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CAN HEALTHCARE AFFORD AUTOMATION?

Maintaining Legacy Auto-Adjudication Systems is Counter-Productive

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INTRODUCTION

Constantly maintaining and upgrading legacy automated claims processing applications is proving to be prohibitively expensive.

Conventional wisdom says that automating key business processes is a sure way to enhance operational efficiencies and drive cost savings. However, as the Affordable Care Act (ACA) continues to transform the healthcare market, constantly maintaining and upgrading legacy automated claims processing applications is proving to be prohibitively expensive.

In response, healthcare payers are reconsidering their IT and business process strategy and, specifically, are rethinking their commitment to maintaining high levels of automation and heavily engineered custom applications. What's emerging as a more viable alternative is a claims processing model characterized by lower levels of automation and application customization, combined with process optimization and increased levels of investment in personnel and training. Many are finding that this approach can be more productive, cost-efficient and flexible.

This ISG white paper examines some of the issues related to claims processing operations in the context of healthcare reform, and outlines several strategies payers are adopting to address this rapidly changing environment.

CHANGING MANDATES

The ACA is driving a fundamental transformation of healthcare operations by mandating significant changes in standards, requirements and regulations regarding how **information is captured, coded, stored and shared**. As a result, the healthcare sector faces unprecedented pressure to build agile systems that can adapt and respond to this highly dynamic environment. Many payers, meanwhile, are finding that established approaches to information management are ill-equipped to address these new challenges.

Over the past decade, payers have poured significant resources into developing myriad applications that automate the reviewing and processing of claims for reimbursement of healthcare costs – in some cases achieving auto-adjudication rates approaching 90 percent. In the process, however, payers have often deferred the task of modernizing the underlying platforms, and simply updated and integrated existing application versions to adjust to slight changes in regulatory standards and reporting requirements. While this approach sacrificed agility and flexibility in favor of automation, it proved to be workable in the relatively static healthcare environment that preceded the ACA.

Today, however, auto-adjudication applications require constant upgrades to respond to rapidly changing regulations and standards. In this environment, payers that continue to pursue a strategy of updating existing versions of "spaghetti-coded" legacy systems – while delaying modernization and rationalization – are painting themselves into a corner. Put simply, they're spending more and more, and piling layer upon layer of additional complexity onto systems that are already highly customized.

In this context, commitment to maintaining high levels of automation can become counter-productive and result in high costs and inflexible systems, making it more difficult to meet mandate deadlines.

The challenges posed by the ACA are causing payers to reconsider their basic operational strategy.

THE SOLUTION

The challenges posed by the ACA are causing payers to reconsider their basic operational strategy. Traditionally, payers have taken a narrow, tower-specific view that considers IT, business processes and regulatory requirements as separate categories. As such, efficiency metrics encouraged prioritizing automation and reducing personnel costs.

Today, this philosophy is giving way to a broader perspective of the operational ecosystem as a whole. Rather than focusing on the cost of IT or the cost of staffing, the total cost of claims processing is the new priority. This total cost model includes investment in base core administration systems, ongoing maintenance and project development, as well as the costs of compliance and the impact of responding to changing regulations. Specifically, the costs of complicating factors like reduced agility and retrofitting are being included in total cost calculations.

By taking this big-picture view, payers are recognizing that maintaining and updating legacy applications and committing to a high level of automation can be prohibitively expense, so much so that the additional expenses of the systems far exceeds the savings achieved through reduced FTE requirements. Instead, payers are finding that decreasing automation and increasing investment in personnel can in many cases produce a more cost-efficient outcome.

This emerging strategy is characterized by these key elements:

Optimize claims review processes:

Kicking the can down the road is no longer an option.

As a result of multiple mergers, acquisitions and organizational consolidations over the years, most health insurers today maintain multiple processes to review and close a claim for reimbursement. While managing this unwieldy combination of multiple processes has long been recognized as a thorny problem, the imperative to address it has been lacking until now – and now it has arrived with a vengeance, in the form of fundamental and rapid changes in regulatory and reporting requirements. Put differently, kicking the can down the road is no longer an option. The foundation of any operational strategy today must include a focus on rationalizing and standardizing claims processing guidelines.

Clearly define compliance ownership roles and responsibilities between the payer organization and third-party providers:

We're seeing payers increasingly shift compliance burden to their providers. While providers will continue to assume overall accountability for compliance, the responsibility for making changes to systems to ensure compliance is currently a gray area, and therefore represents a significant potential risk.

Reduce customization of the claims processing environment:

Rather than over-committing to customizing technology and making automation an end goal, payers should focus on the total cost of processing a claim. Instead of aiming to achieve 90 percent auto-adjudication rates (and ignoring the cost of frequent upgrades and maintenance), a smarter approach is to take a larger view of the cost of claims services. Such an approach is characterized by out-of-the-box programs and limited customization and auto-adjudication rates of 60 percent to 70 percent. While requiring an increased investment in personnel, this strategy involves less customization and complexity, and reduces disruption when modernizing and replacing legacy systems. The result: Lower total cost, coupled with significantly enhanced levels of flexibility and agility.

Optimize investment in additional people through a combination of international and domestic delivery teams:

An effective labor distribution model can enhance the productivity of personnel involved in claims review. International resources can be used to leverage labor arbitrage for rules-based tasks and functions. Domestic resources, meanwhile, can support more complex claims types requiring discretionary actions or knowledge-based claims processing.

HEALTHCARE REFORM AS JOB ENGINE?

As healthcare payers reassess their claims processing strategies, many are scaling back their commitment to high levels of automation. This by definition requires an increased investment in personnel resources.

For several reasons, onshore "rural sourcing" models – either through a third party provider or captive operation – can be ideally suited to meet this surging demand for people resources. For one thing, state and local governments are offering significant tax cuts and other incentives for companies to establish operations in economically distressed rural areas. The scope and scale needed for healthcare claims processing centers are an ideal fit for such a model.

In addition, certain functions involved in healthcare claims processing require discretionary and knowledge-based activities, such as, for example, locating overpayments in a specialty pharmaceutical claim. Such functions require more oversight than is typically feasible in an offshore environment. Moreover, Third Party Administrator accreditation status is mandated for discretionary roles. As a result, offshoring such responsibilities is typically not viable either from a managerial or a regulatory standpoint. Domestically-based rural centers, on the other hand, could be well-positioned to accommodate these requirements.

This combination of these factors, together with the relatively low cost of labor in rural areas, makes domestic sourcing a viable and competitive alternative to offshoring or other sourcing models.

ISG sees a significant opportunity for healthcare payers to enhance operational efficiency.

ISG sees a significant opportunity for healthcare payers to enhance operational efficiency, for service providers to gain an important market niche, and for economically depressed rural areas to attract quality jobs. One key to success will be to provide sufficient managerial oversight; in many cases this will require a concerted commitment to relocate more senior personnel with leadership skills as well as contextual knowledge of the U.S. healthcare industry. While the rural sourcing model often excels at delivering talented labor resources, filling on-site management roles can be a challenge.

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