How To Get More Physicians To Submit Claims Electronically. The fewer paper claims you see, the lower your administrative costs, so follow these tips to get your physicians on board the e-train. (Page 50)

Want To Cut Out The Middleman? More health plans are finding ways to process electronic claims without using a clearing-house by developing direct connections with providers. (Page 51)

Why Medicare Plans Need Strong DM Programs. If you’re considering entry into the revamped — and richer — Medicare Advantage program, you’d better make sure you have an established, successful program for dealing with chronic conditions. (Page 52)

States Searching For Ways To Expand Coverage. As health costs continue to rise, legislators are taking a closer look at the decline in health coverage. (Page 54)

Plan vs. FFS Competition Looking Unlikely. Will Medicare Advantage plans ever be allowed to go head-to-head with fee-for-service Medicare? (Page 55)

Scam Plans On The Rise, GAO Says. If you think you’re losing customers to illegitimate competitors, you’re right. (Page 55)
A world without paper claims may sound like a fantasy, but more health plans are getting closer to that goal thanks to sophisticated programs and savvy partnerships.

Most health plans receive about half their claims electronically, says Bob Strickland of Strickland & Associates in Atlanta. An exceptional health plan might have a connectivity rate of 70 percent, and even that leaves plenty of room for improvement.

As plans continue to look for new ways to lower their administrative expenses, many are “taking dramatic action in trying to improve their connectivity rates,” Strickland says.

“It’s a big administrative expense to process a claim on paper,” says Jim Denny, CEO and president of Navicure, a clearinghouse specializing in electronic data interchange. Every time a health plan needs to reject a claim or communicate other news to a provider, it has to print the correspondence and pay for postage, whereas an EDI system can send an electronic remittance advice online.

Because there are simply “so many transactions” between providers and plans, “it’s a tremendous savings” to use EDI, Denny says.

Though health plans have done a good job of improving their EDI rates, so far they have been focusing only on large providers. Strickland cites “the 80/20 rule,” which states that 20 percent of providers handle 80 percent of the patient volume for the entire health care system, and the remaining 80 percent of providers handles only 20 percent of transactions. For this reason, plans usually focus on making sure that the key 20 percent of providers are using EDI.

Still, plans need to go the next step and pursue the many providers who handle the remaining 20 percent of transactions, because “there’s still an awful lot of volume in that 20 percent,” Strickland says.

Problem: In order to successfully reach these small, often rural providers, plans need to find ways to encourage the “mom and pop” providers who are reluctant to embrace technology to go electronic. Plans need to find ways of reaching these providers and training them in EDI.

Solution: Consider working with small, regional clearinghouses in addition to the large national companies. Even many of the largest health plans are doing this, Strickland says, because the small clearinghouses are better able to “get closer to the providers and get them connected.” If you feel that the larger clearinghouses aren’t doing a good enough job reaching out to the smaller mom-and-pop physicians, the small clearinghouses could be your ticket, as they are more likely to work with small providers.

Many Docs Still Using Paper

Even though “most physicians recognize [EDI] as the right way to do it,” many providers who currently use EDI still send some paper claims as well, Denny says. There are two main reasons for this: lack of trust in EDI and lack of understanding. Some clearinghouses still use old, antiquated systems, and physicians have had a hard time getting good service and reliable transmission through these clearinghouses, he says. As a result, some of the physicians’ claims are not accounted for, and the more this happens, the more discouraged they get.

“It’s jokingly referred to as the black hole,” Denny says, since claims sometimes disappear and no one knows where they are. So physicians often turn to paper claims, which take longer but are as reliable as the U.S. Postal Service.

Tip: Health plans need to educate their providers so they know that they can use EDI. Providers are often uninformed about how exactly EDI works, says Michelle Llewellyn, manager of payer implementation for clearinghouse Gateway EDI, Inc. Sometimes providers aren’t sending e-claims because they don’t realize the plan can accept them. And sometimes
providers only send certain types of claims electronically because they assume that things like physical therapy notes can’t be sent electronically and that they therefore have no choice.

**Problem:** Sometimes providers get so confused about submission guidelines that they give up EDI. Often if one plan says a certain type of claim can’t be submitted electronically, providers assume that every plan works the same way, says Kathy Kennedy, senior vice president of PayerPath, another clearinghouse. As a result, even the plans with foolproof submission guidelines “get undermined unintentionally” by less savvy plans.

**Solution:** Plans need to be persistent about their provider education, using every channel available to them. “You tell them once, you tell them twice, you tell them three times,” Kennedy says. “You send it to them in letters, you highlight it at your provider seminars.” Alas, “There is no silver bullet” to getting providers to embrace EDI, she says; you just need to keep plugging away.

