

# Taking the Paper Out of Paperwork

How Electronic Administration Can Save  
the U.S. Health System Billions



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## Foreword by Newt Gingrich

The American Recovery and Reinvestment Act of 2009, with all its faults, had one positive element – the inclusion of more than \$20 billion toward the development and adoption of health information technology. Implemented correctly, this particular investment can help us modernize our health system through the accelerated adoption of tools such as electronic health records, which can dramatically improve clinical quality and patient safety.

Delivering better care must always be our top priority, but we must also find ways to reduce cost. In these trying economic times, combined with the specter of unsustainable spending, Medicare insolvency and runaway growth in Medicaid, we must find those IT solutions that can not only save lives but can also lower costs.

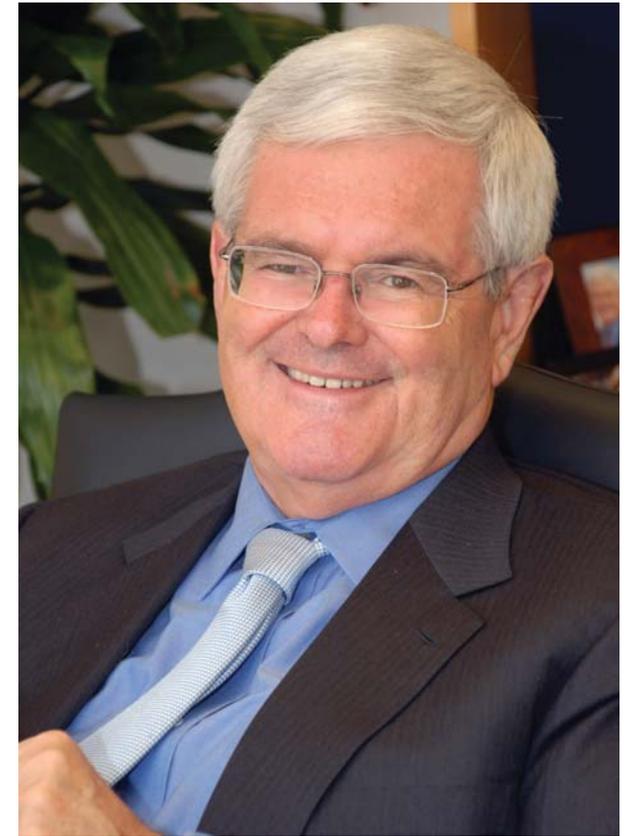
While better quality care often means lower costs, the national dialogue on health information technology often fails to mention the potential savings on the administrative side of healthcare. At a time when the United States spends more than \$2.3 trillion on healthcare a year — 17 percent of the entire economy — these administrative savings are not only significant but can be realized *today*. The U.S. Healthcare Efficiency Index, launched by Emdeon in December 2008, estimates that if the entire U.S. healthcare system moved from a paper-based and phone-based system to an electronic one, we could save \$30 billion a year. Take claims payment as an example. It is inexcusable that in today's modern world 90 percent of all medical claims are paid by printing a paper check and mailing it through the U.S. Postal Service. Electronic payment through direct deposit—think PayPal for health—could alone save an estimated \$11 billion every year.

We must learn from other successful industries that have undergone a shift from paper to modern, electronic transaction. From online financial services to e-commerce, we have seen how automation has cut inefficiencies in various industries. Consider online banking. Today virtually every bank in the United States offers online banking where customers can transfer money from one account to another, pay bills, view statements and securely communicate with bank representatives. There are generations of Americans who will go through their entire lives without stepping foot in a bank.

E-commerce is another example. The U.S. Census Bureau reported that total e-commerce sales in 2007 were \$136 billion, a 19 percent increase from 2006. Online sales have seen a nearly six-fold increase since 1999 and will continue to grow exponentially. We can learn from these experiences to adopt what is clearly working in the world outside the healthcare industry.

Yet there are also successful examples that exist in the healthcare industry today. This paper examines many of these initiatives, as well as the barriers that have precluded broader adoption of electronic exchange. We also explore the steps the industry is taking and must take in the future to migrate to a fully electronic-based system.

We at the Center for Health Transformation would like to thank Emdeon for their support of this paper as well as the leadership that they and others have shown to move the administrative side of healthcare in the 21<sup>st</sup> century.



# Healthcare's Big Secret



The statistic is stunning – in an economy that annually transmits over 18 billion electronic payments between businesses, consumers and government entities, more than half of all financial transactions in the U.S. healthcare industry are still paper-based.<sup>1</sup> When factoring in the fully loaded cost of labor, printing, postage and handling, this results in upwards of \$30 billion a year in waste.<sup>2</sup> It doesn't have to be this way.

Given today's troubled economy, perpetually rising healthcare costs and exploding healthcare budgets as far as the eye can see, we need to make our system leaner, more efficient and more productive.

"It's not about infrastructure," says George Lazenby, chief executive officer of Emdeon, an intermediary revenue and payment cycle solutions provider. The infrastructure is there, the technology exists and everyone is looking for ways to optimize their business processes. So what is standing in the way?

