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## **Payer-Based Processes and Technology Improve Efficiency and Outcomes**

BY DAN SPIREK

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In the days following the American Revolution, the economy ebbed as states fought one another. In Massachusetts, a thousand men refused to pay taxes and seized an arsenal. Anarchy loomed. Into the fray stepped Alexander Hamilton, James Madison, and John Jay. Together they penned the Federalist Papers, which helped win ratification of the Constitution by New York and establish a united America. Hamilton, Madison, and Jay could not have been more dissimilar. Hamilton was dashing and witty; Madison was painfully shy; and Jay was reasoned, patient, and cautious. Theirs was an unlikely alliance, though a most timely and fortunate one.

Shared information is the underpinning of integrated healthcare management that enables clinicians to take a broader role in coordinating their patients' health.

Our healthcare system is not perched on the precipice of anarchy. But it is highly fragmented, and the only certain consequence of healthcare reform is the addition of millions more people to what remains a largely disaggregated system.

Like Hamilton, Madison, and Jay, healthcare payers and providers could not be more dissimilar. Fueled by contentious contract negotiations, the payer-provider relationship can be fairly characterized as strained and sometimes rancorous. An unlikely alliance of the two would improve the U.S. healthcare system significantly by helping achieve sustainable affordability and by enhancing both the administrative efficiency of group practices and clinical outcomes of patients.

Here and there, this alliance has taken hold. Its foundation? New web-based software applications and processes available to group practices through health plans.

Payer organizations have a rich repository of patient health information that is already digitized and that spans across facilities. Information technology (IT) is turning silos of payer information on their sides and sharing data with group practices and consumers. Shared information is the underpinning of integrated healthcare management (IHM), a systems science framework that enables clinicians to take a broader role in coordinating their patients' health and to practice medicine based on evidence-based guidelines. IHM ensures group practices have the right information at the right time, and it aligns health and financial incentives so health plans, clinicians and patients all work toward the same goal of the very best clinical outcomes for every healthcare dollar spent.

Let's look at how new payer-

based processes and applications can enhance the entire cycle of patient care in the group practice setting.

### Contracting with Plans

Today's contracting process is designed to support a fee-for-service reimbursement model and is focused primarily on negotiation of unit cost. This results in a "one-size-fits-all" contract that does little to promote patient health.

A new contracting process is emerging: payers partner with group practices to address the clinician's role and deliver greater value for every healthcare dollar spent. This process seeks to eliminate unwarranted care by rewarding clinicians for coordinating care across medical settings based on proven best practices and guidelines. Examples include new delivery models such as centers of excellence, accountable care organizations, and the patient-centered medical home, and new value-based reimbursement (VBR) processes such as pay for performance, bundled payments, and episode-of-care payments.

The VBR processes incentivize and reward physicians for playing a broader role in managing a patient's overall health. Reimbursement constructs and incentives are tied to adherence to guidelines, improved efficiency, and achievement of health goals. No matter which VBR process is used, common ground exists: health plans and group practices work together to establish contracts that promote proactive patient and population management, reward better outcomes, and deliver the best health for every dollar spent.

### Manage and Improve Patient Health

With new reimbursement processes in place—based on value instead of units of production—clinicians will be rewarded for engaging patients in dialogue about their health from the start. In this new era of IHM, health plans are proactively providing the following resources to help clinicians improve patients' health:

- Information on the health status of all their patients covered under the plan
- Evidence-based best practices for treating their patients
- Personalized health improvement plans for each patient to enable health coaching

Some payer organizations are providing payer-populated personal health records (PHRs) to patients and their clinicians. Complementary to a group practice's in-house electronic medical record, the PHR tells the practice about other clinicians the patient has seen, the full range of medications he's taking, and services he's obtained elsewhere. The PHR is automatically updated by the health plan every time the patient visits a provider. Also, the consumer can update his PHR with important metrics—such as blood pressure, weight, or exercise—that he tracks on his own.

So, for example, a group practice might see a patient whose PHR indicates he has consulted several doctors and received multiple medications for a problem with lower back pain. In reviewing the PHR, the clinician might educate the patient on other treatment options and steer him toward effective care. Together, the clinician and patient could update his health improvement plan and set goals for physical therapy and weight loss, for example. Through the VBR contract with the health plan, the clinician would be rewarded financially for helping the patient make an informed decision.

### Provide Efficient Care and Follow-up

Health plans also can help improve effectiveness and efficiency at the point of care by delivering:

- Information about eligibility, benefit design, and financial responsibility
- Pre-visit patient information, including the PHR

- Point-of-care tools including informed consent, personal health information, and a health improvement plan
- Tools and support to enable coordination of care and follow-up

The first thing a payer organization can do is deliver the right administrative information and basic health history to the clinician's office to help prepare for the patient's visit. Take, for example, a pediatric asthma patient. When the pediatrician's office staff confirms eligibility, they pull the PHR from the health plan's website and view the patient's recent health activity and health issues, including her peak flow measures. This information helps the pediatrician understand the patient's current asthmatic condition. Using the payer's web-based, real-time claims estimation and submission application, the practice can determine how much the patient's parents must pay and how much the insurance plan will pay. In this way, the practice can collect full payment from the parents, or determine a payment plan, before they leave the office. And the automation speeds reimbursement by the healthcare payer, as well.

