Real-time adjudication: an innovative, point-of-care model to reduce healthcare administrative and medical costs while improving beneficiary outcomes

Provided by Conexia Inc

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Section 1: Company information

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Company background:

Conexia assists healthcare payers in transforming the delivery of healthcare services by implementing an innovative model for payer-provider communication, which includes real time authorization and processing of medical transactions. Conexia's clients include workers' compensation, private health and government health payers. Founded in Argentina in 1996, Conexia now has offices in the United States and multiple Latin American countries. Conexia's solutions currently serve over 20 million beneficiaries and process over 2 million healthcare transactions per month.

Section 2: Conexia perspective on challenges with current healthcare administration models

Pharmacy versus doctor visit

Medical consumers in the US experience two very different models when they visit a pharmacy versus a doctor's office or other provider facility. The key differences between those two experiences are contrasted below:

Pharmacy	Doctor visit
▪ Provide patient information one time per network (i.e., CVS, Walgreens, etc)	▪ Patient must fill out paperwork for every provider office, even those within the same network
▪ Any network pharmacy can see data on patient's medications	▪ Providers must manually request patient records, delaying care ▪ Patient must sometimes obtain copies themselves to facilitate information sharing
▪ Pharmacy technician can instantly tell patient if Rx is covered by plan or if a change is required (e.g., generic)	▪ Patient must either wait for pre-authorization (sometimes days or weeks) or receive care without certainty of coverage
▪ Patient makes payment in full before leaving pharmacy; transaction complete at time of service	▪ Patient receives bill in mail after services rendered, sometimes weeks or months later ▪ Patient experiences stress and anxiety in the interim

The disadvantages of a "claims" model for healthcare administration

What distinguishes pharmacy transactions is that participants are electronically connected, all data is accessible via one central database, information is shared in real time, and rules-based decision-making is automated.

Unlike pharmacy, in other healthcare settings the communication between stakeholders (patients, providers, insurers, governments, etc) and exchange of information is largely manual, disconnected and uncoordinated. Communication largely takes place after services have already been rendered. This has two significant implications. First, because administrative processes take place after services have been rendered, management of those processes and reconciliation of transactions becomes labor intensive, time-consuming and expensive. Second, because payers are largely reviewing medical transactions after they have already

been completed (traditional utilization review), they are in a poor position to impact the actual care of the patient, promote adherence to evidence-based medicine practices, and effectively control medical spending. Rather, payers and providers enter into a contentious situation of debating the payment of care that has already been rendered, with providers fighting hard to receive payment of some sort (even if the original claim was rejected) for work that has already been performed.

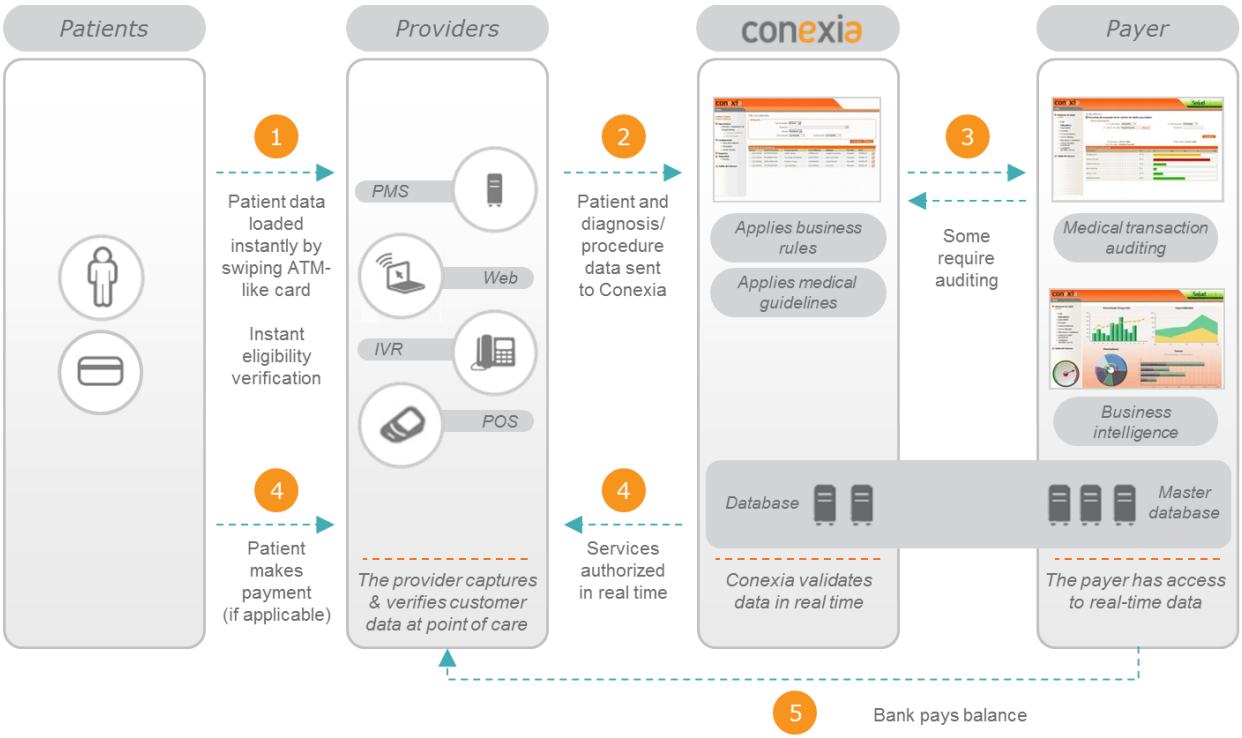
This foregoing description is the medical "claims" process, which our experience suggests is an inefficient way to manage a healthcare system. The net result of the claims model is high administrative costs and poorly controlled medical costs.