Many players in the business of healthcare may find this reality hard to believe. The federal government mandated payers to comply with some automated options, and since 2005, Medicare has required electronic claims submissions with few exceptions.<sup>3</sup> Medicare wields a heavy stick as the largest payer in the nation and has been instrumental in moving this segment of the industry into electronic data interchange (EDI). But even with a mandate, only 75 percent of all claims submissions today are done electronically.<sup>4</sup> Much more can and should be done.

In order to fully appreciate the magnitude of the problem and the role information technology can play in advancing meaningful healthcare reform, this paper analyzes four key contributing factors:

- The factors that drive the continued use of paper and manual processes;
- The barriers that have precluded broader adoption of electronic data exchange;
- The steps the industry is taking to address the needs of both payers and providers; and,
- Best practices employed today that use existing capabilities.

Armed with new insight, both payers and providers can begin the next logical steps to help them achieve greater efficiencies and transform their business processes into a model of best practices. After all, says Lazenby, "Electronic transactions in healthcare get adopted when they meet the needs of both providers and payers...It's about refining the information and putting it at the point where decisions need to be made so that you can take out the rework and manual processes."

<sup>1</sup> National Automated Clearing House Association, *ACH 2007 Volumes*, May 19, 2008; U.S. Healthcare Efficiency Index, <http://www.ushealthcareindex.com>, February 2, 2009.

<sup>2</sup> *Ibid*

<sup>3</sup> *The Health Insurance Portability and Accountability Act of 1996, Title II: Preventing Healthcare Fraud and Abuse; Administrative Simplification; Medical Liability Reform*, 104<sup>th</sup> Congress of the United States, August 21, 1996.

<sup>4</sup> U.S. Healthcare Efficiency Index, <http://www.ushealthcareindex.com>, February 2, 2009.

"Electronic transactions in healthcare get adopted when they meet the needs of both providers and payers."

– George Lazenby, CEO  
Emdeon

# Why Paper?

While the bulk of claims submissions are done electronically, the preceding insurance eligibility verification, claim status, payment and remittance processes are still largely conducted by phone or done on paper. The claim status may indicate the need to submit supplemental information about the service provided while the remittance advice is the documentation that accompanies the payment.

"A claim has to jump through so many hoops, you can end up with a paper claim even when you initially sent an electronic claim," explains Anurag Sinha, director of Health Exchange, a subsidiary of Cerner. Because claims attachments are still primarily paper-based, reconciling a claim with the payment and remittance advice is often easier to do on paper. Electronic eligibility verification is performed only 40 percent of the time, a distant second behind electronic claims submission.<sup>5</sup>

## Current Use of Electronic Billing and Payment

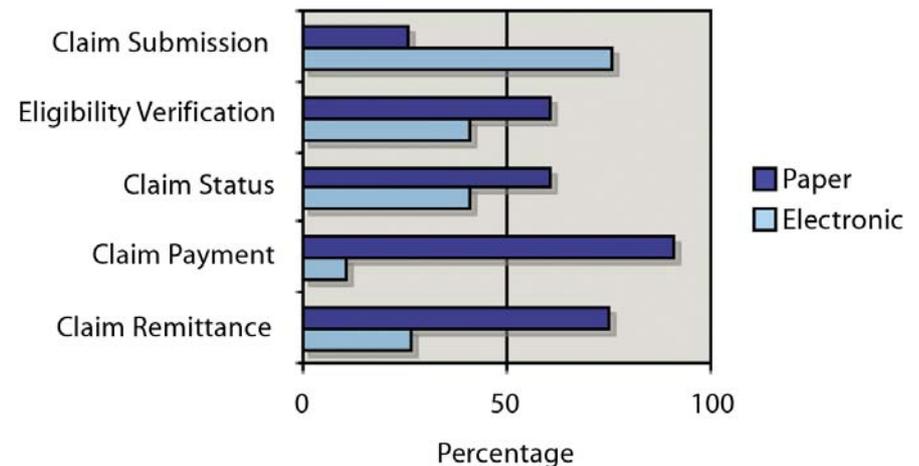


Figure 1: U.S. Healthcare Efficiency Index

# Barriers to Broad Adoption

The barriers to broader adoption are numerous, including lack of integration, lack of complete standards, competing priorities between stakeholders and a perceived lack of value to providers. An end-to-end cycle of electronic eligibility verification, claims processing and payment requires a tightly integrated system for optimum efficiency, but the very nature of the healthcare industry with providers and payers as disparate entities running completely separate systems precludes this capability. "There are multiple stakeholders. Everyone has their piece, and we need to find ways for the processes to dovetail," says Tom Meyers of America's Health Insurance Plans (AHIP), a national association representing 1,300 member companies that provide health insurance to more than 200 million Americans.

Though HIPAA paved the way for interoperability between providers and payers by developing transaction content standards for claims, eligibility and claims status, the content standards only mandated some of the content that goes into the transactions. This creates variations between organizations and often does not give providers enough of the information they need. "HIPAA was a great idea, but [it] didn't go far enough to make the whole process operate without a lot of work," says Julie Klapstein, chief executive officer of Availity, an EDI intermediary for payers and providers.

