Putting the Standards to work

September 13, 2004

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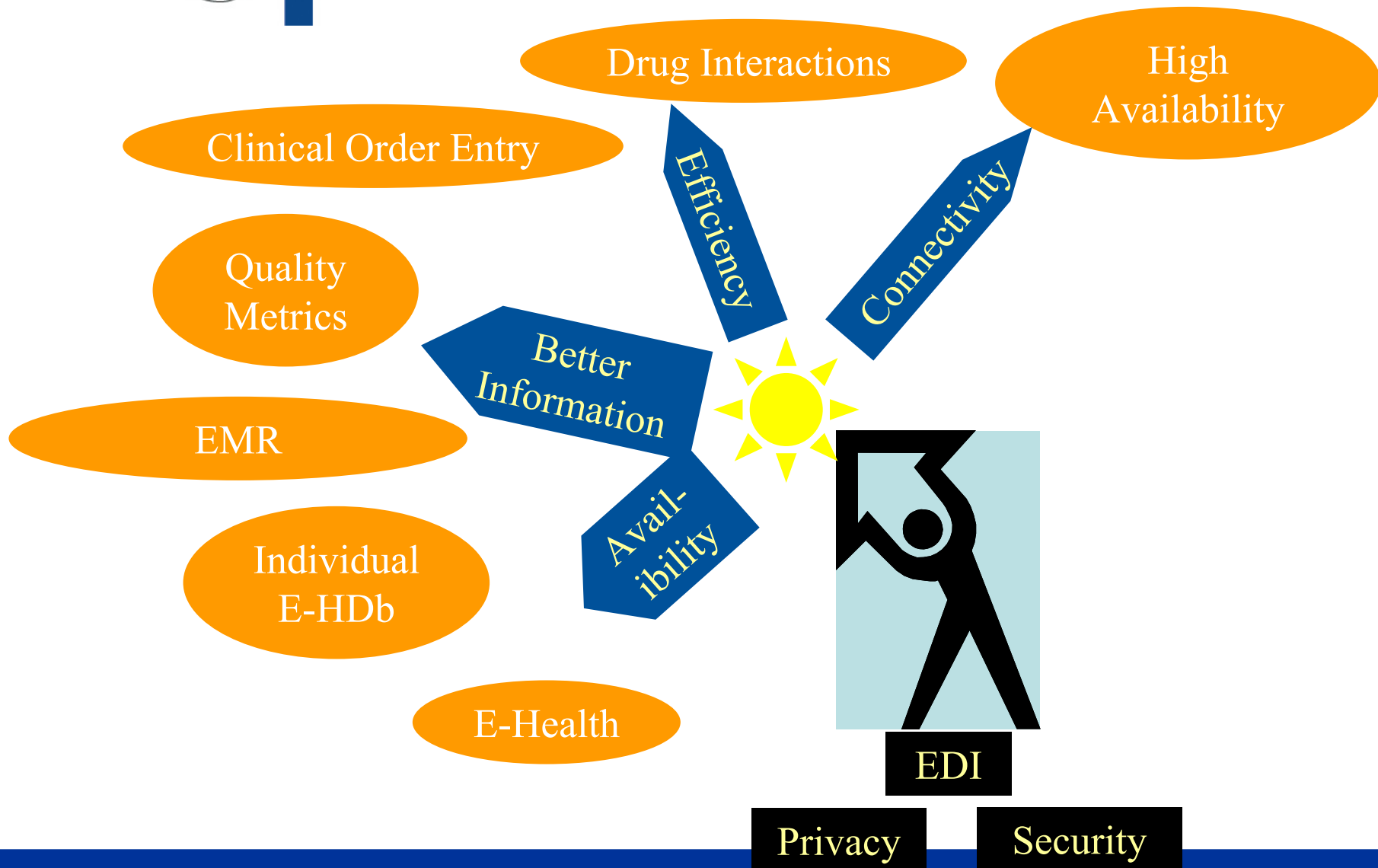"It's a baby. Federal regulations prohibit our mentioning its race, age, or gender."

