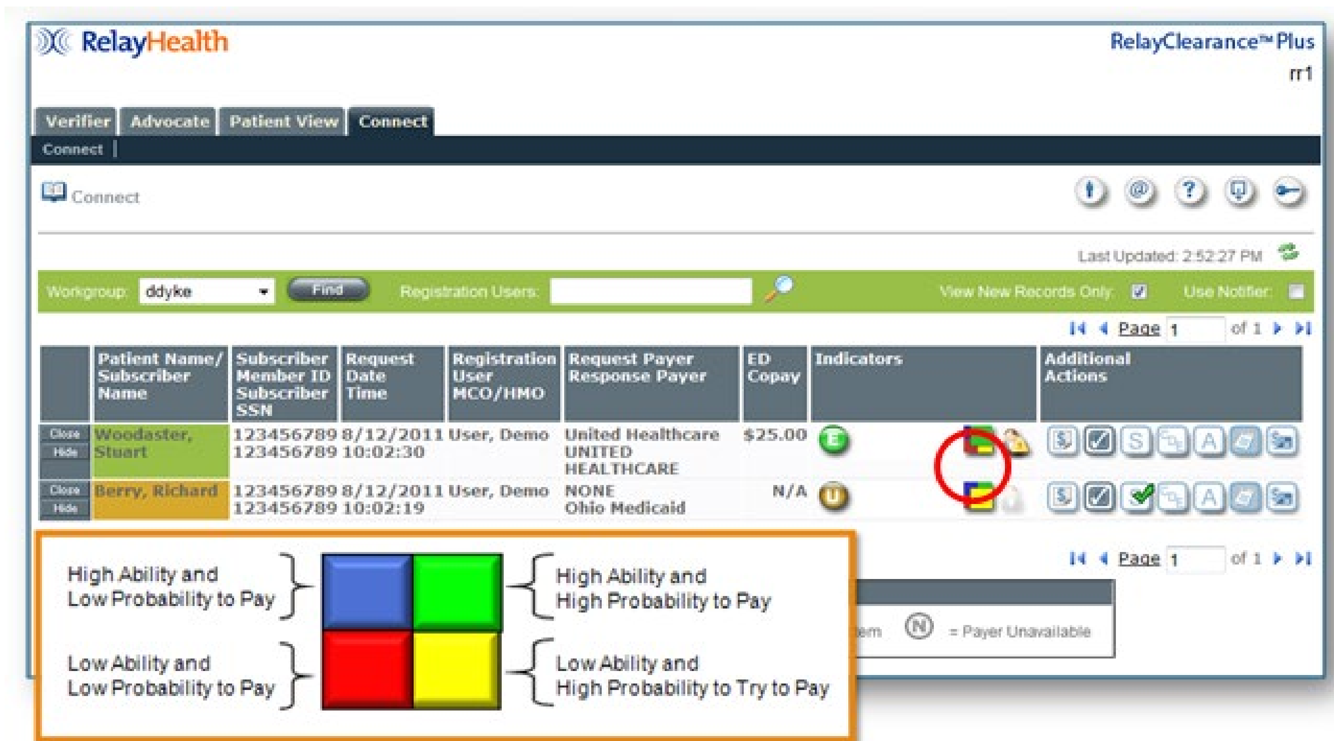

Figure 10. A color-coded screening tool helps your staff make the right collection decisions.

It helps your staff assess the likelihood that a patient will pay and if the payment will be timely. The solution integrates with Epic via the standard Epic HL7 for P2P and PID: Epic sends Change Healthcare a Q22 request and we send the K22 P2P/PID response back to Epic.

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B. Payment Automation and Billing Solutions

SmartPay complements Clearance by providing patients every payment channel available and working seamlessly within CLIENT's hospital and physician operations to collect on any outstanding patient payments. CLIENT benefits from improvements in revenue, cost reduction, and patient satisfaction (as shown in Figure 11). Because this solution leads the way with innovation and technology that focuses on the patient experience, CLIENT can be well-positioned to accelerate patient payment, while lowering costs and increasing patient satisfaction and loyalty.

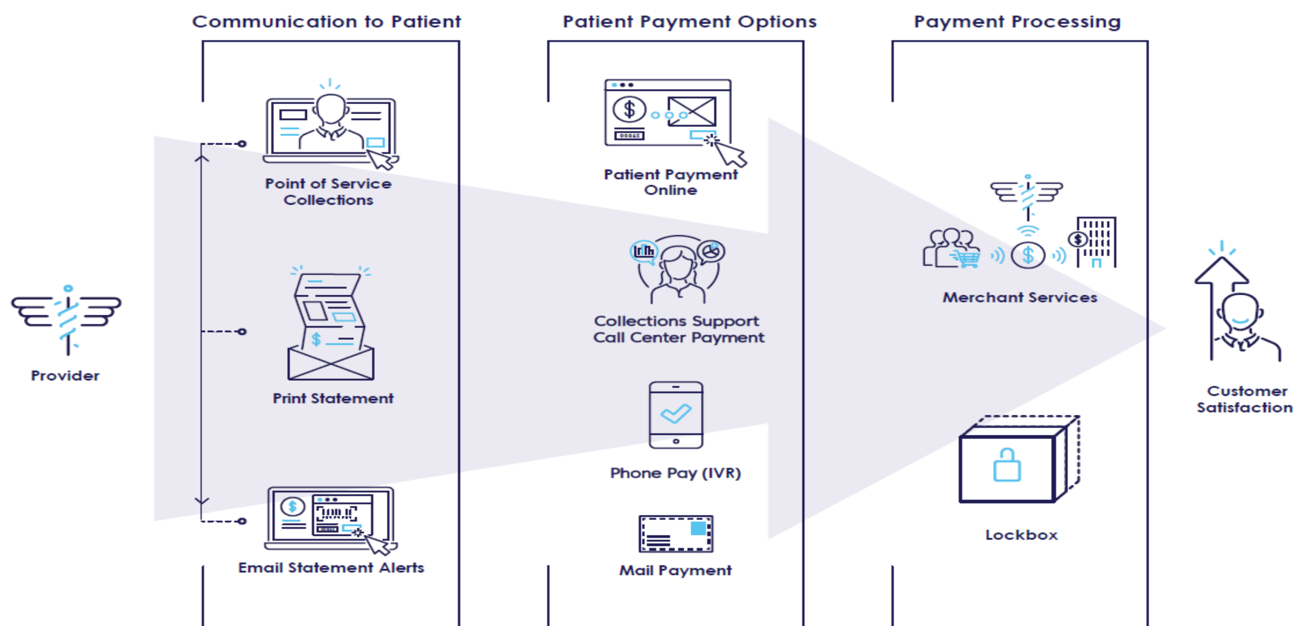

Figure 11. SmartPay workflow offers an end-to-end integrated patient payment processing solution.

We offer a variety of patient-centric solutions such as **Patient Payments – SmartPay Bundled Services**. In fact, we currently serve 480 SmartPay customers who are generating an average of about 770,000 payment transactions. SmartPay bundled services include:

- **Personalized Communications –** reduce costs and increase patient engagement with trackable provider communications and reporting that helps CLIENT evaluate your delivery performance. Driven by analytics, personalized communications provide CLIENT a cost-effective way to communicate with your patients **based on a patient's communication preference** and track their engagement. The solution offers a comprehensive multi-channel communication solution, based on a patient's preferred medium to expedite and promote positive payment behavior. It distributes communications across diverse channels (print, email, and text messaging) including integrated flexible payment alternatives and directs patients to pay their bill online, leading to quicker payment for CLIENT.

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- **Consumer Pay Online (CPOL)** is an online bill payment solution, hosted and managed by Change Healthcare and delivered through CLIENT's existing website. The solution is HIPAA and PCI compliant, and offers 24/7 mobile optimized and user-friendly features to allow your patients to easily view, manage, and pay their accounts online, including the ability to make a one-time payment without enrollment. Patients can elect to receive email notification when each statement or account update is available, linking them directly to the online billing center for account management and payment. It offers easy-to-use customer service support and reporting. Recurring payment, prompt-pay discounting, payment plan, and auto-payment options are also available to consumers, using parameters set by CLIENT, including automatic debits from patients' bank and/or credit card account of choice.

  Moreover, API is available to permit CLIENT to connect MYCHART with Change Healthcare to, accept and post patient payments, request account balances and retrieve PDF documents.
- **Point of Service (POS) collections (eCashiering)** solution **helps your staff accept any form of payment directly from the patient from any location throughout your enterprise**. Payments can be processed for pre-service, POS, or for outstanding A/R balances. Patients can also establish recurring or auto-payment plans. Choose from real-time processing of electronic transactions through CLIENT's existing bundled merchant-processing relationships or our bundled merchant option for credit card and debit card transactions. We can also handle transactions from consumer checking accounts on your behalf. Physical payments, including cash, physical checks, and money orders are captured through the system's virtual cash drawer.

  Standard and custom reporting of consumer payment activity supports the entire cash management process, including real-time receipting, tracking, auditing, and performance reporting. Cash Drawer reporting printouts are used at end of shift to detail users' payment activity for bank deposit aggregation. CLIENT may elect to use our bundled merchant services option.
- **Phone Pay (IVR)** is an automated, interactive phone service (in English and Spanish) that allows patients to make payments towards their outstanding balance from virtually anywhere, anytime over the phone. It provides a customizable script messaging that accepts in-bound checking account, credit card, and debit card payments and uses payment information captured through phone keypad responses. The solutions also offer your staff the ability to transfer calls relating to payment to our phone pay IVR system; freeing up your staff for other calls.
- **Patient Lockbox** automates the process of depositing, posting, and managing patient payments to help CLIENT get paid faster, reduce the costs of correcting errors. This healthcare-specific lockbox eliminates errors because the lockbox process works in concert with the print statement creation on your behalf. Based in Texas., our lockbox service facility is bank and merchant agnostic and can customize and automate payment posting of files for any system. The solution offers automated exception-handling and return item processing, web-based decision tools, image archiving (eliminating physical storage needs), and robust reconciliation and reporting.

- **Merchant Services** combines multi-channel payment applications with merchant processing for credit card and debit card transactions. It delivers streamlined onboarding, simplified pricing, and consolidated billing to support all patient-preferred channels and payment methods. These services

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help CLIENT improve posting and reconciliation of payments by settling all payments activity in full to match the amount paid by the consumer, rather than a settled amount that has processing fees already subtracted.

CLIENT can also reduce costs by leveraging Change Healthcare's collective buying power through our pre-negotiated merchant agreements of preferred partners and eliminate need for CLIENT to select or negotiate with multiple vendors. By aligning multiple payment programs into a unified solution, Merchant Services can simply fees with an all-inclusive pricing and consolidate billing into a single monthly invoice and more.

Patient Billing and Statements offers CLIENT **print services** that use a human-centered, design-thinking processes and integrate provider payments and member communications and engagement to drive behavior change. With omni-channel communications we can reach more stakeholders than ever before. Our print services provide a comprehensive, single source for printing and mailing of patient-centric documents, including postal address cleansing (NCOA™ processing), print-mail processing, and postal pre-sorting and USPS delivery.

