A Primetime View on Real Time 270/271 Transactions

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IVANS Healthcare Community

- IVANS healthcare community includes over 30,000 Submitters
- Partner with CMS to support access for
  - Real Time 270/271 (MEIC: Medicare Eligibility Integration Contractor)
  - Part A Intermediaries / Part B Carriers
  - A/B Medicare Administrative Contactors (MAC)
  - DME Medicare Administrative Contractors (MAC)
  - RHHI (Specialty MACs)
  - Part D Plans / Sponsors
  - COBC (Group Health Inc.)
- Maintain strong relationships with Associations & Standards Organizations
    - Committee on Operating Rules for Information Exchange (CORE)
    - Centers for Medicaid & Medicare Services (CMS)
    - Workgroup for Electronic Data Interchange (WEDI)
    - Association of Telehealth Service Providers (ATSP)
    - American Telemedicine Association (ATA)

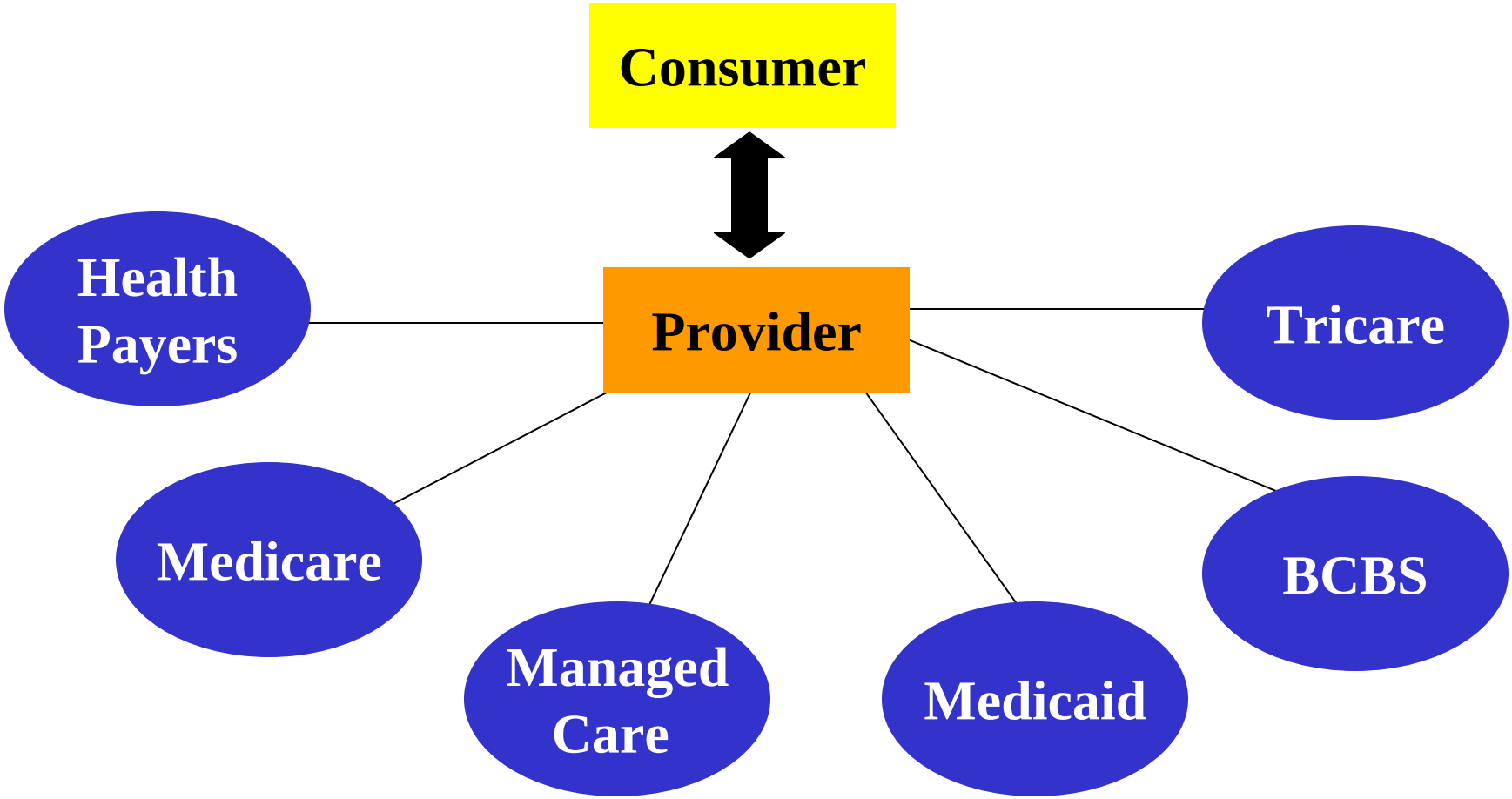
IVANS and Eligibility

- Community of users
- Interconnectivity between providers, vendors, billing agents, clearinghouses, payers
- End-user contracting, billing, enabling, support
- Solution for Medicare
  - Real Time
  - Batch
  - Online / screen scraping
  - IVR
- Solution for BCBS / Commercial Market
  - Batch
  - Real time
  - IVR

Roadblocks to Real-Time Adoption

- Technology
- Security Issues
- Manual Process vs. Backend integration