Section 3: Description of proposed model

On its face, Conexia's proposed model is quite simple: connect stakeholders electronically to allow real-time communication and decision-making.

As illustrated by the chart on the left below, streams of communication are constantly happening between the various stakeholders involved in the care of the patient, although these data streams are disconnected, delayed and manual. The figure on the right illustrates Conexia's approach: an online portal that connects each of the stakeholders. Information can then be shared in real time, payer-provider decisions can be made at the point of care, and all relevant stakeholders have access to the same real-time information on the care of the patient.

The following chart provides a visual representation of how this real-time, point-of-care model works:



1. The patient visits the provider facility and presents her beneficiary card, which has a magnetic stripe, much like a credit card. The patient swipes this card at reception and two things instantly happen. First, because the payer and provider are electronically connected, eligibility is instantly confirmed. Second, the provider is granted instant access to the patient's record, which includes such information as demographic data, diagnosed risk factors (diabetes, heart disease, allergies, etc.), current medications, and results from recent tests or scans.

   In its simplest form, the provider accesses the portal via a secure web page. In other words, as long as the provider has web access, all they need is a valid log-in. This lowers the barrier that many providers face in adopting health information technology. Integration with practice management systems and EHRs is also possible. POS and IVR options are available for providers who lack internet access.

2. While the patient is in the provider office (i.e., at the point of care), the provider enters a code for diagnosis and procedure. All other information that is commonly found on a pre-authorization or claim form has already been captured in the central database. The medical treatment request is instantly processed via the interface, which uses custom-designed business rules to adjudicate the transaction based on evidence-based medical guidelines and other relevant factors (such as past patient utilization). This permits payers to positively impact the care of the patient (as well as cost) by promoting adherence to medical standards.

