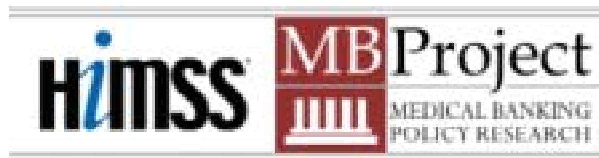
Exploring the Odyssey of Real Time Adjudication *of Healthcare Claims*



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Introduction to the HIMSS HIMSS G7

Recognizing the connection between all components and stakeholders of the electronic exchange of patient clinical and administrative information, HIMSS and the Medical Banking Project merged in 2009 to create a strategic platform around the business of healthcare focusing on information technology requirements. A key element in the Patient Protection and Affordable Care Act (PPACA), the electronic exchange of financial information is a component of the emerging digital interchange in healthcare that must be addressed. It will form the basis for multiple process improvements throughout the national and global healthcare system.

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What Is the HIMSS G7?

HIMSS Medical Banking Project, which is part of HIMSS Business-Centered Systems, formed the HIMSS G7 thought leadership platform to design the healthcare financial network of the future. Improving efficiency in digital financial transactions is a main focus of the HIMSS G7. Other possible issues the HIMSS G7 members will explore include expediting workflow automation with the increasing tide of electronic transactions, health-wealth paradigms, linking online banking with health information exchanges to move forward the adoption of electronic health records and other areas that impact the healthcare financial network.

Why Is the HIMSS G7 Important?

The United States is evolving the policy and technology frameworks that will support a new digital platform for the business of healthcare. This platform includes:

- Regulatory mandates, such as detailed in the Affordable Care Act;
- Convergence of banking and clearinghouse platforms;
- Increased use by healthcare providers of medical banking models; and
- Resolution and acceptance of compliance issues in HIPAA and HITECH.

For the first time, members of the HIMSS G7 convened in October 2010 at the Vanderbilt Center for Better Health in Nashville, Tenn., to facilitate critical thinking about how the healthcare financial network of the future will evolve. Most of the member categories were present for the discussion. Members represent these healthcare stakeholders:

1. Banks
2. Consumers
3. Employers
4. Government
5. Health Plans
6. Providers
7. Technology Firms

> RTA is a multi-step process that will lead to adjudication and payment occurring in real-time at the point of service.

About the Report: *The Intersection between Accountable Care Organizations and the Financial Network of the Future* is the result of the first meeting of the HIMSS G7 in October 2010. This report is not a position statement from HIMSS, but instead, HIMSS G7 members developed these provocative positions around issues healthcare leaders must address and resolve.

For More Information: Contact jcasillas@himss.org for more information on the HIMSS G7 or HIMSS G7 sponsorship.

Introduction

The August 2008 HIMSS White Paper *Real Time Adjudication of Healthcare Claims* authored by the HIMSS Financial Systems Task Force laid the foundation for this follow-on work. The original paper's authors explained the challenges of Real Time Adjudication [RTA] and what needed to happen to further develop the concept into an operational reality. Since 2008, some organizations have developed their own proprietary systems to accomplish RTA and the question came before the HIMSS G7: how is the industry progressing in this area? Participants at the HIMSS HIMSS G7 Leadership Forum set out to discuss the evolution of RTA today and to also define HIMSS MBProject's potential role in moving the RTA dialogue forward. To enable RTA as envisioned by many today will require technological bridges and cross collaboration between banking and financial systems stakeholders as well as others.

The resounding answer of the participants is that RTA is still a focus for MBProject and the members of the Leadership Forum. This conclusion was reached by reviewing the RTA concept and comparing it with the common practices within the health care industry from three perspectives 1) provider outpatient practices, 2) hospital providers, and 3) payers. The results of this work are sets of recommendations that will inform how to aid these different stakeholders to further develop their RTA capability.

