

Jeff Goldsmith

payer-provider connectivity progress elusive but possible

HIPAA has failed to simplify claims processing. The current gridlock requires a new federal strategy.

AT A GLANCE

- > HIPAA's administrative simplification provisions so far have not eased the burden of the healthcare industry's complex payment system.
- > Some organizations have implemented claims management innovations through payer-provider collaborations, e.g., NEHEN, Availity[®], United Healthcare Online, and AthenaHealth's application suite.
- > The Medicare program needs to change the payment system and make it easier to use electronic claims management.

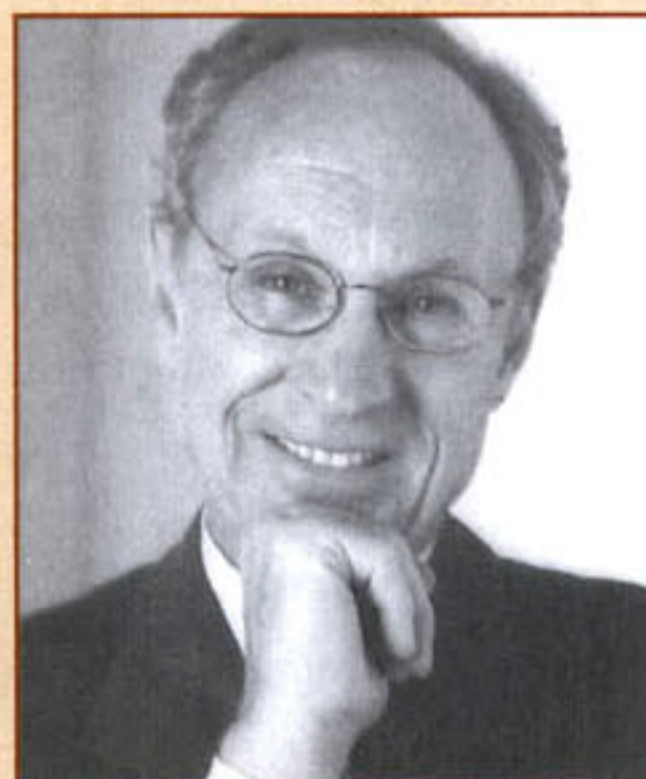
When Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996, it added, almost as an afterthought, administrative simplification provisions to encourage standardization of electronic payment transactions between providers and health plans. The framers of these provisions compared this standardization to the standard banking transaction system (which resulted in electronic coding on our checks and enabled the emergence of automated teller machines).

Though overshadowed at the time by HIPAA's privacy protections, the administrative simplification provisions were viewed by many industry observers as potentially far more significant. Some consultants predicted as much as \$30 billion annual savings in reduced transaction costs for the health system as manual claims processing migrated to electronic platforms. Health plans faced a gigantic system conversion headache and spent more than \$15 billion in regulatory compliance costs related to HIPAA.

Returns on this massive investment and savings for the health system from implementing the HIPAA standards have proven elusive. Health plans do not seem to have been able markedly to reduce their claims management expenses as a result of HIPAA. And on the provider side, as John Glaser, Partners HealthCare vice president and CIO, commented dryly, electronic claims processing technologies have "enabled a level of complexity that beforehand was not possible."

At the heart of the problem may be the glaringly obvious point that healthcare transactions are vastly more complex than banking transactions. The real complexity, however, inheres not only in the variability in clinical conditions but also in the variability of health plan provider contracts as well as

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in their contracts with employers. As Wes Rishel, Gartner's data standards guru, observed, "While HIPAA standardized claims transactions on ANSI x12 standards, it failed to standardize the health plan business rules which applied the data standards." The result was a huge variation around how health plans applied HIPAA transaction standards, and consequently, little or no net complexity reduction.

Crucial pieces of a national claims management system, such as a universal patient identifier and a universal provider identifier, failed to materialize. The patient identifier, viewed as the key to interoperable clinical information systems, was an early casualty (1998) of privacy concerns and a lack of political leadership. The provider identifier, which is expected to be implemented this spring, 12 years after HIPAA's enactment, has had a much longer gestation period than the great Blue Whale.

However, the bewildering variability of health insurance contracts and data systems would have defeated the effort even if the identifiers had been implemented. A large national health plan may have tens of thousands of different health benefits structures (almost employer-specific), as well as multiple years of overlapping provider network contracts and rate structures. Large national plans may also be processing their claims on as many as a half dozen different IT platforms. Remember that many of the large

national plans were rolled up through numerous mergers and acquisitions. Software platform consolidation is enormously expensive and time-consuming, and after the post-HIPAA capital spending orgy, many health plans postponed the capital and consulting investments required.

