CAQH

Collaborating to Take Costs Out of the Business of Healthcare

AHIP Institute

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Presenters

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- Sean Killeen, Kaiser Permanente
- Kelly Toman, Anthem
- Robin Thomashauer, CAQH (moderator)

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Agenda

- Value and impact of collaboration
- The business of healthcare
- Panelist discussion
- Q&A

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Collaboration

- Collaboration is one approach to streamlining the business of healthcare.
- Advantages include:
  - Leverage industry expertise.
    - Enables sharing of best practices to determine the optimal solution.
    - Neutral facilitator ensures input and consideration of impact across the healthcare system.
  - Allocate resources more efficiently.
    - During development, fewer internal resources are necessary to conceptualize, design and implement the solution.
    - After development, health plans are able to manage the business process more efficiently.
  - Improve provider relationships.
    - By being part of a collaborative solution, health plans are able to offer a single process that replaces separate processes required by each individual health plan.
    - This reduces the administrative burden providers traditionally experience working with multiple health plans.

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CAQH Overview

- CAQH, a non-profit alliance, creates shared initiatives to ***streamline the business of healthcare***. CAQH:
  - Collaborates with health plans and healthcare providers.
  - Innovates to accelerate the transformation of business processes.
  - Delivers value to providers, patients and health plans.

- CAQH helps organizations:
  - Streamline coordination of benefits processes with ***COB Smart®***.
  - Ease provider data collection and sharing with ***CAQH ProView™***.
  - Simplify provider enrollment for electronic payments and remittance advice enrollments with ***EnrollHub™***.
  - Develop and implement federally mandated operating rules with ***CAQH CORE®***.
  - Track the adoption of electronic administrative transactions with the ***CAQH Index™.***

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Routine Business Processes

- Many opportunities exist in areas where there is no competitive advantage to developing a proprietary solution.
  - Provider Data.
    - Simplify the collection and maintenance of provider data across health plan departments requiring professional and demographic provider information by utilizing a single secure, reliable, online resource.
  - Provider payments.
    - Increase provider adoption of electronic funds transfer and electronic remittance advice by easing the process for providers to sign up and partnering on outreach.
  - Coordination of benefits.
    - Ensure claims are processed correctly the first time to avoid claims rework.

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Streamline the Business of Healthcare

- Addressing these inefficient routine processes can result in improvements with:
  - Provider relationships.
  - Allocation of resources.
    - Staffing.
    - Costs.
    - Time.
- Ultimately, the healthcare industry agrees on the need to take unnecessary costs out of the system.

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Aetna

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Aetna – Electronic Funds Transfer (EFT) Enrollment Before Collaboration

- Larger provider organizations were early adopters of electronic funds transfer (EFT).
- Small provider groups are difficult to reach and not adopting EFT.
- Effective January 2014, Aetna required all of its contracted providers to be paid electronically.
  - Approach is to enroll groups of providers in phases due to extensive provider network.
  - Challenge is to implement this change with minimal disruption.
  - First national commercial health plan to institute this policy.

