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**100 First Stamford Place
Stamford, CT 06902
800-288-4826
www.ivans.com**

**Healthcare Electronic Transactions:
*Vision and Reality of Real-Time Transactions***

Overview

Creating an interoperable system may have started out as a vision, but electronic transactions are pushing it closer to reality. Implementing real-time technology to perform such electronic transactions as Medicare eligibility verification (270/271) provides many benefits to payers, healthcare providers and patients. For example, real-time eligibility verification not only saves providers time, but lowers their risk when confirming if Medicare covers a patient. Additionally, real-time technology can facilitate the collection of co-pays and deductibles at the time of service, without adding additional work to the staff of a healthcare provider. It also enables providers to verify a secondary payer prior to seeing a patient, all of which improves their cash flow and decreases exposure to uncompensated care. However, the drive toward real-time technology with the ultimate goal of having interoperability throughout the industry is not without its design and implementation challenges.

Success requires a detailed understanding of strategic and operational issues at both the private and government level. This paper will look at eligibility standards and key challenges the healthcare industry is facing in terms of adoption and integration of interoperability. It will discuss the benefits of real-time transactions and what it takes to incorporate real-time technology into the current claims workflow process. Finally the paper will examine how to choose the right connectivity solution for your transaction needs and what the current roadblocks are when it comes to adopting real-time technology.

Eligibility Standards

Standards can be developed, but bringing everyone together to submit to those standards will be critical to improving the delivery of healthcare. The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), otherwise known as HIPAA, was created by the United States Congress as a foundation for healthcare reform. HIPAA has three types of standard requirements: privacy; security; and administrative simplification. The privacy standard is to safeguard patient data from inappropriate disclosure or use. The security standard is for protecting patient information systems and preventing unauthorized access. The last requirement, Administrative Simplification, will replace non-standard formats with a single uniform set of electronic formats.

The HIPAA Administrative Simplification requirement was designed to improve the efficiency and effectiveness through the standardization of electronic data for healthcare transactions, while protecting the security and privacy of that information. There are four parts to the Administrative Simplification: 1) nine claims-related transactions; 2) national identifier requirements for providers, payers, employers and individuals; 3) code sets for diagnosis, therapeutic and treatment; and 4) privacy and security. All payers are required to adopt these standards and requirements, and every electronic transaction that a provider submits must be HIPAA compliant and follow HIPAA standards.

Key Challenges to Interoperability

The greatest benefit of the HIPAA standard requirements is that it saves businesses significant time and money because it will simplify the process and decrease the costs associated with payment for health care services. Further the quality of the delivery of healthcare to patients will greatly improve. However, this only will be achieved if there is collaboration between payers and providers, and if vendors work with all parties to replace legacy systems with newer, updated technology.

Additional issues that need to be addressed before interoperability can be fully achieved include: ensuring security and privacy among all touch points; enabling the backend integration; addressing payer/provider capabilities and limitations; incorporating the financial business model; the need to upgrade claims systems to provide a real-time response; managing the convergence of healthcare and consumer finance; producing clean claims; and successfully integrating a myriad of practice management systems that currently exist throughout the healthcare community.

Individual plan websites are not the solution for providers and health plan/payer portals are not the answer because of limited information in inconsistent formats. Vendors cannot deliver data to providers when the health plan does not make that data available. A business model needs to be built out to show where the industry needs to be. There are transactions that cannot be done in real-time today, those that need attachments, coordination of benefits and others. We need to start with the ones that can be done in real-time and work from there.

Benefits of Real-Time Transactions

In the healthcare community there are benefits to using real-time transactions. Providers are able to reduce costs in claim errors/handling and lower the number of calls fielded by customer service representatives (CSR's). They also will benefit from accurate, timely eligibility data and reduced/reallocated staff through removal of manual process. Both payers and providers will be able to reduce bad debt risk, create accelerated cash flow and increase business productivity. Reduced collections and decreased exposure to non-payment can be expected as well as less time spent researching claims and lower operating costs.

Real-time financial settlement, however, is just the beginning. The ultimate goal is to create an integrated healthcare supply chain, where the all players in the process – health plans, providers and payers – support a value chain that includes service delivery, administration, and disease and care management. The end result is delivering high-quality care to more people and reducing healthcare costs.

The Integration Challenge

The integration challenge for electronic real-time transactions is to have the consumer connected to the provider, and the provider connected to health payers, debit vendors, multiple accounts, funding sources, the Centers for Medicare and Medicaid Services (CMS) and banks. This creates a “consumer directed healthcare” model. An example of

this model would be a Health Savings Account (HSA). This model calls for a need to streamline the business of healthcare with electronic eligibility. The consumer now becomes responsible for more of the cost of their care and is allowed to settle their bill at the time of service.

Here is one example of how a typical real-time transaction would potentially work in a physician office setting:

1. A health-plan member visits a doctor or other medical provider.
2. A staff member at the provider's office enters the claim into the provider's system.
3. The physician's management software enables the claims to be submitted to the health plan in real-time.
4. The health plan's administrative system performs tasks including:
 - * Validating provider, member and claim data
 - * Checking for deductibles, co-payments and/or co-insurance that may apply
 - * Adjudicating the claim
 - * Calculating the member's financial responsibility
5. If the member is enrolled in a benefit plan with a financial account, such as a Healthcare Reimbursement Account (HRA) or HSA, the system also will check the funds available in the member's account(s). This will involve a real-time link to the financial institution where the account resides.
6. The health plan's system then transmits back to the provider information on what amount the member owes the doctor, as well as a final, accurate explanation of benefits.
7. The member will then pay the provider, either out of pocket or using a debit card that is linked to his/her healthcare financial account(s).