Our print services also provide a client portal that allows CLIENT to:

- View stored documents in our electronic archive (*Document Archive*)
- Reprint and re-mail selected documents
- Access and download reporting
- Perform self-service administration

Our print services provide additional custom reporting (available in multiple formats, including html, csv, and xml) via email, SFTP, message queue, or other secure file delivery methods.

With **Document Archive** CLIENT gains real-time online access to exact replicas of documents processed through Patient Billing and Statements. Authorized users can retrieve and view reprint documents from a pdf format. Document Archive benefits CLIENT by reducing file maintenance and record storage, and streamlining patient inquiry response times. With the solution's 24/7 desktop file retrieval and viewing capabilities, CLIENT users can easily help resolve patient issues quickly with real-time access to pdf images of statements, letters, and documents that mirror those sent to patients. A feature of Document Archive is **Document Archive – Push**, which provides CLIENT an option to receive direct file delivery of PDFs for storage within your internal imaging tool for complete ownership.

Our **Return Mail Manager** feature automates the skip tracing process for undeliverable accounts, eliminating 100% of return mail handling. CLIENT would no longer need to process returned mail. Instead, each undeliverable piece of mail would be returned directly to our processing center for review, analysis, and remailing using a newly identified address, while unidentifiable accounts are returned to CLIENT in electronic file formats for immediate revenue recovery processing. Detailed reporting of the status of each account is provided and available for review in the administrative portal.

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Statements

We have successfully partnered with Epic to manage Epic's RTF/PDF file formats for statements or delimited/text files and offer CLIENT the ability to create a consolidated statement by combining data from multiple sources (i.e., PB and HB information in one statement). Files are sent to us with a delimited text file including address information for each PDF. This allows you to work within your Epic environment and successfully use the RTF/PDF image(s) within MYCHART seamlessly. We help CLIENT have more control and flexibility over design of statements and letters by working with you to create custom patient friendly statements and letters. Please see Attachment A Change Healthcare Solutions Brochures.

Dashboard and Reporting Capabilities

Print Statements capabilities include a 360° statement and document tracker application that provides CLIENT with a direct view into our print and payment operations through an effective and efficient self-service tool that assists users to proactively optimize the patient billing and payment process. With the solutions business analytics file monitoring service, users gain greater insight into document processes through dashboard views, management and print performance monitors. It offers a near real-time document receipt file control center including a data warehouse repository that accepts file processing, printed, mailed, and billed data uploads daily. The solution offers standard reports and over 40 custom payment reporting options. CLIENT can receive standard daily, settlement, and physical activity reports or create custom reports showing detail or summary display with additional graph/chart formats. Reports can be downloaded in .csv or excel formats.

Please refer to **Attachment** B for our Change Healthcare Reports Gallery.

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C. Claims Improvement Management Solutions

Assurance is one of the most mature offerings in claims and remittance management today. It integrates with Resolute and leverages intuitive analytics driven technology with advanced user-friendly workflows to improve PB and HB clean claim rates, reduce errors and increase payment velocity and productivity (as shown in Figure 12). **The solution provides real-time claims processing using best in industry edits that are integrated with Epic's Accelerated Claims Reconciliation (ACRD) to facilitate clean claims transmissions to payers, resulting in 99.7% of claims processing without incident and a 97% adjudication rate.**

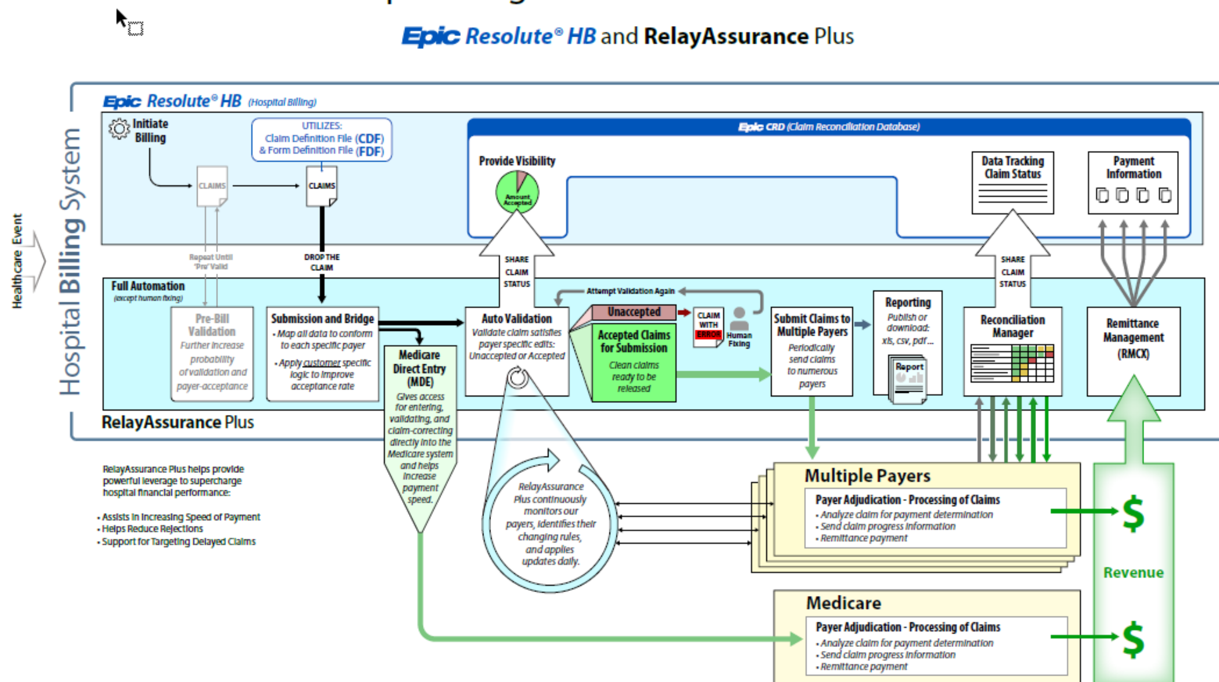

Figure 12. Epic System Integration offers one enhanced functionality in a single automated revenue cycle solution from end-to-end.

No other solution provides you with greater connectivity to our EHNAC-certified clearinghouse (one of the nation's largest IT networks) of more than 2,600 payers. Assurance includes clean claim processing in real time, clear visibility into claims status, claims reconciliation, Medicare Direct Entry features, Attachments, denial management, appeals assistance and over 100 standard configurable reports. Unique to Assurance is the ability to post remit data to a claim in the claims management database. This contributes to the full claims tracking and claims status features in the system and triggers the Automated Secondary Billing (ASB) feature for applicable claims. Please see Attachment A Change Healthcare Solutions Brochures.

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Assurance includes all the following claims management functionalities:

Claims Status supports the receipt of claims status information from payers. It automatically solicits claims status to connected payers, posts the response information to the claim, and returns the normalized ANSI 277 (5010) to CLIENT for use in Epic. It identifies claims that are moving through the process appropriately and those that need attention so staff work more efficiently (as shown in Figure 13).

Figure 13. A visual representation of an operational dashboard depicting claims status.

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Reconciliation Manager automates your claim reconciliation process so that your staff does not waste time searching and monitoring claims that are moving through the process appropriately. This way they can focus on problem claims, ensuring prompt reimbursement and reduced labor costs for CLIENT. Data extraction posting (DEP) allows Epic client to post "notes" back to Epic regarding claims that have been "released" from Assurance. We can return claim edits to Epic and drive Epic work queues through Epic Claim Reconciliation (CRD), if desired.

The solution offers intelligent, exception-based follow-up workflows (as shown in Figure 14) to reduce denials and payment delays. Your staff can gain visibility into the status of claims in real time and easily identify outlier claims that need corrective action.

The following is an example of how the dashboard offers enhanced visibility and processing transparency.

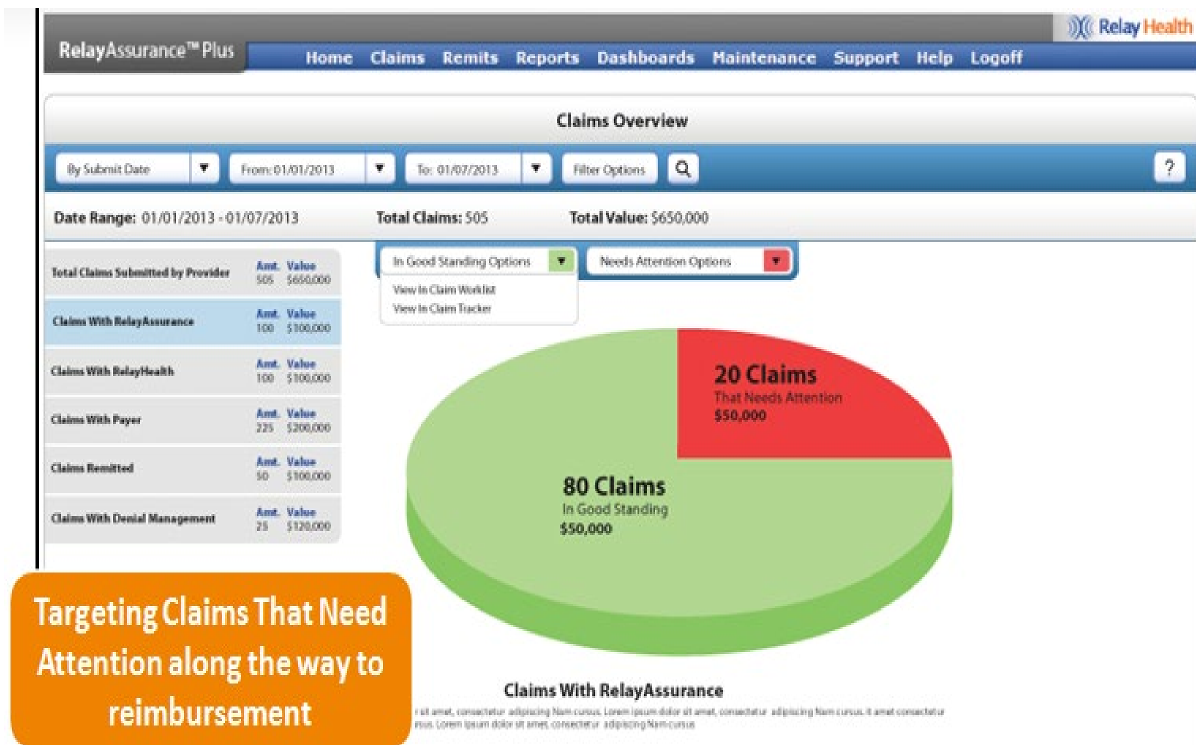

Figure 14. Gain visibility into when claims are heading for trouble so users to react early to avoid delays.

The Reconciliation Manager Claims Tracker (shown in Figure 15) drills down to the individual claim. The system gives billers a visual indicator of how well the claim is progressing. Color-coded alerts indicate issues or potential issues that need immediate action. High- priority denials that meet assigned criteria appear in red on the dashboard and in the tracker view. Staff members can quickly correct the claim and resubmit, helping to reduce denials and A/R days. Early and proactive identification of claim processing exceptions at a payer, either thru leveraging status information provided by a payer or through threshold based alerting, reduces the follow-up cycle time and the "let me go check" workflow models that have burdened claims processing teams for decades.