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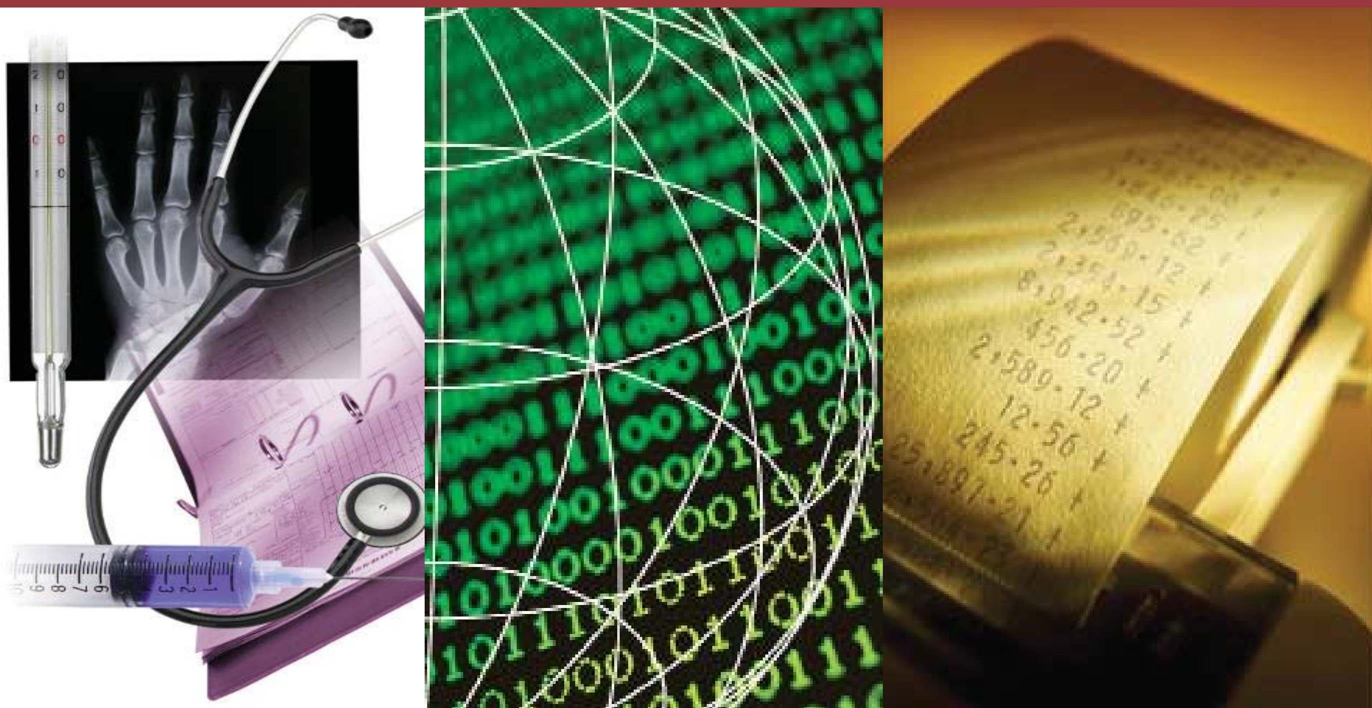

Importantly, the participants noted that RTA is a multi-step process that will lead to adjudication and payment occurring in real-time at the point of service. In fact, some participants felt that in its truest sense, real time payment isn't possible because banking payment and settlement systems work in batch mode.[1]

The HIMSS G7 poses a short answer to the question of progress around RTA: while a claim can be adjudicated at the point of service, payment or settlement at that time within the current configurations and capabilities of systems is not possible. Yet, the HIMSS G7 acknowledges that there are models that are taking root in the industry that provide "hotel" model programs – pricing and virtual settlement at point of service. These will be discussed.

1. There are platforms that can settle funds at established times throughout the day and that can, for all intensive purposes, support real time settlement of funds but the business processes behind this capability are batch-oriented (and this is not perceived as entirely negative). Some of the participants suggested that none of the point of service pharmacy real time adjudication systems nor any of the credit card systems do real time payment and settlement in its truest sense. In addition, it was noted that within the typical health plan operating environment once a claim is adjudicated it is not processed for payment until the "Check Write Cycle" is executed. Typically the "Check Write Cycle" is run at scheduled intervals such as weekly, every other day or everyday. Even if the health plan runs the "Check Write Cycle daily once the payment instructions are transmitted, processing time typically takes at least 24 hours (and in many cases up to 48 hours) before the provider's bank account is credited (settlement).

