

Navigating Alternative Provider Reimbursement Models of the Future

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Executive Overview

Healthcare reform is here, and along with it comes an era of disruption caused by government and market forces. The Affordable Care Act (ACA) gives states flexibility in how they choose to implement its provisions. However they proceed, the reforms will impact three major aspects of our healthcare ecosystem:

- » Access to affordable and quality care
- » Changes to the healthcare delivery model
- » Financing arrangements to support new methods of access and delivery

States and payer/provider stakeholders are adopting new models for provider reimbursement. The initial reforms are shining a light on the inflexibility of legacy claims processing systems to respond to the requirements of reforms driven by both governments and the market changes that are required. They also highlight an important trend toward reimbursement methods that are driven by quality outcomes rather than fee-for-service or quantity of interactions with the healthcare system.

As the administration of healthcare reimbursement requests (claims) and contracts gets more complex—and the need to support periodic payments or alternative reimbursement models increases—payers are finding they need solutions for enterprise-wide control to ensure they make accurate payments to providers.

More than ever, healthcare organizations need a seamless flow of data across the entire value chain, from drug discovery and clinical development to academic medical centers, care providers and care management. When information remains locked in functional silos, we miss opportunities to improve patient outcomes.

As the industry moves to accountable care, the development of alternative provider reimbursement capabilities is an imperative for payers and providers alike. Payers must create a health IT platform that is flexible enough to accommodate rapidly increasing complexity in the system.

In this white paper, we look at the operational challenges posed by changes to provider reimbursement, how stakeholders are constructing compelling market offerings, and the new capabilities and systems that are required to support these changes. We share insight on the state of the industry today and the road ahead for the implementation and execution phases of healthcare reform.

Introduction: The First Steps of Healthcare Reform

Payers across the United States are making rapid changes to support the provisions of the ACA at the Federal and State levels. With more than 34 implementation timelines and reform milestones scheduled between 2013 and 2018, payment models across plans and within geographic medical markets will change on a nearly quarterly basis.

This is placing a premium on the ability of plans to develop and customize capabilities and scenarios to implement these changes from fee-for-service payment to incentive and risk-based payment models. The U.S. Supreme Court ruling in June 2012 addressed eligibility provisions of the ACA. Extensive regulations were finalized in November 2012, and more are coming; however, two other critical elements of healthcare reform must be worked out in order for payers to extend eligibility without incurring crushing healthcare costs:

- » Changes to the healthcare delivery model
- » Changes to healthcare financing arrangements

Provider reimbursement models have taken center stage, as payers grapple with the emergence of a heavy analytics load around episodes of care and within a bundled payment structure, as well as the complexities around driving outcomes in the Medicare segment. Combined with quality initiatives, the emphasis is shifting from expense and cost center metrics to compliant revenue and reimbursement models that are strategic to a health plan's quality and compliance ratings.

Add to these trends the individual mandate and the creation of the federal insurance exchange, the various state models and the emergence of Accountable Care Organizations (ACOs), and the result is pressure for payers to shift responsibility to providers for clinical treatments and outcomes, with incentives for quality improvement. For example, payers could offer capitated arrangements for specific services offered by a provider organization, which would reduce the risk of fee-for-service payment requests to the health plan.

With regard to payments by payers to healthcare providers, ACA regulations creating ACOs will be combined with state and payer-provider contract changes—all intended to align accurate and profitable payments to providers with care delivery model changes. Administrative complexity will be the reality for both payers and providers as they work to improve compliance and share in revenue and profitability.

In a widely read paper in the *New England Journal of Medicine* (NEJM), David Cutler, Ph.D.; Elizabeth Wikler, B.A.; and Peter Basch, M.D., identify opportunities for provider administrative savings of up to \$30 billion annually that can be achieved with the adoption of standard electronic transactions, reporting and automation.¹ To realize such savings, payers and providers will have to invest in new IT systems. An organization's core administration and reimbursement systems support the foundation for improvements in member-centric data around clinical work streams and clinical workflows; together, these systems will provide enhancements in cost and quality of care.

The question is, as providers take on risk, do they have the systems and analytical capabilities they need to respond? For example, to predict readmission risk, providers need to know all the factors that drive the risk of a patient being readmitted in a certain location.