Claim Tracker

By Submit Date | From: 01/01/2013 | To: 01/07/2013 | Filter Options

Total Claims: 500   Total Value: $620,000   Date Range: 01/01/2013 - 01/07/2013   View In Claims Overview   View In Worklist

Actions

CPID	Payer Name	Patient Name Control #	Batch ID	Dollar Amt.	Dates Of Service	Relay Assurance Received	Relay Assurance In Process	Relay Assurance Released	Relay Health In Process	Relay Health Transmitted	Payer Received	Payer Accepted For Adjudication	Relay Assurance Remitted	Relay Assurance Denial Management
1407	BlueShield Of Georgia	Kraisner, Charles 27969237M31H...	0000000000	$4,541.90	03/16/2013 03/16/2013									
5923	Freedom Blue WV	Kraft, Debra 27723545P27H	N/A	$19,561.23	02/15/2013 02/18/2013									
1573	Avmed Inc.	Jones, Gary AGH80589	E10023	$65.00	01/25/2014 01/25/2014									
4500	Aetna	Abbott, Kathleen 27703660	N/A	$999,802,234.16	12/20/2013 02/19/2014									
1707	Advance Data Solutions	Absher, Mary Q07003	OHJUU12	$60,956.25	08/26/2013 08/27/2013									

Items 1 - 10 of 25   First   Previous   Next   Last   Rows to Display 10

Figure 15. Claims Tracker drills down to the individual claim. The system gives billers a visual indicator of how well the claim is progressing. Color-coded alerts indicate issues or potential issues that need immediate action.

Medicare Direct Entry (MDE): MDE is the only product of its kind associated with an EHNAC-accredited clearinghouse. Medicare Direct Entry help manage Medicare claims and integrates with all other workflows, including integrated Return to Provider corrections to offer:

- One-click error correction
- Reduced RTP / rejections
- Accelerated Medicare claims payment by at least one business day
- Simplified and speedy automated secondary billing
- Elimination of the need for additional Medicare claims processing system

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MDE checks claims for eligibility errors and submits them directly to Medicare in real time so CLIENT can avoid fiscal intermediary delays. Claims with errors are corrected within the system. It expedites reimbursement and accelerates your Medicare primary claim cash flow by at least one business day and secondary billing by more than two weeks (see process flow in Figure 16) MDE enhances productivity, accelerates cash flow, and virtually eliminates claim suspensions and rejections.

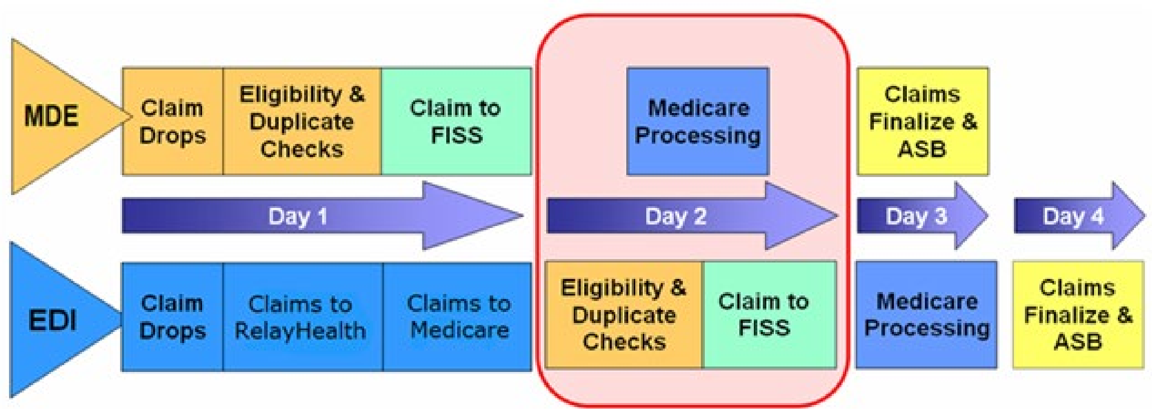

Figure 16. MDE provides a faster avenue to Medicare Reimbursement versus usual EDI processes.

Assurance Attachments is a feature that integrates worker's compensation and property and casualty claims Attachments into the claims workflow at **no additional charge**. This promotes cash acceleration and staff productivity. We also offer Assurance **Attachment**s for Medicare Direct Entry to help you **integrate Attachments into** your claims workflow so you can send supporting documents to payers and Medicare to secure payment and prevent rejections.

Assurance Remittance Management uses normalized 5010a 835 formats to process payer remittances that are delivered into your Patient Accounting System and posted to the claim in Assurance (as shown in Figure 17). Remittance data can be customized, split or otherwise tailored to meet your specific posting needs. Unique to Assurance is the ability to post remit data to the claim in the claims management database. This posting contributes to the full claims tracking and claims status features in the system and triggers the Automated Secondary Billing (ASB) feature for claims that require secondary billing. CLIENT may configure secondary billing options at the remittance payer level (i.e., different rules for operating with a Medicare remit than a Medicaid remit or charity care remit) as well as secondary billing rules specific to the secondary payer (e.g., when secondary is BCBS, add Value Code for Deductible to the claim).

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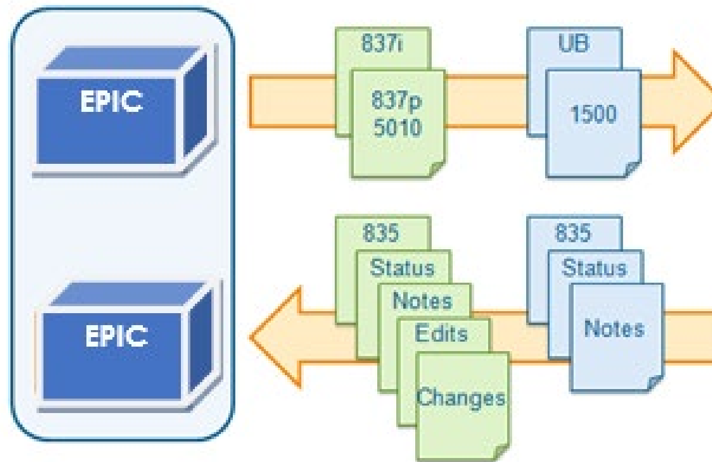

Figure 17. Epic System Integration offers one single automated billing solution with Assurance.

Automated Secondary Billing: Change Healthcare supports electronic submission of secondary claims as supported by payers. The Automated Secondary Billing (ASB) feature of Assurance helps manage your secondary volume by automatically generating the secondary claim, including CAS segments and explanation of benefits (EOB) from the primary remittance advices. These claims/EOBs can be delivered electronically if the payer is capable or Assurance gives you the ability to print and mail your claims in-house. Paper claims can be printed and by CLIENT or by Change Healthcare.

Payment Automation is a blend of technology and a service, that automates paper remittances to expedite payment processing and posting activities (as shown in Figure 18) Today, approximately 20% of remittances are paper and processed manually. Payment Automation complements the electronic remittance capabilities of Assurance by converting CLIENT paper EOBs to 835s to maximize automated posting opportunities and give CLIENT fully electronic tracking capabilities of all your remittance transactions. Images of paper remittances are available alongside the 835 file in the Payment Manager portal to allow users to reference the paper item, as needed. The solution includes the following components:

- ***EOB Conversion*** — uses a blend of technology and skilled revenue cycle experts to comprehensively convert paper EOB documents into 835s and provides meaningful denial code information. It helps CLIENT improve productivity and reduces the cost of payment posting. The solution has achieved higher “first-pass yields” (the amount of 835s that automatically post without human rework).
- ***Correspondence Processing*** — a service that allows CLIENT to efficiently process and archive correspondence in less time with fewer resources, saving you time and money.
- ***Funds Verification*** — neutralizes payer’s varying payment practices by offering CLIENT the ability to automatically re-associate any payment to any remittance item, regardless of whether those items are issued in paper or electronic format or arrive at different times. It delivers an 835 in a

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standard consumable format and simplifies remittance funding validations. Paired with Payment Automation's EOB Paper Conversion, it enables a single posting process for paper and electronic remits, regardless of payer variation.

- ***Healthcare Lockbox* —** is a bank-independent, healthcare-focused solution, designed for the advanced sorting and processing of healthcare paper documents, including: payments, remittances, zero pay denials, and correspondence. It is used in tandem with EOB Conversion services and serves to improve accuracy and efficiency of mailroom processing with healthcare expertise, and reduces cost of processing healthcare remittances and payments associated with lockbox services. The solution can scale as CLIENT grows without having to change established banking relationships.
- ***Posting Enrichment* —** transforms your remittance from a payer format to a provider-defined billing system input. We identify the appropriate billing lines/payees for both native ERAs and ERAs created from paper remittances. This is completed by applying business logic to existing data elements, such as NPI and Tax ID, to determine claim- and line-level splits by entity and billing lines. Streamlining, standardizing, and automating remittance posting increases revenue cycle efficiency and posting accuracy. Operational efficiency is also enhanced by utilizing the incoming remittance as a tool to power your revenue cycle workflow.
- ***New Cash Management Enhancements* —** leverages Payment Automation and Accupost solutions with a cash reconciliation workflow that streamlines a complicated end-to-end process.

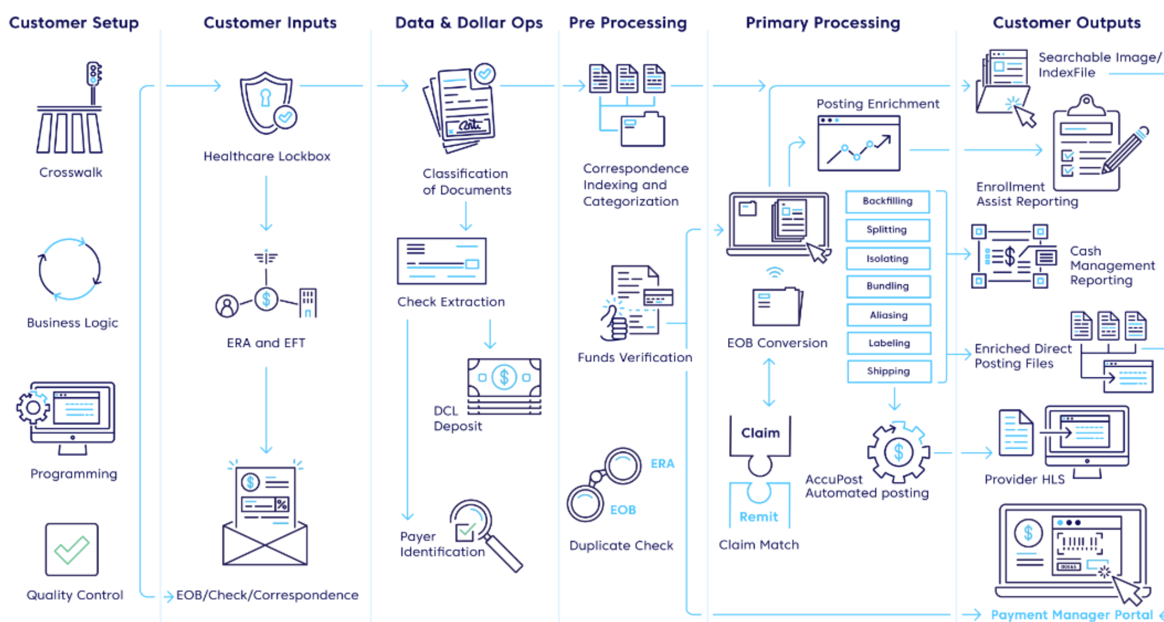

Figure 18. Overview of Payment Automation workflow offers accountability and traceability with real time reporting for posted and unposted cash.

