How Verifying Coverage Pre-Billing Saves Money and Creates Efficiencies for Providers and Payers Alike

State Healthcare IT Connect

March 18, 2019
Agenda

• HMS Overview
• The Problem
• On Demand – how it works
• Ohio’s perspective
• Real-world Results: A Provider’s Story
## Our Solutions: Innovative and Integrated

<table>
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<tr>
<th>Payment Accuracy Solutions</th>
<th>Risk Analytics, Member Engagement, Care Management Solutions</th>
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<td><strong>Coordination of Benefits</strong></td>
<td><strong>Total Population Management</strong></td>
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<td>Industry-leading solution ensures the right payer pays the claim, both prospectively for cost avoidance and retrospectively for recoveries of improper payments.</td>
<td>Provides actionable insights to address quality, cost and compliance by stratifying risk; deploys proven member engagement strategies and a configurable care management platform.</td>
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<td><strong>Payment Integrity</strong></td>
<td><strong>Consulting Services</strong></td>
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<td>A comprehensive and interoperable solution set that addresses a wide range of payment accuracy needs on a prospective and retrospective basis.</td>
<td><strong>HMS Advisory Services</strong></td>
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<td>Assists health care payers to achieve their financial, operational and program goals. Our team of experts provide a consultative approach to enhance premium revenue, reduce operating expenses and ensure regulatory compliance.</td>
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Verify Coverage: When and Where you Want it
The Problem

• Whatever the reason, patients with access to other coverage but who erroneously declare Medicaid as primary create huge expenses and inefficiency for providers, Medicaid, private healthcare payers and healthcare consumers.

• Many claims submitted for these patients are either denied by Medicaid or are incorrectly paid, costing Medicaid agencies and providers billions each year.

• More than half of these improper claims were due to incorrect billing from providers who often don’t have updated coverage information for their Medicaid patients.
On Demand

Coverage on Demand will match, verify and communicate third-party coverage for Medicaid members in near real-time.

- Accurate billing to Medicaid reduces claims and administrative costs and avoids pay and chase activities
- Members receive full range of their coverage benefits
- Providers can reduce administrative burden and gain access to commercial rates from liable commercial third party payers
How it Works

1. Patient at Point of Admissions, Point of Authorization or Point of Billing

2. Provider submits Medicaid-Only Patient List via Batch or Real-Time UI or API

3. Medicaid patient is matched to Identify Other Coverage

4. Matched policies are verified

5. Verified Third-Party Coverage Data is returned to Provider

6. Provider Bills Third Party and/or Medicaid
On Demand Features

Flexible Integration
API, user interface and batch solutions at the point of scheduling, service, prior authorization and billing

Available Anytime
Accurate coverage data is available anytime in the healthcare cycle

Near Real-time Actionable Results
API / UI: 25 seconds or less
Batch: 24 hours or less

Ease of Use
Automated process and simple user interface creates a powerful user experience
Why Ohio is on board
Real-World Results:
A Provider’s Story
One Provider’s Story

• Large medical center in Ohio
• Approximately 80,000 Medicaid members annually
• Their Challenge:
  • Burden of reworking claims post-service with the correct third-party payers is large and contributes to the system’s cost of providing care.
  • Loss of reimbursement on claims that should have been covered by a third-party payer at commercial rates
Benefits Realized

• The medical center leveraged accurate third-party coverage to capture more than $300,000 in incremental revenue for institutional services over the length of the pilot

• The result was a nearly 50 percent reduction in post-payment claims re-work for subscribers who didn’t initially declare coverage with another carrier.

• Over the one-year pilot program, approximately 2,700 billable instances of care (commercial segments) were identified that should have been reimbursed by third-party payers

• Required pre-authorizations may be resolved ahead of scheduling patients for treatment. In certain cases, costly denials and appeals were avoided
In Summary
Payment Accuracy Across the Medicaid Member Journey

Coordinate better care, maximize cost savings, ensure accurate reimbursements and reduce administrative rework.

Prepay Medicaid Member’s Continuum Postpay
In Summary

• Coverage on Demand is no cost to the State
• Cost Savings for both Medicaid and Providers
• Establishing data use permissions enables delivery
• Short implementation timeframe allows providers to be up to speed quickly
Questions?
Moving healthcare forward.

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