House Bill 125
Advisory Committee on Eligibility
and
Real Time Claim Adjudication

Final Report
January 2009

Prepared by the

Ohio | Department of Insurance

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Letter of Transmittal

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House Bill 125 of the 127th General Assembly created the Advisory Committee on Eligibility and Real Time Claim Adjudication. In Section 7 of House Bill 125, the Advisory Committee was required to submit, to the General Assembly, a report of its findings and recommendations for legislative action to standardize eligibility and real time adjudication transactions between providers and payers. The Advisory Committee convened its first meeting in July and held monthly public meetings through December 2008.

The charge of the Advisory Committee was to study and recommend standards to enable providers and payers to communicate electronically with each other regarding patient eligibility for services. The Advisory Committee was also asked to look at the challenges involved with real-time claim adjudication.

Through vigorous debate and discussion, the Advisory Committee reached consensus on an overwhelming majority of the recommendations, although not all. The members of the Advisory Committee agreed that additional information needed to be gathered and that some of the issues discussed needed further study, therefore they would like to continue working on this charge.

I respectfully submit the Report on Eligibility and Real Time Claim Adjudication.

Sincerely,
Mary Jo Hudson
Director

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Executive Summary

House Bill 125 of the 127th Ohio General Assembly required the creation of an Advisory Committee on Eligibility and Real Time Claim Adjudication (the Advisory Committee). The Advisory Committee's charge was to assess and provide recommendations to the General Assembly concerning standardizing the electronic communications for administrative functions within the healthcare sector in Ohio, which has the potential for significantly reducing costs. The bill specifically directed the Advisory Committee to consider the interoperability standards that have been created by the Committee on Operating Rules for Information Exchange (CORE). CORE is a multi-stakeholder initiative created, organized and facilitated by the Council for Affordable Quality Healthcare (CAQH). In addition, the Advisory Committee was asked to advise the General Assembly regarding the adoption of certain data elements and whether certain technologies for eligibility verification should be recommended. The issue of when Providers may rely upon eligibility information provided by Payors was the final issue the General Assembly asked the Advisory Committee to discuss.

The Advisory Committee focused on the issues surrounding the exchange of eligibility information rather than real time claim adjudication. Creating standard rules for simple transactions such as the exchange of eligibility information is a necessary first step to address more complicated claim adjudication transactions. Given the current state of electronic communications in the healthcare sector, it was premature to focus on real time claim adjudication.

The Advisory Committee heard two presentations from CAQH describing the CORE operating rules for electronic eligibility verification between Providers and Payors. The Advisory Committee supported the work of CORE, and recommended its adoption. However, the Advisory Committee could not agree unanimously whether CORE standards should be required by law, nor was there unanimous agreement on the timeline for CORE standards to be adopted.

To complete its work, the Advisory Committee divided into three

subcommittees: Business Processes, Dispute Resolution, and Technology and Infrastructure. The subcommittees confirmed that the technology currently exists for Providers and Payors to exchange eligibility information electronically in a very efficient and cost effective manner. However, significant barriers exist in other areas which have slowed the adoption of this technology.

The Advisory Committee identified the following barriers to the widespread adoption of CORE certified eligibility verification technology: the costs associated with system upgrades for Payors and Providers, the time required to do so, the lack of generally accepted national operating standards for the information exchange, the lack of one simple agreed upon method of checking eligibility information for Providers, and the concern regarding whether the eligibility information received electronically is adequate and reliable.

The Advisory Committee was also unable to reach consensus on what the current extent of incorrect eligibility information given to Providers is and exactly what types of situations cause payments to Providers to be denied after eligibility has been confirmed. To answer these questions, the Advisory Committee recommends that additional data on eligibility denials and "take backs" be gathered. Shortening the "take back" period from two years to one year was an issue the Advisory Committee did not agree upon.

The Advisory Committee did agree that Payors could take steps to provide eligibility information to Providers that was more accurate and Providers agreed that there were actions they could take to promote checking eligibility electronically more frequently. The Advisory Committee listed these agreed upon actions as best practices that should be followed by the various stakeholders.

In order to promote the adoption of CORE rules, to continue the gathering of information on eligibility "take backs", to promote stakeholder adoption of best practices and to address the technical and other questions likely to arise, the Advisory Committee recommends that it continue in operation after January 1, 2009.

The Advisory Committee reached unanimous agreement on the following:

- **Further analysis of broadband connectivity should be undertaken.**

- **Further investigation into alternative methods to provide electronic data interchange should be undertaken. Specifically, attention should be given to additional exploration of established data networks such as**

Regional Health Information Organizations and of possible pilot programs to help facilitate the exchange of administrative transactions.

- **The Advisory Committee should continue to gather additional data on eligibility denials and "take backs" and set the parameters for the respective data collection.**

- **The Advisory Committee should continue in operation to promote stakeholder adoption of best practices, to promote the adoption of CORE rules, and to address the technical and other questions likely to arise during the implementation of CORE.**

- **Stakeholders should not be required to include any data elements beyond those required by CORE for electronic eligibility and benefits verification.**

- **Specific information technology for personal identification, such as smart card, magnetic strip or biometric technology was not identified or recommended.**

- **Specific information technology to be used by Providers to generate a request for eligibility was not identified or recommended.**

A majority of the Advisory Committee agreed on the following recommendations (the exact tally is included in the report):

- **All the electronic administrative transactions related to healthcare insurance eligibility verification, must be CORE Phase I and Phase II compliant no later than three years after the deadline for ICD-10 compliance.**

- **Payments made for services rendered to ineligible employees and dependents should not be permitted to be "taken back" after one year from the date of the original payment, if the Provider confirmed eligibility electronically on the date of service and can demonstrate that eligibility was verified at the time services were rendered.**

The Advisory Committee agreed that the following are best practices for Payors and Providers when applicable:

- **Employers should provide updated employee eligibility information to insurers or third party administrators (TPAs) as soon as possible following an employee's qualifying event and no less frequently than on the Employer's payroll cycle or on a monthly basis.**

- **Employers should include a detailed review of benefits, including a discussion of the responsibility of the employee to promptly notify the Employer when there is a change in the status of an employee's dependent, in every new employee orientation program. The information may be provided as a written policy outlining dependent coverage terms and conditions, or in some other fashion. It should also clearly explain whether coverage ends on the last day of employment or the last day of the month in which the termination occurred.**

- **At the time of termination of employment, Employers should again provide every employee with information clearly identifying the last day of coverage.**

- **Employers should provide updated dependent eligibility information to TPAs/insurers as soon as possible following notice of a dependent's qualifying event.**

- **Employers, or their TPAs, should periodically, but no less often than annually, take appropriate steps to verify dependent eligibility through the use of tools such as dependent audits or employee surveys.**

- **Providers should always verify eligibility and check the insurance identification card at the time of each patient service, when feasible. Providers should also ask for a photo identification card if they do not know the patient, when feasible.**

- **The Provider's office staff should verify insurance eligibility both at the time of service and when the appointment is initially scheduled, as appropriate.**

- **When deciding to purchase a new practice management system, Providers should select a CORE certified practice management system.**

- **Providers should ask patients at the time of service, when appropriate, whether there has been a change in their employment, insurance coverage or dependent status.**

- **Providers who have reason to believe that a patient may not be eligible for insurance or Employer coverage should arrange for payment by the patient, as appropriate.**

- **TPAs should provide electronic access to patient eligibility information received from Employers within two business days of receipt, if received electronically, and within five business days of receipt if received by another method of transmittal.**

- **TPAs should request Employers to update eligibility information no less frequently than on the Employer's payroll cycle or on a monthly basis.**

- **TPAs should request Employers to update employee and dependent eligibility information as soon as possible following an employee or dependent's qualifying event.**

- **During the time period between the termination of coverage and the initial election of COBRA coverage, TPAs should list the employee or dependent as "ineligible" until the Employer receives the first COBRA payment.**

- **Insurers should provide electronic access to patient eligibility information received from Employers within two business days of receipt, if received electronically, and within five business days of receipt if received by another method of transmittal.**

- **Insurers should request Employers to update eligibility information no less frequently than on the Employer's payroll cycle or on a monthly basis.**

- **Insurers should request Employers to update employee and dependent eligibility information as soon as possible following an employee or dependent's qualifying event.**

- **During the time period between the termination of coverage and the initial election of COBRA coverage, the insurer should list the employee**

or dependent as "ineligible" until the Employer receives the first COBRA payment.

- **Insurers should consider that the practice of extending long grace periods to Employers to help them afford the insurance premium can result in employees losing HIPAA protections if the Employer does not ultimately pay premium and coverage is retroactively terminated for a period longer than sixty-three days.**

The Advisory Committee acknowledged there is much work to be done in order to achieve real time eligibility and claim adjudication. A continued commitment by all interested parties and stakeholders is essential to achieving this goal.

Chapter One: Introduction

House Bill 125 (HB 125),[1] passed in 2008 in the 127th Ohio General Assembly (the General Assembly), created an Advisory Committee on Eligibility and Real Time Claim Adjudication (the Advisory Committee). The Advisory Committee was tasked with studying and recommending standards to enable Providers[2] and Payors[3] to communicate electronically with each other regarding a patient's eligibility for services. The Advisory Committee was also asked to look at the challenges involved with real time claim adjudication.

HB 125 specifically directed the Advisory Committee to consider the interoperability standards that have been created by the Committee on Operating Rules for Information Exchange (CORE). CORE is a multi-stakeholder initiative created, organized and facilitated by the Council for Affordable Quality Healthcare (CAQH) with the goal of standardizing the electronic transmission of information in the healthcare sector. Standardizing administrative communications can decrease the amount of time Providers spend verifying patient eligibility information. CORE operating rules, envisioned to be introduced in multiple phases, have begun with exchanging basic eligibility information. As the initiative proceeds and communication rules are standardized by agreement of all those involved in the system, a point will come when sufficient information can be exchanged in a standard way to enable real time claim adjudication to occur.

The Advisory Committee focused in this report on the issues surrounding the exchange of eligibility information rather than real time claim adjudication

[1] For the complete language of Section 7 of HB 125, see Appendix A-1.

[2] The term "Providers" include physicians, hospitals and other healthcare professionals.

[3] The term "Payors" include healthcare insurers, employers and third party administrators (TPAs).

information because eligibility rules must be created first to provide a base for the more complicated claim adjudication communications. Given the current state of electronic communications in the healthcare sector, it was premature to focus on real time claim adjudication at this time.

In addition, the Advisory Committee was asked to advise the General Assembly regarding the adoption of certain data elements listed in HB 125 and whether certain technologies for eligibility verification should be recommended. The General Assembly also asked the AdvisoryCommittee to discuss how to resolve disputes between Providers and Payors when differences of opinion on eligibility arise.

To meet the requirements of HB 125, the Superintendent of the Ohio Department of Insurance appointed twenty-six members to the Advisory Committee to represent various constituencies designated in HB 125. The Advisory Committee met regularly over a six month period and discussed the elements listed in the charge from the General Assembly and created the findings and recommendations contained in this report.

Members of the Real Time Claims Adjudication and Eligibility Advisory Committee

Kathleen Anderson - Ohio Council for Home Care

Jeff Biehl - AccessHealth Columbus

Michelle Cadrin-Msumba – athenaHealth

Jeff Corzine - Unison Health Plan

Melissa Daniels - Aetna

Julie DiRossi/Joseph Liszak - Community Health Centers

Cathy Fuson - Delta Dental

Chris Goff/David Uldricks - Employer's Health

Karen Greenrose - American Association of Preferred Provider Organizations

Carrie Haughawout - Ohio Chamber of Commerce

Bill Hayes – Health Policy Institute of Ohio

Lawrence Kent- Academy of Medicine of Cleveland

Christine Kozobarich – Service Employees International Union

Sue Kucinski/Dave Cook - Paramount Health Plan

Trudi Matthews – HealthBridge

Dan Paoletti - Ohio Hospital Association

Rex Plouck - Office of Information Technology

Michael Ranney - Ohio Psychological Association

Joe San Filipo - Nationwide Better Health

Ray Shealy – RelayHealth

Daniel Sylvester - Quality Care Partners

Martha Simpson - Osteopathic Physician

Jeff Vossler - Grand Lake Health System

Jim Weisent - Medical Benefits Mutual Insurance Company

James Woodward - Ohio Chiropractic Association

Chapter Two: The Council for Affordable Quality Healthcare

A. Background

CAQH describes itself as a not-for-profit alliance of health plans and trade associations, that seeks to simplify healthcare administration. According to CAQH, it achieves administrative simplification by:

- Facilitating effective interactions between plans, providers and other stakeholders;
- Reducing costs and frustrations associated with healthcare administration;
- Facilitating administrative healthcare information exchange; and
- Encouraging administrative and clinical data integration.[4]

CORE was formed by CAQH as a national initiative bringing more than 100 healthcare industry stakeholders together to achieve the above objectives through the improvement of electronic healthcare information exchange (*e.g.*, eligibility and benefit transactions). CORE's mission is to create "an all-Payor solution to streamline electronic healthcare administrative data exchange and improve health plan-Provider interoperability,"[5] through the use of agreed upon business rules.[6] CORE operating rules facilitate the ability for any Payor to exchange administrative information with any Provider electronically, regardless of the technology.

CORE states that it achieves the above objectives through the development of voluntary operating rules that complement and build upon the HIPAA-mandated ANSI X12 standards. CORE also coordinates with other national data exchange-related initiatives[7] to help make electronic administrative transactions more

[4] CAQH website: www.caqh.org.

[5] *Ibid.*

[6] Business rules are the same as operating rules.

[7] Other groups working on national data exchange-related initiatives are the Certification Commission for Healthcare Information Technology (CCHIT), the Healthcare Information Technology Standards Panel (HITSP) and the Workgroup for Electronic Data Interchange

predictable and consistent. CORE operating rules are modeled after proven rules which govern other industry operations such as
banking ATM transactions and airline online reservations. CORE's vision is to facilitate Provider access to healthcare administrative information before or at the time of service using the software of their choice for any patient or health plan.

As an industry-led effort, CORE developed a multi-phase approach to maximize the voluntary adoption of the operating rules by the marketplace. CORE's phased approach allows realistic milestones to be set and attained through a series of incremental, achievable steps. For instance, this approach reduces the burdens (financial, personnel, or otherwise) that may be associated with the potential system upgrades that entities are required to implement in order to meet the CORE rules.

CORE completed and launched Phase I in September 2006 and the Phase II rules were approved for implementation in July 2008. Although, Phase III is a work in progress, according to CORE, at this time more than thirty healthcare organizations are Phase I certified. CORE certification is a process whereby organizations that adopt the CORE operating rules complete CORE-authorized third-party testing. The costs associated with implementation of the CORE rules vary by organization as well as stakeholder-type.[8] CAQH, in coordination with IBM, is currently conducting a study to measure the financial impact of Phase I rule adoption upon Payors and Providers and expects to release the results from this study in 2009.

B. CORE Phase I

CAQH maintains that CORE's Phase I operating rules build upon the data exchange introduced by the Health Insurance Portability and Accountability Act[9] (HIPAA). CORE Phase I operating rules set minimum requirements for the eligibility request/response infrastructure and data elements which exceed the minimum HIPAA requirements. Additionally, CORE adds business value to HIPAA by gaining industry agreement on a more consistent use of these standards. Also, CORE Phase I operating rules are an addition to, not a replacement of the HIPAA standard transactions. Any entity requesting CORE certification must attest to HIPAA compliance as mandated by

[8] Stakeholder types include vendors, health plans and providers.

[9] Health Insurance Portability and Accountability Act, 104 Pub. L. 191 (1996).

the federal government.

The purpose of CORE Phase I is to improve, by voluntary industry consensus, uniformity of how eligibility requests and responses are sent/received and in the data that is included. Each additional Phase will add more information and improve the electronic communications between healthcare entities.[10]

C. CORE Phase II

CORE's Phase II continues to increase the minimum amount of data required to be contained in eligibility requests and responses, builds upon the requirements for system connectivity,[11] and applies Phase I rules to the request and response for the status of a healthcare claim.[12] The inclusion of rules for healthcare transactions beyond eligibility demonstrates CORE's commitment to moving the healthcare industry toward real time claim adjudication. CORE Phase III rules will address other transactions such as remittance and prior authorization.[13]

D. CORE Participation

According to CAQH, over 100 organizations participate in the CORE rule writing process. These organizations, the Advisory Committee was told, represent a diverse range of stakeholders (e.g., health plans, vendors, clearinghouses, associations, Providers, government entities). Additionally, CORE has provided the Advisory Committee with a list of CORE participating entities and/or their affiliates that conduct business in Ohio. There are over thirty-five entities/products already CORE Phase I certified and fourty-nine entities that are committed to implementing or endorsing Phase II.[14]

[10] For CORE Phase I Operating Rules Overwiew Summary see Appendix A-2.

[11] For CORE Phase II Operating Rules Summary Overview see Appendix A-2.

[12] The status of a healthcare claim is an exchange seperate from eligibility and will not be discussed.

[13] For CAQH's discussion on CORE Phase III operating rules see Appendix A-3.

[14] *Phase III and Beyond.* CAQH Administrative SimplificationConference, September 25,2008.

Ohio-specific CORE Participation and Certification
(Refer to www.caqh.org for complete listing)

CORE Participating Organizations	*CORE-certified or **Endorsing Organizations
Health Plans	*Health Plans*
Aetna	Aetna
Anthem Blue Cross and Blue Shield WellPoint, Inc.)	Anthem Blue Cross and Blue Shield (WellPoint, Inc.)
AultCare	AultCare
CIGNA	Humana
Humana	
United Healthcare	*Clearinghouses/Vendors*
	athenahealth, Inc.
Clearinghouses/Vendors	Availity, LLC
athenahealth, Inc.	MedAvant Healthcare Solutions
Availity, LLC	NaviMedix
MedAvant Healthcare Solutions	RelayHealth
NaviMedix	Siemens/HDX
RelayHealth	SureScripts-RxHub, LLC
Siemens/HDX	
SureScripts-RxHub, LLC	*Associations/Providers/Others*
	American Association of Preferred Provider Organizations (AAPPO)
Associations/Providers/Others	American Academy of Family Physicians (AAFP)
American Academy of Family Physicians (AAFP)	American College of Physicians (ACP)
American College of Physicians (ACP)	American Medical Association (AMA)
American Medical Association (AMA)	Health Information and Management Systems Society (HIMSS)
Delta Dental Plans Association	United States Department of Veterans Affairs
Health Information and Management Systems Society (HIMSS)	Work Group for Electronic Data Interchange (WEDI)
United States Centers for Medicare and Medicaid Services (CMS)	
United States Department of Veterans Affairs	*Statements of Support*
Work Group for Electronic Data Interchange (WEDI)	Blue Cross and Blue Shield Association (BCBSA

*CORE-certified organizations have implemented the CORE operating rules and have demonstrated (through a CORE-authorized testing process) the ability to conduct transactions in accordance with CORE operating rules. CORE-certification is paired with CORE Policy that prescribes a complaint submission and resolution process to address a CORE-certified entity's operating rule adherence.
**Organizations that do not use, create or transmit eligibility transactions can officially support CORE through endorsement, e.g., the AMA.

According to CAQH, in addition to Ohio, CORE's voluntary, nationally coordinated approach to improving interoperability between health plans and Providers is being recognized in Virginia, Washington, Wisconsin, Texas and Colorado. CORE believes that as the adoption of its operating rules continues, the transition to a more transparent and efficient healthcare system will become more evident by the "all-Payor" solutions made possible by the uniform information exchange framework that CORE's operating rules deliver.

Chapter Three: Current State of Affairs in Ohio

A. Standards/Operating Rules

In 1996, HIPAA was enacted. Subtitle F of HIPPA entitled "Administrative Simplification," enumerates the types of healthcare information allowed to be exchanged over the Internet, electronically.

CAQH launched CORE in 2005 to develop national operating rules to improve the process for the exchange of eligibility and benefit information. CORE's operating rules (CORE's rules) add value and create consistency in HIPAA's standards through an increase in the amount of data included in an electronic eligibility response. To explain the necessity of adding CORE's rules to HIPAA's standards, a simple analogy may help.

Think of HIPAA as a street. HIPAA's standards dictate the width of the street, how many lanes it has, and where traffic lights should go. The HIPAA standards do not explain what side of the road to drive on, what the different colors of the traffic light represent or what the speed limit is. Now, think of CORE as the "rules of the road." These rules require everyone to drive in the same direction depending on the lane, stop at a red light and go on a green. These rules also include a speed limit. Operating rules similarly establish a reliable and uniform level of compliance to a given system. In the case of insurance eligibility and benefit verification, CORE's operating rules seek to create a predictable and consistent amount of information to be exchanged between Payors and Providers to facilitate payment.

To assist in the implementation of HIPAA's standards, the American National Standards Institute (ANSI) wrote the *ANSI X12 004010A Implementation Guide* (the *4010A*).[15] The *4010A* explains the standards that are required to be HIPAA compliant and explains that "there are 2 levels of scrutiny that all electronic transactions [exchanges] must go through."[16] These levels of scrutiny are described

[15] The *4010A* explains the necessary data contained in an eligibility verification, who creates and responds to an eligibility verification, and the required system capabilities to execute a HIPAA complaint eligibility verification.

[16] *Electronic Data Interchange Transaction Set Implementation Guide: Health Care Eligibility Benefit Inquiry and Response*. American National Standards Institute, March 2003.

as follows:

- **First is standard compliance. These requirements MUST be completely described in the Implementation Guides for the standards, and NOT modified by specific trading partners.**

- **Second is the specific processing, or adjudication, of the transactions in each trading partner's individual system.**[17]

HIPAA's standards for an eligibility determination only require it to contain the subscriber's name, current insurance status and dependent name (if applicable). Additional information such as amounts of co-pay, coinsurance or base deductible amount may be included at the Payor's discretion. Payors and Providers on the Advisory Committee believe that the amount of information required is too limited. In order to ensure that additional information will be exchanged, the *4010A* recommends supplementary trading partner agreements that enable Payor and Provider systems to operate successfully together. A successful data exchange would be an instance of interoperability.[18]

B. Technology

Currently insurance eligibility and benefit verification in Ohio is a voluntary process for Providers. Many Providers still verify eligibility using labor-intensive methods such as the phone or the Internet. These methods require minimal IT investment and little to no additional training. Many smaller practices utilize these methods of verification for this reason. This information was provided by members of the Advisory Committee.

With no requirement to upgrade current computer systems or purchase new hardware, the phone is viewed by many Providers as an inexpensive means of eligibility information exchange. CORE states that the labor costs associated with phone verification for a Provider exceeds more automated methods.[19] The average

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[17] *Ibid.*

[18] The healthcare industry would not be the first to create and utilize national standards for interoperability. For example, the financial industry first addressed the idea of national interoperability standards in the early 1970s. Responding to an increase in the use of bank checks by consumers, a group of bankers formed the Special Committee on Paperless Entries (SCOPE) to explore the technical, operational, and legal framework necessary for banks to operate successfully together.

SCOPE laid the groundwork for what would become the Automated Clearing House (ACH) Association, which began operation in 1972. In 1974, the National Automated Clearing House Association (NACHA) was formed to coordinate the individual ACH associations. The NACHA and the Federal Reserve System then worked together to link the local and re gional ACHs. The work of SCOPE and NACHA eventually led to a nationally interoperable banking network where financial transactions from across the country can be completed regardless of a transaction origin or destination.

[19] For more information regarding average labor costs see Appendix A-4.

labor cost for an eligibility determination over the phone is approximately $2.70.[20] There is also a cost to the Payor who must have an employee answer the calls regarding verification requests. For this reason many Payors have moved their eligibility information to web portals,[21] which allow Providers to access them via the Internet.

Payors have realized benefits with the increased accessibility and lower costs associated with the Internet.[22] This has resulted in many offering access to patient eligibility and benefit information through web portals. These eligibility access points are Internet websites created by either a single Payor or multiple Payors to display their policyholder's eligibility and benefit information over the Internet. Providers are able to access these portals with minimal IT commitment (usually just a computer and an Internet browser) and are able to search for eligibility and benefit information using the patient's name or a Payor oriented patient identification number. This method of making an eligibility determination does not require the Provider to rely on the Payor to answer and confirm searches, thus yielding quicker results. The average labor cost per web portal transaction is $1.37.[23] Additional, savings can be associated with the level of automation offered by web portals. However, search parameters differ between portals requiring some Providers to go to multiple portals for eligibility verification. Other Providers may still have to make a phone call to the Payor if they are unable to confirm a patient's eligibility information. For these reasons some Payors have chosen to develop a similar level of automation through the phone.

Interactive Voice Response (IVR) systems allow Providers to use the phone to call a dedicated number to connect them to a Payor's computer system. Instead of using a computer to search a website with few instructions on how to search for specific patients, the Provider is channeled through a different automated search method. When a Provider calls the IVR number, they are guided through the search with voice prompts explaining each step of the process. The average labor cost per IVR transaction is $0.88, largely due to the combination of computer resources and well-developed instructions steering Providers through the eligibility verification process.[24]

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[20] *Presentation to the Ohio Advisory Committee on Eligibility and Real Time Claim Adjudication.* CAQH, July 2008.

[21] In December, America's Health Insurance Plans chose Ohio and one other state to participate in a single, multi-Payor portal pilot program. Focusing on eligibility determinations, the pilot program's aim is to develop either a single log-in process or an Internet portal where Payors and Providers are able to exchange eligibility information simply. The pilot will focus on determining Provider office satisfaction with a multi-Payor solution, the possible administrative savings that could be achieved by Payors and Providers, as well as the amount of integration and connectivity between Payors and Providers.

[22] *Presentation to the Ohio Advisory Committee on Eligibility and Real Time Claim Adjudication.* CAQH, July 2008.

[23] *Ibid.*

[24] *Ibid.*

If eligibility information is not complete, the Provider may still be required to speak to a person by telephone or may choose not to verify eligibility at all. With each of these labor-intensive methods, verification requires very little investment in the front end, yet labor costs diminish those savings. As reported in the proposed *HIPAA Electronic Transaction Standards Rule,*[25] the Department of Health and Human Services (HHS) contracted Gartner, Inc. (Gartner) to assess the costs and benefits associated with labor-intensive methods of eligibility verification.

Gartner determined that the average labor-intensive eligibility search takes approximately five minutes per patient. With the average annual compensation package (salary plus benefits) for a Provider billing specialist being $60,000/year, Gartner estimated the average labor-intensive eligibility search costs a Provider $2.40 per patient.[26] For a single physician family practitioner who sees an average of eighteen patients per day,[27] ninety minutes of their time is spent verifying eligibility and costs the Provider $43 per day.

Using this as a daily average, calculations for weekly, monthly and yearly costs are estimated as:

1.5 hours and $43/day
7.5 hours and $215/week
30 hours and $860/month
360 hours and $10,320/year

These numbers represent the time and cost associated with making eligibility determinations for a single Provider seeing an average of eighteen patients per day. For a five physician practice with each physician seeing an average of eighteen (18) patients per day, the estimated costs are.

7.5 hours and $215/day
37.5 hours and $1,075/week
150 hours and $4,300/month
1,800 hours and $51,600/year

[25] 45 CFR Part 162, August 22,2008.
[26] *Ibid.*
[27] *The Characteristics of Office Based Physicians and Their Practices: United States, 2005-2006.* The Centers for Disease Control and Prevention.

These figures indicate that, as practices grow and physicians are added, labor-intensive eligibility verification becomes less efficient and more costly. For these reasons many Payors and Providers have tried to integrate their administrative software with each other to create an automated answer to eligibility verification.

The answer to automated eligibility verification is the HIPAA electronic eligibility request and response, otherwise known as a 270/271 exchange. In order to utilize the 270/271 exchange, both Payors and Providers must convert their systems to comply with the HIPAA electronic standards found in the *4010A*.[28] Many larger Providers, especially hospitals, employ 270/271 exchanges in response to the large volume of patients seen daily. This method of verification requires both the Provider and the Payor to have compatible administrative software that connects over the Internet. Providers use practice management software to manage the administrative portion of their practice. When the practice management software is compatible with the Payor systems using 270/271 interoperability standards, eligibility requests are generated automatically, without human intervention or a dditional data entry. The Payor's software then finds the relevant information and sends an automated, electronic response back to the Provider, directly into the Provider's practice management software. Labor costs are drastically reduced because the search is completely automated, only requiring one computer to communicate with another computer. The average labor cost per 270/271 transaction is approximately $0.25.[29]

Unlike the labor-intensive methods of eligibility verification, 270/271 exchanges require front end costs that differ depending on the type of healthcare entity. In the same cost assessment performed by Gartner, the estimated cost for upgrading each respective entity's system to be able to handle 270/271 was calculated.

Healthcare Entity	Estimated Average Cost for 4010A Conversion
Hospitals	$808,639.83
Physician Offices	$9,286.06
Private Health Plans	$4,563,433.78
All Government Health Plans[30]	$1,260,000,000.00
Clearinghouses	$771,604.94

[27] For an explanation of *4010A* refer to Chapter 3 (A): Standards/Operating Rules.

[28] *Presentation*. CAQH, July 2008

[29] *The estimated cost for government health plans would be displaced over all federal and state plans. This dollar amount is not an average.*

The price variation seen among healthcare entities is directly related to the number of Payors with which Providers need to interface and the number of systems that need to be converted. A physician's office may only need one computer that can handle 270/271 exchanges. In contrast, hospitals, because of their size, usually require multiple computer systems, all requiring a conversion to handle 270/271 exchanges. The same is true for private health plans with multiple systems all requiring *4010A* conversion. Due to these upfront costs, many entities choose not to invest in conversion. For those who choose to move forward, savings can be discovered.[31]

According to the Gartner methodology, a five physician practice that sees ninety patients per day would require ninety minutes for eligibility verification at a cost of $22.50. For the five physician practice, labor-intensive verification would take seven and a half hours to verify eligibility and cost $216. Comparing the costs of labor-intensive verification versus the use of 270/271 exchanges, the possibilities for a return on investment can be seen:

Labor-Intensive Methods	Use of 270/271 Exchange
$216/day	$22.50/day
$1,080/week	$112.50/week
$4,320/month	$450/month
$51,840/year	$5,400/year

The above values are estimates and do not represent actual return on investment. The chart does, however, illustrate the cost differences between labor-intensive methods and automation.

C. Eligibility and Benefits Verification Issues

The Ohio State Medical Association (OSMA), the Academy of Medicine of Cleveland and Northern Ohio (AMCNO), the Ohio Psychological Association (OPA) and the Ohio Council for Home Care (OCHC) sent surveys to their respective members requesting information on their eligibility determination practices.[32] The survey responses provided valuable insight into the reasons why many Providers choose not to verify in some instances or all of the time.

[31] For additional information regarding possible savings refer to Appendix A-5.

[32] For the complete survey conducted by OSMA, AMCNO, and OCHC see Appendix A-6. For the complete survey conducted by OPA, see Appendix A-7.

The survey results revealed that a large percentage of Providers do not verify eligibility some or all of the time due to a lack of available time. For some the lack of time is due to their method of verification. Time on the phone, either on hold or waiting for a response, takes too long for some Providers. Others stated that their practices have limited staff and the benefits of verification do not outweigh the loss of employee time. Providers also noted that their current technology is inadequate and the cost of upgrading is too high.

Another issue identified in the survey was the perceived inaccuracy of the eligibility information received from Payors. Some Providers commented that while they had verified eligibility at the time of service, six months later they were informed that the information was incorrect. In these instances the end result is an invalidation of a Payor's previous payment, also known as a "take back". The issue of "take backs" including concerns regarding the accuracy of the information gathered in the Provider surveys will be discussed later in the report.

Chapter Four: HB 125 Advisory Committee Subcommittees

The Advisory Committee created three subcommittees to address the charge in HB 125: the Business Processes Subcommittee, the Technology and Infrastructure Subcommittee and the Dispute Resolution Subcommittee.

A. Business Processes Subcommittee

The purpose of the Business Processes Subcommittee (the subcommittee) was to identify the barriers to Providers using electronic eligibility verification within a private practice setting.

The subcommittee discussed how frequently electronic eligibility verification is used by Providers. It was acknowledged that products and services for electronic eligibility verification including practice management software are currently available. However, these systems are not being utilized by the vast majority of Providers because of the expense to interface them to all the different Payors. Experts from athenaHealth believe that many of their Provider clients who have purchased practice management systems with an electronic eligibility verification function do not use this capability.[33]

The most significant barrier to electronic transactions is the cost of implementation. Another barrier is the absence of a uniform way to check eligibility between Payors and Providers. If office staff must log into a different website and provide different information to each Payor in a different format, checking eligibility becomes cumbersome. Providers want to invest once in a system that will be uniformly used across the country. Subcommittee members agreed that the adoption

[33] For further information provided by athenaHealth, see Appendix A-8.

of CORE standards in Ohio would be a good beginning toward creating a uniform method to verify eligibility.

Providers want to collect the right amount of money from patients with coverage under high-deductible health plans. Currently, the information provided by electronic eligibility verification is insufficient for this purpose.

Finally, office staff may not be accustomed to questioning patients about their eligibility. Office staff will need training if new practice management software is purchased by the Provider. While this may be an initial barrier, it could be eliminated with the development of best practices and adequate training.[34]

B. Technology and Infrastructure Subcommittee

The Technology and Infrastructure Subcommittee (the subcommittee) was created to address issues related to the development, adoption and maintenance of the systems necessary to utilize CORE's operating rules. In doing, so the subcommittee assessed the Internet connectivity in Ohio, the current software being used, and other national standards poised for adoption in the near future.

The subcommittee first assessed the extent of broadband[35] connectivity across the state. Providers in Ohio need to be connected to the Internet to accommodate electronic requests for and responses to eligibility and benefit information. With the help of the Ohio Department of Administrative Services (DAS), OSMA and ConnectOhio, the subcommittee was able to overlay a map of licensed physicians and hospitals with the currently available statewide concentration of broadband access.[36] The overlay revealed very few physicians without access. The subcommittee concluded that access to broadband did not pose a barrier to the adoption of CORE's operating rules. As a consequence, the subcommittee agreed that the larger hurdle to adoption would be upgrading many of the healthcare industry's current systems to be CORE compliant.

The subcommittee and Advisory Committee recognized that upgrading computer systems could impose hardships on smaller Payors and Providers, some of who utilize out-dated practice management software systems or no systems. Vendors

[34] Best practices are addressed in the Final Recommendations.
[35] Broadband refers to the cable and DSL Internet connection.
[36] To view the overlay maps see Appendix A-9.

that develop practice management software systems pointed out that rewriting their software could be costly.

In order for practice management software systems to comply with CORE's operating rules, they must be capable of including more eligibility and benefit information in their requests and responses. The subcommittee agreed that there would be an upfront cost to the development and conversion to CORE practice management software systems, with the adoption of nationally recognized operating rules, future costs would decrease. The hope is that with only one standard to use, future confidence in adopting technology would increase and the fear of purchasing the wrong software would be mitigated.

One possible catalyst for the healthcare industry's adoption of nationally recognized operating rules could be federally mandated improvements to HIPAA's electronic standards. HHS has proposed a new version of HIPAA's electronic standards that would refine and improve many of the eligibility standards originally addressed by HIPAA in the *4010A*. The new HIPAA's standards are the *ASC X12 Version 005010* (the *5010*).[37] Many of the improvements made by the *5010* were anticipated and have been incorporated in the development of CORE's Phase I operating rules. The subcommittee recognizes that the required adoption of the new *5010* standards by April 2010 will necessitate a software upgrade and the result may be simultaneous adoption of CORE Phase I by many entities. This simultaneous adoption could be accomplished if all software upgrades written to be *5010* compliant also adopt the minimal extra requirements for CORE Phase I. Conversely, every healthcare entity that is already CORE Phase I certified would only need to make minimal system changes to become *5010* compliant.

C. Dispute Resolution Subcommittee

The Dispute Resolution Subcommittee discussed the disputes that arise when Providers check eligibility at the outset and the eligibility information is not accurate. The subcommittee agreed that there were both avoidable and unavoidable situations when a Provider checks eligibility, provides services, and then is not paid or must return payment because the patient was not eligible at the time of service. The

[37] The *5010* is the newest version of the *4010A*. The *5010* requires additional data elements and improved system capabilities. The *5010* has not become a final rule as of August 22, 2008, meaning that compliance is not yet required.

subcommittee identified the following types of situations in which incorrect eligibility information can lead to the Payor requesting reimbursement from the Provider, commonly referred to as a "take back":

- Termination of employment or reduction in hours of an employee;
- Termination of dependent eligibility because of a "qualifying event" such as a divorce from the employee or an employee's child reaching the limiting age of coverage;
- Retroactive termination of coverage for an entire Employer group for failing to pay for the premium after an extended grace period; and
- Patient fraud.

In order to determine how frequently "take backs" occur, some subcommittee members surveyed their memberships. The survey conducted by Providers[38] showed that 58% of physicians had, at least on one occasion, verified eligibility and were subsequently requested to return the payment for a service rendered; for 76% of this group, this has happened less than 5% of the time. The percentages are significantly higher for home healthcare Providers and psychologists. The Ohio Association of Health Plans (OAHP) also surveyed its members.[39] OAHP's survey showed that 6% of payments made to Providers involved "take backs" which were less than the amount claimed by the Providers. There was a lack of consensus within the subcommittee whether or not the various surveys taken by the Advisory Committee members accurately captured the extent and cause of "take backs." There was general agreement that additional data gathering by neutral parties who were experienced at conducting precise surveys would be beneficial.

The subcommittee also discussed questions posed by the General Assembly concerning how eligibility disputes could best be resolved. The subcommittee noted that the underlying dispute is not actually over eligibility, but rather over who assumes the risk for the billed services based upon incorrect eligibility information. Currently, the risk falls entirely on the Provider.

[38] *Health Care Providers' Survey*. OSMA, AMCNO, and OCHC, October 22,2008.
[39] For the complete questionnaire conducted by OAHP see Appendix A-10.

The subcommittee discussed ways in which they could share the risk of eligibility inaccuracies. One idea, proposed by Providers, but not agreed to by Payors, was to shorten the time period in which Providers could be required to return payment for services if it turned out, after the fact, that the patient was ineligible for coverage. Currently, Ohio Revised Code 3901.388 permits Payors to initiate payment recoveries from Providers up to two years after payment is made. Providers suggested that if this time period were shortened only for Providers who could demonstrate evidence that they had verified eligibility electronically on the date of service, it would encourage Providers to adopt electronic eligibility verification systems. Furthermore, it was suggested that this also would create an additional financial incentive for Employers to provide more timely and accurate eligibility information.

The subcommittee discussed changing the "take back" period. Providers initially requested that the time period be shortened to sixty days. Employers pointed out that they cannot always determine eligibility status within this timeframe and pointed to situations such as the fact that federal COBRA[40] law provides notice and employee election timeframes that exceed sixty days. Employers emphasized they must rely upon employees for dependent coverage information. The subcommittee discussed whether there should be a different time period for employee "take backs" than for dependent "take backs". Insurers voiced concern that this might cause administrative difficulties if there were different time periods after which "take backs" would not be allowed depending upon the type of ineligible member.

Members of the subcommittee noted that the timeframes for "take backs" were first enacted in 2002 with the passage of Senate Bill 4, also known as the prompt pay statutes.[41] Insurers took the position that the timeframes for one aspect of the current prompt pay structure should not be changed unless the entire prompt pay structure was re-examined. Payors did not agree that there should be a shorter timeframe than the current two years.

The subcommittee explored the idea of establishing a reciprocal time period for adjustments to claims based on eligibility information. By way of example, if Providers were limited by contract from adjusting bills after a certain period of time,

[40] Consolidated Omnibus Budget Reconciliation Act, 99 Pub.L. No. 272 (1985).
[41] Ohio Revised Code 3901.38 *et seq.* (Prompt payments to health care providers).

Payor "take backs" should be limited to the same time period. Members of the sub-committee indicated that these types of contractual provisions are not uncommon in contracts entered into by larger Providers, but would be more difficult for smaller Providers to negotiate.

Employers contended that it is more appropriate for the "take back" risk to stay with the Providers because they are in a better legal position to recover from the patient who received services, and that Employers may be barred under the Supreme Court's decision in *Great-West Life & Annuity Ins. Co v. Knudson*,[42] from recovering for medical expenses from an employee. However, more recent Supreme Court and Sixth Circuit decisions have expressed different views suggesting relief is available to plan fiduciaries seeking reimbursement from unjustly enriched beneficiaries.[43]

[42] 534 U.S. 204 (2002).

[43] *Sereboff v. Mid. Atl. Med. Servs.,* 547 U.S. 356 (2006) and *Gilcrest v. Unum Life Insurance Co. of America*, 2006 WL 1582437 (S.D. Ohio 2006).