- Payer/Provider or Vendor/Payer capability
- Financial business model (historically transaction based)
- Incompatibility of systems
- Need to upgrade claims systems to provide a real-time response
- Integration with Practice Management or Hospital Information Systems

The Integration Challenge



Issues w/ Consistency & Standards

- 271 Data Content
- Acknowledgements
- Response Time
- System Availability
- Connectivity
- Companion Documents

Industry Focus

- Deliver **quality** data between Plans, Providers and other Stakeholders in the industry
- **Reduce costs** and increase satisfaction associated with healthcare administration
- Facilitate administrative healthcare **information exchange**
- Encourage administrative and **clinical data integration**

Key Challenges

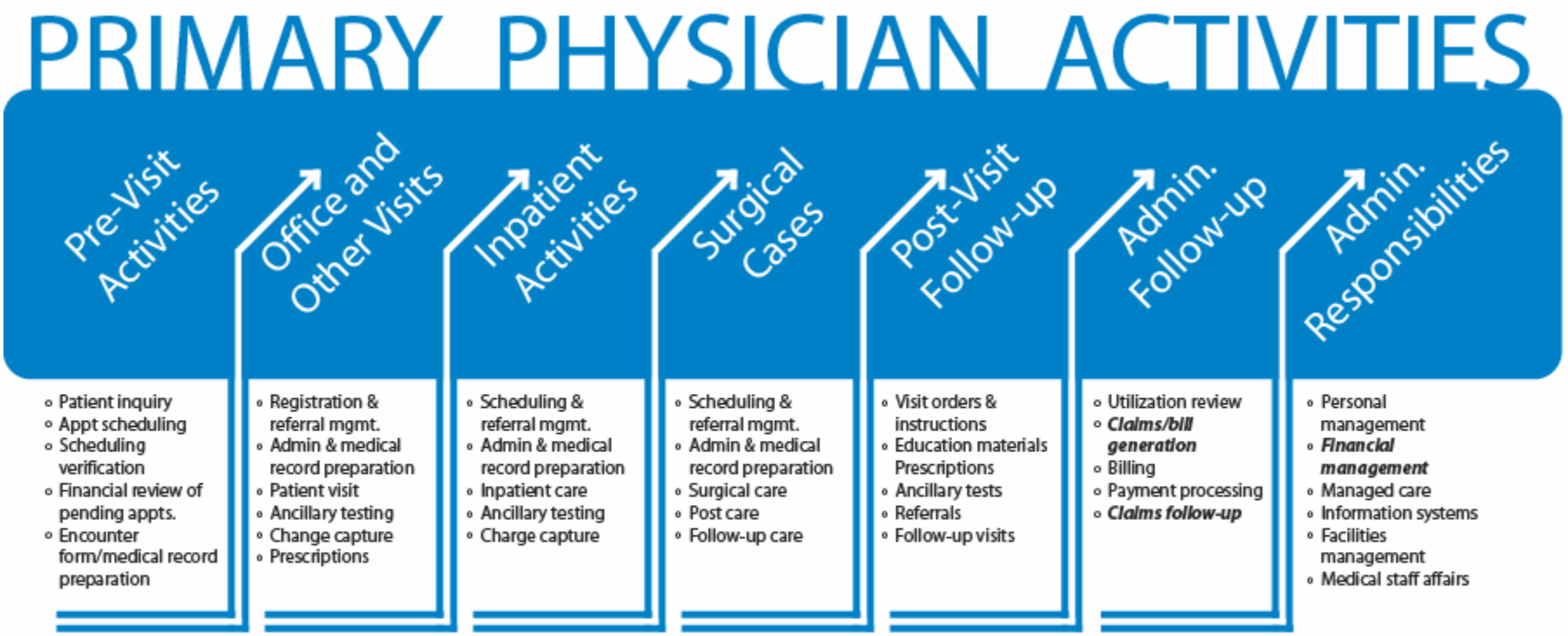
- HIPAA does not address issues with eligibility
  - Data elements needed by providers are not mandated
  - No standards for translation
  - No operational requirements, e.g., response time, availability, connectivity standards
- Individual Plan websites are not the solution for Providers
  - Health Plan/Payer portals are not the answer
    - Limited information in inconsistent format
    - Has to fit into Provider Workflow
- Vendors cannot deliver data to Providers when the health plan does not make that data available

