

WHITE PAPER: UNVEILING THE TRUTH BEHIND REAL-TIME ADJUDICATION AND THE PATH TO PAYMENT ASSURANCE

By Bill Marvin

ABSTRACT:

For the last 10 years, developing real-time adjudication (RTA) for healthcare claims has been one of the top administrative priorities in the healthcare industry. However, the results delivered have not been successful for healthcare providers or payers. This white paper will examine RTA, detailing the challenges with its adoption and application across the industry. Furthermore, it will refocus the same discussion around the core problems that RTA was meant to address and present a new way forward for the industry.

KEYWORD: healthcare payment assurance, provider payment assurance, real-time adjudication, healthcare payments

INTRODUCTION:

Ten years ago, the healthcare industry had successfully completed Y2K and was very close to completing the initial phases of the HIPAA transactional implementation. These were significant milestones for the “administrative” side of healthcare (as opposed to the “clinical” side). Since then, developing real-time adjudication (RTA) for healthcare claims has been one of the top administrative priorities for the industry. From a high-level standpoint, RTA makes sense. However, the healthcare transaction process has nuances both from a technology and business perspective, which present significant challenges to the development and adoption of RTA.

The RTA initiative began with promotions by large payers through industry associations and at conferences. These large payers had recently realized the administrative benefits from their investments in gateways for real-time eligibility, claim status and other capabilities – assets that laid the foundation to take on RTA. With the business case realized from newly built transaction gateways, which created competition to lower the cost per transaction, the next step was to leverage these assets to deliver RTA.

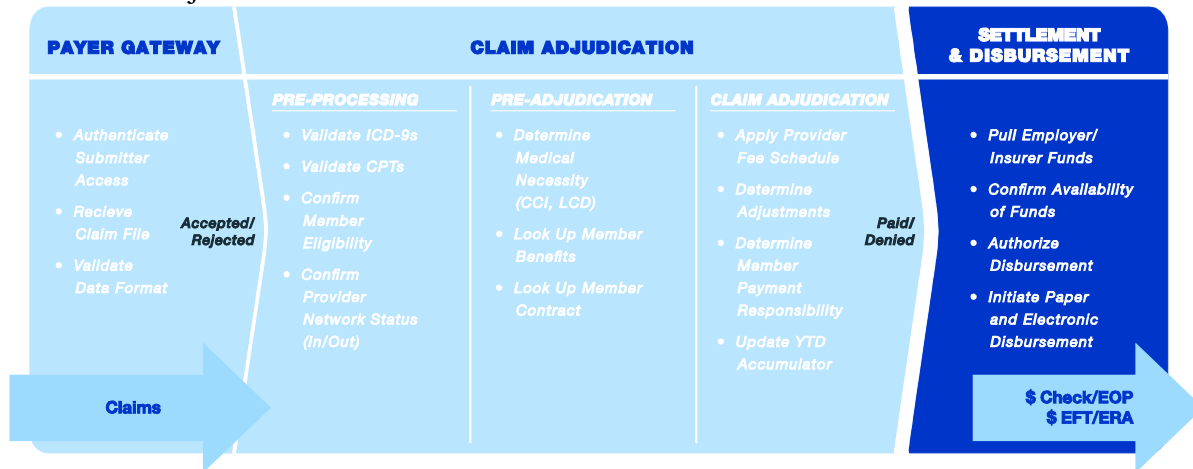
The payer-led RTA promotion campaigns were quickly joined by real development projects, pilots and provider adoption campaigns. By 2005, the RTA effort had attracted the attention of vendors, financial service providers and industry groups – and the RTA initiative had momentum. However, five years later, the results delivered have been underwhelming for both payers and providers. This white paper will examine RTA and the challenges of adopting it. Furthermore, it will refocus the same discussion on the core problems that RTA is meant to address and present a new way forward for the industry in this decade.

WHAT IS RTA?

For the purposes of this white paper, RTA will be defined as the ability for a payer gateway to receive, validate, pre-process, adjudicate and respond to the submitter of a claim (837) with a

final, binding decision on the claim – in less than 30 seconds. See Figure 1 for an illustration of the RTA process.