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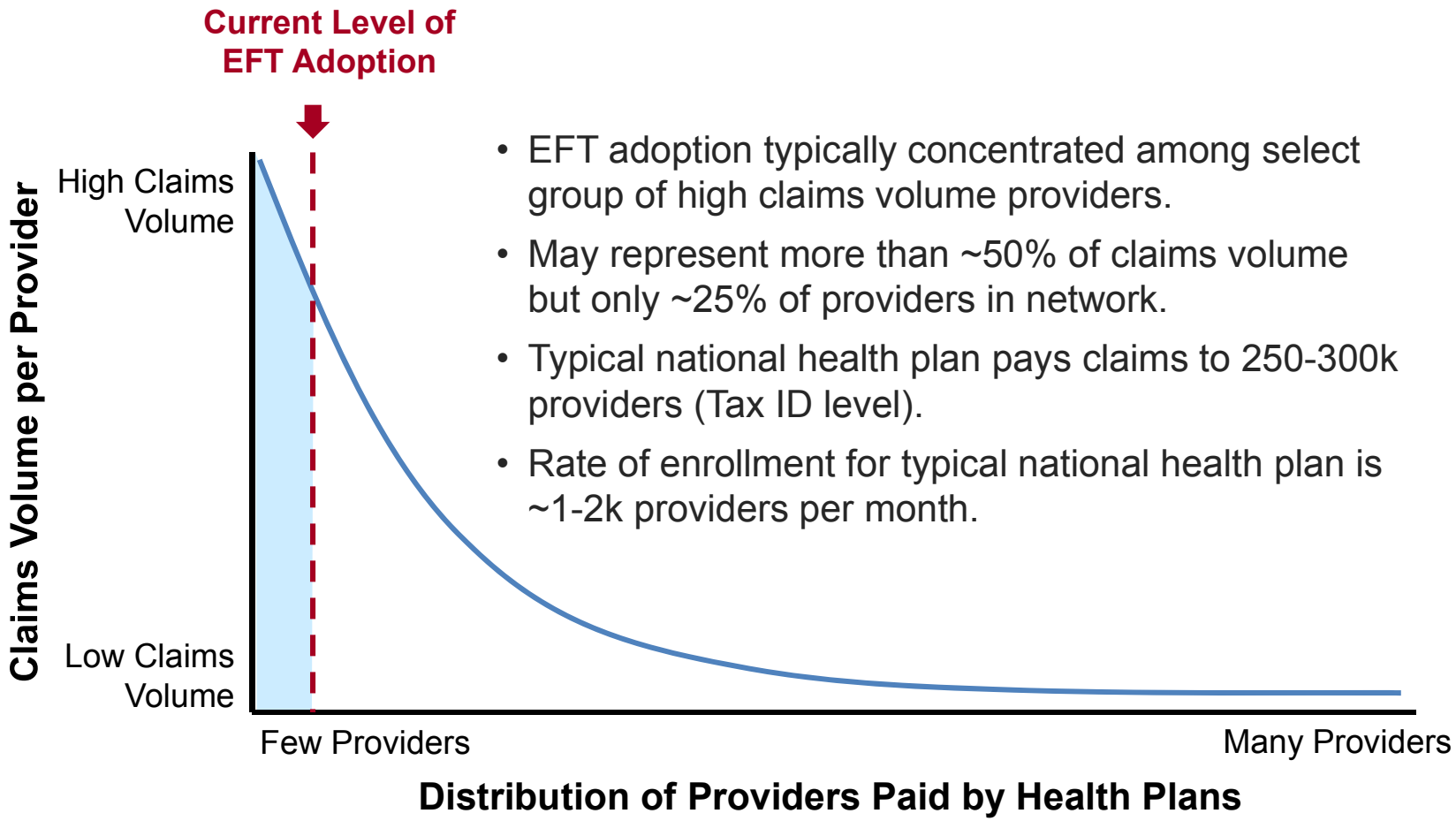
Aetna - EFT Enrollment Challenges

EFT Adoption by Claims Volume and Provider Size



- EFT adoption typically concentrated among select group of high claims volume providers.
- May represent more than ~50% of claims volume but only ~25% of providers in network.
- Typical national health plan pays claims to 250-300k providers (Tax ID level).
- Rate of enrollment for typical national health plan is ~1-2k providers per month.

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Aetna – EFT Enrollment Challenges

- Multiple outreach efforts are necessary to get a provider's attention to complete the enrollment process.
- Providers are less inclined to sign-up with one health plan who may represent a smaller percentage of patients in their practice.
- It is complex and time-consuming for a provider to enroll in EFT with every payer.
- Providers lack trust in the payer relationship. This varies by payer. For example, some providers are reluctant to provide bank account data to payers as they are concerned they will reverse a payment.
- There is a fear of the unknown/change. Providers are concerned they will experience difficulty in using electronic tools to reconcile payments.
- Smaller volume providers lack motivation. Providers are less likely to convert to EFT/ERA for their lowest-volume payers since it requires a different process for each payer.

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Aetna – EFT Enrollment
Why Use a Collaborative Solution?

- Aetna is a member of CAQH and supports the mission and vision of driving down administrative costs.
- The solution enables providers to enroll with multiple payers at once and maintain that information over time using a single online process.
- Marketing efforts can be leveraged across multiple health plans.
- The collaborative solution augments Aetna's internal EFT enrollment program to target specific providers and increase overall provider participation.
- Addresses several of the barriers associated with EFT adoption.
  - Providers trust the collaborative solution and are more receptive to using it.
  - The enrollment and maintenance function is streamlined for providers, encouraging sign ups with more lower-volume payers.

