

Ohio HB125 Advisory Committee

Eligibility & Benefits and Real-time Adjudication



Presenter: Stephanie Schulte
Provider Interface

Date: October 2008

HUMANA
Guidance when you need it most

Who Is Humana

- Health Benefits Company
 - In 50 states and Puerto Rico
- Membership
 - More than 10,000,000 members nationally
 - Appx 400,000 members in Ohio
- Claim transactions
 - More than 75 million annually
 - 5.4 million annually in Ohio
- Committed to making the business of healthcare easier

Current Transactions Available

- Humana makes electronic transactions available to providers.
 - Eligibility and benefits
 - Claim status inquiry
 - Referral/authorization submission and inquiry
 - Electronic remittances
 - Electronic funds transfer
 - Real-time claim adjudication
 - Claim based health information
 - Electronic Prescribing
 - Other non-standard transactions to meet provider administrative needs

Connectivity Options

- Humana leverages multiple connectivity options to meet the technological ability of provider offices.
 - Interactive voice response (IVR)
 - Web-based tools
 - Humana.com
 - Availity.com
 - Other industry web portals, who are able to receive transactions via the Availity Health Information Network
 - Batch electronic submissions
 - B2B integrated connections

Routing Definitions

Batch transactions



PM System “sweeps” to collect all patients scheduled for the next day.

These patients’ information is electronically sent to the provider’s clearinghouse in a “batch”. This is a single one way transmission.

The clearinghouse breaks up the batch and creates subsequent batches to transmit to respective payers. This is a one way transmission.

After processing, payers must open a separate transmission to send responses to each respective clearinghouse.

B2B transactions (real-time)



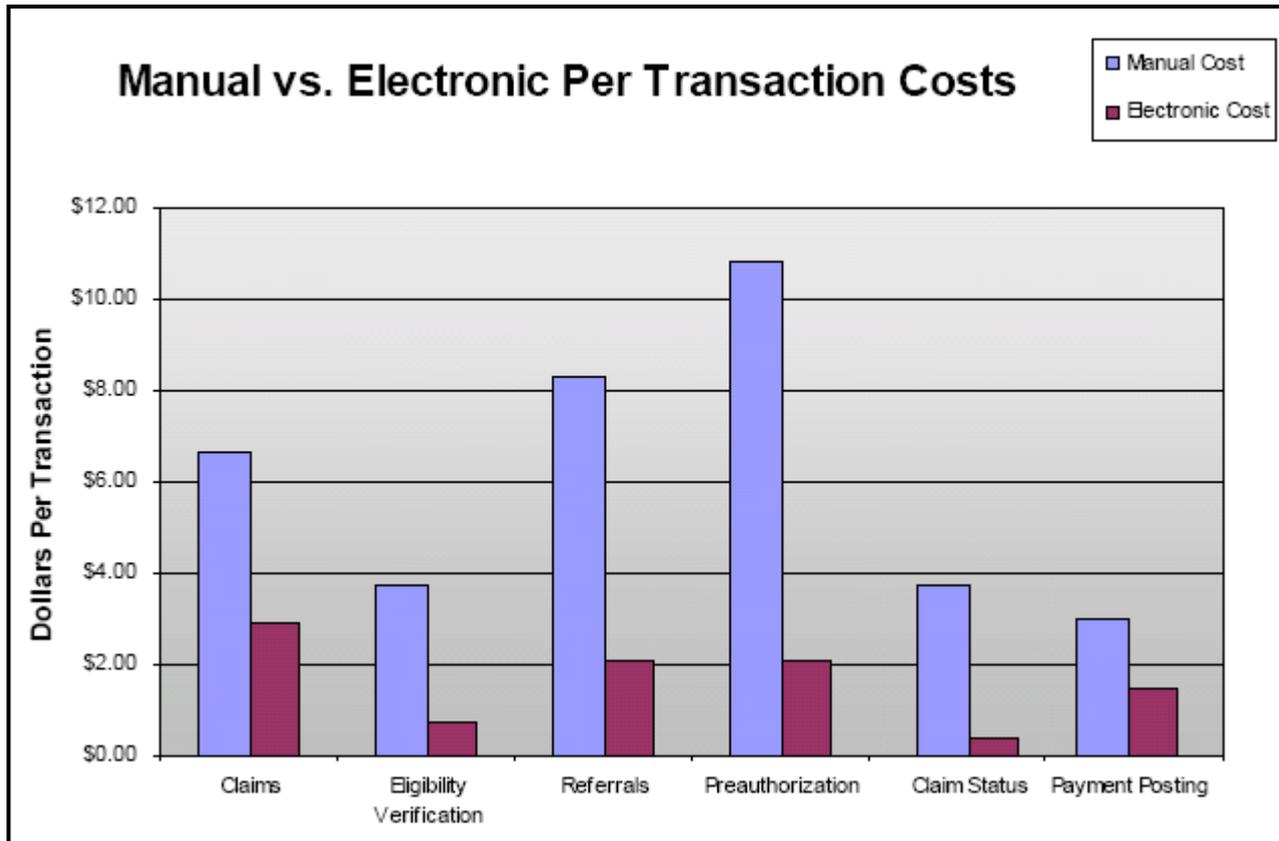
Provider wants to see a patient’s eligibility information.