From eligibility verification to claims remittance to claims attachments, there are various barriers within HIPAA that hinder end-to-end electronic payment. For instance, information provided in the electronic eligibility transaction varies among payers. Often providers get a simple "yes" or "no" response, but what they really need is actionable information at the point of service, i.e., What is actually covered? What is the co-pay? What is the deductible, and how far along is the patient in meeting his or her deductible? Also, providers deal with multiple health plans, many of which utilize different formats in the way they respond to electronic requests.

## Barriers to Adoption

- Lack of systems integration among stakeholders
- Lack of complete standards
- Competing IT priorities between stakeholders
- Perceived lack of value to providers

Figure 2

<sup>5</sup> U.S. Healthcare Efficiency Index, <http://www.ushealthcareindex.com>

Consequently, the learning curve for the provider's staff is high and many times the electronic transaction (due to insufficient content) does not replace a manual step. Claims remittance advice is similar. A payer may send back a discounted \$85 payment for a service that was billed at \$100 because of the discount provision in the contract. Where the paper remittance will include a detailed description explaining the discount to the provider, the electronic remittance may include only a code that can apply to a range of reasons. The provider then has to pick up the phone and call the payer to find out why the payment amount was less than the billed amount. Providers often do not want payments automatically posting to their accounts without first reconciling them with the claims, so they choose to keep that part of the process on paper.

Additionally, some components of the process such as claims attachments have remained paper-based and need to be mailed to the payer and then manually reconciled to the electronic claim. So even in a fully automated cycle between a payer and provider, any claim requiring attachments reverts back to the paper process. As a result of these loose standards, payers and providers may all have HIPAA compliant transactions, yet they are all very different. Or said another way, when you've seen one HIPAA compliant transaction, you've seen one HIPAA compliant transaction.

In addition to loose standards, HIPAA allows exemptions that have impacted progress. Linda Zang, assistant treasurer for the University of Pittsburgh Medical Center, explains that the auto insurance industry, worker's compensation and small providers are all exempt from having to adopt electronic transactions. Payers have had to continue to support both paper and electronic-based processes for these types of claims. Because HIPAA allows auto insurance payments to be paper-based, few auto insurance companies offer electronic remittances. This results in most auto insurance claim payments being posted manually by providers.

Adding to the complication, payers and providers often have competing priorities for their IT dollars, so there are varying degrees of automation between the stakeholders, making it seemingly impossible to close the loop on electronic processing. For example, a payer considering an expensive system upgrade to move from traditional batch processing to online, real-time claims adjudication has to weigh that investment against the number of providers who will be capable of sending an online, real-time eligibility request and who will be able to process the subsequent response and claims transactions.

On the provider's side, he or she has to weigh the cost of implementing an online, real-time system against the number of payers that can receive the transactions and properly process them. A real-time response needs to include enough information about the benefit so the provider won't have to pick up the phone and contact the payer call center. It is the classic chicken-and-egg question: Which comes first?

There is also a lack of perceived value in moving to an electronic system. Unfortunately, payer solutions intended to drive providers toward electronic adoption have not always been successful. "It always has to tie in to the provider's workflow," says John Marron, vice president of business development at GatewayEDI, another intermediary service provider. "Back in the early days, payers often forgot about the value to the provider. Too often we said this will work well for us and we'll produce a lot fewer paper claims, but we didn't understand the workflow of the provider's office," explains Marron. As a result, payers came up with their own individual, proprietary tools such as web portals for eligibility and claims processing. Providers largely rejected using them and chose to keep to the paper and phone call process rather than training their limited staff on a multitude of sign-on procedures and submission processes.

## The Value Proposition

Despite the barriers, there are significant benefits for moving to electronic submission and receipt for administrative transactions.

A 2006 study comparing the provider costs of manually and electronically processed transactions found that a typical solo physician practice could save over \$42,000 per year by implementing EDI.<sup>6</sup>

Electronic claims also tend to be cleaner than paper claims, resulting in reduced costs and faster payments. Another 2006 study found that 71 percent of electronic claims were auto-adjudicated, meaning they were processed without manual intervention, versus only 44 percent of paper claims.<sup>7</sup> A payer saves 78 cents for every

<sup>6</sup> John Phelan and Andrew Naugle, "Electronic Transaction Savings Opportunities for Physician Practices," Milliman, Inc., January 2006.

<sup>7</sup> Hannah Yoo and Karen Harner, "An Updated Survey of Health Care Claims Receipt and Processing Times," AHIP Center for Policy and Research, May 2006.