Chapter Five: Final Recommendations and Best Practices

Based in part on recommendations made by the three subcommittees, the Advisory Committee developed a set of recommendations and best practices which, for the most part, received unanimous approval. A discussion of these recommendations and best practices of the Advisory Committee follow.[44]

A. CORE Recommendations

1. A majority of the members of the Advisory Committee recommend that all electronic administrative transactions related to health care insurance eligibility verification, must be CORE Phase I and Phase II compliant no later than three years after the deadline for ICD-10 compliance. [45]

For (13)		Against (7)	
Trudi Matthews	HealthBridge	Michelle Daniels	Aetna
Michelle Cadrin-Msumba	athenaHealth	Jim Weisent	Medical Benefits Mutual
Christine Kozobarich	SEIU	Karen Greenrose	AAPPO
Dan Paoletti	OHA	Dave Uldricks	Employer's Health
Dan Sylvester	Quality Care Partners	Carrie Haughawout	Ohio Chamber of Commerce
Kathleen Anderson	Ohio Council for Home Care	Jeff Corzine	Unison
Woody Woodward	OSCA	Dave Cook	Paramount
Kathie Fuson	Delta Dental		
Martha Simpson	Osteopathic Physician		
Michael Ranney	OPA		
Rex Plouck	OIT		
Lawrence Kent	Academy of Medicine of Cleveland		
Ray Shealy	RelayHealth		

[44] For opinions submitted by America's Health Insurance Plans, the Ohio Chamber of Commerce, and AMCNO, the OSMA (2) and the insurers (AAPPO, Aetna, Delta Dental, Paramount, and Unison Health Plan) refer to Appendix A-11, A-12, (A-14 and A-15) and A-16, respectively.

[45] The final rule for ICD-10 has not been published. The date for required compliance, therefore, has not been definnitively established.

Not Voting: Jeff Vossler (Joint Township District Memorial Hospital), Joe San Filippo (Nationwide Better Health), Joseph Liszak (Community Health Services), Jeff Biehl (AccessHealth Columbus), Bill Hayes, (Health Policy Institute of Ohio).

The Advisory Committee agreed that CAQH's CORE initiative represented the most advanced national effort to standardize electronic administrative transactions in general. The Advisory Committee further agreed that promoting the adoption of CORE standards was ultimately to the advantage of all segments of the healthcare industry. There was disagreement about whether the adoption of CORE standards should be mandated by law, thus resulting in some no votes.[46]

Those Advisory Committee members who recommended that all electronic administrative transactions be CORE Phase I compliant within the three year period supported the adoption of CORE operating rules by all parties. They believe that HIPAA will require companies to upgrade existing technologies and software or purchase entirely new systems in the next few years and that CORE adoption should be included in the upgrade or new software purchases. Particular mention was made of the fact that the required conversion to the HIPAA *5010* form by 2010 would in essence make entities CORE compliant because of the extensive overlap in requirements.

The Advisory Committee members opposing the adoption of this recommendation did not agree that adoption of CORE should be mandated by law. These members believe compliance with CORE should be voluntary. The larger national entities have, by and large, already adopted CORE and it is the smaller, regional Payors and Providers who have yet to do so. Concerns were raised regarding the possible financial hardships that requiring CORE compliance could present. Payors voiced their concern that setting a certain date by which compliance must be achieved would be burdensome at a time when Payors will be required by federal law to comply with the *5010* by April 2010 and the ICD-10 as early as October 2011.

2. The Advisory Committee recommends that stakeholders should not be required to include any data elements beyond those required by CORE for electronic eligibility and benefits verification.

The data elements required by CORE's Phase I operating rules exceed those

[46] For opinions provided by Athem and Medical Mutual of Ohio (MMO), refer to Appendix A-17 and A-18, respecitively.

currently required by HIPAA and each subsequent CORE phase will add more data elements.[47] The approach adopted by CORE is intended to prevent undue burden on entities who may have limited resources to upgrade their systems to offer a long list of required data elements. The data elements included in HB 125 exceed CORE's required data elements for Phases I and II. Following the requirements of CORE will allow Ohio to develop in accordance with and be consistent with national efforts.

B. Technology Recommendations

1. The Advisory Committee does not recommend any particular information technology for personal identification, such as smart card, magnetic strip or biometric technology.

Smart cards are in use today by a limited number of Payors (*e.g.*, Humana, United Health Care) and both these Payors and their Providers invested heavily into incorporating this technology into their business processes. With the generally short lifetime of new technologies, the Committee chose not to recommend any particular technology since it might become outdated by the time compliance is achieved. Advances in nanotechnology and biometrics[48] illustrate just a few alternative systems that are currently in testing phases and which may be more cost effective in the near future.

2. The Advisory Committee does not recommend any particular information technology to be used by Providers to generate a request for eligibility.

The Advisory Committee recognized that some entities within the healthcare industry will not have the capital to invest and reinvest in IT resources if standards and rules continue to fluctuate. In order to guarantee the highest level of adoption of new IT resources, the industry must possess firm standards and operating rules to build systems around. The Advisory Committee concluded that it is premature to recommend any specific hardware/software because electronic eligibility verification is in its infancy.

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[47] For CAQH's comparison of HB 125's data elements with CORE and HIPAA, refer to Appendix 19.

[48] *E.g.*, fingerprints, retinal scans, gate recognition.

3. The Advisory Committee recommends that further analysis of broadband connectivity be undertaken.

Currently, access to broadband Internet across the state is roughly at 95%. When all entities are required to perform electronic transactions, there may be greater access to broadband.

4. The Advisory Committee recommends that further investigation into alternative methods that provide electronic data exchange be undertaken. There should be specific attention focused toward additional established data networks such as Regional Health Information Organization's and possible pilot programs that may help facilitate electronic administrative transactions.

Utilizing existing electronic networks, clearinghouses[49] and private funding may assist Ohio in creating a more comprehensive network to facilitate the exchange of electronic administrative information. With many private organizations developing networks for the exchange of clinical data,[50] it may be possible to incorporate administrative information into the mix to create a complete network with the ability to provide a complete exchange of all necessary patient information.

C. Dispute Resolution Recommendations

The Advisory Committee recognized that it is not realistic to believe that patient eligibility information can be accurate 100% of the time. Therefore, the discussion focused on ways to promote increased reliability of eligibility information. The Advisory Committee agreed that all parties could take actions designed to increase the accuracy and timeliness of patient eligibility information relied upon by the Providers. Toward this end, the Advisory Committee identified the following best practices for the parties involved in eligibility determinations.

[49] For information about the Availity clearinghouse, refer to Appendix 20.
[50] *E.g.*, lab results, electronic medical records and other patient information.

1. The Advisory Committee recommends the following best practices for Employers:

a. Employers should provide updated employee eligibility information to TPAs/insurers as soon as possible following an employee's qualifying event and no less frequently than on the Employer's payroll cycle or on a monthly basis.

The accuracy of Employer health plan eligibility information begins with the Employer. Employers provide eligibility information to TPAs/insurers which is checked by Providers to determine whether patients are eligible for benefits. When an employee is terminated or becomes ineligible for coverage, Employers should communicate this change to their TPA/insurer. There may be situations when an Employer retroactively terminates an employee, such as when an employee stops coming to work, which may cause eligibility information to be inaccurate for a period of time. Generally, when an Employer terminates an employee, notice should be given to the TPA/insurer as soon as the Employer updates its payroll, but no less frequently than once a month.

If an Employer extends coverage to terminated employees until the end of each month and the Employer is able to notify the TPA/insurer prior to the end of the month, eligibility information regarding this employee should always be accurate. In cases where the Employer does not provide coverage beyond the date of employment termination, and if the Employer does not notify the TPA/insurer for a period of thirty days or more, there is potentially a significant period of time following termination during which the TPA/insurer will be providing inaccurate eligibility information to Providers. Employers should take steps to minimize the amount of time that eligibility information is not accurate.

b. Employers should include a detailed review of benefits, including a discussion of the responsibility of the employee to promptly notify the Employer when there is a change in the status of an employee's dependent, in every new employee orientation program. The information may be provided as a written policy outlining dependent coverage terms and conditions, or in some other fashion. It should also clearly explain whether coverage ends on the last day of employment or the last day of the month in which the termination occurred.

Employers must rely upon employees to notify them of changes to a dependent's status. Employers should be sure that new employees understand their obligation to notify the Employer of these changes in a timely fashion. In order to save Employers from the cost of paying premiums for ineligible dependents and from the administrative costs associated with undoing an eligibility error, Employers should take all necessary steps to discover this information as soon as possible. Employees or their dependents who work for Employers with twenty or more employees are currently required by COBRA to notify the Employer of the qualifying event within sixty days in order to be eligible for COBRA continuation coverage. In addition, orientation materials should clearly explain when coverage ends.

c. At the time of termination of employment, Employers should again provide every employee with information clearly identifying the last day of coverage.

Even though an Employer may have informed an employee at the time of hire whether coverage ends on the date of termination or at the end of the termination month, the Advisory Committee recommends that this information be clearly provided to an employee again at the time of termination. The Consumer Services Division of the Ohio Department of Insurance has heard from many employees who sought medical care in reliance upon the mistaken belief that their insurance coverage extended until the end of the month in which employment was terminated.

d. Employers should provide updated dependent eligibility information to TPAs/insurers as soon as possible following notice of a dependent's qualifying event.

The Advisory Committee considered the situation involving a "qualifying event" of the employee's dependent. Employers are aware of the reasons that trigger a "qualifying event" for a spouse or child, such as the employee's termination from employment, but there are some situations in which the Employer must rely upon the employee to give notice that the event has occurred. The two situations most frequently encountered are divorce and an employee's child reaching the limiting age for coverage. The Advisory Committee recognized the difficulty Employers may

have in obtaining this information in a timely fashion and therefore recommended that the Employers' responsibility to notify the TPA/insurer should be triggered when the Employer receives notice of the change in dependent status.

e. Employers, or their TPAs, should periodically, but no less often than annually, take appropriate steps to verify dependent eligibility through the use of tools such as dependent audits or employee surveys.

It is in the best interests of Employers, TPAs/insurers and Providers to not have ineligible dependents on Employer rolls for long periods of time. Although it is sometimes difficult for Employers to discover ineligible dependents, there are actions Employers should take to do so. For example, Employers can audit dependent status and thereby reduce their health care costs. A 2004 Wall Street Journal article stated that between 10% - 15% of employees had an ineligible dependent on a company health plan.[51] The Ohio School Employees Health Care Board has included undertaking a dependent audit as a best practice standard for all school districts.[52] A less costly option for Employers is to survey employees about changes to dependent status. Employers may also verify dependent eligibility at the time of annual open enrollment, if they do not do so currently.

2. The Advisory Committee recommends the following best practices for Providers:

a. Providers should always verify eligibility and check the insurance identification card at the time of each patient service, when feasible. Providers should also ask for a photo identification card if they do not know the patient, when feasible.

b. The Provider's office staff should verify insurance eligibility both at the time of service and when the appointment is initially scheduled, as appropriate.

[51] Fuhrmans, *To Stem Abuses, Employers Audit Workers" Health Claims,* Wall St. J., Mar. 31, 2004, at B1.
[52] OAC 3306-2-03 (D), effective January 1, 2009. For the compelte document, refer to Appendix 21.

c. When deciding to purchase a new practice management system, Providers should select a CORE certified practice management system.

d. Providers should ask patients at the time of service, when appropriate, whether there has been a change in their employment, insurance coverage or dependent status.

e. Providers who have reason to believe that a patient may not be eligible for insurance or Employer coverage should arrange for payment by the patient, as appropriate.

3. The Advisory Committee recommends the following best practices for Third Party Administrators (TPAs):

a. TPAs should provide electronic access to patient eligibility information received from Employers within two business days of receipt, if received electronically, and within five business days of receipt if received by another method of transmittal.

b. TPAs should request Employers to update eligibility information no less frequently than on the Employer's payroll cycle or on a monthly basis.

c. TPAs should request Employers to update employee and dependent eligibility information as soon as possible following an employee or dependent's qualifying event.

d. During the time period between the termination of coverage and the initial election of COBRA coverage, the TPA should list the employee or dependent as "ineligible" until the Employer receives the first COBRA payment.

COBRA allows thirty days from the date of the employee's termination of employment for the Employer to notify the plan administrator of this "qualifying event". The plan administrator then has an additional fourteen days to give notice of COBRA rights to the employee, after which the employee has an additional sixty days in which to elect and pay for COBRA coverage. In light of these mandatory time

frames, an Employer may not know if the employee will choose COBRA coverage for a total of 104 days after the termination of employment. The COBRA time period for a dependent is even longer because if starts with an additional thirty days for the employee or dependent to notify the plan administrator of the "qualifying event". Because the actual take-up rate for COBRA coverage is small, the Advisory Group recommends that TPAs list the COBRA eligible employee as ineligible from the first notice of the qualifying event. Once the employee/dependent has actually paid the COBRA premium, the file can be adjusted to show retroactive eligibility back to the date that Employer group coverage ended. By following this practice, the Provider is on notice that there is an eligibility issue prior to delivering services and the patient is always free to make the COBRA premium payment and have eligibility reinstated earlier. DAS currently follows this procedure.

4. The Advisory Committee recommends the following best practices for insurers:

a. Insurers should provide electronic access to patient eligibility information received from Employers within two business days of receipt, if received electronically, and within five business days of receipt if received by another method of transmittal.

b. Insurers should request Employers to update eligibility information no less frequently than on the Employer's payroll cycle or on a monthly basis.

c. Insurers should request Employers to update employee and dependent eligibility information as soon as possible following an employee or dependent's qualifying event.

d. During the time period between the termination of coverage and the initial election of COBRA coverage, the insurer should list the employee or dependent as "ineligible" until the Employer receives the first COBRA payment. [53]

[53] See explanation of COBRA timeframe in Recommendation 3(d).

e. Insurers should consider that the practice of extending long grace periods to Employers to help them afford the insurance premium can result in employees loosing HIPAA protections if the Employer does not ultimately pay premium and coverage is retroactively terminated for a period longer than 63 days.

When an Employer does not pay insurance premiums on time, insurers typically will give the Employer a grace period in which to make payment before the coverage is cancelled. This grace period often is extended by the insurer when the Employer gives assurance of payment. If the Employer ultimately does not make the payment, the insurer will retroactively terminate the coverage to the date the payment was due. This practice may cause employees to lose important consumer protections under HIPAA, through no fault of their own. An employee that loses employer coverage must enroll in new coverage within 63 days to avoid pre-existing condition exclusions that may limit the new coverage. Insurers retroactively terminating employer coverage shorten the time during which an employee must find new coverage to preserve their HIPAA rights. If the retroactive termination goes back more than 63 days, which sometimes happens, the employee loses all HIPAA rights, which means the employee will be subject to pre-existing condition exclusions. If the employee has a chronic condition, the new insurer may deny coverage for such conditions for up to twelve months.[54]

Ohio Revised Code 3923.04 (C) requires that insurers offer Employers a minimum ten day grace period for the payment of monthly premium, however, it is commonplace for a monthly premium policy to include a thirty day grace period. In addition to the loss of HIPAA protections, these situations can create dire situations for employees because they may incur substantial medical expenses due to their Employer withholding healthcare contributions from their pay checks without submitting those funds to the insurer.

5. The Advisory Committee recommends that it continue to gather additional data on eligibility denials and "take backs" and set the parameters for the respective data collection.

[54] Ohio Revised Code 3923.57.

There was a lack of consensus within the group regarding whether the data collected through the various surveys accurately captured the extent and cause of the "take back" problem.[55] The group recommended that an independent party gather additional data in order to determine, as precisely as possible, how often the "take backs" occur and why.

6. A majority of the members of the Advisory Committee recommend that payments made for services rendered to ineligible employees and dependents should not be permitted to be "taken back" after one year from the date of the original payment, if the Provider confirmed eligibility electronically on the date of service and can demonstrate that eligibility was verified at the time services were rendered.

For (9)	
Michelle Cadrin-Msumba	athenaHealth
Christine Kozobarich	SEIU
Dan Paoletti	OHA
Dan Sylvester	Quality Care Partners
Kathleen Anderson	Ohio Council for Home Care
Woody Woodward	OSCA
Martha Simpson	Osteopathic Physician
Lawrence Kent	Academy of Medicine of Cleveland
Jim Weisent	Medical Benefits Mutual

Against(6)	
Michelle Daniels	Aetna
Karen Greenrose	AAPPO
Dave Uldricks	Employer's Health
Carrie Haughawout	Ohio Chamber of Commerce
Dave Cook	Paramount
Kathie Fuson	Delta Dental

Not Voting: Jeff Vossler (Joint Township District Memorial Hospital), Joe San Filippo (Nationwide Better Health), Joseph Liszak (Community Health Services), Jeff Biehl (AccessHealth Columbus), Bill Hayes, (Health Policy Institute of Ohio), Ray Shealy (RelayHealth), Michael Ranney (OPA), Rex Plouck (DAS).

The Advisory Committee discussed the potential effects of adjusting the "take back" timeframe from two years to one year. Providers stated that the sooner

[55] The Ohio Hospital Association shared with the Advisory Committee that their board has authorized a project to be conducted in 2009 to collect a significant amount of data on the issue of the magnitude and cause of "take backs" occurring in hospitals.

they become aware that there would be no Employer coverage for a previously treated patient, the sooner they could initiate contact with the patient to secure payment for services rendered. The longer it takes for the Provider's office to be informed of aneligibility correction, the more difficult it is for the Provider to collect based on the contact information taken at the time of service.

Employers pointed out that there are situations, such as coordination of benefits, when another carrier is involved and eligibility status cannot be determined quickly. Insurers voiced concern that this might cause administrative difficulties for them if there were different time periods after which a "take back" would not be allowed depending upon the status of an ineligible member.

Although there was not a consensus, nine of the fifteen Advisory Committee members who voted agreed that the time period for "take backs" should be shortened. This would require amendment of Ohio Revised Code 3901.388.

D. Additional Recommendation

The Advisory Committee recommends that it continue in operation to promote stakeholder adoption of best practices, to promote the adoption of CORE rules, and to address the technical issues and other questions likely to arise during the implementation of CORE.

Chapter Six: Conclusion

Ongoing conversations between Payors and Providers are essential to promote the adoption of CORE operating rules, to continue to work toward promoting electronic eligibility verification by Providers and to identify more precisely what situations cause problems between the parties. All parties share the goal of reducing administrative costs in the healthcare industry and agree that continuing to gather more data, understanding the problems more precisely and working on the implementation of best practices is ultimately in everyone's interest.

Appendix

A-1 House Bill 125 Section 7

A-2 CAQH's CORE Phase I & II *Operating Rules Summary Overviews* (December 2008)

A-3 CAQH's CORE Power Point Presentation (September 25, 2008)
- *The Future of CORE: Phase III and Beyond.* CAQH Administrative Simplification Conference

A-4 CAQH's CORE Power Point Presentation (July 2008)
- *Presentation to the Ohio Advisory Committee on Eligibility and Real Time Claim Adjudication*

A-5 Humana Power point Presentation (October 2008)
- *Ohio HB125 Advisory Committee Eligibility & Benefits and Real-time Adjudication*

A-6 OSMA, AMCNO and OCHC's *Health Care Provider's Survey Repor*t (October 22, 2008)

A-7 OPA's Provider Survey (October 2008)

A-8 athenaHealth Power Point Presentation (August 27, 2008)
- *Real-Time Claim Adjudication*

A-9 Broadband Mapping (OGRIP, DAS, OSMA and ConnectOhio) (October, 2008)
- Physicians by zip code
- Broadband coverage
- Broadband coverage w/ Physicians by zip code
- Hospital locations
- Broadband coverage w/ Hospital locations
- Hospital locations w/ Physicians by zip code
- Broadband coverage w/ Hospital locations w/ Physicians by zip code

A-10 OAHP's Questionnaire (October 2008)

A-11 AHIP Comments on HB 125, submitted by Rebecca L. Egelhoff, Esq., on behalf of AHIP (December19, 2008)

A-12 Ohio Chamber of Commerce Comments on HB 125, updated by Carrie Haughawout, Director, Ohio Small Business Council, Ohio Chamber of Commerce (December 23, 2008)

A-13 AMCNO Comments on HB 125, submitted by Elayne R. Biddlestone, EVP/CEO, AMCNO (December 17, 2008)

A-14 OSMA Comments on HB 125, submitted by Tim Maglione, Esq., Senior Director of Government Relations, OSMA (November 10, 2008)

A-15 OSMA Comments on HB 125, submitted by Jeff S. Smith, Esq., Director of Government Relations (December 19, 2008)

A-16 AAPPO, Aetna, Delta Dental, Paramount and Unisom Health Plan's Comments on HB 125, submitted by Kelly McGivern, President and CEO, OAHP (December 23, 2008)

A-17 Anthem Presentation (August 27, 2008)
- *Ohio Advisory Committee on Eligibility and Real-Time Claims Adjudication Anthem Testimony*

A-18 Medical Mutual of Ohio Presentation (August 27, 2008)
- *Advisory Committee Eligibility and Real Time Claim Adjudication: Presentation by Medical Mutual of Ohio*

A-19 CAQH (October 8, 2008)
- *Data Element Comparison*

A-20 Availity Power Point Presentation (August 27, 2008)
- *Ohio Department of insurance Advisory Committee on Eligibility and Real Time Claims Adjudication*

A-21 Ohio School Employees Health Care Board Best Practice Standards
- OAC 3306-02-03 (D), effective January 1, 2009.

HB 125 – Creation of Advisory Committee on Eligibility and Real Time Claim Adjudication

SECTION 7. (A) There is hereby created the Advisory Committee on Eligibility and Real Time Claim Adjudication to study and recommend mechanisms or standards that will enable providers to send to and receive from payers sufficient information to enable a provider to determine at the time of the enrollee's visit the enrollee's eligibility for services covered by the payer as well as real time adjudication of provider claims for services.

(B) The Superintendent of Insurance or the Superintendent's designee shall be a member of the Advisory Committee and shall appoint at least one representative from each of the following groups or entities:

(1) Persons eligible for health care benefits under a health benefit plan;

(2) Physicians;

(3) Hospitals;

(4) Health benefit plan issuers;

(5) Other health care providers;

(6) Health care administrators;

(7) Payers of health care benefits, including employers;

(8) Preferred provider networks;

(9) Health care technology vendors;

(10) The Office of Information Technology.

(C) Initial appointments to the Advisory Committee shall be made within thirty days after the effective date of this act. The appointments shall be for the term of the Advisory Committee as provided in division (I) of this section. Vacancies shall be filled in the same manner provided for original appointments. Members of the Advisory Committee shall serve without compensation.

(D)(1) The Superintendent of Insurance shall be the Chairperson of the Advisory Committee. Meetings of the Advisory Committee shall be at the call of the Chairperson. All of the members of the Advisory Committee shall be voting members. Meetings of the Advisory Committee shall be held pursuant to section 121.22 of the Revised Code.

(2) The Department of Insurance shall provide office space or other facilities, any administrative or other technical, professional, or clerical employees, and any necessary supplies for the work of the Advisory Committee.

(E)(1) The Advisory Committee shall advise the Superintendent of Insurance on both of the following:

(a) The technical aspects of using the transaction standards mandated by the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., and the transaction standards and rules of the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange to require health benefit plan issuers and administrators to provide access to information technology that will enable physicians and other health care providers to generate a request for eligibility information at the point of service that is compliant with those transaction standards;

(b) The data elements that health benefit plan issuers and administrators are required to make available, using, to the extent possible, the framework adopted by the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange.

(2) The Advisory Committee shall consider including the following data elements in the information that must be made available in eligibility and real time adjudication transactions:

(a) The name, date of birth, member identification number, and coverage status of the patient;

(b) The identification of the payer, insurer, issuer, and administrator, as applicable;

(c) The name and telephone number of the payer's contact person;

(d) The payer's address;

(e) The name and address of the subscriber;

(f) The patient's relationship to the subscriber;

(g) The type of service;

(h) The type of health benefit plan or product;

(i) The effective date of the health care coverage;

(j) For professional services:

(i) The amount of any copayment;

(ii) The amount of an individual deductible;

(iii) The amount of a family deductible;

(iv) Benefit limitations and maximums.

(k) For facility services:

(i) The amount of any copayment or coinsurance;

(ii) The amount of an individual deductible;

(iii) The amount of a family deductible;

(iv) Benefit limitations and maximums.

(l) Precertification or prior authorization requirements;

(m) Policy maximum limits;

(n) Patient liability for a proposed service;

(o) The health benefit plan coverage amount for a proposed service.

(F) The Advisory Committee shall make recommendations regarding all of the following:

(1) The use of internet web site technologies, smart card technologies, magnetic strip technologies, biometric technologies, or other information technologies to facilitate the generation of a request for eligibility information that is compliant with the transaction standards and rules of the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange;

(2) Time frames for the implementation of the recommendations in division (F)(1) of this section;

(3) When a provider may rely upon the eligibility information transmitted by a payer regarding a service provided to an enrollee for purposes of allocating responsibility for payment for services rendered by the provider. The Advisory Committee shall further recommend how disputes over enrollee eligibility for services received shall be resolved taking into consideration the legal relationship between the provider, the enrollee, and the payer.

(G) The recommendations made by the Advisory Committee shall not endorse or otherwise limit the choice of products or services available to health care payers, purchasers, or providers.

(H) Not later than January 1, 2009, the Advisory Committee shall provide the General Assembly with a report of its findings and recommendations for legislative action to standardize eligibility and real time adjudication transactions between providers and payers. The transaction standards adopted by the General Assembly shall, at a minimum, comply with the standards mandated by

the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as further defined in Title 45, part 162 of the Code of Federal Regulations to the extent that the "Health Insurance Portability and Accountability Act of 1996" applies to the transaction.

(I) The Advisory Committee shall cease to exist upon the submission of its report and recommendations to the General Assembly.

CORE Phase I Operating Rules Overview Summary

Infrastructure Requirements *(Note: HIPPA eligibility standard do not specify infrastructure requirements)*	**Data Requirements*** *(Note: HIPPA standards currently only require a yes/no response to whether a person has coverage)*
• Offer real-time response (20 sec or less) • Meet CORE batch response requirements • Meet CORE system availability (86% availability-calendar week) • Use of specified standard-based acknowledgments (TA1, 997) • Offer CORE-compliant connectivity (HTTP/S 1.1) • Provide a CORE-compliant Companion Guide flow and format (developed jointly w/ WEDI)	• The status of coverage (active, inactive) • Health care coverage begin date • The name of the covering health plan (if avail.) • The status of nine required service types in addition to the HIPAA-required Code 30 • Copay, coinsurance and base contract deductible amounts • If deductible is different in-network vs. out-of-network, must return both amounts.

*The data requirements listed apply to a 271 response to a generic 270 inquiry. Health plans must also support an explicit 270 for any of the CORE-required service types.

CORE Phase II Operating Rules Overview Summary

Infrastructure Requirements	**Data Requirements***
• Follow Phase I requirements • Offer two existing envelope standards (ways to send data) and authentication methods using CORE approved specifications that are built upon existing industry standards • Patient ID rules that normalize a patient's name • Standard error coding to help identify why an eligibility request was not able to be completed	• Follow Phase I requirements • Remaining deductible amounts • 39 service type codes added to the original 9 from Phase I

*The data requirements listed apply to a 271 response to a generic 270 inquiry. Health plans must also support an explicit 270 for any of the CORE-required service types

The Future of CORE: Phase III and Beyond

CAQH Administrative Simplification Conference
September 25, 2008

Harry Reynolds
Vice President,
Blue Cross Blue Shield of North Carolina
CORE Chair, CAQH

Gwendolyn Lohse
Managing Director, CORE

Discussion Topics

- The Context for CORE Phase III
  - CORE Strategic Plan
  - Filters for Phase II Scope
  - Expected timeline of Federal mandates and implications
    - 5010
  - CORE's immediate goals
- Potential Scope of Phase III
  - Scope of Phase I and II
  - Potential Categories for Phase III
    - Specific rule areas within categories
- Discussion and Multi-voting
- Next Steps
- Questions

CORE Strategic Plan Highlights

- Phase I
  - Write operating rules for defined set of eligibility transactions
  - Collect data on outcomes (Measures of Success)
- Phase II
  - Gain adoption of Phase I
  - Write more advanced operating rules for the complete eligibility inquiry and response transaction and another identified administrative transaction
  - Address need for further telecommunication standards
  - Collect data on outcomes
- Phase III
  - Gain adoption of Phase I and II
  - Write rules for other administrative transactions
  - Review and address changing technical modes

CORE's Long-Term Vision: A healthcare system that universally employs real-time, standardized and accurate interactive data exchange among all stakeholders.

Filters for Phase III Scope Development

- Alignment with Federal efforts, e.g.:
  - 5010 and HIPAA NPRM
  - HITSP
  - CCHIT
  - Medicaid-MITA
- Coordination with other industry initiatives that address/plan to address implementation, e.g.:
  - BCBSA's Blue Exchange
  - EHNAC
  - AHIP Portal goals
  - AMA Cure for Claims
- Enhancement to CORE pipeline, e.g.:
  - Scope supported by CORE-committed entities (impact on budget, potential timing, business strategies, etc)
  - Policies/rules that promote CORE-certification by trading partners
- Continuation of items identified in Phase I and/or II, but deferred to Phase III, e.g. financials for women's reproductive services

5010 Implications

- Affects all transactions adopted by HIPAA – some to a greater extent than others
- Changes are being made in terms of:
  - Front matter: educational/instructional
  - Technical
  - Structural
  - Data content
  - Some 5010 changes for X12 eligibility transactions included in CORE Phase I Data Content Rules
- Adds new transactions
  - 278: Health Care Services - Notifications
  - Acknowledgements
- Will require significant time to identify all changes, test and implement
- Should result in improvements

Note: CORE is conducting a detailed review of 5010 to identify potential CORE rule adjustments, CORE statement on CORE-5010 alignment, and areas for which CAQH may submit public comments

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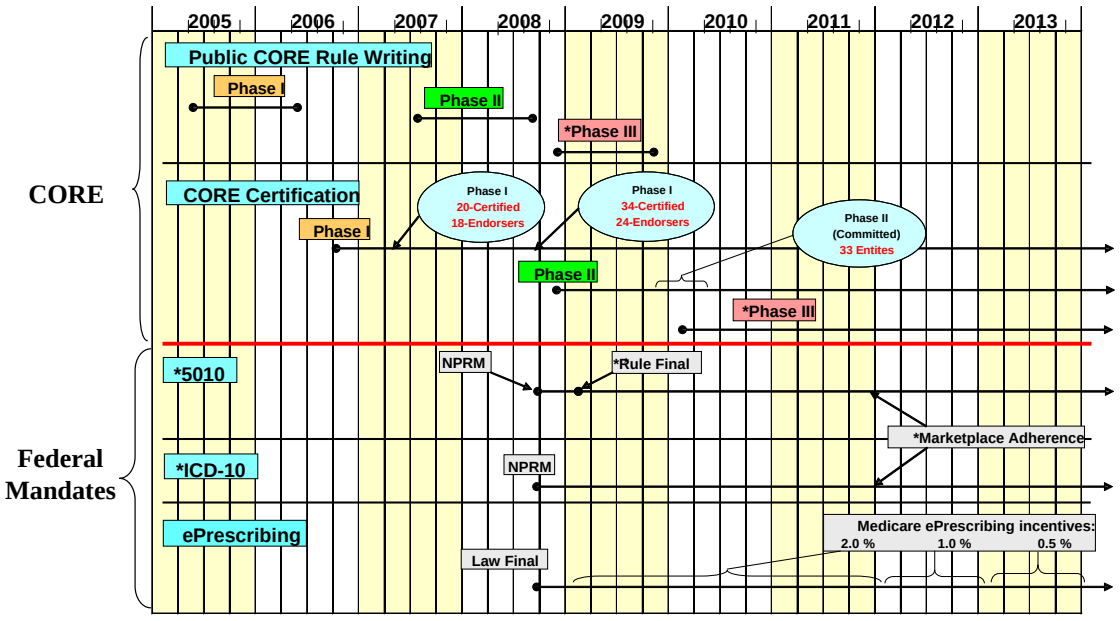
CORE Year-to-Year Timeline: Health Plan and Provider IT Priorities
(as of September 2008)



*** Time estimates related to Federal mandates are based on NPRMs**

CAQH

Key Feedback from CORE Steering Committee and CAQH Board on Filters

- Continue CORE's focus on administrative transactions that will bring market value
- Remain aligned with federally-sponsored initiatives and take into consideration any federal requirements health plans may need to meet during Phase III launch
- Remain aligned with other industry initiatives, partner where possible
  - Where appropriate build off what others have outlined for standards and their accepted uses, as CORE can implement / help bring these visions to market

Is there additional feedback on these filters?

CORE's Immediate Goals

- Gain Phase I and II market adoption – achieve critical mass
- Report on impact of Phase I implementation
- Continue integration with national initiatives
- Decide upon Phase III scope and begin development
  - *Step 1: Phase III initial identification and research gathering (in process)*
  - *Step 2: CORE participant input (in process)*
    - *Phase II Work Groups listed potential Phase III focus*
    - *CAQH has received "wish list" from a number of organizations*
    - *CAQH staff researched current market efforts*
    - *Multi-voting at meeting to identify recommended areas*
    - *Work Group review of meeting results*
    - *Cost/timing assessment*
  - Step 3: Detailed scoping of recommended rule areas
  - Step 4: Final selection

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Overview of CORE Requirements by Phase

Transaction Type and Standard Data Content		Phase I*		Phase II*
Eligibility/ Benefits	Static *Patient Financial Responsibility,* e.g. co-pay, base deductible	X		X
	Remaining *Patient Financial Responsibility, e.g,* remaining deductible for benefit plan and 40+ service types			X
	Data to Support Financials, e.g. dates, in/out of network differences	X		X
	Use of transaction under "Basic Level" Infrastructure/Policy Requirements	X		X
	Use of transaction under "Enhanced 1" Infrastructure/Policy Requirements			X
Claims Status	Use of transaction under "Basic Level" Infrastructure/Policy Requirements			X
Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use				
Basic Level	• Policy requirements: Must offer CORE-certified capabilities to ALL trading partners • Infrastructure requirements: ❑ Real-time: 20-seconds AND batch turn around requirements ❑ System availability: 86% ❑ Connectivity: Internet connection with basic HTTP – certified entity uses own specifications, e.g. SOAP with WSDL ❑ Standard acknowledgements for batch and real-time, e.g. similar to fax machine acknowledgement ❑ Standard Companion Guide *Format and flow*	X		X
Enhanced 1	"Basic Level", plus, additional Infrastructure requirements: ❑ Patient identification rules ❑Standard error codes ❑Normalizing names ❑ Connectivity: Must offer two existing envelope standards using CORE-approved specifications, e.g. allows for direct connect, PHR transfers			X

Note
* There are over 35 entities already CORE Phase I certified and 30 entities that are committed to Phase II; CORE-certification is for health plans, vendors, clearinghouses and large providers.

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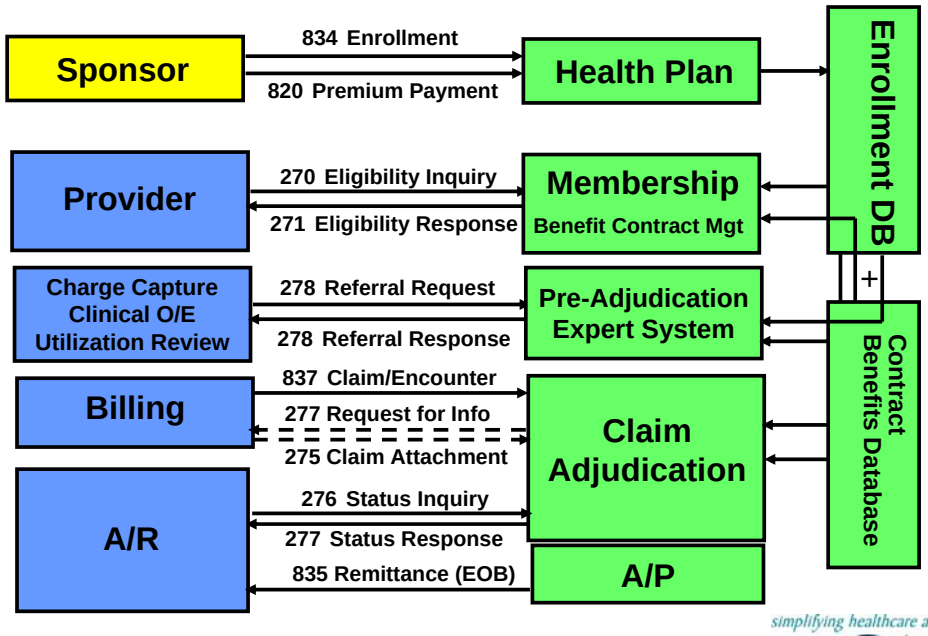
Long-term Range of Administrative Transactions



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Options for Phase III Scope

- Options are sourced by filters
  - Example: Items deferred from Phase II Work Groups and Subgroups
- Presented according to

Category: 5 major categories
- Expand Policy
- Expand Infrastructure
- Expand current transactions
- New transactions
- Other

→ Potential Rule Areas Within Categories

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Potential Phase III Scope (Page 1/5)

Category	Potential Rule Areas	Comments
Expand Policies	Require *health plans* seeking Phase III certification to require 50% or more of their vendor and clearinghouse trading partners to become CORE-certified	• Builds CORE critical mass and encourages adoption
	Develop more extensive certification testing, and more detailed partnerships with CCHIT and EHNAC	• Focuses CORE resources on certification enhancements
	Develop policies/rules that involve banks, employers and/or TPAs: – 834 Benefit Enrollment and Maintenance transaction: policy for how frequently employers provide plans with eligibility files – Policy on retroactive member terminations – Policies on Electronic Funds Transfer (EFT)	• Expands types of stakeholders involved in improving claims processing
	Require all CORE Phase III certified entities to exchange data with one another (and whomever else they chose); moves CORE into an access role	• Trading partner agreements have not been part of CORE scope

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Potential Phase III Scope (page 2/5)

Category	Potential Rule Areas	Comments
Expand Infrastructure	Expand patient identification rules – Adopt alternate search criteria including, potentially, search criteria for when the member ID number is missing	• Significant work completed during Phase II; Phase III would require legal involvement and consideration of 5010 alternate searches • Significant privacy concerns
	Expand Phase II Connectivity and Security, e.g,: – Move to a single authentication standard – digital certificates – Create digital certificate directory and/or list of authorized certificate authorities – Move to a single envelope standard – More structured/standard auditing – Multi-hop messaging	• Not addressed in 5010 • Clinical-administrative uses, and partnership opportunities with federal efforts and HL7
	Create process towards a payer identifier	• Provider request
	Decrease response time, e.g. move from 20 seconds to 10	• Not addressed in 5010
	Increase system availability, e.g.86% to 96%	• Not addressed in 5010
	Move from CORE required 997 Acknowledgements to 999	• Not proposed for 5010 but recommended by WEDI

Potential Phase III Scope (Page 3/5)

Category	Potential Rule Areas	Comments
Expand Current Transactions		
276/277 Claims Status	Apply Phase II infrastructure rules to claims status (patient ID, connectivity)	• Not addressed in 5010
	Build out data content. Options would include: – Rules for responding with both the pend and paid status on the 277; Require use of claims status code (STC segments) fields – Specify minimum 277 response data content to 276 inquiry	• Transaction being built out by many plans due to provider use/request • Builds off Phase II
270/271 Eligibility	Increase # of CORE-required service type codes (and associated financials, e.g. remaining deductible, co-pays, co-insurance, in/out of network variances) – Codes that could be added: Codes HITSP needs, codes not addressed in Phase II due to sensitive benefit issue, carve-outs not supported in Phase II	• Will need to involve attorneys in sensitive benefit discussions
	Develop rules and roadmap related to provider network identification/transparency, includes Phase II deferred work on product identification	• Key issue for provider associations; also being discussed at state level
	Increase use of more detailed cost-related codes and data in transaction, e.g. procedure level codes, lifetime maximums	• Move towards RTA

Potential Phase III Scope (4/5)

Category	Potential Rule Areas	Comments
New Transactions		
837 I, P, D Healthcare Claims	Apply Phase I& II infrastructure rules to claims transactions, e.g. real-time response time, system availability, connectivity, acknowledgements (rule requiring health plans to acknowledge each claim submitted) *and companion guide*	• Not addressed in 5010 • Move toward RTA
278 Authorizations, Precertifications & Referrals	Apply Phase I& II infrastructure rules to prior authorization & referral transactions, e.g. real-time response time, system availability, connectivity, acknowledgements *and companion guide*	• Not addressed in 5010, but required to use transaction in 5010
	Build out data content	• Provider request
835 Electronic Payment/ Remittance Advice	Apply Phase I& II infrastructure rules to electronic remittance advices, e.g. real-time response time, system availability, connectivity, acknowledgements	• Move toward RTA • Not addressed in 5010
	Build out data content, e.g.: - Require use of non-mandated fields such as "allowed amount", "class of contract", "date of claim receipt' - Move toward line item relationship to 837 - Require standard use of claim adjustment reason codes (CARC) and remittance advice remark codes (RARC)	• Requested as focus by provider associations and several plans
834 Benefit Enrollment/ Disenrollment	Described on page 12.	