The Future of HealthCare Success

- **Improved relationships and communications**
- **Transition from transaction processing to partnerships in the healthcare delivery through value added collaborations**
- **Improved models for effective care management and wellness programs**
- **Evolution towards real-time enterprise and a more efficient operating model**

HIPAA is a Catalyst for Necessary Change

Drug Interactions

High Availability

Clinical Order Entry

Efficiency

Connectivity

Quality Metrics

Better Information

EMR

Individual E-HDb

Avail-ibility

E-Health

EDI

Privacy

Security

Working Together

HIPAA Compliance Deadlines

April 14, 2003	Privacy - all covered entities except small health plans.
April 16, 2003	Electronic Health Care Transactions and Code Sets - all covered entities must have started software and systems testing.
October 16, 2003	Electronic Health Care Transactions and Code Sets - all covered entities who filed for an extension and small health plans.
July 30, 2004	Employer Identifier - all covered entities except small health plans.
April 21, 2005	Security Standard - all covered entities except small health plans.
May 23, 2005 - 2007	National Provider Identifier - all covered entities except small health plans.

Now the Reality !

Privacy	Came and went – many complaints - very few cases went to legal
Testing	Very limited testing – few could test end-to-end.. Free testing available – few providers can use it!
Transactions Code Sets	Yeah right! – Stuck in Contingency plan hell.. WebMD reports 90% of providers send non-standard
EIN	Who Cares?
Security	Health plans and Clearinghouses in the race.. Most Providers not even on the starting line – way behind when compared to privacy awareness
NPI	Will have profound implications for Health Plans.. Reimbursement and getting paid issues for Providers

- **Industry is still not ready for HIPAA**
- **CMS Contingency Plan seen as both savior and source of the problem**
- **Most not taking advantage of the full life cycle of standardized data exchange**
- **Not much movement beyond the claims transaction**
- **Plenty of finger pointing**
- **ROI that HIPAA promised is not materializing**

- **Details can be found on the TDI web site**
  - **http://www.tdi.state.tx.us/consumer/taccpapr7.html#notes**
- **Majority of Providers are still not compliant**
  - **WebMD reported that 90% are submitting non-compliant claims**
  - **WebMD sending out HIPAA transactions to 75% of the payers however they estimate that only 10% are truly compliant and passing strict levels of validation**
  - **Reported virtually no adoption of other transactions**
- **Provider vendors have been slow to adopt the standards**
  - **Putting up significant barriers to allow outside access**
  - **View HIPAA as "their" financial opportunity**
  - **Have not moved in any great extent beyond the claim**

- **Payers are viewed as having challenges**
  - **Clearinghouses believe that payers leveraging CMS contingency plan do not want to become compliant**
    - **Continue claims float practices**
    - **Using HIPAA to delay payment**
  - **Relaxed edits will continue for some time**
  - **Wholesale batch file rejections seen as major industry problem**
    - **Many insurance commissioners and provider organizations and associations are raising objections to this practice directly with CMS**
  - **Many providing limited to no support for non-claims**
    - **"E&B: Yes or No answer cited as an example**
  - **Still being forced to use many Payer Portals**
    - **Portal use is being viewed as inefficient for most payer relationships**

Support for Transactions?
From the Winter HIMSS Survey

- **Providers and Payers, asked to specify which types of transactions their organizations were preparing to send and receive initially, indicated that their implementation efforts were primarily focused on the 837 Claims Encounter and 835 Claims Payment transactions**

