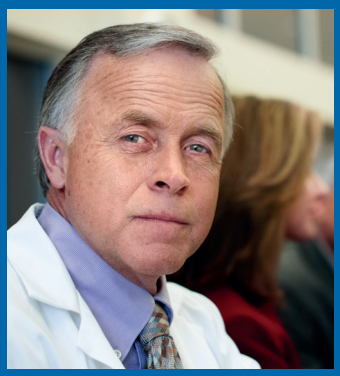
McKESSON

McKesson Health Solutions

McKesson Health Solutions (MHS) is a business unit of McKesson Corporation, the world's largest and oldest healthcare services company. We help payers and providers ease the transition to value by automating, integrating, and transforming financial and clinical processes across healthcare to lower costs, simplify complexity, improve quality, and enhance engagement.

- Decision Management solutions—including InterQual®—help payers and providers ensure the safest, most appropriate care by enabling consistent and optimal application of clinical evidence and help to reduce administrative costs through streamlined medical reviews and automated authorizations.
- Network and Financial Management solutions help health plans accelerate strategic deployment of networks, simplify complex reimbursement, and scale value-based payment.
- RelayHealth Financial helps providers automate the revenue cycle end-to-end, increasing accuracy and speed of payments. RelayHealth Financial solutions are supported by data intelligence tools that inform strategic decisions and revenue health.

MHS is one of the leading technology businesses in the payer market, with solutions used by more than four out of five payers in the country. In addition, more than 4,000 hospitals and facilities use our InterQual evidence-based decision support criteria. Finally, RelayHealth Financial solutions are used to automate 3.3 billion transactions a year worth $1.8 trillion in charges and payments between payers and providers.

BUSINESS
CARE
CONNECTIVITY

McKesson Health Solutions

Decision Management

The foundation of the Decision Management suite is the market-leading clinical resource, InterQual, which helps payers and providers ensure the safest, most appropriate care by enabling the consistent and optimal application of clinical evidence. The Decision Management technology solutions help payers and providers transform traditional utilization management processes by streamlining medical reviews, automating authorizations, and significantly reducing associated administrative costs.

InterQual Criteria

InterQual Criteria connects payers and providers with evidence-based, objective, and patient-specific decision support criteria to help ensure the right care at the right time at the right cost. The portfolio includes four product suites:

- **InterQual® Level of Care Criteria** assess the optimal care level based on severity of illness, comorbidities and complications, and the intensity of services being delivered. The criteria facilitate a holistic view of the patient and proactive care management with a condition-specific approach.
- **InterQual® Care Planning Criteria** identify when imaging studies, procedures, durable medical equipment, molecular diagnostics tests, specialty Rx, and specialty referral consultations are appropriate.
- **InterQual® Behavioral Health Criteria** support initial and continued stay level of care decisions for patients/members. The criteria address the varying needs of patients (children to geriatric) with both psychiatric and substance use disorders.
- **InterQual Coordinated Care Content** manage the most complex of patients with help from patented blended assessments that address multiple conditions to generate a patient-specific care plan. The content is designed to help organizations meet NCQA case and disease program requirements. It integrates into most care management programs.

Access Options

InterQual access options offer a range of technology for payers and providers to access InterQual Criteria in the most effective way for their organizations.

- **InterQual® View** is a convenient solution providing locally installed, reference-only access to InterQual. It features flexible print options, adjustable font sizes, informational notes, and citations.
- **InterQual® Online** provides access to InterQual Criteria via the web.
- **InterQual® Anonymous Review** enables interactive, web-based reviews without specifying patient data, and then transfers the results into another application.
- **InterQual® Transparency Solution** allows payers to give their network providers access to InterQual Criteria in an intuitive, reference-only format via their provider portals.
- **InterQual® Mobile** provides instant access to InterQual Criteria on Android™ or iOS (Apple®) devices. InterQual Mobile is available for InterQual Level of Care and InterQual Behavioral Health Criteria at no additional cost with an existing license.

Workflow Solutions

InterQual workflow solutions automate your medical review and help improve accuracy and enhance data collection.

- **CareEnhance® Review Manager Enterprise** is a browser-based, interactive utilization management workflow solution that puts the power of InterQual at reviewers' fingertips to support reduced variation in clinical decision-making. Review Manager helps automate the care review process, aggregate reporting, and electronically share medical necessity reviews.

Authorization & Connectivity Solutions

InterQual authorization and connectivity solutions help automate prior authorization for care at the point of decision. These technology solutions help lower administrative costs, speed authorizations, and reduce authorization hassle for health plans and the providers they work with.

- **InterQual Connect™** automates the medical review and enables full automated authorization within the context of existing care management workflows to provide additional functionality without sacrificing or duplicating previous investments. It provides a unified workflow that helps lower administrative costs when determining medical necessity or authorizing care.
- **Clear Coverage™** is a cloud-based application platform that automates authorization and coverage decisions in real-time. Clear Coverage incorporates InterQual Criteria and a health plan's business rules into its fully automated, interactive workflow to help streamline medical review. It is the only auto-authorization tool that includes network steerage and benefit/eligibility verification. It enables provider transparency and improves collaboration between payers and providers.