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Potential Phase III Scope (5/5)

Category	Potential Rule Areas	Comments
Other	PHRs: Support adoption of standard PHR that will be used by CORE-certified health plans (275)	• Allows entities not to do more work on HIPAA transactions given they will be working to meet 5010 requirements
	Design rules that support e-prescribing and pharmacy e-health efforts. Revisit Phase II proposal in this area to determine feasibility and current interest.	• Aligns CORE with other industry efforts focused on interoperability
	Require implementation of WEDI Standard ID Card Guide	• Can be used as a vehicle to access information delivered by CORE

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Discussion

- Solicit any additions or adjustments to the scoping list
- Discuss potential rule areas and their link to the appropriate filter

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Phase III Timing Options

- Option 1: Begin Phase III rule writing process immediately after scope is approved (Fall 2008)
- Option 2: Begin after critical mass of organizations become Phase II certified (late 2009)
- Option 3: Before 5010 required implementation
- Option 4: After 5010 required implementation
- Option 5: Other?

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Multi-Voting

- Distribute colored stickers by stakeholder type
  - Health plans  [red]
  - Providers  [yellow]
  - Vendors/clearinghouses  [green]
  - Associations/regional entities/SDOs  [light blue]
  - Government entities  [dark blue]
  - Other  [orange]
- Up to 5 votes per organization on scope items
- 1 vote per organization on timing option
- Discuss results

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Results of Multi-Voting

- Will be presented at the meeting
  - Most selected categories
  - Most selected rules areas
  - Any key variations by stakeholder type
  - Key comments

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Next Steps

October

- Detailed scoping of recommended rule areas and timing
  - Share multi-voting results with Work Group
  - Document Work Group input
  - Conduct interviews with committed entities about cost and timing of recommended Phase III scope to determine key barriers

November (after 5010 and ICD-10 comments are submitted)

- Final selection
  - Led by CORE Steering Committee

Committed to Improving Health Plan-Provider Interoperability

Presentation to the Ohio Advisory Committee on Eligibility and Real Time Claim Adjudication

Ohio Department of Insurance

July 2008

Discussion Topics

The Who

- Overview of CAQH
- Administrative Simplification
  - CAQH Initiatives:
    - Universal Provider Datasource
    - CORE Initiative ***(Topic of today's discussion)***
      - Goals, Mission and Vision

The Why

- Challenges of Health Information Exchange Today
  - Example: Eligibility/Benefits Check
  - Example: Connectivity

The How

- CORE Overview
  - CORE Phase I and II
  - Example: CORE-certified Entities
  - Coordinating with State/Regional and National Initiatives
  - Phase III

2

Who? An Introduction to CAQH

CAQH, an unprecedented nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers.

CAQH solutions:

- Help promote quality interactions between plans, providers and other stakeholders
- Reduce costs and frustrations associated with healthcare administration
- Facilitate administrative healthcare information exchange
- Encourage administrative and clinical data integration

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CAQH Initiatives

- Universal Provider Datasource (UPD)
- Committee on Operating Rules for Information Exchange (CORE)
  - Today's focus will be on CORE's national interoperability and transparency approach

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Example of a CAQH Initiative:

Universal Provider Datasource (UPD)

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Provider Data: Key to Credentialing and Beyond

The Universal Provider Datasource is designed to collect broad and robust data on providers once to accommodate multiple administrative needs for multiple healthcare organizations:

- Demographics, Licenses and Other Identifiers (including NPI)
- Education, Training and Specialties
- Practice Details
- Billing Information
- Hospital Credentials
- Provider Liability Insurance
- Work History and References
- Disclosure Questions
- Images of Supporting Documents

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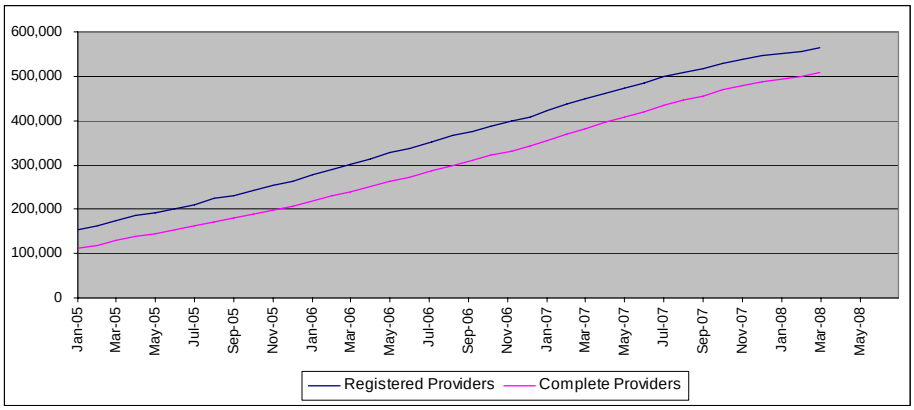
Registered Providers as of April 2008

Current Status: More than 600,000 unique providers have already registered with and are using the system (with nearly 10,000 new providers each registering month).



Note: Used by over 360 health plans

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States Supporting the CAQH Application

- A growing number of states have addressed their local credentialing concerns by supporting the national standard application promoted by CAQH. These states are:
  - **District of Columbia, Indiana, Kentucky, Maryland, Ohio and Vermont**: Adopted CAQH application as their own mandated form
  - **Louisiana, New Jersey and Tennessee**: Require or allow health plans to use either the standard CAQH application or a state-specific alternative
  - **Kansas and Rhode Island**: Insurance Commissioners have agreed to promote voluntary statewide adoption of CAQH application
  - **New York**: Rejected mandating a state specific application because the CAQH application was enjoying widespread voluntary adoption
  - **Missouri**: Is actively considering switching from the current state-mandated form to the CAQH form

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New UPD Users and Uses

- Hospitals starting to participate
  - The Vermont Hospital Association has agreed to participate and is enrolling its members as UPD participating organizations
  - KS, RI, NH, MN and an Upstate NY Hospital Association are also considering participation through association agreements
  - Individual hospitals in several other states have started to participate and many more are recognizing and reviewing the UPD value proposition
- State Medicaid agencies exploring participation
  - PA Medicaid about to sign participation agreement
  - MI Medicaid received grant to develop single source credentialing initiative and identified CAQH application as model data collection tool
  - VA Medicaid is reviewing participation
- Emergency Responder Registries
  - CAQH is exploring the use of the UPD to enable providers to volunteer as Emergency Responders and electronically forward their data to designated state ESAR-VHP registries
    - CAQH has been approached by the Massachusetts MSAR program to use the UPD as a provider outreach and data collection tool for the MSAR program

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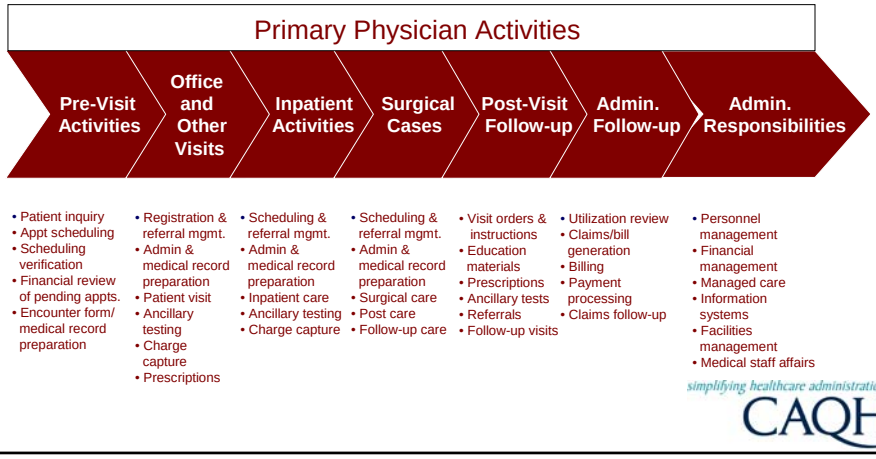
Provider-Payer/Health Plan Interaction

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



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10

CORE™

Committee on Operating Rules for Information Exchange

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11

CORE Goals

- Short-Term
  - Design and lead an initiative that facilitates the development and adoption of industry-wide operating rules for eligibility and benefits
- Long-Term
  - Based on outcome of initiative, apply concept to other administrative transactions

Answer to the question:

Why can't verifying patient eligibility and benefits in providers' offices be as easy as making a cash withdrawal?

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Vision: Online Eligibility and Benefits Inquiry

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 rules are part of HIPAA, but not mandated

** This component is critically important to providers, but is not addressed in the CORE Phase I or Phase II Rules

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Vision: Online Eligibility and Benefits Inquiry

… Using any System for any Patient or Health Plan

As with credit card transactions, the provider will be able to submit these inquiries and receive a real-time response*

- From a single point of entry
- *Using an electronic system of their choice (Vendor Agnostic)*

- For any patient
- For any participating health plan

*Phases I and II require real-time and support batch

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CORE Mission

To build consensus among the essential healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers

- Build on any applicable HIPAA transaction requirements or other appropriate standards such as HTTPS
- Enable providers to submit transactions from the system of their choice and quickly receive a standardized response from any participating stakeholder
- Enable stakeholders to implement CORE phases as their systems allow
- Facilitate stakeholder commitment to and compliance with CORE's long-term vision
- Facilitate administrative and clinical data integration

Key things CORE will not do:

- Build a database
- Replicate the work being done by standard setting bodies like X12 or HL7

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Key to CORE Success: Operating Rules

- Agreed-upon business rules for using and processing transactions
- Encourages the marketplace to achieve a desired outcome – interoperable network governing specific electronic transactions (i.e., ATMs in banking)
- Key components
  - Rights and responsibilities of all parties
  - Transmission standards and formats
  - Response timing standards
  - Liabilities
  - Exception processing
  - Error resolution
  - Security

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Key Administrative Transactions Used By Providers

** 270-271: Eligibility inquiry and response*

- An inquiry from a provider and the response from a health plan regarding a patient's eligibility for coverage, or the benefits for which a patient may be eligible

** 276-277: Claim status inquiry and response*

- An inquiry from a provider and the response from a health plan about the processing status of a submitted claim or encounter

278: Prior authorization and referral

- An inquiry from a provider and the response from the health plan about a patient's prior authorization or referral for services

837: Claims or equivalent encounter information

- Healthcare service information provided to a health plan for reimbursement

835: Payment and remittance advice

- An explanation of claim or encounter processing and/or payment sent by a health plan to a provider

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** Focus of Phase I and II CORE Rules*

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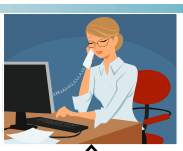
Why? Challenges of Eligibility/Benefits Check Today

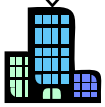
Providers



Patients

- ✓ Multiple Phone Inquiries for Information
- ✓ Extensive administrative service time needed to determine eligibility & patient financial liability
- ✓ Often inaccurate/incomplete eligibility & claims data
- ✓ Rejected claims, large accounts receivable and bad debt

Health Plans



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Challenges: Eligibility and Benefits

- "HIPAA" does not offer relief for the current eligibility problems
  - Data scope is limited; elements needed by providers are not mandated
  - Does not standardize data definitions, so translation is difficult
  - Offers no business requirements, e.g., timely response
- Individual plan websites are not the solution for providers
  - Providers do not want to toggle between numerous websites that each offer varying, limited information in inconsistent formats
- Vendors cannot offer a provider-friendly solution since they depend upon health plan information that is not available

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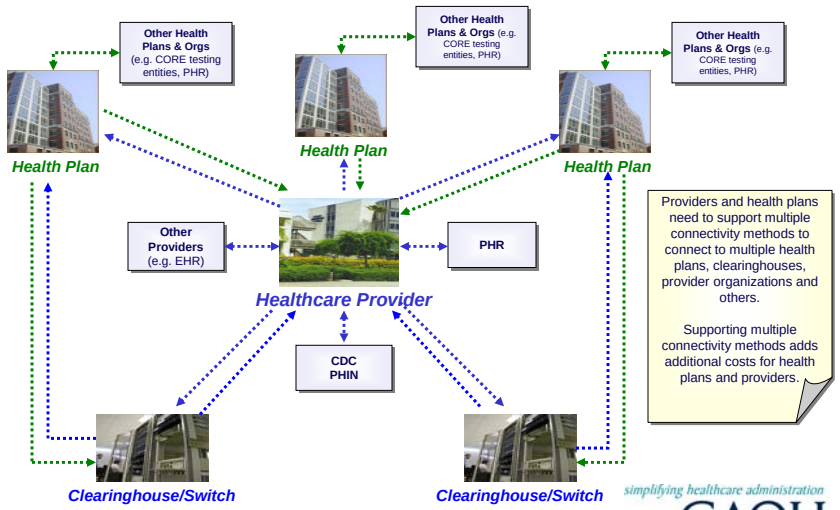
More Challenges: Healthcare Connectivity Today

Currently, multiple connectivity methods are needed across the industry…



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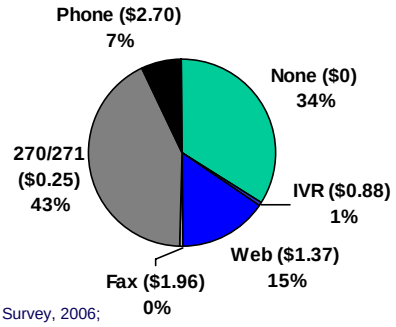
CORE Phase I Patient ID Study: Key Opportunity

Significant Savings

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

Provider Eligibility Verification by Type of Method (Average labor cost per transaction)



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

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How CORE Operating Rules Will Help

- ✓ Standardized process to respond real time to provider administrative data request
- ✓ Improved identification of members and their benefits
- ✓ Increased volume of electronic transactions
- ✓ Reduced administrative time and costs

- ✓ Real-time reliable access to consistent, high-quality claims-related data
- ✓ Part of a national, all-payer administrative data-exchange solution
- ✓ Improved service to provider practices, health plans
- ✓ Increased volume of electronic transactions

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How CORE Operating Rules Will Help

- ✓ Real-time updates and online access to all-payer administrative data
- ✓ Real-time assessment and collection of patient and health plan financial liability at point of service
- ✓ Reduced administrative time and costs

- ✓ Real-time assessment of financial liability at point of service
- ✓ Smoother claims process issue resolution
- ✓ Improved health care experience, service and satisfaction

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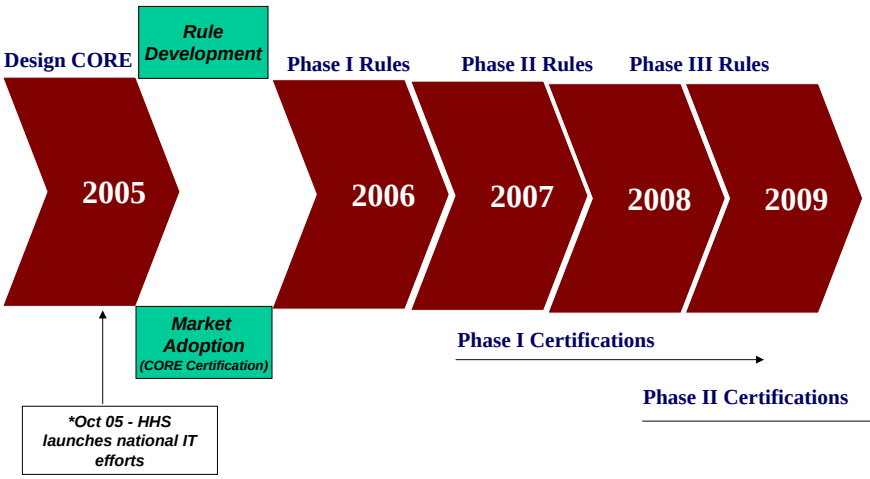
How? Phased Approach – Crawl, Walk, Run



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Key Lessons Learned by CORE

- Given market is fragmented, create trusted partnerships
  - Private-private
  - Public-private
- Do not reinvent the wheel – build upon, learn from and coordinate with what exists
  - Coordinate nationally, so interoperability can be achieved
- Identify leaders – leaders who will participate in identifying change and who will then implement the agreed upon change
  - Example: WellPoint providing CORE-compliant data to their Medicaid business
- Plan for making BIG change, BUT implement in reasonable milestones that add value
  - Recognized that entities have limited resources, and are managing many IT priorities
- Outline the ROI and/or benefits to each stakeholder, and get their help in communicating the benefits to their stakeholder community

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Current Participants

- Over 100 organizations representing all aspects of the industry:
  - 19 health plans
  - 11 providers
  - 5 provider associations
  - 18 regional entities/RHIOS/standard setting bodies/other associations
  - 37 vendors (clearinghouses and PMS)
  - 5 others (consulting companies, banks)
  - 7 government entities, including:
    - Centers for Medicare and Medicaid Services
    - Louisiana Medicaid – Unisys
    - US Department of Veteran Affairs
    - Minnesota Dept. of Human Services
- CORE participants maintain eligibility/benefits data for *over 130 million lives, or more than 75 percent of the commercially insured* plus Medicare and state-based Medicaid beneficiaries.

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CORE Certification and Endorsement

Certification

- CORE-certification is required for each phase of CORE
- Recognizes entities that have met the established operating rules requirements
- Entities that create, transmit or use eligibility data in daily business required to submit to third-party testing (within 180 days of signing pledge); if they are compliant, they receive seal as a CORE-certified health plan, vendor (product specific), clearinghouse or provider

Endorsement

- CORE Endorsement is required for each phase of CORE
- Entities that do not create, transmit or send data – sign Pledge, receive CORE Endorser Seal

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Example: A Health Plan Perspective

WellPoint Background Information

- Eligibility Transactions/yr: 81M+
- 14 - BCBS Plans (Anthem & Empire – covering 35+M individuals in CA, CT, CO, GA, IN, KT, ME, MO, NH, NV, NY, OH, VA, WI)
- 13 - Medicaid Business (CA, CT, CO, IN, KS, MA, TX, NH, NV, NY, VA, WI, WV)

WellPoint's View on CORE Involvement, Participation and Certification

- Key CORE participant, Phase I Certified
  - Serve on all Work Groups and Subgroups
  - Chair Patient Identifiers Subgroup and Data Content Subgroup Co-chair; representative on CORE Steering Committee
- Participation
  - Reduce administrative expense through increased adoption of EDI transactions
  - Respond to its providers in a consistent and single standard
  - Pledged to continue to fully support the CORE initiatives
- Impact of CORE on a national level:
  - Allow consistent eligibility transactions for WellPoint's MEDICAID contracted states
  - The Industry will experience savings as self-service transactions are adopted
  - The vision of CORE promotes increased use of the non-claim transactions

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Example: A Vendor/Clearinghouse Perspective

Siemens Background Information

- 2007 Healthcare transactions: 230M+
- Providers submitting Eligibility Transactions: 1,300
- Payers available through HDX Network for Eligibility: 250+

Siemens View on CORE Involvement, Participation and Certification

- Key CORE participant
  - Chair Technical Work Group and representative on CORE Steering Committee
- Siemens/HDX encourages adoption and further development of the CORE rules
  - Developing consistent operating rules will increase EDI participation, offering customers and the industry greater communication and efficiency
- Participation with prestigious national organization is more effective than individual, separate attempts to influence change
- Siemens anticipates that CORE Connectivity Rules will help simplify future implementations

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Example: A Provider Perspective

Montefiore Medical Center Background Information

- Nearly 2.5 million outpatients seen annually
- Send approximately 60,000 eligibility transactions/month with future projections to 150,000/month
- Payer mix – 70% Medicare/Medicaid, 25% Commercial, 5% other/non-insured

Montefiore's View on CORE Involvement, Participation and Certification

- Key CORE participant
  - Representative on CORE Steering Committee
- Technology and "Standardization" are key – customization is costly
- This is a win-win for providers and patients
  - Providers are able to control costs and decrease bad debt through better eligibility and benefit checks
  - Patients satisfaction is increased – fewer "surprise" bills
- Felt its participation was needed to help drive market adoption – despite lack of immediate ROI
- Providers historically are left out, fail to participate, or are "out-numbered" in the healthcare debate
- Foster better communication among industry stakeholders – CORE has already begun to garner trust and break down barriers among its various members

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Key Principles Included in CORE Phases

- Developed using consensus-based approach among industry stakeholders and is designed to:
  - Facilitate interoperability
  - Improve utilization of electronic transactions
  - Enhance efficiency and help lower the cost of information exchange in healthcare
- Uses existing standards
- Creates a base and not a "ceiling"
  - e.g., certified entities may include additional metadata in a CORE compliant envelope to support their business needs
- Vendor agnostic
- National, multi-stakeholder approach

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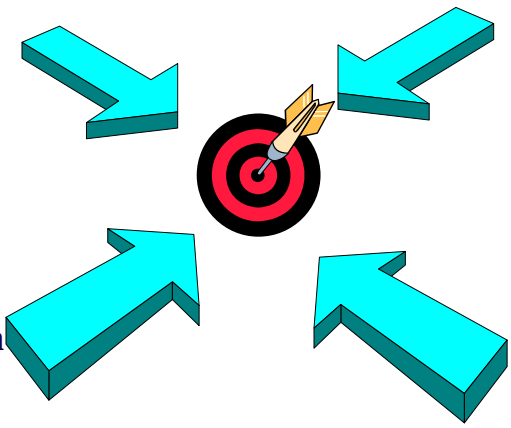
Expected Impact from Implementation of CORE Rules

Decrease Administrative Costs

- Call center
- Registration
- Claims processing/billing
- Mail room
- EDI management

Meet Patient Expectations

- Wait time
- Personal financial responsibility



Increase Satisfaction

- Partners
- Patients
- Staff

Improve Financial Measures

- Reduced denials
- Improved POS collections
- Decreased bad debt
- Reduced cost

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Overview of CORE Requirements by Phase

Transaction Type and Standard Data Content		Phase I*	Phase II*
Eligibility/ Benefits	Static *Patient Financial Responsibility,* e.g. co-pay, base deductible	X	X
	Remaining *Patient Financial Responsibility, e.g,* remaining deductible for benefit plan and 40+ service types		X
	Data to Support Financials, e.g. dates, in/out of network differences	X	X
	Use of transaction under "Basic Level" Infrastructure/Policy Requirements	X	X
	Use of transaction under "Enhanced 1" Infrastructure/Policy Requirements		X
Claims Status	Use of transaction under "Basic Level" Infrastructure/Policy Requirements		X
Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use			
Basic Level	• Policy requirements: Must offer CORE-certified capabilities to ALL trading partners • Infrastructure requirements: ❑ Real-time: 20-seconds AND batch turn around requirements ❑ System availability: 86% ❑ Connectivity: Internet connection with basic HTTP – certified entity uses own specifications, e.g. SOAP with WSDL ❑ Standard acknowledgements for batch and real-time, e.g. similar to fax machine acknowledgement ❑ Standard Companion Guide *Format and flow*	X	X
Enhanced 1	"Basic Level", plus, additional Infrastructure requirements: ❑ Patient identification rules ❑Standard error codes ❑Normalizing names ❑ Connectivity: Must offer two existing envelope standards using CORE-approved specifications, e.g. allows for direct connect, PHR transfers		X

Note : *There are over 30 entities already CORE Phase I certified. CORE-certification is for health plans, vendors, clearinghouses and large providers.

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REFER TO APPENDIX FOR RULE DETAILS

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Coordinating With State/Regional and National Initiatives

(Helping to Connect the Dots)

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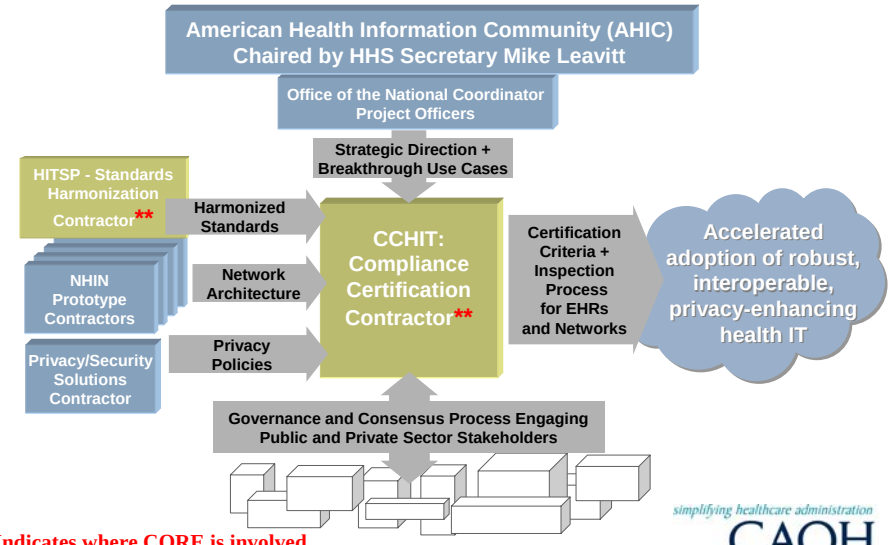
CCHIT and HITSP Roles Within HHS Health IT Strategy



35 ****Indicates where CORE is involved**

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State-Based Outreach: Examples

State-based approaches are emerging, and CAQH is working with the trade associations to encourage CORE's national approach:

- Ohio
  - Recent legislation called for the formation of an advisory committee to present recommendations on issues related to electronic information exchange, including eligibility. CAQH has offered its assistance to the committee as an educational resource given CORE was noted in legislation.
- Colorado
  - Commission report delivered to state legislature in February 2008 stated the cost savings for healthcare administrative simplification. CAQH presented CORE to government and private stakeholders in March
- Texas
  - Texas Department of Insurance had CAQH present CORE in response to state legislation that focuses on administrative simplification and mentions CORE; CORE has presented twice, most recently in March.
- Virginia
  - Secretary of Technology reviewing how technology can reduce the state's healthcare costs; CAQH presented CORE three times, most recently to a statewide Committee in April

(Note: Minnesota did pass state-specific eligibility rules in Dec. 2007, however, they are complementary to CORE Phase I data content requirements)

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Medicaid and CORE

- Why Medicaid and CORE?
  - Interest for all stakeholders
    - Medicaid is a key portion of most provider's payer mix
    - Electronic eligibility, and other administrative transactions, can have a significant impact on efficiency for all stakeholders – public, private, payers, providers, etc - when all-payer solutions are available
  - Interest at Federal level
    - CORE complements a number of federally-sponsored health IT initiatives, e.g. ONC, as well as HIPAA
    - CMS's Center for Medicaid and State Operations is designing the Medicaid Information Technology Architecture (MITA) - CORE rules mirror much of what MITA wants to design for:
      - Data content
      - Connectivity
    - CORE is an example of a public-private collaboration
  - Interest at state level
    - Specific Medicaids reviewing or participating in CORE, and some participating plans and clearinghouse manage Medicaid business
    - CORE could help Medicaids address the administrative requirements of the Deficit Reduction Act (DRA)
    - CORE could be way to have Medicaids involved in RHIOs / state mandates regarding health care administrative cost reduction

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World **Without** CORE...

- Is like an ATM that...
  - Offers no money or bank balance, but does say you have an account
  - Does not have any real-time response...so you may wait hours to get response... or minutes ...or seconds
  - Does not have any system availability requirements...so ATM may not be available on weekends or after 9:00 p.m. weekdays
  - Does not provide you with confirmations....so you don't know if your transaction ever got completed
- And, there is no common agreements among the ATMs one uses...
  - So one needs to learn rules for each bank's ATM system

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Current Participants

- **Health Plans**
  - Aetna, Inc.
  - AultCare
  - Blue Cross Blue Shield of Michigan
  - Blue Cross and Blue Shield of North Carolina
  - BlueCross BlueShield of Tennessee
  - CareFirst BlueCross BlueShield
  - CIGNA
  - Coventry Health Care
  - Excellus Blue Cross Blue Shield
  - Group Health, Inc.
  - Harvard Pilgrim HealthCare
  - Health Care Service Corporation
  - Health Net, Inc.
  - Health Plan of Michigan
  - Horizon Blue Cross Blue Shield of New Jersey
  - Humana Inc.
  - Independence Blue Cross
  - UnitedHealth Group
  - WellPoint, Inc.
- **Providers**
  - Adventist HealthCare, Inc.
  - American Academy of Family Physicians (AAFP)
  - American College of Physicians (ACP)
  - American Medical Association (AMA)
  - Catholic Healthcare West
  - Cedars-Sinai Health System
  - Greater New York Hospital Association (GNYHA)
  - HealthCare Partners Medical Group
  - Mayo Clinic
  - Medical Group Management Association (MGMA)
  - Mobility Medical, Inc.
  - Montefiore Medical Center of New York
  - New York-Presbyterian Hospital
  - North Shore LIJ Health System
  - Partners HealthCare System
  - University Physicians, Inc. (University of Maryland)
- **Government Agencies**
  - Louisiana Medicaid – Unisys
  - Michigan Department of Community Health
  - Michigan Public Health Institute
  - Minnesota Department of Human Services
  - Oregon Department of Human Resources
  - United States Centers for Medicare and Medicaid Services (CMS)
  - United States Department of Veterans Affairs
- **Associations / Regional Entities / Standard Setting Organizations**
  - America's Health Insurance Plans (AHIP)
  - ASC X12
  - Blue Cross and Blue Shield Association (BCBSA)
  - Delta Dental Plans Association
  - eHealth Initiative
  - Health Level 7
  - Healthcare Association of New York State
  - Healthcare Billing and Management Association
  - Healthcare Financial Management Association (HFMA)
  - Healthcare Information & Management Systems Society
  - LINXUS (an initiative of GNYHA)
  - National Committee for Quality Assurance (NCQA)
  - National Council for Prescription Drug Programs (NCPDP)
  - NJ SHORE
  - Private Sector Technology Group
  - Smart Card Alliance Council
  - Utah Health Information Network (UHIN)
  - Utilization Review Accreditation Commission (URAC)
  - Work Group for Electronic Data Interchange (WEDI)

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Current Participants (continued)

- **Vendors**
  - ACS EDI Gateway, Inc.
  - athenahealth, Inc.
  - Availity LLC
  - CareMedic Systems, Inc.
  - ClaimRemedi, Inc.
  - Claredi (an Ingenix Division)
  - EDIFECS
  - Electronic Data Systems (EDS)
  - Electronic Network Systems (ENS) (an Ingenix Division)
  - Emdeon Business Services
  - Enclarity, Inc.
  - First Data Corp.
  - GE Healthcare
  - GHN-Online
  - Health Management Systems, Inc.
  - Healthcare Administration Technologies, Inc.
  - HTP, Inc.
  - IBM Corporation
  - Infotech Global, Inc.
  - InstaMed
  - MedAvant Healthcare Solutions
  - MedData
  - Microsoft Corporation
  - NASCO
  - NaviMedix
  - NextGen Healthcare Information Systems, Inc.
  - Passport Health Communications
  - Payerpath, a Misys Company
  - RealMed Corporation
  - Recondo Technology, Inc.
  - RelayHealth
  - RxHub
  - Siemens / HDX
  - SureScripts
  - The SSI Group, Inc.
  - The TriZetto Group, Inc.
  - VisionShare, Inc.
- **Other**
  - Accenture
  - Foresight Corp.
  - Omega Technology Solutions
  - PNC Bank
  - PricewaterhouseCoopers LLP

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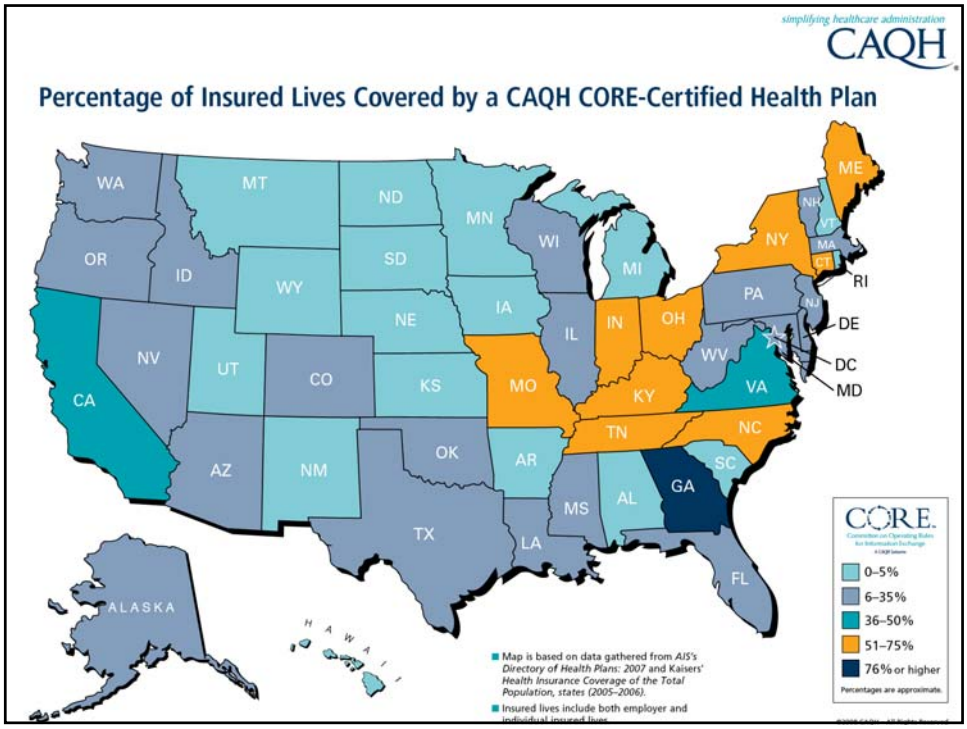

CORE Certification Seals: Who Pays?

Every entity pays for their own CORE Participation and Certification

CERTIFIED CORE CLEARINGHOUSE
A CAQH Initiative

CORE ENDORSER
A CAQH Initiative

CERTIFIED CORE HEALTH PLAN
A CAQH Initiative

CERTIFIED CORE PROVIDER
A CAQH Initiative

CERTIFIED CORE VENDOR
A CAQH Initiative

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Implementation: Phase I – Certified Entities/Products

Clearinghouses

- ACS EDI Gateway, Inc. / ACS EDI Gateway, Inc. Eligibility Engine
- Availity, LLC / Availity Health Information Network
- Emdeon Business Services / Emdeon Real-Time Exchange
- Emdeon Business Services / Emdeon Batch Verification
- Health Management Systems, Inc. / HMS
- MD On-Line, Inc./ACCE$$ Patient Eligibility Verification
- MedAvant Healthcare Solutions / Phoenix Processing System
- MedData / MedConnect
- NaviMedix, Inc. / NaviNet
- Passport Health Communications / OneSource
- RelayHealth / Real Time Eligibility
- RxHub / PRN
- Siemens Medical Solutions / Healthcare Data Exchange
- The SSI Group, Inc. / ClickON® E-Verify

Health Plans

- Aetna Inc.
- AultCare
- Blue Cross and Blue Shield of North Carolina
- BlueCross BlueShield of Tennessee
- Health Net
- WellPoint, Inc. (and its 14 blue-licensed affiliates)

Providers

- Mayo Clinic
- Montefiore Medical Center
- US Department of Veterans Affairs

Vendors

- athenahealth, Inc. / athenaCollector
- CSC Consulting, Inc./CSC DirectConnect sm
- Emerging Health Information Technology, LLC / TREKS
- GE Healthcare / EDI Eligibility 270/271
- RelayHealth / RevRunner
- Medical Informatics Engineering, Inc. (MIE) / WebChart EMR *
- NoMoreClipboard.com
- Post-N-Track / Doohickey™ Web Services
- The SSI Group, Inc. / ClickON® Net Eligibility
- VisionShare, Inc. / Secure Exchange Software

* Product also certified by the Certification Commission for Healthcare Information Technology (CCHIT℠). For accurate information on certified products, please refer to the product listings at www.cchit.org.

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Implementation: Phase I – Endorsers

Endorsement

- Accenture
- American Academy of Family Physicians (AAFP)
- American Association of Preferred Provider Organizations (AAPPO)
- American College of Physicians (ACP)
- American Health Information Management Association (AHIMA)
- California Regional Health Information Organization
- Claredi, an Ingenix Division
- Edifecs, Inc.
- eHealth Initiative
- Electronic Healthcare Network Accreditation Commission (EHNAC)
- Enclarity, Inc.
- Foresight Corporation
- Greater New York Hospital Association and Linxus
- Healthcare Financial Management Association (HFMA)
- Healthcare Information and Management Systems Society (HIMSS)
- Medical Group Management Association (MGMA)
- Michigan Public Health Institute
- Microsoft Corporation
- MultiPlan, Inc.
- NACHA – The Electronic Payments Association
- Pillsbury Winthrop Shaw Pittman, LLP
- Smart Card Alliance
- URAC
- Workgroup for Electronic Data Interchange (WEDI)

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Appendix

- Basic Infrastructure Requirements
  - Phase I
- 270/271 Data Content Rule
  - Phase I and II
- Patient Identifier Rule
  - Phase II
  - Patient ID Study
- 276/277 Claim Status Rule
  - Phase II
- Connectivity Rule
  - Phase I and II
- Phase III Priorities

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Phase I: Basic Infrastructure Requirements

- Offer real-time response
  - 20 seconds or less
- Meet CORE batch response requirements (if batch offered)
  - Receipt by 9pm ET requires response by 7am ET next business day
- Meet CORE system availability requirements
  - 86% availability (calendar week)
- Use of CORE-compliant acknowledgements
  - Specifies when to use TA1 and 997
- Offer a CORE-compliant Connectivity option
  - Support HTTP/S 1.1
- Provide a CORE-compliant Companion Guide flow and format
  - Developed jointly with WEDI

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Phase I Overview - 270/271 Data Content Rule

- Specifies what must be included in the 271 response to a Generic 270 inquiry or a non-required CORE service type

- Response must include
  - The status of coverage (active, inactive)
  - The health plan coverage begin 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
    - 48 - Hospital Inpatient
    - 50 - Hospital Outpatient
    - 86 - Emergency Services
    - 88 - Pharmacy
    - 98 - Professional Physician Office Visit
    - AL - Vision (optometry)

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Phase I 270/271 Data Content Rule (cont'd)

CORE Data Content Rule also Includes Patient Financial Responsibility

- Co-pay, co-insurance and base contract deductible amounts required for
  - 33 - Chiropractic
  - 48 - 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

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Phase II 270/271 Data Content Rule

- Builds and expands on Phase I eligibility content
- Requires health plan to support explicit 270 eligibility inquiry for 39 service type codes
- Response must include all patient financial liability *(except for the 8 discretionary service types; a few codes from Phase I and mental health codes added in Phase II)*
  - Base contract deductible *AND* remaining deductible
  - Co-pay
  - Co-insurance
  - In/out of network amounts if different
  - Related dates
- Recommended use of 3 codes for coverage time period for health plan
  - 22 – Service Year (a 365-day contractual period)
  - 23 – Calendar year (January 1 through December 31 of same year
  - 25 – Contract (duration of patient's specific coverage

EXAMPLES OF SERVICE TYPE CODES
2 Surgical
4 Diagnostic X-Ray
5 Diagnostic Lab
6 Radiation Therapy
7 Anesthesia
8 Surgical Assistance
12 Durable Medical Equipment Purchase
13 Ambulatory Service Center Facility
18 Durable Medical Equipment Rental
20 Second Surgical Opinion
40 Oral Surgery
42 Home Health Care
45 Hospice
51 Hospital - Emergency Accident
52 Hospital - Emergency Medical
53 Hospital - Ambulatory Surgical
62 MRI/CAT Scan
65 Newborn Care
68 Well Baby Care
73 Diagnostic Medical
76 Dialysis
78 Chemotherapy
80 Immunizations
81 Routine Physical
82 Family Planning
93 Podiatry
99 Professional (Physician) Visit – Inpatient
A0 Professional (Physician) Visit – Outpatient
A3 Professional (Physician) Visit – Home
*A6 Psychotherapy
*A7 Psychiatric – Inpatient
*A8 Psychiatric – Outpatient
AD Occupational Therapy
AE Physical Medicine
AF Speech Therapy
AG Skilled Nursing Care
*AI Substance Abuse
BG Cardiac Rehabilitation
BH Pediatric
** Indicates examples of discretionary service types*

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Phase II: 270/271 Patient Identification Rules

- Two Patient ID Surveys funded by California Health Care Foundation led to business justification for developing rules that enhance patient matching and provide better information on why a match did not occur:
  - Draft rule on Last Name Normalization
  - Draft rule on Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers and Names

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CORE Phase II Patient ID Study

Valid Response Rate by Eligibility Inquiry Method

There are continued challenges with lower validation rates on the 270/271 compared to other methods. Increasing the match rate of the 270/271 is a key focus of the CORE Patient ID Rules.