During the visit, the pediatrician and patient review progress with her health improvement plan and peak flow levels—all recorded in her PHR. Based on the information, they might decide she should see a pulmonary specialist. The pediatrician then uses the health plan's web-based treatment cost navigator to help the parents choose a specialist, who reviews the patient's PHR in advance. In this way, the appointment with the specialist days later focuses on next steps, not on reviewing history, and the patients are spared the wasted time and expense of duplicative tests and procedures. During the patient's next visit at the pediatric practice, the pediatrician views the PHR to see what the specialist diagnosed and which medications were prescribed.

In this example, the PHR, real-time claims estimation and submission tool, and treatment cost navigator—all provided by the healthcare payer organization—enable the clinician to spend more quality time with the patient, help her and her family make informed decisions, and “quarterback” the coordinated care that the patient obtains from a second clinician.

### Reimbursement, Getting Answers

Following a patient’s office visit, the health plan has an opportunity to help the group practice by streamlining reimbursement and improving information flow. Now under development, payer-based IT will soon enable:

- Next-generation claims and payment capabilities
- An integrated, self-service platform

Currently, a group practice spends considerable time managing reimbursement from health plans. Staff must access several different websites and use different software applications to get claims submitted and questions answered. Each payer organization has a different system, so sometimes information arrives on paper and at other times by e-mail. And the templates and terms vary, making interpretation cumbersome.

Soon, one common payer platform will enable group practices to access multiple health plans from a single website. Information will come in one, uniform format. When practice staff asks questions about payment status, pricing, network information, or patient eligibility, a support system will respond in real time—from one portal. Patients, too, will have access to the same information, with the same level of accuracy, eliminating a lot of confusion, miscommunication, and misunderstanding. Group practices will be paid more quickly, and their processing costs will decline.

IHM, enabled by payer-based

technology and processes, can reduce inefficiencies throughout a group practice’s business and care cycle, ultimately delivering quality care at greater value.

### Group Practices in Tennessee

Consider the experience of group practices in Tennessee.

The TriZetto Group’s web-based Provider POS Direct™ application accurately calculates patient financial liability and enables real-time claims submission at the point of service. It allows group practices to obtain real-time calculations of patient liability directly from the payer’s claims system before care is delivered. This helps practices collect full payment when, or even before, services are rendered, not days or weeks later.

BlueCross BlueShield of Tennessee made this application available to all practices in its network. Just one month later, more than 500 individual clinicians had used it—an increase of 150 percent over a pilot project. Clinicians who used the application reported improvements in administrative efficiency and collections.

Before they used the payer-based system, staff at Franklin Surgical Specialists in Franklin, Tennessee, set aside one day a week to get cost estimates for patients. Weeks later, with roughly a 300-percent increase in efficiency, that task had become a small part of their daily workflow. The office could get more than six estimates in 15 to 20 minutes. Previously, this would have taken at least an hour and required numerous phone calls.

Others in the pilot group reported that calculating patient liability formerly took 15 minutes to an hour per estimate (pre-care), depending on the availability and accuracy of payer information on the web, telephone hold times, and other factors. With the Provider POS Direct application, group practices got an accurate calculation in three minutes or less.

The payer system also helped practices increase collections. In the

first month that Franklin Surgical used this solution extensively, it enjoyed an additional \$30,000 in cash flow. That amount was significant for a three-doctor office; it was easily a 40-percent to 50-percent increase.

“This is a whole lot better than what we were doing before,” said Nancy Salyer of Tri-Cities Gastroenterology, which also used the application. “Patients love the fact that when they come in, if they haven’t met the deductible, they know how much they will be responsible to pay.” She added that collections rose 20 to 30 percent.

### Conclusion

Group practices and health plans stand on somewhat shaky ground. They are constituents of a largely fragmented healthcare system into which legislative reform is introducing millions more uninsured or underinsured patients. But in the words of Oliver Wendell Holmes, “The greater thing in this world is not so much where we stand as in what direction we are going.” And we are most certainly going in the direction of integrated healthcare management. The road to IHM requires that clinicians and insurers redefine the nature of their traditional, adversarial relationship to take full advantage of payer-based processes and technology, as well as health plans’ rich repository of patient health information spanning across facilities. If group practices and payers seize the moment, they can surely fix what ails U.S. health care, improving its affordability, efficiency, transparency, and most important, clinical outcomes.

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