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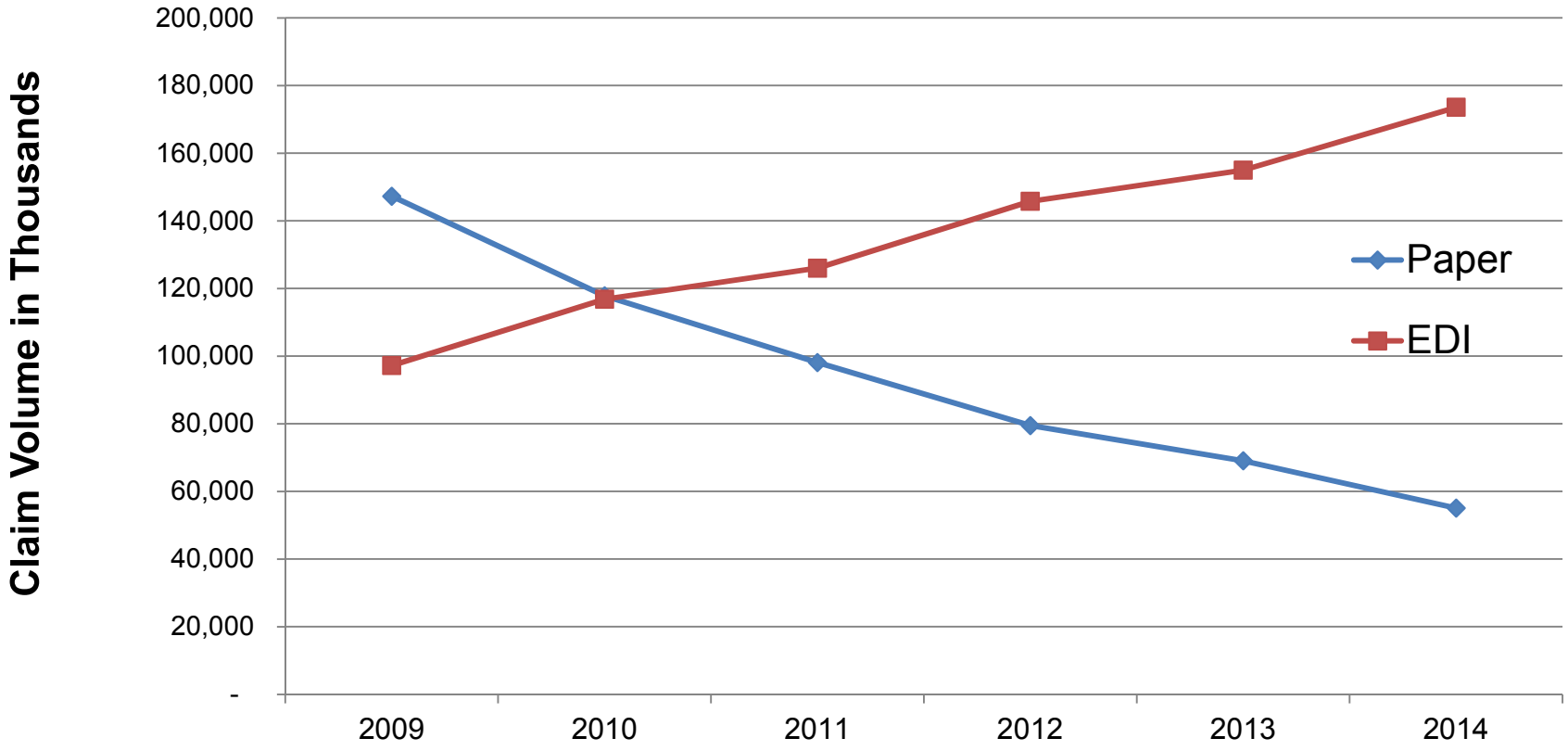
Aetna – EFT Enrollment Results

Claim Payments & Explanations by EDI and Paper



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Aetna – EFT Enrollment Results

- Aetna tracks and measures success for reducing paper as a percent of claims no longer printed: meaning no paper EOB or check.
  - Currently about 90% of medical claims paid electronically.
  - 76% of contracted medical providers no longer receiving any paper.
- Aetna also introduced virtual card payment as an option for providers.
- Continual multi-channel, repetitive communications are necessary:
  - Outbound calls to providers.
  - Inserting EFT enrollment forms into paper check mailings.
  - Monthly webinars to train providers on using Aetna tools to reconcile payments.
  - Frequent collaboration with clearinghouse vendors and industry groups, such as Health Billing Management Association, to educate their members on benefits of EFT and encourage their members to enroll.
- Aetna has expanded its electronic payment policy to include dental providers.