Valid Response Analysis		270/271	Web	IVR	Phone
Plan A**	Valid responses	93%		NA	95%
	Patient ID errors	5%		NA	5%
	Other errors	1%		NA	0%
Plan B	Valid responses	81%	86%	81%	99%
	Patient ID errors	17%	14%	0%	1%
	Other errors	2%	0%	19%	
Plan C	Valid responses	62%	NA	NA	97%
	Patient ID errors	31%	NA	NA	3%
	Other errors	8%	NA	NA	
Plan D	Valid responses	NA	NA	NA	98%
	Patient ID errors	NA	NA	NA	2%
	Other errors	NA	NA	NA	

** Plan A's usual rate of valid responses for the 270/271 is 83-85%.

Source: CORE Phase II Patient Identification Survey, 2007; funded, in part, by the California HealthCare Foundation

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Phase II: 270/271 Patient Identification Rules

- Normalizing Patient Last Name
  - **Goal**: Reduce errors related to patient name matching due to use of special characters and name prefixes/suffixes
    - Recommends approaches for submitters to capture and store name suffix and prefix so that it can be stored separately or parsed from the last name
    - Requires health plans to normalize submitted and stored last name before using the submitted and stored last names:
      - Remove specified suffix and prefix character strings
      - Remove special characters and punctuation
    - If normalized name validated, return 271 with CORE-required content
    - If normalized name validated but un-normalized names do not match, return last name as stored by health plan and specified INS segment
    - If normalized name not validated, return specified AAA code
    - Recommends that health plans use a no-more-restrictive name validation logic in downstream HIPAA transactions than what is used for the 270/271 transactions

Phase II: 270/271 Patient Identification Rules

- Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names in 271 response
  - **Goal**: Provide consistent and specific patient identification error reporting on the 271 so that appropriate follow-up action can be taken to obtain and re-send correct information
    - Requires health plans to return a unique combination of one or more AAA segments along with one or more of the submitted patient identifying data elements in order to communicate the specific errors to the submitter
    - Designed to work with any search and match criteria or logic
    - The receiver of the 271 response is required to detect all error conditions reported and display to the end user text that uniquely describes the specific error conditions and data elements determined to be missing or invalid

Phase II: Claims Status Rule

- Entities must provide claims status under the CORE Phase I infrastructure requirements, e.g.,
  - Offer real-time response
    - 20 seconds or less
  - Meet CORE batch response requirements (if batch offered)
    - Receipt by 9pm ET requires response by 7am ET next business day
  - Meet CORE system availability requirements
    - 86% availability (calendar week)
  - Use of CORE-compliant acknowledgements
    - Specifies when to use TA1 and 997
  - Offer a CORE-compliant Connectivity option
    - Support HTTP/S 1.1
  - Provide a CORE-compliant Companion Guide flow and format
    - Developed jointly with WEDI

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CORE Phase I Connectivity Rule Overview

- CORE-certified entities must support HTTP/S 1.1 over the public Internet as a transport method for both batch and real-time eligibility inquiry and response transactions
- Real-time requests
- Batch requests, submissions and response pickup
- Security and authentication data requirements
- Response time, time out parameters and re-transmission
- Response message options & error notification

NOTE: CORE Rules are a base and not a ceiling

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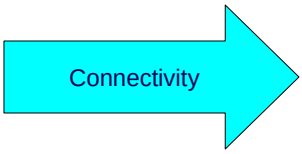
CORE Phase I Connectivity Rule: Benefits



- Like other industries have done, supports healthcare movement towards at least one common, affordable connectivity platform. As a result, provides a minimum "*safe harbor*" connectivity and transport method that practice management vendors, clearinghouses and plans that are CORE-certified can easily and affordably implement
- Enables small providers not doing EDI today to connect to all clearinghouses and plans that are CORE-certified using any CORE-certified PMS
- Enables vendors to differentiate themselves to offer improved products cost-effectively

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CORE Phase I Connectivity Rule: Challenges

- As expected, the long-term level of rule specificity to enable connectivity interoperability was not yet achieved. Significant variations in:
  - Names for Phase I metadata, names and location for other critical metadata
  - Message envelope structure
  - Authentication methods
  - Routing approaches
  - Security related information
- CORE Phase I was intended as an incremental "step" toward interoperability
- Remember – Crawl, Walk, Run

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CORE Phase I "Real World" Implementations

Entity	Message Envelope	Authentication
Health plan A	WS (SOAP + WSDL schema I)	WS-Security
Clearinghouse A	HTTP POST: name/value pair	User/password
Clearinghouse B	HTTP POST	User/password
Clearinghouse C	HTTP POST with MIME	User/password encoded in MIME
Clearinghouse D	WS (SOAP+WSDL schema II)	User/password basic authentication
RHIO A	WS(SOAP+WSDL schema III)	Digital signature with X.509 certificate
RHIO B	MIME	User/password encoded in MIME

Note: Small sampling, range in variation is great

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CORE Phase I Connectivity: Lessons Learned

- Industry has many connectivity approaches (proprietary and non-proprietary) with large installed bases
- Stakeholders are ready to come together and build consensus on connectivity methods for interoperability
- CORE Phase I is a step in the right direction – from proprietary and/or private networks, to public Internet (HTTP/S)
- While having a uniform transport standard is an important first step, many variations exist within CORE Phase I compliant implementations - interoperability requires a more definitive rule

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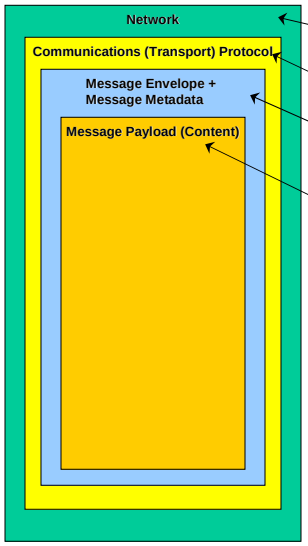
Achieving Connectivity Interoperability Requires Standards



= Public Internet – CORE Phase I Rule

= HTTP/S – CORE Phase I Rule

= Message Envelope & Message Metadata – **CORE Phase II Rule**
(independent of payload – required by Phase I)

= HIPAA Administrative Transactions (X12)
HL7 Clinical Messages
NCPDP Messages
Zipped Files
Personal Health Record
Other Content

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CORE Phase II Connectivity Rule Overview

- Open Standards
  - Message Envelope
    - SOAP 1.2 + WSDL + MTOM
    - HTTP + MIME Multipart
  - Submitter Authentication
    - Username/Password (WS-Security Username Token)
    - X.509 Certificate over SSL (two-way SSL)
- Envelope Metadata
    - Field names (e.g., SenderID, ReceiverID)
    - Field syntax (value-sets, length restrictions)
    - Semantics (suggested use)
- Error Handling, Auditing

CORE connectivity rules can be used to send administrative or clinical data as CORE selected standards that are aligned with other industry efforts

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Phase II : Rationale for Two Envelope Standards

- Decision on supporting two message envelope standards
  - SOAP+WSDL
    - Well aligned with HITSP and HL7
    - Lends itself to future rule development using Web-services standards for more advanced requirements (e.g., reliability)
  - HTTP MIME Multipart
    - Relatively simple and well understood protocol framework
    - CORE-certified entities have already implemented HTTP as part of Phase I
  - Incremental “stepped” approach:
    - Facilitates adoption in a market that is still maturing
    - Facilitates interoperability relative to the current state of envelope standard variability in the marketplace

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Envelope Analogy

- US Post Office Rules and other market options
  - Specific requirements for envelope size, addressing and use of postal barcode
    - Impose surcharge on mailers not conforming to requirements to offset costs to handle non-standard envelopes
  - FedEx, UPS, etc all have their own standard envelope requirements but include basic “metadata”
- Implications for CORE?
  - Use standard envelope and metadata to
    - Increase interoperability leading to increased use of administrative transactions
    - Improve efficiency
    - Reduce cost

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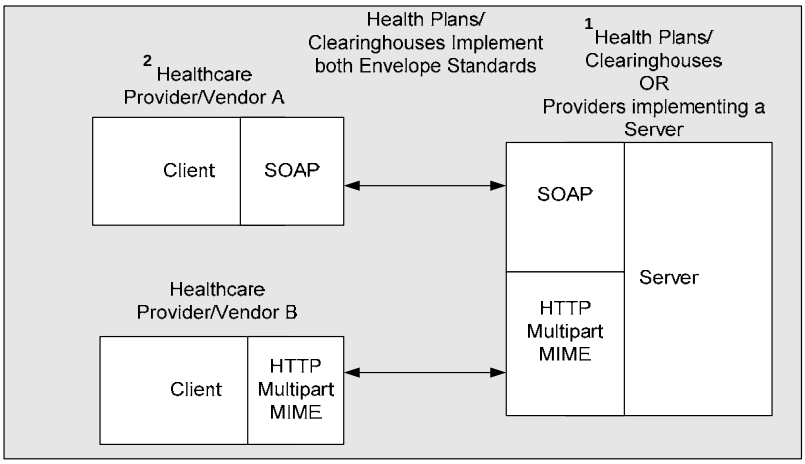
Phase II Connectivity: Envelope Conformance



[1] Health Plans, Health Plan Vendors, Clearinghouses or Providers implementing a server must support* both envelope standards.

[2] Providers and Provider Vendors acting as a client need only support one of the envelope standards.

Note: Standards are paired with a metadata list; * Refer to Rule for definition

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Basic Conformance Requirements Rationale

Standards

- **SOAP+WSDL** : Well aligned with HITSP, HL7, and current direction of market
- **HTTP MIME Multipart** : Simple, mature protocol; Large installed user base

Conformance Requirements Rationale

- Health Plans/Clearinghouses are typically “Servers” and Health Providers are typically “Clients”
- Servers can accept more client connections by supporting two envelope standards (big improvement from the current state of industry)
- Server sites typically have higher technical expertise than Client sites. Increased complexity of supporting two envelope standards may not be significant for Server sites

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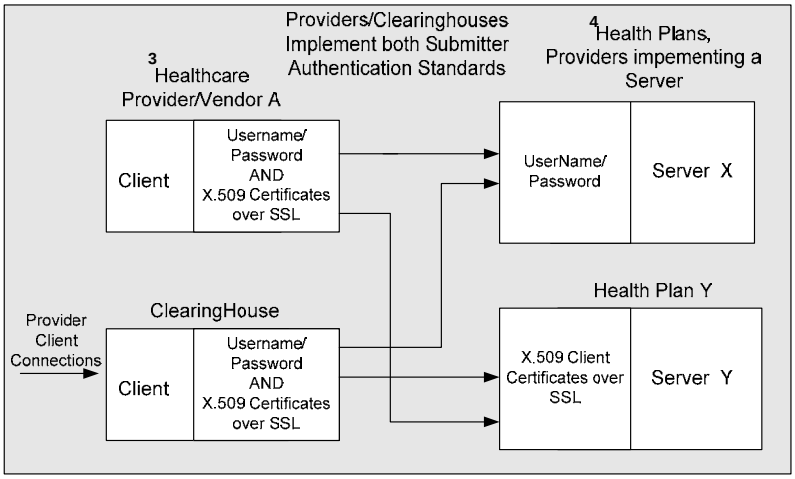
Phase II Connectivity: Submitter Authentication



[3] Providers, Provider Vendors or Clearinghouses acting as a client must support* both submitter authentication standards.

[4] Health Plans, Health Plan Vendors or Providers implementing a server need only support one submitter authentication standard.

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* Refer to Rule for definition

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Basic Conformance Requirements Rationale

Standards

- **Username/password**: Simple, ubiquitous
- **X.509 Certificate over SSL**: Aligned with HITSP/IHE (ATNA)

Conformance Requirements Rationale

- Health-Plans/Clearinghouses act as "Servers", Health Providers act as "Clients"
- Server implementations manage identities, credentials, hence more complex to support both authentication methods at Server
- Client implementations only install their own credentials for each connection to Health-Plan/Clearinghouse, hence simpler to support two authentication methods at Client

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CORE Phase II Connectivity: Metadata

Decision: For simplicity, use same metadata for request and response

- Payload Type
- Processing Mode
- Payload Length
- Payload ID
- Time Stamp
- User Name
- Password
- Sender Identifier
- Receiver Identifier
- CORE Rule Version
- Checksum
- Error Code
- Error Message

See CORE Phase II Rule for detailed descriptions, intended use for each element

Phase II Connectivity: Metadata Will be Outside the Payload

Concept applied in Phase I, and confirmed again in Phase II.

Rationale:

- Facilitates connectivity standardization as well as administrative and clinical integration
- Accelerates industry interoperability
- Entities are able to do auditing and authentication without parsing payload/bring payload into their system
- Payload agnostic
  - Allows CORE's connectivity rules to evolve to future phases independent of payload standard evolution; in other CORE rules, e.g. Eligibility Data Content, adoption of payloads are promoted for content
  - Supports approach of other national initiatives

Phase II Envelope Metadata Requirements

- Metadata provides the ability to
  - Identify both sender and receiver
  - Authenticate sender and authorize access
  - Identify type of payload
  - Route payload to the correct receiver entry point for the type of payload
  - Audit date/time of message
  - Specify payload size in either kilo or megabytes
- Metadata must be independent of the payload (content) {***CORE Phase I Decision***}
  - Does not require receiver to examine payload
- Metadata needs to be standardized for
  - Metadata element names
  - Intended use of each metadata element (as agreed to by the trading partners)
  - Requirement for presence of each metadata element (required/optional)
  - Structure of message envelope

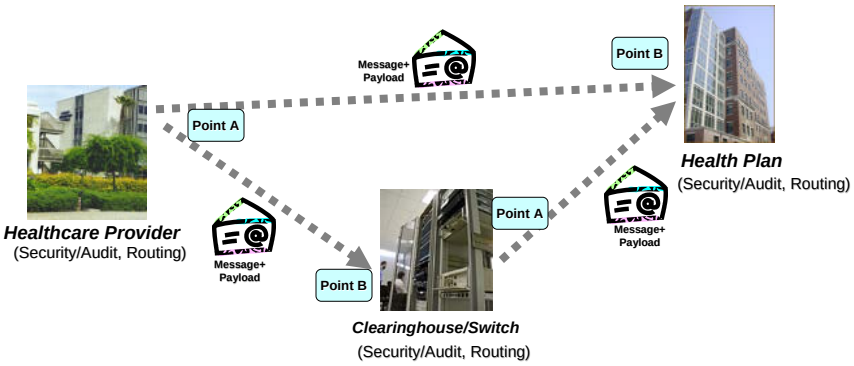
Phase II Connectivity Challenges: Envelope Metadata

Challenges of Payload Specific Metadata

- Not all metadata is present in all types of payload
  - Some payload standards are content focused with no transport/message metadata (e.g., HL7 does not have routing and security information so they are supporting the adoption of an existing envelope standard)
- Different payloads use different structure, position, syntax, semantics for the same metadata
  - HL7 and X12 message structures are different
  - Standards for different payload types are evolving independently of one another

Intended Use of Metadata in CORE Phase II

All message exchanges are point-to-point even when the message goes through one or more intermediaries before receipt by the ultimate end point.



Multi-hop message exchange is not a Phase II requirement

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Phase III Priorities?

- Administrative rules that complement clinical goals of Federal government, e.g., detailed payment information for lab services
- Rules related to transactions not yet addressed in Phase I or II
  - Data content aspects of Claims Status
  - Terms and definitions used in electronic remittances
  - Referrals/ Prior authorizations
  - Coordination of benefits
- More detailed cost information
  - Additional data related to patient financial responsibility
  - Procedure-level data?
- Support for the electronic delivery of pharmacy benefit information
  - Detailed proposal created in Phase II, deferred to Phase III
- Policies encouraging CORE-certified entities to require certain of their trading partners to be CORE-certified
- Further enhancement of Connectivity rules

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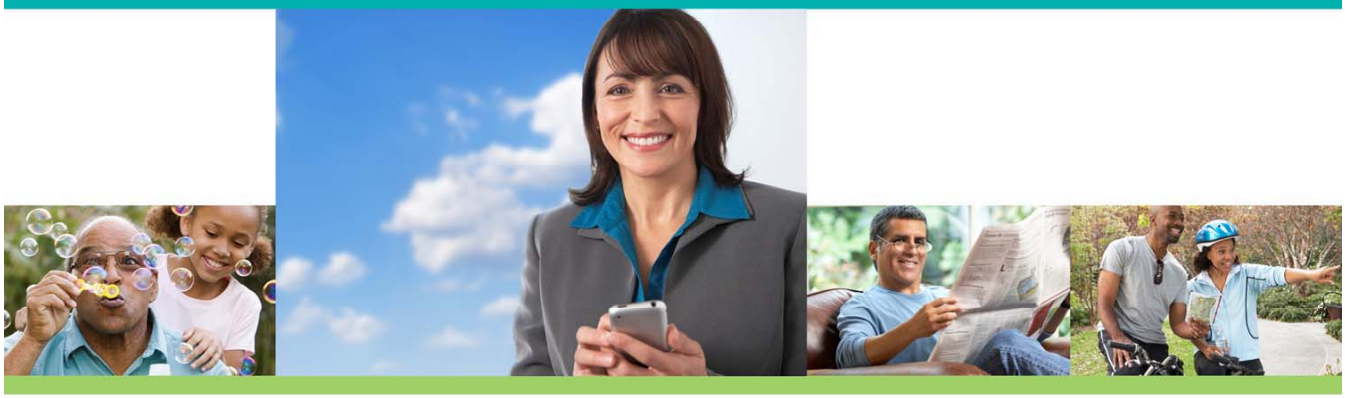
Ohio HB125 Advisory Committee
Eligibility & Benefits and Real-time Adjudication



Presenter: Stephanie Schulte
Provider Interface
Date: October 2008

HUMANA
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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

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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

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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

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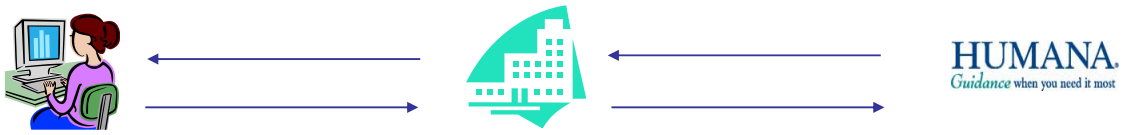
Routing Definitions

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)

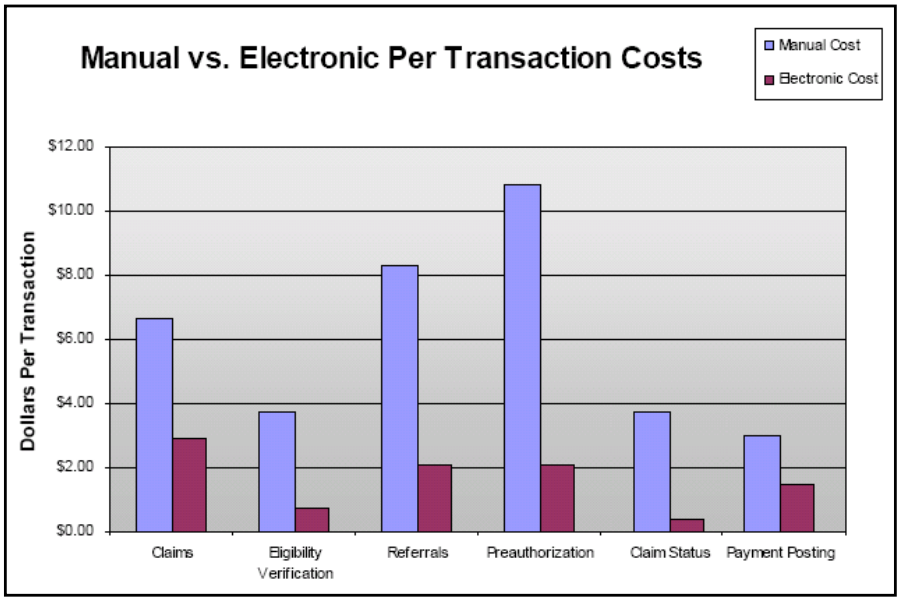
Provider wants to see a patient's eligibility information.

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
Milliman
Technology and Operations Solutions
Revised: January 2006

Potential Savings

Estimated Annual Savings from Electronic Transactions
For Typical Physician Office Practice

	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**

Prepared by
Milliman
Technology and Operations Solutions
Revised: January 2006

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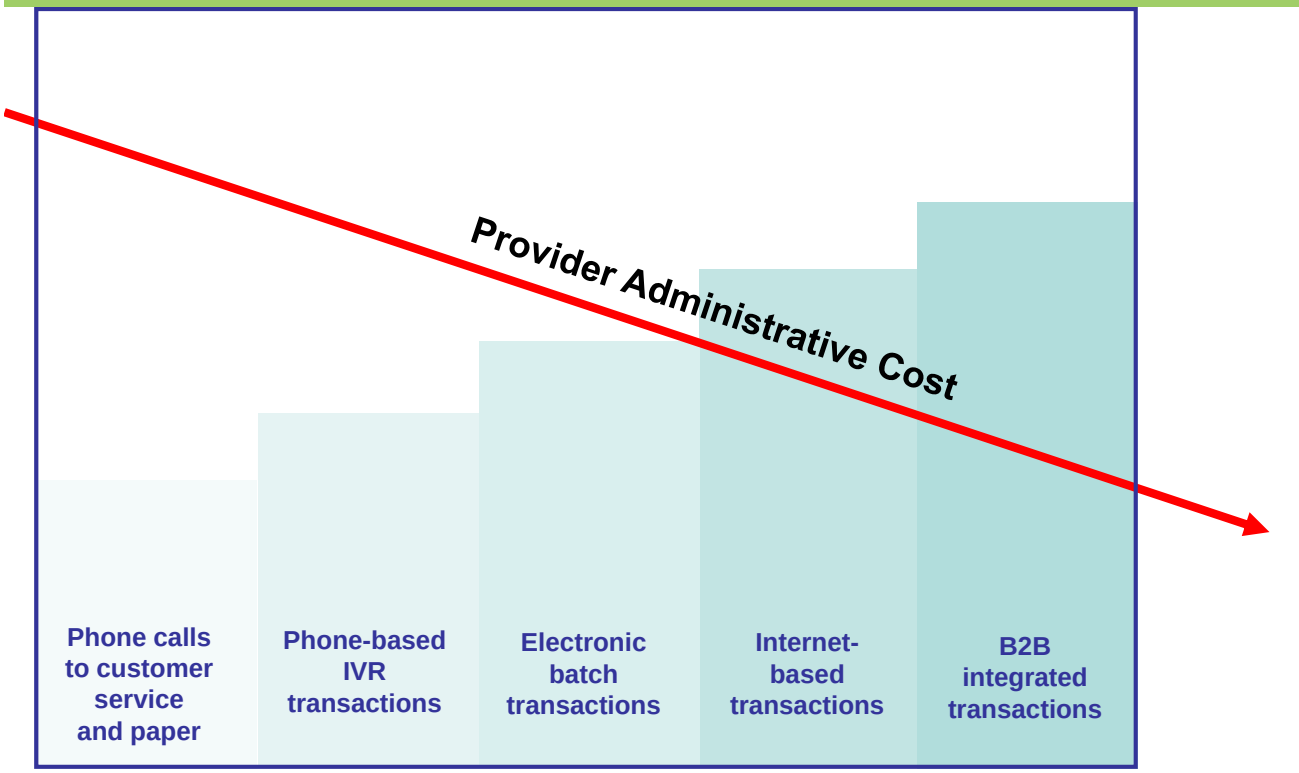
The Affect of Technology – Bending the Trend



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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.

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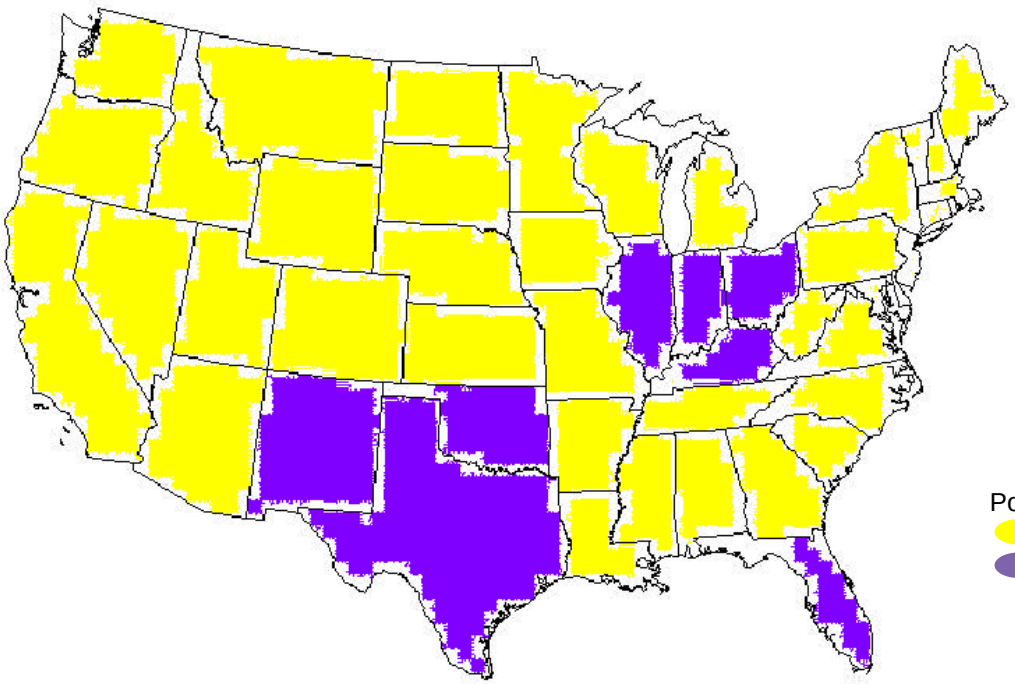
Availability of Availity.com



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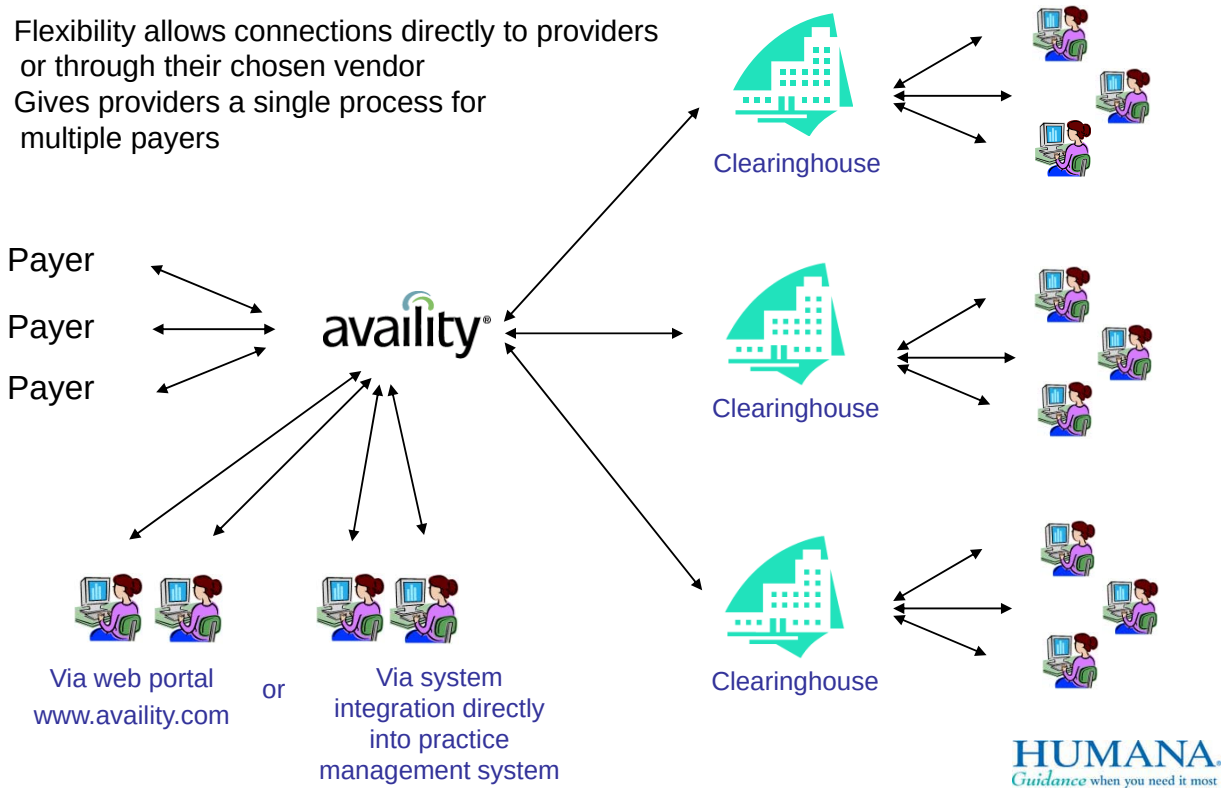
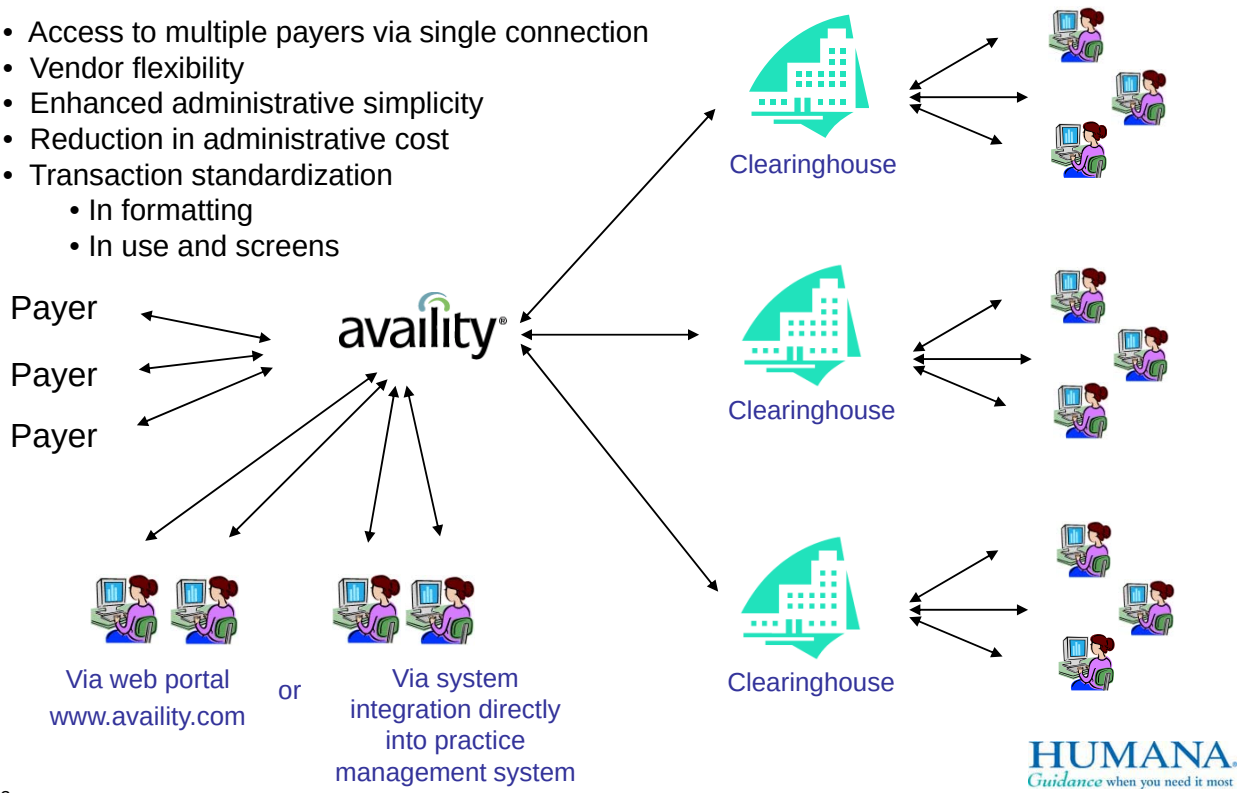
The Multi-payer Model

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



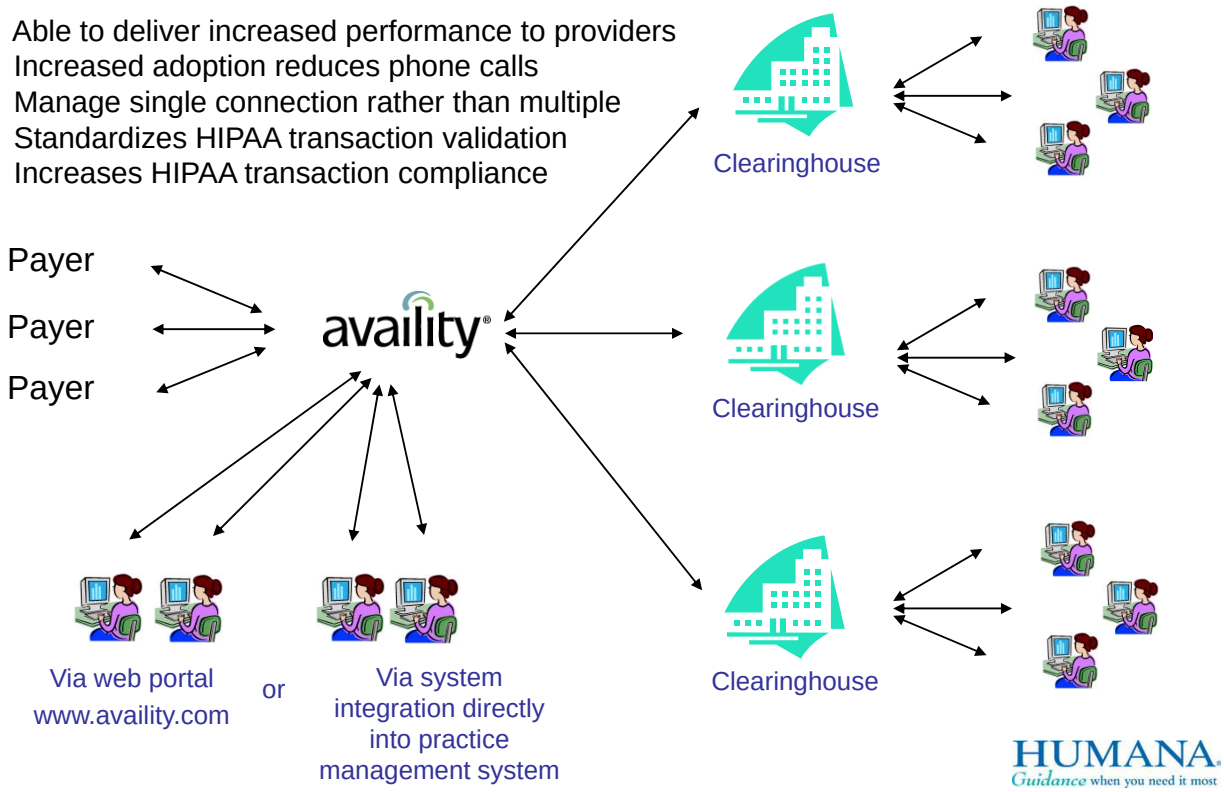
The Multi-payer Model – Provider Benefits

- 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

Automation

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

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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

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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

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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

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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.

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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

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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

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Thank You

Questions

Stephanie Schulte
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Integrated Provider Solutions
502.476.0107
sschulte@humana.com

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Health Care Providers Survey

Question: 1. What is the name of the county in Ohio where your primary practice site is located?

Number Who Answered: 1067

Question: 2. What size is your practice?

Number Who Answered: 1008

	Physician	Physician	Home Health
Solo Practice	370	37 %	N/A
2-6 Physicians	457	45 %	N/A
7-10 Physicians	64	6 %	N/A
11-20 Physicians	55	5 %	N/A
21 + Physicians	62	6 %	N/A

Question: 3. What is your practice specialty area?

Number Who Answered: 1007

	Physician	Physician	Home Health
Anesthesiology	18	2 %	N/A
Cardiology	25	2 %	N/A
Dermatology	34	3 %	N/A
Emergency Medicine	5	0 %	N/A
Family Medicine	205	20 %	N/A
Gynecology/Obstetrics	110	11 %	N/A
Internal Medicine	82	8 %	N/A
Neurology	18	2 %	N/A
Oncology	14	1 %	N/A
Pathology	6	1 %	N/A
Pediatric	45	4 %	N/A
Radiology	8	1 %	N/A
Surgeon	107	11 %	N/A
Other Answers	330	33 %	N/A

Question: 4. Identify your office internet access:

Number Who Answered: 1082

	Physician	Physician	Home Health
None	33	3 %	0%
Dial Up	25	3 %	4%
Broadband	299	30 %	35%
DSL	455	46 %	38%
Wireless	86	9 %	10%
Don't Know	89	9 %	13%

Question: 5. How do you submit claims for payment?

Number Who Answered: 1088

	Physician	Physician	Home Health
Practice Management Software (e.g. Misys)	338	34 %	56%
Application Service Provider (e.g. AthenaHealth)	88	9 %	2%
Clearinghouse (e.g. Availity)	312	31 %	11%
Paper Claims	62	6 %	13%
Other Answers	193	19 %	19%

Question: 6. If you selected Practice Management Software above, please specify name and version:

Number Who Answered: 446

Question: 7. Do you use an Electronic Medical Records (EMR) system for your clinical records?

Number Who Answered: 1096

Physician	Physician	Home Health	Home Health
Yes	**No**	**Yes**	**No**

266	735	45	50
27 %	73 %	47%	53%

Question: 8. Do you use electronic transmissions for prescribing? (i.e. E-Prescribing)

Number Who Answered: 998

Physician	Physician	Home Health	Home Health
Yes	**No**	**Yes**	**No**
164	834	N/A	N/A
16 %	84 %	N/A	N/A

Question: 9. What percent of the time do you check patient insurance eligibility?

Number Who Answered: 1086

	Physician	Physician	Home Health
0-10%	328	33 %	6%
11-25%	172	17 %	6%
26-50%	133	13 %	9%
51-75%	112	11 %	4%
76-100%	246	25 %	75%

Question: 10. When you check a patient's insurance eligibility status, what method(s) do you use?

Number Who Answered: 1063

	Physician	Physician	Home Health
Automated Verification through Practice Management System or Software	157	16 %	6%
Internet/Payer Web Portal	517	53 %	25%
Clearinghouse	46	5 %	1%
Phone	731	76 %	44%
Fax	67	7 %	1%
Other Answers	44	5 %	22%

Question: 10a. When you check eligibility, you use automated verification through a practice management system or software _____ of the time.

Number Who Answered: 926

	Physician	Physician	Home Health
0-10%	651	75 %	59%
11-25%	53	6 %	9%
26-50%	46	5 %	10%
51-75%	29	3 %	7%
76-100%	88	10 %	15%

Question: 10b. When you check eligibility, you use internet/payer web portal _____ of the time.

Number Who Answered: 977

	Physician	Physician	Home Health
0-10%	417	46 %	32%
11-25%	133	15 %	20%
26-50%	125	14 %	10%
51-75%	83	9 %	10%
76-100%	148	16 %	28%

Question: 10c. When you check eligibility, you use a clearinghouse _____ of the time.

Number Who Answered: 892

	Physician	Physician	Home Health
0-10%	759	90 %	86%
11-25%	28	3 %	7%
26-50%	21	2 %	5%
51-75%	14	2 %	0%
76-100%	26	3 %	2%

Question: 10d. When you check eligibility, you use the phone _____ of the time.

Number Who Answered: 1015

	Physician	Physician	Home Health
0-10%	276	29 %	15%
11-25%	194	21 %	15%
26-50%	119	13 %	11%
51-75%	103	11 %	14%
76-100%	250	27 %	45%

Question: 10e. When you check eligibility, you use the fax _____ of the time.

Number Who Answered: 937

	Physician	Physician	Home Health
0-10%	800	91 %	79%
11-25%	43	5 %	14%
26-50%	19	2 %	2%
51-75%	17	2 %	2%
76-100%	2	0 %	3%

Question: 11. When your office does not verify eligibility, please indicate the reason(s) why:

Number Who Answered: 679

Question: 12. Has your office ever verified eligibility and later been asked to return payment because the patient was not eligible?

Number Who Answered: 1001

Physician	Physician	Home Health	Home Health
Yes	**No**	**Yes**	**No**
543	388	70	25
58 %	42 %	74%	26%

Question: 13. If yes, to what percent of your claims does this apply?