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Assurance Status Amplifier gives CLIENT detailed visibility into claims status as early as one-day post submission and advises users how to remedy pended or denied claims. It uses proprietary payer portals to return the following benchmarks:

- 91% of claims paid in full within 30 days
- 85% reduction in denials
- 75% decrease in write-offs
- 51% increase in net revenue per FTE while reducing FTEs by 16%
- 42% reduction in A/R days (28 days) for our customers

Amplifier helps your staff resolve claims issues faster and reduces tedious and costly follow-up tasks that waste staff resources and delay payment. It automatically and quickly tracks down, inspects and reports accurate reasons for non-payment on claims from hundreds of payer portals. It offers CLIENT users specific advice about what action to take to resolve claims issues. ***(One hospital realized a 51% increase in net revenue per FTE even when challenged with a 34% increase in volume.)***

Assurance Appeals Assist enables CLIENT to respond to denied claims with an appeal, faster and more efficiently. It helps your staff create and track multiple levels of appeals, removing dependences on in-house resources or outsourcing firms. Using a library of standard forms and templates, based on built-in state-by-state (and Medicare) requirements for filing and processing appeals, your staff can streamline your approach to capture revenue on initially denied claims.

Assurance Comprehensive Reporting offers CLIENT over 100 standard and configurable reports to support all the solution's modules.

All our solutions provide exception-based reporting within the application. These reports, known as work queues (worklists), can be run against all the records in the database. Staff can query and filter reports based on the amount of information included in the request and returned by the payer. For example, you can use these parameters to filter by eligibility status, specific payers, specific claims status, financial classes, and more. Reports can be run on a daily, weekly, or monthly basis depending on need. Exception work queue capabilities let non-technical users easily create their own work queues or work queues that can be shared.

Specifically, Assurance error reports provide information of all edit errors contained on a claim including a claim error summary report, claim error detail report, field error detail, field error summary, Medical Necessity Errors, Eligibility Errors and CCI error details, to name a few. Error reports are available in various machine-readable formats, including xml, generally used by Epic clients to populate Epic work queues for errors requiring correction within Epic. All Assurance reports can be produced automatically as scheduled events and returned electronically. If CLIENT chooses to use Epic reporting, Assurance can feed claims data to Epic dashboard via csv.

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D. Comprehensive Analytics and Strategic Reporting

To add more value to your community, CLIENT needs to understand the drivers of performance, the impact of quality on financial outcomes, and the impact of potential efficiency gains. Pairing analytics-driven technology with our consultative feedback, we can help CLIENT leadership turn complex data into visionary plans that improve lives and the health of your community.

Our solutions are customized for CLIENT to leverage Epic platforms to drive transparency and layering in our Acuity analytics to improve revenue cycle performance. As the owners of the largest Intelligent Healthcare Network, **our data assets and consultative feedback are unparalleled in the industry**. Our national footprint and superior connectivity means you can count on Change Healthcare to help you leverage data to improve processes, profitability, and patient reach.

Assurance and Clearance Comprehensive Reporting offers CLIENT over 100 standard and configurable reports to support all of your business needs. It ingests information from Epic to provide exception-based reporting within the application. These reports, known as workqueues (worklists), can be run against all the records in the database. Staff can query and filter reports based on the amount of information included in the request and returned by the payer. For example, you can use these demographic parameters to filter by eligibility status, specific payers, specific claims status, financial classes, and more. Reports can be run on a daily, weekly, or monthly basis depending on need. Exception workqueue capabilities let non-technical users easily create their own workqueues or workqueues that can be shared. **Robust Clearance QA reporting also helps CLIENT set customized performance metrics, assess employee performance through dashboards and generate report cards for easy analyses.** Management can use the reports for remedial training and set actionable goals. With Clearance QA reports, your employees and supervisors receive the feedback they need to drive optimum speed and accuracy.

Clearance and Assurance data is layered into our robust Acuity Revenue Cycle Analytics business intelligence tool providing instant access to data and to drive revenue cycle performance. The platform provides you with access to historical data and trends across all of your facilities within minutes enabling deep analysis of patient access, billing efficiencies, denials, reimbursements, payer relations, ICD-10 impact, charge processes and clinical services (as shown in Figure X).

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We provide access to historical data and trends across all of your facilities enabling deep analysis of patient access, billing efficiencies, denials, reimbursements, payer relations, ICD-10 impact, charge processes, clinical services, and root causes of denials (as shown in Figure 19).

With near real-time access to key revenue cycle data, you receive information that is consistently up-to-date so you can stay on the pulse of your business and gain the agility you need to respond rapidly. The solutions provide you with hundreds of standard and ad-hoc reports that run as scheduled events or on-demand to answer your business questions and provide actionable insights into how to improve patient access process and revenue cycle issues. Data can be exported to Excel, Access or other Business Intelligence tools.

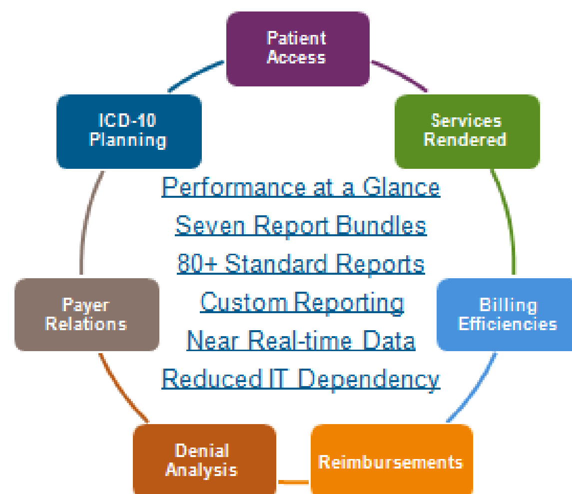

Figure 19. Acuity Revenue Cycle Analytics offers value to drive revenue cycle performance from patient access to reimbursements and denial analysis.

By having access to data across your revenue cycle, you gain increased visibility into your financial performance, payment velocity, and cash flow. The solution offers:

- A systematic approach to easily find answers from within your vast stores of revenue cycle data. With a search wizard, you can enter common terms to obtain a list of available reports relating to specific topics that align to your business objectives.
- Dozens of pre-packaged reports that align specifically to the business processes impacting your revenue cycle. Each report is configurable to access specialized data. You can drill down to obtain the unique information needed by your organization and track operational and financial performance over time. You can easily recognize trends, and quickly act to accelerate change when needed. The simplified, intuitive interface offers color-coded (red, yellow, green) report

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indicators to alert you when you are outperforming, on target, or underperforming per your goals. Please see Attachment B Change Healthcare Reports Gallery.

- An executive dashboard that provides an overview and drill-down capabilities of critical metrics within your operations relating to claim submissions, status and payment velocity.
- Acuity permits easy analysis of financial performance and operational results and offers dozens of pre-packaged reports that align to the specific business processes affecting your revenue cycle and can be easily configured to fulfill your organizational needs.
- Information to help you identify areas of risk for non-compliance, when regulatory requirements change, so you can adjust systems or processes to help avoid unnecessary penalties or rework.
- Services to help you optimize revenue analytics performance, e.g., training, quarterly business reviews, and access to on-call resources. These services help you better leverage your data to enable you to take strategic action, fully utilize the features, and help improve results

Additionally, our SmartPay solution provides standard and custom reporting of remittance data. Standard and custom reporting of consumer payment activity supports the entire cash management process, including real-time receipting, tracking, auditing, and performance reporting. Cash Drawer reporting printouts are used at end of shift to detail users' payment activity for bank deposit aggregation. CLIENT may elect to use our bundled merchant services option. Reports are sent daily by email and are also available within the solution portal. Standard reports include data related to duplicate checks, single checks, and other parameters related to lockbox deposits.

Acuity permits easy analysis of financial performance and operational results, and offers dozens of pre-packaged reports that align to the specific business processes affecting your revenue cycle, and can be easily configured to fulfill your organizational needs (as shown in Figure 20). represents a landing page of Acuity Revenue Cycle Analytics portraying some key information CLIENT might wish to view without running a complete report.

Given the multiple facilities that make up CLIENT, you can appreciate that Acuity Revenue Cycle Analytics provides access to historical data and trends within and across your facilities. It provides unrestricted access to existing patient access and claims data, allowing analysis of financial performance and operational results in minutes. Meaning that your IT resources can focus on other areas of operational importance.

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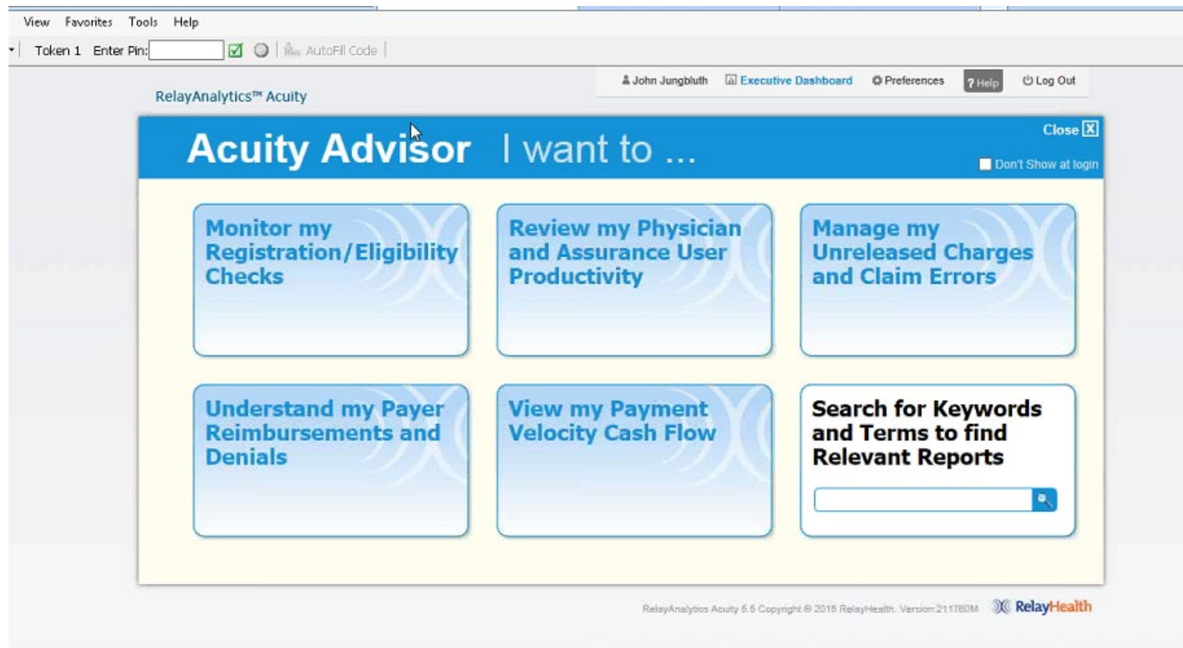

Figure 20. This landing page of Acuity Revenue Cycle Analytics Overview highlights key revenue cycle information without having to run a complete report.