Key Challenges

- Market focus on Single Payer to Provider vs. Industry Solution
- Who owns enforcement of standards?
- Focus on Interoperability

Physician-Payer Interaction

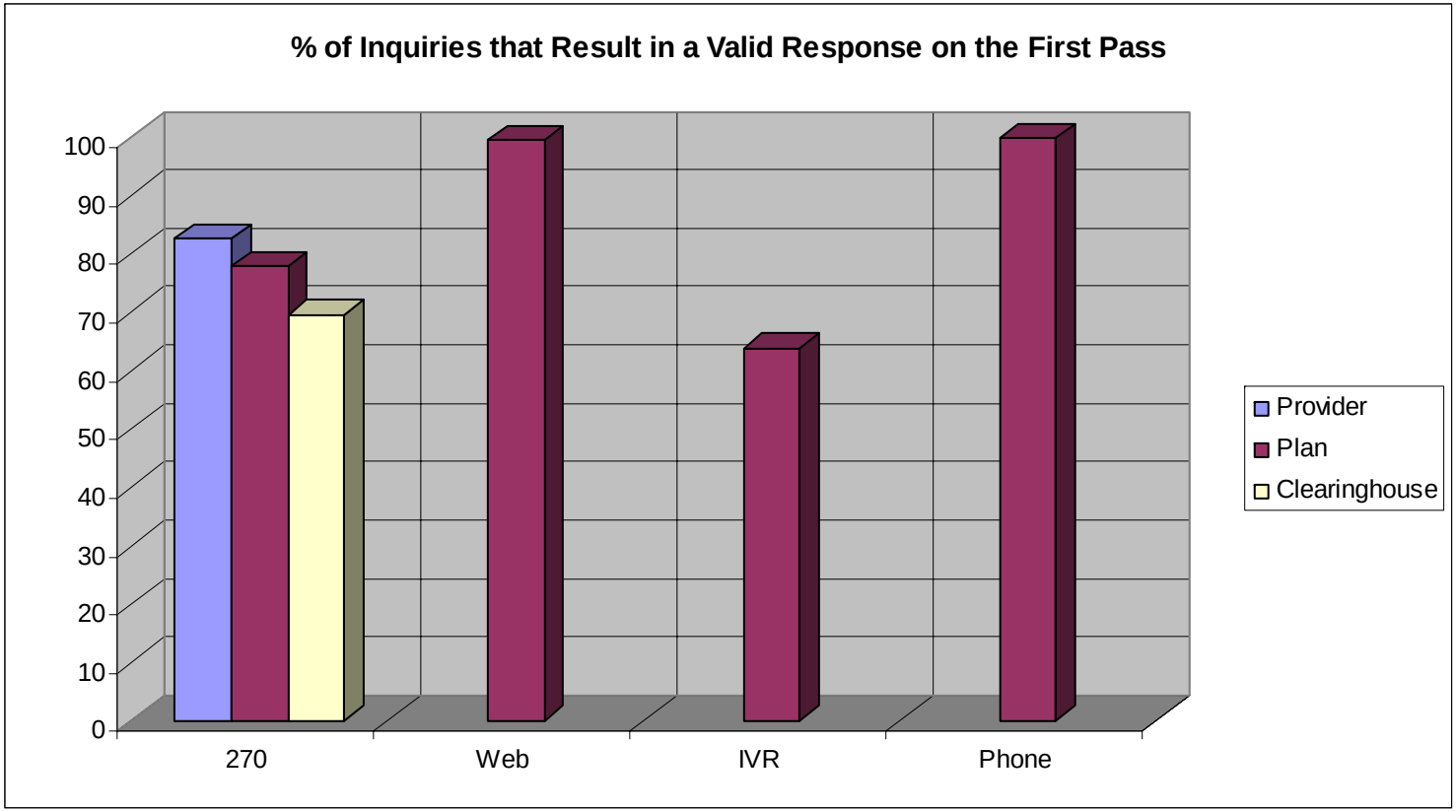
Physician Activities That Interact With Payers are Primarily Administrative in Nature (with Some Clinical Interaction)