Provider sends a single transaction to their clearinghouse from their PM system.

The clearinghouse transmits this request on to the payer. The electronic connection stays open.

The payer receives the transaction and responds in real time, via the same open connection.

Cost of Doing Business Manually



Prepared by



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Technology and Operations Solutions
Revised: January 2006

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Potential Savings

<i>Estimated Annual Savings from Electronic Transactions For Typical Physician Office Practice</i>					
	Manual Cost	Electronic Cost	Savings/ Transaction	Transactions Per Year	Estimated Annual Savings
Claims	\$6.63	\$2.90	\$3.73	6,200	\$23,124.21
Eligibility Verification	\$3.70	\$0.74	\$2.95	1,250	\$3,693.04
Referrals	\$8.30	\$2.07	\$6.22	1,000	\$6,223.17
Preauthorization	\$10.78	\$2.07	\$8.71	100	\$870.62
Claim Status	\$3.70	\$0.37	\$3.33	620	\$2,065.59
Payment Posting	\$2.96	\$1.48	\$1.49	4,340	\$6,456.59
TOTAL					\$42,433.23

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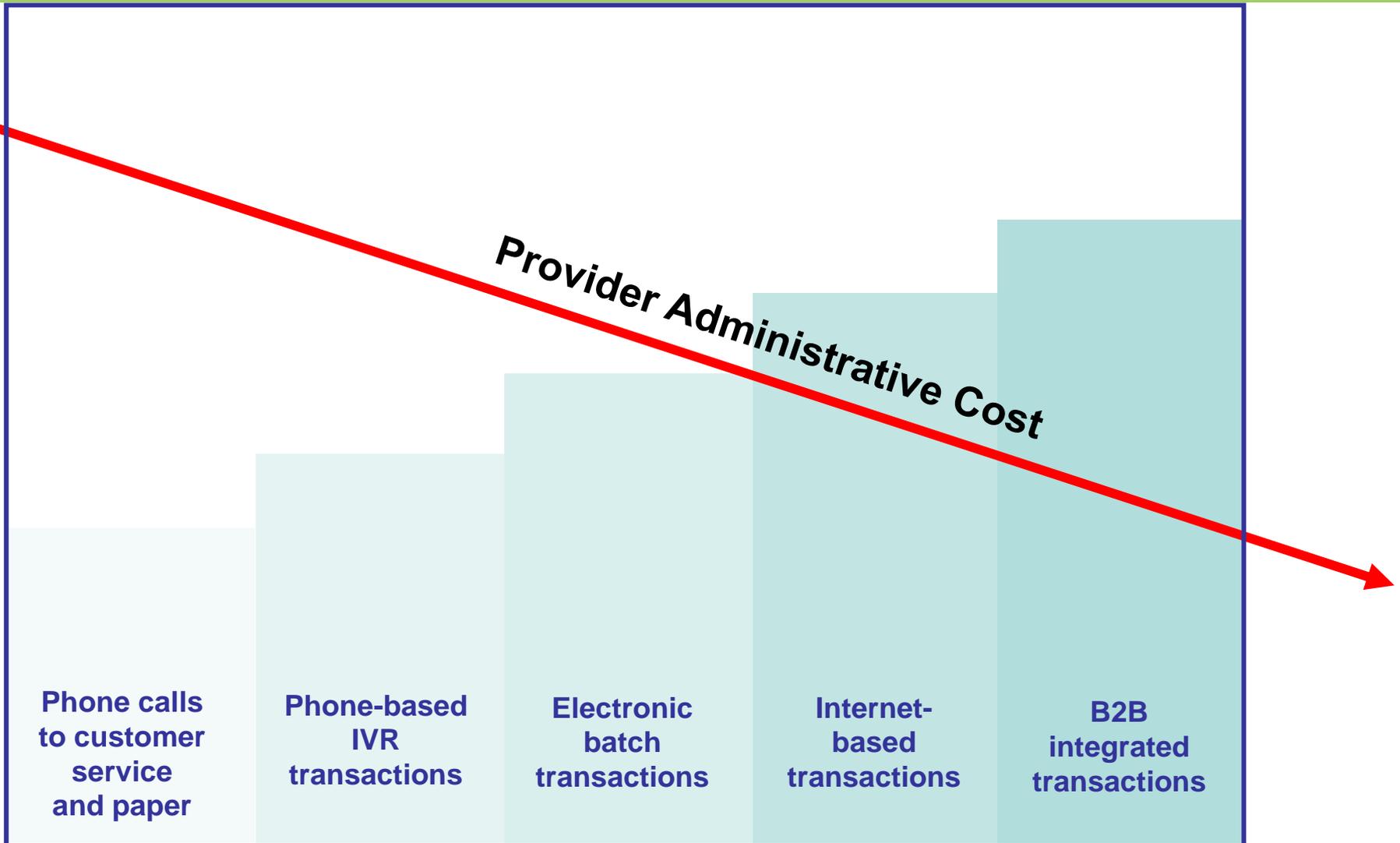


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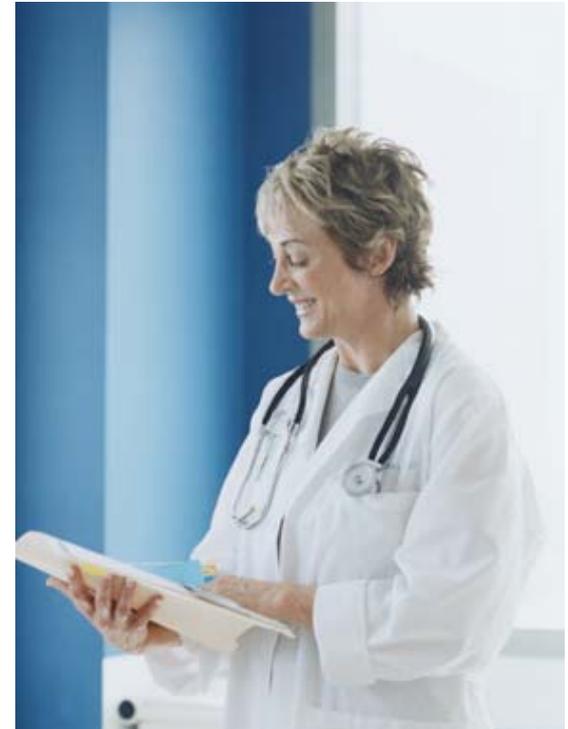
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The Affect of Technology – Bending the Trend

