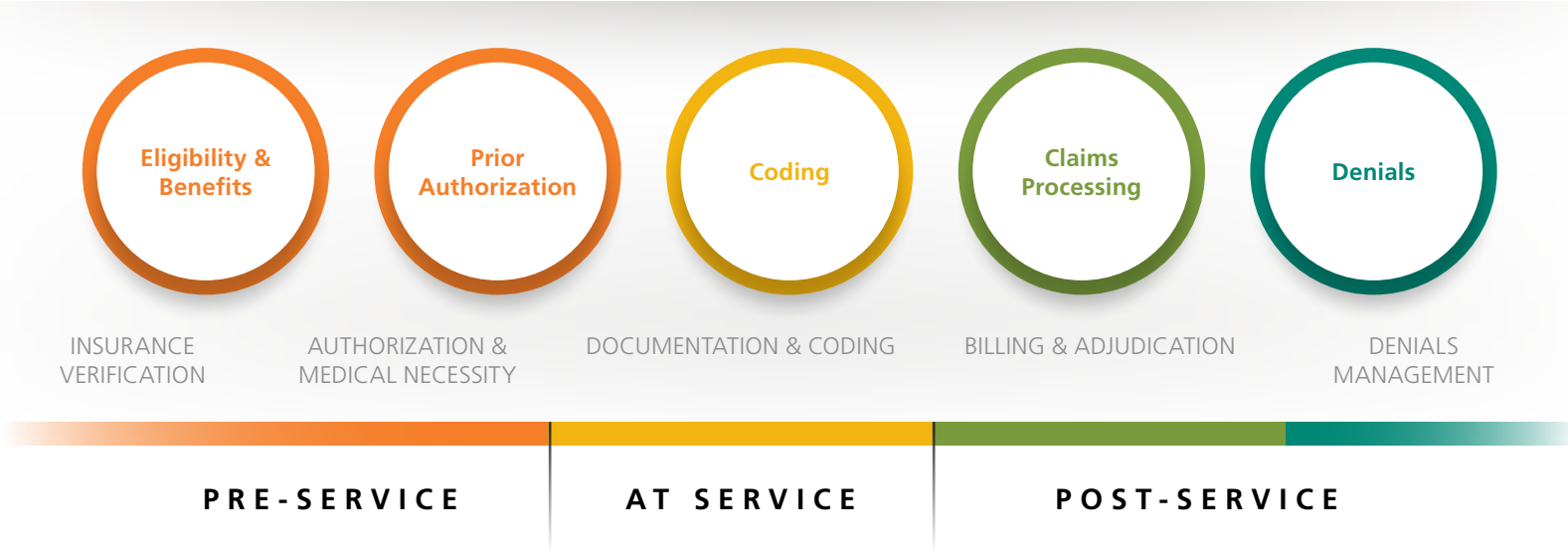
Modernizing payment systems together

Aligning around shared pain points to tackle cost of care



Across the health care industry, no single group has been able to reduce the $200 billion in annual administrative waste.[1] Through cross-system collaboration, we can help tackle this challenge and chip away at the total cost of care.

We recognize that different stakeholders share many of the same frustrations. We can start to look for opportunities to align on financial goals, care outcomes, and patient or member satisfaction. One significant source of shared frustration is the end-to-end payment continuum. To address the friction and complexity that affect revenue cycle management and payment integrity, payers and providers need to collaborate. Transparent data sharing and integrated workflows are part of that collaboration.

By cooperating throughout each phase of the payment process, payers and providers can help end inefficient practices and uncover previously hidden value.

Collaboration uncovers value

Uncovering value is a key to growth, since no one can afford higher costs. Health care systems and other providers can't negotiate for higher rates. Health plans and other payers can't increase premiums. Employers can't further shift costs to employees. Improving or reinventing current administrative practices can capture value. According to Dr. Mitch Morris, executive vice president at Optum Advisory Services:

> "We have put a tremendous amount of process and procedure around authorizing care, validating that someone is covered by insurance, and paying for care. That creates a lot of friction in the system and it does not work well today — even with technology enablement."

