FIFTH THIRD BANK

Preventive Treatment for the Provider's Back-office

A Closer Look at Administrative Simplification and the Key Strategies Healthcare Providers Can Take to Prepare

By some estimates, nearly a third of every dollar spent on healthcare in the U.S. is consumed by administrative expenses.

There has been a lot of information published on the impact of the sweeping healthcare industry reforms passed under the Patient Protection and Affordable Care Act of 2010 (PPACA or commonly referred to as "Healthcare Reform"). Much of this research has focused on the impact of coverage expansion, reimbursement rate changes, and more macro impacts on healthcare providers. However, there are also significant pending changes still being designed as PPACA is implemented that will require providers to radically alter the way they handle basic administrative processes with an eye towards achieving the legislation's goal of reducing administrative costs in the nation's healthcare system. By some estimates, nearly a third of every dollar spent on healthcare in the U.S. is consumed by administrative expenses[1]. One of the primary goals of reform is to reduce these spiraling costs.

Pending Administrative Simplification rules will target inefficiencies around the medical claim payments process, which has been identified as a potential source for significant cost savings.

[1] "Preparing for Healthcare Reform & Administrative Simplification: Key Strategies for Providers" prepared by Fifth Third Bank and the Boundary Information Group, November, 2010.

Today's healthcare payment cycle is ten times less efficient[2], and decidedly more complex than payment processes found in virtually any other industry. The claims process is both costly and prone to error with a sizeable number of claims requiring re-submission by healthcare providers seeking payment. The problem is compounded by the fact that payments and related remittance data are predominantly paper-based or require other manual manipulation to properly post and account for insurer and government claim payments. According to a 2010 U.S. Healthcare Efficiency Advisory Council report, 90 percent[3] of all payments are made by check. Add to this the fact that payments and remittance data often travel different paths, arriving at different times, and the challenges posed by these inefficient processes becomes abundantly clear.

The combination of Administrative Simplification mandates, industry efforts, and advances in technology solutions are ushering in new opportunities to transition from paper to electronic processes—delivering critical savings for the healthcare industry and facilitating compliance to coming mandates. A UnitedHealth Center for Health Reform and Modernization report, published in July 2009, concluded that there are approximately $161 billion in savings opportunities possible over the next 10 years through full adoption of integrated electronic payments and remittance advices[4].

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INFORMATION, EDUCATION, AND CONVERSATION

The intent of this article is to provide current information on this evolving topic and to encourage a dialogue around Administrative Simplification, helping providers gain a more thorough understanding of the potential implications of new rules on their business operations. This discussion is intended to afford providers valuable insights into how they can prepare to take advantage of increased interoperability, real-time access to health plan information, and other performance criteria in order to operate more efficiently and be more productive in their revenue cycle management.

While the industry as a whole faces considerable challenges, the potential to achieve enormous improvements in efficiency lies ahead for providers. Realizing such efficiency will require close analysis, difficult decisions, technology investments, process changes, and the genuine commitment of and cooperation amongst all participants across the industry. It will also require an open dialogue and true leadership in order to cultivate efficient solutions that deliver tangible benefits to all industry stakeholders.

To promote learning and dialogue, we will examine:

- **The Road Ahead: What Providers Need to Know—** What are the critical reform requirements of Administrative Simplification that providers need to understand?
- **Key Strategies: What Providers Should be Addressing Today—** With compliance deadlines looming, what are the steps providers need to be engaged in immediately in terms of preparation, capital investments and implementation?
- **Preparing to Meet Mandates: Where to go for Help?—** What resources exist and where can providers go to find help in planning for, preparing and executing needed systems to support compliance?

[2] ibid

[3] U.S. Healthcare Efficiency Advisory Council, National Report on Healthcare Efficiency, 2010

[4] UnitedHealth Center for Health Reform and Modernization; Working Paper 2—Healthcare Cost Containment—How Technology Can Cut Red Tape and Simplify Healthcare Administration, July 2009

THE ROAD AHEAD: WHAT PROVIDERS NEED TO KNOW

The recently passed PPACA expands upon previous efforts to foster Administrative Simplification, with the goal of reducing the clerical burden on patients, providers and insurers. PPACA builds upon the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which began to focus on the administrative waste in the U.S. healthcare system. To help tackle this problem, HIPAA introduced initial data standards and practices designed to begin creating processing efficiencies in the healthcare claim payment cycle.

In 2009, the American Recovery and Reinvestment Act (ARRA) became law, and included the Health Information Technology for Economic and Clinical Health Act (HITECH Act). This legislation advanced the HIPAA standards even further, mandating the adoption of updated versions of the initial HIPAA standards (v5010 and ICD-10), and adding government incentives for industry adoption of Electronic Health Record (EHR) capabilities to improve overall efficiency and process accuracy.