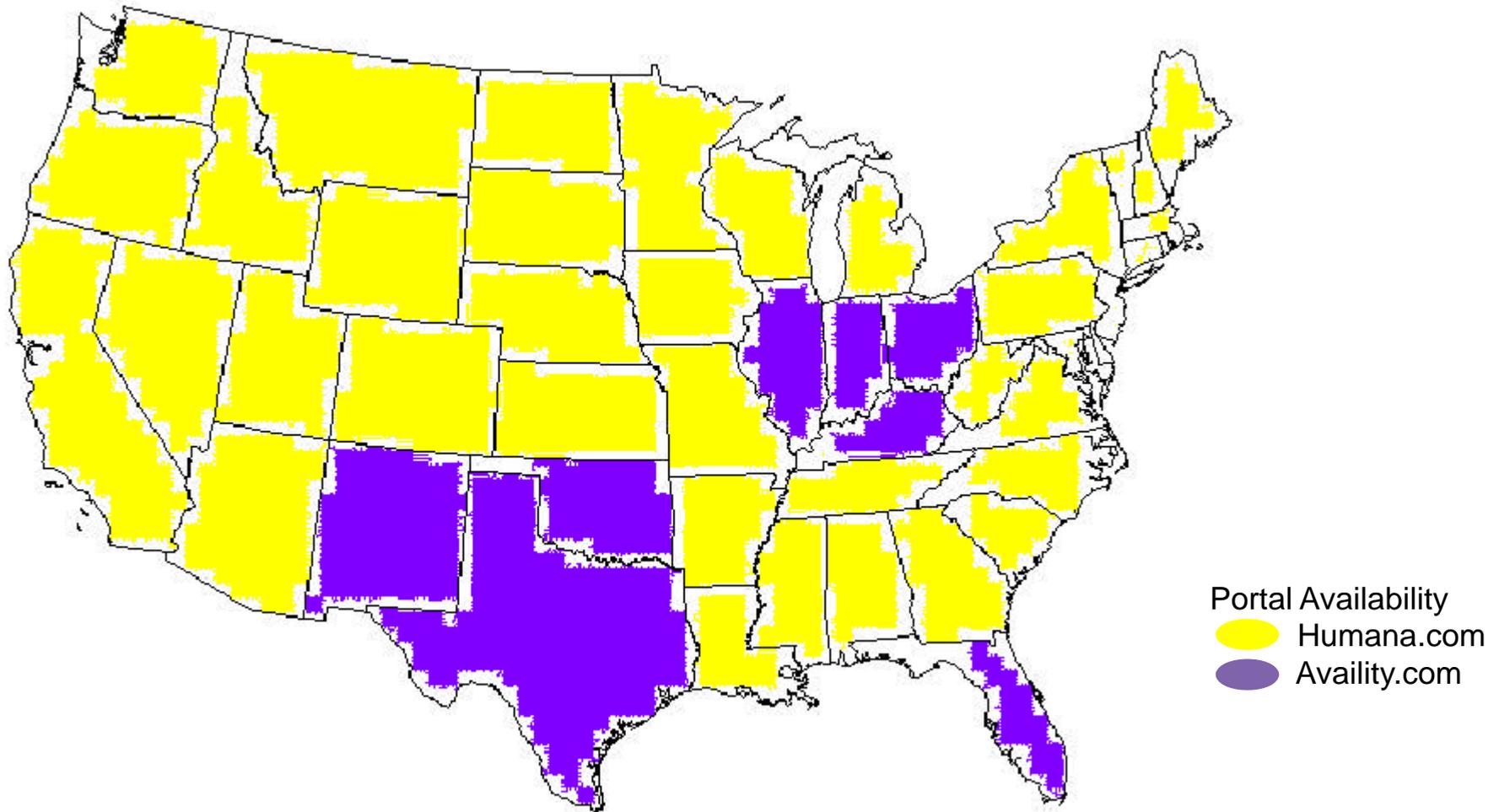


Enabling Humana's Real-time Strategy

- Availity, L.L.C. is an independent company formed as a joint venture between Blue Cross and Blue Shield of Florida and Humana Inc in 2001.
- Founded as a means to take cost out of the industry.
- Based on the premise that the ability to access multi-payer membership drives adoption (registration AND use).
- Health Care Service Corporation (holding company for Blue Cross of Texas, Illinois, Oklahoma, New Mexico) joined as an owner in 2006, as The Health Information Network (THIN) combined assets with Availity.
- Provides tools for web based, batch and B2B transactions.