In 2008, the most prevalent type of integration between health plans and providers in claims management remains what Rishel calls "swivel chair integration"—claim-specific interaction over the telephone or computer screens between experienced claims management staffs at the provider and health plan end. Despite the rapid advance of business process automation in other fields, large pieces of healthcare transaction processing seem frozen in the early 1990s.

Claims Management Innovations

There are important nodes of innovation in claims management, however. Some of the progress is occurring through provider-payer collaboration in regions and metropolitan markets, while new business models are emerging in the private sector. After the garish public collapse of Jim Clark's Healtheon, an ill-starred attempt to create an Internet-enabled national electronic claims clearinghouse, most of the action in electronic claims management shifted to the regional level. Application of data standards to electronic claims transactions became more tractable at the regional or metropolitan level where you could at

least put the handful of major provider and health plan decision makers around a single table.

The realization that face-to-face interaction could be crucial led to the founding of the Boston-based New England Healthcare EDI Network (NEHEN) in 1998. NEHEN was intended to act as a seamless electronic claims management framework that linked health plans and hospitals without creating a new claims processing infrastructure. NEHEN created a rules-based claims processing and management interface among participants, initially for verifying eligibility, but subsequently for a full suite of applications, including benefits verification, referral inquiry and submission, claims status inquiries, claim submission, and, eventually, electronic remittance. It is a "dumb pipe" system; each of the above functions is defined by rules that participating payers apply to electronic claims filed by their network members.

processing of transactions between health providers and health plans called Availity®. The founders were Blue Cross and Blue Shield of Florida, Inc., and Humana Inc. In 2006, Health Care Service Corporation, a large multistate Blue Cross plan, entered into the joint venture, expanding Availity's reach into Illinois, New Mexico, Oklahoma, and Texas.

Availity provides both real-time and batch processing of administrative, financial, and clinical transactions via its secure web portal, business-to-business vendor connections, and EDI clearinghouse. Transactions include eligibility and benefits, authorizations and referrals, claims, claim status, and electronic health records. In an effort to streamline access, Availity supports the ability for providers to swipe patients' magnetic stripe-enabled health plan identification (ID) cards through a three-track-enabled card reader and read the information contained on the card.

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NEHEN has grown from the five founding members in 1998 to more than 30 members in 2007. Transaction volume has grown from a little less than 3 million a year in 2000 to 3 million a month in 2007. NEHEN was part of a late 1990s wave of regional collaborations, including Minneapolis/St. Paul, Salt Lake City, and the Pacific Northwest. However, the labor- and relationship-intensive process of community-based interface development has failed to catch on in other parts of the country with a less robust history of community-wide collaboration.

In late 2001, an unlikely coalition of publicly traded and not-for-profit health plan competitors created a web-based electronic health information exchange for both real-time and batch

Availity and its payer partners have provided more than 6,000 card readers to Florida and Texas providers to increase adoption and utilization of this time-saving capability. In 2008, the same readers

will be able to accommodate payment from debit, credit, and combination member ID cards connected to health savings accounts and other consumer-directed health plans. Availity CareProfileSM also enables physicians and their designees access to their patients' electronic health records on first contact and afterward. This application retrieves claim history from multiple (participating) health plans in real-time, presenting diagnosis history, prescription medications, and other clinically relevant information to consider at the point of care.

Availity began in Florida, and has achieved 100 percent hospital penetration and 95 percent physician office penetration in the state. Although its claims clearinghouse is available nationwide,

deployment of its web portal is under way in Arizona, Illinois, Indiana, Kentucky, New Mexico, Ohio, Oklahoma, and Texas. Availity achieved profitability in 2004, turning a majority of its profits back into research and development.

According to Julie Klapstein, Availity's CEO, the major constraints in growth of real-time adjudication are the legacy claims systems used by payers and in hospitals and physician offices. Very few of the existing systems support real-time processing. Availity supports this functionality today, and can enable payers and providers to take advantage of it when their back-end systems can support it.

