Common Claims Work Group
Interim Report

TO

THE COMMISSION ON HEALTH CARE REFORM

January 15, 2007

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Executive Summary

The Common Claims Work Group was created by H.861 Section 55 to design, recommend and implement steps to achieve the following goals:

1) Simplifying the administrative process for consumers, health care providers and others so the process is more understandable and less time consuming.
2) Lowering the administrative cost in the health care financing system.

As outlined in Section 55 of H.861 (Appendix A) the work group that convened consisted of (Appendix B):

1) Two representatives selected by the Vermont Association of Hospitals and Health Systems.
2) Two representatives selected by the Vermont Medical Society.
3) One representative from each of the three largest health care insurers
4) The Director of the Office of Health Access or designee
5) Two representatives of the business groups appointed by the Governor
6) The health care ombudsman or designee
7) One representative for consumers appointed by the Governor
8) The Commissioner of Banking, Insurance, Securities and Health Care Administration or designee.

The work plan (Appendix C) focuses on areas of the claims administrative process, including claim forms, patient invoices, explanation of benefit forms, payment codes, claims submission and processing procedures, including electronic claims processing, issues related to prior authorization and issues related to the credentialing process.

On July 1, 2006 the work group convened and has been meeting monthly. During the meetings the work group developed a work plan and identified sub groups to work on the following seven items:

I.   Maximization of the electronic claims process
II.   Simplification of Explanation of Benefits and Patient Bills
III.   Pre-Authorization
IV.   Credentialing
V.   Improving the Efficiency of Claims Adjudication
VI.   Simplification of Workers Compensation claims processing
VII.   Revise work plan tasks as needed to meet the intent of the Act.

Background and Identified Goals of Work Plan

I. Maximization of the Electronic Claims Process (Appendix D):

Goal: To inventory the electronic claims processing submission capabilities available to decrease claims processing times, increase electronic claims volume and support timely and accurate payment of claims.

The sub group has met and inventoried ways to improve upon the standardization. The group has focused significant attention on the Utah Health Information Network. The Utah Health Information Network (UHIN) is a broad-based coalition of health care insurers, providers, and other interested parties, including State government. UHIN participants have come together for the common goal of reducing health care administrative costs through data standardization of administrative health data and electronic commerce. (Appendix E - UHIN presentation to the work group)

The Common Claims Work Group and representatives from Banking, Insurance, Securities and Health Care Administration (BISHCA) agree that there should be further research into UHIN standards to determine if there are opportunities that could be leveraged in Vermont. In particular, the work group agrees that there are opportunities to adopt the UHIN approach of developing consensus on administrative efficiencies and then adopting them as state rules, with respect to all matters addressed by the work group.

The work group will now be focusing on the best in class functionality related to electronic claims submission and will continue to explore standardization methodologies and how they might be implemented in Vermont.

II. Simplification of Explanation of Benefits (EOB) and Patient Bills (Appendix F)

Goal: To recommend a consistent and consumer friendly, understandable, accurate EOB, hospital and physician billing statements to minimize confusion and improve consumer satisfaction to result in an informed patient.

To date the work group has:
1) Analyzed patient statements from hospitals bills.
2) Identified variation in terminology.
3) Develop a minimum data set and terminology for payor EOBs.

The next steps for the work group will to be to develop standard definitions to be utilized with the minimum data set terminology and to further develop recommendations related to patient friendly billing.

III. <u>Pre-Authorization Pilot</u>

The initial goal of the pre-authorization sub committee was to develop a pilot program that would test whether the prior authorization process added value in controlling inappropriate utilization. The pilot was to focus on high volume radiology procedures.

Through the process of meeting with the insurers' Medical Directors and exploring the goals and objectives of the pilot it became evident that the goal as outlined would not be achievable. Insurers expressed concern about the need to change or alter individual organization business practices, which they consider to be proprietary in nature.

Through this process the goal has been revised. The new goal of the sub committee is to develop by carrier, a transparent list of services that require pre-authorization. The sub-committee will then compare the lists for commonality and variation. Based on the outcomes the sub-committee will then make recommendations on how to proceed with the findings.

IV. <u>Credentialing (Appendix G)</u>

Goal: To standardize and eliminate variation amongst carriers on provider billing eligibility and establish uniform periods in which organizations must act on completed credentialing applications.

A typical physician contracts with multiple healthcare organizations, each of which requires the physician to complete an extensive separate credentialing application.   When implemented, the CAQH (Council for Affordable Quality Healthcare) Universal Credentialing Datasource called for in Section 56 of Act 191 will simplify this process by enabling physicians and other health care professionals to submit one standard credentialing application.

Section 56 of Act 191establishes uniform time periods within which an organization must notify a provider concerning the status of a completed credentialing application. However, there is currently no time period within which an organization must act on a completed credentialing application.   Establishing a uniform period within which an organization acts on completed credentialing applications will help to reduce revenue loss for health care services provided while an application is under review.

Existing quality certification requirements prevent certain health care organizations from paying claims for services provided prior to the physician or health care professional being certified. Given the lengthy delay in acting on completed credentialing applications by some organizations, regulatory organizations need to acknowledge the revenue loss for health care services provided while an application is under review.

Health insurance companies have different rules regarding the ability of physician assistants and nurse practitioners to bill separately for health care services. Some payers allow for direct billing by physician assistants and nurse practitioners, while others require that the billing be done under a physician's name and number. Eliminating this variation will reduce the administrative burden for practices.

V. Improving the Efficiency of Claims Adjudication (Appendix H)

Goal: Providers are seeking improved standardization and agreement on common policies that determine how a claim may be adjudicated. If adopted, providers and payers would know in advance the appropriate billing method, and both parties would realize the benefit of a much more efficient process.

The sub group has met to determine the common bottlenecks that exist in the current claims adjudication process. They include:

- Recognize Hospital Bill Type on Hospital Claim
- Claims that have Assistant Surgeons
- Billing procedure codes with Modifiers
- Claims bundling and unbundling

The next steps of the Subcommittee will be to examine and study commonly encountered scenarios from each of the four case types listed above. The Subcommittee will attempt to reach consensus on how common scenarios should be adjudicated.

VI. Simplification of Claims Processing for Workers Compensation (Appendix I)

Goal: Explore means to simplify the process for worker's compensation claim filings, status tracking and adjudication of services.

Although there are extensive administrative requirements set by Rule 40, the major item identified as the root problem for both providers and the Department of Labor is the inability for providers to submit claims electronically to payors. The default is a manual process which adds significant cost to processing workers compensation claims.

The sub group will be exploring information on how claims are processed in other states. They will be meeting with the Department of Labor to determine if modifications to Rule 40 could be revised and continue to research electronic claims filing options.

VII. Revise Work Plan as Needed

Goal: Ensure that the Common Claims Work Group continues to explore all opportunities to simplify administrative processes and lower administrative costs.