The benefits to these consumer-driven health plans will be that individuals and families can save for future health care expenses, including those in retirement. Further, individuals will have more control of their healthcare decision-making, and as a result, they will be more empowered and make better choices.

As the healthcare and consumer finance industries converge, multiple entry points are being created. As a result, providers are looking for single sign-on processes which are not yet in place. Payers, on the other hand, will need to integrate multiple feeds across many domains – healthcare, finance, retail.

Connectivity Options

Traditionally, IT management teams had a limited set of connectivity options available to integrate affordably and effectively into their business continuity plans. These services included private T1 lines, ISDN, satellite and analog dial. Unfortunately, these options did not often provide enough flexibility to meet the business needs of the entire organization; this resulted in poor performance, high costs, or possibly both. This can be

especially concerning for users at remote site offices who are expected to produce results just as effectively as users at the headquarters or datacenter locations.

Today, IT managers have more options to consider as part of the business continuity solution for their enterprise. In some cases, these are newer technologies that are displacing outdated architectures, such as 3G wireless over ISDN, or broadband access solutions such as ADSL, SDSL, IDSL and cable. Generally speaking, these options are capable of providing both high bandwidth and reliable performance and often at a very affordable, fixed rate.

As technology continues to evolve, newer solutions are making it easier and simpler for providers to process claims. For example, a high-speed, multi-user Internet-based solution allows providers to take advantage of their Internet connectivity for performing Medicare transactions via a managed, secure gateway. In addition to being faster than other connectivity options such as the dial modem, this solution is part of a highly secure network that is approved by CMS and fully compliant with HIPAA. Additionally, as a multi-user, high-speed solution, it can enable a healthcare provider with up to 25 concurrent users to establish a secure connection over the Internet with the necessary Medicare Contractor from their facility.

With the delivery of healthcare becoming increasingly complex and costly, the ability to provide support and guidance, and wrap that around a simplified, high-speed solution will be valued more in the marketplace than transaction-based solutions that do not address the entire claims workflow from a price point perspective. Internet solutions that follow a high touch, high service model will pave the way for providers looking to increase productivity, reduce inefficiencies, strengthen customer relationships and improve their bottom line.

Roadblocks to Real-Time Adoption

A nationwide IVANS survey of over 800 U.S. healthcare providers found that more than 75 percent of providers currently employ some type of electronic eligibility verification technology, with almost 64 percent rating the level of their eligibility verification as “good” or “excellent.” Access to reliable eligibility information at the point of care reduces the amount of time a provider spends on administration and improves the accuracy of the claims submitted.

The IVANS study found that, of those not using electronic real-time eligibility verification technologies, one-third said it was because they are “unaware of the technology” and over 28% said it was due to either limitations placed on equipment, limitations placed on staffing or limitations placed on technology budgets. When insurance inquiries for eligibility are sent electronically, providers can receive the information from the health plan almost immediately. However, in current practice, each health plan may have different edits and requirements that do not match the format required by other health plans. This means the provider must maintain the capability to send and receive in different ways. Because of this, the adoption of electronic real-time eligibility has been inhibited and the reliance on paper forms or the telephone has continued.

Many providers across the United States already have taken action by implementing real-time electronic eligibility. This is largely due in part to mounting pressures which leave providers little time to manage administrative tasks such as eligibility verification. To get 100% adoption, payers and vendors have to agree to adhere to the same standards (i.e., delivery of useful information in the eligibility response that is delivered back to the provider so they can get to that information in real-time before seeing a patient). Access to all payers has to be standard and technology should not matter. The industry presently has standards for eligibility as discussed earlier but the amount of data provided differs from payer to payer.

Solution – Implementing a Real-Time Transaction Solution

It has been proven that real-time electronic transactions saves money, time and improves cash flow. There are many benefits such as higher staff productivity, fewer rejected claims and the elimination of lost claims. There is a growing market demand for data sharing and real-time transactions. When looking to implement real-time technology and interoperability into their workflow, the following points should be considered:

- **Community of users:** Confirm who the users are at each touch point in the claims workflow process.
- **Interconnectivity between trading partners – banks, payers, providers, clearinghouses, debit providers:** Determine which types of interconnectivity currently exist and where the system incompatibilities are.
- **End-user contracting, billing, enablement:** Look for a vendor that can offer a consistent point of contact and a billing/reporting system that provides options that will alleviate the burden of allocating costs and collecting fees from end-users for networking services. By doing so, the cost of doing business is not the sole responsibility of the information source. It is important that the vendor who provides enablement can trigger it reactively or proactively, and has a proven track record in end-user installation and contract enablement.
- **Claim presentment validation, routing and reporting/payment tracking functions:** It is especially helpful to seek a partnership with a vendor that can help you achieve the desired results without jeopardizing existing priorities.

Most importantly, look for a vendor that has a deep understanding of the healthcare business and workflow. It is essential that the company be a preferred and approved vendor of the Centers for Medicare and Medicaid Services (CMS) and is compliant with all HIPAA standards. Some vendors may provide pieces of what is needed but the optimum situation is to partner with a company that not only offers a one-stop solution for the entire claims workflow process but can provide technical desk support, guidance and guarantee a connection to the right network access every time.

Conclusion

As the industry moves more towards consumer-driven healthcare models and the financial model of healthcare evolves to one where the patient has more involvement in how his or her healthcare dollars are spent, this will require the patient to know upfront the costs before getting the service. Interoperability becomes more of a challenge with the different financial sources funding the healthcare coverage, but it will become an essential requirement as healthcare and personal finances converge. The industry will be required to integrate multiple sources to create a single consumer view of healthcare, and leading edge solutions such as real-time eligibility verification will play a major role in facilitating the new provider/payer/patient relationships that inevitably will result.

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