Tools

InterQual tools help payers and providers optimize their investment and the use of InterQual across their organizations.

- **InterQual® InterRater Reliability Suite** is a web-based testing application that is designed to help improve consistency across an organization, measuring how well and how consistently staff applies InterQual Criteria.
- **InterQual® Content Customization Tool** enables organizations to author and edit custom content to more closely match their medical and business policies and create a single workflow for all utilization management content.

McKesson Diagnostics Exchange™

McKesson Diagnostics Exchange is a test identification and policy management solution that connects payers, laboratories, and physicians to drive appropriate molecular diagnostics coverage and reimbursement. Tests are precisely identified using McKesson Z-Code™ Identifiers and test information, including evidence, is accessible through an open, online catalog.

Network & Financial Management

McKesson's Network and Financial Management solution suite provides advanced technology, professional services, and industry expertise to help payers accelerate network deployment strategies, simplify complex reimbursement, and scale value-based payment. Our solutions are designed to help payers extend their current technology investments by providing scalable and increasingly interoperable modules that enable plans to successfully navigate rapid regulatory change, evolve payment models, and establish new relationships with providers and consumers.

ClaimsXten™

Used by more than half of all health plans, ClaimsXten™ is an advanced claims auditing solution which combines fee-for-service and value-based capabilities to enhance claims payment accuracy, savings and transparency while helping health plans transition to value-based payment models. A combination of a sophisticated rules engine and a library of clinical rule content, ClaimsXten helps departments across a health plan reduce their dependence on IT staffs to maintain the system changes needed to comply with

regulatory, coding and reimbursement policy changes.

ClaimsXten™ Select

ClaimsXten Select gives small and midsize payers a robust rules engine that pre-configures complex rules to promote savings with an underlying technology designed to increase administrative efficiency.

Bundled Payment Solutions

McKesson's suite of value-based reimbursement solutions supports payers in developing and running full-scale bundled payment programs with either a retrospective or prospective rules-based approach as they transition from volume- to value-based care.

- **HealthQx**™ A value-based analytics platform which provides the capabilities to design, implement and monitor retrospective payment programs in support of episodic, bundled or accountable care arrangements.
- **McKesson Episode Management**™ Automates episode definitions and initiations for claims bundling within current claims workflows to support health plans in developing and running full-scale prospective bundled payment programs.

McKesson Contract Manager™

McKesson Contract Manager is the preeminent contracting solution for streamlining the entire contracting process, helping health plans keep up with healthcare system transformation and fast-changing regulations. It connects a central repository for provider contracts with flexible contracting workflows and a standard contract template library, helping to eliminate configuration and payment errors while improving compliance. Its cloud-based contract fulfillment capabilities help improve transparency and adoption of new care delivery, reimbursement, and payment initiatives.

McKesson Payer Connectivity Services™

McKesson Payer Connectivity Services is a payer-facing, HIPAA-compliant EDI gateway solution that lets payers consolidate and manage inbound and outbound transaction streams at a single connection point. This flexible and scalable SaaS platform provides an end-to-end connectivity solution that helps enhance claims workflow.

McKesson Provider Manager™

McKesson Provider Manager is a highly flexible, scalable solution that helps health plans improve the accuracy and efficiency of network operations, health plan care delivery, and reimbursement initiatives—all while helping to reduce costs and enhancing provider and member engagement. With a choice of standardized and orchestrated workflows, McKesson Provider Manager stores provider information and represents complexity of relationships. It helps payers manage provider data with the agility required to support and connect new products, care models, and reimbursement designs.

McKesson Reimbursement Manager™

McKesson Reimbursement Manager provides the flexibility, intelligence, and transparency needed to unleash fast, effective, and efficient payment model innovation. It helps create and manage a range of payment methods; connecting and automating the claims adjudication process for virtually any arrangement. Health plans can apply business logic to build new payment methods and implement them quickly, and configure a pricing component library. Reimbursement Manager helps increase payment accuracy and transparency while reducing costly, one-off claims system customizations.

RelayHealth Financial

RelayHealth Financial provides intelligent connections to power providers' financial workflows. Its electronic data exchange manages eligibility, claims, remits, and claim status transactions with connections to over 2,200 payers. RelayHealth Financial platforms have been optimized for each of the major EHR-EMR platforms. An experienced network of professionals delivers superior customer experience through excellent implementations, training, service, and support of market-leading financial applications.

RelayHealth Financial Patient Access

RelayHealth Financial's Patient Access product suite connects patients, providers, and payers to get the right information up front helping to prevent denials and accelerate revenue.

- **RelayClearance™ Plus** helps manage critical patient access activities as early in the revenue cycle as possible to enhance the provider's ability to collect payment at or before the time of service. It also helps improve data accuracy at patient registration and manages the pre-authorization screening and verification process, which reduces claim denials and rework.