There is no subgroup for this item. Rather, the objective is an overarching one – to ensure that the full work group continues to review efforts in Utah, North Carolina, Wisconsin, Washington and other states to identify opportunities for improvement and efficiency.

Appendices

A.   H.861 Section 55 Legislation

B.   Common Claims Work Group Members

C.   Common Claims Work Plan

D.   Maximization of Electronic Claims Process Status Report

E.   Utah Health Information Network presentation

F.   EOB Simplification and Patient Bills Status Report

G.   Credentialing Status Report

H.   Improving the Efficiency of Claims Adjudication Status Report

I.   Simplification of Claims Processing for Workers Compensation Status Report

J.   Cigna HealthePass Presentation

Appendix A

H. 861 Sec. 55. COMMON CLAIMS AND PROCEDURES

   (a) No later than July 1, 2008, the commissioner shall amend the rules adopted pursuant to section 9408 of Title 18 as may be necessary to implement the recommendations of the final report described in subsection (g) of this section, as the commissioner deems appropriate in his or her discretion. Nothing in this section shall be construed to alter the commissioner's authority under Title 8 or chapter 221 of Title 18.

   (b) No later than July 1, 2006, a common claims and procedures work group shall form, composed of:

      (1) two representatives selected by the Vermont association of hospitals and health systems;

      (2) two representatives selected by the Vermont medical society;

      (3) one representative of each of the three largest health care insurers;

      (4) the director of the office of health access or designee;

      (5) two representatives from business groups appointed by the governor;

      (6) the health care ombudsman or designee;

      (7) one representative of consumers appointed by the governor; and

      (8) the commissioner of the department of banking, insurance, securities and health care administration or designee.

   (c) The group shall design, recommend, and implement steps to achieve the following goals:

      (1) Simplifying the claims administration process for consumers, health care providers, and others so that the process is more understandable and less time-consuming.

      (2) Lowering administrative costs in the health care financing system.

   (d) The group shall elect a chair at its first meeting. The chair, or the chair's designee, shall be responsible for scheduling meetings and ensuring the completion of the reports called for in subsection (g) of this section. Each organization represented on the work group shall be asked to contribute funds for the group's administrative costs.

   (e) On or before September 1, 2006, the work group shall present a two-year work plan and budget to the house committee on health care and the senate committee on health and welfare.

  (f) This work plan may include the elements of the claims administration process, including claims forms, patient invoices, and explanation of benefits forms, payment codes, claims submission and processing procedures, including electronic claims processing, issues relating to the prior authorization process and reimbursement for services provided prior to being credentialed.

  (g) The work group shall make an interim report to the governor and the general assembly on or before January 15, 2007 describing the progress of the group and any interim steps taken to achieve the goals of the work plan. The work group shall make a final report to the governor and the general assembly on or before January 15, 2008 with the findings that illustrate the outcomes of implementations derived from the work group actions along with a list of future actions and goals, which shall specify cost savings achieved and expected future savings.

Appendix B

Common Claims Work Group

2 Hospital Representatives
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2 Vermont Medical Society Representatives
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David Jillson	djillson@aosvt.com	862-3983

1 Representative from Each Insurer
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Director of OVHA or Designee
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2 Business Group Representatives
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Allen Nassif	Allen@vtbenefits.com	865-2733

Health Care Ombudsman or Designee
Jenny Prosser	jprosser@vtlegalaid.org	863-7155

1 Consumer Representative
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Commissioner of BISHCA or Designee
Herb W. Olson	hwolson@bishca.vt.state.us	828-2900

Additional workgroup participants
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Appendix C

Common Claims Work Plan

Attached Electronic Excel File

Appendix D

Common Claims -Maximization of Electronic Process Status Update

Coordination of Benefits & Electronic Remediation Updates:

The team has begun researching organizations in the nation which provide opportunities to streamline processes and accomplish the tasks outlined in H.861, Section 55. One of the organizations which the team has reviewed is the Utah Health Information Network. The Utah Health Information Network (UHIN) is a broad-based coalition of health care insurers, providers, and other interested parties, including State government. UHIN participants have come together for the common goal of reducing health care administrative costs through data standardization of administrative health data and electronic commerce. The team began evaluating the UHIN organization because they have been in place since 1993 and have accomplished many of the tasks which have been requested of the Common Claims Work Group with relative success.

The team spent time with Julie Nelson a representative from UHIN as well as having conversations with the Utah Blue Cross who originally began UHIN for Medicare billing. On November 27, 2006 Julie attended the Common Claims meeting via conference call and gave an overview of the UHIN organization and the accomplishments they have made. The main purpose of UHIN was to provide a centralized and standardized tool that could act as a vehicle for electronic claims submissions. Each Payer was than responsible for mapping the data into their individual systems and following the established submission guidelines set forth by the UHIN board of directors.

The team has completed a summary of current functionality available by Vermont Payers for COB and electronic remediation. Key findings indicate that most payers currently cannot accept coordination of benefits information in an electronic format which impacts the volume of transactions which can be sent electronically. This finding was also validated by the UHIN organization who is also currently working to implement this enhancement in 2007.

Blue Cross Blue Shield of Vermont has conducted outreach efforts to other Plans to obtain benchmarking information to gage the level of functionality available through other Payers. So far other Plans are not using the 837 attachment files and are obtaining COB through other fields on the 837. In addition, both CIGNA and MVP have done internal research and determined similar findings.

Standardization of ID Cards & Out of Pocket Expenses:

Based on feedback from billers at (MBC) and Fletcher Allen Health Care (FAHC) the team has obtained consensus as to which payer ID cards have the right amount of information which allow billers to efficiently do their jobs. CIGNA was identified as having the best card and the team decided that the following items should be present:
- Copay amount
- Primary Care Doctor

- o Effective Date
- o Subscriber Name on dependent cards
- o Billing address
- o Phone Number- CS & MH
- o Prescription information

The team's initial requirements were shared with BCBS of VT who is currently evaluating ID cards and looking to revise them in the 2007/2008 calendar year. While MVP was not represented on this sub-team, the information has been shared with them and they will be evaluating it in the future.

CIGNA has provided the team with an update on the HealthePass which is to be released in the first quarter of 2007. This was created by a third party and can be purchased by other Payers in the state. This tool is designed to store member out-of-pocket information and also act as a credit card if needed. The HealthePass can be used with a basic credit card machine.   It is the team's suggestion that each Payer evaluate the cost of this Healthepass because it would again be an opportunity to promote consistency.

Next Steps:

Continue to gather information on "best in class" functionality related to electronic claims submission and remediation.

Conduct out-reach activities to organizations that have an association with UHIN to gage their perception and validation of the successes UHIN has outlined.

Contact other states who have also created centralized submission hubs to assess other alternatives. At this time the following states have similar organizations:

- o North Carolina
- o Wisconsin
- o Washington

Review standards created by these organizations to determine how it may be used in Vermont.