RTA Concept

As stated in the HIMSS 2008 White Paper, Real-Time Adjudication (RTA) of claims refers to the immediate and complete adjudication of a healthcare claim upon receipt by the payer from a provider. Unlike the current method of submitting and processing claims in batches over a period of weeks to months, RTA, as it implies, anticipates that the complete process from billing to patient payment occurs during the patient visit to the healthcare provider's office or other facility.

The example below illustrates one approach to RTA:

- When Mary checks in for a sick visit, her provider's system makes an eligibility query to her payer. Her account is also flagged as one that can participate in RTA.
- At the conclusion of the encounter, Mary's physician closes her visit on the EHR system, which then sends procedure and diagnosis codes to the billing system.
- The practice management system sends an RTA query to Mary's payer. This query contains procedure and diagnosis codes from the visit, date of service, provider ID, and other information necessary for adjudication
- Upon receipt the payer's system calculates and returns the payment amount to the provider and the amount owed by Mary. It should be noted that today, RTA from the payer would

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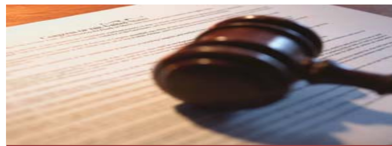
only work if the patient is "in network". "Out of network" patient responsibility, in today's environment, will not be accurate because the payer will not have the provider's fee schedule available to perform the calculation.

- The practice management system auto-posts the adjudication information received from the payer, including data such as allowed amount, co-pays, deductible, patient responsibility, etc.
- The clerk requests payment from Ms. Smith for her share of the visit cost.
- Payment of the payers portion of the claim is received within several days via electronic funds transfer (EFT) payment deposited to the provider's bank account.

This scenario will help to frame the HIMSS G7 findings and help us to arrive at possible areas that need to be explored to move RTA forward in the industry. Again, we note that there are companies that are enabling RTA-like approaches today, however there is not general market uptake. RTA is thus quite limited in application and remains much of a "pipe dream" in reality.

Analysis of RTA Scenario

There are several important and widely agreed on characteristics of RTA. The provider who submits a claim via RTA would expect a response from the payer within seconds. The adjudication is also expected to be complete which includes all editing required by the payer to determine eligibility for service and final payment for the claim. In addition, the response from the payer will be sufficiently complete and detailed to allow the provider to understand the amount of provider payment, adjustments, and contractual allowances. The response will also include sufficient information to allow the provider to explain information used to determine the patient's responsibility including deductibles, co-pays, and the total amount due to the provider at the time of service. Again, this scenario, in today's typical operating environment, would only work if the patient is "in network" as "out of network" patient responsibility is impossible to ascertain because a payer would not have the provider's fee schedule available to perform the calculation. Even so, in a number of ways, RTA represents a significant change in how healthcare claims are submitted, adjudicated, remitted, paid and reconciled today.



Since 2008, mandates and regulations such as 5010, ICD-10 and PPACA have caused a competing demand for resources.

RTA in the Present: What has changed?

In terms of widespread adoption of real time claims adjudication not much of anything has changed. It has not rolled out as a best practice and even the largest health plans have limited engagement. Moreover, there appears to be little appetite among providers for RTA. Note that when a patient is admitted the treatments may change dramatically from those expected. The admitting diagnosis is only the starting point thus aggregation of all the charges during a patient visit in a real time manner is difficult, if not impossible in the current environment, and thus the whole idea of RTA does not typically resonate among many providers of care, especially in hospital settings.