FIGURE 1
Real-Time Adjudication Process



WHAT ARE THE CHALLENGES OF ADOPTING RTA?

Processing Maturity for 835s

In the 1990s, the healthcare industry began using Electronic Data Interchange (EDI), built on a one-way (uni-directional), batch-based infrastructure for claims submission, which was developed by vendors and clearinghouses, along with government contractors. By the mid-1990s, most government and some commercial payers and blues plans (members of the Blue Cross and Blue Shield Association) added the ability to receive an electronic remittance advice (ERA), known at the time as a “recon file” and today known as an “835.” Since the healthcare industry completed Y2K and the HIPAA transactional implementation requirements, the healthcare EDI infrastructure has matured into a bi-directional, batch-based infrastructure, enabling healthcare providers to rapidly adopt the 835. Nevertheless, this bi-directional, batch-based processing of 835s is not always reliable and hardly ever standard across payers, or even the government. For example, SLAs (service level agreements) vary widely and, for the most part, are not published even to providers and claim submitters. This results in confusion and many phone calls to customer service when outages are poorly communicated or unscheduled system maintenance occurs. Most providers and claim submitters have expressed great frustration with the current claims submission and 835 receipt processes and, likewise, most would agree that more maturity is still needed for even a basic batch-based 835. Before RTA can be adopted and applied, it is necessary for the 835 processing capabilities to mature, which will put the industry in a better position to deliver on RTA.

835 Format Deficiencies

In addition to its need for maturity, the 835 also has several known deficiencies, though it was adopted by HIPAA to be the standard communication transaction for reporting on claim payments, adjustments and patient responsibility. As implemented by many payers, the 835 inhibits the provider’s ability to perform denial management and secondary payer and patient billing. This is due to the variations in the association of Claim Adjustment Reason Codes

(CARCs) and Claim Adjustment Group Codes (CAGCs), whereby incorrect coding can lead to costly and unnecessary manual follow-up, faulty electronic secondary billing, inappropriate write-offs of billable charges and incorrect billing of patients for co-pays and deductibles.¹ And this is just one of the deficiencies limiting provider adoption of 835s, which is a requirement for RTA.

Complex Business Process and Outsourcing

The inherent complexities of creating a claim also present a challenge for the adoption of RTA, and if this process is not completed with the patient present, RTA's value diminishes significantly. The challenge starts with the fact that providers do not necessarily know ahead of time what services they will perform on a patient. Once care is given, most providers and front desk staff are unable to translate the services performed, along with patient diagnosis and other necessary information, into a properly coded claim. Frequently, clinical notes from a provider-patient encounter must be interpreted by an expert "coder" in order to create a claim. And this coding activity can be as much of an "art" as it is a "science," especially when dealing with certain provider specialties or submitting to certain payers.

As a result of the inherent complexities and increased administrative costs associated with creating claims, many hospitals choose to outsource their billing.² In fact, between 55 and 65 percent of hospital radiology and anesthesiology departments have outsourced their billing. And when billing is outsourced, claims are created and submitted in a batch mode, without the patient present. Therefore, outsourcing has driven up the number of incidents where there is no chance to create a claim with the patient present, which limits the value for RTA. Furthermore, as the industry moves from ICD-9 to ICD-10, the claim creation process will become even more complex, which will further reduce the opportunity for providers to benefit from RTA.

Fraud and Abuse

Another factor hindering the adoption of RTA is the provider's challenge of meeting the fraud and abuse requirements for claims. As the industry has grown to exceed \$2.5 trillion, the government and commercial payers have increasingly audited providers for fraud and abuse. While it is less common for providers to submit fraudulent claims, up-coding claims (increasing the complexity of the diagnosis and/or procedure of a claim) does occur in a significant number of transactions. To combat this, federal regulators and commercial payers have aggressively prosecuted healthcare fraud since the early 1990s, leading to billions of dollars in financial recoveries.³ The result for providers is the risk of huge fines, contractual penalties, offsets to future claim payments and other negative consequences. Examples include:

- National Health Laboratories Inc. paid the federal government and state Medicaid programs \$111 million to settle a whistleblower case. The lawsuit charged the company billed Medicare for blood tests added to the standard panel of blood chemistry tests even though providers had not ordered the extra tests and they were medically unnecessary.⁴
- Columbia/HCA (now known as HCA) paid \$92 million to settle a whistleblower lawsuit, which stated that each time a physician ordered a complete blood count (CBC) for a patient in the emergency room or outpatient services, Columbia hospitals also billed Medicare for additional blood chemistry tests, known as "CBC indices," that providers had not ordered. In addition, according to the lawsuit, when a

provider ordered a “chemistry profile” for a patient in the emergency room or outpatient services, the hospitals also charged for various other blood tests that had not been ordered.⁵

The fraud and abuse requirements present a significant challenge for the widespread adoption of RTA, as they create a need for more caution, quality assurance and, frequently, outsourced billing. Hospitals will not risk coding and submitting a claim at the point of service if it will increase the chance of fraud and abuse.

Technology and Workflow

The complexities around workflow and systems integration also present a challenge for the adoption of RTA. Provider systems still lack standards, and a large percentage are legacy based. Integrating workflow and systems properly to support RTA is challenging for both providers and payers. Another technical obstacle will be presented when ICD-10 becomes mandatory; this will not only require significant provider system upgrades and enhancements, but will challenge the human workflow and decision-making process by dramatically increasing the scope of diagnosis codes that must be considered.

WHAT PROBLEM DOES RTA SOLVE?

Many industries can boast consumer-to-business or business-to-business transactions, such as payment card and pharmacy transactions, that occur in real-time. Of course, it stands to reason that the completion of a transaction in real-time is better than slow-time, and certainly better than days or weeks. Therefore, logic says that full adoption of RTA would be beneficial to the healthcare industry. But what is the relative value of RTA and, just because it will be a good thing in the future, would it solve the industry’s problems right now? And for that matter, what problem is the industry trying to solve with RTA?

While logic points to adopting RTA, it appears that the healthcare industry is more focused on the problem of building out RTA than solving the problem that RTA is meant to solve. Many smart executives in healthcare believe that the industry’s problem is its lack of RTA. While logic, along with the comparison to other industries, supports this belief, it is incorrect. RTA is a technology feature, not a solution to the existing problem in the industry – a point that has been widely overlooked. The real problem is that the healthcare industry lacks the ability to deliver payment assurance to providers and an efficient payment disbursement process for payers. This simple deficiency leads to significant administrative costs that amount to several hundred billion dollars per year, including an estimated \$65 billion in bad debt for providers.⁶ This administrative cost equates to at least 10 percent of the \$2.5 trillion per year (and growing) that flow through the healthcare industry.

The Lack of Payment Assurance is the Problem

While payment assurance, RTA and fast payment settlement (relative to claims processing) all have value, payment assurance has the highest level of relative value. When determining the value of RTA, it is necessary to separate the process of RTA from the process of payment settlement, or available funds in a bank account. This is because, while adjudication or an authorization can happen in real-time, the payment settlement process cannot. Therefore, the

concept of completing the adjudication process in real-time with money in the bank is impractical within the U.S. financial payment networks, and it is unprecedented for a transaction process. Even a point-of-sale payment card transaction process does not deliver payment settlement in real-time. Rather, its first objective in the process is an authorization, and then the payment settlement occurs, usually 24 to 72 hours after the authorization. This is because payment settlement in less than 24 hours through the Federal Reserve System can only occur via a wire transfer process, which is expensive, involves human manual processes and is not scalable for the billions of healthcare payment transactions per year. Thus, the pursuit to deliver payment settlement within the RTA process is impractical for healthcare claims, as, ultimately, all U.S. healthcare payments must flow through the Federal Reserve System.