The RelayClearance Plus suite offers the following solutions to help improve patient financial visibility:

- **RelayClearance™ Verifier** performs eligibility verification, identifies additional coverage for self-pay patients and provides batch processing with sophisticated exception worklisting to assist in faster payment, and proper collection efforts.
- **RelayClearance™ QA** identifies errors at registration to provide accurate data for downstream processes, helping prevent claim denials later in the revenue cycle.
- **RelayClearance™ Authorization** automates manual screening and verification processes by determining if a pre-authorization is required and on file with the payer.
- **RelayClearance™ Estimator** calculates patient financial responsibility at or before the point of service to help set patient financial expectations prior to care delivery.
- **RelayClearance™ Advocate** screens patients who cannot pay and evaluates them for charity, Medicaid, or other financial assistance.
- **RelayClearance™ Propensity to Pay** automatically screens to determine a patient's ability and inclination to pay.
- **RelayClearance™ Address Validation with Fraud Alerts** provides comprehensive identity authentication to confirm that patients are who they say they are and that core demographic information is correct.
- **RelayClearance™ Lobby** helps put patients at ease, beginning with a paperless sign-in, and helps alleviate long wait times by assisting in discovering and averting bottlenecks in a provider's service delivery areas.
- **RelayClearance™ Professional Services** help organizations further integrate our solutions to develop and optimize daily workflow. An assessment is conducted to determine areas that need improvement, and research and analysis is offered to determine possible solutions. Teams then work together to leverage the technology to help increase productivity and efficiency.

RelayAccount™ Solutions

RelayAccount solutions help providers efficiently manage patient accounts and provide convenient methods for patients to make payments.

- **RelayAccount™** is an online patient payment and account management solution that helps bring clarity to patients about what they owe and when it's due. It also provides patients a simple, convenient way to pay anytime and anywhere, which helps increase cash flow and reduce A/R days.

- **RelayAccount™ WebPay** helps providers collect estimated amounts at pre-service and then process payments at every point of service anywhere in their facilities. Providers can also assist patients with paying over time, paying later with a scheduled payment, or paying when the bill is ready (electronically paying the estimated amount after insurance has paid).

RelayHealth Financial Claims Management

RelayHealth Financial Claims Management solutions connect providers and payers so claims are paid in full the first time, helping to accelerate cash flow.

- **RelayAssurance™ Plus** helps speed reimbursement and reduce costs by applying comprehensive business rules to claims, to help increase first pass claim acceptance rates, and pairing automation and advanced workflow with meaningful reporting.
- **RelayAssurance™ Appeals Assist** offers a streamlined approach to create and track multiple levels of appeals for denied claims directly within the RelayAssurance Plus workflow. The solution handles the three levels of denied Medicare claims appeals, and includes integrated denial management workflow that helps providers initiate and track submitted appeals.
- **Status Amplifier™** is a web-based, claim status inquiry system that enables providers to gather thorough information about pending claims from proprietary payer portals as soon as one day after claim submission. Unlike manual processes including payer portal queries or phone calls, Status Amplifier helps providers gather batch or individual claim status via the use of automation. The enhanced visibility into claim status information helps providers become more efficient and take early, targeted action on pended or denied claims.
- **Revenue Recovery Services** Emergency Recovery, Inc. provides revenue recovery services to RelayHealth Financial customers. Using claims data from an extensive network of public and proprietary databases, this service helps identify potential revenue leakage caused by claims determined to be uncollectable, underpaid, or in self-pay status, and identifies revenue from those claims that can be recovered for providers.
- **RelayAssurance™ Professional Services** help integrate RelayAssurance Plus into daily workflow processes and assists in the automation of as many manual processes as possible to increase staff productivity and process efficiency. Leveraging a provider's data, this service can help each organization understand how to use RelayAssurance Plus to optimize its revenue cycle experience.

RelayHealth Financial Analytics Solutions

RelayHealth Financial Analytics Solutions help providers to analyze operational and financial data across their organizations and the marketplace to empower strategic decisions and improve revenue cycle performance.

- **RelayAnalytics Pulse™** provides near real-time visibility into hospital performance and context for metrics by comparing them to similar hospitals across the country. Identification of payment obstacles and root cause analysis of issues can be performed quickly to guide business process improvements and help positively impact revenue cycle results.
- **RelayAnalytics™ Acuity** is a business intelligence tool offering revenue cycle leaders strategic insight into the large volume of data that their hospital generates to inform decisions made in key areas impacting the revenue cycle.

RelayHealth Business Partner Solutions

RelayHealth Business Partner Solutions help create a strategic advantage for companies serving the provider community by enhancing their technology and services without large investments in development and ongoing management. Advanced implementation and support tools help our business partners and providers gain efficiencies and realize financial benefits more quickly.

Relay Learn™

Relay Learn is a web-based knowledge portal that provides online education offerings for RelayHealth Financial solutions. The Portal, available 24/7, can assist staff with refresher training and is available when new employees need to get up to speed quickly on RelayHealth's solutions.

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