In addition, the health care industry has had many distractions over the last two years since the white paper was written. ARRA, HITECH, 5010 and ICD10 issues and operating rules under PPACA have commanded attention thus it has been hard to make large system changes or innovations within the context of the changing environment spurred by these new rules and their impact on providers and health plans. These mandates and regulations have caused a competing demand for resources, and, while mandates such as 5010, ICD-10 and PPACA have real deadlines no such hard deadlines exist for RTA. As a result, RTA has been put on the back burner for most payers and providers. This has been a major factor effecting RTA from changing dramatically from where it was a couple of years ago.

A significant change in the health care industry also stems from the increasing number of consumer driven health plans. The High Deductible Health Plan puts the increasing responsibility of the cost of the initial healthcare services rendered on the plan member. As a result, there is much more engagement of the consumer. The consumer / patient want to know "what's my price tag to pay for this office visit". Understanding the price and cost of services is becoming a more relevant question for patients.

From the provider's perspective, an increase in consumer driven health plans is putting more pressure on front end or walk-in collections from patients. As can be

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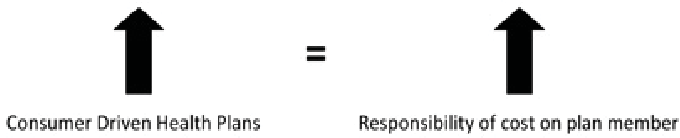


expected, the impact of a sluggish economy exasperates the issue of point of service collections from consumers.

Within this context, one aspect of RTA, implementing an automated patient responsibility estimator or mechanism is viewed by many providers as a strategic imperative today. This will ideally assist in collecting more money up front. Most providers understand that when a patient leaves the office the ability to collect diminishes rapidly. The consensus that High Deductible Health Plans will continue to increase is a major driver for automated patient responsibility estimation, and, as this is a core component of RTA, this dynamic will continue to push RTA to the forefront of health care industry.

Over the last two years, there has been an increase in vendor alternatives for real time patient estimation including online calculators that could provide alternatives to RTA. As a result, more providers are giving patients some form of patient responsibility information at point of service via real time calculators. Even with these advances, payers have very limited capabilities to support real-time adjudication. As a result, payer-based RTA has only marginally increased.

Clearinghouses are beginning to develop solutions for real time capability and have created solutions that fill the gap in RTA, but it is not to the extent that it needs to be for widespread industry adoption. Again, RTA involves organizational design and transformation issues that are not technology-dependent and so there may be only narrow opportunities for adoption. In addition, administrative workflow and practice management systems are not significantly changed between 2008 and 2010. In order to make this a reality the practice's workflow and practice management systems transaction processing architecture will likely need to change.

Perspectives

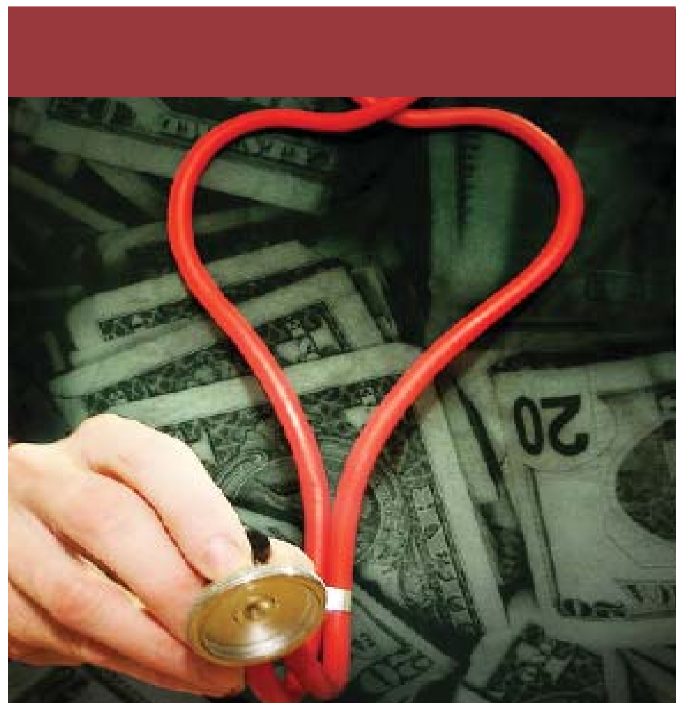
After reviewing how RTA's have changed in the last two years and understanding what was holding some of the progression at a standstill, the Leadership Forum took an in depth look at RTA and compared it with the common practices within the health care industry. They looked at it from three perspectives: 1) provider outpatient practices, 2) hospital providers, and 3) payers.