Manual vs. EDI Per Transaction Cost

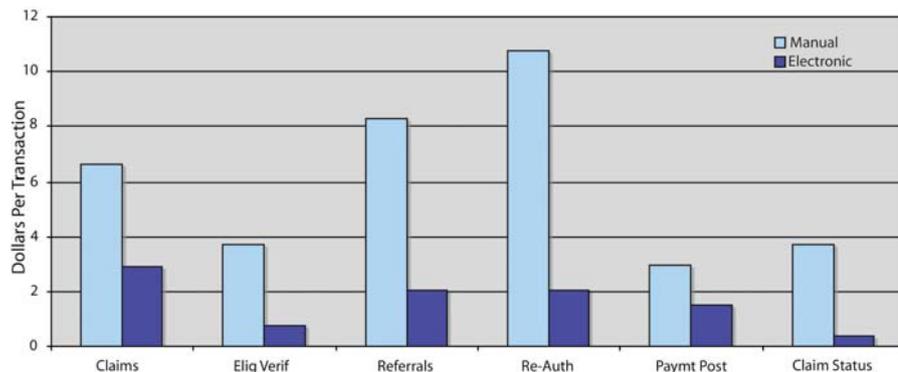


Figure 3

claim processed electronically, and \$1.20 for every electronic claim that can be auto-adjudicated. For payers that process 20 million claims a year that adds up to over \$21 million in potential savings. That is a powerful incentive for EDI and debunks the myth that cleaner claims and faster payments impact cash-on-hand interest earnings and are therefore a disincentive for broader adoption. "Today's economy and interest rates don't make the float a viable issue," says Marron.

Consider other financial incentives for payers to move to EDI for claims processing. Based on its experience, Emdeon estimates it costs payers between \$1.50-\$3.50 for simple eligibility verification and up to \$10 for complex referrals per provider phone call versus 25 cents to process an electronic transaction. And processing a denied claim that has been appealed may cost payers as much as \$55 per denial. While appeals are not the norm, it is clearly an expense payers try to avoid up front with better eligibility checking and claims processing.

There are significant savings to be realized on the payment side as well. A provider can save \$1.49 for every payment posted electronically.<sup>8</sup> This can add up quickly in high volume settings. UPMC's Zang says her organization posts 10 million hospital payments a year, 90 percent of which are electronic and can be handled by a staff of three to four. The remaining 10 percent of payments that are paper-based require 12 to 13 people to process.

## Moving Forward

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Most electronic transactions are processed in batch mode with increasing movement to online, real-time processing. It is important to understand that the value of electronic transactions, batch or real-time, will only be optimized when it works in a tightly integrated system that meets the needs of both payers and providers. While the infrastructure is already in place for electronic transaction processing, there is still work to be done with systems integration and process improvement across stakeholders.

"If you want to drive value and take cost out of the system, you've got to ... change behaviors and change processes," says Erik Swanson, vice president of corporate strategy at WellPoint Inc. There are many efforts underway in the industry that are successfully beginning to break down the barriers to broader adoption. Payers and providers that once worked in silos are beginning to work collaboratively.

### *The Role of Electronic Transaction Intermediaries*

One way providers and payers can take advantage of EDI is through intermediaries, or clearinghouses. An electronic transaction intermediary serves as a transition agent to both the provider and payer by offering various services and tools that improve the interoperability required in an end-to-end electronic cycle where the stakeholders are at different stages of automation. It does this by using existing infrastructure and translating or scrubbing the data from providers into formats required by the payers, and vice versa. Companies such as Emdeon, Availity and Gateway EDI offer a variety of solutions that close the gaps created by a lack of standards and barriers created by organizational silos.

One solution converts paper claims from the provider into an electronic format for the payer, introducing the converted document into the same electronic stream as the electronic claim that can be tracked by both parties.

Another solution is a multi-payer portal that gives providers a consistent look and feel in interacting with all of their payers, and therefore patients, using a single sign-on and workflow.

Yet another solution offers a batch eligibility verification capability that lets providers download tomorrow's schedule into a file where the data is edited, validated and converted into the electronic HIPAA 270 transactions that are then sent to the payers. The payers respond with a corresponding 271 transaction that is then batched and sent back to the provider in time for the appointments the next day.

These are just a few examples of how intermediaries work with payers and providers to enable efficient use of electronic transactions. Many of these third-party service providers offer web-based solutions at little or no charge to physician offices. They also offer such tools as magnetic stripe cards for patient identification, host real-time processing services and provide business optimization services such as rejection analysis and utilization trends.

<sup>8</sup> Phelan and Naugle, Millman, Inc., January 2006.

## CORE Initiatives

The Council for Affordable Quality Healthcare (CAQH) is a nonprofit alliance of health plans and trade associations that serves as a catalyst for collaboration on industry initiatives to simplify healthcare administration. "We are focused specifically on non-proprietary health plan business processes that unintentionally cause administrative burden in the provider's office," explains Robin Thomashauer, executive director of CAQH. To this end, CAQH launched an initiative to develop an all-payer solution that streamlines electronic data exchange and closes gaps in payer-provider interoperability.

The Committee on Operating Rules for Information Exchange (CORE) is achieving CAQH's goal. CORE is a multi-phase set of voluntary, technology-independent business rules that build on existing HIPAA and other standards to make electronic transactions more predictable and consistent. CORE is focused on improving provider access to electronic patient administrative and payer information before or at the time of service using any technology the provider chooses. Each phase expands the pool of available data and augments the functional requirements to exchange it electronically.

CAQH also works in harmony with and complements federally sponsored efforts. CORE rules were included in the interoperability standards recommended to the U.S. Department of Health and Human Services by the Health Information Technology Standards Panel (HITSP). Other work has been done with the American Health Information Community (AHIC), now called the National eHealth Collaborative, the Certification Commission for Healthcare Information Technology (CCHIT) and the Office of the National Coordinator for Health Information Technology (ONC).

