In Support of the Next Generation Health Plan

The Transformative Health Information Network

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• Why current clearinghouses can’t support tomorrow’s data
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Introduction

It is no secret that the U.S. health care system continues to be plagued by inefficiencies that add cost to an already overburdened system. In 2010, we spent $2.6 trillion on health care in this country, with projections to hit $4.6 trillion (approaching 20% of the GDP) by 2020. Annual increases in health care spending are expected to outpace the average growth in the overall economy over the next 10 years, and according to a survey by PwC’s Health Research Institute, 42% of US adults polled would rather have lower health care costs than see improvements in the economy. Given these statistics, it is no wonder why cost containment ranks among the highest priorities for many health care stakeholders. In fact, a 2011 study by the Managed Executive Group and consulting firm HTMS, noted ‘bending the cost trend’ as one of the top three priorities for 2012 as reported by health plan respondents.

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The underpinning of our delivery system is an equally inefficient payment and transaction system. While other industries such as retail, financial services, and logistics have deployed information technology to dramatically improve operations, reduce manual intervention and the attendant human errors, health care continues to wade through its slow migration from paper to electronic transactions and payments. The primary culprits include a lack of comprehensive transaction and information sharing standards between health plans and physicians (creating silos of information), and a fee for service system that rewards volume over quality. Health plans responding to a 2011 HealthLeaders Media survey cited overutilization of health care services as the top driver of health care costs overall. And the silos resulting from interoperability issues are said to fuel an estimated $700 billion in waste and unnecessary care.

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How to contain costs while juggling the demands imposed by multiple factors affecting our businesses is the challenge. Government mandates like the Patient Protection and Affordable Care Act (PPACA) and the migration to HIPAA version 5010 can hinder efforts to remove cost in the near term. Addressing these mandates demands precious resources, leaving many organizations with fewer hours, dollars and human capital focused on their core businesses and related initiatives to drive efficiencies in daily operations. The upcoming conversion to ICD-10; PPACA requirements regarding medical loss ratios (MLR); premium pressures; and state health insurance exchanges; compounded by the effects of provider-focused initiatives including the Health Information Technology for Economic and Clinical Health (HITECH) Act’s Meaningful Use program and planned reductions
in Medicare reimbursements, round out a host of others at the top of many lists.

**Health Plan Focus: Cut Costs and Control Premiums**

For health plans, “value will start with cutting administrative costs and keeping premiums down.” To do this, health plans are looking beyond current-day cost cutting measures to solutions that result in rapid and measurable returns on investment in their biggest areas of spend. Account and member administration activities make up one of the costliest areas for health plans, and include functions such as enrollment and billing, claims processing, and customer service. And while many health plans leverage solutions such as clearinghouses founded on electronic data interchange (EDI) technologies, they are not enough. Consider the fact that the industry continues to incur nearly $30 billion in waste each year due to manual transaction handling. Then consider the growing pressure to reduce premiums combined with MLR mandates, and it is clear that better ways to eliminate cost are vital.

Additionally, many health plans are making the move toward value-based payment structures, including accountable care organizations (ACOs) and patient-centered medical homes (PCHMs), as a means to reducing cost and improving quality. A recent study cited 47% of health plan respondents ‘were actively planning for ACO development’ and included new payment models as a top priority for 2012. As this shift gains momentum, the demand for the electronic exchange of ‘new’ information required for these payment models to operate efficiently and effectively intensifies. Likewise, the complex nature of this new information calls for more sophisticated solutions than traditional clearinghouse vendors can offer.

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The good news is the opportunity to meet these demands has never been better—as health care stakeholders align around improved care delivery and outcomes, technologies and services are coming together to meet the ‘new’ needs.

**Thriving in the ‘New Normal’**

What are the best ways to address these issues? Some exist, some are emerging, and each has its positives and negatives. The right answer necessitates a combination of solutions, and will depend largely on each health plan’s unique situation, capabilities, and goals.
Physician Self-Service

Over the years, many health plans have made the strategic decision to build and/or acquire tools, such as Web portals, to enable physician self-service with the goal of reducing manual interactions that offer low value to the physician and health plan. A 2011 survey by InformationWeek Analytics ranked ‘web-enable applications to provide doctors, other clinicians…with more self-service capabilities’ as a high priority for health plans.

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<th>Positives</th>
<th>Negatives</th>
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<td>• Offer connectivity to many physicians via a single link</td>
<td>• Require time and resources to manage multiple clearinghouse relationships</td>
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<td>• Support most HIPAA transactions and related mandates</td>
<td>• Are prone to change management challenges (ex. managing the conversion to HIPAA 5010 across multiple clearinghouses)</td>
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<td>• Integrate with physician practice management and EMR systems (critical for optimizing physician connectivity)</td>
<td>• Lack the ability to exchange information needed to manage value-based payment models</td>
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<td>• Reduce the need for health plans to invest in capabilities outside their core competence</td>
<td>• Do not support information exchange supporting care management programs</td>
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<td>• Proven to reduce provider calls, paper transactions, and manual claim adjudication, reducing costs</td>
<td>• Can suffer data quality issues, adversely affecting NCQA/HEDIS reporting</td>
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<td>• Inability to handle non-standard transactions necessary for certain health care interactions and self-service</td>
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Clearinghouses

To satisfy the need to automate administrative interactions with providers, most health plans maintain at least one clearinghouse relationship, though a large number work with multiple vendors. Clearinghouses have expertise in the electronic receipt and distribution of HIPAA transactions from providers to the health plans, making them a good solution for reducing the costs associated with paper claims processing, provider phone calls inquiring about the status of their claims, patient benefits, etc.