Provider Outpatient Practice Perspective

Many of the new regulations and mandates (such as 5010 and ICD-10) have put Provider Outpatient Practices under resource constraints. There is too much on their plate already and because of that RTA many times gets put on the back burner. In order to implement RTA in the provider setting, significant workflow changes will likely be required. In Provider Outpatient Practices, every dollar counts and right now there is not much buy in to the RTA concept because of its lack of availability or because the priorities for making it top of mind simply isn't there. Providers may not be aware of the benefits and value add that existing patient responsibility calculators or RTA can provide. As a result, many providers are not currently using the existing tools.

Clearly the tide of interest is changing as higher deductible plans take hold in the marketplace. Wide availability of RTA could provide many value adds to the provider. Over the last couple of years there have been increasing problems with cash flow and bad debt – life threatening trends for the enterprise and practice. Providers are very concerned about every dollar. RTA could equip providers with more efficient ways of filing claims and collecting from both patients and payers.

RTA would not only assist in the collection of money but also improve patient relations with the provider by increasing transparency. If patients have questions regarding their bill, the provider can answer them right in the office. Overall, it will improve how providers relate to their patients and this has strong appeal among



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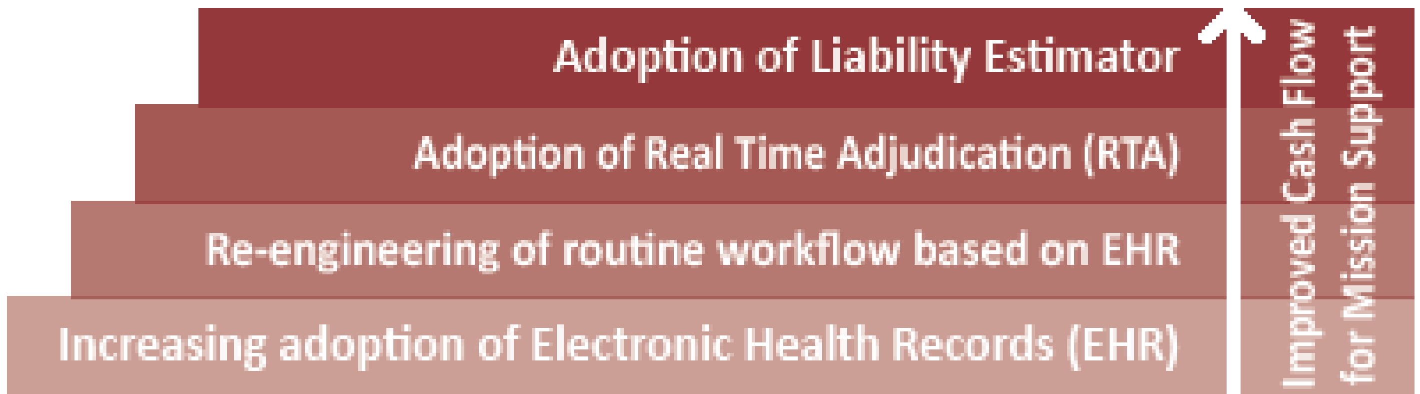

physicians who value and seek to foster high quality interactions with their patients. The doctor-patient relationship is still "sacrosanct" according to many studies and enabling technologies that equip physicians and patients to better interact are valuable.

Once put in place, RTA could also simplify provider administration by settling the claim quickly and automatically. The HIMSS G7 participants believe that with increasing consumer responsibility for healthcare costs as a result of high deductible plans, RTA, and one of its key components - patient responsibility calculators – will help increase the efficacy of the enterprise or practice in terms of cashflow, workflow and higher quality patient interactions.