Transaction Types for Initial Use	Provider	Payer
837 Claims, COB, Equivalent Encounter	**78%**	**85%**
835 Payment, Remittance Advice	**68%**	**82%**
276/277 Claims Status	**41%**	**72%**
270/271 Eligibility	**41%**	**63%**
834 Enrollment and Disenrollment	**19%**	**55%**
820 Premium Payment	**8%**	**38%**
None	**2%**	**0%**
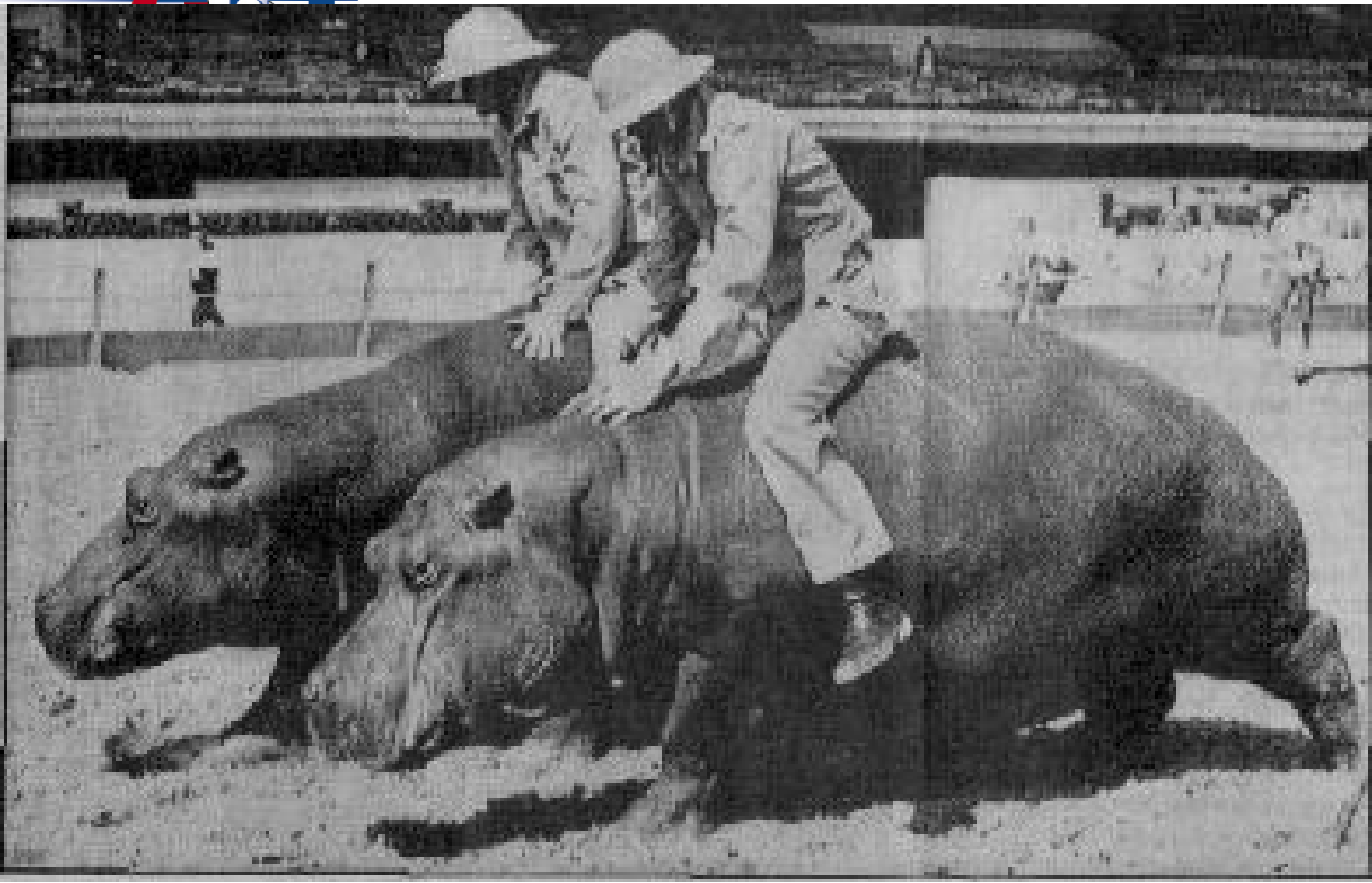
Moving Away from Paper.. ALL EDI

- Electronic transactions are less likely to have errors
- Takes less time to complete electronic forms
- Less payer processing time
- Status information more readily available
- More easily tracked and secured
- Possibility to upload adjudication information into management systems
- Computer costs vary based on type of operation
  - Automate claims management, Pre-registration, revenue cycle
  - Data access controls; applied security practices
  - Audit trails

First Step.. Get rid of the Paper

- Possibility of errors
- More time intensive
- Administrative costs are higher (forms, envelopes, postage, FTE requirements)
- Paper requires additional processing from the payer/plan
- Increased follow-up time with payers
- Rejections from payer/plan result in delayed payment and resubmission
- Misfiled, in another patient's file; missing (may be in stack to be filed)
- Exposed individually identifiable information
- Access to files