To date, more than 35 leading organizations including Emdeon, Availity, GE Healthcare, WellPoint, Aetna, Humana, Blue Cross Blue Shield of North Carolina and other Blues plans are certified as using CORE's Phase I rules. CORE-certified health plans provide health insurance to approximately 65 million Americans.

CORE's Phase I rules focus on eligibility and benefits data to address the need of providers to receive actionable information when verifying eligibility. This information removes a key barrier to broader adoption and gives providers valuable information regarding their patients' coverage information. (See Fig. 4 below)

Complete eligibility information improves efficiency down the line, and now with CORE, payers can more easily make that information available to providers.

CORE's Phase II rules add requirements for reporting patient financial responsibility for an increased number of service codes included in the HIPAA standards. Additionally, the Phase II rules cover further requirements for electronic connectivity and add patient identification and claims status. CAQH expects to begin announcing Phase II rules certifications by summer 2009. Phase III, currently underway, will focus on additional administrative transactions such as prior authorization and remittance advice.

"The discussions have, changed so much over the last few years because stakeholders are now willing to view processes once considered proprietary as common to the industry...I think there is also a growing appreciation that, even if a stakeholder made the most significant changes themselves — whether they are a vendor, payer or provider — if everyone else isn't making changes that are compatible and complementary, their efforts are not going to get them the end goal they want."

– Gwen Lohse, deputy executive director of CAQH and director of CORE

Data Elements	Governance/Infrastructure
Health plan coverage confirmation	For eligibility and/or claims status:
Patient benefit coverage	<ul style="list-style-type: none"> <li>• System connectivity/security</li> </ul>
Patient financial responsibility for a range of treatments, including: <ul style="list-style-type: none"> <li>• Co-pay amount</li> <li>• Co-insurance level</li> <li>• Base and YTD deductible levels</li> </ul>	<ul style="list-style-type: none"> <li>• Standard inquiry acknowledgements</li> <li>• Maximum response times (batch- and real-time)</li> <li>• Patient identification</li> <li>• Minimum hours a system must be available</li> </ul>
Financial variances between in- and out-of-network providers	<ul style="list-style-type: none"> <li>• Standard companion guide flow and format</li> <li>• Standard testing, certification and enforcement processes</li> </ul>

CORE certification requires an organization to conduct a gap analysis of where its systems or products are in relation to the rules and where they need to be in order to demonstrate that they can exchange electronic data in accordance with the rules. The organization then needs to develop a budget and project plan. Finally, the organization needs to successfully complete a rules-certification testing process conducted by a CAQH-authorized testing vendor.

While CORE certification can compete with other budgetary items, organizations that have been able to tie certification to its overall strategic plan have been most successful in pushing the project through. The entire process takes between 12 and 18 months, with the bulk of the work being systems development and process re-engineering, and only about two to three weeks for system testing to validate the changes. Once that initial investment is made, connecting to trading partners becomes much easier. CAQH has been able to assist smaller plans with their gap analysis by sharing the experiences and lessons learned by larger plans, helping to make certification attainable by smaller plans with more limited resources.

CORE initiatives have been drawing interest at both the state and federal levels. Colorado, Ohio, Texas and Virginia have all expressed interest in adopting Phase I rules. Medicare has been actively involved in the initiative since its inception and publicly supportive of its administrative simplification goals. Medicaid, which is similar to commercial plans in that it operates through different plans, providers and vendors, cannot issue mandates to the states but is working with CAQH to determine how CORE can support its Medicaid Information Technology Architecture (MITA) guidelines.

## *Universal Provider Datasource (UPD)*

Although provider credentialing is not specific to EDI adoption, any provider that has a contract with a health plan has to be credentialed every two to three years, adding to their administrative burden. Beginning in 2002, CAQH worked across the industry to create a universal data-collection tool that simplifies this labor-intensive process, saving providers millions of dollars a year. Providers enter and maintain information free of charge into a single, uniform online application that, once created, requires periodic updates that take roughly three clicks with a mouse. UPD collects all information needed by health plans, hospitals and managed care organizations and meets the data-collection requirements of URAC, the National Committee for Quality Assurance and the Joint Commission. A 20-month study by CAQH found that providers perform an average 4.7 attestations a year and update the information 61 percent of the time. The UPD streamlines this process for providers allowing them more time to focus on their patients and not paperwork.

## *HIPAA 5010*

HIPAA 5010 is the federal government's response to the issues posed by the first set of HIPAA standards described earlier in this paper. The healthcare industry has asked for more than 500 changes to the current HIPAA standards to support new business requirements or correct old problems. HIPAA 5010 addresses these issues and brings more value to the healthcare community, significantly eliminating many of the barriers to broader adoption.

HIPAA 5010 improves the authorization and referral transactions and enhances the eligibility verification transactions, complementing CORE rules. New implementation rules will require health plans to provide fuller, more complete benefit and coverage information about a patient, thus eliminating phone calls. New claim transactions and instructions should help reduce accounts receivable (AR) days by bringing faster payments. Additionally, HIPAA 5010 will provide more automation for secondary claims. Health plans will be able to populate remittance transactions more accurately and completely, allowing providers to more easily automate claims payment.