*Source: CORE Patient Indentification Survey, 2006; funded, in part, by California HealthCare Foundation

Key Challenge:

Lower Hit Rate on HIPAA Eligibility Transactions



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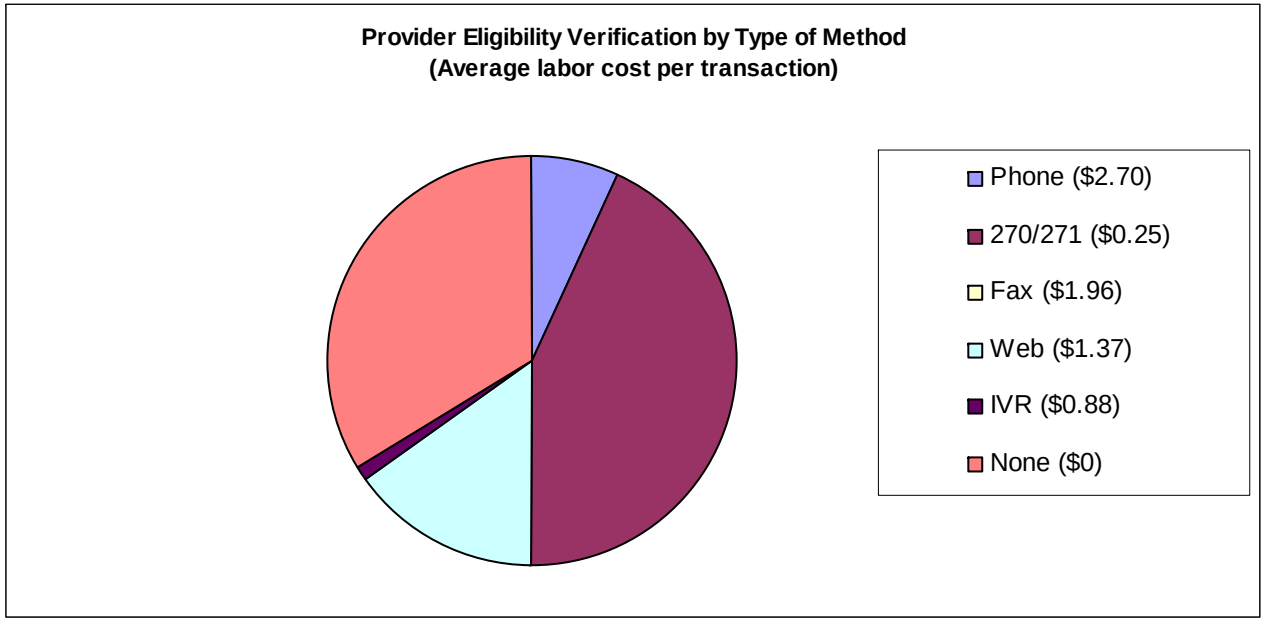
Key Challenge: Significant Savings

Providers (and health plans) can achieve significant savings by shifting from more labor-intensive verification methods to automated eligibility verification.