Other Industries Have Payment Assurance

Think of the payment assurance that Best Buy has in a payment transaction: it allows a consumer to walk out of its store with a thousand-dollar television, even though the payment is not yet in the company's bank account in the form of available funds. The only thing Best Buy has to fall back on is its trust in an authorization, delivered by a payments network, after a consumer's payment card is processed. Imagine telling Sam Walton in 1960 that he would just have to trust that the money owed to Wal-Mart would be in the bank. Yet this concept is what healthcare needs: the concept of trust, payment assurance and the efficiency for the provider and the payer to transact money. Even if payers were to make funds available in 10 business days, while delivering a highly reliable authorization code of trust to the provider, the industry would produce a significantly improved level of payment assurance. In fact, the value to the provider of payment assurance with 10-day funding far outweighs the incremental value of going from 10- to one-day funding, especially with low interest rates. This is because payment assurance has nothing to do with receiving money in one day, or in 20 days. It just has to do with the certainty that one will get paid.

THE PATH TO PAYMENT ASSURANCE

Understand the Current Situation

Today, the healthcare payments infrastructure is predominantly composed of the healthcare EDI infrastructure, which has no connectivity to the payment infrastructure involving the Federal Reserve System. This infrastructure, having reported over 150 data breaches in 2010, requires significant improvements in security and also needs to mature from a technical and operational perspective to address the lack of payment assurance. Additionally, it should define and adopt an operating rules framework that meets its needs, similar to the payment infrastructure (examples of such are NACHA, Visa and MasterCard). By requiring participants in the healthcare EDI infrastructure to register and then publish and continuously meet minimum criteria for SLAs, the healthcare payments infrastructure could begin to improve its current state.

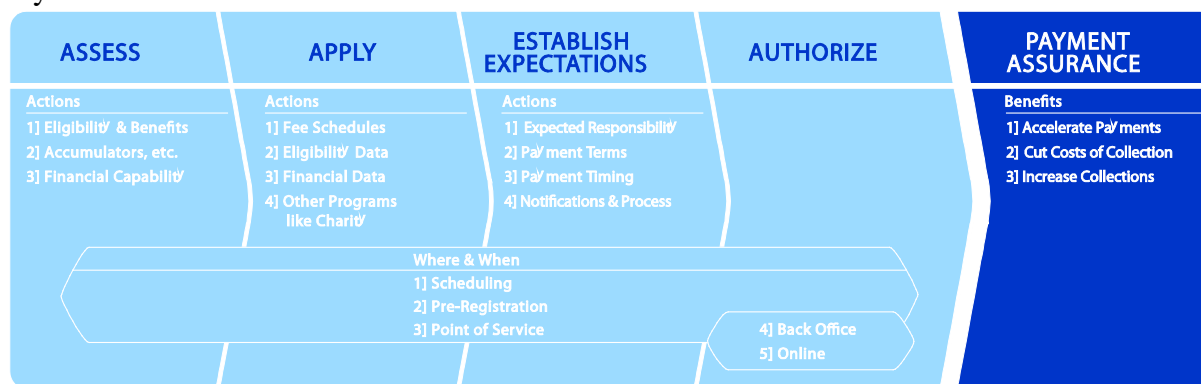
Change the Paradigm

It is necessary to acknowledge that the industry's problem is not that it lacks RTA, but that it lacks payment assurance. And while RTA is an attractive technology, it is neither effective nor required in achieving payment assurance.

By changing the paradigm, it becomes clear that the objective of building RTA is not as important as delivering payment assurance. Once the real problem is understood, the healthcare industry can shift its focus from RTA and getting paid in real-time to achieving timely, accurate and reliable communication with a claim submitter, and downstream in the process, a more efficient communication and payment disbursement experience. This is the problem the industry needs to solve, not the problem of building RTA.

The next step for the industry is to develop a new technology and operating model that can deliver payment assurance to providers and simplify the payment experience for payers. This new model should be built on top of the healthcare industry's existing infrastructure of technology, process and compliance. See Figure 2 for a payment assurance framework.

FIGURE 2
Payment Assurance Framework



With an emphasis on payment processing, this new model integrates the healthcare network of payers (insurance companies, health plans, PPOs, HMOs and TPAs serving employers), healthcare providers (physicians, hospitals, labs, etc.) and patients, with all leading payment networks (Visa, MasterCard, Amex, NACHA/ACH, etc.).

The new model for payment assurance includes the following:

At the point of service, providers must:

- Assess eligibility and benefits, accumulators and financial capability through standard transactions triggered by front office software and/or health plan identification cards.
- Apply fee schedules, eligibility data, financial data and other programs such as charity.
- Establish expectations with patients by estimating the expected patient responsibility and communicating payment terms, timing, notifications and process.