Appendix E

Utah Health Information Network presentation

Attached Electronic PowerPoint File

Appendix F

Simplification of EOBs & Patient Bills Status Report

OPPORTUNITY STATEMENT: To produce a consistent and consumer-friendly, understandable EOB and hospital billing statement to minimize confusion and improve consumer satisfaction.

GOAL/OUTPUT OF GROUP'S WORK: At the conclusion of our work we will produce two items:

1. A common terminology and definition list with a minimum content data set as well as a layout for payers explanation's of benefits which are mailed to patients; and
2. A common terminology and definition list with a minimum content data set and layout for hospital and physician statements to patients.

WORK COMPLETED TO DATE:

1. Collected and analyzed patient statements from hospitals. Great variation between hospitals was noted.
2. Collected and analyzed explanations of benefits from the three major payers (MVP, BCBSVT, and CIGNA). Great variation between the three payers was noted.
3. Analyzed the differences in terminology used by hospitals and payers. Again, great variation was noted.
4. Prepared an RFI to do consumer focus groups, received responses, reviewed data and it was decided by the overall group the cost to do these was prohibitive especially considering that similar work has already been done under the Patient Friendly Billing Project from the Healthcare Financial Management Association.
5. Patient calls are being monitored at MBA Resources (a billing company) for a period of six months to see how many of the complaints/calls coming in have to do with EOBs and what they specifically are.
6. A minimum data content set and terminology has been defined for the payer EOBs (attached). Note: This will be adjusted if the data gathered in item #5 dictates change.

NEXT STEPS:

1. Develop the definition to go with each terminology item and have it adjusted to 5th grade reading level. (In the process of writing the definitions)
2. Define the hospital statement content and terminology requirements (keeping in mind work already done by Patient Friendly Billing Project).
3. Develop the definitions to go with the terminology on the hospital statements.

Appendix G

Credentialing Status Report

Statement of Principles regarding the Physician Credentialing Process

[Endorsed by the Vermont Medical Society, the Vermont Association of Hospitals and Health Systems, Blue Cross & Blue Shield of Vermont, MVP and CIGNA]

[The Vermont Medical Society, the Vermont Association of Hospitals and Health Systems Blue Cross & Blue Shield of Vermont, MVP and CIGNA] recognize the vital importance of adding qualified physicians to health insurance plan networks in a timely fashion to ensure that enrollees and patients have access to needed health care services. The provisions included in this Statement have been developed by representatives from Vermont Medical Society, the Vermont Association of Hospitals and Health Systems, Blue Cross & Blue Shield of Vermont, MVP and CIGNA (hereinafter collectively referred to as "Sponsors").

18 V.S.A. § 9408a mandates that the Vermont Department of Banking, Insurance, Securities and Health Care Administration prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH), or a similar, nationally recognized form, in electronic or paper format, which must be used beginning January 1, 2007 by an insurer or a hospital that performs credentialing.

18 V.S.A. § 9408a also requires that an insurer or a hospital notify a provider concerning a deficiency on a completed credentialing application form no later than 30 business days after the insurer or hospital receives the completed credentialing application form; and an insurer or a hospital shall notify a provider concerning the status of the provider's completed credentialing application no later than sixty days after the insurer or hospital receives the completed credentialing application form; and every 30 days thereafter until the insurer or hospital makes a final credentialing determination concerning the provider.

The Sponsors believe that any strategies to streamline credentialing must be in compliance with existing federal and state laws and regulations, with accrediting organization standards and guidelines. These strategies may require modifications as those laws, regulations, standards and guidelines change.

Sponsors therefore endorse provisions designed to streamline, coordinate, and improve physician credentialing and re-credentialing processes throughout the State of Vermont as follows:

> Participating health insurance plans and hospitals shall strive to act upon and finish the credentialing process of complete initial credentialing applications submitted by or on behalf of a physician applicant within 60 calendar days of receipt of a complete application;

> All sponsors agree to work together to identify process improvements in the physician, hospital and payer settings to expedite the credentialing process;

Hospitals shall strive to reply to each request from physicians and/or participating health plans for verification of credentialing and privilege status within 30 calendar days of the date of request; and

Health insurance plans shall strive to communicate to the physician applicant or designee within four business days of the credentials committee date, informing them of the committee's decision and date of the decision.

All Sponsors agree to work together to develop a reporting process to measure success in meeting the voluntary 60-calendar day processing goal described herein.

Appendix H

Improving Efficiency of Claims Adjudication Status Report

Synopsis of Problem: Vermont hospitals and physician offices experience considerable effort and delay in seeking to have certain types of claims adjudicated by payers under a relatively uniform claims adjudication process. On many occasions, a claim that one payer accepts and adjudicates will be rejected by another payer.

Goal: Providers are seeking improved standardization and agreement on common policies that determine how a claim may be adjudicated. If adopted, providers and payers would know in advance the appropriate billing method, and both parties would realize the benefit of a much more efficient process without considerable time spent by both parties processing appeals.

Progress to Date: The Subcommittee has held three monthly meetings to date. The first step was to attempt to understand what claims adjudication software was currently in use by the three commercial and one government payer represented on the Subcommittee. Payer representatives stated that claims auditing software systems have a claims edit foundation based on the National Correct Coding Initiative (NCCI) claims edits, and these systems can then be modified by both the software vendor and payers using other industry edits as NCCI is based on Medicare guidelines. Payers then may add customization to support state mandates and payer specific business practices/policies. Therefore, the majority of services are adjudicated in a relatively uniform methodology across various payers. There are also a subset of claims that are adjudicated under varying methodology by payers as they are adjudicated based on payers' specific business practices/policies and claim adjudication rules.

The Subcommittee's hospital and medical office billing representatives shared information about some of the most common situations that cause wasted time and effort.
- **Bill Type** is a field on a facility (e.g. hospital) claim that is used to indicate what type of claim is being submitted - 1st inpatient claim, subsequent inpatient claim, replacement claim, etc. If a payer ignores or cannot accept Bill Type, then the claim may be rejected as a duplicate.
- **Assistant Surgeons** are sometimes used to help the primary surgeon on a more complex procedure. Medicare publishes a list of procedures where an assistant surgeon is

permitted, but commercial payer's business rules with regard to assistant surgeons are not uniform and are not always aligned with Medicare.

- **Modifiers** are standardized codes developed by the American Medical Association, and are recognized by Medicare and many commercial payers. Modifiers are often used to provide additional information about the procedures that were billed. The issue with modifiers is that the payer needs to accept, recognize, and act on them. Typically, the payer asks for chart notes whenever a modifier is used, or denies the claim, or simply does not pay the procedure with modifier. Again, commercial payer's business rules with regard to modifiers and adjudication of modifiers are not uniform and are not always aligned with Medicare.