Hospital Provider Perspective

Hospital Providers are facing similar resourcing constraints as the Provider Outpatient Services and all ambulatory settings. The new mandates and regulations have put a heavy strain on all resources. Unlike the Outpatient Provider, the hospitals have a bit more room to change workflow to accommodate RTA. Even with their resource constraint, they are at a slight advantage over the Provider Outpatient Practices.

For all providers, but specifically for Hospital Providers, there is a negative incentive for moving to real-time adjudication. For example, there is the issue of inability to determine the precise cost for a patient encounter in that treatments will vary, as described earlier. Some also have suggested that there may be concern especially in a tough economy that patients will cancel services or surgery after finding out costs upfront. Thus there could be a hidden threat of loss of business.

In order for RTA to be adopted in the enterprise or hospital setting, a number of "moving parts" will need to be closely reviewed and re-engineered to support real time information aggregation. There may be greater complexity dealing with complex inpatient claims that are typically higher dollar. For example, a $30,000 claim will need to be reviewed and will generally require input from various departments within the hospital, with some procedures requiring precertification, service limit and attachment documentation. Because if these added complexities it is much more difficult to resolve inpatient claims in a real time setting.

Institutional providers will probably achieve greater returns by being able to provide patients with estimates of financial responsibility before services are provided Patient and payer transparency would likely increase and should create a better working relationship between the patient and provider. Payments, and or the creation of payment plans, can be arranged up front. A Liability Estimator will help in this area and will likely be adopted in the near term with real time adjudication of claims at some point in the future when hospital workflow routines are re-engineered and electronic healthcare records are more generally adopted. The overall effect of this will be to increase cash flow and support the hospital's mission in the community.

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Payer Perspective

In the current environment, payers are also experiencing resource constraints. Significant resources are required to modify or develop systems that process claims in a real time environment. At the present, payers are struggling with federally mandated changes and deadlines with which they must comply, like Medical Loss Ratio analysis and review, 5010 testing and implementation and ICD-10 transformation and impact on technology systems. As a result for most, RTA investment are likely to be deferred. It is interesting to note that “claims technologies” do not count towards the Medical Loss Ratio (MLR) and as a result there is less incentive to invest in RTA, even though it would positively impact all the healthcare stakeholders including the health plan.

Notwithstanding the artificial barrier caused by MLR regulations, RTA could become a value added service that is offered as a competitive differentiator by payers. Some HIMSS G7 participants expressed the opinion that if the Obama healthcare legislation is implemented to include regional exchanges that some of these exchanges may be implemented to include real time adjudication. This could put into play a competitive shift in thinking around RTA, especially if the benefit is clearly presented to the consumer.

There is an understanding that the drivers behind RTA are unlikely to compel payers to modify their legacy adjudication systems until there is a clear business case to justify the investment. Within this context, however, payers payers could create new plan designs external to their legacy platforms that would incorporate real time adjudication.

For example, a payer could bundle RTA with a health plan that has high deductibles. In fact, the payer could use RTA as a selling point for the high deductibles, as the end-consumers would be better informed in their decisions. The high deductible plans could carry lower premium payments and thus create an attractive proposition to employers. This could make them more competitive when trying to package and sell their plans to employers or even directly to consumers in healthcare reforms emerging “insurance Exchange” marketplace. This type of configuration could provide a a cutting edge in an environment where more consumers are becoming increasingly responsible for the cost of their healthcare.

RTA would also increase the transparency between the provider and the payer. RTA assists in dealing with the claims that are kicked back or rejected because they can be dealt with up front rather than later down the road where costs on both sides of the transaction increase. This would improve how payers relate to providers and vice versa. A factor in this context is that providers often limit their network because of the perceived aggravation of dealing with multiple payers and reimbursement requirements. A good RTA system, offered by a Third Party Administrator for example, could support multiple payers and would allow new opportunities for group contracting. This would support value added opportunities to not only the payers, but also the entire Healthcare System.