And plans shouldn’t expect clearinghouses and software vendors to do all the heavy lifting. As Kennedy says, she can always call providers and beg them to use EDI, but that plea carries more weight when it comes from the plan itself.

**Tip:** Some plans have provider representatives who call the physician offices to offer support and help solve problems relating to claims, Denny says. Plans

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**ELECTRONIC CLAIMS**

**Want To Cut Out The Middleman?**

**Why pay a clearinghouse when you can have a direct connection with providers?**

As the next step in electronic claims submission, more plans are developing direct connections with providers as a way of avoiding clearinghouses — and the fees they charge.

**Harvard Pilgrim Health Care** of Wellesley, MA, recently announced a partnership with athenahealth, a process management system and billing service, that will enable providers to submit claims directly to Harvard without using a clearinghouse. This is a good deal for both the provider and the payer, both of whom would normally have to pay a clearinghouse for processing claims.

“There’s an immediate economic advantage to the payer” if it opts for direct connect, says Kim LaFontana, director of collector services and payor relationships for athenahealth. Plans don’t have to devote as many administrative resources because they start receiving cleaner claims, receive fewer phone calls from providers asking about missing claims, have higher auto-adjudication rates and lower resubmission rates.

LaFontana says some plans experience a 70-percent cost difference as a result of using direct connect. And providers like it because they get paid faster and stop worrying about missing claims.

**Blue Cross and Blue Shield of Mississippi** recently announced that **MD On-Line** will provide electronic claims submission services off the plan’s Web site. MD On-Line gives providers a platform through which they can submit claims online not only for BCBSMS, but also for other plans.

This solves a common dilemma for providers, in which they work with so many health plans that it’s logistically impossible to submit online claims via all of the plans’ programs, explains Bill Bartzak, CEO of MD On-Line. His company has devised a way for providers to submit claims that can be sent to all plans. As a result, a plan using MD On-Line improves its own e-claims rates as well as the e-claims rates for other plans in the area.

With more software and practice management companies designing new solutions for electronic claims submission, plans should expect to see more ways of connecting with providers by dodging clearinghouses. ■
ELECTRONIC CLAIMS

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can use these contacts to convey to physicians what services are available. Large health plans that are allied with clearinghouses like WebMD often use these calls as an opportunity to pitch the clearinghouse’s services.

All the provider education in the world will go for naught, however, if your own systems aren’t up to speed. Some large insurers, as well as some clearinghouses, are still having trouble getting their houses in order to be able to handle HIPAA-compliant claims, Strickland says. Many health plans aren’t compliant and haven’t tested with the clearinghouses, and many clearinghouses themselves haven’t tested.

It’s vitally important to make sure your plan and your clearinghouse are fully HIPAA-tested and ready to roll. This way you can focus on provider education and not worry about any technical problems. ■

THE WORD ON THE HILL

Plan vs. FFS Competition Looking Unlikely

- Plans might have to be satisfied with new reimbursement rates for now.

Will Medicare managed care plans ever be allowed to go head-to-head with fee-for-service Medicare to determine which is most cost-effective and efficient?

Last year’s Medicare reform obviously has given a big boost to Medicare managed care plans, but the potentially most intriguing aspect of the bill is also the one furthest off in the future. In 2010, Medicare will sponsor some “premium support” demonstration projects in which Medicare Advantage plans will finally be allowed to compete with FFS. Unfortunately for plans, not only is that the distant future, but it may be a future that never happens.

Eighteen senators and seven representatives in Congress have already proposed bills that would exempt their states from participating in the demos. This outbreak of “not in my backyard” syndrome is likely to spread — legislators fear the public backlash against managed care, and they don’t want their constituents to feel that they were “forced” to join health plans.

“It’s pretty political,” says Marsha Gold, a senior fellow with Mathematica Policy Research. She doesn’t think the demo’s will happen unless there is a strong shift in the numbers of beneficiaries in FFS and in private plans between now and 2010. ■

INDUSTRY NOTES

Scam Plans On The Rise, GAO Says

- Legit health plans forced to compete with hucksters.

If you think you’ve been losing customers to some illegitimate insurers, you’re not alone.

According to a new General Accounting Office report, the number of “entities not authorized to sell health benefits” but doing so anyway doubled between 2000 to 2002 — and is continuing to rise. The Department of Labor and the states identified at least 144 such companies in that time period.

Many industry insiders believe the rising cost of health care premiums has priced many employers and individuals out of the legitimate market for health coverage, making them easy prey for hucksters whopromise