- **Claims Bundling/Unbundling** is the term used when a provider lists several similar procedures that were performed on the same date of service. For example, a surgeon should not report closing the wound and suturing in addition to reporting a total hip replacement, because the hip replacement code includes suturing. The Medicare program developed the NCCI to ensure the most comprehensive groups of codes are billed rather than the component parts, and to check for mutually exclusive code pairs. However, because many commercial payers have modified NCCI adjudication methodology as described, when claims are submitted which meet the unmodified NCCI rules, the claim may be denied. Commercial payer's business rules with regard to claims bundling/unbundling are not uniform and not always aligned with Medicare.

In all the scenarios described above, a provider's billing office will appeal the denial because they believe the claim was submitted correctly and appropriately. The resulting appeal process may last weeks or months, and takes considerable staff time by both the provider and the payer. Some providers believe that these denials are arbitrary, and are done to delay payment or to discourage seeking appropriate payment. On the other hand, some payers believe that providers submit incorrect or fraudulent claims in an effort to inappropriately increase their reimbursement.

The next steps of the Subcommittee will be to examine and study commonly encountered scenarios from each of the four case types listed above. The Subcommittee will attempt to reach consensus on how common scenarios should be adjudicated.

Subcommittee Members

David Jillson, Chair - Associates in Orthopedic Surgery
Cherie Bergeron - OVHA
Pam Biron - BCBS VT
Kathy Bonanno - MVP
Mickey Gleeson - MVP
Holly Tribley - MVP
Lauren Parker - MBA Resources
Kathy Peterson - Rutland Regional Medical Center
Jason Soukup - Cigna

Appendix I

Consider ways to Simplify Claims processing for Workers Compensation Status Report

Goal: Explore means to simplify the process for worker's compensation claims filing, status tracking and adjudication of services.

The group consists of a representative from the hospital billing department as well as the physician office billing. These parties have defined the processes that exist today and are compiling data to make recommendations for how the regulations and requirements could change to improve service, save time which equals money for all parties involved.

Several problem areas have been defined by both provider entities.

1)   All claims require attachment of the clinical note to the claim (Rule 40).
2)   The timely payment and penalties for non-timely payment guidelines needs to be revisited.
3)   Existing regulation of penalties for failure to provide first report of injury are not regularly assessed to remiss employers.
4)   Many claims adjusters, including the State of Vermont, do not presently have the capability to receive claims electronically. This is not a high priority for most carriers contacted by the committee due to costs and concern about provider readiness to provide electronic notes.
5)   Electronic case management is not available to many claims adjusters or providers.
6)   The claims review process appears to be very manual and greatly delays progress in assessing claims.

Several problem areas have been defined by the Department of Labor.

1)   The process of reviewing claims and matching them to billed services creates the greatest delay in the adjudication of the claim, whether executed in-house or outsourced.
2)   The lack of Information Technology to automate the claims processing or the case management required with those claims has created a slow and tedious process.
3)   The lack of Information Technology existing at the employer locations to file data electronically as well as employee access to e-mail, creates limitations to what the state can require.

Next Steps:

◊   Continue to explore how Workers Compensation claims are filed in other states to address the question of how to best implement change.
◊   Meet with Department of Labor and BISHCA to determine where Rule 40 and associated revisions allow for better implementation of the regulation.
◊   Continue to research electronic filing options for Workers Compensation claims and notes. Analyze costs and benefits of such a transition.

Appendix J

Cigna HealthePass Presentation

See PPT attached

I. MAXIMIZATION OF ELECTRONIC PROCESS

GOAL STATEMENT:

Determine electronic claims submission capabilities available to decrease processing timeframes, increase electronic claim volume, and support timely and accurate payment of claims.

SPECIFIC TASKS TO ATTAIN GOAL	Due Date	Owner	Identified Possible Barriers	Status
a.	**Coordination of Benefits**				
1) Research best in class practices around electronic claims submission of coordination of benefits (COB) and workers compensation claims to include available technology, potential cost and document outcomes.	12/11/06	Jason & Emily	Lack of response from Blues Plans, second requests have been sent. \n\nCIGNA possible anti-trust issue have emerged.	Information is being gathered at this time
2) Define appropriate usage of situational fields on the 837(standard electronic claims submission format) to support the submission of coordination of benefit claims in an electronic format.		Cherie		Obtaining how OVHA is using them today (findings on this due to the group 11/13/06)
3) Conduct a gap analysis of current processing systems to identify barriers.	11/13/06	Jason& Emily		In progress
4) Define documentation high level requirements and evaluate the use of 837attachment files to assess feasibility of usage in relation to the processing of Workers comp and COB.	01/22/07	Team	Available time to devote to task.	Present high level direction and concept to full workgroup 12/11/06
5) Evaluate centralized and external solutions which would result in enhanced functionality.	06/15/07	Team		
6) Develop cost benefit analysis to determine the most cost effective approach.	07/15/07	Team		
7) Implement auditing processes to assess accuracy of information provided on 837 COB claims submissions.	12/31/08	Team		
b.	**Electronic Claims Remediation Process**				
1) Research best in class practices around electronic claims submission remediation to included available technology potential cost and document outcomes.	10/16/06	Emily, Wayne, Jason		Gather information as to OVHAs current functionality. Emily and Jason will provide information from the payer point of view. \nWayne will indicate desired functionality from the Provider point of view both facility and professional. \nEmily will contact BSBC
2) Evaluate functionality in place at Office of Vermont Health Access (OVHA) and Medicare to obtain high level requirements.	11/13/06	Cherie		in progress
3) Identify three possible solutions and high-level timeframes which would allow Carriers to enhance their systems to accept resubmission/correction to claims submissions.	02/19/07	Team		
4) Determine if Carriers could obtain electronic claims resubmission functionality through the usage usage of a centralized common agency or if functionality would need to be obtained through individual system enhancements.	06/11/07	Team		
5) Once options have been defined, work with Submitters to determine if internal system changes are required.	08/20/07	Team		
c.	**Standardization of ID Cards & Accessibility of Out of Pocket Expenses**				
1) Research best in class health plans to determine available technology, and level of information available	10/16/06	Lauren		BCBS of GA identified for technology \nCIGNA best id card
2) Define critical out of pocket elements which need to be captured on member ID cards.	10/16/06	Team		o Copay amount \no Primary care physician \no Effective date \no Subscriber name even on dependent cards \no Billing address \no Phone number – CS and MH \no RX information \nTask Complete

3)	Review the 270/271 capabilities and determine what information can be provided through the use of the 270/271 transaction	11/13/06	Team		
4)	Determine costs associated with addition of information and determine manner in which reissued cards will be handled.	01/31/07	Team		
5)	Research implications of making out of pocket information available via the web in relation to the disclosure of sensitive issues.	01/31/07	Team		
6)	Identify barriers which may contribute to delays/accuracy of out of pocket information and develop interventions to reduce them.	03/31/07	Team		

KNOWN ESTIMATED COSTS:
a.
b.
c.

II. SIMPLIFICATION OF EOBs & PATIENT BILLS Lead: Kathy Peterson

GOAL STATEMENT:

   To recommend a consistent and consumer-friendly, understandable, informative & accurate EOB,
hospital and physician billing statement to minimize confusion and improve consumer satisfaction,
which results in an informed patient.

