Government
Healthcare

Your Medicaid population is growing.

You can deftly balance care and costs.

xerox®

Health program costs are increasing. So can your agency's efficiency.

You already see it: The Medicaid population is about to skyrocket – and with it, healthcare costs. As state administrators respond to the new challenges and opportunities of healthcare reform, they're looking to meet new government mandates. Make the most of funding. Rein in expenses and improve efficiencies. All without compromising provider relationships or care outcomes.

Xerox can help. Our services can help you make better decisions, ease administrative burdens on providers, and improve access to care. With our solutions, you can go beyond mere member enrollment and claims processing and support the entire healthcare ecosystem with truly patient-focused healthcare management.

When you partner with us, you simplify business processes across your entire healthcare program. The outcome of this efficiency? Fewer dollars go toward administration, and more go toward improving your program – and the health of your citizens. That's what we mean by giving you more freedom to care.

Facts to Consider

- 40 years of experience in Medicaid administration (MMIS)
- Work with more than 31 states, Washington, D.C., and the U.S. Department of Labor
- $50 billion in provider payments distributed annually
- 570 million claims processed annually
- 4,300 employees focused on government healthcare

Your program population is growing. Your agency can evolve to keep pace.

Medicaid enrollment has tripled in the past 20 years. As programs' median age rises and health declines, state budgets experience increased pressure. Today, 95 percent of a typical agency's program budget goes toward the costs of care. Our suite of technology tools is among the most innovative in the industry for monitoring and managing healthcare trends. You can use those tools – for modeling, profiling, benchmarking, reporting and predicting health risks – to better care for your citizens, at less cost, where and when care is needed.

For example, you can:

- Manage the influx of newly eligible populations through seamless enrollment and management programs
- Easily analyze information about the populations you serve
- Streamline operations and communication through a holistic approach
- Identify health trends earlier and respond to emerging risks faster
- Integrate sophisticated reimbursement models across programs and drive cost savings
- Use health information exchanges (HIEs) to share critical care information with patients, providers and payers.

Case in Point

The State of California mandated conversion of all its indemnity and Fee-For-Service Medi-Cal (Medicaid) recipients to a managed care model: a new Gold Coast Health Plan, designed to coordinate care and administer Medi-Cal benefits.

To make the Plan work, we built a robust provider network complete with credentialing, claims processing, customer service, customized fulfillment, reporting and a data center with disaster recovery capabilities. The result: More than 100,000 Medi-Cal eligible residents now receive better coordinated care and state benefits.

Facts to Consider

- 885,000 eligibility and renewal applications managed annually
- 4.2 million calls and faxes processed every year by our call centers
- 570 million health program claims processed annually
- 36 million people served by our government health services

The goal: more positive outcomes.
The way there: more informed decisions.

There certainly is no shortage of critical goals in today's healthcare landscape. You need to improve patient information portability. Reduce treatment risks. Enhance care delivery. And improve health outcomes through more portable health records and actionable data.

Finding ways to achieve these multiple, often conflicting goals is our specialty. When you partner with us, you can improve the efficiency and effectiveness of your program by:

- Developing HIEs so you can secure access to complete, integrated health records
- Implementing document management services and communications systems, so you can replace fractured, manual processes with automated alternatives that save time and money
- Using clinical analytics and predictive modeling tools, so you can compare member data against risk profiles, identify problems sooner and avoid serious health issues
- Scaling solutions based on present and future needs, so you can plan programs and budgets without worrying about the costs of retooling legacy solutions.

Informed Health Services for State Governments

- HIE/EHR/PHR
- EMR integration
- Clinical analytics
- Predictive modeling
- Health risk assessment
- Care/Case/Disease management
- Wellness programs
- Benefit plan and absence management
- Utilization/quality management
- ER diversion

Case in Point

Missouri's Medicaid program needed to improve its delivery of healthcare information to providers, pharmacists and recipients across the state. The solution was an advanced suite of electronic health record (EHR) applications supported by a robust clinical rules engine. The new solution delivers actionable information, including full medical and pharmacy claims histories, as well as automated authorization for prescriptions and billing.

Over 3,500 physicians were enrolled in the EHR solution. Quality of care has improved, and so has the program's bottom line: a savings of more than $280 million over four years.

Juggling care and cost takes skill. An MMIS can strike the delicate balance.

How can you reduce the costs of care while simultaneously improving program performance and patient outcomes? The answer lies in improving accountability while driving new innovations in care.

Partner with a full-service provider of proven, scalable Medicaid Management Information Systems (MMIS). With the deepest MMIS experience in the industry, we can help you determine eligibility and predict risk, accurately pay claims and quickly reimburse providers and manage your populations better by integrating program information and platforms. Among the benefits:

- Automate claims processing while encouraging best practices in provider behavior
- Detect program fraud and abuse through stringent auditing services
- Place patients in appropriate care settings, at home or in a care facility, ensuring quality service at the right cost
- Coordinate care management programs to predict trends and identify prospects for intervention – and use data to improve health outcomes
- Save as much as 30 percent on print and IT infrastructure costs.

Case in Point

The outdated legacy system of a state's Department of Health and Social Services (DHSS) was a burden on its Medicaid staff, as well as the provider community. After performing a comprehensive review, we streamlined administrative functions and MMIS workflow to speed application processing, then conducted call center and management training.