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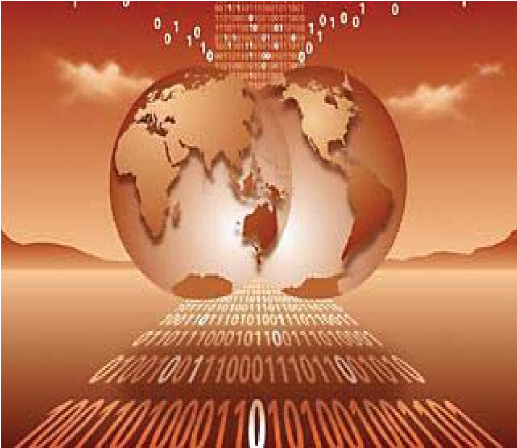

Other value offered by RTA

Realtime adjudication also creates new opportunities for banks and clearinghouses to accelerate money. Banks that work in conjunction with health plans and/or clearinghouses could become a conduit for adjudication with services that include payment plan development at point of service or other models that use holding payment authorizations similar to what hotels and airlines use. RTA would open the doors to see how banks and clearinghouses can better work within the Healthcare Industry.

RTA is an emerging area that is important for preparing the Healthcare Industry for the coming years. Patient responsibility and receivables for practices are expected to to increase relative to other financial classes. Knowing that the consumer driven-health market is going to be increasing significantly in the future, providers will need to have either real time adjudication or patient responsibility calculators and consumers will demand it as well.

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The HIMSS G7 participants agreed that provider organizations would be more capable of engaging in the RTA dialog when they have implemented and coupled their clinical and administrative information systems. This is a likely outcome of the work providers are currently undergoing in response to ARRA funding and meaningful use requirements and milestones. There was consensus that once the information system transformations are complete, organizations will look to leverage these new capabilities to improve their revenue-cycle without relying on proprietary networks or applications.

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Recommendations

The Leadership Forum created a set of recommendations to further develop RTA capability and buy in.

Define the concept of Real Time Adjudication by creating defined metrics for RTA.

- There needs to be a good set of metrics so we have a clear picture of what's happening or could potentially happen.
- We need to have quantifiable data sets.
- We need to define if RTA is just a shortened adjudication time period or if it is a real time transaction that returns adjudication status and payment information within a few seconds.

Do not have the government mandate RTA.

- We need to step back from mandates in the short term
- We need to focus on letting the private sector evolve a bit further.
- It is difficult to enforce mandates of this nature on payers or providers.

Demonstrate a return on investment for RTA.

- Focus on the benefits to physicians, hospitals and payers.

Incentivize providers to submit electronic claims and receive electronic payments.

- A good case study is Medicare when in 1992 it implemented its 835 Electronic Remittance Advice and incented its use by quicker payment via Electronic Funds Transfer to the provider's bank account. Payers could adopt programs based on the widespread success of this approach.
- RTA needs to be broadened to include not only adjudicate of claims and posting of cash, but all parts of the claims posting process – contractual allowances, reject notes and automation of other areas that capitalize on the value of return claim information.

Provide education to practice managers regarding RTA and patient responsibility calculators.

- Help practice managers understand how RTA or patient responsibility calculators can improve productivity and cash flow.

Develop partnerships between clearinghouses, banks and payers.

- Encourage clearinghouses, payers and banks to engage strategies that support partnering to support RTA

Encourage RTA pilots and demonstration programs.

- For example, Kaiser Permanente is a plan that sees its own patients and contracts with other payers to provide healthcare services to their members as well. This could be a good model for RTA testing.

Consumer educational tools.

- Educate consumers on health plan options
- Provide consumers with online tools from payers to do their own estimation of their patient responsibility b+efore the doctor visit.

Revisit the RTA model and identify what we should do differently.

- Think about a system where RTA is not just automating the paper process.
- How can RTA potentially combine or streamline transactions (for example, using the eligibility transaction for the entire claim cycle)?
- Is it possible to do the eligibility and claim submission at the same time? (Note: Today it appears feasible to verify eligibility and get a liability estimate at the same time, before the encounter. Generally, claim submission occurs after the encounter. If the patient is ineligible there is no claim and the patient is treated as self-pay or charity.)

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