Coverage on Demand

Proof of Concept

As a fresh arrival on the market, Coverage on Demand has demonstrated strong results in a pilot implementation with a large healthcare system (see case study "Solving the Case of the Missing Third-Party Payers"). Coverage on Demand is now available to offer similar value to providers of all sizes.

Demonstrating to prospective clients the results they can achieve in their own organization, HMS has created a Proof of Concept service.

Coverage on Demand's advanced matching logic, algorithms and validation processes accurately identify members with other coverage.

The Proof of Concept process uses a slice of actual Medicaid primary data (typically 30 or 60 days) provided by the prospective client, then generates results (using a simple calculator developed by HMS) that estimates the anticipated revenue advantages Coverage on Demand can deliver.

How it Works

The Proof of Concept process is identical to the steps a subscribing client would follow:

- To start, the prospective client provides Medicaid primary patient demographics using a standardized data file format created by HMS.
- The data is transferred securely to HMS, where other coverage is identified.
- Other coverage information is categorized by inpatient, outpatient and professional visit types.
- The prospective client determines the average payments for both Medicaid and blended commercial payers for inpatient, outpatient and professional, then provides this information to HMS.
- HMS conducts analysis incorporating average payments by type, other coverage results and historical post-pay activities.
- HMS reviews the Proof of Concept results with the prospective client and answers any questions.

Understanding the Results

The completed Proof of Concept form HMS provides back to the prospective client contains clear insights and key actionable data.

From these results, the prospective client will be able to:

- Project with confidence the increased net revenue they can expect annually through correct billing to, and reimbursement by, the responsible third-party payers.
- See an accurate view of the percentage of their Medicaid population with third-party commercial coverage.
- Understand the pre-payment value of claims with other coverage when billed properly compared to the post-payment value when incorrectly billed to Medicaid.

In the pilot implementation, Coverage on Demand demonstrated that the provider received only 37 percent of the pre-payment value of claims when billed erroneously to Medicaid. The remaining 63 percent represents the incremental reimbursement revenue Coverage on Demand can help the provider recover if TPL is correctly identified at the pre-billing and pre-payment stage.

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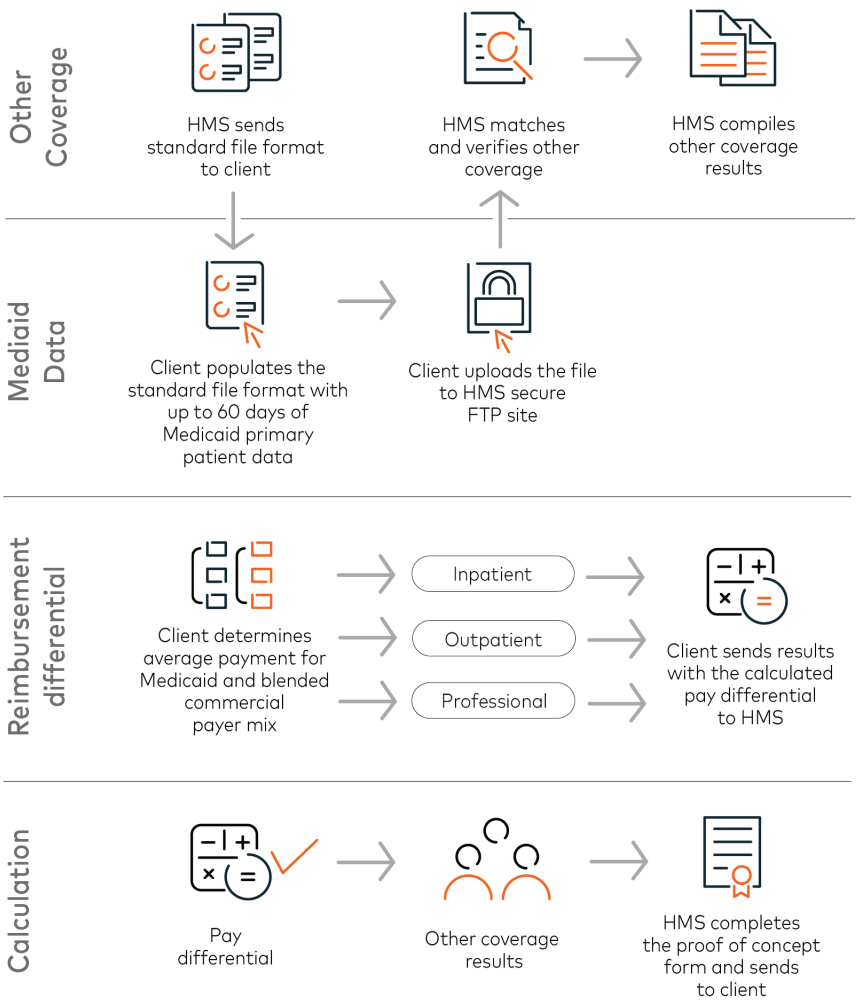
Coverage on Demand Proof of Concept Service



Demonstrating Value

The Proof of Concept will give the prospective client a clear picture of how implementing Coverage on Demand will benefit their organization. For most providers, the Proof of Concept will demonstrate significantly increased commercial reimbursement if third-party coverage is determined at the point of care, pre-authorization or pre-billing.

The prospective client will also understand the value of more accurate claims and billing within their own operations by reducing the administrative burden of claims re-work and re-billing and lost revenue from denied claims.

Contact HMS to find out more about how Coverage on Demand can improve your coordination of benefits program.

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HMS® delivers healthcare technology, analytics, and engagement solutions to help reduce costs, improve health outcomes and enhance member experiences.