Number Who Answered: 650

	Physician	Physician	Home Health
1-5%	443	76 %	64%
6-10%	97	17 %	25%
11-15%	27	5 %	7%
16-20%	9	2 %	3%
21-25%	4	1 %	1%
Over 25%	1	0 %	0%

Question: 14. Comments

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survey title:
Verifying a Patient's Eligibility Edit Title

design survey | collect responses | analyze results

View Summary
Browse Responses
Filter Responses
Download Responses
Share Responses

current report: Default Report Add Report

Response Summary

Total Started Survey: 63
Total Completed Survey: 63 (100%)

Page: Default Section

1. Do you accept any insurance?

	Response Percent	Response Count
Yes	96.8%	61
No	3.2%	2
answered question		63
skipped question		0

2. What is the size of your practice?

	Response Percent	Response Count
Solo practice	58.1%	36
2-6 Psychologists and other clinicians	27.4%	17
7-10 Psychologists and other clinicians	6.5%	4
11-20 Psychologists and other clinicians	4.8%	3
21 or more Psychologists and other clinicians	3.2%	2

answered question	**62**
skipped question	**1**

3. Identify your office internet access:

	Response Percent	Response Count
None	12.7%	8
Dial Up	3.2%	2
Broadband	20.6%	13
DSL	**44.4%**	28
Wireless	15.9%	10
Don't Know	6.3%	4
answered question		**63**
skipped question		**0**

4. How do you submit claims for payment?

	Response Percent	Response Count
Practice Management Software	22.2%	14
Internet/Payer Web portal	27.0%	17
Clearinghouse	27.0%	17
Paper Claims	**66.7%**	42
view Other (please specify)	12.7%	8
answered question		**63**
skipped question		**0**

5. If you selected practice management software above, please specify the name and version:

	Response

	Count
view	15
answered question	**15**
skipped question	**48**

6. Do you use an electronic medical records system for your clinical records?

	Response Percent	Response Count
Yes	6.5%	4
No	**93.5%**	58
answered question		**62**
skipped question		**1**

7. What percent of the time do you check patient insurance eligibility?

	Response Percent	Response Count
0-10%	22.2%	14
11-25%	15.9%	10
26-50%	9.5%	6
51-75%	3.2%	2
75-99%	20.6%	13
100%	**28.6%**	18
answered question		**63**
skipped question		**0**

8. When you do check a patient's eligibility, what methods do you use?

	Response Percent	Response Count

Automated verification through practice management system/software		9.8%	6
Internet/Payer portal		41.0%	25
Clearinghouse		1.6%	1
Phone		**98.4%**	60
Fax		16.4%	10
view Other (please specify)		3.3%	2
		answered question	**61**
		skipped question	**2**

9. When you check eligibility, you use automated verification through practice management software ___% of the time?

	Response Percent	Response Count
0-10%	**97.9%**	46
11-25%	0.0%	0
26-50%	0.0%	0
51-75%	2.1%	1
76-99%	2.1%	1
100%	0.0%	0
answered question		**47**
skipped question		**16**

10. When you check eligibility, you use internet/payer portal __% of the time?

	Response Percent	Response Count
0-10%	**62.7%**	32
11-25%	17.6%	9

26-50%	5.9%	3
51-75%	7.8%	4
76-99%	7.8%	4
100%	0.0%	0
answered question		**51**
skipped question		**12**

11. When you check eligibility, you use a clearinghouse ___% of the time?

	Response Percent	Response Count
0-10%	**97.8%**	44
11-25%	2.2%	1
26-50%	0.0%	0
51-75%	0.0%	0
76-99%	0.0%	0
100%	0.0%	0
answered question		**45**
skipped question		**18**

12. When you check eligibility, you use phone ___% of the time?

	Response Percent	Response Count
0-10%	8.3%	5
11-25%	13.3%	8
26-50%	11.7%	7
51-75%	5.0%	3
76-99%	30.0%	18
100%	**33.3%**	20

answered question	**60**
skipped question	**3**

13. When you check eligibility, you use fax ___% of the time?

	Response Percent	Response Count
0-10%	**91.7%**	44
11-25%	2.1%	1
26-50%	4.2%	2
51-75%	0.0%	0
76-99%	2.1%	1
100%	0.0%	0
answered question		**48**
skipped question		**15**

14. Does the method used to verify eligibility vaires by type of insurance?

	Response Percent	Response Count
Yes	**65.0%**	39
No	35.0%	21
answered question		**60**
skipped question		**3**

15. When your office does not verify eligibility, please indicate the reason why?

	Response Count
view	43
answered question	**43**

skipped question	**20**

16. On an average, how much time do you spend verifying a patient's eligibility?

	Response Percent	Response Count
Less than 3 minutes	8.1%	5
3-5 minutes	11.3%	7
6-10 minutes	25.8%	16
11-15 minutes	**30.6%**	19
16-20 minutes	12.9%	8
over 21 minutes	17.7%	11
answered question		**62**
skipped question		**1**

17. Do you verify other aspects of a patient's coverage (deductible, benefits, covered services) at the same time you verify eligibility?

	Response Percent	Response Count
Yes	**76.7%**	46
No	6.7%	4
Sometimes	16.7%	10
answered question		**60**
skipped question		**3**

18. If yes, are you required to contact another source for this additional information?

	Response Percent	Response Count
Yes	8.6%	5
No	20.7%	12

Yes, with some insurance plans	**70.7%**	41
answered question		**58**
skipped question		**5**

19. Has your office ever verified that a patient was eligible and later been asked to return the payment because the patient was not eligible?

	Response Percent	Response Count
Yes	**77.0%**	47
No	23.0%	14
answered question		**61**
skipped question		**2**

20. If yes, to what percent of your claims does this apply?

	Response Percent	Response Count
1-5%	**80.9%**	38
6-10%	10.6%	5
11-15%	6.4%	3
16-20%	2.1%	1
21-25%	0.0%	0
Over 25%	0.0%	0
answered question		**47**
skipped question		**16**

21. If yes, on an average how much time is spent to recitify this?

	Response Count
view	40

answered question	**40**
skipped question	**23**

22. Has your office ever been asked to return a payment because the service you provided was not covered by the patient's insurance?

	Response Percent	Response Count
Yes	**71.0%**	44
No	29.0%	18
answered question		**62**
skipped question		**1**

23. If yes, to what percent of your claims does this apply?

	Response Percent	Response Count
1-5%	**84.4%**	38
6-10%	11.1%	5
11-15%	2.2%	1
16-20%	2.2%	1
21-25%	0.0%	0
Over 25%	0.0%	0
answered question		**45**
skipped question		**18**

24. Comments:

	Response Count
view	18
answered question	**18**

#4 - How do you submit claims for payment.

Displaying 1 - 8 of 8 responses << Prev Next >> **Jump To:** 1 Go >>

	Comment Text	Response Date
Find	1. Pay a person to file claims/have person file with their company	Wed, 10/8/08 1:24 PM
Find	2. by modem to Medicare	Tue, 10/7/08 12:50 PM
Find	3. Mostly paper; occasionally online, e.g., when a denied claim is resubmitted or the usual hcfa 1500 does not apply (e.g., EAP claim).	Tue, 10/7/08 9:52 AM
Find	4. BILLING SERVICE	Tue, 10/7/08 9:07 AM
Find	5. billing service	Mon, 10/6/08 7:44 PM
Find	6. Medical Professional Billing Solutions does my billing electronically.	Mon, 10/6/08 1:16 PM
Find	7. billing agency does it for me	Fri, 10/3/08 5:30 PM
Find	8. Emdeon Office	Fri, 10/3/08 9:47 AM

10 responses per page

5 - Name / Version of Practice mgmt Software

Displaying 1 - 15 of 15 responses << Prev Next >> **Jump To:** 1 Go >>

	Comment Text	Response Date
Find	1. FILEMAKER PRO	Mon, 10/20/08 1:54 PM
Find	2. QuicDoc 7.5.5	Fri, 10/17/08 3:43 PM
Find	3. SOFT AID	Thu, 10/16/08 7:39 AM
Find	4. Therapist Helper	Thu, 10/9/08 8:07 PM
Find	5. Delphi	Tue, 10/7/08 3:34 PM
Find	6. Office Therapy 7.5, Clearinghouse is Gateway EDI	Tue, 10/7/08 11:09 AM
Find	7. DOC PROVIDED BY PBSI (POSITIVE BUSINESS SOLUTIONS INC. IN CINCINNATI, OH)	Tue, 10/7/08 10:35 AM
Find	8. TherapistHelper 6.41	Mon, 10/6/08 10:35 PM
Find	9. Therapist Helper	Mon, 10/6/08 1:18 PM
Find	10. Therapist Helper 7.4	Mon, 10/6/08 1:07 PM
Find	11. Therapist Pro 2.5	Mon, 10/6/08 11:58 AM
Find	12. SOS's Office Manager for Windows	Mon, 10/6/08 10:57 AM
Find	13. Therapist Helper	Thu, 10/2/08 11:19 PM
Find	14. Sosoft Office Manager (latest version)	Thu, 10/2/08 5:05 PM
Find	15. softaid	Thu, 10/2/08 5:02 PM

25 responses per page

#8 - When you check a patient's eligibility - what method do you use?

Displaying 1 - 2 of 2 responses << Prev Next >> Jump To: 1 Go >>

	Comment Text	Response Date
Find	1. Person to file their own ins claims	Wed, 10/8/08 1:24 PM
Find	2. Insurance Card	Mon, 10/6/08 10:35 PM

10 responses per page

When your office does not verify #15 - eligibility, please indicate the reason why.

Displaying 1 - 25 of 43 responses << Prev Next >> Jump To: 1 Go >>

	Comment Text	Response Date
Find	1. N/A	Mon, 10/20/08 1:54 PM
Find	2. Sometimes we already know, sometimes the PT. isn't using their insurance	Sun, 10/19/08 8:26 PM
Find	3. We have a form that we give the patient to determine elegibility	Fri, 10/17/08 3:43 PM
Find	4. NO NEED	Fri, 10/17/08 9:26 AM
Find	5. If they're Workers Comp we already know they're eligible per their attorney.	Thu, 10/16/08 2:27 PM
Find	6. TO TIME CONSUMING AND QUITE OFTEN WRONG INFO GIVEN	Thu, 10/16/08 7:39 AM
Find	7. need to get patient in quickly. Do I provide services or do I protect my income?	Thu, 10/16/08 6:45 AM
Find	8. pt has already checked	Wed, 10/15/08 11:00 AM
Find	9. too time consuming	Tue, 10/14/08 8:57 AM
Find	10. I have to verify each and every insurance for each and every patient.	Mon, 10/13/08 5:21 PM
Find	11. Time Demands	Thu, 10/9/08 8:07 PM
Find	12. Have person pay for session and file for themselves.	Wed, 10/8/08 1:24 PM
Find	13. insufficient support staff	Tue, 10/7/08 4:22 PM
Find	14. If we cannot get insurance info before appt. We Then check when pt arrives in office.	Tue, 10/7/08 12:50 PM
Find	15. the practice is just me, although I have a billing person I am terrible at keeping track of the business end of things. It does not help that there are so many insurance companies, each with its own arbitrary convoluted bureacracy. Insurance companies do as they damn well please, with no real accountability to anyone, especially not the people they supposedly cover.	Tue, 10/7/08 12:41 PM
Find	16. we already are familiar with the employer and the benefits	Tue, 10/7/08 11:19 AM
Find	17. Medicare with secondary insurance (tho we do check the secondary for MH caps and deducts.)	Tue, 10/7/08 11:09 AM
Find	18. Authorization letter provided by insurance company or patient has contacted insurance company and provided me with authorization number.	Tue, 10/7/08 9:52 AM
Find	19. MEDICARE STANDARD BENEFITS	Tue, 10/7/08 9:07 AM
Find	20. Insurance is always verified through this office.	Tue, 10/7/08 9:02 AM
Find	21. We may ask the subscriber to verify, as they have the contract with their insurance company.	Tue, 10/7/08 8:49 AM
Find	22. n/a	Tue, 10/7/08 8:35 AM
Find	23. Information already known	Mon, 10/6/08 10:35 PM
Find	24. Pt is self pay and/or has no insurance.	Mon, 10/6/08 6:10 PM
Find	25. I only check for eligibility when indicated on the back of their insurance card.	Mon, 10/6/08 2:10 PM

25 responses per page

#15 - continued

Displaying 26 - 43 of 43 responses << Prev Next >> **Jump To:** 1 Go >>

	Comment Text	Response Date
Find	**26.** When people are paying out of pocket or come for a service that is not covered by insurance, such as mediation.	Mon, 10/6/08 1:46 PM
Find	**27.** To TRY to obtain authorization for services and to TRY to assure payment	Mon, 10/6/08 1:16 PM
Find	**28.** N/A	Mon, 10/6/08 1:07 PM
Find	**29.** Occasionally, a patient's eligibility verification slips through the cracks...but this is rare.	Mon, 10/6/08 12:03 PM
Find	**30.** Client presents card, positive experience with provider &/or authorization letter/number provided	Mon, 10/6/08 11:58 AM
Find	**31.** Given our volume, it is cost prohibitive to verify all insurances. At this point, we know the policies for most of the local employers.	Mon, 10/6/08 10:57 AM
Find	**32.** Too much effort	Mon, 10/6/08 10:49 AM
Find	**33.** We always verify benefits.	Mon, 10/6/08 9:49 AM
Find	**34.** Emergent care needed	Sun, 10/5/08 12:05 PM
Find	**35.** No time. Insurance card believed. Have only been burned a handful of times over my 25 year career	Sun, 10/5/08 11:30 AM
Find	**36.** The client verifies insurance coverage, co-pay, no. of sessions, obtains any required auth. numbers, dates of coverage, limits, etc. If there is any question for any reason, I call insurance company to verify.	Sun, 10/5/08 9:24 AM
Find	**37.** no time	Sat, 10/4/08 11:29 AM
Find	**38.** patient has brought authorization number to the office with my name on it	Fri, 10/3/08 5:30 PM
Find	**39.** Client says they have insurance coverage	Fri, 10/3/08 9:49 AM
Find	**40.** already know the benefits since a majority of clients work for Ohio University and have Anthem insurance - which is always the same for the mental health benefits	Fri, 10/3/08 9:47 AM
Find	**41.** Client is asked to know their benefits and benefit limits. I know what plans I am a provider for and which clients I will accept based on that.	Thu, 10/2/08 11:19 PM
Find	**42.** receive prior auth via fax or mail	Thu, 10/2/08 5:02 PM
Find	**43.** Some companies use automated phone verification exclusively. Most often coverage provided in this fashion does not cover mental health benefits. In these circumstances it is often very difficult or too time consuming to reach a live person to request mh benefit information.	Thu, 10/2/08 4:52 PM

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#21 - Of go (#20) on an average how much time is spent to rectify this

Displaying 1 - 25 of 40 responses << Prev Next >> Jump To: 1 Go >>

	Comment Text	Response Date
Find	1. varies	Sun, 10/19/08 8:26 PM
Find	2. 1-2 hours	Sun, 10/19/08 8:03 PM
Find	3. 10-15 MINS	Thu, 10/16/08 7:39 AM
Find	4. an hour per claim	Thu, 10/16/08 6:45 AM
Find	5. Hours over months generally pass.	Wed, 10/15/08 11:34 AM
Find	6. it can be hours	Wed, 10/15/08 11:00 AM
Find	7. Unsure	Mon, 10/13/08 5:21 PM
Find	8. 15 - 20 Mins. per month	Thu, 10/9/08 8:07 PM
Find	9. Could be hours	Wed, 10/8/08 10:49 AM
Find	10. It is rarely recitified other than us sending back the money and sending the client a bill, which we rarely get paid for.	Tue, 10/7/08 3:34 PM
Find	11. This is usually a write-off because we are unable to collect from the patient.	Tue, 10/7/08 12:50 PM
Find	12. 2-3 hours	Tue, 10/7/08 11:19 AM
Find	13. anywhere from 20 min to hours depending how easy it is to reach someone at the ins co.	Tue, 10/7/08 11:09 AM
Find	14. WEEKS - GERNALLY IT'S THE BENEFITS THAT ARE QUOTED WRONG	Tue, 10/7/08 9:07 AM
Find	15. 20 minutes per refund.	Tue, 10/7/08 9:02 AM
Find	16. One hour, combined time of the subscriber's and the office	Tue, 10/7/08 8:49 AM
Find	17. ALOT!!!	Mon, 10/6/08 10:35 PM
Find	18. 15 min???	Mon, 10/6/08 9:22 PM
Find	19. hours	Mon, 10/6/08 7:44 PM
Find	20. Variable. Sometimes takes a lot of time. Other times, can be done quite quickly.	Mon, 10/6/08 6:10 PM
Find	21. 2-4 hours spread over days or weeks. The insurance companies are known to delay resolutions as long as they can keep the money.	Mon, 10/6/08 2:10 PM
Find	22. One hour.	Mon, 10/6/08 1:46 PM
Find	23. hours and hours	Mon, 10/6/08 1:29 PM
Find	24. sometimes it can be done with a phone call (few minutes) but often will take several phone calls, a letter of two, and even a threat to involve the insurance board via a complaint (several hours, postage, fax and phone time, etc.)	Mon, 10/6/08 1:18 PM
Find	25. Weeks to months	Mon, 10/6/08 1:16 PM

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#21 continued

Displaying 26 - 40 of 40 responses << Prev Next >> Jump To: 1 Go >>

	Comment Text	Response Date
Find	**26.** 3-4 hours per person--usually 2-3 times a year	Mon, 10/6/08 1:07 PM
Find	**27.** several hours	Mon, 10/6/08 12:03 PM
Find	**28.** hours	Mon, 10/6/08 11:58 AM
Find	**29.** Months	Mon, 10/6/08 11:33 AM
Find	**30.** 1-2 hours	Mon, 10/6/08 10:57 AM
Find	**31.** Never mable to rectify	Mon, 10/6/08 10:49 AM
Find	**32.** Several calls 30 minutes per call	Sun, 10/5/08 12:05 PM
Find	**33.** Can take anywhere from 30min. to two days, depending on the amount of time I have available to do the work. The client may also do some of the investigation.	Sun, 10/5/08 9:24 AM
Find	**34.** a lot	Sat, 10/4/08 11:29 AM
Find	**35.** 1 hour	Sat, 10/4/08 9:48 AM
Find	**36.** too much time	Fri, 10/3/08 5:30 PM
Find	**37.** too much, usually over an hour	Fri, 10/3/08 9:49 AM
Find	**38.** 1 hour	Fri, 10/3/08 9:47 AM
Find	**39.** Several infuriiating hours. Then I am given the run around and am rwuired to take several more hours to fight them.	Thu, 10/2/08 11:19 PM
Find	**40.** It depends on the circumstances. Sometimes the person who does my billing spends on hour on one phone call. Sometimes she has to call back at a later time because she is disconnected.	Thu, 10/2/08 5:48 PM

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#24 - comments

Displaying 1 - 10 of 18 responses << Prev Next >> **Jump To:** 1 Go >>

	Comment Text	Response Date
Find	**1.** A number of insurance companies provide inadequate service for providers (i.e. IVR systems that don't provide the information we need, long waits to reach a human, and they eventually provide incorrect information)	Sun, 10/19/08 8:26 PM
Find	**2.** It's ridiculous that an Insurance Company can request a refund after two years. There is no way to recoup from the patient.	Fri, 10/17/08 3:43 PM
Find	**3.** Reimbursement rates stay at 1990's rates while support costs rise. The insurance companies find more ways for us to invest our time while they make NO adjustments to our reimbursement.	Thu, 10/16/08 6:45 AM
Find	**4.** The main improvement to the current system of checking benefits, eligibility, copays, deductibles, etc. would be to be able to access all the information in one place electronically 24/7.	Tue, 10/7/08 1:02 PM
Find	**5.** This happened once when the patient changed from managed care to Medicaid and did not tell us.	Tue, 10/7/08 12:50 PM
Find	**6.** Eligibility is not as big a problem as determining benefits for MH. Ins co.s do not incl. benefit and authorization info on websites or in CH info. Also, no OON benefits are ever given, so we make a phone call on 90%. We check benefits on every outpatient, IN and OON.	Tue, 10/7/08 11:09 AM
Find	**7.** INCREASING PROBLEM WITH BENEFITS BEING QUOTED INCORRECTLY.	Tue, 10/7/08 9:07 AM
Find	**8.** Ninety-nine percent of the time, this has happened with Medical Mutual. They don't ask for reimbursement. They subtract the amount from their next payment for another patient, leaving the office to collect it from the original patient. which can't always be done, so many months after the fact.	Tue, 10/7/08 8:49 AM
Find	**9.** Sometimes payment is denied after the service was provided because insurance reps said the service was not preauthorized or the previous authorization ran out and our office did not ask for more sessions prior to having the next session. Sometimes they refuse to retroactively authorize even 1 session. We get denials more often than we get requests to return a payment.	Mon, 10/6/08 9:22 PM
Find	**10.** This happened to me twice within the past month when I was told on my initial call for precertification that the person did not need to be precertified and was covered under Anthem BC/BS only to be denied payment. I was told by Anthem that the bill had to go to Connecticut General but they did not have the client in their computer. I finally discovered that their mental health coverage had to go to CARELINE - ValueOptions. If this information had been printed on the reverse side of the patient's insurance card would have eliminated several hours work and prompt payment. Instead several weeks lapsed before my billling service tracked down the problem. Considering I have a small solo practice with relatively few patients, I can't imagine what large practices go through with insurance claims.	Mon, 10/6/08 2:10 PM

10 responses per page

#24 - continued

Displaying 11 - 18 of 18 responses << Prev Next >> Jump To: 1 Go >>

	Comment Text	Response Date
Find	11. The problem is not that a request for fees to be returned. We have many many patients told that I am in-network or that I am covered at a certain level by an insurer and then the claim is denied and we find my services are not covered after all. Often both the patient and we are told that I am a covered provider. This happens far too often, on average about 3 patients weekly.	Mon, 10/6/08 1:46 PM
Find	12. The most troubling is when an insurance company just automatically deducts it for current claim checks and doesn't even give you the option.	Mon, 10/6/08 1:18 PM
Find	13. These ordeals make me want to return to Iraq.	Mon, 10/6/08 1:16 PM
Find	14. Working with insurance is an expensive, time consuming and frustrating experience. They seem to feel little responsibility for handling claims accurately, promptly or appropriately the first time around. The rules constantly change and confuse us and the payment barely covers the administrative costs let alone the cost of providing professional services	Mon, 10/6/08 11:58 AM
Find	15. Anthem and Blue Cross/Blue Shield are the worse offender for quoting benefits and eligibility incorrectly. I have had multiple problems with benefits being quoted as "no authorization needed" and being denied payment because authorization was needed but the agent quoted the benefits incorrectly (you cannot go ahead and get authorization any way if they tell you no authorization is needed, I've tried that too and been told since it was not needed that authorization would not be given).	Mon, 10/6/08 11:33 AM
Find	16. Biggest issue is with Anthem! Thet avoided paying all out-of-state claims	Mon, 10/6/08 10:49 AM
Find	17. My biggest problem comes from having claims rejected for other "silly" reasons such as "sex of client missing"	Fri, 10/3/08 9:49 AM
Find	18. They have always been regarding clean claims that were authorized and covered by the client's plan.	Thu, 10/2/08 11:19 PM

10 responses per page

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Real-Time Claim Adjudication

Presented by,
Michelle Cadrin-Msumba
August 27, 2008

athenahealth

RTA Session Objectives

- *What is RTA*
- Why RTA Why Now
- How to Access RTA
- RTA Results Review
- athenahealth's Approach

athenahealth

What is Real Time Adjudication (RTA)?

- RTA is the ability to submit a claim through the payer's adjudication system to receive an adjudication response within seconds
- RTA allows you to:
  - Know the patient's obligation for any given claim almost instantly
  - Collect the patient liability amount at check out, reducing the dollars potentially lost as the patient walks out the door
  - Receive denial information, depending on the payer

Note: RTA is sometimes referred to as Real Time Claim Adjudication or RTCA

Page 3

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What RTA Isn't

- **RTA is a lot of things, but it is not:**
  - **An Estimator**, which only *estimates* the patient financial responsibility to collect at the point of care
  - **An Eligibility and Benefits Inquiry**, which retrieves eligibility and benefits information via multiple search criteria, including demographics and possibly deductible/accumulator information
  - **Electronic Remittance Advice (ERA)**, which allows you to reconcile accounts receivable by receiving electronic remittance
  - **A Claim Status Inquiry (CSI)**, as that inquiry verifies the *status* of a submitted claim
  - **A Health Care Services Review** that submits *authorizations* and *referrals*
  - **A Health Care Services Inquiry** that inquires about existing authorizations and referrals

Page 4

But is the Claim Really Adjudicated or Just Kind of "Adjudicated"?

- RTA means adjudication. Your claim really is adjudicated!
- The claim goes through the payer's actual adjudication system and the response will be the same as what you will find on the actual ERA/EoB.
  - This does not mean you will never ever see a take back. In fact you should expect to see a few but they will occur under the exact same circumstances as if the claim had been submitted via the batch submission process.
  - And of course post-adjudication fraud and abuse checks will still be made by the payers, but again, this same process would have happened under the batch scenario.

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RTA Session Objectives

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Page 6

Practices are Losing Self-Pay Money

- We estimate that practices lose 7% of gross revenue to self-pay write-offs and patient collections activities
  - Practices typically collected only 75-80% of coinsurance and deductibles before sending patients to collections
  - Collections agencies usually charge 30% on money they collect
  - Practices typically spend $1 per patient for statements, plus the cost of phone calls and "pre-collection" letters

Page 7

Self-Pay is Big Money

- Self-pay is already a large portion of the physician bill:
  1. **Non-covered services**
     - A patient comes in for an office visit, labs and also receives a Zoster vaccine which is not covered under their plan. In this case, RTA identifies that the patient owes a total of $236 including the patient's co-pay of $15 and $221 for the cost of vaccine.
  2. **Coinsurance**
     - A patient has a knee arthroscopy with a total allowed amount of $1,260 for two distinct procedures. The patient's plan requires 20% coinsurance payment thus a total of $252 is owed by the patient.
- Although there is no deductible, the patient is still responsible for a significant portion of the allowed amount in both scenarios

Page 8

CDHC is on the Rise

Consumer directed health care (CDHC) initiatives are on the rise:

- Since March 2005, HAS/HDHP enrollment has grown 400%

"One of the greatest public-relations coups in the history of the health-care industry is the creation of the term 'consumer-driven health care.' Anyone that follows healthcare knows that consumers had nothing to do with this latest cost-saving invention from the minds of employers and health insurers."

- *David Burda Editor Modern Healthcare Oct 10, 2005*

Page 9

Healthcare Industry is Adapting

Payers need tools to help providers collect money up front

- ASC X12 Positioned for Standards Innovation 11/16/2007
  - Enabling and enhancing real-time adjudication (RTA) of health care claims
- WEDI & ASC X12
  - Collaborating with the industry and other standards bodies on such topics as RTA, Health Savings Accounts (HSAs) and Consumer Driven Health Plans (CDHPs)
- Clearinghouses & Payers
  - Emdeon – Committed to solving the challenge of pricing transparency for its provider and payer clients. They currently support both RTA and a Patient Responsibility Estimator, RTA Conference Oct-2007
  - Humana – 'RTA, A requirement for consumerism, A must for retail healthcare' RTA Conference Oct-2007
  - UnitedHealth Group– From the *Boston Globe* dated December 5, 2007, "Insurer vows to improve its service"
    - "UnitedHealth officials outlined changes aimed at improving its service reputation: It will show doctors and patients on the day of a doctor's visit how a claim will be paid"

Page 10

But Processes Are Still Too Manual

Keep In Mind…

- The healthcare industry is currently defined by IT challenges similar to those faced in earlier decades by other industries, including finance, retail, and air travel, namely:
  - Manual processes
  - Multiple platforms
  - Paper intensive
  - Increased administrative costs
  - Lack of standardization
  - Lack of transparency
  - Increased bad debt and decreased cash flow
  - Inability to collect accurate patient liability at the point of care
  - Lack of real-time information sharing
  - Overcharges (or undercharges) on HSAs
  - Negative impact on patient relations
  - And the list goes on…
- **RTA addresses all of these issues**

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Benefits of Real-Time Adjudication (RTA)

- Providers Need RTA
  - Increases self pay collections and cash flow
  - Patient statement savings
  - Improves claim cycle time (i.e. DAR)
  - Provider, insurer and patient know precisely what will be paid when the service is rendered
- And Consumers Want It!
  - RTA improves customer (patient) satisfaction
  - RTA supports consumer directed healthcare

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RTA Session Objectives

- ✓ What is RTA
- ✓ Why RTA Why Now
- *How to Access RTA*
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How to Access RTA
Web Portals & Clearing Houses

- Web Portals
  - Double entry system; requires logging onto the payer website and key in claim information
  - BCBS-SC RTA offering requires direct-data entry through their web portal
- Clearinghouses
  - EDI transaction via a clearinghouse
  - United and Humana support this method

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How to Access RTA
Single-Entry Approach

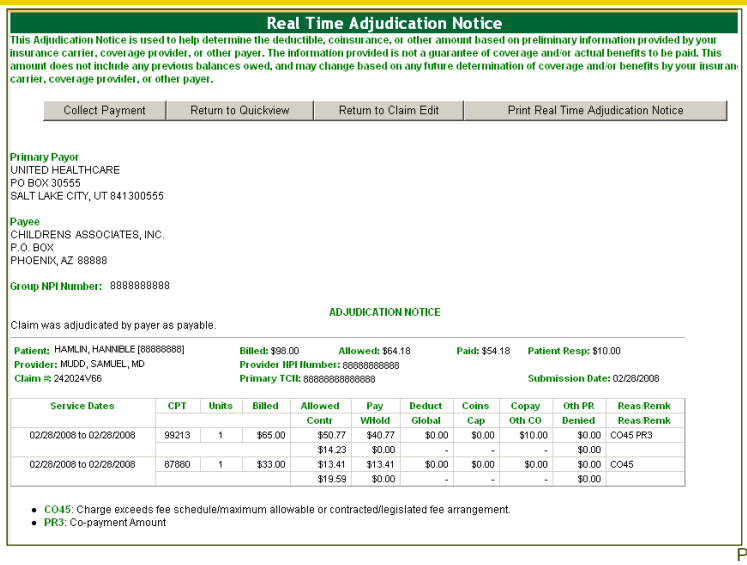
- Single entry system
  - Data is entered once at charge entry – that's it!
  - Users never have to enter charge or claim information a second time for RTA
- Payer neutral
  - One work-flow
  - Just as with the standard claims submission workflow you don't have to worry about which claims go through a clearinghouse and which go direct to a payer
  - Humana and United are the only payers that currently support this

Page 15

Real-Time Claim Adjudication:
Claim Creation

Page 16

RTA Response



Real Time Adjudication Notice

This Adjudication Notice is used to help determine the deductible, coinsurance, or other amount based on preliminary information provided by your insurance carrier, coverage provider, or other payer. The information provided is not a guarantee of coverage and/or actual benefits to be paid. This amount does not include any previous balances owed, and may change based on any future determination of coverage and/or benefits by your insuran carrier, coverage provider, or other payer.

Collect Payment | Return to Quickview | Return to Claim Edit | Print Real Time Adjudication Notice

Primary Payor
UNITED HEALTHCARE
PO BOX 30555
SALT LAKE CITY, UT 841300555

Payee
CHILDRENS ASSOCIATES, INC.
P.O. BOX
PHOENIX, AZ 88888

Group NPI Number: 8888888888

ADJUDICATION NOTICE

Claim was adjudicated by payer as payable.

Patient: HAMLIN, HANNIBLE [88888888] **Billed:** $98.00 **Allowed:** $64.18 **Paid:** $54.18 **Patient Resp:** $10.00
Provider: MUDD, SAMUEL, MD **Provider NPI Number:** 88888888888
Claim #: 242024V66 **Primary TCN:** 88888888888888 **Submission Date:** 02/28/2008

Service Dates	CPT	Units	Billed	Allowed	Pay	Deduct	Coins	Copay	Oth PR	Reas/Remk
				Contr	Whold	Global	Cap	Oth CO	Denied	Reas/Remk
02/28/2008 to 02/28/2008	99213	1	$65.00	$50.77	$40.77	$0.00	$0.00	$10.00	$0.00	CO45 PR3
				$14.23	$0.00	-	-	-	$0.00	
02/28/2008 to 02/28/2008	87880	1	$33.00	$13.41	$13.41	$0.00	$0.00	$0.00	$0.00	CO45
				$19.59	$0.00	-	-	-	$0.00	

- **CO45**: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- **PR3**: Co-payment Amount

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RTA Session Objectives

- ✓ What is RTA
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- • athenahealth's Approach

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RTA Single-Entry Results Review

- United has seen DAR drop by 4.5 days in the first half of 2008 as a result of real-time adjudication
- We examined RTA results* for the week of 1/23/2008 – 1/29/2008 in four specialties:
  - Cardio
  - Family
  - OB/GYN
  - Ortho
- Following are results from one specialty, cardiology

*Results are based on athenahealth's RTA experience

Page 19

Results Review - Cardiology

- During this one week period athenahealth submitted 1,232 claims via RTA for practices classified as Cardiology
- 1,232 claims were submitted and 917 of these claims were adjudicated on the first pass (74.4%)
- Patient liability for first pass claims averaged $4,504 per practice
- This represents an opportunity to collect over $234,000 in self-pay at the time of service
- With 23% of self-pay typically lost (written off or paid to collection agencies), this represents over $58,000 to the bottom line annually

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Results Review - Cardiology

Quote from client using athenaColletor's RTA capabilities:

"There are some claims that we can't send through RTA, but it has definitely improved our workflow - and cash flow - since we're not waiting and following up on a lot of self pay balances anymore."

RTA Session Objectives

- ✓ What is RTA
- ✓ Why RTA Why Now
- ✓ How to Access RTA
- ✓ RTA Results Review
- • ***athenahealth's Approach***

What is athena Doing that is Different than Other Real-Time Solutions?

Obstacles to Provider Adoption of Real-Time Claim Adjudication:

• Access to an all-payer solution	• Athena has developed a payer-neutral platform. Solution will work with payers that have built real-time claim adjudication capabilities
• Seamless PMIS integration – acquiring the "last mile"	• Tightly integrated into athenaNet claim creation and payment workflow. Most systems have to generate a batch and then send it through another system. Athena submits on behalf of our practices and works directly with payers.
• Time of service charge entry	• Athena is uniquely poised to incorporate intelligence in platform through the use of rules to guide providers on patients that have high deductible plans and when time of service charge entry is appropriate

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athenahealth's Approach – Improving the RTA experience

- Industry-wide, approximately 30-50% of claims are ineligible for RTA depending on specialty, coding combinations, demographics and payer policies
- Not all claims are RTA candidates, athenahealth overlays the intelligence that identifies these scenarios so that users aren't needlessly waiting for an actionable RTA response
  - athenahealth uses its Rules Engine to filter out claims that can not be adjudicated in real time, such as:
    - Claims with secondary insurance packages (COB)
    - Claims with multiple charge lines (actual number varies by payer)
    - Medicare replacement products
    - Claims that span multiple days of service
    - Certain procedure codes e.g. venipuncture, imaging, immunizations (varies by payer)

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RTA First Pass/Yield Rate

First Pass/Yield Rate: defined as percent of claims submitted via RTA that receive an "actionable" response (e.g. paid, denied)

RTA Response	Explanation
Payable	**The payer has adjudicated the claim as payable.**
Denied	**The payer has adjudicated the claim as denied.**
Pended	The payer has adjudicated the claim as pended. No immediate action is required; final determination will be communicated after payer review.
Submitted	Claim was submitted to the payer but is ineligible for Real Time Adjudication. No immediate action is required; final determination will be communicated after payer review.
Error	There was an error submitting the claim; athenaNet will resubmit it in the normal batch process. No action is required.

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RTA Statistics

- First Pass/Yield Rate — 70% - 80%
  Industry Goal: 70%
- Elapsed Time — 7 – 12 secs
  Industry Goal: 30 secs
- Claims Submitted at TOS — < 5%
- % Patient Liability Collected at TOS — < 1%

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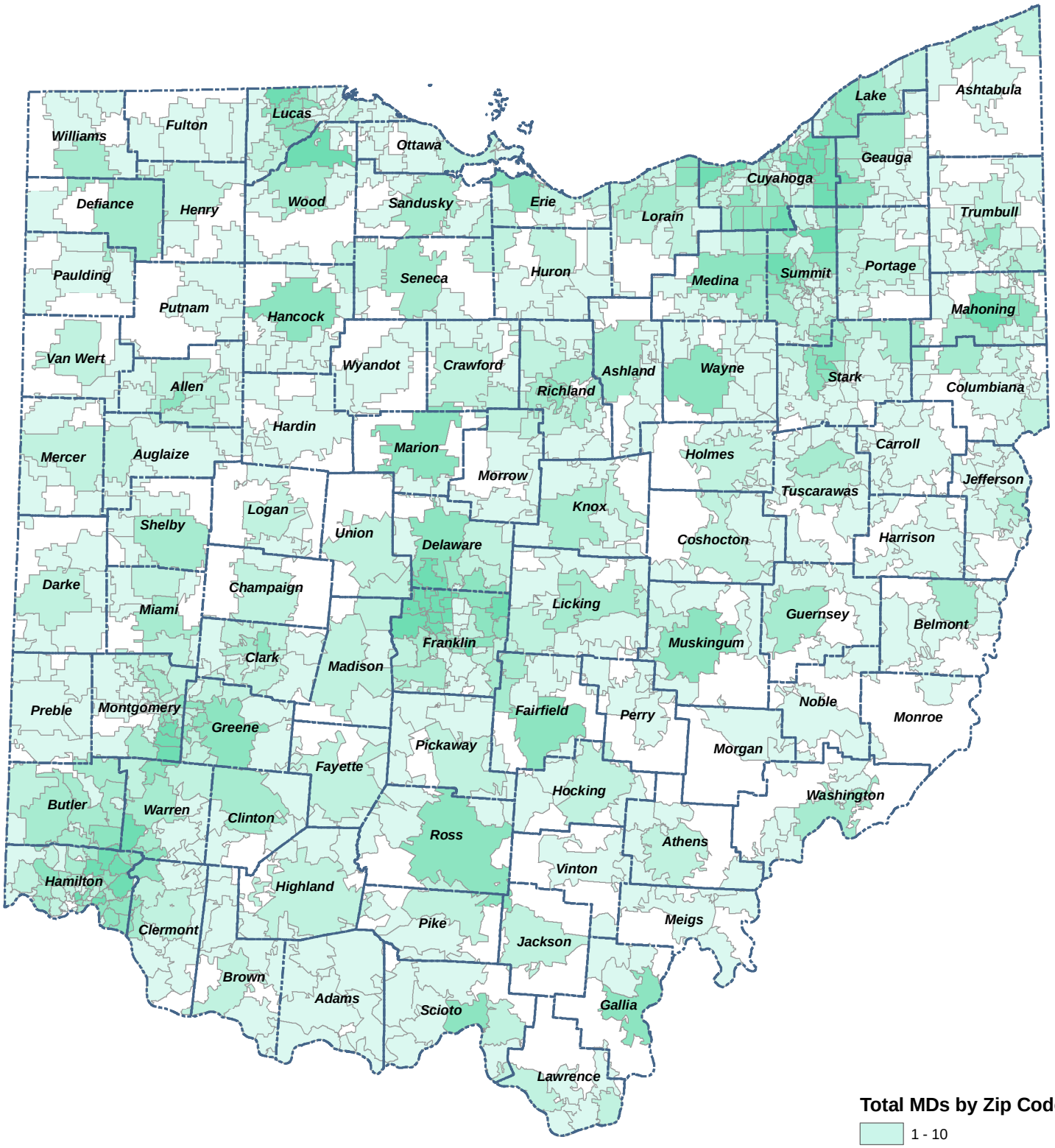
Physicians by Zip Code



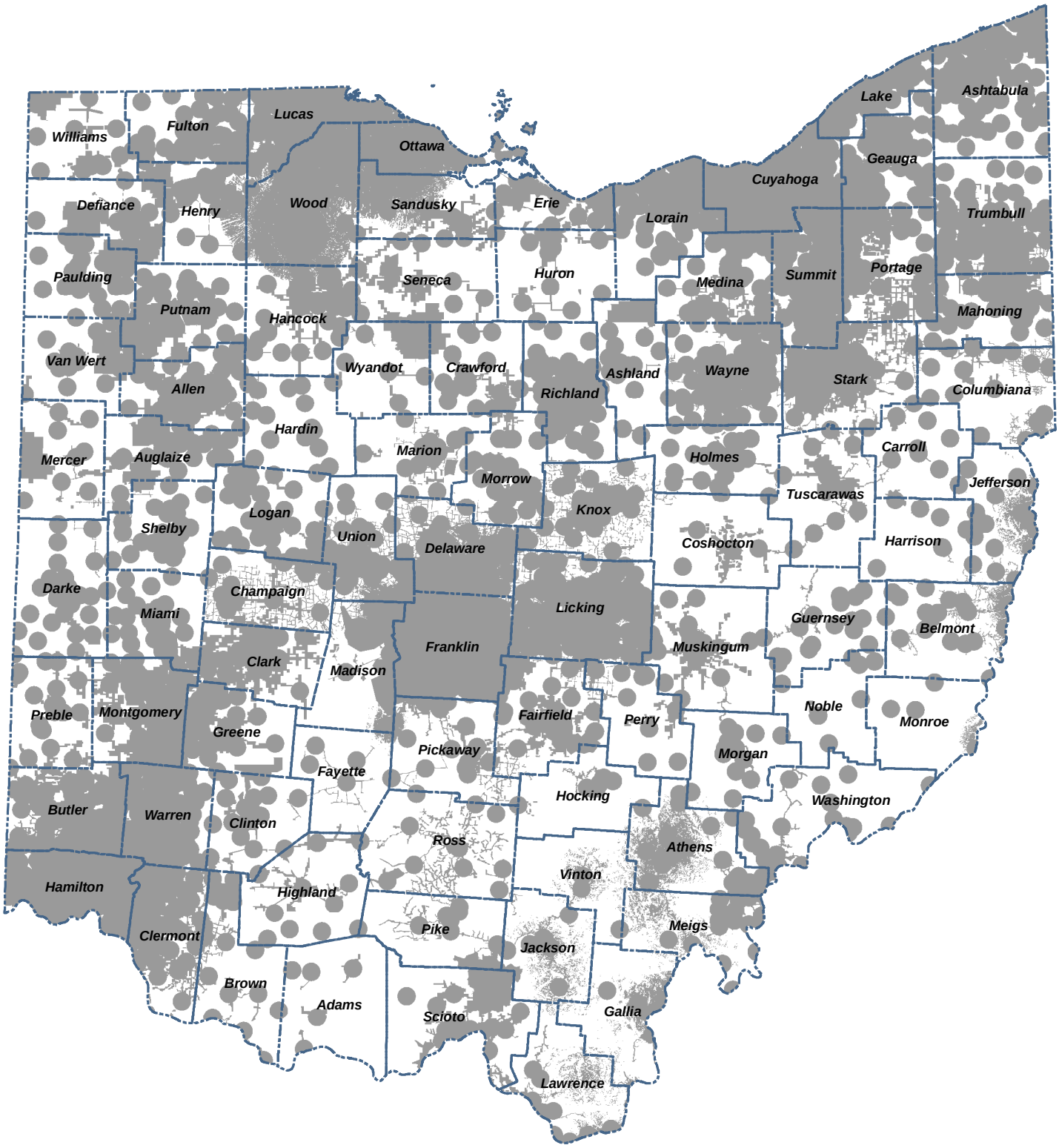
Total MDs by Zip Code

- 1 - 10
- 11 - 35
- 35 - 75
- 75 - 150
- > 150

Data Source:
Places 2 Protect - Hospitals 2007
ConnectOhio Broadband Coverage
Ohio Statewide Imagery Program
Ohio Office of Information Technology GIS Support Center 10/22/08
State Medical Board of Ohio MD Counts By Postal-Code.xls 10/20/08

The data contained on this map represents an approximation of coverage based on data supplied by Connect Ohio and facility location information derived from various sources. This is only an estimate of coverage and should not replace site specific evaluations to ascertain actual coverage extents.