SPECIFIC TASKS TO ATTAIN GOAL	Responsible Person	Due Date
a. Identification of the differences amongst payer and hospital statements	Emily, Kathy & Gisele	complete
b. Complete RFI for focus groups	Emily, Kathy, Cherie, & Gisele	complete
c. Present focus group costs to committee for discussion and vote	Kathy	25-Sep-06
d. Present work to date the workgroup has completed on this project	Kathy	25-Sep-06
e. Review results of studies from other consumer groups such as AARP, HFMA Patient Friendly billing project and others as identified and make recommendations for adopting any of their results	Full Team	31-Dec-06
f. Monitor incoming calls at MBA resources to understand pt issues around EOB's	Lauren	30-Apr-07
g. Define common terminology for eob's	Full Team	12/31/2007
h. Determine definitions of terminology for eobs	Full Team	01/31/2007
i. Determine common terminology for hospital statements	Full Team	03/31/2007
j. Determine definitions of terminology for hospital statements	Full Team	04/30/2007
k. Determine common terminology for physician statements	Full Team	05/31/2007
l. Determine definitions of terminology for physician statements	Full Team	06/30/2007

Due Date

m. Make final recommendations for enhanced EOB's and patient statements.	Full Team	31-Dec-07	31-Aug-06

KNOWN ESTIMATED COSTS:

30-Nov-06

a. Each facility and physicians will have to program their systems to produce "consumer-friendly" statements   31-Dec-06
Costs are unknown to author and will vary by facility. There will be both a design and implementation cost.   31-Jan-07
b. Each payer will have to program their systems to produce "consumer-friendly" explanation of benefits.   31-Jan-08
Costs are unknown to author and will vary by payer. There will be both a design and implementation cost.

III. PRE-AUTHORIZATION OF PILOT

GOAL STATEMENT:

To develop a pilot program that will test whether prior authorizations bring value in controlling
inappropriate utilization and potentially eliminate prior authorizations for high
volume radiology procedures. Suggested procedures for the pilot include: CT and MRI of the
pelvis, CT and MRI of the abdomen, and MRI of the upper/lower extremity.

SPECIFIC TASKS TO ATTAIN GOAL	**Responsible Person**	Status	
a. Payers will gather and review auth data of proposed procedures	Dr. Perkins, Dr. Hockmuph,	complete	
	Dr. Mangiapane, Dr. Strenio		**Due Date**
b. Group will meet, review data & gain consensus of what the pilot will look like and what procedures will be involved (multiple meetings)	Full workgroup **	complete	Jan-07
c. Group will plan implementation of pilot	Full workgroup **	complete	
d. Group will roll out pilot			Apr-07
e. Gather additional data need to make, make modifications as required	Full workgroup **		
f. Based on reccomendation wait for legislative approval and next steps			Apr-07

** Full workgroup= Dr. Perkins, BCBSVT; Dr. Hockmuph, Bretta Karp, Jaime Ellermann (all CIGNA);   Jul-07
Dr. Mangiapane, Gisele Carbonneau, Nancy Dahm (all MVP); Esther Perelman, Dr. Strenio, Dr. Cody-Reisfeld,
John Dick (All OVHA); Dr. Biebuyck, Kathy Peterson (all RRMC).

KNOWN ESTIMATED COSTS:
a. Each payer will have to program their systems to make adjustments for the authorizations which are no
longer required.   Costs are unknown at this time and will vary by payer.

IV. CREDENTIALING

GOAL STATEMENT:

A typical physician contracts with multiple healthcare organizations, each of which requires the physician to complete
an extensive separate credentialing application.   When implemented, the CAQH Universal Credentialing Datasource
called for in Section 56 of Act 191 will simplify this process by enabling physicians and other health care professionals to submit
one standard credentialing application.

Health insurance companies have different rules regarding the ability of physician assistants and nurse practitioners
to bill separately for health care services. Some payers allow for direct billing by physician assistants and nurse practitioners,
while others require that the billing be done under a physician's name and number. Eliminating this variation will reduce the
administrative burden for practices.

Section 56 of Act 191establishes uniform time periods within which an organization must notify a provider concerning
the status of a completed credentialing application. However, there is currently no time period within which an organization
must act on completed credentialing application.   Establishing a uniform period within which an organization must act on completed
credentialing application will help to reduce revenue loss for health care services provided while an application is under review.

Existing quality certification requirements prevent certain health care organizations from paying claims for services provided
prior to the physician or health care professional being certified. Given the lengthy delay in acting on completed credentialing
applications by some organizations, regulatory organizations need to acknowledge the revenue loss for health care services provided
while an application is under review.

SPECIFIC TASKS TO ATTAIN GOAL   **Responsible Person**

a. The committee will work with BISHCA to ensure the successful adoption of the credentialing application form used by CAQH   Paul Harrington
        or a similar, nationally recognized form.
b. The committee will work with Vermont's third-party payers to achieve a uniform policy regarding a time period within which   Paul Harrington
        an organization must act on completed credentialing application. (PH, 4/1/07)
c. The committee will work with Vermont's third-party payers and regulators to achieve a uniform policy regarding the payment
        for health care services provided prior to being credentialed.   Paul Harrington
d. The committee will work with Vermont's third-party payers to achieve a uniform policy regarding billing for the services of
        physician assistants and nurse practitioners.   Paul Harrington
                                                                                                                          David Jillson

KNOWN ESTIMATED COSTS:
a. N/A

V. IMPROVING THE EFFICIENCY OF CLAIMS ADJUDICATION   Lead : David Jillson

Sub-Committee

GOAL STATEMENT:	Jason Soukup - Cigna
Providers and payers will collaborate to establish uniform practices in adjudicating clean claims.	Kathy Bonanno - MVP
	Mickey Gleeson - MVP
Agreement on common adjudication policies would increase the efficiency of the claims payment	Holly Tribley - MVP
process. NCCI is comprehensive code auditing software used by the Centers for Medicare and Medicaid	Pam Biron - BCBS
Services (CMS) in order to achieve consistency in interpreting codes and modifiers submitted by	Cherie Bergeron - OVHA
physicians and facilities for services rendered. Although payers use NCCI as a foundation for their	Kathy Peterson - RRMC
adjudication process, they make modifications to support various business practices and policies.	Lauren Parker - MBA Res.

SPECIFIC TASKS TO ATTAIN GOAL	**Due Date**	**Responsible Person**	**Status**
a. Determine which major VT payers currently use NCCI edits exclusively, and which	01-Jan-07	All	Completed
use other code auditing software such as ClaimCheck ®.			
b. Evaluate the feasibility of adopting uniform adjudication policies for some of the most common	01-Apr-07	All	
reasons for claims being denied or reprocessed on their initial submission.			
c. Estimate the feasibility and cost of adopting selected common adjudication processes by VT payers.	01-May-07	All	

KNOWN ESTIMATED COSTS:
a. Tasks above can probably be accomplished using existing resources of the Committee.