To reduce friction, he says, stakeholders need to define common objectives, common rewards and common risks.

To modernize payment processes, stakeholders need to:

- Find alignment
- Transform the dynamics of payer-provider interactions
- Focus on eliminating waste

Alignment can begin by recognizing shared pain points and frustrations with each step of the payment process. Here are five key issues experienced by both payers and providers — and collaborative methods for addressing them.

1. Lack of access to complete benefit data

A comprehensive view of eligibility and benefits data, policies, and terms or requirements is lacking. This hinders the ability to accurately identify patient out-of-pocket costs and payer liabilities. It means payers may be billed for patients outside of their network. Or they might not receive enough information to determine coverage. Providers can't determine point-of-care pricing or time-of-service collections. It also limits opportunities for coordination of benefits.

"Health care is the only industry where consumers buy something without knowing how much it is," says Dr. Morris. "It's not until a patient receives their bill that they know the real cost. We really should have much more transparency."

Through a collaborative strategy, payers and providers can build systems for collecting and sharing the most up-to-date and accurate coverage data. This includes information on multiple liabilities, third-party payers, primary payer determinations and more.

By exchanging insurance coverage and eligibility data upfront, payer-provider partners reduce confusion. They allow all parties to understand their financial responsibility.

2. Confusion about which services require prior authorization

Misunderstandings about prior authorization, including which services require it, may lead to patients not receiving timely and appropriate care. Providers tell Optum that they find it difficult to keep up with payer requirements for prior authorization. These requirements are often specific to a plan and frequently updated. The problem can be exacerbated when communication between ordering and rendering physicians is conducted through handwritten notes with invalid or insufficient information.

Payers say the confusion means they do not always know what services are planned. That means they might miss opportunities for better utilization and site-of-care management.

"The payment system, in the way it's administered, limits our ability to move to alternative sites of care. Or to move to more coordinated care for those with chronic illness," says Dr. Morris. "And to really embrace some of the emerging approaches — like home care and virtual or online care."

Strategies to improve coordination before and during care might include integrated technology designed to connect payer and provider data. For example, connecting electronic health records (EHRs) with patient scheduling data could allow systems to automatically identify whether an ordered service meets prior authorization requirements. It would also generate authorization requests for an appropriate payer.

The goal is reduced clinical variability, improved policy compliance and more opportunities to influence utilization.

3. Exchange of incomplete and delayed clinical documentation and coding

Varied payer-specific documentation requirements, along with outdated service codes, mean payers and providers exchange incomplete information or encounter delays. Codes don't accurately capture services rendered, which can skew reimbursement and quality scores. It perpetuates fragmentation in the system. Establishing shared confidence in source or reference data can support complete documentation and accurate, timely billing.

Technology solutions can help. For example, natural language processing (NLP) tools read and understand clinical documentation to recognize key facts. NLP can be used to assign codes and identify potential gaps and quality events.

4. Claim submissions with inaccurate or incomplete information

Claims submitted with missing information or in a manner that is not compliant with payer requirements could lead to rejections and denials. Reworking rejections, denials or partially paid claims requires costly follow-up. By aligning on documentation guidelines, payer-specific rules and contractual terms prior to claim submission, much of that expensive rework can be minimized.

Providers and payers who collaborate can avoid negotiated contracts that set up separate payment formulas or claim editing logics that don't reconcile against each other and can lead to denials.

Data sharing between collaborators informs data that informs editing solutions designed to help providers identify errors before claims are submitted. This also allows payers to scan submitted claims and return those with potential errors prior to processing.

5. Inability to determine root cause of denials

Any one of the above four pain points can lead to a denial. The common issues at the core of each are lack of administrative and clinical policy transparency, coordination and clear communication. These issues inhibit providers from identifying the root cause of a denial. This lack of timely feedback leads to error reoccurrence and appeals.