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Incentive: Significant Savings

- Providers could reduce eligibility verification labor costs by up to 50%
- Health plans would also realize significant savings given that the average labor cost per call is $1.38

Source: CORE Patient Identification Survey, 2006;
funded, in part, by California HealthCare Foundation

Case Study: Partners eCommerce View

Partners EDI volume. 2006

- –14 million real time transactions; eligibility, referral, claims status
- – $ 6 billion batch transactions; claims, remits

NEHEN eGateway Connections

- –14 payers, inclusive of IVANS
- –11 provider systems

IVANS Medicare Workflows

- –270/271 eligibility transactions
- –837 claim
- –835 remittances
- –997 and payer scrubber reports
- –Access to DDE on-line Medicare system

Partners ROI, Qualitative

1. **Integrating payer response data**

   - ***Exception Processing versus Compliance checking***

   Workflows focus on exception processing versus making sure each patient is checked

   - Optimizing data versus re-keying data

   More time is spent leveraging the response data from the payer to reduce claim denials.

   - Trending Reports versus Transactional Reports

   The revenue cycle can be analyzed, comparing remittances against eligibility detail for further enhancements to the process

2. **Improved on-line Medicare access**

   Currently, over 75 staff members have on-line access to DDE across the member hospitals. Technical support is now centralized. Medicare system access is faster and more reliable.

3. **Efficient workflows**

   Front end :7-10% of requests fall into an exception-based work queue; improved plan code assignment

   Back end: enhanced Self Pay collections process; improving reserve modeling

Partners ROI, Quantitative

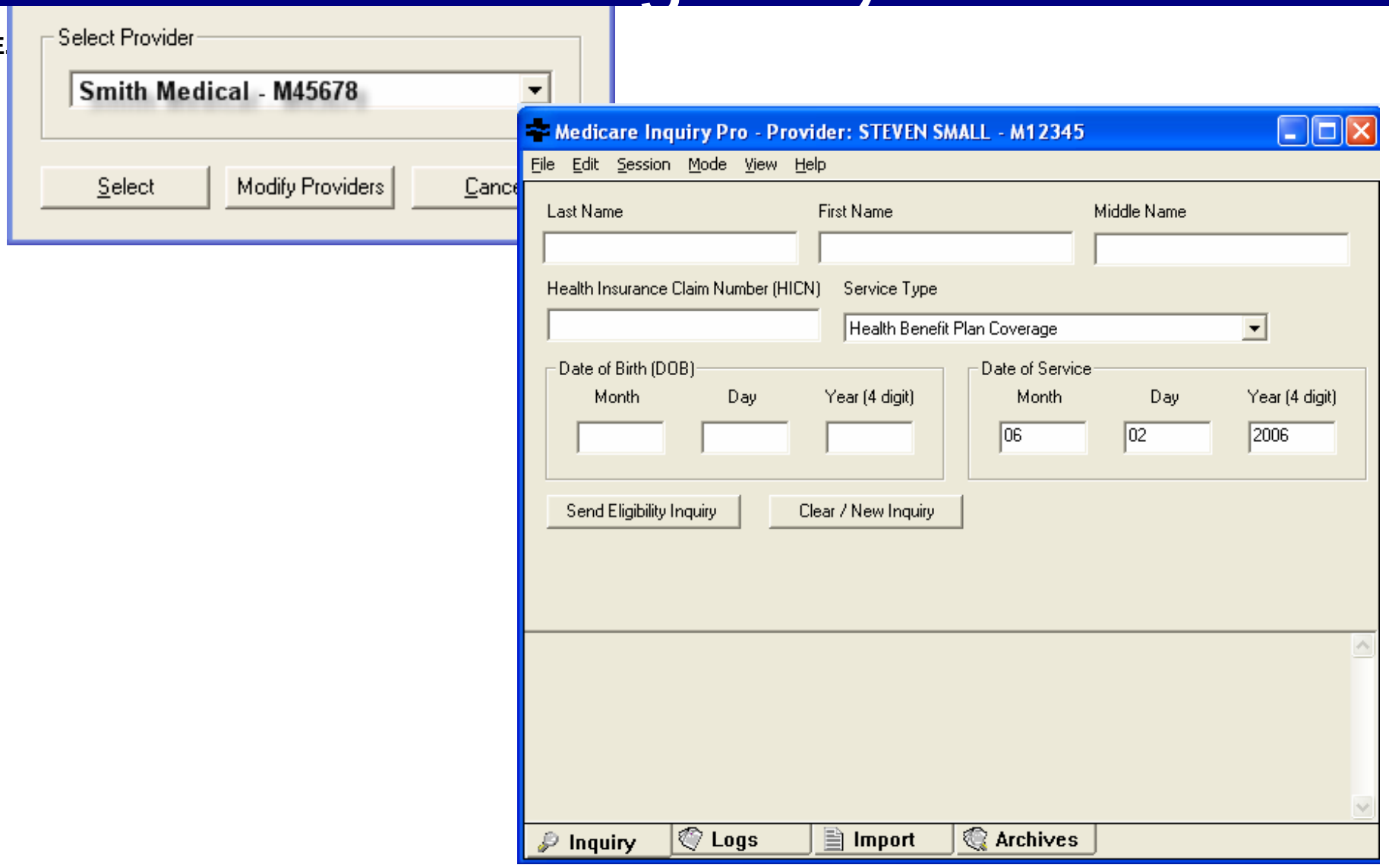
	ROI / Value description	SAVINGS
IVANS Connectivity	NSMC replaced 3 modems with the IVANS connection.	**$50,000 / year**
Eligibility	MGH "Pending Self Pay" billing lag time reduced	**In 2006, reduced 88 days to 21 days**
Eligibility	PHS, no transaction fees; (one eligibility / Medicare claim)	**$135,000 / year**
Referrals	PCHI automated their Radiology Authorization process for BCBS, HPHC, and THP	**Central office: 1 FTE saved -or- Specialty PCP offices: opportunity cost; phone time saved based on Radiology volume**
Claim Status Inquiry	BWH and MGH target claims requiring follow-up, reduce filing limit write-off for HPHC, THP	**In 2005, $300,000 / year**
Claim Status Inquiry	NWH migrates from Aged Trial Balance report follow-up to CSI exception processing for HPHC	**In 2006, reduced 1 FTE; A/R > 90 days decreased from 20.43% to 6.33%**