¹ "Reducing Administrative Costs and Improving the Health Care System." David Cutler, Ph.D.; Elizabeth Wikler, B.A.; and Peter Basch, M.D., *New England Journal of Medicine*, 367:20, www.nejm.org, November 15, 2012.

The Basics of Provider Reimbursement

In the past, provider contracts with payers typically offered discounted fees associated with billed services (fee-for-service or FFS). Like any commercial supplier contract, the services are coded and unit billing occurs. Packaged services, such as diagnosis-related groups or DRGs, can be included in the contract, as well as the ability to negotiate “case rates” for individual cases. Implementing these contracts in technology systems requires the ability to recognize the codes on a bill (claim) and apply contract discounts. HIPAA standard codes and claim forms enable the automated processing of millions of these claims every day.

The historical HMO payer/provider compensation model is different and presents challenges in developing a bundled payment financial partnership. This is essentially a capitation model of agreed periodic payments for a contracted schedule of services provided and an alternative reimbursement approach to the traditional volume-based fee-for-service model. Providers are reimbursed based on the enrolled eligible member population they serve.

Claims are still submitted, and member liability (co-pay and co-insurance) is calculated. Processing these claims in a traditional payer IT system requires recognizing that the claims in this arrangement are not paid to the provider but captured for the recording of the encounter and the determination of future payment rates.

Current Challenges with Provider Reimbursement

Payers and providers have found that the two primary FFS and HMO forms of reimbursement are not adequate to cover the complexity of care delivery. All claims reimbursement systems rely on the ability of the provider to bill using standard data and claim forms, as well as the ability of the system to recognize those bills as either an encounter to be captured for informational purposes or a request for reimbursement.

“In the past, we had the HMO and PPO models. Now we will have different tiered products, provider-centric products and additional payments all within one system. These different products require different pricing in a much more complex way for providers,” says Dr. Rick Weisblatt, SVP Provider Network and Product Development, Harvard Pilgrim Health Care.

One of the challenges is in the area of gain-sharing, which is shared savings created from improvements and changes in clinical workflows and clinical work streams. Shared savings can come from more efficient utilization of inpatient and outpatient provider services that enhance quality, reduce costs and drive improved outcomes. Gain-sharing can apply to episodes of care, whether provider systems or services, or to provider-based office care, for example, in a bundled payment model. In these cases, each payer must customize its legacy claims system to address the requirements for gain-sharing models. These requirements include emerging services performed by traditional providers, previously associated with reimbursement or non-traditional “office visits.”

Today, there is no standard code for a provider to bill for “telemedicine” services such as email, phone, text or Internet chat, and yet the population is increasingly expecting these services from providers. It’s a challenge for legacy systems to enable ongoing configuration for alternative reimbursement for other new benefits and services, such as:

- » Product-based payments, e.g., radiology
- » Enrollment-based payments, e.g., primary care physician (PCP)
- » Claims-based payments, e.g., ACO care coordination fees
- » Claims-based compliance payments, e.g., state/city social services and Health Reimbursement Arrangement (HRA)/Department of Social Services (DSS) services
- » Member-based periodic payments, e.g., disability



Even when these contracts are written in legacy terms (fee-for-service or capitation) to address the variety of payments, reporting and medical cost accounting compliance require changes to legacy systems to ensure consistent accounting of expenses and billing to self-funded customers. Most payers resort to using homegrown external or manual systems to manage capitation payments, removing this processing even further from core administrative systems.

These are usually customized internal approaches to attempt a shift in managing encounter data for an increasingly expanding menu of services that are not scalable or easily handled by existing core administration systems, provider communication transaction networks or common standard administration, financial and clinical transactions sets.

The convergence of these trends results in data requirements and technology and solution gaps, creating a need for a standalone component solution that calculates payments to providers that are not directly billed on claims.