Leveraging this information, providers must support all payers, all banks and all cards, as well as the ability for patients to pay online and make payment arrangements.

Additionally, providers must have access to an integrated electronic claim submission and claim status gateway that features timely adjudication and real-time information, as well as an 835 that

is reconciled and linked to an electronic funds transfer for the payer's responsible portion of the claim. This payment must be made to the bank account of the provider's choice, in a timely manner.

Once services are rendered, providers must:

- Collect any known patient responsibility and/or pre-authorize the patient's preferred payment method.
- Submit the claim.
- Upon claim adjudication and receipt of the 835 from the payer, trigger an automated payment to get a direct deposit of the exact patient responsibility from the patient's preferred payment method.

Many companies have already built one or more components of these enabling features of the model. These features have been shown to dramatically expedite the provider's collection of outstanding receivables, increase patient collections up to 200 percent, accelerate patient payments up to 50 percent and reduce operational costs up to 60 percent.⁷ However, the new model for payment assurance is comprehensive, incorporating all features outlined above, rather than offering just one component.

WHAT ARE THE BENEFITS?

Healthcare providers, payers and patients will all benefit from payment assurance. The benefits to providers are fairly clear: increased revenue from payers and patients, reduced bad debt from patients, lower costs for a claim follow-up and lower costs to collect. However, the benefits to patients are more subtle, generally pointing toward increased satisfaction with the billing and payment process, and, therefore, with their provider and payer. These benefits will in turn accrue to the patient's provider and payer in the form of loyalty and repeat business. The benefits of payment assurance to payers are probably the least understood. While payers may lose out on income generated by float, it is also true that a large part of many payers' businesses is ASO (administrative services only – for self-insured companies), which lessens the float factor's negative impact on this non-EBITDA float income. Furthermore, the benefits of payment assurance will far outweigh the loss of float income to payers and to any of their ASO employer clients through reduced administrative costs, which does impact EBITDA. This is because provider and patient customer service calls to payers related to the claim payment process will decrease, and payers will be able to translate increased provider and patient satisfaction into deeper discounts, yielding improvements in medical loss ratios.

CONCLUSIONS

- RTA is challenging for payers to build and requires further maturation of 835 processing capabilities.
- Technology and business challenges in the industry hinder the provider's ability to adopt and benefit from RTA.
- The industry needs to shift its focus to its real problem: the lack of payment assurance.

- While RTA is an attractive technology feature, it is not the silver bullet for delivering payment assurance.
- A single integrated clearinghouse (healthcare EDI) and payment processing platform is the foundation for delivering payment assurance and the new model for U.S. healthcare payments.

For the past 10 years, the healthcare industry has been more focused on RTA than on RTA's initial purpose: delivering payment assurance and payment efficiency. RTA is challenging for payers to build, difficult for providers to adopt and may only be applicable for simple claims that are created in non-outsourced provider environments. While RTA is an attractive technology, it is not a pre-requisite for delivering payment assurance.

In order for the healthcare industry to evolve, it needs to build a new healthcare payments model that integrates the healthcare EDI infrastructure with the payment infrastructure. This is not just a technology build, but also involves operating rules and compliance. This new model would generate tens of billions of dollars of savings for providers, patients and payers.

ABOUT INSTAMED

InstaMed is the leading Healthcare Payments Network, connecting providers, payers and patients with healthcare clearinghouse, eligibility, estimation and payment transactions on one integrated platform. InstaMed enables providers to get paid more efficiently, payers to disburse payments at a lower cost with fewer incidents of fraud, and patients to experience a simple, convenient and secure way to pay. The InstaMed Network powers healthcare payments for over 100,000 users nationally with tens of billions of dollars in healthcare payments processed. Visit InstaMed on the web at www.instamed.com.

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Bill Marvin, co-founder and CEO of InstaMed, has been in the revenue cycle industry since 1993. He is a former executive in Accenture's Health and Life Sciences practice and founder of CareWide (now AllScripts).

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