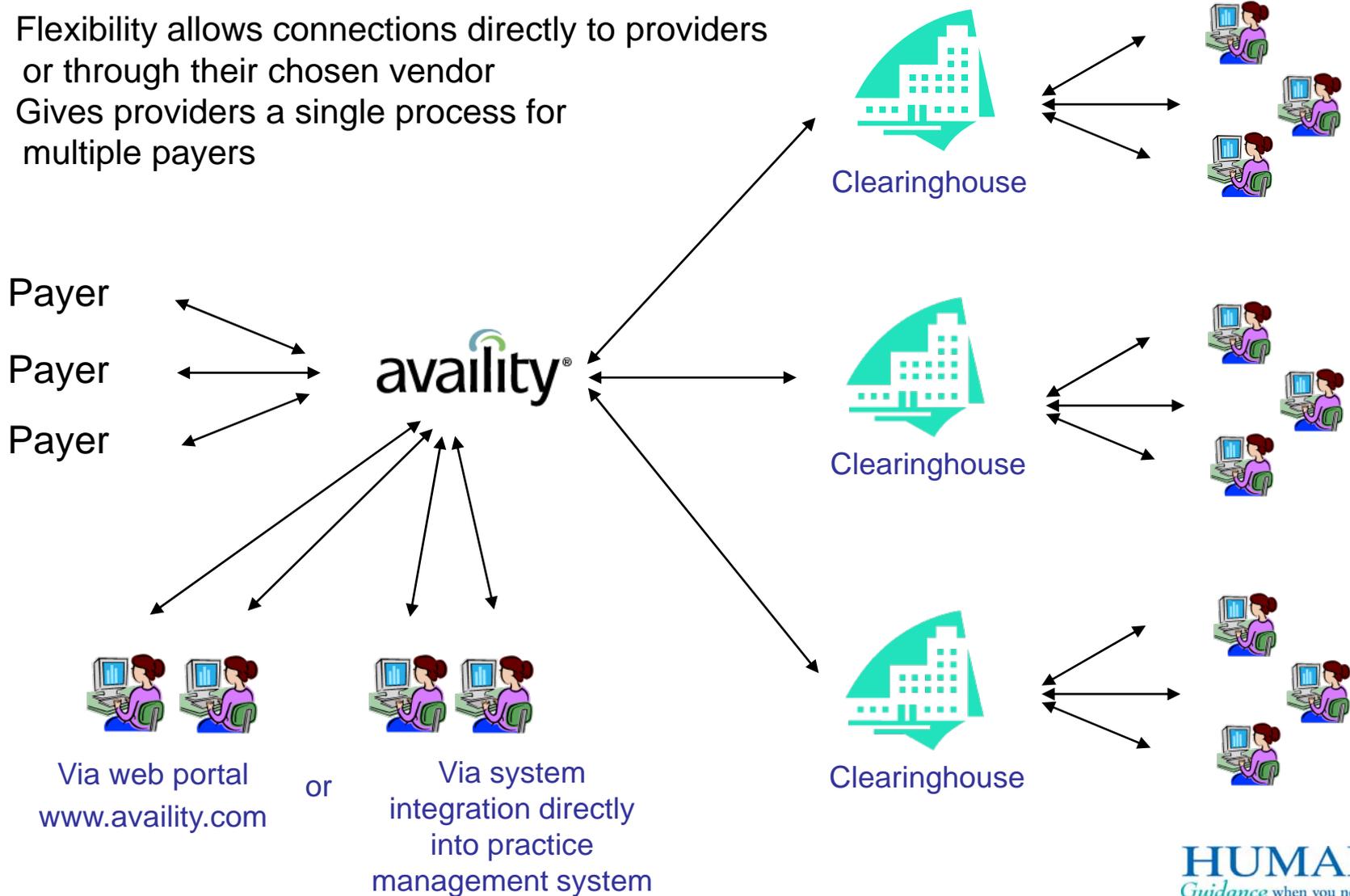


Availability of Availity.com



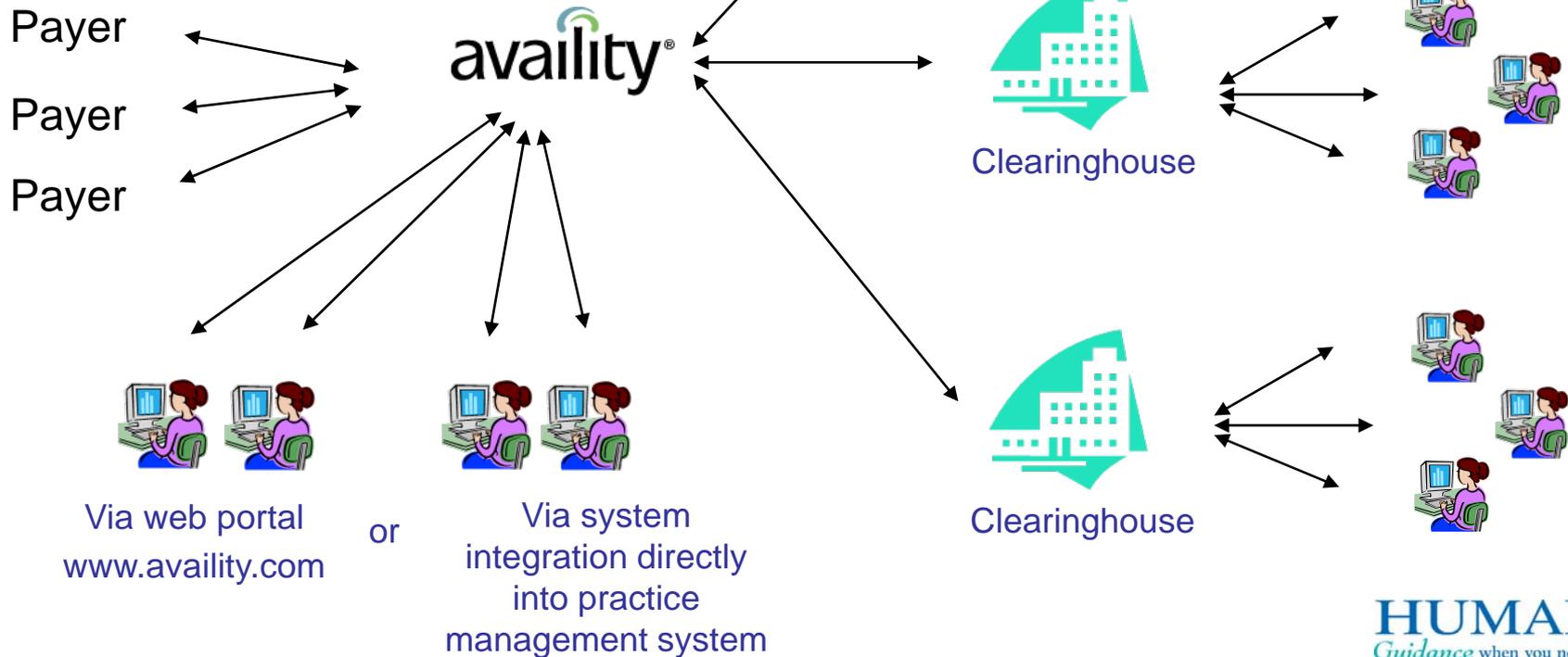
The Multi-payer Model

- Flexibility allows connections directly to providers or through their chosen vendor
- Gives providers a single process for multiple payers



