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Commentary

Processing Mismanagement:

Responding to Change Healthcare's Meltdown

By Ken Terry
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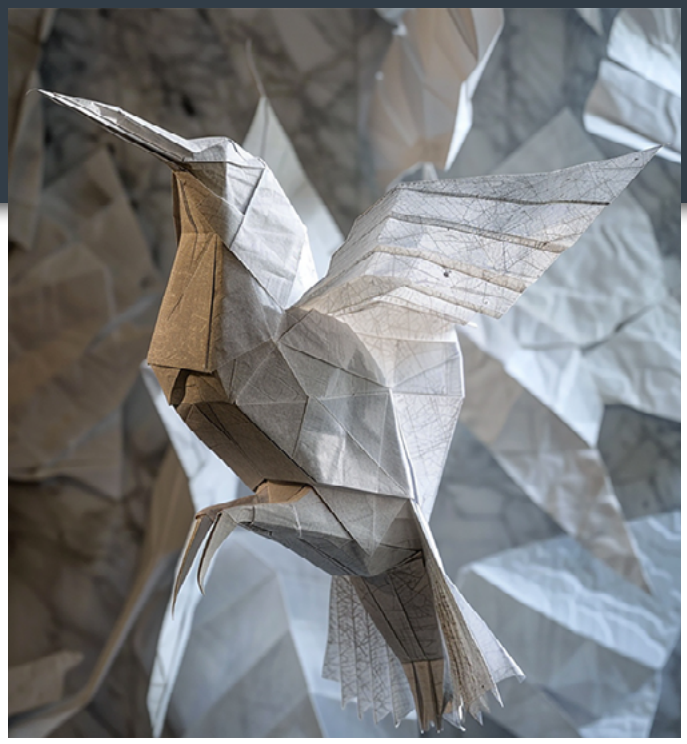

Could the crisis caused by the hacking of Change Healthcare, the nation's largest claims clearinghouse, lead to a change in claims processing and payment?

Jeff Goldsmith, the widely respected health policy expert, hopes so. In a take-no-prisoners commentary in *Health Affairs Forefront*, he says from a cybersecurity viewpoint, it's crazy that one company should be allowed to handle 15 billion claims transactions a year. That's about a third of all U.S. medical and drug transactions, worth about $1.5 trillion annually.

Goldsmith doesn't believe that a national single payer system, in which the federal government paid all claims, would protect claims-related information any better than Change Healthcare's system did. The government is too clumsy and incompetent, he argues, citing the initial failure of the healthcare.gov website and the inability of the Department of Veterans Affairs to develop a modified commercial EHR model despite spending billions of dollars on the project.

Goldsmith then makes an audacious proposal. Noting that the use of private Medicare Administrative Contractors (MACs) to pay claims has worked fine for decades, he suggests that similar entities could process and pay all claims on behalf of all public and private payers. Goldsmith's scheme would compel all health insurers that receive federal money from Medicare, the VA, the Department of Defense or any other source to use these administrative service providers or ASPs.

These ASPs would compete for business from a minimum of six non-geographical groupings of provider entities, Goldsmith writes. The contractors would have to follow National Security Agency protocols to guard against cyberterrorism and hacker attacks. They would all have to use a single set of claims forms and business rules for processing claims, regardless of payer, which would save providers a huge amount of time and money.

"The common rule set would be evidence-based and cover eligibility, service coverage and medical necessity provisions, yet provide flexibility for different payment rates and models, discounts and rebates depending on the health plan," Goldsmith explains. In addition, he says, prior authorization requests would be limited, and retrospective denials of coverage and down-coding of claims would be banned.

Of course, taking claims processing away from health insurers would eliminate one of the main functions for which self-insured employers engage them. Moreover, limiting medical management and benefit variations would reduce the plans' ability to constrain their costs. However, Goldsmith says, "Health plans would compete based on price, customer service, payment model innovations and improved health status of their beneficiaries," which sounds a lot like value-based care.

A ROADMAP FOR RESTRUCTURING HEALTHCARE

This breathtakingly broad proposal would not only help protect providers and payers against cyber terrorists and thieves. It could also trigger a major reordering of the provider-payer relationship and pave the way for real value-based competition among providers.

Since all healthcare is local, the competition among health plans would take place in local markets. To bolster security, however, Goldsmith doesn't think that single ASPs should process all claims in any market. A non-geographic basis of dividing the market, he writes, is stronger from a data security standpoint than using geographic regions. Perhaps this might entail having each ASP serve slices of several geographic markets.

At the same time, however, his idea of having health plans compete on price, service and outcomes would require a mechanism for regrouping claims data along regional lines. With modern information technologies and a federal mandate, it would be relatively easy to compile data from relevant ASPs to provide comprehensive performance profiles, which would allow comparisons of health plans both within and between markets.

One could also imagine the establishment of non-governmental regional health authorities, perhaps representing employers, consumers and healthcare providers, that would use this data to create report cards on locally available health plans. If this information were published online, employers and consumers could use it to choose health insurers.

PROVIDER VS. HEALTH PLAN COMPETITION

Of course, competition at the insurer level doesn't compel providers to practice efficiently or to improve healthcare quality, except to the extent that the plans incentivize them to do so. Despite experimentation with dozens of pay-for-performance schemes, none has moved the needle on value-based care.

However, by putting providers at financial risk and incentivizing performance-based competition among physician groups or accountable care organizations (ACOs), we could actually reduce the cost of care delivery and improve patient outcomes. Moving claims processing and medical management away from insurers would thus support the implementation of value-based care.

In the short run, Goldsmith's proposal could point the way to a regional multi-payer system managed by impartial, nongovernmental entities that represent local stakeholders. Private health plans would still exist and would still negotiate terms with providers, but they'd lose the ability to micromanage clinical decisions and interfere in the doctor-patient relationship. Although their medical loss ratios would probably rise as a result, their administrative costs would drop even after they paid ASPs for claims processing.

A future like this might seem impossible, given the power of existing healthcare players. But, as Goldsmith points out, no fundamental change in our system of healthcare reimbursement can occur without federal action. Another Change-like collapse of the claims payment system might spur Washington to intervene.

Constructive restructuring of claims processing and payment might then become a reality. A pluralistic approach would maintain a competitive multi-payer system that is both more secure and competitive. This is an idea whose time has come.

AUTHOR

Ken Terry is a healthcare journalist and author who has written several books on healthcare reform and value-based care, including a new book coauthored with Stephen Klasko.