Please see **Attachment** B Change Healthcare Reports Gallery and Attachment A Change Healthcare Solutions Brochures for information about the key functionality and features offered by Acuity Revenue Cycle Analytics.

Optional Solutions Not Priced in this Proposal

While many vendors provide multiple niche products for certain points of the revenue cycle, the Change Healthcare portfolio comprises unique data sciences, expert staff, and end-to-end revenue cycle technology that can hand you the keys to financial security. Change Healthcare offers you a full continuum of revenue cycle management services that includes patient access and financial clearance, financial counseling, call center appointment scheduling, coding and billing, claims submission, claims denial management, accounts receivables, and revenue optimization services including underpayment services. Our single vendor portfolio can further reduce risk and improve revenue predictability for a high-performing revenue cycle at CLIENT.

To support holistic revenue cycle management, CLIENT may also wish to consider the following optional revenue cycle solutions and services:

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Optional Revenue Cycle Management Services

We are a proven source of managing all aspects of hospital-owned and independent physician practices for over 35 years.

Our specialists have an average of 7-10 years of experience and a 95% accuracy rate. As a national leader in coding and billing, we process more than $18 billion in charges for more than 30,000 physicians annually. Additionally, we handle roughly 9.5 million patient contacts a year through our call centers. **Our team is certified in Epic PB Resolute and Epic Cadence credentialed trainers. Overall, we have 780+ Epic user team members encompassing 2,000+ physician representing 17.5M procedures, $4.85B in Charges with $1.30B in Collections annually supporting twelve health and academic health systems nationally. Other RCM Services include:**

- **Patient Call Center Services** provides compassionate, clinically-certified quality staff to schedule your patients, remind them of appointments, and accept payments to increase collections
- **Medical Coding and Billing Services** offers expert and credentialed staff to help CLIENT expedite third-party and self-pay collections and keep you compliant

Eligibility and Enrollment Advocate (EEA)

Our Eligibility and Enrollment Advocate solution augments CLIENT's staff to recover revenue by identifying missed government and third-party coverage. Our Patient Benefits Advocates (PBA) consult with patients at the bedside to determine their eligibility for enrollment in government, local, or state funding and secure payment for care that would otherwise be uncompensated.

EEA helps CLIENT stay focused on quality care delivery to improve patient satisfaction and revenue. Our onsite staff helps patients understand their financial responsibility and devise payment plans, if needed, prior to service. The EEA solution suite can enhance and expand your Emergency Departments, inpatient and outpatient services and staff. The suite includes:

- **Self-Pay Coverage:** help decrease uncompensated care and reduce bad debt by helping patients find appropriate funding sources for medical bills
- **Third-Party Coverage:** optimize reimbursement for all accident-related claims
- **Financial Counseling:** that educates and enrolls your patients in resolutions to pay their medical expenses and reduce risk

No-Risk, Performance-Based Revenue Optimization Services

Charge Insight cloud-based predictive analytic solution integrates with Epic to identify missing charges both pre-and post-bill. The solution is an advanced analytics-based charge capture solution which combines machine learning techniques and human intelligence to learn complex relationships and relevant patterns hidden in the patient billing data and predict missing charges with high level of accuracy.

Underpayment Audit and Recovery Services audits every claim to recover undetected and/or unrecovered contractual underpayments. Some health systems rely solely on a contract management module in their HIS. While these modules are helpful, you may

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be leaving dollars on the table. Our contract modeling system is robust and we are often asked to come in behind a current vendor partner to do a second sweep. For instance, in zero balance accounts and demonstrating our value by finding millions of uncovered dollars.

Denial and Appeals Management utilizes expert clinicians to generate appeals on all types of denials including medical necessity, authorization, DRG downgrades, and other clinical-related claims. We can create placement files for CLIENT (from the 835's & 837's) and work denials based on criteria like dollar amount and denial reason. A seamless process, and we can help ensure you don't miss an opportunity to appeal because of untimely filing. We also provide reports on root-cause analysis, and hold regular meetings with our clients to help solve problems that are causing denials.

Reimbursement Manager supports both professional and institutional contracts. It offers CLIENT the ability to input payer contracts using an intuitive reimbursement framework that simplifies even the most complex payer contracts. It offers real-time user guidance and validation when creating or updating contract rate schedules. Users can create pricing calculations leveraging multiple data points and variables with the ability to save pricing components to a library for reuse. The system offers pre-define payment methodologies and self-service capabilities to create formulas using math operations,

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Section 2: Company Overview

We are uniquely positioned to consolidate CLIENT's hospital and physician revenue cycle management into one single automated solution within Epic so you can stay focused on quality care delivery. Since 2003, we have been CLIENT Affiliated Practice's trusted revenue cycle management services partner and are providing Business Intelligence Performance reporting to enhance operations. To date, we have achieved a net collection rate of 99.68% along with the following ROI benchmarks:

- Days in AR 22
- AR Over 120 Days 4.5%

As one of the largest independent healthcare technology companies, we are dedicated to making healthcare smarter and to creating intelligent networks that expand access, are environmentally responsible (reduce waste), and bring people and information closer together to improve healthcare. **Our solutions are actively transforming a healthcare system burdened by paper to one that is enabled by automated solutions to reduce costs while advancing safety and efficiency.**

A champion of innovation, we have re-engineered and automated the revenue cycle end-to-end to reduce your cost to collect and help you achieve and maintain the highest performing revenue cycle (as shown in Figure 21). Our Software-as-a-Service (SaaS) model enables seamless integration with Epic across your enterprise to improve efficiencies and add value to CLIENT.

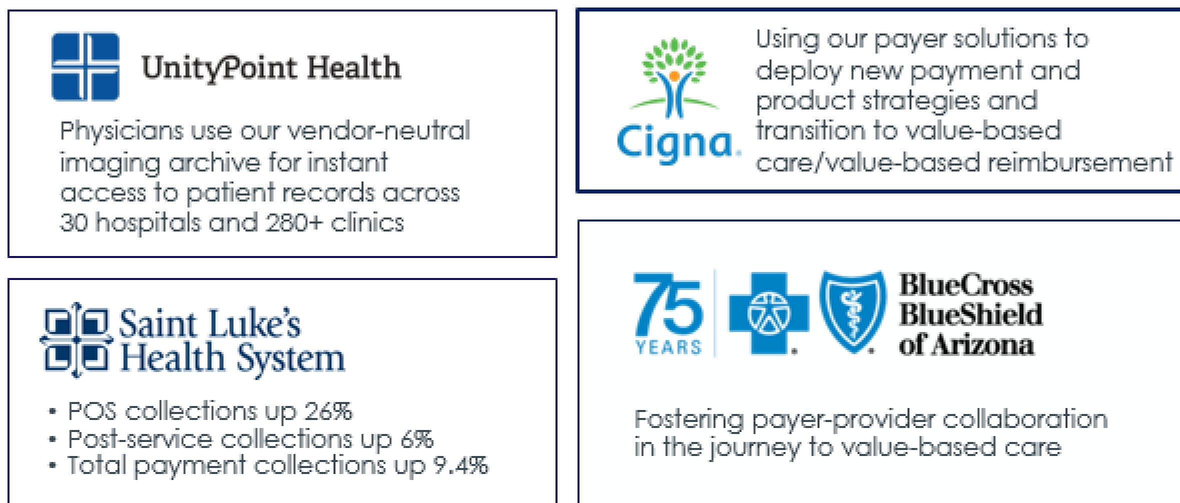

Figure 21. Change Healthcare is driving collaborative and positive change across the healthcare industry.

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As a key catalyst in the journey to value-based care, we are fostering collaboration and innovation to help you achieve a healthier bottom line and future. CLIENT can benefit from our healthcare experience — over 35 years of providing financial, operational, and clinical benefits to payers, providers, and patients. Our insight-driven innovation and expanded capabilities mean that you receive more strategic services and 24/7 award-winning customer support to achieve your goals.

Our solutions are built on top of our Intelligent Healthcare Network™, the single largest financial and administrative network in the United States. With the most diverse client footprint in the industry (as shown in Figure 22), we represent the single greatest point of connectivity in the U.S. Our growing network connects more than 5,500 hospitals/health systems and 800,000 physicians, to more than 2,600 payers, processes 4+ billion financial transactions annually, representing more than $2 trillion in billing.

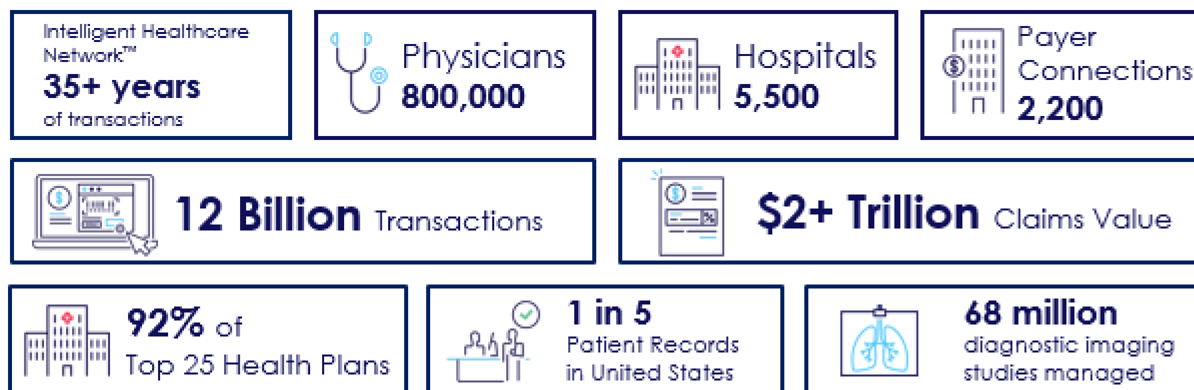

Figure 22. Change Healthcare offers our clients a breadth of revenue cycle technology and services that are unmatched by competitors.

We have the largest footprint in the industry processing patient eligibility verification and claims in more than 60% of hospitals/health systems nationwide and reaching 90% of covered lives. Change Healthcare owns and operates one of the world's largest EHNAC-certified clearinghouse's with direct access to 97% of 2,600 payers and to 5,500 hospitals/health systems with 800,000 clinicians (as shown in Figure X). Our company has $3.4 billion in pro forma combined total annual revenues for the fiscal year ended March 31, 2016. Last year, we managed 4+ billion acute and ambulatory financial transactions valued at more than $2 trillion in annual healthcare billing.

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Our comprehensive, cloud-based, high-performance revenue cycle solutions successfully integrate value-based models into your existing Epic to meet all your requirements. Our end-to-end solutions offer linkages and analytic tools from pre-service to point-of-service to post service to improve care delivery, reduce debt, and inspire better healthcare systems. ***While many vendors provide multiple niche products for certain points of the revenue cycle, our portfolio comprises unique data sciences, expert staff, and end-to-end revenue cycle technology that can hand you the keys to financial security. Our single vendor portfolio (as shown in Figure 23) can further reduce risk and improve revenue predictability for a high-performing revenue cycle at CLIENT.*** The full suite of automated patient access and claims management technology as well as comprehensive revenue cycle services are tailored to enrich integration and enhance the Epic user experience.