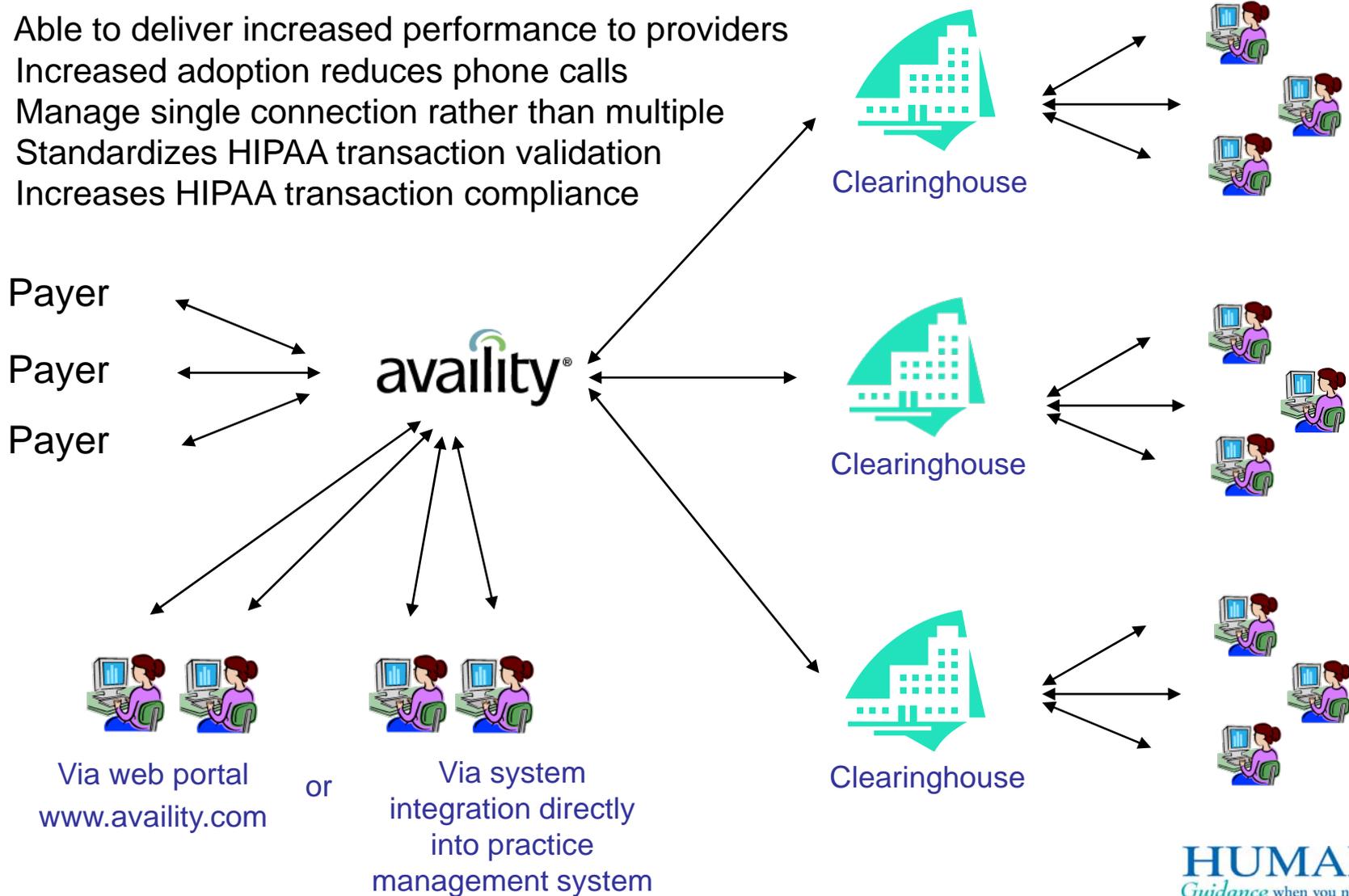
The Multi-payer Model – Provider Benefits

- Access to multiple payers via single connection
- Vendor flexibility
- Enhanced administrative simplicity
- Reduction in administrative cost
- Transaction standardization
 - In formatting
 - In use and screens



The Multi-payer Model – Payer Benefits

- Able to deliver increased performance to providers
- Increased adoption reduces phone calls
- Manage single connection rather than multiple
- Standardizes HIPAA transaction validation
- Increases HIPAA transaction compliance



Why Real-Time Adjudication

An Example...

“Dr. Barbara Hummel, an independent family physician in West Allis, estimates her office had to refer about \$9,000 in unpaid patient fees to a collection agency last year....

About 10 percent of Dr. Hummel's patients pay after receiving the first billing statement; another 20 percent pay after the third; and 7 percent never pay” she said.

Milwaukee Business Journal

Industry factors...