VI. CONSIDER WAYS TO SIMPLIFY CLAIMS PROCESSING FOR WORKERS COMPENSATION   Lead: Lauren Parker

GOAL STATEMENT:
    Explore means to simplify the process for workers compensation claims filing and follow-up. We will
    also consider other carriers that require clinical documentation with specific claims with the intention of
    recommending changes in the process.

SPECIFIC TASKS TO ATTAIN GOAL   **Sub-Committee**

SPECIFIC TASKS TO ATTAIN GOAL	**Sub-Committee**
a. Define existing processes for hospitals and physician practices.	Stephen Monahan - Dept Labor
b. Define state and carrier regulations.	Kathy Peterson _RRMC
c. Determine what changes could be implemented to improve the process without impacting	
the desired outcome which is efficient and accurate claims processing.	

KNOWN ESTIMATED COSTS:
a.
b.
c.

VII. REVIEW WORK PLAN AND ADD ADDITIONAL TASKS THAT MAY BE NECESSARY TO ACHIEVE THE GOALS OF THE ACT.

GOAL STATEMENT:

Examine other initiatives and programs designed to simplify the claims administration process and lower administrative costs,
 including an examination of the Utah Health Information Network and related Utah Department of Insurance standards,
and consider whether such initiatives and programs can be adapted to the benefit of the Vermont health care system.

SPECIFIC TASKS TO ATTAIN GOAL   **Entire Committee**
a.   Identify initiatives and programs worthy of further examination.
b.   Invite participants from other states or regions to inform the Task Force of their initiatives and programs.
c.   Review the Work Plan and add additional tasks that may be necessary to achieve the goals of the Act no less frequently
          than January 2007, June 2007 and January 2008.

KNOWN ESTIMATED COSTS:
a.   None

Utah Health Information Network

Presentation to Health Care Representatives in Vermont

uhin

What is UHIN?

UHIN as an independent community resource, is governed by a Board of Directors representative of UHIN membership. No single entity controls the Board. UHIN works towards developing products and means which enhance health care information collections efforts. The objective is to reduce the administrative and clinical burdens on payers, providers and other health care entities that increase health care costs.

UHIN's Beginnings

- Need for standardization in the Utah Health care community.
  - Payers implementing different methods for receiving electronic claims.
  - Providers trying to connect to 14 Payers using over 200 different types of billing software (Practice Management Systems).

- Governor Michael Leavitt - Health Print 2000.

- Utah Health Cost Management Foundation.

- Articles of Incorporation and By-laws signed November 1993.

UHIN's Mission

Create and manage an electronic value-added network

- ❑ Link health care community participants
- ❑ Interchange financial and clinical data

Standardize health care transactions

- ❑ Be a national leader in development of standards

Reduce the cost of Health Care to all entities

UHIN's Mission

Uses principal of cooperative competition instead of top-down mandates

- ❑ Uses best baseline activities of each member
- ❑ Financial incentives for each participant
- ❑ Uses State for control of the health statistical data
- ❑ Integrate with information highway network infrastructure
- ❑ Leverages practice management vendors to use UHIN protocols and procedures
- ❑ Connect to national clearinghouses and other RHIO's for out of state transactions
- ❑ Use National Standards where applicable

Result

❑ UHIN is a not-for-profit coalition of competing entities which operates a network utilizing a central hub (UHIN Gateway) to exchange standardized messages; one connection gets you to all members.

❑ UHIN is a value added network (not a clearinghouse); UHIN acts like the post office; UHIN does not store data; members transmit only standardized messages.

Providers

Laboratory

Pharmacies

Hospitals

UHIN Gateway

Payers

DOH

National clearinghouses

Other RHIO's

UHIN

Government:
- Reduce the Burden of Government
- State Insurance Commission
- Office of Recovery Services
- Utah Public Health
  - Birth Record
  - Disease Surveillance
- Immunization
  - Health Data Authority
  - Telehealth
- Medicare
- Medicaid

Transactions:
- UHINET/UHINT
  - HIPAA Transactions
  - Utah Transactions
  - Federal Transactions
  - State/Government Agency Transactions
- Future Transactions

Data Gathering:
- USIIS
- HDA
- HealthInsight
- Provider

Security:
- Education
- Utah Standards
- USET
- Consulting

Privacy:
- Consulting
- Education/Awareness

Consulting:
- Transactions
- Security
- Privacy Awareness
- EDI
- Internet
- Secure Email
- Certification

Coalition Building:
- Common Baseline Activities
- Financial Benefits to all
- State Controlled Health Statistical Data
- Integrate with Utah Information Highway
- Leverage PM Vendors
- Connect to National Clearinghouses
- National Standards

UHIN Standards:
- 34 Standards that have become Utah Insurance Commission Rule
- UHIN Operating Standards
- Recommendations to Members

HIPAA Standards:
- Transactions/Code Sets
- Identifiers
- Privacy
- Security

Education:
- EDI
- Privacy Awareness
- Security
- Hands-on Training for UHIN Products
- Value of Transactions
- ASC X12N Tech. Education
- Business implications
- Other

National Commitments:
- UHIN Staff and/or members serve or chair on at least 10 national committees, i.e.:
  - WEDI
  - WEDI/SNIP
  - EHNAC
  - ANSI ASC X12N
  - HL7
  - HealthKey
  - Other HIPAA Fed. Agencies
    - NCVHS

TX

Data

Gov.

Cons.

Coalition Building

Security

Privacy

Education

Nat. Commit.

UHIN

Utah Health Information Network

HIPAA

Building labels: Gov. | Coalition Building | Cons. | Security | Privacy | Education | Nat. Commit. | TX | Data

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  - HL7
  - HealthKey
  - Other HIPAA Fed. Agencies
    - NCVHS

UHIN Overview

- ❑ UHIN is a standards setting organization; set state rule for uniform claim exchange

- ❑ UHIN is not a quality improvement entity; UHIN makes it possible for members to accomplish this in a cost effective manner

- ❑ UHIN is involved in the national SDOs (X12, HL7, NCPDP, HIMNS, WEDi) UHIN staff brings this knowledge back to Utah

What UHIN has Accomplished

- Established Standards that have been nationally adopted
- Contribute a free pipeline for health data reporting to the state
- Members >1500 including:
  - 100% of hospitals
  - ~90% of medical providers
  - 100% of labs
- Brought significant savings to members

Funding

- ❑ Board of Directors Membership fee
  - ❑ One Time (All fees are determined by the Board – Pricing Sub committee recommendation)

- ❑ Annual Membership Fees to participating providers
  - ❑ Based on size of provider organization

- ❑ Transaction Charges

- ❑ Fees for Non-Core Services
  - ❑ UHINSpeedi
  - ❑ UHINTracker
  - ❑ Claredi
  - ❑ Other Value Added Services

- ❑ Self Sufficient

Legal Implications

- ❑ Anti-Trust Rules

- ❑ Trading Partner Agreements

- ❑ Business Associate Agreements

- ❑ Privacy

- ❑ Security

How does it work?