Drivers of Alternative Provider Reimbursement

As they attempt to respond to government-driven and market-driven reform requirements, payers and providers together face a number of challenges entering into capitated payment partnerships and contracts. First is striking a balance between efficiencies in the contracting process while ensuring agreement upon performance metrics on episodes of care-based payments. Other challenges include:

- » Choosing a methodology for setting pricing and calculation that factors in fee-for-service or gain-sharing models bundled with performance-based or incentive-based payments and bonus programs
- » Making provisions for risk-sharing and risk-adjustment
- » Allowing for payer or health plan and provider risk-bearing, as well as payment frequency
- » Moving to claims processing and adjudication systems with manual processing for outliers
- » Establishing quality improvement metrics and clarity around who makes those determinations

As payers begin to find innovative solutions to these challenges, they can support member health status improvements by linking performance to reimbursement.

“Health plans and providers already are partnering to advance accountable care,” says Charles Stellar, Executive Vice President, America’s Health Insurance Plans (AHIP). “We are seeing new payment models emerge from active collaboration in the private sector.”

Opportunities for Payer Health IT Innovation

Payers and providers often have different health information technology concerns related to reimbursement. Providers should consider their billing and payment operations and the impact on claims, workflow and decision support tools. This white paper does not address provider considerations other than to acknowledge that providers have an important interest in the appropriate reimbursement and risk-sharing as tied to care delivery and outcomes.

Essentially, the goals of payment reform are to:

- » Drive quality and quality metrics or in the case of Medicare Advantage Plans CMS STARs ratings
- » Manage utilization
- » Support provider integration and network management

For payers, health IT systems that determine provider reimbursement and related business rules and compliance requirements should address the following five areas:

- » The ability to adjudicate and review claims for correctly bundled services—for example, claims outside of the payment window; data validation inside bundles; or Fraud, Waste and Abuse (FWA) in identifying duplicate claims or services
- » Electronic data interchange (EDI) transaction standards to support bundled payments for payers and providers
- » Moving from the International Statistical Classification of Diseases and Related Health Problems 9th Revision (ICD-9) to ICD-10 standards to enable applications and analytics platforms that support the shift from per-occurrence claims to payments linked to a clinical outcome payment with incentives
- » Supporting provisions of both the American Recovery and Reinvestment Act (ARRA) and Health Information Technology for Economic and Clinical Health (HITECH) Act for infrastructure development to drive provider adoption of electronic medical records (EMR) and the development of the federal and various state health information exchanges
- » The next logical generation of capabilities to support these initiatives is to develop EMR and clinical capabilities designed with modern reimbursement models.
- » These will enable large agencies such as the Centers for Medicare and Medicaid Services (CMS), state healthcare and social services agencies or payer organizations and ACOs to leverage clinical workflows tied to compliance and outcome-based measurements.
- » This linkage will provide capabilities to unlock value through the parallel adoption of alternative reimbursement systems and electronic medical records, which will be directly linked to financial incentives around capitation and gain-sharing. This will move stakeholders toward the shared goal of enhanced outcomes and behavioral change opportunities that improve the health status of the member/beneficiary at those critical encounters with the physician or service providers that link member behavior to provider incentives.

Additional technical considerations should address the benefits of a service-oriented architecture (SOA) component solution within a healthcare payer's system landscape. These SOA approaches will require integration options for payers that enable:

- » Integration points to import reference information, configuration and setup
- » The ability to work from payer reference information (members, parties, enrollment, providers, products, etc.) to reduce per-period data transfer volumes
- » User capabilities to view reference information and drive configuration and setup
- » User configuration and setup for capitated contracts, rate sheets and settings
- » Integration points available to initiate and control calculations
- » Receipt of member information directly per period to enable provider reimbursement per period
- » Leveraging core financial messaging capability to distribute calculation results for payments and downstream processes

Whether driven and influenced by the ACA, annual planned cuts restored out of the 2 percent Medicare provider fees (often referred to as the "Medicare Doc FIX" legislation), state reform activity or market requirements, development of alternative provider reimbursement capabilities is an imperative for payers and providers. While these reforms have different requirements, the core prerequisite for payers is to create a Health IT platform that allows for claim processing and coordination of care that facilitates member benefit administration and other systems to create alternative provider reimbursements.

This would include, for example, global payments for limited or all services/diagnoses with or without risk adjustments, shared savings incentives, standard reimbursements across all payers in the state/system, care management (coordination) payments, incentives for self-funded plans to participate and episode of care payments. The "future-proof" enterprise IT platform must support all of these possibilities.