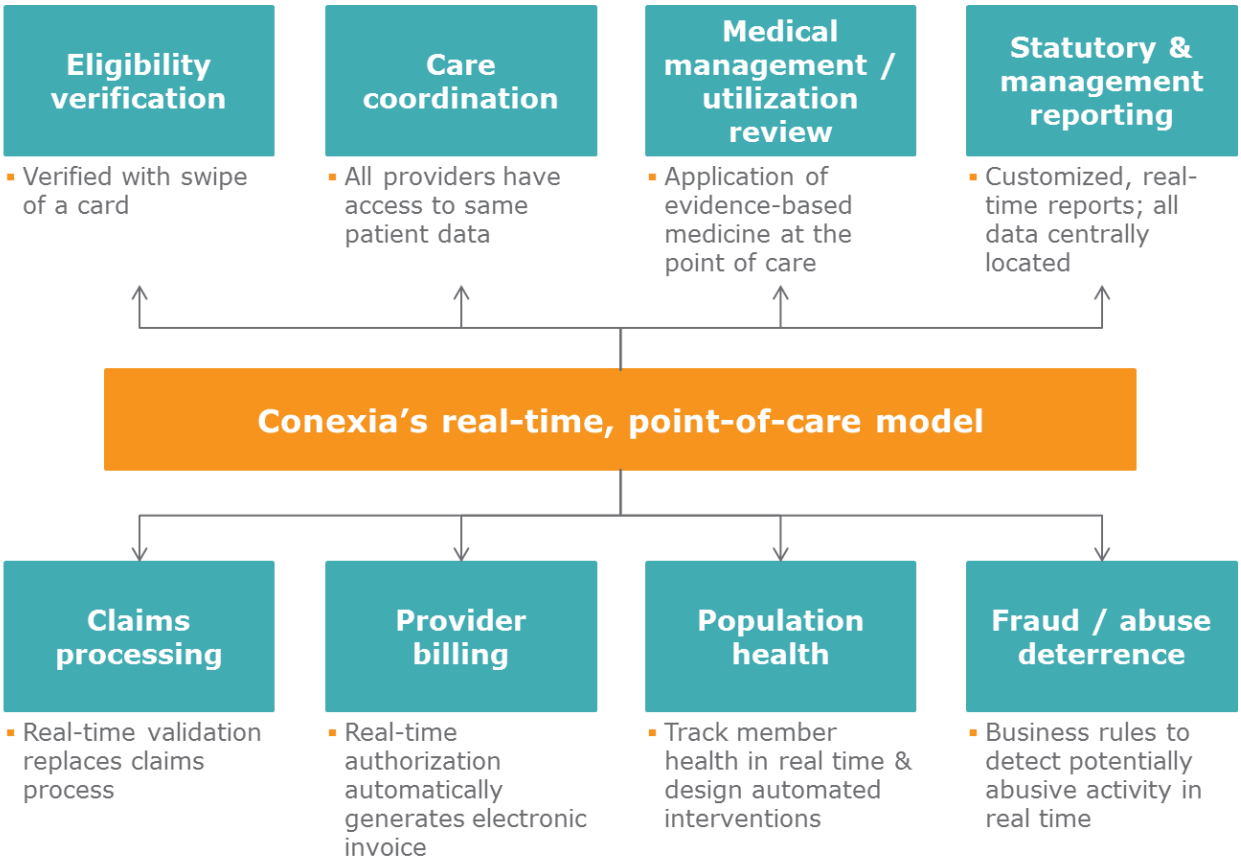
3. In our experience, 85-90 percent of medical transactions can be adjudicated in real time using business rules. Transactions that are unusual, outside of medical guidelines, very costly, or suspicious in nature are routed to auditors at the payer (or a designated vendor) for immediate review. Auditors are notified of the transaction in real time and have instant access to complete case information for the patient. Once the auditor has made a determination, the provider is instantly notified of the action.

4. Because medical services are authorized in real time (or near real time in the case of a medical audit), providers are given certainty of payment at the time of service. Because fee schedules are automatically applied as part of this transaction, providers also know what their payment will be for the service. Additionally, patients can be made aware of their financial responsibility, where applicable, at or before the time of service.

5. Because the medical transaction has been fully adjudicated, there is no "claim" for the provider to submit. Instead, the system automatically generates an electronic invoice for payment by the payer. Most of the activities that take place during the traditional billing process (fee schedule application, utilization review, coding validation, reconciliation with pre-authorization) have already been completed. Payment of invoices becomes prompt and simple.

Section 4: Benefits of proposed model

A summary of the proposed model's impact on eight common healthcare administrative activities is summarized in the figure below:



Eligibility verification

Each time the patient presents his or her beneficiary card and it is swiped by the provider, eligibility is instantly confirmed via the portal. The same function can be accomplished by keying the beneficiary's SSN or other ID into the portal interface.

Care coordination

Because information on diagnoses and treatments is exchanged in real time, all authorized providers have access to the same patient information. If a patient visits Doctor A on Monday and Doctor B on Wednesday, Doctor B can see new diagnoses, treatments or medications provided by Doctor A. Likewise, case managers at the payer have current information on patient health.

Medical management / utilization review

Disparity in treatment patterns and adherence to evidence-based medical standards is a well-documented phenomenon in our current system. Adjudicating medical transactions in real time and at the point of care enables the payer to play a meaningful role in promoting adherence to standards, which results in better care and lower medical spending.

Statutory and management reporting

Because patient data is stored in a central database and new medical information is available in real time, reporting and monitoring becomes much simpler than in our current model of disconnected, disparate, and time-lagged data. Payers, governments and other entities can easily monitor utilization patterns, diagnosis trends, and other relevant information.

Claims processing

Real-time validation of medical transactions replaces the claims model. Patients and providers are given financial certainty at the point of care and invoicing becomes a simple, largely automated task.

Provider billing

The same transaction that provided the provider with real time authorization of the medical service automatically generates an electronic invoice. Once the service is complete, the provider simply submits the invoice via the portal. Most of the activities that are currently part of the provider billing process (fee schedule application, utilization review, coding validation, reconciliation with pre-authorization) have already been completed.