Our End-to-End Revenue Cycle Solutions help your organization to:

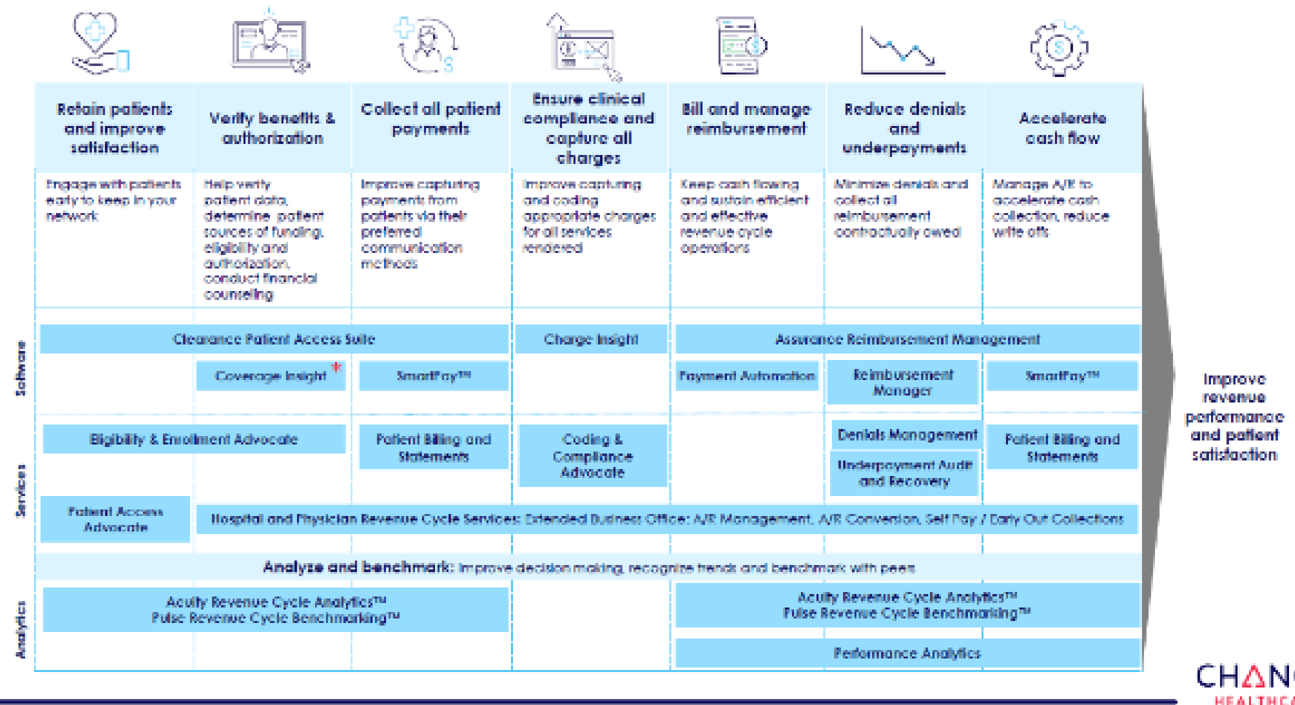

Figure 23. No other vendor can provide CLIENT with more connectivity and services to take charge of your revenue cycle to improve performance and patient satisfaction.

Our interoperable, end-to-end revenue cycle products and artificial intelligence (AI)-driven automation deliver more value with less effort, allowing you to perform tasks more easily and accurately to accelerate revenue. It also provides CLIENT with strategic insight where improvements might be most favorable across your enterprise.

Change Healthcare solutions provide superior operational workflow, better revenue opportunities, and greater scale than others in the industry. With our solutions, you'll receive analytics-driven, exception-based workflows that help CLIENT efficiently manage all types of

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acute and non-acute claims (commercial, workers' compensation, Medicare, Medicaid) and remittances in one system improve to better care for your patients and community.

We can also provide CLIENT leadership with access to superior revenue cycle support. We have over 14,000 employees based at 100 locations nationwide and 10 international locations to support CLIENT, our clients, and partners. We currently support CLIENT with our four virtual customer support centers (Atlanta, GA; Dubuque, IA; Columbus, OH and Tulsa, OK) where you obtain award-winning customer service and submit any service orders for issues you may have. Our corporate offices are in Nashville, TN and in Alpharetta, GA, which houses our Education Center where CLIENT employees can attend hands-on training.

Demonstrated Competence and Industry Experience

Change Healthcare is a leader in revenue cycle solutions (shown in Figure X) and is committed to being the single greatest point of connectivity in the U.S. for our clients and the industry. As a key catalyst to a value-based healthcare system, we can work alongside CLIENT and provide you with proactive ways to provide measurable impact as you navigate industry changes. **Our comprehensive, cloud-based, high-performance revenue cycle solutions successfully integrate value-based models into Epic to reduce manual touchpoints and standardize processes across your enterprise to provide:**

- Direct access to 97% of 2,600 payers through our EHNAC-certified clearinghouse, reaching nearly all United States government and commercial payers. We serve 5,500 hospitals and more than 800,000 physicians, helping health system leaders achieve strategic objectives.
- Our best-in-industry library of more than 10M payer-, government-, clinical-and client-specific edits (with a 99.5% rate of updating prior to the effective) throughout the revenue cycle to prevent denials and drive clean claims.

24/7 Award-winning Customer Support

CLIENT can expect to receive quality customer service as evidenced by our numerous industry awards and accreditations (Omega Northface, SCP Certification, EHNAC Certification) and our recent benchmarks:

- **We maintain a 98% client retention rate.**
- Our award-winning customer support and service is delivered by 14,000 employees at over 100 locations nationwide.
- Our customer support centers have an average speed-to-answer of 20 seconds or less with a call abandonment rate less than 3%.
- Our average customer support resolution time for claims processing issues is 1.97 days.
- Epic-certified consultants working together with Epic for more than a decade to develop bi-directional revenue cycle solution interfaces to more than 400 clients.

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- Our customer support team ratio is one support person to every 16 clients (1:16) and more than 60% of all issues are resolved on first call.
- **More than 70% of our product enhancements come directly from client feedback.**

Pricing Advantage

By choosing Change Healthcare as your vendor, CLIENT can immediately add value and ROI to your current investment with:

- Unlimited eligibility checks across your revenue cycle **for a flat fee.**
- Unlimited client-specific edits at **no additional charge.**
- Unlimited business edits provided four times a week at **no additional charge.**
- Automated application updates or upgrades at **no additional charge.**
- User-friendly and intuitive workflows that minimize training needs.
- More net revenue per FTE.
- No hardware or maintenance requirements to use our system.
- No licensing requirements.

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Section 3: System Functionality

Please see completed Exhibit A for our response to the System Functionality questionnaire.

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Section 4: Additional Questions

a) Describe the general usage of your product, including workflows between Epic and your application.

While the point of care delivery is the most visible measure of quality and value, we are a healthcare technology solutions company that uniquely champions the improvement of all the points before, after and in-between care episodes. **Our comprehensive, cloud-based, high-performance revenue cycle solutions successfully integrate value-based models into your existing Epic to standardize processes and add value across your enterprise.**

The Software-as-a-Service (SaaS) model enables seamless integration with Epic across your enterprise to improve patient access, claims management, and billing efficiencies and add value to CLIENT. Our solutions are provided in a hosted SaaS delivery model. We manage the application environment and implement software upgrades on your behalf at no additional cost. No hardware or software is required, users only need internet access. **Detailed systems integration diagrams have been provided in Section 1: Solution Descriptions.**

Our host integration provides CLIENT a flexible and customer-configured data extraction process that is tailored to meet the specific format requirements of your Epic patient accounting system. Specifically, we offer an integrated connectivity option that enables you to seamlessly integrate with our intelligent healthcare network with blockchain, from your client application. For example, this API offering provides an alternative to FTP batch submissions and gives you flexibility in how you submit claims to us for editing.

For greater service and value-added solutions, we have an API available in .NET or Java formats that can facilitate development efforts. This powerful, easily implemented toolkit decreases your implementation time, promotes seamless user experience, and enhances efforts to be fully compliant with regulatory requirements.

Points of Integration with Clearance Patient Access Suite

Clearance automates the exchange of ADT and eligibility information. Each customer has unique needs that are evaluated during the implementation process to determine how they can be best supported.

Interfacing can be readily accomplished by:

- HL7 Outbound and Inbound ADT transactions
- ANSI X12 270 / 271 transactions
- Flat File Outbound and Inbound

With API integration, Clearance allows inquiries to be automatically initiated in real time and return responses in a matter of seconds. During the registration process, the 270 initiates the eligibility request, making it possible to submit the request prior to the registration being finalized. To process eligibility transactions, HIS generates the 270 transaction that is routed to Clearance via

a secure VPN connection. Clearance can process the request through the payer and return a 271 to the VPN. The 271 is then loaded via the 271 interface back to the HIS.

Points of Integration with Assurance Reimbursement Management

Assurance/ Epic host Integration provides claim, claim status and claim history information through an automated extraction process that supports integration of information within Epic. Claims are automatically scrubbed with our industry-leading library of more than 10M edits which are embedded in the application and at our clearinghouse of more than 2,600 payers.

- Integrates directly with Epic with detailed 835 data automatically posting back to the individual account or line item
- Receipt of transactions from payers such as 277, 997, and payer response reports. Solicited 277 files can be uploaded into your HIS and Assurance can provide other payer rejection data in an up loadable file format.
- Receipt of claims status information from payers, Assurance automatically solicits claims status to connected payers, posts the response information to the claim, and returns the normalized ANSI 277 (5010) for use in your HIS
- Generated file that includes changed claim data and edits can be uploaded to the host patient accounting system.

Updates, maintenance and upgrades to our solutions are provided at no additional cost to CLIENT for the life of your contract. We manage the application environment and automatically implement software upgrades on your behalf ensuring you operate on the most recent version for optimal results.

Upgrades are usually performed quarterly, depending on the features enhanced and patches required. To minimize downtime, maintenance is performed during off-peak hours (typically less than one hour). Downtime is not always required, and is driven by the scope of the upgrade. Scheduled outages can consist of software upgrades (both production application or as required for OS, security or compliance), hardware updates (bios, new devices), and network enhancements and maintenance. During maintenance windows or pre-arranged client upgrade windows, our staff is available in the office to serve your needs.

Notification for system upgrades is provided to our customers with generous lead times. System updates (i.e., product update to new version) take place on weekends and client notification begins two to four weeks prior to the release. Our customer support team provides email notifications two weeks prior to the upgrade and a reminder one week prior to the maintenance date including documentation related to any changes in the product. A final notice is sent the day prior to the upgrade.

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b) Describe your backup system in the event of system downtime.

Backups are performed daily on all production systems. Real-time and daily backup technologies are in use across the system, depending on the volatility of the data. We maintain seven years of archived claims and ERA data–as required by federal law in our two data centers, which can be retrieved upon request.