PPACA sets forth a process for the development and adoption of what will become the operating rules for the industry's next stage in adopting the electronic exchange of information. In July 2010, the National Committee on Vital Health Statistics (NCVHS) held public hearings as the first step in the development of the new Administrative Simplification rules and regulations. A final rule, based on report recommendations, will likely be published by Health Human Services (HHS) in time to meet the July 1, 2011 adoption date specified in the legislation. The next area of focus for NCVHS has just begun with initial hearings held on December 3, 2010, with the goal of tackling operating rules for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) transactions.

> As PPACA rules are finalized, providers and health plans will face critical implementation and compliance deadlines.

The following chart lists the pertinent dates when Eligibility, Claims Status, EFT, ERA, Health Plan Identifier, Health Claims and Attachments and ICD-9 to ICD-10 Crosswalk rules are expected to be adopted and when providers and health plans must be in compliance:

Operating Rule	Adoption Date	Effective Date
Eligibility (270/271)	July 1, 2011	January 1, 2013
Claims Status (276)	July 1, 2011	January 1, 2013
EFT	July 1, 2012	January 1, 2014*
Payment and Remittance Advice (835)	July 1, 2012	January 1, 2014*
Health Plan Identifier	July 1, 2012	January 1, 2014
Health Claims and Attachments	January 1, 2014	January 1, 2016**
ICD-9 to ICD-10 Crosswalk (Section 10109)	No date specified	No date specified***

Notes:
* Health plan certification of compliance required by Dec. 31, 2013
** Health plan certification of compliance required by Dec. 31, 2015
*** Review Process by Jan. 1, 2011 and ICD-10 Required by Oct. 1, 2013

As PPACA rules are finalized, providers and health plans will face critical implementation and compliance deadlines. ***Some of the requirements will include:***

Eligibility— Operating rules will require health plans to achieve real-time eligibility transactions, a high level of available access 24/7/365, and a data rich response containing remaining deductible, specific benefits, and detailed information. Providers will be able to rely on a consistent process for registration/pre-registration, admitting/check-in, and discharge/billing that is expected to achieve lower bad debt, increased patient collections at the time of service, and lower total costs of collection. For health plans, studies indicate significant cost savings will be achieved through reduced provider and beneficiary phone calls to health plan call centers, as well as fewer rejected claims.

Claims Status— The rules will be designed to support electronic claims status inquiries and responses to provide faster follow-ups, offering more accurate and efficient processing and payment of claims. By empowering providers with tools to manage the process of tracking and resolving claim problems that are not adjudicated in a timely manner by health plans, there will be less staff time spent on phone calls and Web site tracking.

EFT and ERA Payments— This important phase is expected to mandate messaging standards and allow for improved ability to automate the reconciliation of the electronic payment with the remittance advice. Providers, insurers and the financial industry will be compelled to coordinate efforts removing paper from the system, and identifying and implementing interoperable end-to-end electronic processing capabilities that ensure privacy while improving efficiency. It is expected that providers will be able to achieve significant benefits through automatic posting of payments to patient accounting and practice management systems, with significant savings in manpower and the reduction of errors that require resolution.

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Health Plan Identifier— Impending rules will most likely consider both machine readable and non-machine readable health plan identification cards, as well as the amount of information that will be associated with identifiers.

Health Claims and Attachments— Rules for securely moving information electronically between providers and health plans will establish standards for the attachment of data in an EHR to create more efficient exchange of clinical information.

ICD-9 to ICD-10 Crosswalk— New rules pertaining to the crosswalk between ICD-9 and ICD-10 will have a widespread impact on how health plans and providers meet diagnosis coding system transition requirements. We must maintain focus on a much needed standard reference crosswalk from ICD-9 to ICD-10 in order to help create consistency among different users.

KEY STRATEGIES: WHAT PROVIDERS SHOULD BE ADDRESSING TODAY

As the specific rules associated with reform, and the new policies around Administrative Simplification emerge over the coming months and years, providers will be faced with the challenge of making necessary back-office process and system changes to meet aggressive regulatory deadlines. Once finalized, key operating rules for EFT and ERA will begin in July 2012 and become effective by January 1, 2014. While those deadlines may seem to be far off, the system and technology investments required to deal with and integrate payment and remittance transactions, necessitates immediate action. Failure to prepare and comply with these mandates could result in costly penalties being assessed, while also impeding critical opportunities to improve efficiency and lower administrative costs.

> Providers who embrace new models that provide better, more efficient service and easier access to information, will gain a competitive edge. Taking a leadership role will ensure future success.

As providers consider systems upgrades, and/or evaluate patient accounting or practice management systems in preparation for compliance with EHR mandates, they should take a careful and strategic approach to their back-office technology investments. By incorporating electronic capabilities into operational models, providers will not only reap significant efficiency benefits, but can also take advantage of current government incentives for new systems that meet "meaningful use" guidelines.

Sitting on the sidelines or taking a "wait and see" approach in this time of change is an ill-advised strategy. Providers need to be actively engaged in preparing for impending changes. Now is the time providers should begin examining their organization to determine what specifically will be required to meet compliance deadlines. Such an examination should include evaluating current technologies, staff deployments and operating practices.