Healthcare Opportunities

➢ Healthcare e-Transactions delivery will result in a new generation of healthcare "Services" and Healthcare Relationship Management

Providers

Billing Services

A new generation of integrated practice management, claims and billing services are already starting to appear

Major investments are being made in the electronic creation, delivery, adjudication, and payment of healthcare transactions

Patients and plan participants will acquire benefits and monitor status more directly and via the Internet

Beneficiaries

A new generation of integrated banking services will emerge as Financial institutions participate directly in the EDI workflow with electronic funds transfer replacing paper check drafts

Banks

EDI

Employer Sponsor

A new generation of integrated employer benefits services will emerge as benefit sponsors and plan participants have more choices in receiving and providing relevant information

TPAs

ASC X12N Implementation will be felt the hardest by Insurance companies and a host of various Payers and Third Party Administrators who handle benefits in any fashion.

Conversely this group will derive most of the benefits of the estimated $13-26* billion in annual savings through the mandatory introduction of standardized EDI

Insurance and Payers

*1997 estimate

Movement towards Real-Time

- Plan for HIPAA compliance to evolve in the next three years

- Focus first on surviving, then on becoming an Real-Time Enterprise (RTE)

- RTE will be the foundation for NHII

- If you are not in a community, create one!

- Health plans: go beyond minimal implementations
  - it's good for the providers, and
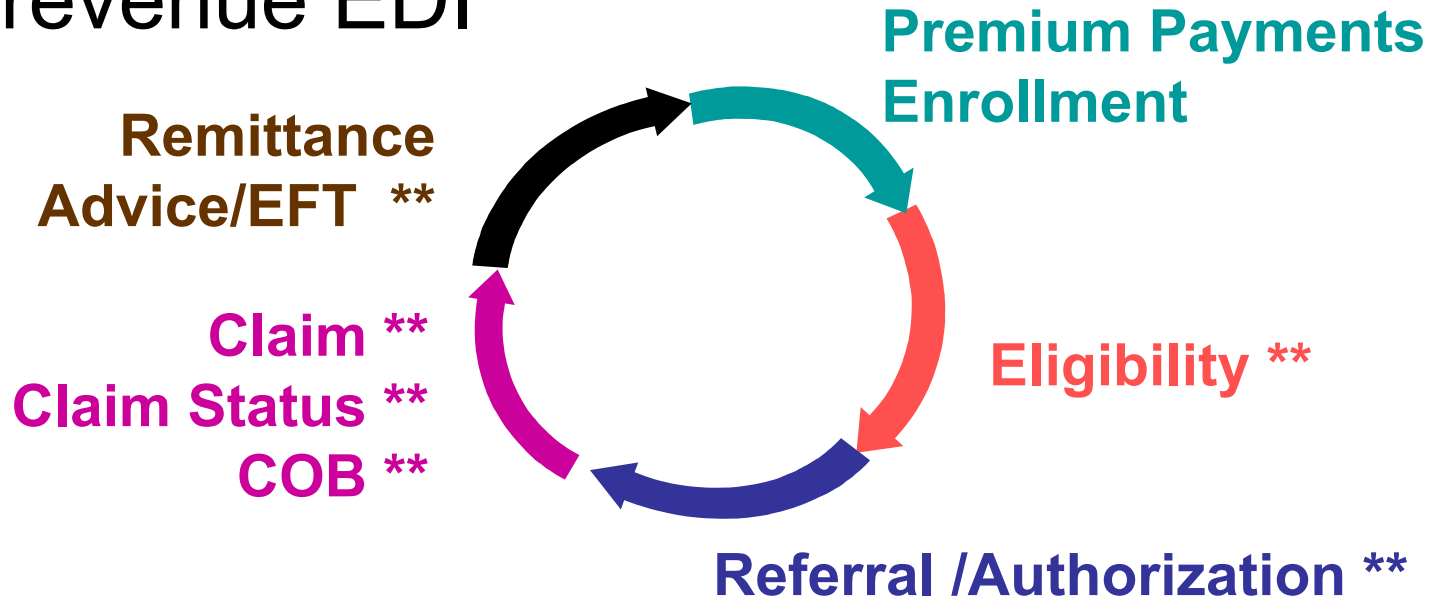 - that is good for you!