The new standards are targeted to take affect January 2012. To that end, a collaborative initiative between CAQH, the Healthcare Information and Management Systems Society (HIMSS), the Integrating the Healthcare Enterprise (IHE) and the Blue Cross Blue Shield Association (BCBSA) will conduct a testing project in April 2009 at the annual HIMSS conference that will demonstrate the synergies between 5010 guidelines and existing testing and certification efforts. The purpose of the test is to help the industry better understand what needs to be done to successfully implement the 5010 transactions within the required timeframe.

## *Incentives versus Mandates*

The Centers for Medicare and Medicaid Services (CMS) gave electronic transaction adoption a boost when it mandated the electronic submission of claims. It has also recently enacted the Medicare Improvements for Patients and Provider Act (MIPPA) of 2008, which offers a two percent incentive payment to providers who use electronic prescribing technology. The American Recovery and Reinvestment Act, signed into law by President Barack Obama in February 2009, included more

than \$17 billion in provider incentives to adopt electronic health records. These kinds of reward-based initiatives could create a tipping point that moves the industry along, and could be a catalyst in making the use of automated transactions, such as electronic funds transfer for payments or electronic and real-time eligibility verification ubiquitous, throughout the industry.

Many payers in the industry have come to the conclusion that the best incentive to getting providers to increase their adoption of electronic transactions is to demonstrate the value to them, and provider network contracts that are incentive-based can be a vehicle for doing that. "The value equation should be the driver. Mandates and penalties tend to backfire," explains GatewayEDI's Marron.

Jeanette Thornton of AHIP agrees and believes that there is another danger in mandates and penalties by commercial payers: "Incenting a provider to make a change in process that only works with one payer will continue to keep those silos intact," which is not the path the industry wants to follow. Marron of GatewayEDI calls the preferred strategy a form of "consultative selling" that has a value equation at its core and is benefits driven. Provider network contracts that focus on value rather than on mandates and penalties will ultimately result in a better outcome for both payers and providers.

## Best Practices and Outcomes

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Many payers have been successful in rolling out collaborative solutions to their provider networks that have begun to show positive results for both stakeholders. The following examples are just a few of the results that the industry is beginning to see as stakeholders work together to transform the administrative processes of healthcare into a more efficient, cost-effective and integrated model.

### *Blue Cross Blue Shield of Massachusetts*

Blue Cross Blue Shield of Massachusetts (BCBS-MA) was successful in eliminating an annual yield of over \$2 million in administrative costs associated with claims processing by working with its providers to decrease paper processing and increase auto-adjudication rates.<sup>9</sup> The study, conducted in 2006, found that reducing paper claims 27 percent over three years shifted two million claim receipts from paper to EDI format, saving it \$1 million in administrative costs annually. This was accomplished by creating a dedicated team for EDI research that first analyzed data from individual providers against EDI benchmark levels and then worked with the patient account directors at the provider's offices to understand why some claims were still being processed on paper. Providers viewed this as a win-win approach because ultimately it saved them money as well as improved payment times.

BCBS-MA also provides financial incentives to shift providers from paper processing to EDI. Incentives include cost sharing of EDI transmission expenses in exchange for a guaranteed number of EDI submissions over a specific period of time.

BCBS-MA has realized significant benefits from its efforts to improve auto-adjudication rates. It uses the same data-driven approach to look for opportunities to track both improvements and deviations. It improved its auto-adjudication rates by five basis points, saving the organization 40 FTEs, or \$1.2 million in annual administrative costs.<sup>10</sup>

Blue Cross Blue Shield of  
Massachusetts saved over \$2  
million by eliminating manual  
workload.

– *e-Health Insider*

<sup>9</sup> "How BCBSMA Boosted Its EDI and First Pass Auto Adjudication Rates," *eHealth Insider*, [www.e-health-insider.com](http://www.e-health-insider.com). March 2006.

<sup>10</sup> Ibid

## Blue Cross Blue Shield of North Carolina

Blue Cross Blue Shield of North Carolina (BCBS-NC) was one of the first CORE-certified health plans. It experienced a three-fold increase in the use of HIPAA (X12) electronic eligibility and benefits verification transactions within 12 months of implementing the CORE rules. Real-time eligibility transactions increased from 20 percent to over 90 percent of total HIPAA (X12) inquiries, which has resulted in increased satisfaction among many of its 44,000 providers who now have easier and faster access to patient coverage information at the point of service. CORE Phase I rules have also resulted in faster electronic transaction implementations with provider and vendor trading partners because of the straightforward implementation of CORE telecommunications, testing and data content, and because CORE rules adoption serves as a good floor for trading data between business associates. As a result, BCBS-NC is now encouraging all of its vendor partners to become CORE certified.

BCBS-NC real-time transactions increased to more than 90% of total HIPAA inquiries after implementing CORE rules



## Healthe

Healthe is a wholly-owned subsidiary of Cerner Corporation that provides a full suite of third-party administrative health services to self-insured employers, including:

- **Healthe Exchange:** benefits design and administration
- **Healthe Management:** wellness programs and condition management services
- **Healthe Record:** an electronic, personal health record
- **Healthe Clinic:** individual-centered, primary care facility

Healthe began in 2006 as a solution for Cerner's own self-insured needs. Its guiding principles were to use information technology to provide individual-centered coordinated care, eliminate as much friction as possible between the payer and provider, improve health outcomes and decrease cost.