United Healthcare has created a real-time claims adjudication function, which can be accessed through its web portal United Healthcare Online. According to Tim Caja, senior vice president of network operations for United, real time electronic claims volume has reached 175,000 a month direct from providers. United is working to integrate its online system with claims management software in both hospital and physician offices to accommodate batch processing of claims submitted directly from providers. A very high percentage of United's overall claims are submitted and adjudicated electronically through batch processing by clearinghouses, but the leap to direct connectivity with providers will be a slow process.

United has also applied Six Sigma principles to identifying and optimizing its claims processing relationships to individual providers through its Hospital Process Performance Program (HP3), extending the face-to-face logic of the above cited regional efforts into joint process improvement.

Finally, on the small physician practice front, AthenaHealth has created a web-hosted (ASP) "smart pipe" application suite, which includes practice management, scheduling, and billing systems, as well as an electronic health record. AthenaHealth has built a nationwide payer rules engine, which enables physician claims to be scrubbed and edited before being submitted, and

an application called Athena Collector, which manages physicians' claims adjudication and payment remotely. AthenaHealth has also created a payer rating system based upon their claims management performance, as well as a capacity for individual practices to benchmark their collection efficiency relative to other users. AthenaHealth went public during the credit market meltdown last summer, and has grown to a market capitalization of \$1.4 billion in spite of an ugly stock market.

The Federal Role

Although the above cited examples are encouraging, they represent a tiny fraction of the tens of billions of claims generated and "managed" annually by our fragmented healthcare payment system. Providers and patients are losing the battle against administrative complexity, and a further lurch toward gridlock looms.

The migration of ambulatory payment under Medicare to ICD-10 will mean a quantum expansion in the data required for ambulatory care payment. Hospitals are mired in system conversions to the new Medicare severity diagnosis-related group (DRG) system, with an uncertain financial outcome. Further, the spreading adoption of multiple pay-for-performance schemes will drown the health sector in data requirements and attendant administrative costs at the very time that provider payment is likely to be tightening.

These moves beg the question of how sustainable our present model of microscopic payment per incident of service is likely to be. Heaping new P4P data requirements on a fundamentally antiquated fee-for-service payment model is, in my view, questionable health policy. A promising path to simplification for health plans and the

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federal government may be to bundle care payment both for hospital and physician components into “episodes of care” (in a more comprehensive fashion than DRGs did for Medicare inpatient hospital payment in the 1980s) or to pay for physician care through limited risk capitation or subscription models, or through support for the emerging “medical home” concept.

Payment methodologies must change for another, more compelling reason—correcting the hyperinflationary bias of present payment incentives, which encourages care of marginal value to patients. Consolidating payment for multiple instances of service would reduce the absurd number of transactions surrounding the care process and have a greater effect in simplifying healthcare payment transactions than any new wave of congressional or regulatory mandates.

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A major imponderable is what role Medicare will take in accelerating the adoption of electronic payment technologies. Medicare shelved a pilot project on electronic eligibility verification in 2007, and is currently unable to accept or process real-time transactions. Given the rapid progress being made on multiple fronts on the private side, this lack of leadership on Medicare’s part is inexcusable. Most people interviewed for this article agreed that Medicare could profoundly influence adoption of real-time claims adjudication and management because of its leverage with private health plans through its fiscal intermediary contracts and its extensive relationships with private health plans through Part D.

Thus, a major opportunity for the next administration in Washington will be to use Medicare’s leverage as the pivotal healthcare payer to press for more rapid adoption of electronic connectivity between providers and payers in processing Medicare claims. Changes in Medicare payment strategy and claims management policy could have a more profound impact on health costs than the current policy focus on universal adoption of electronic health records by helping eliminate some of the vast army of health payment facilitators in every health plan and every provider organization.

The alternative path, a congressionally enacted HIPAA II, is fraught with challenges and may not be worth the effort. Bob Booz, the health plan practice leader for Gartner, doubted that a return to the unfunded (and woefully understaffed) con-

gressional mandate as embodied in HIPAA would be a good idea. “There is never an ROI for regulatory compliance,” Booz observed. Unless the federal government wanted to force health plans to standardize their employer contracts and provider network negotiation

frameworks, the achievement of the original HIPAA dream of a vastly simplified electronic claims management system by regulatory fiat is unlikely to be realized.

The encouraging signs of limited progress in real-time claims adjudication and payment suggest that the root causes of the current gridlock are not technological, but rather bureaucratic inertia and lack of leadership. Ultimately, changing how we pay for care and dragging an antiquated Medicare program into the 21st century may make it easier to adopt and use these technologies than a further wave of regulatory mandates. ●