HIPAA Jump Start

- HIPAA claims are a threat (if not done well or compliant)

  – The other HIPAA transactions are opportunities

- HIPAA jump-starts the real-time enterprise

- Surviving and thriving are community affairs

Electronic Highway Round One

- HIPAA required HHS adopt industry-developed standards for administrative and revenue EDI

Premium Payments Enrollment

**Remittance Advice/EFT **

Eligibility *

Claim *
Claim Status *
COB *

Referral /Authorization *

** Transactions applicable to providers

Standard Transaction Flow

Providers

Functions

- Eligibility Verification
- Pre-Authorization and Referrals
- Service Billing Claim Submission
- Claims Status Inquiries
- Accounts Receivable (AR)

270 (Eligibility Inquiry) →
← 271 (Eligibility Information)

278 (Referral Authorization and Certification) ↔

148 (First Report of Injury)* →
837 (Claims Submission) →

275 (Claims Attachment)* →

276 (Claim Status Inquiry) →
← 277 (Claim Status Response)

835 (HealthCare Claim Payment Advice) ←

Payers

Functions

- Enrollment
- Pre-Certification & Adjudication
- Claims Acceptance
- Claims Adjudication
- Accounts Payable

← 834 (Benefit Enrollment & Maintenance)

← 270 (Eligibility Inquiry)

271 (Eligibility Information) →

810 (Invoice)** →
← 820 (Payment Order/RA)

Sponsors

Functions

- Enrollment

These are not contained in the initial Transactions and Code Sets Final Rule*

Provider RTE Round Two: Revenue Cycle Management

- Pre-care
  - Self-service registration and scheduling
  - Accurate patient demographic/coverage information
  - Eligibility and referral checking, not labor-limited
  - Pre-established health plan data requirements
- Concurrent with care
  - Simultaneous documentation through delivery systems
  - Point-of-service collections
- Post-care
  - Rapid closing of case
  - Non-labor-intensive claim follow-up (status, posting, secondary coverage)
  - Consumer access to statements/Web payments

Providers.. Start your engines!

- Demand your HIPAA Rights
  - The right to send a standard transaction
  - The right to have the transaction serviced with reasonable telecommunications fees applied
  - The right to exchange the full lifecycle of HIPAA transactions

- Implement a pre-registration process
  - Leverage the Eligibility and Benefits 270/271
  - Implement the Authorization and Referral 278
  - Pro-active use of the Claims Status 276-277

Providers.. Rev your engines!

- Preventive care is good for you too!
  - Always check E&B BEFORE the visit when possible
  - Obtain approvals and authorizations
  - Reduce bad encounters by eliminating validation on the date of service
- Significant results are possible
  - Much shorter "check-in" process
  - Push for co-pays, deductibles, other OOP no later than the date of service
  - Time for you and the patient to make choices

Providers… GO GO GO
The Claims Attachment (275)

• The claims attachment standard will allow the electronic attachment of clinical data (medical opinions, diagnostic information from lab tests and radiology reports, EKG readings and similar)