Healthe Outcomes	
Source: Cerner Corporation	
Emergency Department Services	▼ 10 %
Specialty Services	▼ 15 %
Outpatient Services	▼ 30 %
Overall Spending	▼ 15 %

Figure 5

"Healthē was put in place to take a step back, look at a population in total and figure out how to transform care delivery to that population," explains Bill Wing, vice president of Cerner Healthē. The goal of eliminating friction between payers and providers made them look at the payment side of the equation and develop innovative ways to create a real-time point-of-service payment. "Ultimately we believe you have to tie the clinical and financial information together in real-time to facilitate a new reimbursement model," says Wing.

The system uses a simple magnetic stripe card carried by every member that serves as a debit card that can be used in any retail setting. It includes member, pharmacy, Health Savings Account and Health Reimbursement Account information. The card is used within the Healthē system by the provider to submit a real-time eligibility verification that remits a response within 15 seconds thereby telling the provider what the member is eligible for; how much money is in the member's Health Savings Account; progress toward meeting the deductible; co-pay amount, etc.

During the visit, the physician documents the coded information into an electronic medical record. When the member returns to the front desk to check out, the card is swiped again, the member pays the co-pay, and the claim is submitted and adjudicated in real-time with an electronic funds transfer to the provider's bank account within 24 hours. The early returns have been impressive. The overall program has helped Cerner reduce its overall health plan spending by 15 percent.

## Cleveland Clinic

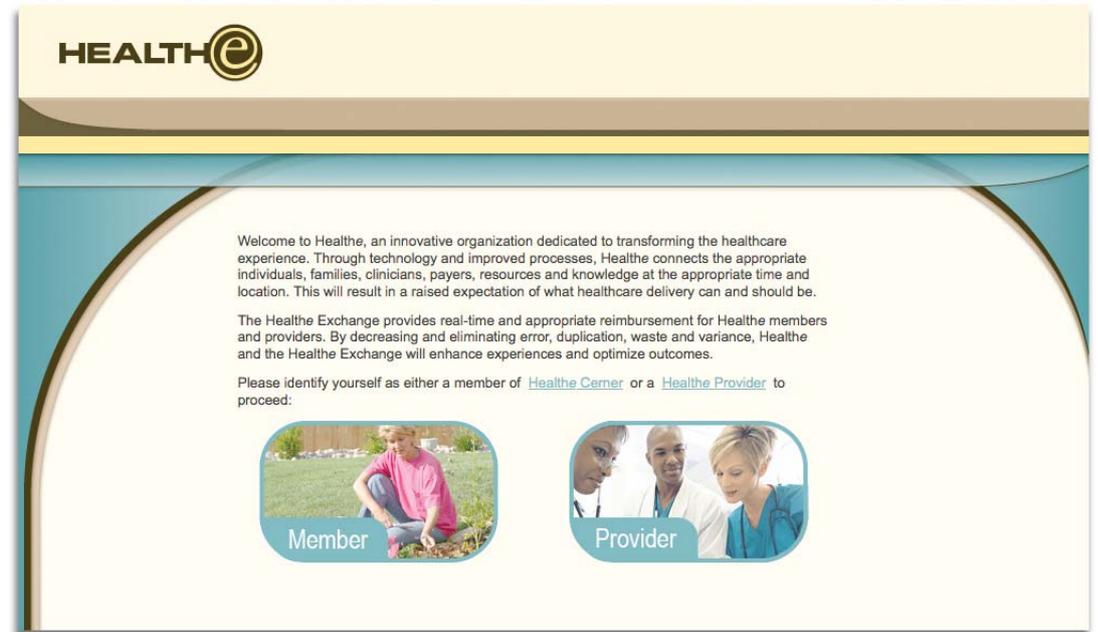
The Cleveland Clinic is a non-profit multi-specialty academic medical center that integrates clinical and hospital care with education and research. It has become one of the most respected health systems in the world and is consistently ranked as one of the "Best Hospitals" in the nation by U.S. News and World Report.

Lyman Sornberger, executive director of patient financial services at Cleveland Clinic, focuses on the financial experience of the patient as he works to reign in costs. He finds that providing greater transparency and cost information to patients helps to increase cash collections, but more importantly, increases patient satisfaction. Patients who are informed and presented with cost and care options ahead of time tend to be more engaged in their own care. They are also better prepared to pay their bill, which ultimately helps keep AR days low.

Cleveland Clinic implemented real-time eligibility verification in 2008 with the transparency goal in mind. Through this verification process, 99 percent of eligibility coverage is verified, with a majority even completed in real-time. Responses that providers are now getting back have more complete information about the patient's eligible services than ever before. The goal, says Sornberger, is to get "perfected" responses, which means the payer provides complete benefit information including covered services and the co-pay for each service. Though "perfected" responses currently only happen five percent of the time, the information coming back in the other responses is richer and helps physicians provide better care. "I personalize it," he explains. "If my doctor tells me I am 50 and need a colonoscopy...and it's going to cost me \$100...I should have the right to make that decision."