The results: We eliminated provider enrollment backlog, increased Medicaid resources and reduced the call center transfer rates by an impressive 24 percent.

Drug expenses continue to soar. A PBM program can keep costs in check.

Prescription drug costs continue to climb at double-digit rates, strapping already tight state budgets. At the same time, federal requirements for Medicaid drug programs change constantly, making your processes increasingly complex.

Amidst these pressures, implementing a successful pharmacy benefits management (PBM) program can seem like an elusive goal. But it doesn't have to be. Let us help you develop automated, streamlined processes for all or any part of your pharmacy program.

Whether you choose single program support or a comprehensive PBM system, the right solution can:

- Balance your population's health with pharmacy needs
- Better serve members while controlling expenses
- Reduce costs by monitoring prescribing habits and drug compliance
- Combat prescription drug fraud, waste and abuse
- Scale up or down to meet changing program needs and goals.

Case in Point

In Texas, prescription abuse and waste – overuse of opiates, duplicate drug therapies – taxed physician and ER resources. We solved the problem by reviewing claim histories and identifying patients not complying with treatment guidelines. Then we used educational interventions to align doctors' prescribing habits with clinically-based program standards. Finally, our SmartPA Point of Service program identified lower-cost generic substitutes.

The result of this multi-tiered approach: Denial of over 150,000 non-complying claims, generic substitution savings reaching into the millions, and a net savings of $6 million.

Facts to Consider

- Cost-efficient PBM results in 21 states and Washington, D.C.
- $13 billion in drug expenditures managed per year
- #1 in government-funded PBM programs served
- #1 in volume of drug claims processed

How to care for an aging citizenry? A well-managed LTC program.

As Americans live longer, long-term care (LTC) and home- and community-based services (HCBS) take on a higher priority for states. They must find innovative ways to address the growing need for senior care – and manage its costs.

Of critical importance: an efficiently managed LTC and HCBS program – one that enables you to simplify administration, while gaining a holistic view of participants' needs. We can help you institute and enhance such a program, so you can achieve administrative efficiencies, create cost savings and improve participants' independence and quality of life.

Scalable LTC and HCBS Services

- Automated level-of-care assessments
- Individual service plan development
- Provider credentialing
- Secure incident reporting systems
- Standardized reporting tools and procedures
- Fee schedule implementation, monitoring, automated reconciliation
- Visit verification systems
- LTC policy, program development

Case in Point

In one state, most infirm patients prefer home care to LTC facilities – a choice that threatened to overburden the state's provider network and healthcare budget. The solution: the Nursing Home Diversion program. We conducted and analyzed 20,000 in-home assessments for suitability, then developed care plans and submitted recommendations to the state for approval.

The program's results were impressive. Participants received higher-quality care without increasing costs. And the state realized savings of up to $300,000 per year.

Are your underinsured underserved? Help them find health coverage.

Fact: 17 percent of U.S. citizens had no health insurance in 2011. Managing a population's healthcare coverage means more than just serving the eligible and enrolled. It also means helping uninsured and underinsured individuals understand and obtain the coverage they need.

With our Eligibility & Exchange Services, you can inform your underinsured citizenry of their healthcare options – Medicaid, CHIP and others – and help them enroll in a plan. You can also educate them on positive behaviors that yield improved health outcomes and lower costs.

By 2014, every state must implement online portals for citizens to comparison-shop and choose a health insurance carrier. Employing our full suite of eligibility and health insurance exchange services, you can meet this federal requirement, while:

- Increasing program effectiveness and efficiency
- Decreasing your uninsured population
- Improving customer service.

We provide immediate online access to healthcare options. Our web portal is a one-stop marketplace that people can use to determine their eligibility, estimate and compare costs, get plan and provider information, and choose and apply for the right coverage.

Eligibility & Exchange Services

- Proactive outreach and retention of consumers, providers, employers, carriers and stakeholders
- Health insurance exchange shop-and-compare services
- Premium billing, processing, collection, aggregation and remittance
- 24/7 multilingual customer care
- Complaints, grievances, appeals and fair hearing support
- Consumer satisfaction monitoring
- Objective health plan quality review and compliance reporting
- Data analytics and actuarial support
- Incorporation of tax credits and subsidies in cost calculations
- Manage consumer life-change events to ensure continuity of coverage

Enhancing programs is the objective. Ensuring health is the outcome.

By teaming with Xerox, state Medicaid agencies are enhancing the efficiency of their programs and reducing overall costs, while helping improve care for their citizens. Our end-to-end capabilities address a wide array of needs – from HIEs to EHRs, analytics to reporting, fraud and abuse prevention to management of pharmacy benefits.

Across a rapidly changing healthcare ecosystem, we're proud to help ensure the health of people – and of the organizations that care for them.

Innovation in Action

A state's Medicaid auditors needed to scan, copy and mail over a million pages of claims and other paper records per year from healthcare providers. Our Chart Connect electronic workflow solution automated the records and moved them to the Cloud. Now auditors' comments, conclusions and final reports are indexed and stored securely for easy access, research and review.

To learn more, call us at 1.877.414.2676 or visit xerox.com/freedomtocare.

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