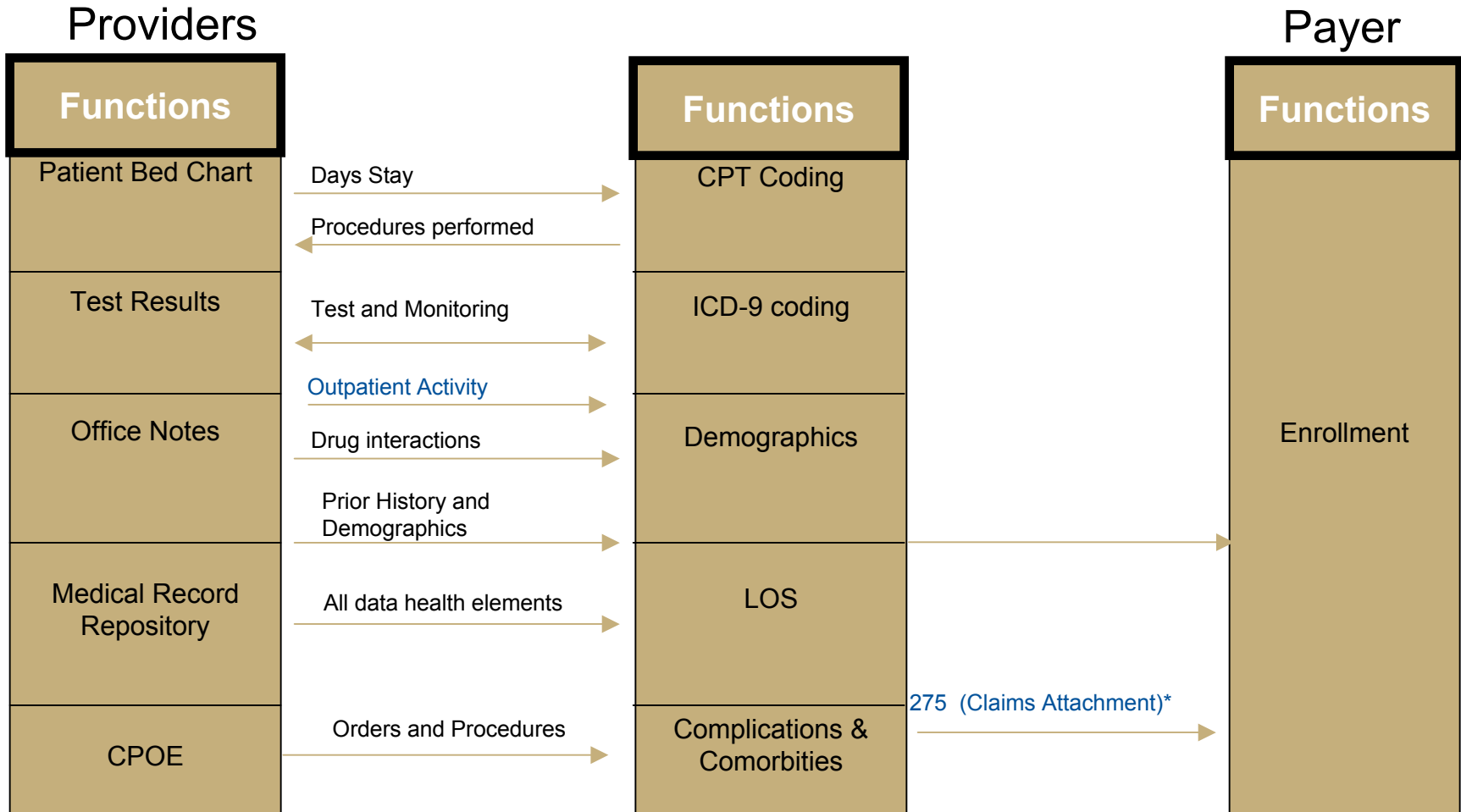• One day we may be able to add radiology images and scans

- Clinical Integration can save additional costs in the areas of:
  - Coding
  - Justification of DRG and levels
  - Faster claims submission
  - Lower Human Error Rates (automated)
  - Greater compliance via AI 100% reviewed

Clinical to Revenue Cycle Flow

Providers

Functions
Patient Bed Chart
Test Results
Office Notes
Medical Record Repository
CPOE

Functions (Middle)

Functions
CPT Coding
ICD-9 coding
Demographics
LOS
Complications & Comorbities

Payer

Functions
Enrollment

Days Stay

Procedures performed

Test and Monitoring

Outpatient Activity

Drug interactions

Prior History and Demographics

All data health elements

Orders and Procedures

275 (Claims Attachment)*

- Leverage Internet and Real-Time connections used for administrative and revenue transactions for provider to provider interactions

- Focus on applied digital healthcare through the use of technology for more effective clinical outcomes

- Enabling technologies will be required
  - Voice-to-text is a critical element to clinical adoption
  - Interoperable security and authentication
  - High availability and on-demand architectures

The Cost, Quality, Standards Relationship

Standards-based automation of routine functions lowers rate of rising costs (labor)
- Only possible if accompanied by process redesign
- Could allow increased investment in clinical IT support

Standardized data increases its usefulness for quality improvement studies
- Knowing what's best can improve quality, but doesn't prevent error
- 4th leading cause of death: medical errors!

Standards for clinical information will allow more cost-effective introduction of IT support at point of clinical decision making
- Which in turn, will lead to fewer errors, higher quality care, and lower costs (e.g. e-Rx, CPOE).
- NCVHS recommendations for PMRI standards.