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Value-based Programs/Clinical Information Exchange

Value-based physician reimbursement continues to gain traction in the market, and many health plans have already introduced initiatives founded on these principles. 68% of health plans surveyed by HealthLeaders believe ACO-type programs will have a positive impact on their organizations over the next three years, and 85% cite paying physicians based on quality measures as ‘effective’ or ‘very effective’ in terms of improving quality of care.\textsuperscript{viii} Thus, the ability to exchange clinical information supporting the operations of these programs ‘is critical’ to success\textsuperscript{ix}.

**Positives**

- Reward quality care leading to better patient outcomes
- Promote highest and best service utilization
- Help reduce overutilization of ineffective services—removing cost from the system
- Support health plans goals to improve quality and reduce costs

**Negatives**

- Can be costly to administer
- Demand automation and standards not readily available in the market
  - Require manual information exchange with physicians (due to clearinghouse/vendor capability limitations)
  - Present connectivity challenges (physician, vendor, and health plan)

Integration and Connectivity

Health plans that successfully execute on the options noted above (maintaining effective clearinghouse relationships, promoting self-service tools, and automating quality-based payment programs) will be well on the path to thriving in the ‘new’ health care landscape. However, to truly be positioned for the next generation requires these components, plus a broad and deep level of connectivity to your current and emerging health information stakeholders. While functionality is important, it drives real value and savings only when it reaches the right participants through integration and connectivity.

**Positives**

- Optimizes physician adoption and utilization by integrating with their primary systems and workflow
- Enhances scale and reach of automated solutions, further reducing costs
- Offers easier and faster deployment of new information exchange solutions
- Promotes physician satisfaction

**Negatives**

- Demands capabilities not widely available (i.e. ability to exchange information for quality programs)
- May necessitate new relationships (as few existing vendors offer deep and broad enough capabilities alone to satisfy changing health plan needs)
Availity: A Transformative Health Information Network

Whether a health plan needs to boost the benefits of their transaction processing, leverage a fully outsourced ‘gateway’ service designed to increase physician self-service dramatically, or automate operational components of its quality programs, Availity can help. We also understand the capabilities we enable for you are only as good as our ability to deliver them to the organizations you need to reach, so we have spent the last decade building one of the most expansive real-time networks in the nation.

Behind our capabilities and network connectivity is a deep understanding of health plan challenges and an appreciation that these challenges can vary greatly from...
plan to plan. We offer a portfolio of solutions aimed at solving key problems, no matter where your organization is on the path to becoming a next generation health plan.

**Our combination of capabilities and network connectivity helps:**
- Reduce unnecessary calls to your call center
- Improve provider utilization of online/self-service tools
- Drives scale and reach through physician system integration
- Decrease claim pends, rejections, and resubmissions due to errors
- Improve auto-adjudication rates
- Automate the exchange of non-standard information needed for quality programs (P4P, PCMH, ACO)
- Facilitate compliance with government mandates (HIPAA 5010, ICD-10)

**Our solution portfolio includes:**
- An EDI sourcing layer (for batch and real-time transactions)
- A multi-payer physician portal layer (facilitating consolidation and migration from single-payer solutions)
- An advanced transactional layer (offering value-added capabilities such as real-time claims adjudication/correction and member liability estimators)
- A quality program layer (enabling the exchange of information needed to support reporting needs for ACOs, PCMH and P4P)

Availity solutions are proven to save health plans time and money. In the aggregate, the Availity portfolio provides a comprehensive health information management framework to facilitate true administrative, financial and clinical interoperability. Our experts will work with you to identify the best suite of options to help accelerate execution of your business strategies, enabling you to achieve your goals faster.

With Availity solutions, your organization can do more with less, realize tangible savings, and move quickly to becoming a health plan for the next generation.

**Notes**

i National Health Expenditure Projections 2010-2020, Centers for Medicare and Medicaid
ii HealthLeaders Media Industry Survey 2011, Health Plan Leaders
iv PwC Health Research Institute, Top Health Industry Issues of 2012: Connecting in Uncertainty, November 2011
v American Academy of Actuaries, Critical Issues in Health Reform, Administrative Expenses, September 2009
vii Managed Care Executive Group and HTMS, Moving Forward with Reform: The Health Plan Pulse for 2012 and Beyond
viii HealthLeaders Media Industry Survey 2011, Health Plan Leaders
ix Managed Care Executive Group and HTMS, Moving Forward with Reform: The Health Plan Pulse for 2012 and Beyond
Availity and its subsidiary, RealMed, are national leaders in health information exchange that help the health care system run faster and better. We connect providers, plans and practice management systems with essential business and clinical information to streamline care delivery, drive productivity and lead to better patient experiences.

Availity optimizes information exchange among health care stakeholders through a single, secure network that supports both real-time and batch electronic data interchange via the Web and B2B integration. RealMed’s revenue cycle management solutions build on that value by bundling and automating functions that maximize operational results.