Partnerships between payers and providers can improve communication, education and training surrounding the reasons for denials and underpayments. That would allow both sides to incorporate the findings to avoid claim rejections and denials in the upstream process.

Shifting focus away from post-service collections

Payers and providers spend a significant amount of energy chasing down information or reworking claims. This work is completed in the "post-service" part of the payment continuum.

By connecting payers and providers and helping ensure accuracy on the front end, much of the work can shift to "pre-service" or "at service."

That shift can reveal opportunities to uncover hidden value, as it did for one provider hoping to reduce the number of bills unpaid and ignored by patients. The provider needed a way to collect at the point of care.

Optum connected the provider's records system with data on payer benefits and patient copay requirements. Staff members were able to access information on patient benefits and request appropriate payment at the time the service was rendered.

The ability to share data at the right place and right time increased up-front collections by 20 percent. Ninety-three percent of the time, the provider received an estimate from Optum that outlined the patient responsibility for a given procedure.[2]

The changes reduced denials, gave the consumer an understanding of out-of-pocket obligations and improved patient satisfaction by eliminating the need for multiple bills.

Transparency and collaboration in the payment process makes this kind of success more achievable. It took the work of combining provider and payer systems to provide needed information at the point of care to improve patient liability.

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Benefits of collaboration

Collaboration across the payment continuum allows for transparency, coordination and communication. This results in fewer inaccuracies and less confusion when administering care and submitting or approving claims.

Less time spent chasing down payments. Less time reworking claims submissions and reconsidering care options when faced with pre-authorization challenges. All of this translates to less administrative waste. That, in turn, benefits providers and payers along with patients.

Dr. Morris says the ultimate objective is a denial-free system. On the path to that goal, groups will realize other benefits.

Provider benefits

For providers, collaboration holds the promise of accelerated payments and lower costs for collecting payments. It can lower the risk of inappropriate denials and write-offs, which should lead to happier patients. Reduced administrative work should also boost physician satisfaction and engagement.

Payer benefits

Alignment and cooperation can enable payers to reduce claims overpayments and lower costs for payment integrity. In addition, provider satisfaction and member Net Promoter Scores (NPS) may improve. They will also be better able to influence utilization and coordinate benefits.

Health ecosystem benefits

Payer- and provider-specific benefits will have another effect. They can help create a health system that is focused on the patient. With clarity on coverage and financial responsibility, patients can become empowered to ask questions about the cost of care. Better care coordination and fewer delays in access to care can lead to better outcomes and better experiences.

Dr. Morris says achieving these goals will require a shift from a transactional relationship between payers and providers to a strategic relationship. "Making these changes is not easy. We've had the fee-for-service billing system for an awfully long time. It is deeply ingrained into the business of health care in this country," he says.

Optum can help make the connections that allow for collaboration. "We bring technology, managed services, change management and the expertise of Optum advisory services to local markets to enable some of these changes," says Dr. Morris. "It could be financial incentive changes around forming risk-bearing entities. It could be managed services to lower total cost. It could be finding partners who are willing to do some really new things to eliminate denials and establish a simplified and fluid payment process to remove cost and friction."

"The first step for organizations coming together to create a better payment process is to define a shared vision of where they want to be."

With leadership, vision and the willingness to take on some risk, providers and payers can find alignment. They can form strategic relationships to create a more efficient payment system and reduce administrative waste to positively affect the total cost of care.

Learn more about how Optum helps health care leaders collaborate to modernize the payment process.

info@optum.com 1-866-386-3404

About Mitchell Morris, MD

Mitchell Morris, MD, is executive vice president of Optum. Dr. Morris brings 30 years' experience to his work with health systems, academic organizations and government agencies. He assists them with developing and implementing strategies around health reform, growth, technology and innovation.

Prior to joining Optum, Dr. Morris held leadership roles at MD Anderson Cancer Center and Deloitte LLP.

Sources:

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2. Optum client results.

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11000 Optum Circle, Eden Prairie, MN 55344