Moving forward, providers should consider the following five strategic recommendations, in order to better prepare themselves for the impacts of reform:

1. **Lead your peer group—** As with all transformational changes, the most savvy industry leaders will be rewarded amongst their peers with a distinct competitive advantage. Beyond simply staying in compliance and avoiding penalties, industry leaders will be in a better position to compete and grow their business. As the healthcare industry moves toward a price transparent model, providers who embrace new models that provide better, more efficient service and easier access to information, will gain a competitive edge. It is important that providers not let the enormity of the changes stop them from moving forward. Taking a leadership role will ensure future success.

2. **Focus on core business competencies—** Providers should evaluate the strengths and weaknesses of their organization in order to determine the future direction of their business. Providers should implement strategies that accentuate their core competencies and seek help in areas that are lacking. For example, a provider might determine their greatest weakness is in their back-office systems and infrastructure, leading to consideration of combining their practice within a hospital or larger physician group which is more competent in this area. Or, perhaps it makes the most sense to consider outsourcing those operations to improve efficiency. Conversely, a provider who has developed a strong proficiency in back-office processes might consider acquiring competitors to further leverage those strengths.

3. **Consolidate back-office systems—** Wherever possible, providers should look to consolidate their back-office systems in order to eliminate redundancies, including the potential integration of smaller subordinate business units onto a single technology platform for improved efficiency.

4. **Free up capital—** As the many changes mandated by reform come into force, it is important for providers to begin freeing up capital – both working and human – to be prepared to meet varying demands. Providers will need the right human resources to ensure strategic business goals can be met. From a working capital perspective, providers will want to be in a position to invest in strategic business decisions, both operational as well as technical. To ensure that working capital is available, providers may need to consider improvements to their revenue cycle management procedures.

5. **Ensure all future needs are factored into strategic investment decisions—** It is important to keep an eye toward future needs when evaluating strategic investments. Considerations should include EHR, healthcare coding (ICD-10), claims processing, patient billing, point of service and downstream payment management, and remittance posting. As providers migrate to newer, more electronically enabled systems, it is important to be sure they are capable of adapting to electronic transactions in the future.

Through strategic conversation with a banking partner, providers can examine ways to streamline processes by deploying new tools, electronifying existing functions and outsourcing others where appropriate.

PREPARING TO MEET MANDATES: WHERE TO GO FOR HELP?

Preparing to meet the healthcare reform mandates presents a considerable challenge for most providers. Making the right choices is critical, which is why providers should work closely with trusted business advisors and partners to gain a broader perspective on the coming changes and efficiency opportunities. In talking to technology vendors, industry associations, and banking partners, providers can gain valuable insights into the best path for bringing their business systems into compliance.

Preparation begins with dialogue. Some banks are uniquely qualified to help providers plan for and implement needed systems to support compliance and drive efficiency. Through strategic conversation with a banking partner, providers can examine ways to streamline processes by deploying new tools, electronifying existing functions and outsourcing others where appropriate. Because many of the underlying healthcare transactions are financial transactions at their core, banks already have a deep understanding of how best to process them. Revenue cycle management tools and cash optimization support are expertise that banks can bring to the provider who is looking to begin the process of preparing to meet Administrative Simplification rules.

Fifth Third offers a team of treasury management professionals experienced in supporting healthcare providers with tools and solutions that meet their unique needs. The bank has demonstrated its commitment to the healthcare industry by investing significant resources into the development of solutions that remain ahead of changing market needs, allowing clients to remain competitive and lead their peer groups.

The unprecedented nature of the changes that are occurring, and the reality that many of the specifics of the reform mandates have yet to be decided, makes it all the more critical that providers begin planning today with an eye toward the future.

THE IMPORTANCE OF TAKING A LONG-TERM PERSPECTIVE TO CHANGE

It would be difficult to overstate the importance for providers to begin addressing the requirements of PPACA compliance sooner rather than later. Organizations risk falling into the trap of short-sightedness if they fail to address these challenges head on, committing instead to minimal compliance with Federal regulations. The downside to this incremental approach is that it can result in short-term responses to complex, strategically important processes. In the final analysis, this can result in an exponentially greater time and resource commitment, which is why it is important to look at technology upgrades, process and system decisions with a three- to seven-year time frame in mind. The unprecedented nature of the changes that are occurring, and the reality that many of the specifics of the reform mandates have yet to be decided, makes it all the more critical that providers begin planning today with an eye toward the future.

Fifth Third Bank invites providers to start a dialogue with its healthcare experts to begin moving forward in meeting reform mandates and taking advantage of the efficiencies made possible through the latest industry tools.

For a more in-depth analysis of healthcare reform and its implications for providers, please read the industry white paper, "Preparing for Healthcare Reform & Administrative Simplification: Key Strategies for Providers" prepared by Stuart Hanson, Vice President, Healthcare Solutions, Fifth Third Bank and Steven S. Lazarus, PhD, CPEHR, CPHIE, CPHIT, FHIMSS, President, Boundary Information Group.

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