UHIN

Claims →

← Remittance advice and Acknowledgement Reports

Claims →

← Remittance advice and Acknowledgement Reports

UHIN just reads the address and delivers the envelope
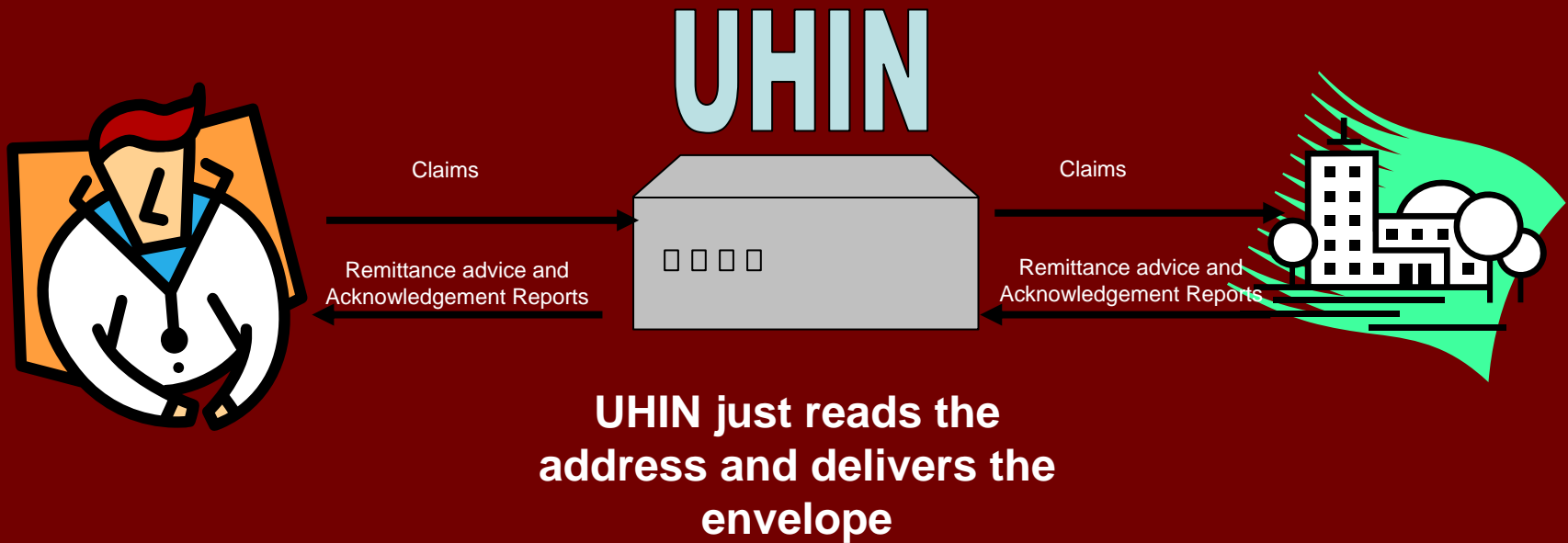
Education

Courses include:

- ❑ Introductory E-Commerce
- ❑ E-Commerce Transactions
  - ❑ Code Sets, Identifiers, Reports, Implementation
- ❑ UHIN Transactor
- ❑ HIPAA
- ❑ Security
- ❑ Privacy Awareness
- ❑ UHIN Security Tool – USET
- ❑ UHINSpeedi (Provider Credentialing and Enrollment Tool)
- ❑ EOB Reconciliation and EFT
- ❑ Certification and Testing
- ❑ Any requested topic that lies within the UHIN scope

Education

- ❑ UHIN has been approved as WEDI/SNIP Regional Affiliate

- ❑ Responsible for educating the UHIN Community which includes:

  - ❑ Payers

  - ❑ Providers

  - ❑ Purchasers

  - ❑ Government

    - ❑ State Legislators

  - ❑ Other health care entities

Futures

- Clinical Transactions
  - Provider to Provider Communications
    - Hospital Discharge Notes
    - Laboratory Reports

  - Additional Payer Messages
    - Attachments
    - Pharmacy Orders
    - Medication Histories

Lessons Learned

- ❑ Identify stakeholders.
- ❑ Define of the value you bring to individual members and/or their organizations?
- ❑ Prepare several very broad goals.
- ❑ Be inclusive not exclusive.
- ❑ Outline the steps you may take in accomplish these goals?

Define the Following

- ❑ What community is being served?
- ❑ Who is going to run it?
- ❑ What is the value proposition?
- ❑ What are the benefits of participation?
- ❑ What are the deliverables?
- ❑ What incentives are going to be offered?
- ❑ Are participants willing to wear a community hat rather than their organizational hats?

Encourage Participation

- Use active and practical methods
- Begin with an activity which is of interest to all
- Use small pilot groups
- Provide meaningful information
- Facilitate access to more information
- Trust
- **FUN**

Use Active and Practical Methods

- [ ] Identify and elect individuals who can provide leadership and hold the trust of the entire community.
- [ ] Identify participants and **_personally_** invite them to attend.
- [ ] Stick to predetermined agendas.
- [ ] Provide attendees with a mission statement and list of expectations for membership.
- [ ] Mentor each new member.
- [ ] Keep everyone focused on short and long term goals.
- [ ] **Be open to new ideas – and willing to give-up any preconceived notion.**

Begin with An Activity Which is of Interest To the Entire Community

- ❑ State Mandate
- ❑ Support of State and Local Government involved
- ❑ Personally Invite Major Players (CMS, HHS, Large Hospitals and Clinics)
- ❑ Include all Entities (Payers, Providers, Government, and Employers)

Use Small Groups

HIPAA Type

- ❑ Transactions
- ❑ Security
- ❑ Privacy
- ❑ Educational Outreach
- ❑ Sub-Committees

Organizational Type

- ❑ Board of Directors
- ❑ Executive Committee
- ❑ Standards Committee
- ❑ Technical Committee
- ❑ Sub-Committees
- ❑ Educational Outreach

Provide meaningful data and information

- ❑ Provide agendas for every meeting and stick to them!
- ❑ Email / Fax / Mail Notification
- ❑ Post Agendas, Attachments, Minutes on a Website
- ❑ Education and Training may be necessary.
- ❑ Always Start and End - ON TIME

Facilitate access to more information

- ❑ Provide Educational Outreach
- ❑ Maintain a Current Website
    - ❑ Opening Page
    - ❑ Easy to understand links
    - ❑ News/Current Informational Articles
    - ❑ Links to other sources
- ❑ Participation on National Committees

Education How

- Open House
- State-wide Outreach to Rural Areas
- Seminars
- Streaming Media
- Webinar
- Conference Calls
- In-Office Visits