CORE Initiative
Online Eligibility Vision to Reality

- *Give Providers Access to Information Before or at the Time of Service…*
- Providers will send an online inquiry and know:
  - –Whether the health plan covers the patient*
  - –Whether the service to be rendered is a covered benefit (including copays, coinsurance levels and base deductible levels as defined in member contract)
  - –What amount the patient owes for the service**
  - –What amount the health plan will pay for authorized services**

- Note: No guarantees would be provided
- *This is the only HIPAA-mandated data element; other elements addressed within Phase I scope are part of HIPAA, but not mandated
- ** These components are critically important to providers, but are not proposed for Phase I

IVANS Real-Time Medicare Eligibility Solution



Medicare 271 Output / Response

- Part A / B entitlement term dates
- Deductible part A
- Deductible part B
- ESRD
- MCO Data
- MSP Data
- Home Health Data
- Hospice
- Hospital days remaining
- Hospital coinsurance days remaining
- Lifetime reserve days
- Skilled Nursing Facility Days Remaining
- Skilled Nursing Facility Coinsurance Days Remaining

Industry requires MORE in the 271

- Specifies what must be included in the 271 response to a Generic 270 inquiry
- Response must include
  - The status of coverage (active, inactive)
  - The health plan coverage start date
  - The name of the health plan covering the individual (if the name is available)
  - The status of nine required service types (benefits) in addition to the *HIPAA required Code 30*
    - 1-Medical Care
    - 33 - Chiropractic
    - 35 - Dental Care
    - 47 - Hospital Inpatient
    - 50 - Hospital Outpatient
    - 86 - Emergency Services
    - 88 - Pharmacy
    - 98 - Professional Physician Office Visit
    - AL - Vision (optometry)

271 Output cont'd

- Co-pay, co-insurance and base contract deductible amounts required for
  - 33 -Chiropractic
  - 47 -Hospital Inpatient
  - 50 -Hospital Outpatient
  - 86 -Emergency Services
  - 98 -Professional Physician Office Visit
- Co-pay, co-insurance and deductibles (discretionary) for
  - 1-Medical Care
  - 35 -Dental Care
  - 88 -Pharmacy
  - AL -Vision (optometry)
  - 30 -Health Benefit Plan Coverage
- If different for in-network vs. out-of-network, must return both amounts
- Health plans must also support an explicit 270 for any of the CORE-required service types

270/271 Benefits

- Health Plans
  - Reduce # of calls fielded by CSR's in Call Center
  - Reduced costs in Claim errors/handling
- Providers
  - Accurate, timely Eligibility data
  - Reduce / reallocate Staff by removing Manual processes
  - Reduce bad debt / risk
  - Accelerate cash flow

Questions?

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