Patient Centered Clinical IT Support - NHII

Patients will take an increasing role in IT interactions with healthcare system:

– Patient answers computer-based questionnaire before each visit to give complete info to provider

– Provider interacts with decision supporting EMR in presence of patient

– Patient takes home paper/electronic copy of record/instructions generated during each visit

– Patient interactions with provider are often asynchronous and electronic (e.g., e-mail with web reference material) and depend more on self- care, unless hands-on visit is required

– Result is higher quality, lower risk, lower cost, and more satisfying healthcare

For claims, the goal is to survive a threat:

- Dropping back to paper
- Increase claims failure
- Increase reliance on 3'rd party clearinghouses

Other transactions are opportunities to thrive

- Early adopters are demonstrating this
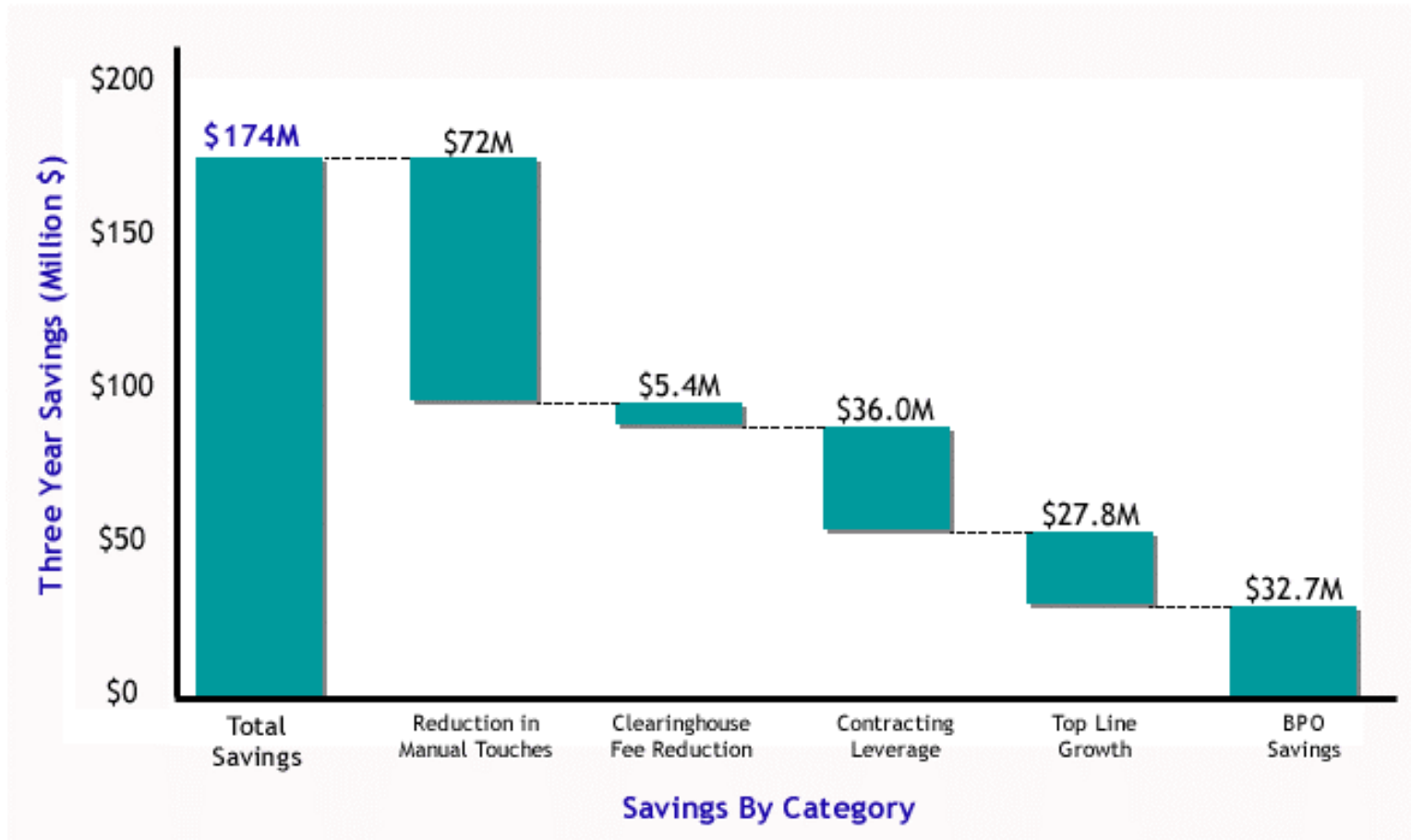- Full realization is a complex process

Follow the leader

How to Get Paid Under HIPAA?