In the event of a disaster, there are sufficient redundancies built into the configuration to ensure that adequate resources are available to continue processing your organization's transactions. Having our system servers housed in two geographically separated secure data centers allows us shift work to an alternate data center as applicable and necessary. Because our data centers and backup are geographically separated, should a disaster occur, data and processes can be restored within a reasonable time. Our disaster recovery plan has a RPO of 36 hours and a RTO of 72 hours. Change Healthcare system uptime is 99.83%.

c) Describe your backup process in the event of Epic downtime.

Backups are performed daily on all production systems. Real-time and daily backup technologies are in use across the system, depending on the volatility of the data. We maintain seven years of archived claims and ERA data–as required by federal law in our two data centers, which can be retrieved upon request. Because our data centers and backup are geographically separated, should a disaster occur, data and processes can be restored within a reasonable time. Our disaster recovery plan has a RPO of 36 hours and a RTO of 72 hours.

d) Please attach examples of "out of the box" reports that will be available with the recommended solution.

As the owners of the largest Intelligent Healthcare Network, our data assets and consultative feedback are unparalleled in the industry. Our national footprint and superior connectivity means you can count on Change Healthcare to help you turn your data and industry benchmarks into visionary plans that improve processes, profitability, and patient reach.

We understand that to be competitive and add more value to your community, CLIENT needs to understand the drivers of performance, and the impact of quality on financial outcomes. **As such, our analytics-driven platform is layered with AI-learning analytics and hundreds of customizable out-of-the-box reports that can help CLIENT track trends and improve care delivery to your patients. Training in the analytics and reporting functionality is included as part of our standard implementation.**

Please see Attachment B Change Healthcare Gallery of Reports.

e) Provide an overview of the professional services included in the quote, including implementation, validation, and ongoing support.

Change Healthcare offers CLIENT award-winning customer service that is provided at no additional cost for the life of your contact. Our Product Support Center has received the prestigious Service Capability & Performance (SCP) certification as a world-class support center

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for the past 18 years. We have a dedicated team of implementation and support personnel who pass the rigorous SCP Call Center Certification each year. Other service differentiators include:

- We maintain a 98% client retention rate
- Our award-winning customer support and service is delivered by 14,000 employees at over 100 locations nationwide
- Our customer support centers have an average speed-to-answer of 20 seconds or less with a call abandonment rate less than 3%
- Our customer support team ratio is one support person to every 16 clients (1:16) and more than 60% of all issues are resolved on first call

Proactive Support through an Assigned Client Executive

Your satisfaction and success with our solutions is our number one priority. In addition, CLIENT receives proactive customer support through the relationship management activities of your assigned client executive (CE). Your CE serves as your trusted advisor and is readily available to assist you as a single point of contact for issues, escalations, strategic planning, process improvements or any other business-related needs. Your CE liaises with CLIENT leadership and your client executives to ensure that all your revenue cycle business needs are met. **The CE maintains an intimate knowledge of all aspects of your business, including overall strategy, IT initiatives, and any market challenges to drive optimum utilization of our technology.** He/she schedules regular status and planning discussions to review Return on Investment (ROI) and business processes, and meets with your management team to review our performance. An important part of these sessions is a discussion of any opportunities to add value as a business partner.

In-House Epic Consultants

Within two weeks of contract execution, we assign a Revenue Cycle Management Advisory team and designated project manager to CLIENT to ensure a successful implementation. **Our in-house Epic consultants will work with your RCM Advisory and CLIENT's project team to enrich Epic integration and create new functionality to improve systems.** Customized project plans are configured to align with CLIENT's unique needs and business objectives. Your Advisory team is tasked with helping CLIENT gain rapid proficiency with our solutions, optimize workflows within your operations, and improve system performance and ROI. Weekly status meetings are held via webex to track progress toward system performance enhancement. Please see Attachment C for a sample of our Epic Implementation Guides and sample project plan.

Unlimited Training for the Life of Your Contract

Your success is our success. We understand that education is a critical component to CLIENT's success. We understand that education is a critical component to CLIENT's success and work with you to determine your specific training needs and custom design a training plan and schedule accordingly. **Our multi-channel learning platforms help equip CLIENT with the knowledge and skills necessary to build competency with our industry-leading solutions and maximize your ROI.**

We offer a blended approach to training that helps you integrate our revenue cycle solutions into your processes and workflows to optimize performance. **Resources include a synergy of educational tools for quickly establishing proficiency and maintaining knowledge through a combination of classroom instruction, 24/7 self-service portals, real-time dashboards, skills assessment portals, and computer-based tutorials, and policy and process manuals**. Materials address the needs of all tiers of employees and topics whether it be for a new employee or a tenured employee seeking refresher or remedial course training. Training is generally organized into four phases:

- Introductory education for the project team enables appropriate decisions to be made during implementation
- Site administration training prepares CLIENT to set up and support the solution
- Train-the-trainer education enables users/trainers to be fully prepared to use the system at go-live
- Ongoing training for post go-live educational support

Hands-on, Instructor-led Training at Georgia Training Center

We encourage CLIENT staff to take advantage of our instructor-led classes that are taught at our Education Center located in Alpharetta, Georgia.

Specifically, we offer a variety of classes to instruct your staff on how to integrate our revenue cycle solutions into your processes and workflows. The foundation of our education programs are instructor-led classes providing hands-on activities designed to facilitate knowledge transfer.

Any number of your staff can attend training. We encourage key members of your hospital revenue cycle team, including trainers, business system analysts, patient access and registration managers, business office managers, and lead billers to attend live training sessions at our Education Center, in addition to those who are a part of the implementation project team.

Ongoing Guidance Tools

We provided post go-live learning tools to educate your organizational trainers. We fully prepare them to execute training plans for other Apria staff. Available training resources include:

- Job aids
- User documentation
- Training guides
- Training videos
- 24/7 access to our online knowledge portal, a catalog of in-depth, self-guided, training offerings
- Instructor-led or Train-the-trainer education services
- Web-based training (recorded or instructor-led)

Other guidance and training tools available to your staff include:

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- Help button on each dashboard
- Job aids
- User documentation

f) Provide background on how the system integrates with Epic. Include detailed system requirement and integration points to allow the CLIENT integration team to determine if the configuration will be compatible and sufficient.

Change Healthcare has a strategic partnership with Epic that spans more than a decade that has inspired deep integration and workflow efficiencies to improve revenue cycle performance. We have one of the largest Epic footprints in the industry and have our solutions and services installed with more than 1,000 Epic clients. Additionally, out in-house Epic consultants will work with CLIENT to customize our solutions to meet your business and charitable requirements.

Our host integration provides CLIENT a flexible and customer-configured data extraction process that is tailored to meet the specific format requirements of your Epic patient accounting system. Specifically, we offer an integrated connectivity option that enables you to seamlessly integrate with our intelligent healthcare network with blockchain, from your client application. For example, this API offering provides an alternative to FTP batch submissions and gives you flexibility in how you submit claims to us for editing.

For greater service and value-added solutions, we have an API available in .NET or Java formats that can facilitate development efforts. This powerful, easily implemented toolkit decreases your implementation time, promotes seamless user experience, and enhances efforts to be fully compliant with regulatory requirements.

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- Generated file that includes changed claim data and edits can be uploaded to the host patient accounting system.

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Section 5: Time Availability

We look forward to demonstrating how our extensive RCM portfolio can add value to CLIENT's current investment with Change Healthcare. Our sales team and subject matter experts are available to present our solutions according to CLIENT's time schedule. We would request at least a week's advance notice to make travel arrangements.

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Section 6: Security Risk Assessment

Please see completed Exhibit B for our response to the Security Risk Assessment questionnaire.

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Section 7: References

Company Epic References

CONFIDENTIAL MATERIAL CONTAINS HIGHLY SENSITIVE PROPRIETARY INFORMATION

Out of consideration for our clients, **we coordinate reference calls upon being named vendor of choice. Our reference clients greatly appreciate working through our Change Healthcare account executive team in this process**. CLIENT can expect the same level of confidentiality and protection with respect to your privacy.

Reference #1	

Reference #2	

Reference #3	

Reference #4	

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Reference #5	
Company Name:	[redacted]
Contact:	[redacted] [redacted]
Solution:	[redacted]
Length of Contract:	[redacted]

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Section 8: Cost

Please see completed Exhibit A for a copy of our Cost Proposal.

A. Assumptions

Pricing is based on the following assumptions:

- Pricing is **valid until 8/1/19.**
- Pricing is based on a 36-60 month contract.
- The services offered are based on Epic integration.
- Pricing for **Clearance Eligibility** checking offers unlimited transactions.
- Pricing for **Clearance Estimator** is based on a minimum encounter volume of up to 70,000 per month.
- Pricing for **Assurance** is based on an estimated HB claims volume of up to 100,000 claims per month.
- Pricing **for Patient Billing and Statements – Print** pricing assumes 890,000 statements per year for all services.
- Pricing for **Clearance Enhanced Eligibility** is a contingency based fee optional with monthly subscription.
- The proposed pricing is not considered Best and Final Offer. We are open to negotiation.

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Section 9: Mission and Values

a) Demonstration of overall alignment.

As one of the largest independent healthcare technology companies in the nation, we are dedicated to making healthcare smarter and to creating intelligent networks and paperless-technology that is expanding access, is environmentally responsible (reduces waste), and brings people and information closer together to improve healthcare. **We are champions of innovation and technology that streamlines and automates the day-to-day business of healthcare, so that you can focus on what you do best- delivering compassionate, charitable care. Together, we are working across the industry to deliver healthcare innovations that help our customers and their patients flourish.**

As a key catalyst to a value-based healthcare system, we can work alongside CLIENT and provide you with proactive ways to provide measurable impact as you consolidate vendors. **Our comprehensive, cloud-based, high-performance revenue cycle solutions successfully integrate value-based models into your existing Epic to standardize processes and add value across your enterprise.**

Inspiring a Better Healthcare System

While the point of care delivery is the most visible measure of quality and value, we are a healthcare technology solutions company that uniquely champions the improvement of all the points before, after and in-between care episodes.

Inspiring better healthcare systems, not only means creating technology to help our clients become better stewards of their resources, but it means fostering collaboration. **Working with your assigned Change Healthcare project team and Epic implementation experts, we can collaborate to create a stronger, better coordinated, and more efficient CLIENT healthcare system that enables better patient care, expanded access for the underserved, and choice and outcomes at scale.** Through our unique perspective and interconnected position at the center of healthcare, we can accelerate your path to value-based care and help CLIENT create more relevant engagement with your communities to positively impact the underserved.

b) Usage of proprietary patient data.

As a leading healthcare IT company, Change Healthcare offers you greater protection and security of your consumer data to mitigate risk, fraud, and abuse. We stringently comply with all federal and state-protected health information (PHI) regulations, security laws, and guidelines, including HIPAA standards for privacy and security, as they are refined over time. Our network has been continuously certified with the industry benchmark EHNAC accreditation for the past 18 years. Criteria include security, privacy and confidentiality, technical performance, business practices, physical and personnel resources, and data integrity. With a greater than 99% score on the last accreditation, we exceed the requirements for all aspects of security and privacy to deliver protection of our client’s interests.