Broadband Coverage



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BROADBAND COVERAGE

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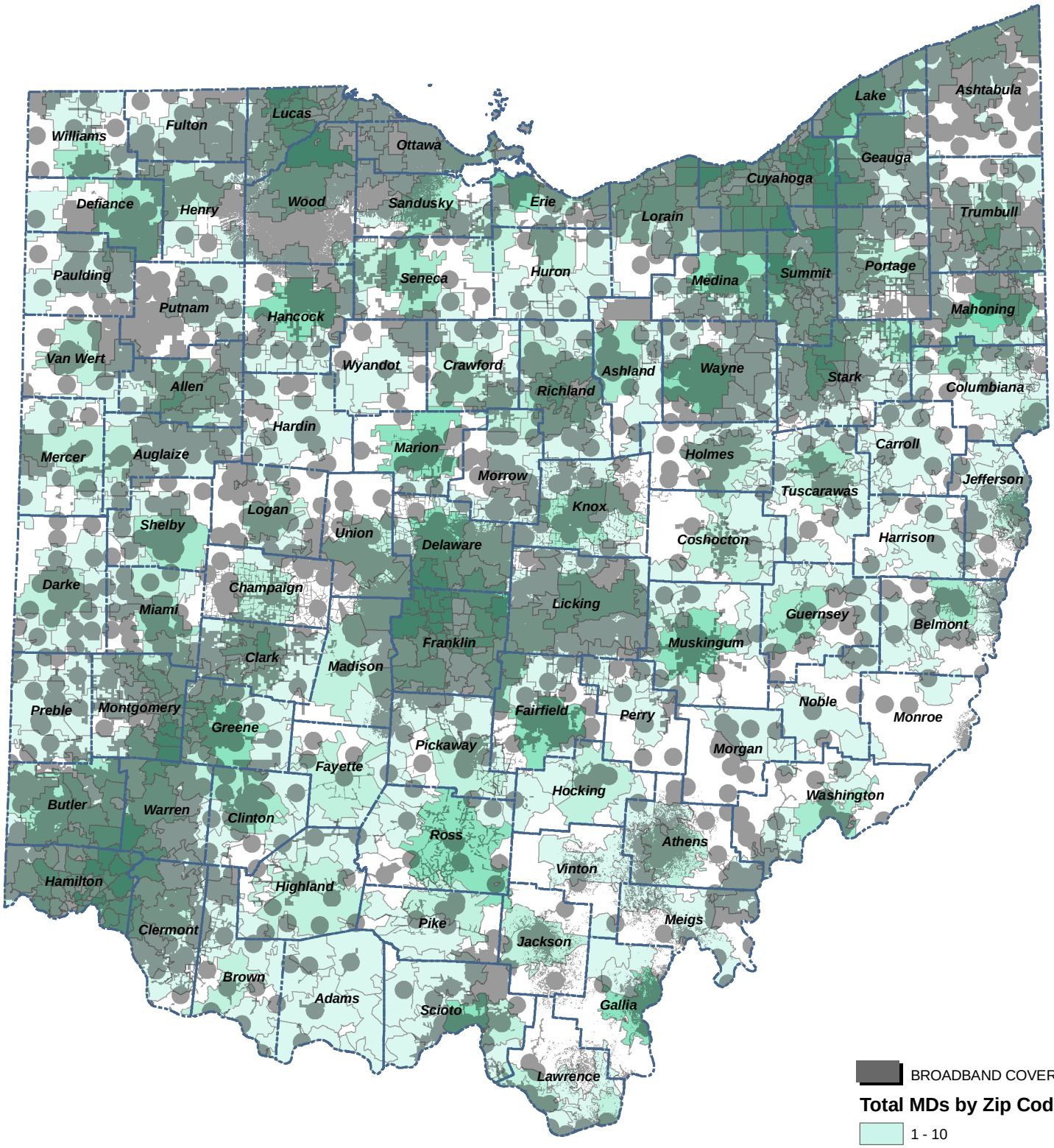
Broadband Coverage with Physicians by Zip Code



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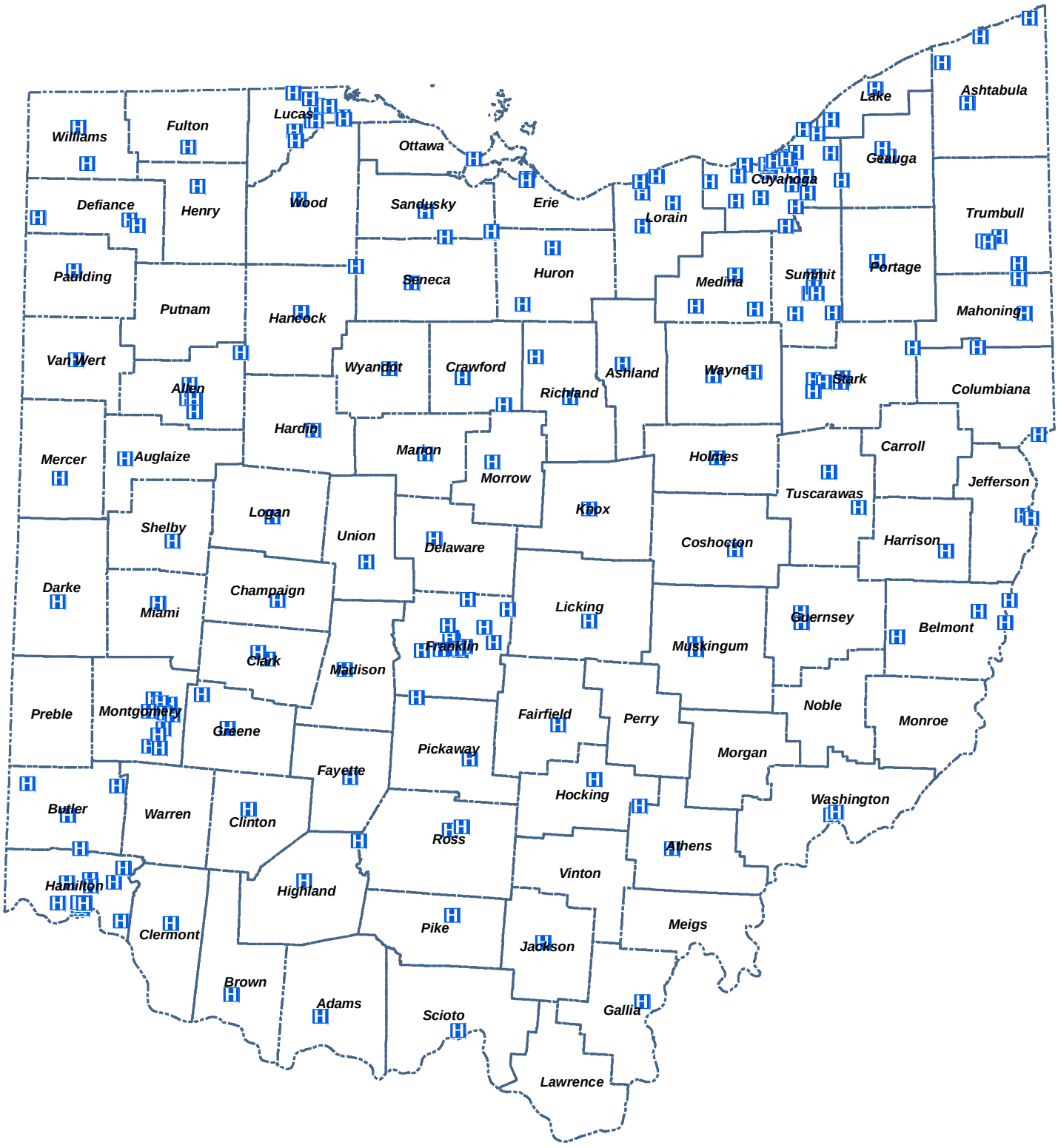
Hospital Locations



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H Hospitals

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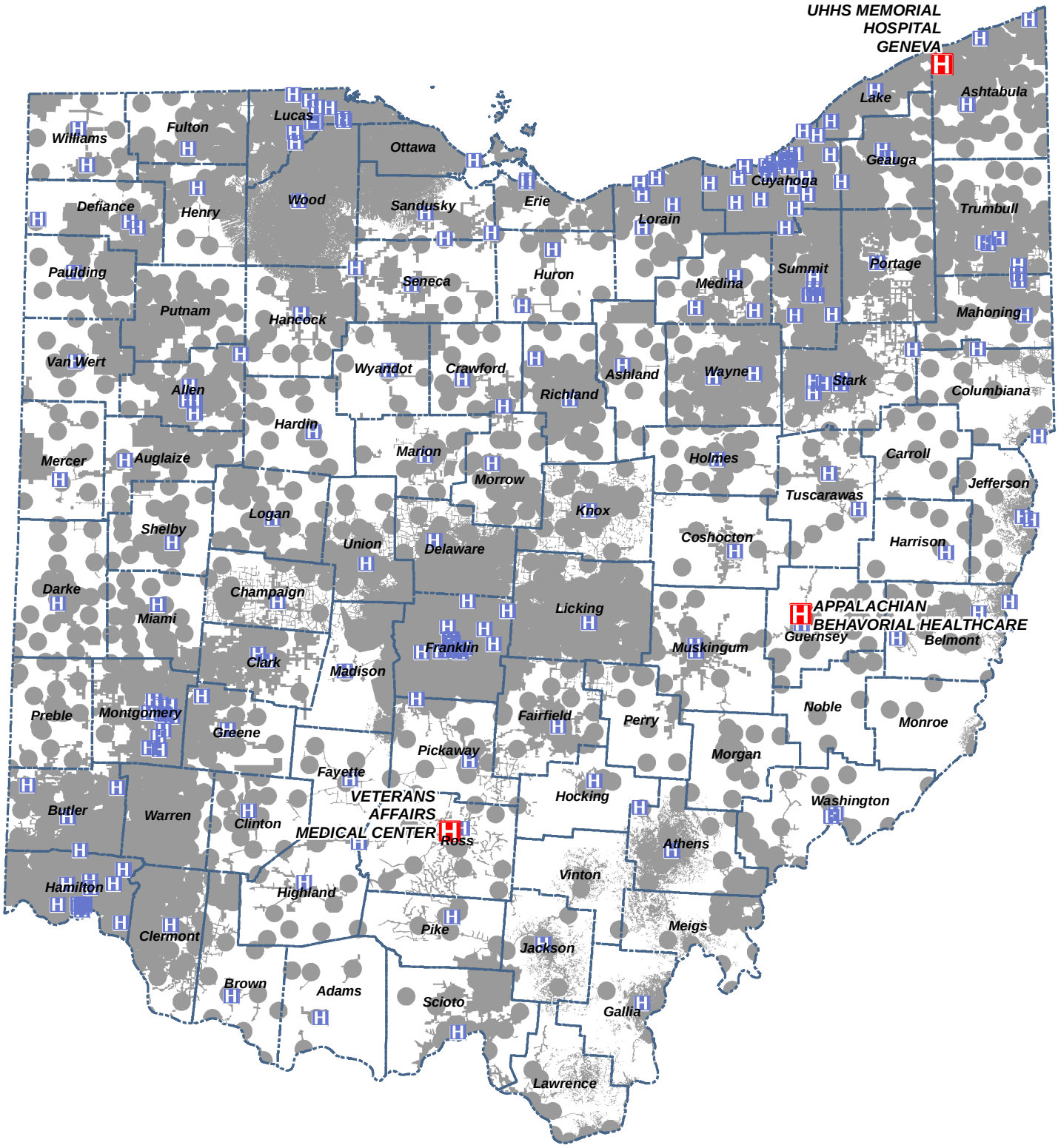
Broadband Coverage with Hospital Locations



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Hospitals

- Outside Coverage Area
- Within Coverage Area
- BROADBAND COVERAGE

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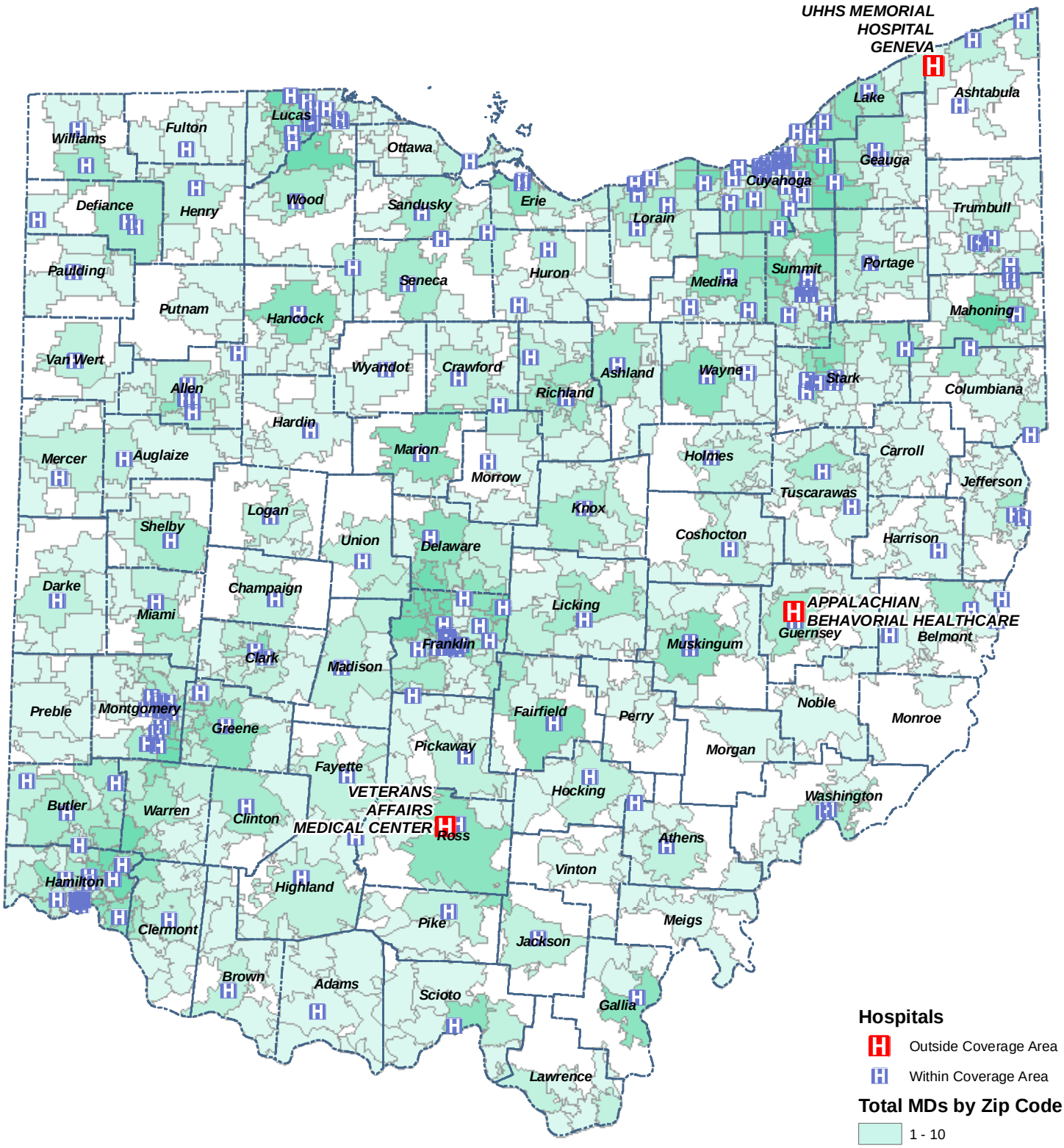
Hospital Locations and Physicians by Zip Code



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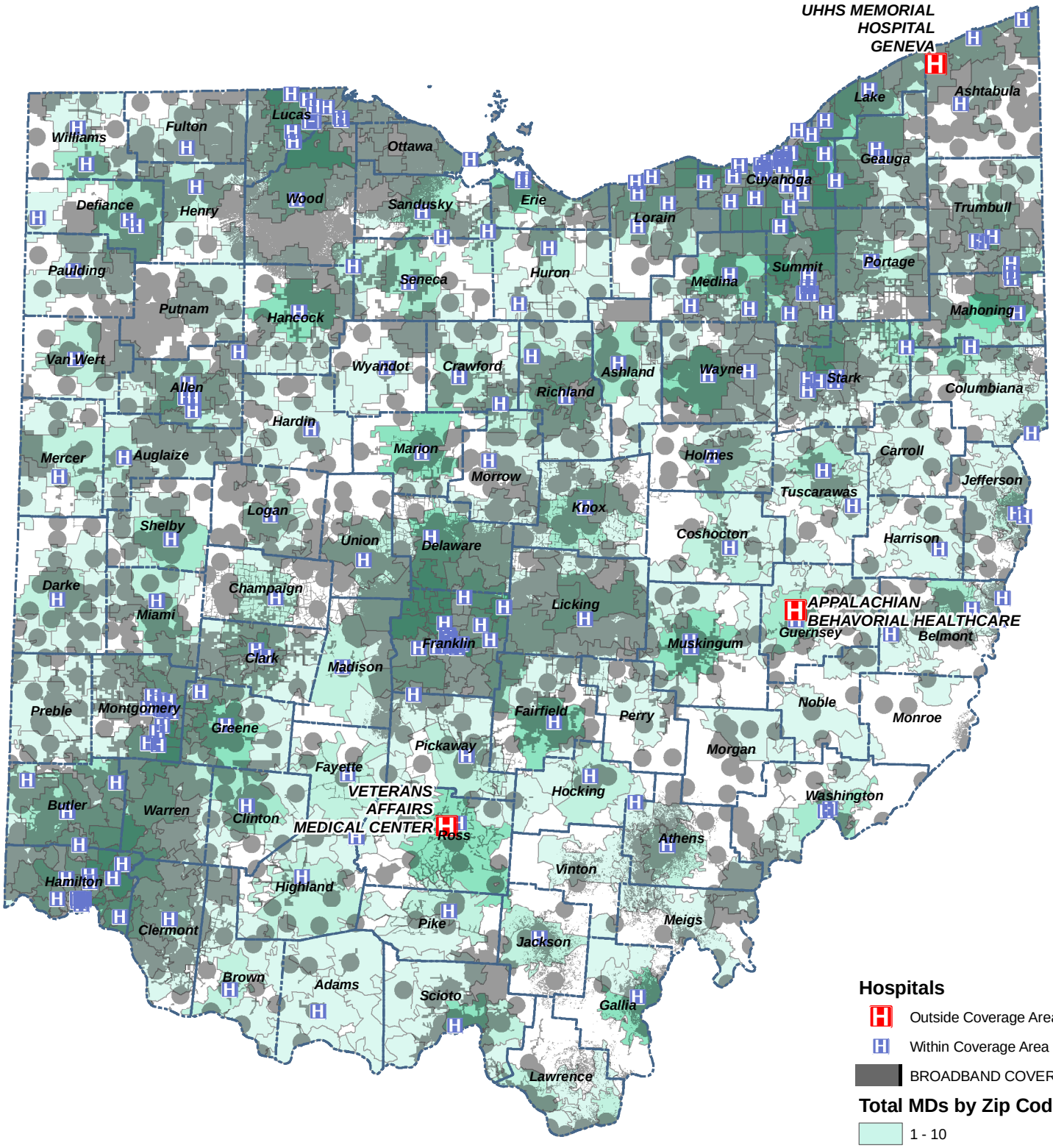
Broadband Coverage
with
Hospital Locations and Physicians by Zip Code



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OAHP Questionnaire

OAHP has worked with ODI to identify information that would be helpful to collect from insurers and TPA's, aggregate and share with the Advisory Committee on Eligibility and Real Time Claim Adjudication. All information is confidential and no data will be shared on individual companies. The purpose is to provide the Committee with information on the issues of electronic eligibility determinations, claim adjudication, and resolution of disputes. For this survey, ***eligibility*** means a consumer is enrolled in your plan (not eligibility for a specific service). Estimates of % are fine. If you have different data for self-insured vs. fully insured please indicate the information for both in "other" category. If your systems cannot identify the answer to a specific question – just leave it blank.

Business Processes

1. What grace period do you allow before retroactively canceling coverage for non-payment of premiums? 14 responses – 13 @ 30 and 1 @ 10 days

2. How often do you receive employee eligibility information from employer groups? Respondents allow all options. Depends on the employer.

☒ Daily ☒ Weekly ☒ Biweekly ☒ Monthly ☐ Other (specify) _____

3. How do you collect eligibility information from employer groups? ☒ electronically ☒ Other (specify) all options are used including on-line web access updates and paper.

4. What % of your employers cover their employees until the end of the month of employment termination? 13 responses: 15, 20, 25, 25, 30, 40, 55, 60, 90, 100, 100, 100, and 100 percent.

5. What is the average length of time from the date of service to the request for reimbursement? 10 Responses: 5, 22, 22, 24, 25.75, 30, 30, 31, 38, and 40 days

6. Do you pay a claim if the premium for an enrollee has not been paid? ☒ Yes ☒No

7. What % of claims receive prior authorization? Answers reported are combined with 8. 7 Responses: 5% - ?, 1.55% - <1%, 4% <.01%, 10%- ?, 5%-1%, 6% - <1%, 3% - 1%

8. What % of claims that receive prior authorization are later denied? See above

What are some of the reasons this can occur? Policy is rescinded, retroactive cancellation

9. What % of payments to providers results in a *take back or adjustments*? Combined with 10. 10 Responses: 2.9% - 12.56%, <1%-75%, 3%-?, .62% - 9%, 6%-17.4%, 4%-0.1%, 3%-10%, 4.21%-1.3%, 2%-5%, and 5% -?

10. What % of *take backs or adjustments* are due to the determination the patient was not an eligible enrollee? See Above

11. Does your PBM recover claims paid to pharmacies for consumers that were later determined to be ineligible? 11 Reponses: 6 yes, 4 No and 1 recovers from employer.

12. Aside from changes from employers and fraud by consumers, what other barriers exist to eligibility information being accurate at the time of inquiry from the provider?

Timeliness of submission of eligibility updates and the entry of the update into eligibiltiy files
age of data sent to vendors
grace period
terminated employees who are not told policy has lapsed
employee doesn't share changes with employer
inaccurate information from brokers
waiting on COBRA or conversion elective.

Technology

13. Do you provide eligibility information electronically? ☒ Yes ☐ No

If yes, what % of your total claims had eligibility checked electronically? 13 Responded Yes - they have an electronic eligibility system. Not all 13 could track this. Five responded with the following: 33%, 35%, 38%, 40%, and 43%

14. Do you adjudicate claims electronically? ☒ Yes ☐ No

If yes, what % of claims are submitted electronically? 14 Responded Yes – they adjudicate claims electronically. 11 could track: 54%, 60%, 60.5%, 70%, 70%, 70.3%, 79%, 80%, 82%, 85% and 91%

s your plan reviewed the CAQH CORE standards (Phase I and Phase II)? ☒ Yes ☒ No

16. Does your plan intend to adopt and implement the CORE Standards? ☒ Yes ☒ No
If yes, what is your projected implementation date? Three of the respondents are in the process of implementation. The others have not reviewed the standards or decided not to implement

17. What would be the barriers for your plan if you are required by law to adopt the CORE Standards?
The barriers sited are cost, time to incorporate the IT hurdles that will be involved with system changes or purchasing new systems, and lack of providers that use the existing IT systems (i.e. claims submission).

18. How much time would it require to implement the standards? This is unknown at this time

19. What would the potential cost be to your plan? This is unknown at this time

Please send the information above to OAHP electronically info@oahp.org or fax (614) 228-5816 before October 17.
All information will be confidential and aggregated to provide an average industry response.

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

December 19, 2008

Ms. Mary Jo Hudson, Director
Ohio Department of Insurance
50 W. Town St., 3rd Floor, Suite 300
Columbus, Ohio 43215

Re: *H.B. 125 Real Time Eligibility and Claim Adjudication Advisory Committee - Final Recommendations*

Dear Director Hudson:

I am writing on behalf of America's Health Insurance Plans (AHIP) to provide comments on the final recommendations of the Real Time Eligibility and Claim Adjudication Advisory Committee established by Ohio H.B. 125. AHIP is a national trade association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and have demonstrated a strong commitment to participation in public programs.

AHIP members are eager to work with the Advisory Committee to develop administrative simplification solutions for the State of Ohio. Incorporating greater administrative efficiencies into the health care system is a laudable goal that we fully support to reduce costs, improve administrative functions, and reduce consumer health insurance premiums. Our members have a history of working collaboratively with key stakeholder groups – including providers, hospitals, vendors, the Centers for Medicare and Medicaid Services (CMS) and other government agencies, regional entities, standard-setting organizations, and other healthcare entities – at the national level under the Council for Affordable Quality Healthcare (CAQH) umbrella and stand ready to do the same in Ohio.

We applaud the Advisory Committee's efforts to: 1) enable the transfer of information that would allow providers to determine an enrollee's eligibility for services at the time of the enrollee's visit; and 2) provide real time claim adjudication for provider services. AHIP was an active participant in the debate on H.B. 125, and we are grateful for the opportunity to continue to be a part of the dialogue on these important issues. We appreciate the Advisory Committee's recommendation to support the CAQH Committee on Operating Rules for Information Exchange (CORE) initiative.

AHIP has long been a supporter of CORE as a way to reduce administrative burdens and improve access to eligibility and other administrative data. CORE establishes uniform standards,

and policies to use those standards, that can be applied uniformly in all states. The standards are built off of those that are federally-recognized and complement the use of policies to ensure business drivers are considered. We also support the voluntary, market-based approach suggested to implement the Advisory Committee recommendations. However, during our analysis of the Advisory Committee's recommendations, we have identified some areas of concern and respectfully request that the Committee consider the following comments.

Best Practices

The Advisory Committee recommends best practices be established whereby employers provide updated eligibility information to insurers and third-party administrators "as soon as possible following an employee or dependent's qualifying event and no less frequently than on the employer's payroll cycle or on a monthly basis." The standards then propose to require insurers to make electronic information available after it is received from employers.

With regard to this proposal, we suggest that the recommendation: (1) be further clarified to specifically state to whom insurers are making the information available (e.g., health care providers or employers); and (2) incorporate language to address situations where an insurer and health care provider verify an individual's eligibility in good faith but later discover that the information was inaccurate or incorrect. This can occur if the information provided by the employer is erroneous or is not reported in a timely fashion. These recommendations are intended to address situations where an insurer learns, subsequent to a verification transaction with a provider and after services are rendered, that an individual patient was not an eligible enrollee.

"Take back" period

Finally, AHIP requests that the "take back" period addressed in Section III(6) be revised by modifying the trigger for when the one year timeframe begins. Specifically, we request that the "take back" period during which an insurer can recoup payments made for services rendered to an ineligible employee or dependent be amended to 1 year from the date an employer notifies the insurer that an employee or dependent was no longer eligible for coverage -- rather than 1 year from the date of original payment as recommended by the Advisory Committee. Insurers may receive delayed updates or retroactive terminations from employers and the insurer's ability to recoup payments should not be restricted based on circumstances outside of the insurer's control. One year from the date services were rendered does not allow ample time to retrieve ineligible payments made when insurer's receive late and/or retroactive termination notices.

Thank you for the opportunity to comment on the recommendations. Please feel free to contact me with any questions you may have at 202.861.1463 or LKuiper@ahip.org.

Sincerely,

Laurie Kuiper
Regional Director, State Affairs

Memorandum

To: Members of the Real Time Eligibility and Claim Adjudication Advisory Committee

From: Carrie Haughawout
Ohio Chamber of Commerce

Dave Uldricks J.D, LL.M
Employers Health Purchasing Corporation of Ohio

Date: December 30, 2008

RE: Recommendations

With health care being one of the biggest concerns for both business owners and consumers alike- it is no wonder real time claims adjudication has become such an important issue. Creating a fully functioning real time adjudication (RTA) system would simplify our current approach to health care by allowing both patients and providers to understand the up-front costs of services. RTA could also help reduce cost, improve transparency and ultimately increase access.

While we agree that RTA can have a positive impact on health care and that the state can and should actively participate in the creation of a national system, we do not believe Ohio should develop separate standards for implementation at the state level. Mandating policies on payers and employers only serves to increase the cost of administration and compliance, thereby making it harder for businesses to provide coverage and consumers to access coverage.

Further, it should be noted that while RTA is a worthy goal to strive for- it will not solve the problems occurring in our system today. Our health care system should endeavor to educate consumers, promote health and wellness and be transparent and open. We can use technology to assist in achieving these goals, but not as a substitute. In fact, it would be impossible to prevent every piece of bad data from entering the system. Likewise, RTA will not prevent those who are intent on committing fraud from doing so.

Employers that provide health insurance do so as a benefit to their employees. Once the perceived cost, both in actual dollars and time spent on administration, outweighs the advantages of providing the benefit, employers will increasingly choose not to provide health insurance at all. In reality, we already know there are companies that have chosen to stop offering coverage in states where the regulatory burdens of doing so overshadow the advantages.

Below we have outlined advances in RTA efforts and technology, the current accuracy of eligibility data, and the importance of the patient/provider relationship. Further, we discuss why we cannot agree that the time frame for "take backs" should be shortened, as referenced in the committee's report.

ADVANCES IN REAL-TIME ADJUDICATION EFFORTS AND TECHNOLOGY

Most, if not all, of the major payers are working on electronic health solutions that include real-time adjudication. In this study committee alone, we've heard from Humana, Athena Health, and Anthem/WellPoint about what they are doing to move toward real-time adjudication. In addition, there are a number of different efforts on the national level to create standards and encourage electronic health data exchanges, including the Coalition for Affordable Quality Healthcare (CAQH).

CAQH is made up of stakeholders across the health care industry that put intense focus on building consensus and not reinventing the wheel. One of their current projects is Committee on Operating Rules for Information Exchange also referred to as CORE. The goal of CORE is to develop operating rules for the exchange of electronic data to streamline electronic communications between payers and providers. CORE has been in place for more than 3 years and is already working towards its third phase of rules.

CORE is a national effort that involves all major stakeholders. Individual state mandates only diminish the ability for CORE to succeed. Since there is a significant movement in the direction of RTA already underway by the payers, implementing mandates specific to Ohio will only hinder our ability to keep costs down and stay competitive. The state of Ohio, through Medicaid, is the largest payer of insurance claims; therefore the state can use its significant leverage to encourage vendors to participate in the development and adoption of national standards.

Finally, the committee has repeatedly heard from the full group presentations and throughout the subcommittee process that, as a group, providers are not investing in the necessary technology to take advantage of a fully implemented RTA system. According to their own data, the Ohio State Medical Association's (OSMA) members responded that only 35 percent check eligibility more than half the time. Even fewer (24%) check eligibility regularly (more than 75% of the time). Therefore, placing expensive and burdensome regulations on employers before most providers are even able to utilize RTA, in its fully implemented state, seems excessive.

ACCURACY OF ELIGIBILITY DATA

To the extent that employers may choose to help employees pay for medical services through health insurance, employers should also make every effort to ensure the accuracy of the data provided to the payer. By all accounts this is already occurring today. The OSMA's data even shows this is the case. According to a recent survey, nearly half (45%) of those responding said that they have never been asked to return payment for an ineligible patient, if provider verified eligibility before the provision of services. Of the remaining half (55%) the overwhelming majority (91%) stated overpayments related to eligibility changes or "take backs" represent less than 10% of their claims. This notion is confirmed by a similar survey conducted by the Ohio Association of Health Plans (OAHP), in which the responding payers indicated "take back" requests account for less than 6% of payments to providers.

Aside from these two, non-scientific surveys, there is an alarming lack of data surrounding this issue. Neither the entire study committee nor this dispute resolution subcommittee was afforded the necessary amount of time and resources to determine how often "take backs" are occurring and propose meaningful solutions.

Before making recommendations that will increase liability and therefore cost for payers and employers, this committee and the Ohio General Assembly should insist that there be clear, reliable evidence to demonstrate that current eligibility and claims data is frequently flawed. The absence of this information, coupled with the surveys and information that were presented to this committee lead employers to the conclusion that eligibility and claims data is largely accurate and that expensive mandates are wholly unnecessary.

RELATIONSHIP BETWEEN PROVIDER AND PATIENT

The patient/provider relationship is the cornerstone of our health care system today, both because of the important role it plays in determining health outcomes but also because of the financial implications as well. Providers and patients enjoy a unique relationship of trust and confidentiality.

As part of providing health care services, providers routinely ask their patients for information about lifestyle and other stressors to ascertain any relevant health impacts from these events. In the course of asking for this information the provider is already obtaining most, if not all, pertinent information regarding changes to insurance coverage and/or eligibility. Conversely, employees do not usually provide this information to their employers, and in some case employers are prohibited by law from asking for such information.

Benefit administrators across the board point out that managing benefits goes far beyond whether or not an individual is employed or not. They must consider dependent qualifications, COBRA or FMLA status, domestic partner laws or policies, as well as, other legal duties to the employee when determining eligibility. Because of the complexities of employer administered health insurance plans and because legal obligations to the employee/patient so drastically differ between employers and providers, it makes little sense to promote mandates that further employer involvement in this process. In fact, providers are in the best position to identify pertinent information that may impact the health status of a patient and therefore changes to insurance coverage and/or eligibility.

"Take Backs"

While employers agree with many of the Advisory Committee recommendations, employers cannot agree with the recommendation to shorten from two years to one year the time frame allowed for the recoupment of inappropriately paid benefit monies (the Recommendation) for the following reasons:

- The Recommendation is outside the scope of the Advisory Committee's charge,
- Research conducted by insurance companies and TPAs indicate that eligibility information currently received by providers is highly reliable, and
- The law is unsettled concerning the ability of an insurance company, TPA or employer to recover from a health plan participant or dependant monies inappropriately paid to a provider due to lack of eligibility.

HB 125 charges the Advisory Committee with the task of providing comments related to when a provider may rely on eligibility information transmitted by a payer, and recommendations related to how disputes over enrollee eligibility are to be resolved. The Recommendation to shorten the recoupment time frame for inappropriately paid benefit monies addresses neither of the tasks charged to the Advisory Committee by HB 125. While the Recommendation may incent providers to verify eligibility for health benefit insurance coverage, it does not address whether or when currently available eligibility information is reliable, and it does not address how to resolve enrollee eligibility disputes. Thus, the Recommendation is outside the scope contemplated by HB 125.

The appropriateness of the Recommendation notwithstanding, research conducted by insurance companies and TPAs indicate that the eligibility information currently available to providers is highly reliable. According to the research only 0.19% of all claim payments are recovered from providers because of retroactive termination of health benefits. A provider survey was presented to the Sub-Committee on Dispute Resolution that inferred that "claw backs" occur with some frequency. However, this survey cannot be used to quantify the prevalence of payment recoveries from providers due to retroactive termination of eligibility because the provider survey included in its results recoveries for duplicate payments, inaccurate billing, medically unnecessary services, coordination of benefits, and all other reasons. Thus, the only credible evidence to determine the reliability of currently available eligibility information indicates a highly reliable confidence rating of over 99%.

On the rare occasion when retroactive termination of health plan benefits is merited and inappropriately paid benefit monies must be recovered, the law is unsettled concerning the ability of an insurance company, TPA or employer to recover those monies from a health plan participant or dependant. On the other hand, providers have a well established direct claim at law against an individual to obtain a judgment for payment for services rendered when health insurance is not available. While payment collection may become increasingly difficult with the passage of time, providers still maintain a more clearly defined and superior standing for collecting such payment.

In conclusion, HB 125 asks when eligibility information is reliable and how eligibility disputes should be resolved considering the legal relationship of the parties. Evidence presented to the Advisory Committee suggests that currently available eligibility information is highly reliable and that the current system for dispute resolution is the most practical, considering the legal relationship of the parties involved. The Recommendation of the Advisory Committee ignores HB 125's charge and promotes the agenda of the majority party sitting on the Advisory Committee, regardless of its lack of demonstrable merit. To the extent that the Recommendation results in inappropriately paid benefit monies without the possibility for recovery, such unrecovered monies will result in increased insurance rates or decreases in employer sponsored insurance coverage.

Dear Ms. Jewel: transaction

The AMCNO is of the opinion that overall the final recommendations contained in the HB 125 Real Time Eligibility and Claim Adjudication Advisory Committee are well done, however, we would like to provide a few comments on some specific points. I believe that you had asked for comments by today so I hope that I am in time.

I. CORE Recommendations

1. **The Committee recommends that all electronic administrative transactions related to health care insurance eligibility verification, must be CORE Phase I and Phase II compliant no later than three (3) years after the deadline for ICD-10 compliance.**

AMCNO Comment on I. 1: ***The AMCNO does not believe that there is a need to include the timeline. Technology is moving fast and many advances are being made in the usage of technology in the medical field. In addition, a good percentage of insurers are already CORE compliant and we do not agree that CORE adoption should be linked to the adoption of ICD-10 which could result in a five-year lapse in time before this recommendation had to be met.***

III. Dispute Resolution Sub-Committee Recommendations

2c. When deciding to purchase a new practice management system, providers should select a CORE certified practice management system.

AMCNO comment on III. 2c : The AMCNO agrees with this recommendation and we plan to review this recommendation with our board to consider adoption of this item as AMCNO policy.

3. The Advisory Committee recommends that TPAs adopt the following best practices:

3b. TPAs should request employers to update eligibility information no less frequently than on the employer's payroll cycle or on a monthly basis.

AMCNO comment on III 3b: We believe that the word "request" implies that a request can be made but it does not necessarily have to be done in an expeditious manner. If the TPAs are not required to have employers update eligibility information on the employer's payroll cycle or on a monthly basis it may not be in done a timely fashion. AMCNO would like to see this as a "requirement."