Education

- ❑ New Member Orientation
- ❑ Introductory E-Commerce
- ❑ E-Commerce Transactions
    - ❑ Code Sets, Identifiers, Reports, Implementation
- ❑ HIPAA
- ❑ Security
- ❑ Privacy Awareness
- ❑ Any requested topic that lies within the scope of the organization

Trust

Payers
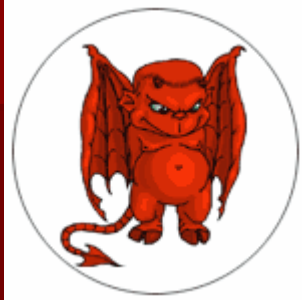
Lawyers

Providers

CMS

Your RHIO

Government

Clearinghouses
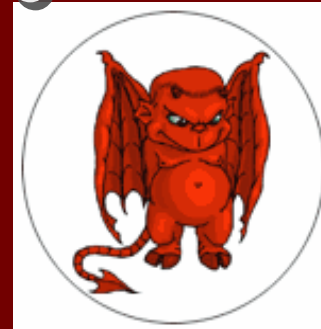
Employers

Vendors

Fun – Reasons Why People Participate

- ❑ Because it is interesting.

- ❑ The organization gains.

- ❑ The individual gains.

- ❑ Opportunity to be a part of the community.

- ❑ Personal growth through participation, organization, presentation and responsibility.

- ❑ Networking – meet and interact with new and interesting people.

Ask yourselves the following:

- ❑ Does it involve all stake holders?
- ❑ Is it the right thing to do?
- ❑ Is it based on correct principles?
- ❑ Does it reduce costs?
- ❑ Does it bring value to everyone?
- ❑ Are there any short term successes?
- ❑ What is the long-term vision?
- ❑ Goals?
- ❑ Is it fair for everyone?
- ❑ Does it accomplish anything?
- ❑ Is everyone willing to segment?
- ❑ Is everyone willing to keep talking?
- ❑ When crisis occurs, ask the first two questions again. If the answer is still **_YES_** -- continue on

Questions?

HealthePass Overview

Vermont Common Claims Committee

December 18, 2006

Margaret Mello- HealthePass Market Trial Lead

Rhonda Scurlock- HealthePass Financial Services Stream Lead

Rationale for HealthePass

During the past decade, the following market place trends have impacted the payment process from patients to providers:

- Payers & employers change benefit plans to variable designs (deductible/ coinsurance) from fixed (copay) designs

- Payers & employers increase the proportional share borne by the patient/member – CDHP's are accelerating this trend

- Consumer issues - entitlement mentality & limited "product knowledge"

- Provider business issues - model is B2B...issues shifting to B2C...notably delays in charge capture – takes between 2-10 days after the service is rendered

Effects on Patients and Providers

Members/Patients

Dissatisfied with their benefit plan:

- Confused about how much they owe
- Wasted time in an outdated payment process (e.g. reconciling provider bills to EOB)
- Strained relationship with their doctor

Providers

Dissatisfied with health plans & employers:

- Lost earnings (late payments, bad debt and increased collection costs)
- Strained relationship with the patient

Responding by:

- Collecting estimates of patient obligation up front
- Contractual measures to make up for lost earnings (incremental cost increase &/or product carve-outs)

How It Works – Member Estimates Cost

Before Care

Eva Smith
Estimated Obligation
of Services

$36.00 - $52.00

Based upon the following status
of your benefits:
- Your deductible has been met
- Your plan coinsurance after
  deductible of 20%
- Your out-of-pocket maximum
  has not yet been met

1. **Members easily access estimates of out-of-pocket costs for their health care encounters**

   ◆ available prior to care

   ◆ convenient access via phone or online

2. **Estimate is personalized**

   ◆ specific treatment/procedure

   ◆ specific provider

   ◆ specific benefits

3. **Makes information transparency practical for the member**

   ◆ seamless connection from provider comparison & other cost & quality tools

How It Works – Estimate At Point Of Care

During Care

CIGNA

Bob Williams
Estimated Obligation
of Services

$44.00

Based upon the following status
of your benefits:
- The patient is eligible
  for benefits
- The patient's deductible
  has been met
- The patient's plan coinsurance
  after deductible of 20%
- The patient's out-of-pocket
  maximum has not yet been met

1. **The provider updates the estimate**

   ◆ more details regarding specific services & codes

   ◆ real-time snap shot of accumulated benefits

2. **The provider reviews the estimate with the patient/member**

   ◆ estimate can be printed for member's records

   ◆ ensures member's consent prior to reserving funds

How It Works – Reserving Payment

During Care

1. **The multi-purse card is swiped for the estimated amount**

   - works with a standard card reader – no new technology needed

   - the estimated amount is keyed by the provider

2. **If the member has available funds, they are reserved**

   - multiple patient funds (HRA, HSA, FSA, Line of Credit) can be accessed through one card

   - a "hold" is placed on funds for the estimated amount

   - the "hold" is kept until the claim is submitted & paid

3. **A receipt is printed for the "hold amount"**

   - establishes member's consent

   - leaving the office, both member & provider are aware of estimated amount owed & method of payment

How It Works – Payment

After Care

1. **The provider submits the claim to CIGNA**

   ◆ no material changes to today's process

2. **Once paid, claim is matched to the "reserve" transaction**

   ◆ exact member obligation is known

   ◆ member fund accounts are settled

3. **One payment is made to provider – member + health plan**

   ◆ advice statement is sent explaining the transaction

   ◆ eliminates the need to bill the member

4. **Simple statement is sent to the member**

   ◆ explains the transaction

   ◆ remaining fund balances

Health*e*Pass Capabilities

Health*e*Pass will deliver the following capabilities to address patient liability and dramatically improve the payment process:

◆ **Estimator/Calculator** for real time estimates of patient out-of-pocket costs

◆ **Integrated healthcare and financial services card** with "multi-purse" access to financing options

◆ **"Hold-and-Settle"** payment processes to reserve funds at the point of care and, after care, automatically settle patient accounts and pay the provider

HealthePass Benefits

Members/Patients

- Eliminates confusion around payment obligation for a specific care encounter

- Reduces time and hassle associated with an outdated payment process

- Offers convenient access to multiple funds offered by industry-leading financial services firms via a single, integrated card

Providers

- Assurance of member payment

- Shortened patient revenue cycle

- Reduced administrative costs

Healt*e*Pass Differentiators

1. Automatic Processing Features

- ◆ "Hold-and-settle" features eliminate the time-consuming reconciliations associated with other forms of point-of-care payment

- ◆ First approach to address the needs of *both* patient and provider

2. Communication Features

- ◆ Estimator "does the math for you" - making information actionable for the users & available real-time

- ◆ Estimator is seamlessly connected with cost & quality transparency tools – once you're done shopping, you can estimate your costs

3. Flexibility of Model

- ◆ "Open design" to enable customer choice of some of the best financial services firms in the industry starting with American Express

- ◆ Capabilities are built on a configurable, multi-payer platform