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All our solutions adhere to HIPAA and all confidential client information is protected by encryption. This is accomplished through several encryption technologies, including PGP, SFTP and TLS, or through a direct network VPN. End users accessing the user interface are on a TLS- encrypted session at all times. User activity reports, database requests, file processing and all transactions with third-parties are logged. Diagnostic logging can be set to multiple levels as needed when troubleshooting problems.

Change Healthcare is committed to protecting the privacy and security of CLIENT and your patients' data. We are a frontrunner in developing HIPAA-compliant solutions, and we work with industry leaders to establish standards and best practices with respect to HIPAA. We also dedicate significant investments in technology upgrades and implementation resources to meet applicable HIPAA requirements. Our comprehensive compliance program, with an annual budget of more than $7 million, assures that appropriate rules/regulations are followed, including stringent Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines and other state and federal regulations relating to the security and protection of patient data.

We take extensive measures to safeguard patient information. Our SmartPay solution is PCI Level 1 compliant, and all applications are HIPAA compliant. All data is stored at Change Healthcare's secured data centers with logical access separation where strict, industry-standard security controls are implemented. SmartPay can save payment methods such as credit cards, debit cards, and bank accounts to digital wallets for timely payment of recurring obligations.

SmartPay offers protection on credit and debit card data when swiped and dipped for card present transactions. With our point-to-point encryption and Chip-Enabled Card Acceptance (EMV) readers, payment security is enhanced and reduces your Payment Card Industry Data Security Standard (PCI DSS) scope.

We have established connectivity using HIPAA-standard formats with more providers, vendors, and health plans than any other company, and we currently process the most HIPAA-compliant transactions in the industry. We fully embrace and will comply with all applicable rules. Change Healthcare's compliance program covers the seven elements as outlined by the Office of Inspector General: Designation of an official Compliance Officer and Compliance Committee; implementation of written policies and procedures including a Code of Conduct; conducting/delivering appropriate training and education; implementation of effective lines of communication; conducting audit and monitoring activities; establishing disciplinary guidelines; consistency in investigation protocols and corrective actions. Our compliance program helps to ensure that we conduct business honestly and ethically, and in compliance with the fundamental principles, policies and procedures that define our work.

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c) Adoption of CLIENT approach, including Healthcare Assistance Program (HAP) / Charity Care program.

Our in-house Epic consultants can easily configure our solutions to align with your HAP and Charity Care programs. Further, **our solutions are embedded with business logic and rules that offer unlimited, custom edits at no additional charge to CLIENT for the life of your contract.**

d) Evidence of social accountability.

We partner with our customers to reduce costs, create efficiencies, and effectively manage complex workflows. **Together, we are accelerating the journey toward improved lives and healthier communities.**

Today's healthcare environment is constantly evolving and we are committed to accountability to our customers and their patients and providing measurable impact as they navigate through these changes (as shown in Figure 24).

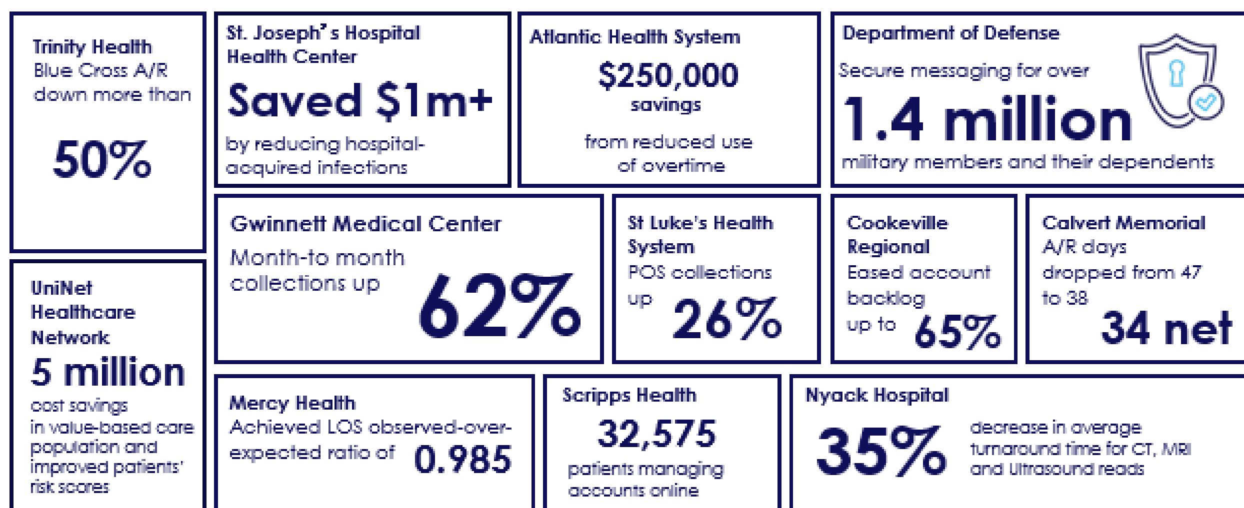

Figure 24. Change Healthcare solutions are helping our clients better steward resources to improve efficiency, reduce costs, and more effectively deliver quality care to improve lives.

Change Healthcare Social Accountability Initiatives

Change Healthcare invests broadly in practical healthcare technology innovations that are transforming a healthcare system burdened by paper to one that is enabled by automated

solutions that reduce cost while advancing efficiency and quality care. As leaders in healthcare technology, **we believe it is our responsibility to test, adopt, and refine new infrastructure and technologies.** Our investments extend the reach of emerging technologies across healthcare, supporting a healthy ecosystem of competitive applications.

Paperless Revenue Cycle Solutions- Change Healthcare has re-engineered and automated the revenue cycle end-to-end to create a paperless, environmentally friendly system that is seamlessly integrating with Epic to transform revenue cycles for more than 1,000 Epic clients.

Artificial intelligence (AI) in healthcare has the potential for a vast number of applications from increased personalization of healthcare to improved decision making. AI and machine learning are creating new efficiencies, such as mammograms that can be co-read by machines, reducing the impact of human error. Mostly impactfully, AI can significantly impact the financial and administrative aspects of healthcare by reducing waste and manual processes. At Change Healthcare, we are embedding AI into our solutions to reduce repetitive manual work, create operational efficiencies, and make healthcare more cost-effective.

Blockchain technology can help improve the efficiency, transparency, and security of the data reconciliation activities that plague the healthcare system. In January 2018, we launched the first enterprise-scale blockchain network in healthcare, allowing customers to track claims submissions and remittances in real time. By exploring the many uses for blockchain within our financial, clinical, and engagement solutions, we aim to provide cost-effective data integrity for high-volume transactions that offer greater accountability and traceability.

Leader in PHI Protection

Change Healthcare maintains superior qualifications, industry certifications, and licenses that ensure accountability to our customers.

The U.S. healthcare industry is regulated under mandates established by the U.S. Department of Health & Human Services (HSS) and Office of Civil Rights (OCR) resulting principally from the HIPAA and administrative simplification provisions of the Affordable Care Act (ACA) and other regulating entities and mandates.

Change Healthcare attains all certifications and licenses to meet Federal and State guidelines and regulations. We maintain the following industry recognized and trusted accreditations and certifications:

Change Healthcare maintains the following accreditations and certifications:

- PCI Certified
- HITRUST Certification
- Utilization Review Accreditation Commission (URAC) Health Utilization Management standard HUM 4
- Level 3 of the CMMI Institute’s Capability Maturity Model Integration (CMMI)
- Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE®) Phase I, II, and III certified
- CAQH CORE III certification seal
- Electronic Healthcare Network Accreditation Commission (EHNAC) Accreditation (Healthcare Network Accreditation Program (HNAP) Electronic Health Network (EHN) Program, e-Prescribing Accreditation Program (ePAP), and Direct Trusted Agent Accreditation Program (DTAAP) Privacy & Security accreditation)

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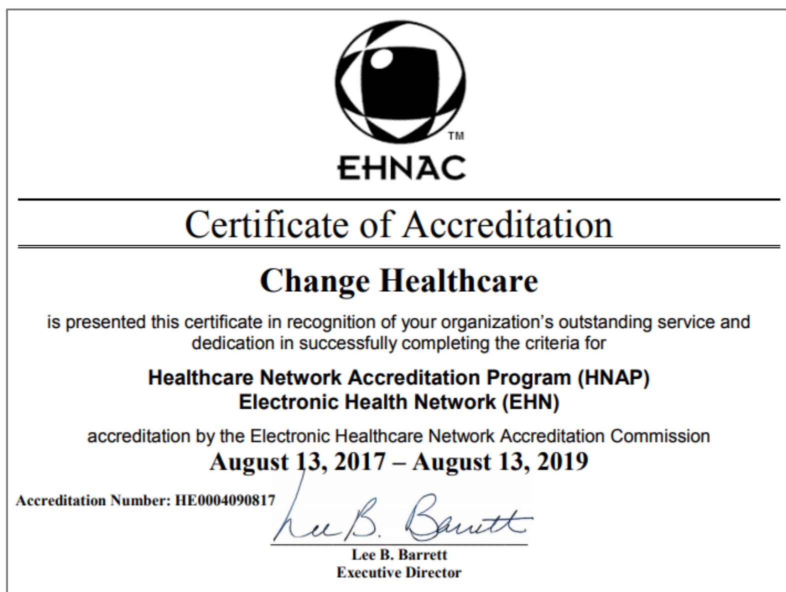

EHNAC

Certificate of Accreditation

Change Healthcare

is presented this certificate in recognition of your organization's outstanding service and dedication in successfully completing the criteria for

Healthcare Network Accreditation Program (HNAP)
Electronic Health Network (EHN)

accreditation by the Electronic Healthcare Network Accreditation Commission

August 13, 2017 – August 13, 2019

Accreditation Number: HE0004090817

Lee B. Barrett
Executive Director

- Maryland Healthcare Commission (MHCC) certified Electronic Health Network (EHN)
- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Measure Certification, California Value Based Pay for Performance (VBPP) Program Certification, and NCQA Health Information Product Physician and Hospital Directories (HIP4) Certification (the Change Healthcare Physician and Hospital Directory is certified for the 2018 HIP4 reporting season and is valid through 01.20.2020).
- Payment Card Industry Data Security Standard (PCI DSS) certification

Among the Change Healthcare NCQA-certified HEDIS products are Quality Performance Advisor™, Compliance Reporter, Risk Manager, and HEDIS© Smart (all comply with HEDIS 2018 technical specifications and are certified for the HEDIS 2018 annual reporting season)

As an organization that gathers data and checks the credentials of doctors and other healthcare practitioners, we have earned the following NCQA Credentials Verification Organization (CVO) certifications, all of which are valid for the CVO 2018 reporting season (through 11.23.2019): Application and Attestation Content, Application and Attestation Processing, DEA, Education and Training, Malpractice Claims History, Medical Board Sanctions, Medicare/Medicaid Sanctions, Ongoing Monitoring of Sanctions, Verification of Licensure, Work History.

For more information, visit: https://www.changehealthcare.com/about/accreditations-certifications

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Section 10: List of Attachments

Attachments	Description
Attachment A	Change Healthcare Solution Descriptions Brochures
Attachment B	Change Healthcare Reports Gallery
Attachment C	Epic Implementation Guides and Project Plan

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