3c. TPAs should request employers to update employee and dependent eligibility information as soon as possible following an employee or dependent's qualifying event.

AMCNO comment on III 3c: We believe that the word "request" implies that a request can be made but it does not necessarily have to be done in an expeditious

manner. If the TPAs are not required to have employers update employee and dependent eligibility information as soon as possible following an employee or dependent's qualifying event it may not be done in a timely fashion. AMCNO would like to see this as a "requirement."

4. The Advisory Committee recommends that Insurers adopt the following best practices:

4b. Insurers should request employers to update eligibility information no less frequently than on the employer's payroll cycle or on a monthly basis.

AMCNO comment on III 4b: We believe that the word "request" implies that a request can be made but it does not necessarily have to be done in an expeditious manner. If the insurers are not required to have employers update eligibility information on the employer's payroll cycle or on a monthly basis it may not be done in a timely fashion. AMCNO would like to see this as a "requirement."

4c. Insurers should request employers to update employee and dependent eligibility information as soon as possible following an employee or dependent's qualifying event.

AMCNO comment on III 4c: We believe that the word "request" implies that a request can be made but it does not necessarily have to be done in an expeditious manner. If the insurers are not required to have employers update employee and dependent eligibility information as soon as possible following an employee or dependent's qualifying event it may not be done in a timely fashion. AMCNO would like to see this as a "requirement."

5. The Advisory Committee recommends that the continuing committee gather additional data on eligibility, denials and "take backs" and set the parameters for the respective data collection.

AMCNO Comment III 5.: The AMCNO is of the opinion that the issue of takebacks needs to be studied further. The AMCNO and our physician members would like to see the takeback time issue reviewed and studied by the advisory committee to determine if the overall takeback time on insurance claims should be reduced even further in the future. In addition, claim denials are also problematic for physician practices and data collection and review of this issue would be very useful. The AMCNO would like to continue as a participant on this committee if it does remain in existence.

6. The Advisory Committee recommends that payments made for services rendered to ineligible employees and dependents should not be permitted to be "taken back" after one year from the date of the original payment, if the provider confirmed

eligibility electronically on the date of service and can demonstrate that eligibility was verified at the time services were rendered.

AMCNO comments on III 6.: The AMCNO is of the opinion that if the physician confirmed eligibility status electronically on the date of service and can demonstrate that eligibility was verified at the time services were rendered then the insurer should not be permitted to "take back" funds after six months from the date of the original payment of a claim and perhaps even a shorter timeframe than six months for takebacks should be further evaluated in the future.

I hope that I have numbered these correctly – I did not have a final revised copy from ODI to work from and utilized my notes and changes. For example I was not sure if item 5 was now listed under IV. General Recommendations rather than under III. Dispute Resolution. If I have missed something or worded something differently in the committee recommendation please let me know. And thank you for providing the AMCNO with the opportunity to comment on the final recommendations.

Sincerely,

Elayne R. Biddlestone
EVP/CEO
The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)
6100 Oak Tree Blvd. Ste. 440
Independence, Ohio 44131

Ohio State Medical Association
The power of many. The voice of one.

November 10, 2008

Anne Jewel
Assistant Director, Office of Policy and Research
Ohio Department of Insurance
50 West Town Street, Suite 300
Columbus, Ohio 43215

Re: Dispute Resolution Subcommittee - OSMA recommendations

Dear Assistant Director Jewel -

The Ohio State Medical Association is pleased to present recommendations to the Dispute Resolution Subcommittee regarding when a provider may rely upon coverage and eligibility information provided by a third party payer. You will recall that H.B. 125, Section 7(F)(3) states:

> *The Advisory Committee shall make recommendations . . . when a provider may rely upon the eligibility information transmitted by a payer regarding a service provided to an enrollee for purposes of allocating responsibility for payment for services rendered by the provider. The Advisory Committee shall further recommend how disputes over enrollee eligibility for services received should be resolved taking into consideration the legal relationship between the provider, the enrollee, and the payer.*

Eligibility Verification Problem

Based upon the Health Care Providers' Survey Report[1], 58% of the physicians' surveyed indicated that they had verified insurance eligibility of their patients only later to be asked to return payment because the eligibility information provided by the third party payer was inaccurate.

Of the physicians reporting inaccurate eligibility information as a problem, 76% stated that it applied to as many as 5% of their claims, while 17% reported it as an issue in 6-10% of their claims, and the remaining 7% reported it applying to a more significant portion, 11-25% of their claims submitted.

For many physicians, the lack of reliability of the third party payers' eligibility verification systems can cause undue burden and increased administrative expenses to their practices.

[1] The Health Care Providers' Survey was a joint survey of the Members of the Academy of Medicine of Cleveland & Northern Ohio, Ohio Council for Home Care, Ohio Osteopathic Association, and the Ohio State Medical Association. Please contact ODI for a complete copy of the survey results.

Current Eligibility Dispute Process

Under the current eligibility dispute resolution process, providers unfairly bear the entire risk and burden of an eligibility dispute. In this process, providers are dependant upon the information presented to them by the patient (insurance ID card) and supported by the third party payer (web portal/fax/phone) at the time the medical services are rendered.

While providers are in a good position to determine the patient's insurance eligibility at the time of the visit, the provider's attempt to verify eligibility is only as good the information being provided by the patient and confirmed by the third party payer.

For example, if the patient presents an insurance ID card and the provider verifies and confirms the insurance eligibility information with the third party payer, **the provider is still at risk that the third party payer will *retroactively* revoke the eligibility verification**. If this occurs, it results in the third party payer instituting a "take back" from the provider, and retroactively denying all reimbursements for any claims paid relating to that particular eligibility verification.

Incredibly, these "take backs" can occur up to 2 years after a payment was received, even though the physician relied on the third party payer's eligibility verification.

Shared Risk and Responsibility for Eligibility Disputes

Given the advancements in health information exchange, in many instances eligibility information moves seamlessly between the patient, provider and third party payer. However, despite these advancements, we have not reached a point where the provider may rely upon the accuracy of the eligibility information provided by the third party payer.

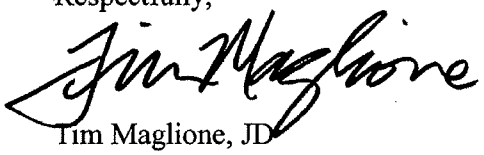
Therefore, in order to create a more equitable risk distribution system, incentives to report accurate information and shared responsibility among the parties in eligibility disputes, we are proposing limiting the take back/payment recovery period to 60 days after payment for a claim has been made, when eligibility was verified by the provider.

It is axiomatic that where a third party payer has approved eligibility verification, it is fundamentally unfair for the third party payer to later retroactively deny reimbursement of the paid claim.

By statutorily adopting this concept when eligibility has been verified, Ohio will more equitably share the risk among the parties in an insurance eligibility dispute. In addition, the state will be providing an incentive for insurers to report more timely and accurate eligibility information and an incentive for providers to use electronic eligibility verification in order to receive the protections of the law.

Thank you again for the opportunity to provide recommendations to the Dispute Resolution Subcommittee regarding when a provider may rely upon coverage and eligibility information provided by a third party payer. We look forward to continuing this dialogue as the committee prepares its report to the General Assembly.

Respectfully,



Tim Maglione, JD
Senior Director, Government Relations Group
Ohio State Medical Association

Anne, Malika and Adam,

I am writing in regards to the Ohio State Medical Association's (OSMA) comments on the HB 125 Real Time Eligibility and Claim Adjudication Advisory Committee Report, specifically the CORE recommendations. While the OSMA supports the Committee's recommendation that all administrative transactions related to eligibility verification must be CORE Phase I and II compliant, we do not agree with linking adoption of CORE to the ICD-10 implementation timeline.

Over the course of the Committee's deliberations, all committee members and stakeholders unanimously agreed that CORE is the national standard for electronic eligibility information exchange. The CAQH-CORE process has proven to be a valuable and unprecedented approach to building a consensus among healthcare industry stakeholders in the effort to establish standards for eligibility information exchange. Ohio's health care delivery system has benefited from those voluntarily complying with CORE and will benefit in the future from the Committee's recommendation that all entities adopt CORE. However, linking the recommendation for CORE adoption to the ICD-10 implementation timeline could have several negative consequences in moving this effort forward.

According to a rule issued by the U.S. Department of Health and Human Services (HHS), ICD-10 compliance is scheduled for October 1, 2011. Assuming the October 1, 2011 ICD-10 deadline remains (It should be noted that the OSMA, American Medical Association, American Health Insurance Plans and other healthcare industry stakeholders have requested an extension in the ICD-10 implementation timeline), under the recommendation, CORE adoption in Ohio could be delayed until October, 2014. This raises several concerns:

1. CORE Adoption and Rulemaking is not connected to other timeframes- CORE does not connect its current Phase I and II certification process to the implementation of ICD-10 and neither should Ohio. In addition, CORE continues to move forward with its rules development process despite the federal ICD-10 and 5010 update deadlines. To date, Ohio has experienced CORE certification by health plans and payers apart from the ICD-10 implementation timeframe and it would be beneficial for CORE adoption to continue in this manner.

2. Consumer Driven Health Care/High Deductible Health Plans (HDHP)- Providers have eligibility information exchange problems that are threatening the administrative and financial viability of their practices today. As more patients move into HDHPs, the health care system must ensure that these plans have complete transparency in the eligibility information exchanged between all parties at the time medical services are rendered. Fortunately some Ohio health plans and payers have voluntarily adopted the CORE standards for information exchange, however not all have or will. Failure to adopt the CORE standards in Ohio in a reasonable timeframe will add to the administrative complexity providers are experiencing with HDHPs as they continue to proliferate in the marketplace.

3. Recommendation may discourage voluntary compliance with CORE certification- We are concerned that the Committee's recommendation of connecting CORE adoption to ICD-10 implementation may have the negative effect on those health plans and payers that are

voluntarily in the process of complying with CORE to discontinue compliance or delay adoption based upon the Committee's recommendations.

Therefore, we feel it is in the best interest of Ohio's patients, providers, employers, health plans, and payers to adopt the CORE Phase I and II standards in a timeframe unattached to ICD-10 implementation.

However, if the Committee insists on recommending a timeframe for CORE adoption in Ohio linked to to a federal timeline, it would seem more appropriate and prudent to link the timeline to the 5010 HIPAA update rather than ICD-10 implementation. Many of the data elements required for CORE Phase I and II compliance are also required by the 5010 HIPAA update, thus most of the IT updates will be completed during the 5010 implementation.

Thank you for considering these comments. We also would like you to consider our previous letter regarding the dispute resolution process as our comments on that issue. Please let me know if you have any questions. Have a good weekend,

Jeff S. Smith, JD
Director, Government Relations
Ohio State Medical Association
3401 Mill Run Dr.
Hilliard, Ohio 43026

Memorandum

To: Members of the Real Time Eligibility and Claim Adjudication Advisory Committee

From:

Jeff Corzine
Unison Health Plan

Sue Harris
Paramount

Kathie Fuson
Delta Dental

Michelle Mathieu
Aetna

Karen Greenrose
AAPPO

Date: December 23, 2008

Subj: Statement of Concern

We appreciate the opportunity to be involved in the Real Time Eligibility and Claim Adjudication Workgroup. We believe, in simple terms, that this group was charged with reviewing the issues surrounding implementation of systems for real time eligibility and claims adjudication. Our industry is proud that we have been able to participate as leaders in this field through the development of national operating rules and voluntary implementation and compliance with these market driven rules. In fact, in the short time since these initial rules were developed, there has been significant penetration in the number of companies that are either in compliance with the rule or are planning for the financial investments needed to comply in the near future. Therefore, it is disappointing that the workgroup became driven to force compliance upon all health plans licensed in Ohio. We believe the reason for this was two fold. First, the make up of the committee was dominated by medical providers or their contractors who wanted only to look at what insurers must be mandated to do. Second, the short timeframe for the review did not allow a study of all issues surrounding creating and implementation of these systems, including any cost analysis. Therefore, we must oppose the inclusion of the following recommendations in the report.

Real Time Electronic Adjudication of Claims

We disagree with the recommendation to require electronic administrative transactions related to health care insurance eligibility verification to be compliant with Phase 1 and Phase II of the Committee on Operating Rules for Information Exchange (CORE) compliant no later than three (3) years after the deadline for ICD-10 compliance. While we support the continued development and implementation of the CORE standards, we are troubled with a state specific requirement that opens up questions of who determines compliance and penalties associated with that compliance and forces the expenditure of an unknown amount of premium dollars without a return on investment assessment.

As you know, the health insurance industry is responsible for developing these national rules and is voluntarily moving towards adoption of these best practice guidelines. As in many areas, the marketplace identified the challenges in the system and created a solution that we hope will result in system efficiencies nationwide. However, these standards may change in the future, based on new best practices, and Ohio should not jump to impose these requirements upon a company that has not yet planned for the financial resources needed to implement the needed changes.

The committee also did not receive enough information on the effectiveness and projected utilization by medical providers of real-time adjudication technology. As a result, the Committee's recommendation rushes to impose the burden of an expensive investment in technology that may not be utilized by providers.

Additionally, we raise concerns with process used to vote on this recommendation and those that were involved in its development. The committee heard the testimony of only one expert concerning an operation of a real-time adjudication system. While the presentation Athena Health RTA may have been useful as proof of concept for the underlying technology, the low number of claims processed and the low number of providers using the system indicate that we do not yet have an effective demonstration of a real-time adjudication system that justifies what appears to be a speculative technology investment at this time for some. A system that, by Athena Health's own admission, processed less than 5% of pilot claims and was utilized by less that 1% of participating providers is insufficient to support the Committee's recommendation of mandated compliance. The lack of provider utilization and acceptance of the costs of such a system is troubling considering a much larger share of implementation costs will be born by industry payers and ultimately passed on to consumers.

While the small amount of data to support the Committee's decision is troubling, our concerns are intensified by the process used to make the decision. We believe it was inappropriate to allow a medical provider representative to serve as the Chair of the workgroup that developed this recommendation yet conveniently failed to also include a requirement for providers to use such a system. Additionally, we question allowing voting by vendors that would directly benefit financially from such a mandate and government representatives that are not responsible for the additional costs that the state will also incur from the requirement.

We also believe that the development of the CORE rules must continue and that it should be utilized by the industry. A significant number of industry payers have committed to the utilization of CORE, and are on their way to Phase I and Phase II compliance. We are pleased that the State of Ohio wants to encourage CORE compliance, and we support that position. Nevertheless, mandating CORE is not appropriate.

Dispute Resolution

The dispute resolution committee spent a great deal of time discussing the reasons why information provided on eligibility may be incorrect and therefore result in a dispute after payment has been made. Unfortunately, the group lost focus of the goal which was to create a process for resolving disputes. Instead of considering suggestions made on mediating disputes, the group spent the majority of the time discussing current Ohio laws and ultimately splintered on a recommendation to limit the amount of time a health plan has to recover a payment made in error to a provider for services provided to an individual that was not eligible for those services.

We do not support a proposal to change current laws that provide a balance for dealing with claims that are incorrectly paid. The current law regarding correction of payments was carefully negotiated during the prompt pay legislation several years ago. If there is going to be a change to the current 2-year safeguard time frame that was established at that time, then a much broader discussion needs to occur between the industry, the providers, employers and policymakers about the allowing more time on the front end to make sure the payments are correct at the beginning of the process. We should not be making such recommendations in this study committee without far greater input from interested/affected parties.

We are also confused as to why the group agreed that additional information on "takebacks" was needed to determine the scope of problem yet jumped ahead to a conclusion that Ohio law needed to be changed. During this process, the Ohio Association of Health Plans with input from DOI, surveyed the major health insurers in Ohio to gather data on this issue. The results, which represent companies that provide benefits to over 4 million Ohioans, show that the number of payments made that were later taken back due to an eligibility is approximately 0.19% of payments.
Despite this information, some claim that the actual scale of the problems on recovering erroneous payments is uncertain. If this is the case, then it is imperative that decision-makers understand the extent of the problem before jumping ahead with any policy changes. It is certainly not in the interest of the health care delivery system to pursue a legislative change that may force a new claims system simply to address a relatively small problem.

We appreciated the opportunity to be involved in the discussions of the group and that Ohio is interested in catching up to an issue that is already being discussed and solutions crafted at a national level that involves all stakeholders. However, we do not agree that these two recommendations should be included in the report.

We look forward to continuing the dialogue that has begun on these issues.

Anthem

Ohio Advisory Committee on Eligibility and Real-Time Claims Adjudication
Anthem Testimony
08/27/08

I. Introduction

Madam Chairwoman, members of the Committee, distinguished guests: My name is Pam Jodock and I am the Director of Issues Management for the Public Policy area of WellPoint, the parent company of Anthem Blue Cross Blue Shield. We commend the Committee on the work that it has undertaken and thank you for the opportunity to testify.

Anthem is a member of the WellPoint family of health insurance plans, having merged with WellPoint Health Networks Inc. in 2004. We have been providing health insurance to the citizens of Ohio since 1939 and currently provide coverage to more than three million individuals across the state through our individual, group and Medicare supplement products. Our in-state networks include nearly 10,000 primary care physicians and over 20,000 specialty care physicians.

WellPoint is the nation's largest commercial health insurer, providing coverage to nearly 35 million members. We are an independent licensee of the Blue Cross and Blue Shield Association and offer localized coverage in fourteen states. Our local experience and national expertise create opportunities for collaboration on a variety of programs targeted at improving the quality of healthcare while reducing administrative burdens and making the healthcare delivery system more accessible to all.

It is in this spirit of collaboration, and with a strong commitment to creating a solution that is the most productive and cost-effective for everyone concerned that we offer the following testimony.

Anthem has been asked to address the following areas of interest:

- Activities Anthem is engaged in to facilitate electronic communication with providers
- Challenges Anthem has faced in implementing electronic eligibility verification and real-time claims adjudication
- Recommendations for how the work group may accomplish its goals

Anthem has chosen to begin with our recommendations and the logic behind them. As you will see from our comments, there is a direct correlation between the reasoning for our recommendations to this work group and the principles that guide Anthem's efforts in electronic communications with providers; our principles are based on both our goal to make universal, all-payer electronic access a reality and the lessons we have learned while working with the industry to do so.

II. Recommendations for Work Group

This work group has been assigned a difficult task – to recommend communication standards between providers and payers that will enable a medical provider to send to and receive from any payer the information necessary to allow that provider to determine both the patient's eligibility for benefits at the point of service and to identify what the patient's financial responsibility will be for the services delivered. The good news is that you are not alone in your goals or your efforts to achieve them.

The Workgroup for Electronic Data Interchange (WEDI), American National Standards Institute (ANSI), and the Health Information Technology Standards Panel (HITSP) are examples of some of the many entities currently engaged in developing standards or providing guidance to achieve the functionality you desire. The Blue Cross Blue Shield Association (BCBSA) and America's Health Insurance Plans (AHIP) have also joined the effort. Anthem is involved at some level with all of these organizations. For example, we have a seat on the WEDI Board of Directors and actively participate in WEDI, AHIP, ANSI ASC X12, and HITSP work groups. By basing our shared goals on agreed upon standards, Anthem is working across the healthcare industry to ensure that we have a solid, comprehensive foundation upon which the industry can build its electronic healthcare system. One of the most inclusive approaches is found with the Coalition for Affordable Quality Healthcare (CAQH).

As you learned from their earlier testimony, CAQH is committed through its various initiatives to:

- Promote quality interactions between plans, providers and other stakeholders
- Reduce costs and frustrations associated with healthcare administration
- Facilitate administrative healthcare information exchange
- Encourage administrative and clinical data integration

One initiative facilitated by CAQH, is the Committee on Operating Rules for Information Exchange (CORE). CORE's mission is to bring together healthcare industry stakeholders to create operating rules that help guide the consistent and robust electronic exchange of healthcare information. Such operating rules will allow interoperability to become a reality. The overarching method CORE applies to reach its mission is the promotion of uniformly using national standards that will guide implementation efforts of payers, vendors and providers alike, thus limiting the financial and educational investment required by those who deliver healthcare services. CORE membership involves multiple stakeholders and includes health insurance carriers responsible for providing coverage to more than 75% of the nation's commercially insured population.

CAQH established CORE based on its experience in envisioning, designing and implementing a national health information technology initiative that has gained the critical mass necessary to ensure a positive impact. In 2002 CAQH recognized the industry's need for a uniform standard provider credentialing application process. CAQH responded by creating the Universal Provider Data Source (UPD), which eliminates the need for a provider to submit multiple credentialing

applications if they wish to contract with more than one payer. This service is free of charge to providers and is available in all 50 states and the District of Columbia. In just five years, more than 600,000 providers have registered with the service, and it is continuing to grow at a rate of 10,000 providers per month. According to estimates based on a Medical Group Management Association (MGMA) cost analysis, UPD today is effectively reducing provider administrative costs by nearly $79 million per year[1]. CAQH is applying its experience with UPD and implementing CORE in a phased, stakeholder-driven, cost-effective approach that takes into consideration the processes and strategies that need to be shared by the industry if we are to achieve an interoperable system.

The solutions offered and facilitated by CAQH have the potential to dramatically influence the administrative efficiency and quality of our healthcare delivery system while reducing administrative costs and improving the overall experience of all who encounter it.

An integral part of CAQH's success is an underlying philosophy of working with a comprehensive cross-section of industry stakeholders to achieve the most effective outcome for the stakeholders and the healthcare delivery system as a whole. Rather than competing with other cross-industry collaborations, such as WEDI, ANSI ASC X12 and HITSP, CORE's approach is to work with these organizations to build upon work already begun. For example, CORE is gaining industry agreement on a set of business rules for electronic transaction standards legislated by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). CORE is focusing on gaining agreement on the use of these standards, including the non-mandated aspects of the standards in response to consumer demand, as well as aspects of future HIPAA regulations, such as the eligibility components of HIPAA 5010. Each phase of CORE will bring increased functionality, including the functions your Ohio work group is charged with addressing.

Common among the efforts mentioned above is the idea of national standards and uniform operating rules. It is widely accepted that unique, piecemeal solutions to electronic communications between providers and payers will only serve to further complicate an already fragmented and overly-complex health care delivery system. As we meet today, there are no fewer than fifteen individual state efforts underway to address electronic claims adjudication and eligibility requirements are an integral part of that effort. Imagine the world we would create if the measure of success for each of these groups was to develop its own unique technological solution for delivering this functionality. Now expand this notion to include individual efforts by commercial payers, vendors and provider groups across the nation. This competitive approach to achieving a common goal would result in a technological nightmare for all concerned akin to the world we lived in prior to the implementation of a common claim form. Carriers operating across state lines would have to develop a different system for each state in which they did business; providers who deal with multiple payers would need to purchase a variety of processing tools and train their staff on their use to be able to take advantage of the functionality, and even if those providers mastered the requirements for the state in which they did business,

[1]Medical Group Management Association. "Analyzing the Cost of Administrative Complexity." September 2004. http://www.mgma.com/about/default.aspx?id=280 (08/22/08).

they would be faced with unnecessary challenges when providing care to a patient visiting from out of the area. Focusing the efforts of all of those involved in the healthcare delivery system on the coordination of national standards and implementation of uniform operating rules allows us to pool our economic and intellectual resources, resulting in a more rapid development and deployment of the functionality we seek. It creates an opportunity for vendors to compete on the efficiency of the tools and services they offer while containing administrative costs by allowing payers and providers to invest in only one system. Mike Leavitt, Secretary of the U.S. Department of Health and Human Services, tells the story of an encounter he had with a medical student about to graduate and open his own practice. The young man asked Secretary Leavitt what system he should purchase to be able to offer electronic health records to his patients. "I can only afford to do this once," he said, "and I can't get it wrong." The development of national standards for interoperability ensures that he won't have to worry about either of these issues, not just as it relates to electronic health records, but as it relates to any electronic transaction between himself and a payer.

It is with these thoughts in mind that Anthem respectfully makes the following recommendations to the work group:

1. Rather than developing standards unique to Ohio, call for the support and endorsement of efforts already underway, in particularly those led by CAQH.
2. Encourage the Governor to appoint a representative from the state Medicaid program to participate in CAQH activities.
3. Encourage the state to endorse CORE certification.
4. Encourage the Governor to promote CORE endorsement and certification among his fellow governors through the National Governor's Association.
5. Promote awareness that real-time claims adjudication functionality is not solely dependent on a payer's willingness to offer it. It is a three-legged stool: payers must develop the functionality within their own systems to deliver real-time claims adjudication; vendors must develop tools that will support submission of claims for real-time adjudication; and providers must purchase and use the vendor-developed tools.

III. Related Activities Anthem is Currently Involved In

Anthem takes its responsibility as an industry leader seriously. Following is a partial list of the many activities we are engaged in that are designed to facilitate our electronic communication with providers.

- Received CORE Phase I certification effective March 2007. Functionality associated with this certification includes the ability to provide (real-time static) electronic verification of a patient's
  - Eligibility, including benefit details such as
    - Base contract deductible
    - Co-Insurance/Co-Pay Requirements
    - In- and Out-of-Network Differences

- Expanded real-time eligibility connectivity options that include the ability of providers to access information via the web using HTTP technology;
- Established real-time connectivity with more than twenty national eligibility vendors that currently provide clearing house services to approximately 75% of our contracted providers;
- Partnered with MD-Online to offer CORE Phase I transaction services (listed above) at no cost to Anthem-contracted providers (MD-Online is a service available for provider purchase that allows providers to access information from a variety of payers using a web-based tool);
- Applied CORE certification to all of our Medicaid managed care products (offered in fourteen states);
- Participating in CAQH, WEDI, ANSI, ASC X12 and trade association activities focused on making electronic communications a reality;
- Serving on HITSP, sponsored by HHS and responsible for developing a road map for national standards work;
- Actively promoting endorsement and adoption of CORE standards and certification by our business and trading partners;
- Providing a 1% increase in the fee schedule of primary groups in Northern and Southern Ohio that use e-prescribing and a 2% increase to those who use electronic medical records;
- Scheduled to deliver year-to-date real-time eligibility and patient financial responsibility information, in compliance with CORE Phase II certification requirements, by the end of 2009;
- In the process of evaluating business process and technical functionality to ensure we can deliver real-time claims adjudication functionality when the marketplace agrees upon and establishes a standard operating procedure

Challenges

We understand that developing administrative capabilities similar to those found in the financial industry will reduce costs, improve quality, simplify administrative processes and improve the overall experience of those accessing the healthcare delivery system. We are firmly committed to helping the healthcare delivery system achieve this vision. However, such efforts are not without their challenges.

- Developing this capability is new territory for everyone involved. Technological experts are learning as they go.
- There are few national standards in place to guide our efforts and no agreed-upon road map to help us find our way.
- Claims processing involves a variety of business units – eligibility, benefits, prior-authorization, and privacy, just to name a few; real-time claims adjudication requires immediate coordination of information from a variety of systems.

- Real-time claims adjudication requires payers to transition from business and technological process that currently allow thirty days to process a properly submitted claim to completing the same task in seconds.
- Any functionality we develop must include the ability to meet HIPAA requirements that we track all exchanges of a member's personal health information (PHI). National regulations on PHI are currently being developed; it would be fiscally irresponsible for us to build processes that we know will require almost immediate modification.
- Functionality must provide stringent protections of an individual's right to privacy.
- As a national carrier, offering coverage to employers who may be headquartered in a state like Ohio but who have employees across the U.S., it is imperative to the fiduciary responsibility we have to our members that solutions can be applied across state lines.
- Anthem's history of mergers and acquisitions has resulted in an environment that depends on a variety of different computer systems, none of which were designed with interoperability in mind.
- Enterprise-wide we process nearly 400 million claims a year. Creating a system capable of supporting this volume of activity poses a particularly unique challenge for us.
- Perhaps the biggest challenge of all will be found in the recent announcement of compliance dates for the new HIPAA 5010 standards and the 2011 implementation date for ICD-10. In addition to the technological challenges these provisions introduce to real-time claims adjudication, the effort required to operationalize these requirements will divert critical financial and personnel resources away from what may be viewed as "nice to have" technological advancements towards these regulatory mandates.

Even after all of these challenges are met, real-time claims adjudication will become a reality only after vendors develop the tools necessary to submit claims for real-time adjudication and providers adjust their work flow processes and invest in these tools. It is important to understand that real-time claims adjudication will rely on the electronic submission of the same information standard claims processing requires today, to include identification of proper billing, or CPT codes. Implementation and adoption of real-times claims adjudication will require providers to become conversant not only in the current ICD-9 diagnostic and procedure codes used today, but with an entirely new and significantly expanded set of codes introduced in ICD-10 (from 17,000 under ICD-9 to 155,000 under ICD-10).

IV. Conclusion

There is no question that our healthcare delivery system is in serious need of reform, and each of us in this room has a role to play. The establishment of national standards is a critical first-step in achieving our long-term goals of reducing administrative costs, gaining efficiencies and improving outcomes. It is an effort that requires the active participation of all sectors of the healthcare delivery system. Focusing on a state-specific solution targeting one sector of this very complicated and fragmented delivery system will do a disservice to the members of our communities who are counting on us to work together to identify effective uniform, sustainable solutions. As eager as we are to achieve our goals, it is incumbent upon us to proceed in a deliberate and thoughtful manner that does not underestimate the challenges we face and the regulatory environment in which we are operating.

Again, thank you for the opportunity to contribute to your efforts. I would be happy to answer any questions you may have at this time. Should questions or the need for additional information arise after this meeting, please feel free to contact either of the individuals listed below.

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August 27, 2008

ADVISORY COMMITTEE
ELIGIBILITY AND REAL TIME CLAIM ADJUDICATION

PRESENTATION BY MEDICAL MUTUAL OF OHIO

Distinguished committee members and guests, good morning. My name is Richard Waldron, and I am a Director of Network Management for Medical Mutual of Ohio. I am joined by Beverly Seese and Jason Haines from our Information Technology area, Ken Payne, who manages our Provider Network Policy and Administration group, and Laura Baciu, Medical Mutual's Network Performance Improvement leader.

Medical Mutual is pleased to participate in this meeting today to share our experiences and to help identify and craft improvements to current systems for eligibility determinations and real time claim adjudication pursuant to this committee's mandates. We believe that there are significant opportunities for improvement but that prudence dictates a certain degree of caution so that innovation is not stifled and so that market evolution is permitted to develop in the direction of the best possible results for the communities we serve, including healthcare providers.

Medical Mutual is a mutual insurance company that provides health benefit plans and related services to fully insured and self insured groups and individuals in Ohio and beyond. We provide health benefits administration for more than one and one-half million (1,500,000) covered persons in Ohio alone.

In order to service its customers, Medical Mutual contracts with thousands of doctors and other medical providers (including hospitals, surgery centers, allied-health professionals and ancillary facilities and providers). It processes over 100,000 claims per day that come into the company in both paper and electronic format, some directly from providers but most from billing companies and clearinghouses. These claims run across a wide gamut of services and can be simple or quite complex. A sample of the many issues that might influence claim processing would include:

- Is the claim complete or does it lack necessary information?
- Is the patient a member of a group that has full administration from Medical Mutual or does the group itself determine eligibility and/or coverage?
- Is the claim duplicative of a claim already processed?
- Has the group paid its premium or is the statutory grace period in effect?
- Was the patient a member on the date of service?

Payers like Medical Mutual balance between the "need for speed" and the need to safeguard limited funds to maximize the ability of our customers to afford healthcare. Pursuant to statutory mandate and provider contracts as well as industry convention and

expectations, claims must be processed and paid in a prompt fashion, despite the challenges I listed for you. About 88% of the claims we receive are paid, and approximately 82% of electronic claims (which are a large majority of all claims) pass through the system without pending in any fashion. An average claim goes through our processing system in 5.5 days. Customers meanwhile expect that payers like Medical Mutual are exercising diligence with their healthcare dollars to assure that only Covered Services are paid under their plans, and that inappropriate services and improper or even fraudulent claims are identified without payment being sent. These are not insignificant concerns as the escalating cost of healthcare has dramatic consequences that are widely known to the members of this committee. Fraud alone is estimated by the FBI to amount to between 3% and 10% of all healthcare spending. We must be mindful of systems that impose burdens that will be borne by communities in need of affordable care, and we must be careful not to abandon the mechanisms that allow for identification of improper claims or expired eligibility.

This committee seeks a constructive role in steering the industry toward simpler and more effective eligibility confirmation and real time claims adjudications. These are obviously worthy goals. Let me first address the subject of eligibility confirmation and describe some of the challenges inherent in assuring that consistently accurate information is available to providers when they need it.

Eligibility information is currently available for most of Medical Mutual's customers through a website lookup as well as through a voice response unit (VRU) on a 24-hour-per-day, seven-day-per-week basis. Medical Mutual contracts with Emdeon, a CAQH certified company, to provide web-based eligibility lookup for providers. So what keeps a provider from iron-clad assurance of eligibility for all patients based on looking at the website or checking through the VRU? There are at least 3 main issues:

1. The group could be subject to the statutory grace period for premium payment, meaning that its members are shown as eligible on the date of service but fail to keep eligibility if premiums remain unpaid by the group.

2. The eligibility information that is available through a payer such as Medical Mutual is provided by the customer in most cases. In particular, groups provide names and demographic and benefit information for each subscriber or member. Industry convention allows these groups to retroactively make changes, including after-the-fact notification of members leaving the group or otherwise losing eligibility.

3. The patient might be enrolled with a group that keeps its own membership records, choosing not to have its benefit administrator maintain or track its membership. There are numerous organizations that do not share enrollment with Medical Mutual or their payer/insurer, including a significant number of labor unions and those employers working with a third-party administrator (TPA). In such cases, eligibility verification is quite difficult for the payer to accomplish, if not impossible.

Real time claim adjudication is an even more difficult task to accomplish. The world of healthcare for providers, patients and payers is built upon processes developed over many decades. From a provider perspective, this world involves treatments and services that take place independent of claim preparation, billing and payment. Most claims are not prepared during an office visit or while a patient recovers from a surgery earlier that day. Rather, the provider shares information about his or her services with a billing company or practice manager. That entity prepares claims that are then sent to a clearinghouse which batches large numbers of claims for submission to a payer like Medical Mutual. Staffing and office systems are built upon this batch processing model that, while subject to many criticisms, is efficient in many respects. For example, a physician's office need not maintain expertise on CPT or HCPCS coding. The office can focus more of its administrative energies on patient interaction and clinical information accuracy, counting on its practice managers and billing companies to translate healthcare work into claims data for processing and payment.

Even given these issues, it is clear that providers wish to have the capability to have claims adjudicated in real time, that is while the patient is still in the office. This will provide a greater opportunity to collect patient obligations that are only finalized once a claim is adjudicated. Therefore, over the past year, Medical Mutual has developed a tool that will process claims in real time. We worked with several physician practices that provided us with feedback about their needs and capabilities. These practices are part of a pilot that will begin taking in and processing claims during the week of September 8, 2008.

During our development of this RTCA tool, we identified key obstacles to RTCA that will need to be addressed or they will hinder adoption or use of these tools. These include:

- Provider offices will need to communicate clearly with patients about expectations for payment at the time of service or risk significant patient pushback. Even with such communication, there is likely to be greater friction in provider offices.

- Providers will need to create the organizational framework to code claims at the front desk. This means hiring and training staff to code claims as well as creating systems to submit and track claims episodically rather than in batch fashion as is done today.

- There is some increased risk of improper or even fraudulent claims. This will mean either higher healthcare costs or greater audit and retrospective enforcement activities. In addition, there might be greater risks of HIPPA violations as transactions move into an accelerated process.

- There is enormous variation between benefit plans and their funding and coverage. Plans can be simple in offering basic benefits that are insured by the payer or they can involve complex HRA or HSA arrangements with carve outs for various types of healthcare services. Many of these simply cannot support real-time adjudication at this point.

- Providers are likely to need to continue batch processing of claims that do not fit the RTCA model (e.g. claims that are highly complex that simply cannot be coded at the office). That will mean reduced efficiencies as providers operate on both a real-time and batch basis.

- Until practice management systems are integrated with RTCA, offices will need to do double entry for claims that go through RTCA systems. Thus, an office visit for Mr. Brown will involve an office worker typing information about the services into the RTCA system to submit the claim and then retyping much of the same information about Mr. Brown and his treatments into the practice management system to track everything from patient records to payment or collection.

With the challenges around eligibility lookup and RTCA in mind, we naturally ask whether it would help to have a uniform set of standards by which to conduct these activities. In particular, I understand that this committee is interested in Medical Mutual's position regarding the so-called CORE Standards promulgated through the Council for Affordable Quality Healthcare (CAQH). These transaction standards and rules appear to be a positive step toward the goal of simplification and consistency. They are likely to encourage the development of multi-payer platforms which are essential to assure that web-based eligibility lookup and RTCA achieve their fullest potential benefit for healthcare providers and for the healthcare system as a whole. Without a multi-payer approach, these systems are likely to serve as fairly narrow tools that address only a small range of the issues confronting providers. Whether CORE standards are the only approach or the best possible standard can only be determined over time, but Medical Mutual's view of CAQH's CORE Standards is favorable. We are currently undertaking a review of whether to commit fully to the CORE Standards at this time as we previously did with respect to CAQH's credentialing processes. However, we should not see uniformity as a panacea, and the best standards will not erase the many difficulties in seeking to balance the need to act quickly on behalf of providers and members versus the need for prudence with limited healthcare dollars in a system that counts cost as a major, if not THE major, problem.

Medical Mutual is committed to playing a constructive role to make the healthcare system simpler and more effective for providers and patients. We believe that a government mandate is unwarranted and could severely hamper the development of eligibility and claim processing innovations. In addition, we would be concerned if any single state were to seek to establish the direction for technology through mandate. That said, however, we also believe that sharing information and ideas can allow even greater

process improvements, and we welcome this committee's contributions to the effort to make healthcare better and more affordable.

Thank you for your time and attention. I would be happy to respond now to any questions you might have.

Data Element Comparison

HB125 – *For Discussion Only*

HIPAA Background:

Under the current HIPAA Standard Version 4010A1, the minimum requirements for compliant 270/271 eligibility transactions are as follows:

1.) An information source (payer) must support a "generic" request for eligibility;
2.) The information source (payer) must respond to those eligibility requests only with an acknowledgment that the individual has active or inactive coverage or is not found in their system.

This equates to a response (if the person is found) of "yes" or "no" the person has coverage. First name, last name, date of birth, and member identification number represent the maximum set of data elements that can be required to identify a patient. If these four elements are provided to the payer, a search must be conducted and if the patient is found, a response generated.

The 270/271 is a paired transaction set; the 270 is an eligibility inquiry from an information requestor (provider) and the 271 is the response to that inquiry from the payer. The standard eligibility transaction itself is *capable* of providing much more detailed information than the requirements listed above. While both HIPAA and CORE encourage as elaborate/specific as possible a response to an eligibility inquiry, the baseline CORE requirements are more extensive than the above noted HIPPA mandated minimum response.

CORE Background:

As stated above, the baseline CORE requirements for the 270/271 are more extensive than the HIPAA mandated response. CORE was formed with a short term goal of facilitating a more definitive exchange of electronic healthcare eligibility information (i.e., more robust and consistent) through the use of operating rules. This is done through a voluntary, consensus based process using the HIPAA mandated transactions as a foundation. CORE's long term goal is to apply operating rules to other HIPAA transactions including the 837 which is also a focus area for the Ohio HB125 Committee.

Data element comparison between CORE and HIPAA v4010A1

The charge of the Ohio Advisory Committee on Eligibility and Real Time Claims Adjudication (RTCA), in part, is to consider including the attached data elements (see table below) in the scope of information that must be made available in eligibility and real time adjudication transactions. However, the paired nature of the eligibility transaction and the broadness of the HB 125 wording as to how the data elements are to be addressed lends itself to a certain degree of interpretation.

An underlying CORE guiding principle is that any CORE-certified entity is HIPAA compliant. Although CORE does not test for HIPAA compliance, entities undergoing CORE certification must sign an attestation form affirming, from an executive level, its compliance with the most current version of HIPAA. Therefore, any element addressed by HIPAA is automatically a CORE requirement whether or not it is specifically addressed in the CORE operating rules. Current CORE operating rules (Phase I and Phase II) are focused on the eligibility (270/271) and claim status (276/277) transactions.