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Kaiser Permanente

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Kaiser Permanente – Coordination of Benefits (COB) Before Collaboration

- Primarily relied on the member interaction at Point of Service in plan facilities to collect Other Coverage Information (OCI).
- Also sourced OCI from:
  - Claims received as a secondary payer.
  - “Recovery Vendor” findings.
- Both mail and telephonic surveying supplemented this information, but were not used frequently.

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Kaiser Permanente - COB Challenges

- The Point of Service inquiry for COB information was being delivered inconsistently.
- Surveys were ineffective and inefficient.
  - Low response rates equated to a high cost per acquired OCI, impacting the breakeven proposition.
  - Conducted on an annual basis.
  - The inherent time lag required to process information often resulted in out-of-date data.
- Member confusion with forms caused inconsistent responses and a lack of full disclosure.

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Kaiser Permanente - COB
Why Use a Collaborative Solution?

- The scalable solution enables assessment of coverage for entire member roster.
- Automated file generation, data comparison and results distribution permits efficient COB processing.
- A weekly file submittal stays current with eligibility changes and supports timely reporting of data required for accurate COB processes.
- The solution is non-invasive since no member or group contact is necessary.

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Kaiser Permanente - COB Results

- Identifying a substantial number of new instances of overlapping coverage, along with higher volumes of dual (and triple) coverage than expected.
- Cost per acquired OCI are significantly lower - 90%+ reduction.
- Establishing processes to consume the volumes of new data.
- All participants that are part of the collaborative solution are learning how to use the COB information to improve data quality.

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Anthem

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Anthem – Provider Data
Before Collaboration

- Required providers to complete health plan-specific forms (paper) in order to be credentialed and loaded into provider databases.
- Ongoing provider outreach to obtain and confirm updated and current professional and demographic provider information.
- Dedicated significant staff resources to reviewing and processing provider credentialing forms.
  - Manual process, usually involving combination of mail, fax, phone, and sometimes even office visits.
  - Forms would “expire” and require additional visits and outreach to obtain updated information.
  - Data was inconsistent and often missing required information/fields.

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Anthem – Provider Data Challenges

- Committed to ensuring only qualified providers are serving members.
- Providers articulated burden associated with reporting information separately with each health plan for routine administrative processes (directories, claims payment, authorizations and referral data).
- Keeping provider information up-to-date required multiple inquiries and outreach from several departments, depending upon the reason for the data inquiry.
- Multiple provider databases used for numerous markets; as Anthem grew, new provider databases were acquired.
- Credentialing required a longer lead time. The process began 4-6 months before contract execution and entry into provider databases.

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Anthem – Provider Data
Why Use a Collaborative Solution?

- Providers trust and embrace this solution that enables a single process to report credentialing information and then share it with multiple health plans, hospitals and provider groups.
  - Provider satisfaction based on reduced paperwork and time saved.
  - All participating health plans, hospitals and provider groups receive the same information in the same format; it is less likely that the information will differ between health plans.
- Eases the process for providers to make updates, so information is maintained proactively, electronically and in “real time”.
- Data quality study found self-reported provider information to be highly functionally accurate.
- Collaborative solution contains data elements useful for processes beyond credentialing, such as provider directory maintenance and claims administration.

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Anthem – Provider Data Results

- 95 – 99% of Anthem providers and practitioners use CAQH for credentialing and/or re-credentialing, streamlining the process for more than 115,000 applications last year alone.
- Relatively short turnaround time to receive complete credentialing information compared to manual process.
  - Prior to single source of credentialing data, credentialing could take 6-12 months.
  - Credentialing turn-around time averages 3-6 months in industry. At Anthem, the process can take less than 45 days if information is current and no additional state specific/product specific forms are required.
- Provider data is easy to consume through electronic data summaries.
- Accrediting bodies acceptance and state adoption of credentialing applications directly impacted improvements felt by all health plans.
- Provider information is kept up-to-date, including electronic re-attestations, prompted by automated-system alerts to the providers.

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Q&A

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