Population health

Because current patient health information is available in real time, payers can design automated interventions to track health and flag the need for case management interventions. This becomes particularly relevant in ensuring that preventative services are being delivered in a timely fashion and tracking adherence to therapy for patients with chronic conditions. See Section 5 for more information on the population health benefits of the proposed model.

Fraud / abuse deterrence

Similar to how credit card companies track card usage patterns in real time and automatically flag suspicious behavior for immediate intervention, the proposed model enables payers and governments to immediately flag potentially fraudulent or abusive activity by providers or patients. Real-time monitoring and automated interventions are more effective and less expensive than "pay and chase" approaches prevalent today.

Section 5: Population health advantages of proposed model

The US healthcare system has long wrestled with how to effectively monitor population health. We release evidence-based standards of care regarding preventive treatments and chronic condition management, but consistent application of those standards proves challenging.

Conexia's experience suggests that the "claims" model, which perpetuates a disconnected, disparate and time-lagged approach to care, is itself a challenge to successful population health management. When the model is changed and information on patient care is available in real time, stakeholders are able to design automated and coordinated monitoring and interventions. A few examples are noted below.

Preventive care

Medical evidence tells us that men should receive a colon cancer screening at age 50, age 30 if there's a family history of colon cancer. When these guidelines are adhered to, lives can be saved and medical costs can be significantly diminished by discovering and removing potentially cancerous polyps early. Yet we still continue to miss opportunities for such preventive care.

A business rule can be designed to automatically flag patients for preventive services. If a 50-year-old man visits his doctor for a flu shot (or any other reason), an automated prompt can appear at the time the patient swipes his beneficiary card, suggesting that the provider have a conversation with the patient regarding a colon screening. Similar interventions can be designed for mammography and other preventive health screenings.

Chronic conditions

Patients with chronic conditions are the most expensive to care for, particularly when they fail to adhere to treatment. For instance, blood pressure medication for a hypertension patient is effective at controlling the condition and relatively inexpensive compared to the cost of hospitalization, stroke, etc that may occur if the condition is not well maintained.

With real-time data flows, payers can automatically track maintenance medication refills and physician follow-up appointments. If the patient fails to fill a medication as scheduled or doesn't visit her physician with the regularity expected, an automated flag can be sent to either the payer or the treating physician for follow up. Likewise, automated text messages or emails can be sent to the patient on a regular basis requesting blood pressure measurements, allowing the payer and provider to track control of the condition outside of scheduled doctor appointments.

Section 6: Compliance with HIPAA and ICD-10 requirements

HIPAA

The proposed model can be implemented consistent with the requirements of HIPAA and other state-specific privacy and security laws. All data is stored, transmitted and otherwise protected in accordance with statutory requirements.

As the most stringent of the privacy and security laws under which Conexia operates, it is Conexia's policy to be HIPAA compliant across the entire company's operations[1].

ICD-10

Part of the challenging in moving the US from ICD-9 to ICD-10 is our disconnected, time-lagged and disparate model for sharing health information. Even as providers move toward greater use of electronic systems, we continue to have silos of systems that must all communicate with each other and be individually updated in order to share health information.

The proposed model simplifies the task of moving from ICD-9 to ICD-10. Since each stakeholder is using the same database of information to track and report on the care of the patient, and information is shared among stakeholders via the same electronic system, updating the database to use ICD-10 terminology is a relatively simple task. The sole challenge is that of personnel training, not overcoming IT obstacles.

Conexia's international clients have been using ICD-10 terminology for a number of years and Conexia has already been intimately involved in a successful transition from ICD-9 to ICD-10.

[1] Except for obvious exceptions such as HIPAA mandates for certain code sets. CPT codes, for instance, are particular to the US and other countries use different code sets to describe medical treatments.

Section 7: Compatibility of proposed model with other innovation models

It's important to distinguish between an experimental concept and a proven model. In a continuing effort to meaningfully control costs while improving outcomes and population health, state governments, payers and providers are experimenting with a number of different concepts. In most cases, we have yet to move from a concept to a proven model.

The advantage of Conexia's proposed model is that it has been proven through 17 years of implementation experience. Our model is used in other multi-payer environments with the same dynamics and challenges as those faced by payers in the US. We know it works and we know how to implement it effectively.

That said, our proposed model is not mutually exclusive with respect to other models being tested today, such as ACOs, bundled payments, capitation, etc. In fact, our experience suggests that the proposed model can be complimentary to many of these other initiatives and enhance their effectiveness in transforming the delivery of health care.