Data Element Comparison

HB125 – *For Discussion Only*

Data Element Comparison:

Usage requirement as defined by the 4010A1 Implementation Guide:

- **Required** = the element must be used to be HIPAA compliant. Denoted in the table below as **(R)**
- **Situational** = the element is not required but should be sent if the data is available. Denoted in the table below as **(S)**

Data Element Category	HB 125 Data Element	Addressed by:		Explanation	
		HIPAAv4010A1	CORE	HIPAA v4010A1	CORE
Patient Information	**Name**	R*	(HIPAA + other items)	*These data elements are addressed by HIPAA in terms of searching and patient matching. See background information above regarding required search data elements.	CORE does not address the usage of these patient identification data elements in terms of searching and patient matching. However, CORE Phase II rules do address mechanisms for improving matching the submitted patient's last name by the payer's system and enhanced error reporting to the provider when a match cannot be made.
	DOB	R*	(HIPAA + other items)		
	Member ID	R*	(HIPAA + other items)		
	Coverage Status	R	(HIPAA + other items)	Required to be returned by payer in response to a generic inquiry if the patient is found in the system.	Required by CORE to be returned in the response to a generic inquiry along with patient liability, including remaining deductible amounts for both the health plan and 9 other service types.
	Patient's relationship to subscriber	S	S	Situational - used only if the patient is a dependent and cannot be uniquely identified by a payer-assigned member identifier.	As stated in the Background section, CORE-certified entities attest to being HIPAA compliant and so the same 4010A1 implementation guidelines would apply to how

Data Element Comparison

HB125 – *For Discussion Only*

Data Element Comparison:

Usage requirement as defined by the 4010A1 Implementation Guide:

- **Required** = the element must be used to be HIPAA compliant. Denoted in the table below as **(R)**
- **Situational** = the element is not required but should be sent if the data is available. Denoted in the table below as **(S)**

Data Element Category	HB 125 Data Element	Addressed by:		Explanation	
		HIPAAv4010A1	CORE	HIPAA v4010A1	CORE
					CORE-certified entities handle this data element.
Payer Information	**Payer**	R	R	***Note**: Payer data elements are typically outlined in a payer's companion guide. Companion guides serve to supplement the v4010A1 Implementation Guide.*	The CORE 152 Eligibility and Benefit Companion Guide Rule was designed is to reduce variation in payer companion guides by specifying a template for common flow and content. Payer Contact information is a category within this template.
	Payer's contact name	S	R	This is situational usage.	
	Payer's contact telephone	S	R	This is situational usage.	
	Payer address	S	R	This is situational usage.	
	Insurer			***(?)** The intent of these data elements is unclear. For the most part, these elements are synonymous with the Payer information.*	
	Issuer				
	Administrator				
Subscriber Information	**Subscriber name**	R	R		There is no specific CORE rule requiring the use of the Subscriber's name. However, as stated in the Background section, CORE-certified entities attest to being HIPAA compliant and so the same 4010A1 implementation guidelines would apply to how CORE-certified entities handle
	Address	S	S	Per HIPAA, use of this data element is required ***if*** the transaction is not rejected and address information is available from the information source's database.	

Data Element Comparison:
Usage requirement as defined by the 4010A1 Implementation Guide:

- **Required** = the element must be used to be HIPAA compliant. Denoted in the table below as **(R)**
- **Situational** = the element is not required but should be sent if the data is available. Denoted in the table below as **(S)**

Data Element Category	HB 125 Data Element	Addressed by:		Explanation	
		HIPAAv4010A1	CORE	HIPAA v4010A1	CORE
					this data element.
Benefits Information	**Type of service**	S	R	Per HIPAA, a payer is required to return ONLY whether or not the patient has health plan coverage. No other information about such coverage is required to be returned in the response. There are more than 140 service type codes in v4010A1 which identify the classification of service about a particular service. Usage in v4010A1 is situational.	CORE requires a payer to return information for 48 service types depending on what service type was included in the inquiry from the provider. CORE requires comprehensive benefits information for each service type be returned by the payer, including patient liability, remaining deductible, in/out of network coverage.
	Type of health plan or product	S	R	This is situational usage.	CORE requires a payer to return the name of the health plan if this information is available.
	Effective date of healthcare coverage	S	R	This is situational usage.	CORE requires that a payer return the date on which active healthcare coverage is operational and in force.
	Co-payment	S	R	This is situational usage.	CORE requires this data element for a specified set of benefits, some of which are at the discretion of the information source. ***NOTE:*** *CORE rules set minimums and so returning*
	Patient liability for a proposed service	S	R	This is situational usage.	

Data Element Comparison

HB125 – *For Discussion Only*

Data Element Comparison:

Usage requirement as defined by the 4010A1 Implementation Guide:

- **Required** = the element must be used to be HIPAA compliant. Denoted in the table below as **(R)**
- **Situational** = the element is not required but should be sent if the data is available. Denoted in the table below as **(S)**

Data Element Category	HB 125 Data Element	Addressed by:		Explanation	
		HIPAAv4010A1	CORE	HIPAA v4010A1	CORE
					more information than required by CORE is not prohibited.
	Individual deductible	S	R	This is situational usage.	CORE requires this data element for a specified set of benefits, some of which are at the discretion of the information source. CORE rules specify base contract amount in Phase I and remaining amount in Phase II. Refer to NOTE above.
	Family deductible	S	R	This is situational usage.	
	Benefit limitations and maximums	S	TBD Phase III	This is situational usage.	*These data elements are under consideration for CORE Phase III.*
	Policy maximum limits	S	TBD Phase III	This is situational usage.	
	Precertification or prior authorization requirements	S	TBD Phase III	This is situational usage only. *Although the Eligibility 270/271 Transaction can be used to identify whether or not referral and/or prior authorization is required for patients, prior authorization of services is explicitly defined by a different HIPAA transaction (ASC X12N 278 - Referral Certification and Authorization transaction),*	*Operating rules for the 278 transaction are being considered for inclusion in CORE Phase III.*

Data Element Comparison

HB125 – *For Discussion Only*

Data Element Comparison:

Usage requirement as defined by the 4010A1 Implementation Guide:

- **Required** = the element must be used to be HIPAA compliant. Denoted in the table below as **(R)**
- **Situational** = the element is not required but should be sent if the data is available. Denoted in the table below as **(S)**

Data Element Category	HB 125 Data Element	Addressed by:		Explanation	
		HIPAAv4010A1	CORE	HIPAA v4010A1	CORE
				which must be used for this specific purpose.	
	The health benefit plan coverage amount for a proposed service			***(?)*** *If this data element is analogous to the provider reimbursement amount, the current implementation of the 270/271 standard is not designed to accommodate this information. If this is a reference to patient liability for a proposed service see "*Patient liability for a proposed service*" data element listed above.*	

Availity Presentation
Ohio Department of Insurance

Advisory Committee on Eligibility and
Real Time Claims Adjudication

availity
Patients. Not paperwork.

Agenda

- Availity Background
- Five Most Frequently Asked Questions About Availity
- Availity and HB 125
- Administrative Solutions
- Clinical Solutions
- Financial Solutions
- Patient Self Service Strategy
- Technology
- Summary

Availity Background

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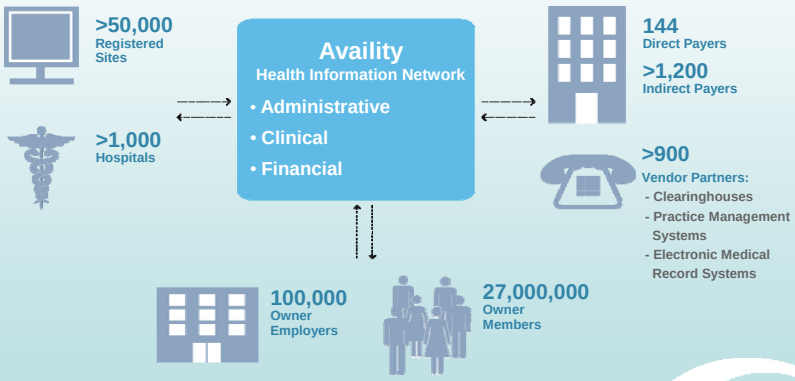
The Availity Perspective

- **Availity's mission is to be the premier health information exchange connecting payers and providers in Availity's targeted geographies.**
- **Our goals are your goals:**
  - **Reduce administrative costs**
  - **Improve relationships between payers, providers, employers, patients**
  - **Use technology to improve workflow**
  - **Foster innovation and speed to market**
  - **Improve the quality, safety, and affordability of health care**
- **"Availity is one of the best kept secrets in health care. But it shouldn't stay that way. Much of health care remains in the dark ages technologically, and the success that Availity has had in Florida alone, where virtually every doctor and hospital is connected, should be a model for others to follow."**
  - **Newt Gingrich, Founder, Center for Health Transformation**

Availity: Connecting Communities

More than 500 million annual transactions



Ownership and Financials

- Availity, L.L.C. is an independent company formed as a joint venture between BCBSF and Humana in February 2001
- Health Care Service Corp. (HCSC) joined as an owner in 2006
- Availity is cash-flow positive and profitable
- Availity returned 100% of the owners' original investment
- Availity has reduced transaction costs every year
- Availity is processing more than 500 million administrative, clinical, and financial transactions

Products and Services

Administrative Solutions

- Claims clearinghouse
- Real-time transactions
  - Eligibility and Benefits Inquiry
  - Claim Submission
  - Claim Status Inquiry
  - Remittance
  - Authorization and Referral Submission and Inquiry
- CareRead℠ – member ID card processing (replaces data entry)

Financial Solutions

- CareCost Estimator℠ – real-time patient responsibility estimation
- CareCollect℠ – combo ID, debit card, credit card, check processing

Clinical Solutions

- CareProfile℠ – real-time electronic health records
- CarePrescribe℠ – new prescriptions and renewals

 *Future availability 7

Availity Solution Principles

- Provide standard transactions at no or minimal cost to providers
  - Receive payment from partners (e.g., payers)
  - Optional value-added services are offered to providers for a charge
- Provide administrative, clinical, and financial information exchange on a regional basis
- Support web, business to business (B2B), and electronic data interchange (EDI) transaction options
- Support a federated, real-time data model
- Support HIPAA compliance and industry standards, such as ASC X12, HL7, and Continuity of Care Record (CCR)
- Invite payers, vendors, and other constituents to join Availity

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Product Traction

Administrative Solutions

- **Health Plan Transactions: Launched February 2002**
  - >40K sites | >500M annual transactions
- **CareRead℠: Launched May 2007**
  - >7,500 card readers to >4,600 sites | >182,000 life to date transactions
  - >3,978,000 ID cards

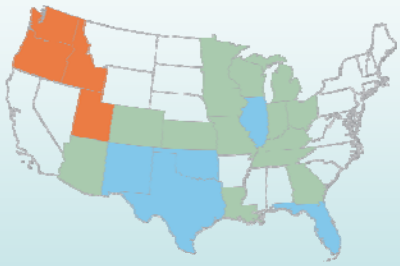
Financial Solutions

- **CareCost Estimator℠: Launched July 2006**
  - >3,500 sites | >216,200 life to date transactions
- **CareCollect℠: Launched February 2008**
  - 58 sites | >2,160 life to date transactions

Clinical Solutions

- **CareProfile℠: Launched September 2007**
  - >5,000 sites | >53,000 life to date transactions
  - <1% of members opted out
- **CarePrescribe℠: Launched June 2008**
  - 10 sites

Availity State Presence



- **Florida**
  - 95% market share; 100% of hospitals
  - ~5,000 CareRead and ~12,000 CareProfile sites
- **HCSC**
  - ~16,000 sites migrated in less than 12 months
  - >9,000 sites submitting portal transactions
- **The Regence Group**
  - 3M transactions per month; 1,800 sites
  - BlueExchange portal
- **States with significant activity**
  - More than 100,000 transactions per month
- **All other states**
  - Less than 100,000 transactions per month

Five Most Frequently Asked Questions About Availity

1. How does it work having competitors as owners?
2. How does Availity reduce cost to the health care system?
3. Where does Availity fit in HIT?
4. What is Availity's clinical strategy?
5. What's next for Availity?

1. How does it work having competitors as owners?

Actually, it works quite well.

- **Payers have same fundamental objectives**
  - Reduce cost, not attach toll
- **Shared multi-payer philosophy**
  - Failed single-payer investments
  - Providers demand multi-payer
- **Critical mass necessary to gain wide adoption**
  - Adoption creates distribution channel for additional services
- **Collaboration increases visibility**
  - Not a place for payers to compete
  - Everyone is looking for leadership over self-interest

The Results Are Clear

- Availity market presence
  - More than 40,000 registered office locations
  - More than 500 million transactions annually
  - Conducts business in all 50 states
- More than 27 million owner members benefit from Availity services
- Third largest claims clearinghouse in country
- Largest submitter to the BlueExchange
- Administrative, financial, and clinical services in production today
- No re-capitalization required; original investment repaid
- Profitable since 2004
- Over 600 unique sites in Ohio

Leader in Real-Time Claims Adjudication (RTCA)

- Payer Adjudication Rates – Professional Claims
  - Payer 1: ~75% of claims submitted via web or B2B are adjudicated in real-time
  - Payer 2: ~60% of claims submitted via web or B2B are adjudicated in real-time
  - Payer 3: ~45% of claims submitted via web (this payer does not offer B2B) are adjudicated in real-time
- In 2007, >4,600 sites submitted real-time claims through Availity and received real-time adjudication responses from payers
- Member responsibility calculator provides solution for payers that don't yet support RTCA
  - Single-payer RTCA will not achieve adoption goals

2. How does Availity reduce cost to the health care system?

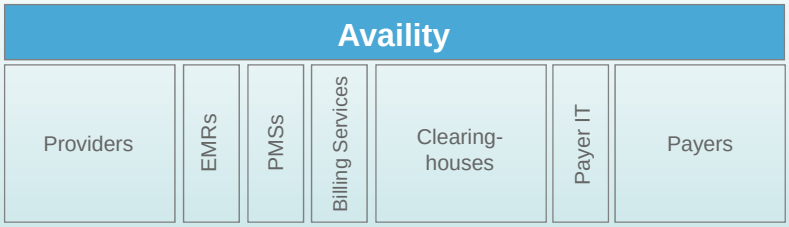
- Savings is our top goal, not profit maximization
- Rapid market penetration is achieved by not charging providers, offering simple registration, and partnering with payer staff
- Alternative channels – paper/phone calls – are much more expensive for payers, providers, and patients
- Use of the Availity portal creates a platform for everything that follows – clinical, financial, pay for performance (P4P), etc.
- Proven financial model; consistent financial results

Quantified Benefits – Payers and Providers

- Payer reduced EDI costs by $2M annually
- Payer obtained call center savings of more than $1M per year with real time portal in multi-payer environment
- Payer achieved 33% cost reduction in deployment and vendor management
- Payer increased electronic claim submission rate from 71.34% to 79.88%
- CareProfile℠ – saves physicians 3-6 minutes per assessment; duplicative lab tests avoided
- CareRead℠ – Reduced user correctible errors by 75%; 66% of offices reported reduced calls to health plans

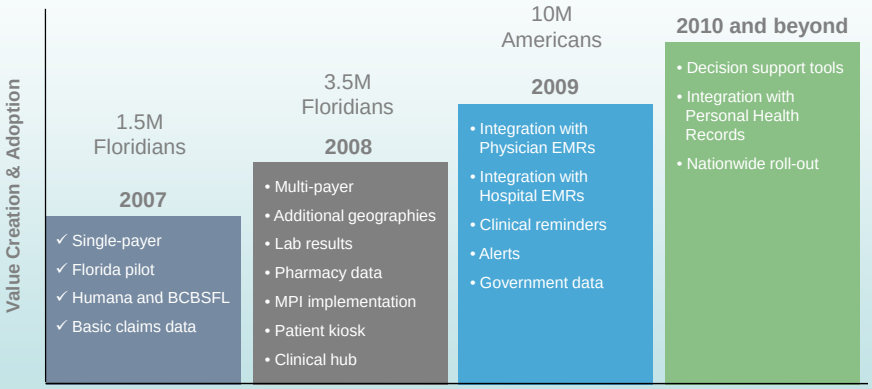
3. Where does Availity fit in HIT?

Availity believes in working within the existing system, not against it



- **Partnership achieves mass adoption**
- **Leverage owner and payer relationships**
- **Rebates**

Availity CareProfile Evolution



5. What's next for Availity in 2008?

- User interface and web framework improvements
- Reporting enhancements
- Claim attachments (medical records)
- Claim reconciliation and settlement
- Clinical hub
  - CareProfile℠ enhancements – electronic health records
  - CareLab℠ – lab orders and results
  - CarePrescribe℠ – electronic prescribing
  - Medication reconciliation (JCAHO)
- Patient self-service kiosks
- RHIO and state HIE connectivity
- Geographic expansion

Availity and HB 125

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Availity and Advisory Committee on Eligibility and RTCA

- Availity has advised and sat on similar committees including
  - Texas HB 522
- Availity currently offers services being discussed in HB125 in Ohio
- Co-opitition among health plans in this space
- Availity is already deeply involved with current standardization groups
  - CORE
  - WEDI
  - X12
  - HIPAA

Administrative Solutions

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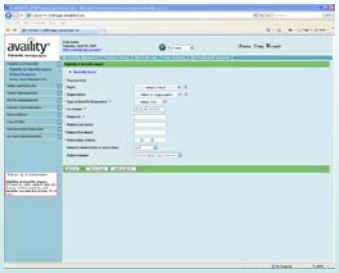
Health Plan Transactions

- **HIPAA compliant transactions with multiple health plans**
  - Eligibility and Benefits
  - Authorizations and Referrals
  - Claims
  - Claim Status
  - Remittance
- **Information is shared in real-time**
- **Edits ensure data accuracy**
- **Helps improve accounts receivable**
- **Offered to providers at no charge**
- **Available nationwide**



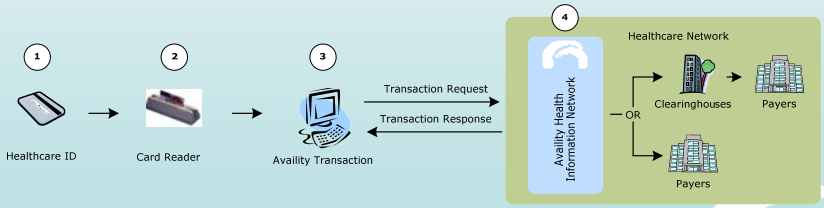
Health Plan Partners

- **Web Transactions**
  - Aetna
  - America's Health Choice*
  - AvMed*
  - Blue Cross and Blue Shield of Arizona, Florida, Illinois, New Mexico, Oklahoma, Texas*
    - All Blue Plans Nationwide (through local plan)
  - Capital Health Plan*
  - CarePlus*
  - CIGNA
  - Citrus Health*
  - Florida Hospital Healthcare System*
  - Great-West Healthcare
  - Humana
  - Leon Medical Center Health Plan*
  - Medicaid*
  - Medicare*
  - METCARE*
  - Physicians United Plan*
  - United Healthcare
  - Vista Healthplan*
  - WellCare
- **EDI Transactions**
  - More than 1,300 health plans

*Available in certain regions only

CareRead℠

- Reads information on member ID cards through a card reader connected to the computer
- Automatically populates the information on the Availity transaction page, eliminating the need to key the information
  - Eligibility and Benefits and CareProfile currently supported
- Streamlines workflow and helps to avoid data entry errors
- Offered to providers at no charge



CareRead℠ Benefits

- Payer
  - Increased provider satisfaction
  - Increased member satisfaction
  - Increased adoption and utilization of Availity portal
  - Decreased phone calls
  - Decreased user-correctable errors
- Provider
  - Simplified administrative transactions
  - Reduced direct data entry
- Member
  - Increased member responsibility accuracy
  - Reduced wait time

CareRead℠ Deployment Status

- More than 3 Million health care ID cards have been deployed between BCBSF, Humana, and United Healthcare
- Availity has deployed more than 8,000 card readers to more than 5,000 sites
  - Coordinated deployment of more than 6,000 card readers and shared card reader expense with BCBSFL, BCBSTX, Humana, and United
  - BCBSTX is piloting CareRead in Austin, Texas
  - Providers have purchased more than 1,700 card readers
- Other national payers have expressed strong interest in supporting Availity CareRead
- Collaborated with WEDI to set industry standards for health care ID card track 3 data format

Future Administrative Services

- Claim Attachments
  - Support solicited delivery of claim electronic attachments
- Claim Reconciliation
  - Support claim search, summary claim results, and detail drill-down
  - Enable real-time electronic remittance advice (ERA) search, view, and print
- Reporting Enhancements
  - Refine clearinghouse reports
  - Enhance ad-hoc reports

Clinical Solutions

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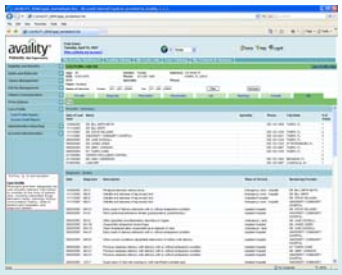
CareProfile℠

- **Real-time payer-based health records**
  - Office visits and hospitalizations
  - Diagnoses and associated procedures
  - Prescription history
  - Lab event history
  - Lab results
  - Radiology event history
  - Immunization history



- **Currently sourced from claims information, which resides with the health plans**

CareProfile℠ Benefits

- Provides information about patients when little information is available
  - First time patients
  - Emergency visits
  - Post hospital discharge
  - Natural disasters
- Other benefits include
  - Improves coordination and continuity of care
  - Improves patient safety and sense of security
  - Eliminates duplicate, and reduces unnecessary, procedures
  - Protects against fraud
- Offered to providers at no charge

CareProfile℠ Deployment Status

- Generally available in Florida
  - More than 12,000 sites enrolled; estimated 36,000 physicians
  - More than 3.5 million members statewide included
  - High member acceptance – only 0.81% members opted-out
- High satisfaction with functionality and data quality
  - Physicians like having access to treatment information from other providers
  - Surveyed customers find it easy to use and 100% would recommend to colleagues
- Will deploy in Texas this summer, followed by New Mexico and Oklahoma

CarePrescribe℠

- **Comprehensive E-Prescribing, Powered by Prematics**
  - Easy to use "consumer oriented" design
  - Enables new prescriptions and renewals from physicians to pharmacies
  - Supports generic alternatives, drug to drug interactions, and fraud and abuse checking
  - Prescriptions securely transacted over Prematics' private, end-to-end network\
  - All-inclusive service eliminates cost and technology barriers to physician adoption
  - Prematics recruits, deploys, trains, and continually monitors and supports practices
  - Absolutely no charge to practices in participating payer networks
- **Web and handheld Workflow**
  - Web: Availity portal access includes live web-based set-up assistance and training
  - Handheld: In-office technology set-up and training. Equipment includes PDAs, thermal Rx printer, controller box, and broadband connectivity.

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CarePrescribe℠ – Physician Benefits

- **More Informed Decisions**
  - Patient-specific Rx history
  - Patient formulary and co-pay
  - Adverse drug alerts
  - Lower cost alternatives
  - Coverage alerts (e.g., step therapy)
- **Practice efficiencies**
  - Reduce pharmacy callbacks, rework
  - Streamline fills and renewals
  - Lower administrative costs
- **Improved patient care**
  - Enhance patient safety
  - Lower patient out-of-pocket costs
  - Less pharmacy hassle
- **Security and Reliability**
  - HIPAA compliant
  - Protect patient information
- **No Technology Hassles**
  - PDAs fully-loaded with CarePrescribe
  - Installation and training provided
  - No physician cost or troubleshooting

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CarePrescribe℠ – Payer Benefits

- **Decreased Costs**
  - Increase generic utilization
  - Reduce unnecessary medical costs
- **Improved Safety**
  - Legible, accurate prescriptions
  - Present clinical safety messaging
- **Enhanced Physician Relations**
  - Workflow efficiency
  - Reduced administrative hassle
- **Greater Member Satisfaction**
  - Lower member out of pocket costs
  - Less delay and care disruption
- **Acquisition and Retention**
  - Distinct product differentiation
  - Competitive cost and premiums

CarePrescribe℠ – Payer Advantages

- **No Upfront Costs**
  - Transaction-based fees reduce payer financial risk
- **Tailored Services**
  - Coordinated with existing clinical programs
  - Targeted physician and patient messaging
- **Complete Physician Solution**
  - Fully-installed hardware, software, and connectivity at no cost to practices
- **Intuitive Design**
  - Sleek simplicity maximizes physician adoption and long-term utilization
- **Clinical Decision Support**
  - Fast, reliable access to real-time information eliminates clinical “blind spots”
- **End-to-End Network**
  - Prematics’ network connects physicians to all points in the prescribing process
  - Continual monitoring enables proactive support
- **Insights and Reporting**
  - Real-time insight and reporting at the prescriber-level

CarePrescribe℠ – Deployment Status

- **CarePrescribe launched in Florida Summer 2008**
  - Payer support from Blue Cross and Blue Shield of Florida and Humana
  - Limited initial deployment to 20 practices in Miami
  - General deployment will begin in late July to early August
- **Regional deployment model to drive mainstream penetration**
  - Current 2008 Markets: Miami and Tampa, Florida (currently underway)
  - Subsequent deployment planned for Texas
- **Prematics covers up-front costs of deployment including**
  - Regional office to recruit, deploy, and support CarePrescribe practices
  - For the handheld service, hardware, software, and network connectivity provided
  - Training and "high-touch" support by dedicated product specialists

Future Clinical Services

- **CareProfile℠ Enhancements**
  - Utilize Master Person Index (MPI) to retrieve data from multiple sources
  - Retrieve information from additional data sources (e.g., labs, RHIOs)
  - Support medication reconciliation, which assists with JCAHO requirements
  - Support B2B connectivity
- **CareLab℠**
  - Serve as a lab information hub
  - Facilitate lab order submission and result retrieval with multiple laboratories on the portal

Financial Solutions

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Financial Solutions Overview

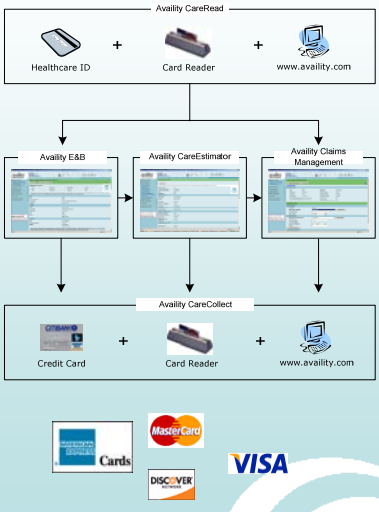
- **Drivers**
  - Rising cost of health care / premiums
  - Adoption of high deductible plans (e.g., HSAs)
  - Provider bad debt crisis
- **Member Responsibility Identification**
- **Payment Collection**
- **Payment Assurance**
- **Payment Reconciliation**
- **Provider Workflow Enhancements**

CareCost Estimator℠

- Helps determine a patient's financial responsibility
  - Based on member benefits, deductibles, provider contractual allowances, and benefit maximum accumulators at the time of inquiry
- Collect the patient's responsibility at the time of treatment, reducing accounts receivable
- Offered to providers at no charge

CareCollect℠

- Process credit and debit transactions
- Turn paper checks into electronic transactions
- Set up recurring payments for repeat patients or installment payment plans
- Void and credit payments
- Perform end-of-day settlements
- Run customized reports
- Can replace existing point of sale device



CareCollect℠ Benefits

- **Payer**
  - Increased provider satisfaction; increase member satisfaction
  - Decreased phone calls
  - Decreased user-correctable errors
  - Aligns with member responsibility calculators and real-time claim adjudication
- **Provider**
  - Simplification of payment processing; reduction in direct data entry
- **Member**
  - Resolves member responsibility at the point of care

Future Financial Services

- **Patient Kiosks (supports administrative, clinical, and financial)**
  - Enable patient self-service
  - Automate data collection
- **Claim Settlement**
  - Enable auto-posting of electronic remittance advices (ERAs)
  - Integrate CareCollect to support patient settlement with cards on file
  - Centralize the ERA and electronic funds transfer (EFT) registration for multiple payers

Patient Self-Service Strategy

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Self-Service Observations

- **Self Service Channels**
  - Point-of-sale device (consumer facing)
  - Kiosk
  - Portal
- **Types of Interaction**
  - Collect Information
  - Collect Payment
  - Provide Information
  - Capture Signature/Consent

Patient Self-Service Benefits

- **Payer**
  - Improved provider and member satisfaction
  - Reduced customer service calls
  - Increased auto-adjudication rates
  - Increased real-time claim adjudication adoption
  - Support member-facing initiatives
- **Provider**
  - Reduced paperwork; increased efficiency
  - Reduced costs
  - Maximized throughput
  - Improved revenue cycle management
  - Improved patient satisfaction
- **Member**
  - Convenience
  - Faster service

Technology

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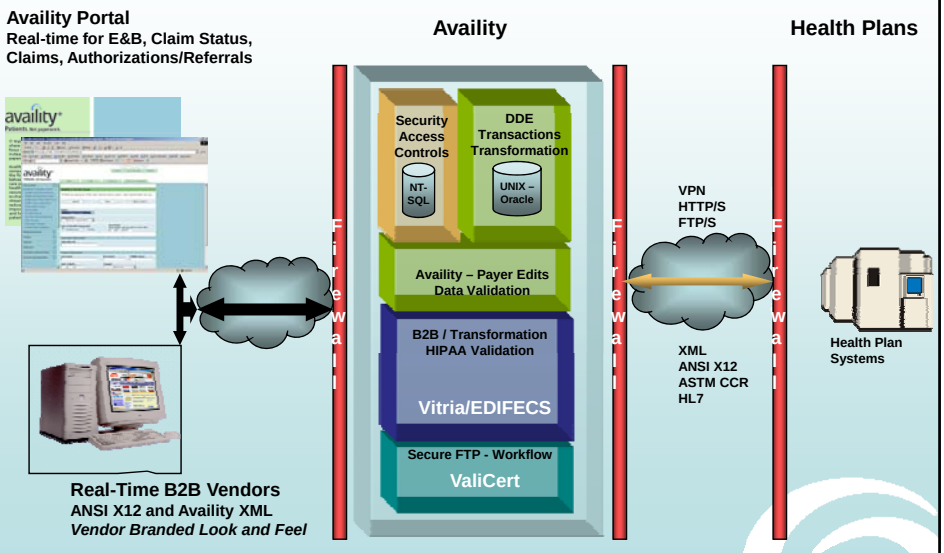
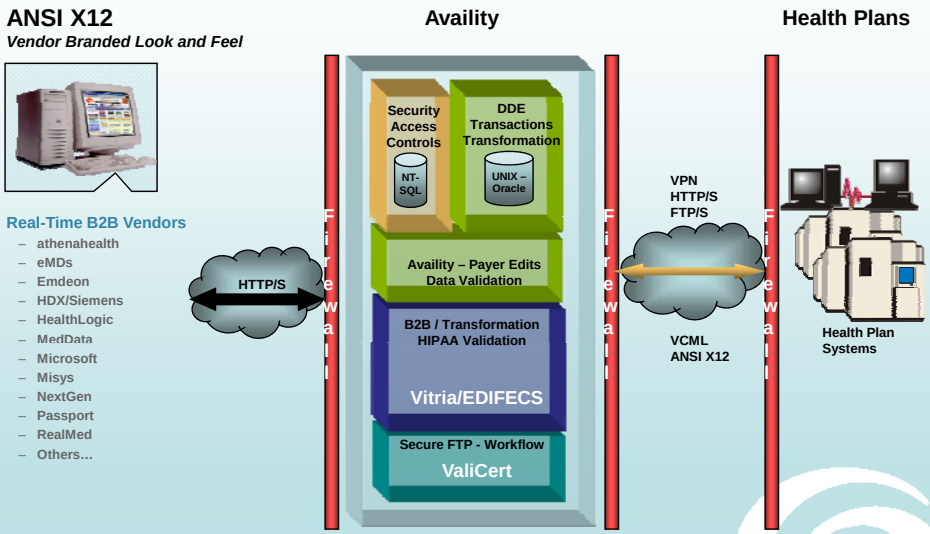
Technology and Product Principles

- Support privacy and security
  - Arguably the number one issue/topic regarding health care technology
- Support federated data services
- Seamless integration with existing systems
- Standards based compliance
- Designed for usability and workflow
- Single sign-on authentication and authorization
- Real-time performance and scalability
- Component based technology
- Open connectivity platform
- Self-service oriented

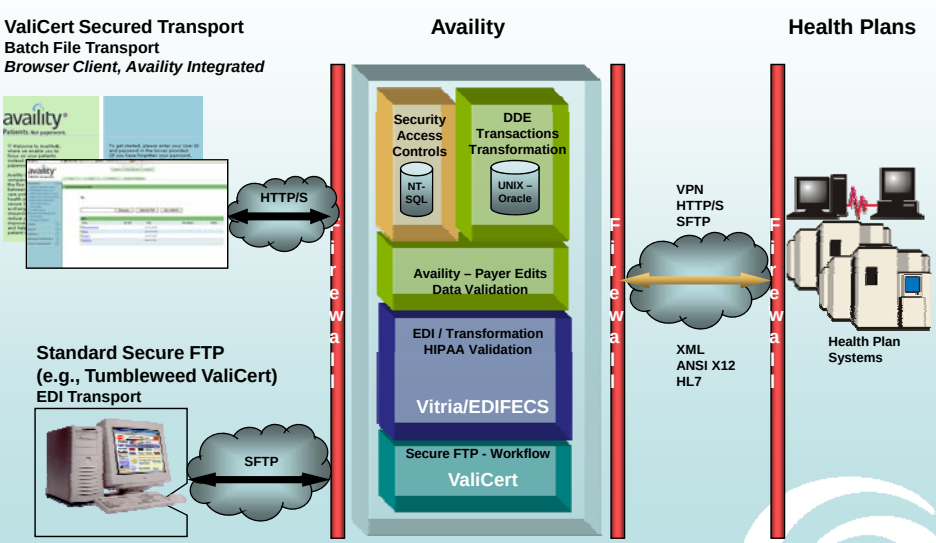
Web Architecture



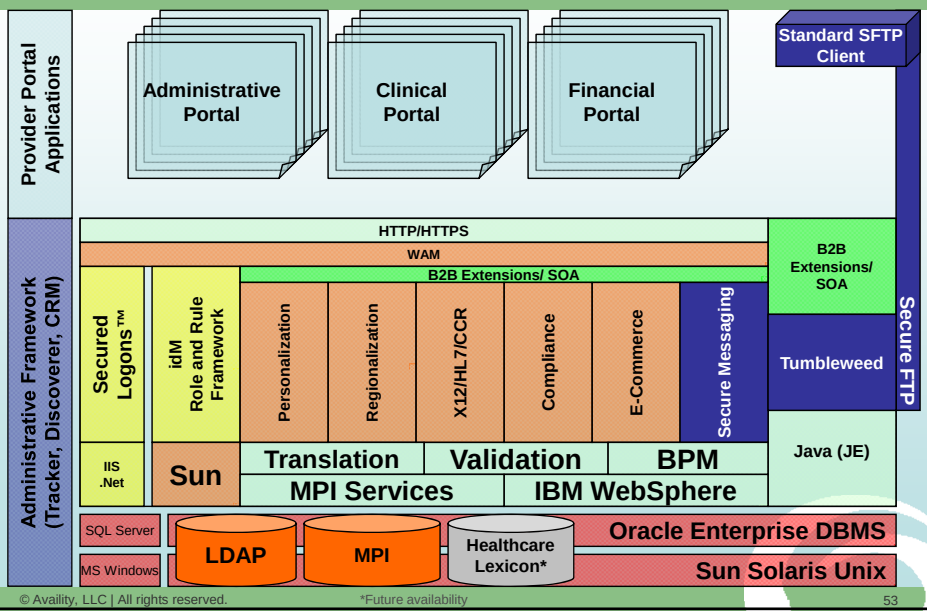
B2B Architecture



EDI Architecture



Platform Technology Stack



 *Future availability

Our Payer Throughput

Payer	Transaction Type	Average Response (Seconds)	Transactions/Hour (Single Thread)
Payer A	Web	4.77	755
Payer B	Web	5.22	690
Payer C	Web	5.51	653
Payer D	Web	3.22	1118
Payer E	Web	3.30	1090
Payer F	Web	14.38	250
Payer G	Web	1.31	2748

- Multiple threads are allocated to each payer
- This represents payer throughput as it relates to response time

Summary

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Availity is a Platform for Growth

- We have proven that we can efficiently handle large, complex projects and migration
  - BCBSF clearinghouse consolidation
  - Humana clearinghouse consolidation
  - HCSC integration
  - THIN migration
- We have proven that we can scale our technology
- We have proven that we can innovate and introduce new services every year
- We have a proven financial model that supports growth and significant R&D
- We have grown both organically and through M&A

Why partner with Availity?

- Availity is an “industry” solution, not a niche player – we support all aspects of the health care value chain
- Our mission is to reduce costs, waste, and friction in the US health care system
- We have repeatedly proven that we can enter a market and gain mass adoption
- We work to make the system better, not to attach a toll to every transaction
- In helping providers and payers work better together, they can better serve patients
- We have been able to lower costs to our owners every year
- We have a strong management team with proven track record

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Availity, L.L.C.

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3306-2-03 **Best practice standards.**

For purposes of this chapter, best practice standards require:

(A) All health care plans offered to employees by a school district shall include a wellness or healthy lifestyle program.

(1) The required components of an acceptable wellness or healthy lifestyle program under this rule specifically include but are not limited to:

(a) Conducting an initial evaluation of historical claims experience if available to specifically identify health conditions that are modifiable and preventable through health improvement, health management, and patient compliance.

(b) A personal health assessment tool capable of providing an accurate and comprehensive baseline of population health status. The personal health assessment must:

(i) Be available in multiple formats including both online and paper media;

(ii) Be reasonable in length;

(iii) Capture modifiable and non-modifiable risk factors;

(iv) Assess an individual's confidence and readiness to change his or her lifestyle, potential barriers to change, and include quality of life measures;

(v) Capture current contact information and preferred means of contact;

(vi) Generate a personalized report for the individual that addresses lifestyle changes they can make to improve their health and reduce risks.

(c) Conduct a biometric screening at the health plan sponsor location(s) of choice. This screening must include:

(i) Cholesterol levels;

(ii) Diabetic risk assessment;

(iii) Blood pressure;

(iv) Body mass index (BMI), including recording of height and weight and body composition.

(d) Provide proactive, ongoing support and education for individuals with lifestyle health risks, such as tobacco use, obesity, high blood pressure, high cholesterol, and high stress. This support and education must:

(i) Include access to personalized health coaching;

(ii) Be available in multiple formats, including telephone, email and the internet;

(iii) Be provided by qualified professionals.

(e) Include processes or programs that encourage the highest levels of participation possible at the onset of the program, make it attractive to enroll in the program at any time and to keep participants engaged throughout the duration of the program.

(f) Provide regularly scheduled reports to the health plan sponsor demonstrating the impact of the program in aggregate, including:

(i) Personal health assessment completion rates;

(ii) Outcome-oriented metrics such as reductions in BMI, smoking cessation rates and other quantifiable improvements in behavior.

(2) The use and disclosure of health information collected through health risk assessments shall respect patient confidentiality and may not be used or disclosed for any purpose other than allowed by state or federal law to improve the health status of participating members.

(B) All health care plans offered to employees by a school district shall include a disease management program.

(1) The required components of an acceptable disease management program under this rule specifically include:

(a) An initial evaluation of plan history and claims if available to specifically identify the prevalence of diseases amenable to disease management interventions;

(b) Identification, classification and tracking of defined patient populations;

(c) Patient education and involvement in self-care techniques;

(d) Drug management and protocol adherence;

(e) Feedback to physicians on the progress of patients in the program;

(f) Integration of the services provided and the sharing of information with the health plan's employee wellness or healthy lifestyle program.

(2) A disease management program offered under this rule shall address chronic diseases, including but not limited to:

(a) Asthma;

(b) Diabetes;

(c) Chronic obstructive pulmonary disease;

(d) Morbid obesity

If such diseases have been identified as being prevalent in the population being served.

(3) A disease management program under this rule must provide the health plan sponsor with regular reports documenting the impact of the program in aggregate, specifically including but not limited to:

(a) Participation rates and satisfaction;

(b) Disease-specific clinical outcomes;

(c) Financial outcomes.

(C) All health care plans offered to employees by a school district shall include access to institutions and providers offering demonstrated clinically superior health care for complex medical conditions.

(1) Complex medical conditions may include but need not be limited to:

(a) Transplantation (solid organ, blood and bone marrow);

(b) Cancer;

(c) Chronic kidney disease;

(d) Congenital heart disease;

(e) Infertility (if a covered condition);

(f) Neonatology;

(g) Morbid obesity;

(h) High risk pregnancy.

(2) All health care plans offered to employees by a school district shall be required to use objective, measurable criteria to evaluate participating institutions and providers.

(3) All health care plans offered to employees by a school district shall provide the health plan sponsor access to the evaluations of all participating institutions and providers so long as the release of specific information is not in breach of any agreement between an institution or provider and the health care plan.

(D) All health plan sponsors offering health care plans to employees of a public school district shall undertake periodic dependent eligibility audits. The aggregate results of each dependent eligibility audit shall be furnished by each health plan sponsor to the school employees health care board.

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Certification

10/15/2008

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