Executing on Alternative Reimbursement

In order to implement automation in the management and fulfillment of alternative provider reimbursement arrangements, payers will need systems that do not exist today.

“We need a component-based architecture where we can swap in and swap out different capabilities,” says Deborah Norton, Chief Information Officer, Harvard Pilgrim Health Care. “If you have it all in one giant box, I don’t see how you do this. Rapid cycles of development and deployment are key. It can’t take a year to stand one of these things up.”

Traditionally managed via spreadsheets and “special transactions” when they accounted for a small number of payments with limited financial impact, periodic provider payments will require systems that manage the healthcare ecosystem in new ways:

- » In order to manage to Medical Loss Ratio (MLR) requirements and cost controls under ACA, payers will need provider contract applications and decision-support analytics that drive profitability for payers. They should be customized and acceptable via rules-based modeling to the providers in the network, and also account for periodic quarterly and annual bonus or incentive payment and reimbursement arrangements that include such factors as product, state, location, member, member’s medical home and diagnosis.
- » They also will need claims pricing systems that accurately identify encounter data and claims for FFS reimbursement, in order to apply appropriate contract and payment terms paid by alternative reimbursement methods. Additional capabilities to support modern reimbursement methods will need to focus on transparency, operational controls via trial processes and retroactive changes and adjustments capabilities.
- » Benefit adjudication systems must recognize member-centric medical cases and appropriately apply member cost-sharing. Consider the use of a non-contracted anesthesiologist in a contracted surgical facility. In this case, the service should be aligned with the medical case of the surgery, and member liability would be calculated once without penalty for the out-of-network anesthesiologist.
- » Provider alternative reimbursement systems will need to support a centralized review of all payments to a provider and calculate and provide transparency into the members, providers and outcomes used to calculate payments.
- » Systems that generate accurate payment transactions will be used to implement process controls and contract implementation audits to ensure accurate payment of claims without duplicative payment or under-payment.
- » Reporting and analytics tools must enable all stakeholders to have a common understanding of payments made and the savings provided by alternative payment methods.

To meet these industry requirements, payers will need to componentize the core health IT platform, as operations transition from managing claims payments to new business models built on collaborating with providers. (See Figure 1. Alternative Provider Reimbursement Architecture.)

“Current IT systems may be an impediment to managing to Medical Loss Ratio requirements and cost controls under the ACA,” says Srini Venkat, Vice President of Insurance Products, Oracle. “Through an agile, component-based health insurance platform, payers will be better able to innovate on provider reimbursement models and adapt to ongoing change in our healthcare system.”

Providers will be increasing their responsibility for clinical treatments and outcomes under capitated payment arrangements. Payers will need to develop requirements and deploy operational and provider network management capabilities to process claims that are bundled while providing the core foundational systems and rules-based component solutions.

This will allow for the sharing of clinical and financial and information with stakeholders and, specifically, providers under integrated delivery networks, office or ACO models. Given the range of systems deployed from legacy to commercial off-the-shelf “big box” or internally developed platforms, alternative reimbursement solutions will prepare

payers to link strategic planning with systems capabilities that provide ongoing flexibility to address reform and change in the future.

Providing information from core systems to all stakeholders will take the form of standard enterprise services, reducing the cost of developing custom reporting from transactional systems. Leading payers and providers are moving to create competitive advantage by implementing IT systems that support a variety of business models, enable increased automation of operations processing and offer the ability to create and manage standards for information use across the enterprise. Consistency and accuracy are the cornerstones of operational excellence, and payers will need these qualities to manage upcoming changes.

“Payers have had the benefit of sophisticated analytical tools for a long time; most providers have not. And no one has had the full actionable data set to base decisions on,” says Kris Joshi, Global Vice President of Oracle’s Health Sciences Global Business Unit. “There are a number of experiments underway in the market today where payers and providers are coming together to understand how they can measure outcomes reliably and set meaningful baselines around quality in each therapeutic area.”