Sornberger concedes it is a challenge to allow patients to make the wrong decision since they may only focus on their financial situation, but there are risks to the other approach as well. A patient who is not forewarned of the cost of a particular service and then gets hit with the bill a few months down the road can be intimidated by the cost and could stop pursuing proper care in the future for fear of another shock. "I don't want to drive a clinical decision, but it's blinded right now for a patient, especially around anything they should decide to do," he says.

About 89 percent of Cleveland Clinic's receivables are processed electronically. But within that 89 percent, half of those transactions do not remit a complete



response and require manual intervention, which keeps costs high. Sornberger and colleagues from Cleveland Clinic sit on various boards and committees within the industry to help reinforce and influence the necessary changes to close those remaining gaps. In the meantime, "We need to create the future state around what real-time means, create current state, do a gap analysis with all the levels of service, and then deploy it around that," advises Sornberger.

## Next Steps

While there is work to be done, payers and providers should begin to explore the products and services that are available today that can improve efficiency, improve workflow and increase productivity. Here are several actions that both payers and providers can do to accelerate their movement to broader adoption of electronic transactions:

Payers	Providers
Invest in becoming CORE-certified and participate in rule development.	Become CORE-certified and/or require CORE-certification of your vendor systems.
Develop and pilot reimbursement programs that reward quality healthcare practice and results, including EDI.	Become a catalyst for administrative interoperability in your market by facilitating the adoption of CORE rules across stakeholders and measuring impact.
Encourage/require your business associates to become CORE-certified.	Include CORE certification in vendor system evaluations.
Ensure all future IT development is done according to industry standards.	Take advantage of intermediaries to reduce implementation burden and ensure workflow success transition.
Collaborate around multi payer functionality, understanding that providers want a single resource for interacting health plans.	Keep abreast of federal funding opportunities for health information technology. For example, the Office of the National Coordinator for Health Information Technology has been allocated \$2 billion for a variety of initiatives, including promoting interoperability and standards development. Details on how the funds will be dispersed will be released in May 2009
Support "next generation" products and services that will improve health payment quality and reduce cost, like e-prescribing, expansion of electronic health records, and electronic submission and payment tools.	Include process re-engineering for an electronic end-to-end eligibility, claims and process in EHR implementation strategies.
Educate employers about the actions being taken by payer organizations to reduce administrative costs and increase transparency.	Work with medical societies and specialty groups to advance national standardization goals.
Evaluate provider access to a health plan's administrative data to assure that all methods offer consistent, robust and standard information.	
Work with the appropriate standards development organizations to advance interoperability goals.	

Figure 6

# Conclusion

The healthcare industry is poised to dramatically improve efficiency and streamline administration processes through IT. It will take time, but we can move to an end-to-end cycle of electronic eligibility, claims adjudication and payment. Consumer-directed health plans will put increasing pressure on payers and providers to give patients the transparency and real-time transactions they will need to manage their care more easily and efficiently and ultimately become more empowered consumers of healthcare. Physicians and hospitals are finding themselves increasingly in the debt collection business as the ranks of the uninsured increase along with the current economic tide of layoffs and financial uncertainty.<sup>11</sup> Pressures to do more with less on both the payer and provider side have helped foster a collaborative spirit, and initiatives such as CORE and HIPAA 5010 provide a pragmatic approach to broader adoption. The federal government is increasing its financial support for health IT initiatives that could also spur growth. "The providers have been asking for help for some time," says CAQH's Thomashauer. "There is also a recognition by both payers and providers that, without collaboration, the industry isn't going to be able to adapt or adjust to the demands that will be placed on it over the next couple of years. Particularly now with the new administration, the pressure to work together on meaningful reform is much stronger."

## About the Center for Health Transformation

The Center for Health Transformation, founded and led by former Speaker Newt Gingrich, is a collaboration of leaders dedicated to the creation of a 21<sup>st</sup> Century Intelligent Health System that saves lives and saves money for all Americans. Members and organizations highlighted in this report include: Emdeon, Availity, GatewayEDI, WellPoint, Council for Affordable Quality Healthcare, America's Health Insurance Plans, and Cerner Corporation. For more information on The Center, please visit [www.healthtransformation.net](http://www.healthtransformation.net).

## About Emdeon

Special thanks goes to Emdeon for providing an educational grant in support of this paper. Emdeon is a leading provider of revenue and payment cycle solutions that connect payers, providers and patients to integrate and automate key business and administrative functions throughout the patient encounter. Through the use of Emdeon's comprehensive suite of products and services, its customers are able to improve efficiency, reduce costs, increase cash flow and more efficiently manage the complex revenue and payment cycle process. Emdeon makes this possible by connecting a network of 1,200 payers, 340,000 providers, 600 vendors and 150 million patients. To find out more about their services, their commitment to improving healthcare and how you can do more with Emdeon, visit [www.emdeon.com](http://www.emdeon.com).

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<sup>11</sup> "Hospital Bad Debt Is On the Rise", <http://www.debtcollectionsteps.com/hospital-bad-debt.html>, accessed January 30, 2009.

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