USE IT!

Webify Health Plan Value Proposition

Assumptions: Typical Blue handles 30M claim per year, 12M touches.
Source: Blue Cross CIO Interviews, Internal Analysis

E&B Success Stories - Benefit All!

- **One of the nations largest hospital chains reported early results of a pilot..**

  – Manual work to do E&B transactions with Payers was reduced 80% (direct connect v. keying into a browser)

- **Another practice reported that they had 27 % of the office deductibles in their patient record wrong.**

- **An analysis of other practice reported that upon examination claim pend reasons found wrong name accounted for 66% of pends, the next largest category was 4%**

  – After Implementation of the E&B they reported an immediate 50% reduction in pends and denials

Success Case Study

- The GOAL

  – Clopton Clinic used the Webify direct connect solution to solve their need to translate all claim files from NSF 3.01 to the HIPAA compliant 837

  – The goal was to avoid excessive investment in their current PMS and to avoid having to subscribe to expensive clearinghouse services
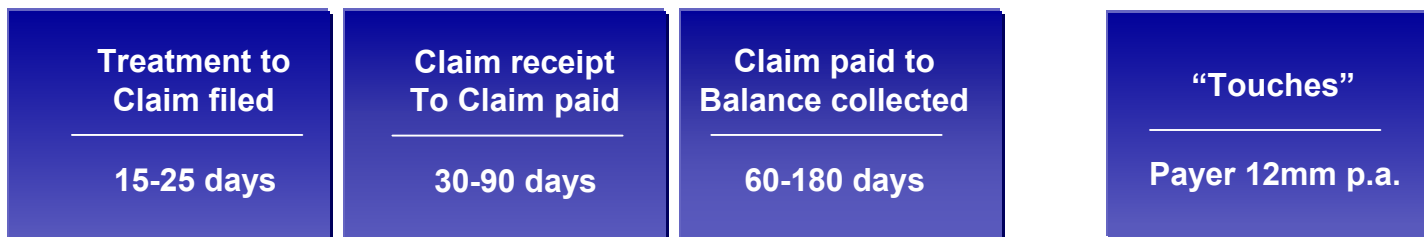
Success Case Study

• The RESULT

– Compton realized nearly a 20% reduction in time required to submit and manage claims

– Achieved a reduction to 14 days for payment even on problem claims

– Clopton Clinic receives 835s from their payers and their direct connect HIPAA solution converts it to the format that they used in the past

  • With few changes the converted files are placed it in the appropriate directory so that Clopton continues auto posting today even in the 835 world today
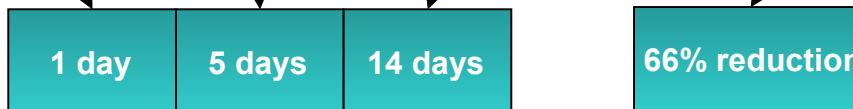
Business Efficiency Impact

Challenge with Claims (Before)

Treatment to Claim filed	Claim receipt To Claim paid	Claim paid to Balance collected	"Touches"
15-25 days	30-90 days	60-180 days	Payer 12mm p.a.

Typical Insurance Payer: Reduction of ~$20M in recurring annual costs

Problem Claims (After Webify HealthTransactions)

1 day	5 days	14 days	66% reduction

Eye Towards the Future

Nature-wildlife.com

Where to get help?

Southern Healthcare Administrative Regional Process

A Public and Private Industry Partnership

SharpWorkGroup is striving to meet the needs of all regional stakeholders by providing a collaborative regional health care and provider focus.

SharpWorkGroup helps achieve understanding of the HIPAA standards, MMA, and NHII, and fosters the implementation of _reasonable_ compliance efforts which realize the benefits of those standards.

www.sharpworkgroup.com

Thank You

- Questions?

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