Already, the rise in electronic claims processing systems has expedited receipt and processing of claims submitted by healthcare providers, according to a study by America’s Health Insurance Plans (AHIP). Between 2002 and 2011, the percent of claims submitted and processed electronically nearly doubled from 44 percent in 2002 to 94 percent in 2011. Furthermore, health plans received 66 percent of claims within two weeks of the service date, up from 58 percent in 2009 and 45 percent in 2002.

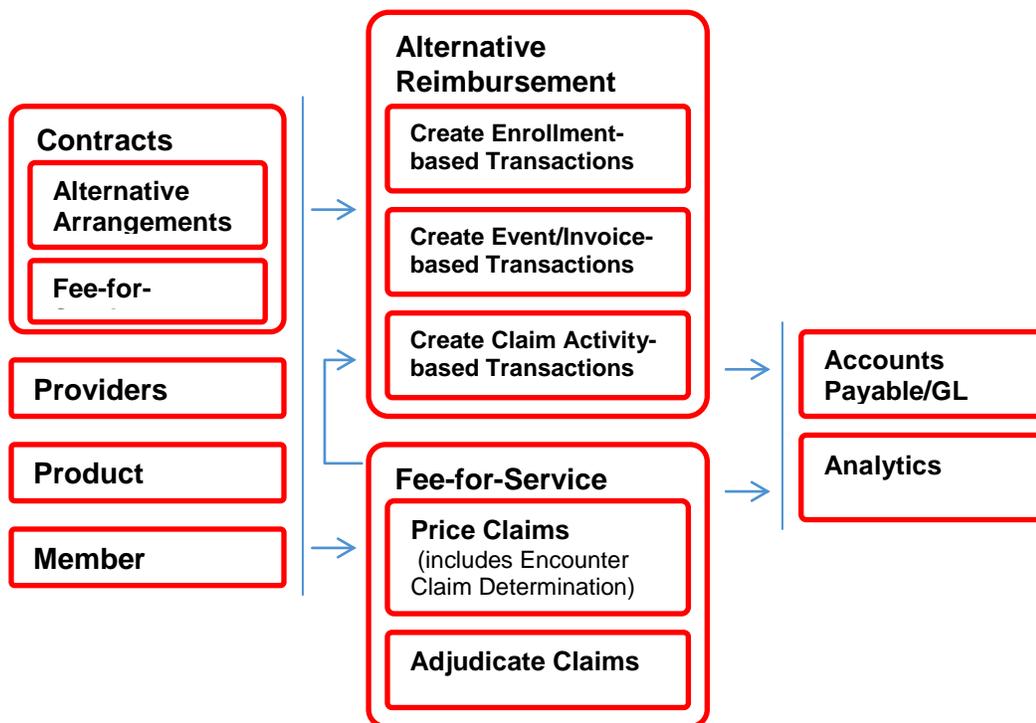


Figure 1. Alternative Reimbursement Architecture



Conclusion: Changing with the Times

Market-disrupting change is everywhere in the healthcare payer ecosystem. To change with the times, payers need to create opportunities to transform provider reimbursement—from bill presentment and payment to shared understanding and reward for achieving outcomes. How successfully they implement these strategies will determine whether they succeed over the long term.

“Our goal is to attain proof of concept rapidly and to measure rigorously,” says Dr. Michael Sherman, Chief Medical Officer and SVP, Harvard Pilgrim Health Care. “We want to know we are undertaking new initiatives because they improve value. In the end, good business decisions are about improving quality and reducing cost.”

Payers can take two important steps to prepare for this radically different future: First, expand thinking beyond claims data and find ways to leverage clinical data through creative partnerships with providers and better patient engagement. While claims data will continue to be valuable, it will become increasingly important to augment it with rich clinical data to get an unbiased view of health outcomes and costs. Then, look beyond the normal care delivery process to the science of medicine.

“Targeted therapies, molecular diagnostics, and personalized healthcare will be here faster than many payers realize,” Joshi says. “Everyone needs to think about how rapidly evolving medical science will change the therapeutic options available to patients, how they will be paid for, and how that will impact their business competitiveness.”

Today’s healthcare leaders are looking for ways to enable health IT systems to align payers with providers. Many of the systems described here are available today to accelerate speed to market for payers and reduce the time it takes for providers to receive accurate payment.



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