- Many practices do not ask for payment at the time of service.
- Patients' expectation of being able to pay later.
- “Minimalization” of medical debt.
- Traditional need to wait for adjudication to calculate coinsurance

Today's RTCA Routes

Web Screen Entry

- Manually enter claim information into web form
- Duplicate effort for office after entering charges to their PMS

Web Claim Upload

- Upload single claim when provider's system can not submit RTCA
- Eliminates duplicate charge entry

Integration

- RT claim is submitted and received via provider's system
- Fully integrated into systems and work flow

Available to all practices in FL, TX, IL, KY, IN, OH, NM and OK via Availity.com



Over 3,000 sites nationally...and growing!

First pass rate >75%

Round-trip averaging less than 10 seconds

Automation

Real World Results...From Early Adopters

- Provider reports RTCA delivering >\$160,000 in administrative savings and increased collections
- Provider reports members beginning to expect full resolution at the time of service
- Provider reports bad debt reduced to 1%
- Receptionists surprised at patients thanking them for being able to avoid bills and EOBs
- Provider reports collection of small balances previously written off
- Provider reports RTA benefit resulting in a full month's revenue being added to the bottom line

So Why Aren't Practices Swarming?

- Practices overwhelmingly tell us they want/need RTA
- But there still is not the critical mass of patients to motivate the necessary change in work flow
- Yes, there are additional payers who can perform RTA...but either manually keyed through their website...or through a proprietary vendor
- Today, success still depends on two factors
 - RTA must be multi-payer
 - RTA must be integrated
 - Into THEIR systems
 - Into THEIR work flow

Moving the Ball Forward - Vendor Flexibility

▪ **Supporting Flexibility In Practices Nationally**

- Availity
- ZirMed
- Datatel (MOMS AT practice management system)
- Final Support (Centricity practice management system)
- ServeData
- InstaMed
- Athenahealth (First vendor to make RTA available to all sites)

▪ **Keeping the Momentum Going**

- Bringing another 2 vendors to the market in Q4 2008
- Over a dozen more in the pipeline
- Encouraging payers to develop
- WEDI, X12 and AHIP are working to set standards and direction

National Efforts

- National standards are equally directed at payers and providers
 - HIPAA
 - Compliance is mandated
 - Both requests and responses must be compliant
 - Providers rely on their vendors for compliance
 - Many providers still have older PM system versions that can not create compliant transactions
 - CORE
 - Compliance is voluntary for both payer and provider
 - Providers will rely on their vendors for compliance
 - WEDI – Magnetic striped ID cards
 - Converting to the national standard 2009
 - Creates machine readable card for launching real-time transactions

Humana's Efforts

- Humana supports national standards
 - Transactions are HIPAA compliant
 - CORE
 - Availity is Phase 1 compliant
 - Humana
 - Code completed for Phase 1
 - Completing certification process
 - Evaluating scope of Phase 2 effort

- Humana participates in national organizations
 - Collaborating with other payers, vendors and providers
 - Developing and enhancing standards based on experience and best practices
 - CORE, WEDI, X12, HIMSS, MGMA, AHIP, etc.

Considerations for Eligibility and Benefits

- National standards are already in place
 - HIPAA compliance is mandated
 - CORE phase 1 and 2 rules are already approved but are voluntary today
 - Distinct state mandates create difficult challenges for national payers and vendors

- Committee considerations
 - First determine the desired outcome and propose a PLAN that meets that outcome
 - While Humana supports the CORE initiatives, it involves costly development, which may be a prohibitive factor for some payers
 - Payer compliance does not automatically deliver vendor compliance or provider use
 - Ultimate impact is dependent upon provider utilization

Considerations For Real-time Adjudication

- National efforts are underway
 - The RTA submission uses the standard HIPAA 837
 - Formalization of a response format is underway
 - Distinct state mandates create difficult challenges for national payers and vendors

- Committee considerations
 - Technologically, RTA and E&B are dramatically different transactions and come from distinct systems
 - RTA requires considerable rewrite to how claims are routed/prioritized in the payer systems
 - Both PM vendors and clearinghouses are traditionally built on batch processes
 - Most practices are unwilling to pay for vendor upgrades for formats and RTA

Thank You

Questions

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