ANALYST BRIEF
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For healthcare payers, a strategically planned implementation journey for regulatory mandates encourages data flexibility, democratizes workflow, and enables innovation across the enterprise. Continue building your enterprise infrastructure, tempering the zeal to go at mandates one-at-a-time.

How Healthcare Payers Can Strategically Leverage Regulatory Mandates for Enterprise Innovation

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Introduction

Healthcare payers have implemented technology solutions to address state and federal mandates for over a decade. A timeline of mandated requirements during this period includes notable developments such as:

- 2010: Medical loss ratio
- 2011-17: Affordable Care Act
- 2017-24: Value-based reimbursement
- 2019-22: COVID-19-based telehealth regulations
- 2017-22: Directory accuracy and network adequacy
- 2020-24: API-based Interoperability
- 2021-24: Price transparency
- 2023-27: Interoperability and prior authorizations

Without a doubt, more mandates are forthcoming.

At the same time, the payer business model is in flux. Alignment and collaboration with healthcare providers, other payers, and non-traditional organizations is flourishing as payers attempt to address the cost of care.

AT A GLANCE

WHAT'S IMPORTANT

- Establish an overall vision for data and workflow ecosystems, then modularly implement sections of the architecture using mandates to help sequence investments.
- Resist the temptation to "check the box" with minimally compliant implementations of mandated requirements.
- Allow requirements around mandates to be a driver to innovation instead of a necessary evil to be dispatched.

KEY TAKEAWAY

Standardization of data formats, consumerization, payer-provider organizational shifts, and whole-person approaches to healthcare require optimizing merged data as part of your integrated, less tactical mandate journey.

Even as vendors demonstrate their ability to deliver enterprise-grade solutions that address both current and future mandated requirements, many payers continue to take a one-year, tactical approach for each project. To ensure

operational excellence for members, providers, and internal constituents, payers instead need to evaluate individual mandates in the context of an overall vision.

Deploying technology to address mandates is not a linear destination but a multi-faceted journey. This journey takes into consideration costs and compliance, but more importantly, it can lead to the emergence of an ecosystem that encompasses comprehensively managed data and workflow enhancement for competitive advantage.

Traditional payer applications such as enrollment, claims, billing, and revenue management have grown to include clinically focused applications such as wellness and care coordination; hospital admission, discharge, and transfer tracking; and the creation of internal electronic health records. This expansion allows clinical data to join administrative data in the payer scope. When merged into a longitudinal patient record (Member-360), this data becomes a centrally deployed asset that can be used to continuously segment and categorize members/patients.

A Member-360 record allows customer service, enrollment, claims, and care coordination teams to access and use the same information base to profile members and provide the level of service members require in today's consumerization of healthcare and health insurance. But to achieve these goals effectively, the implementation strategies used by a payer for regulatory mandates also need to optimize this data asset.

Just as a 360-degree understanding of members should evolve to become more comprehensive, so too should a payer's plans to comply with regulatory requirements. Allow requirements around mandates to be an innovation driver rather than a necessary evil to be dispatched.

Benefits

Standardization of data formats, payer-provider organizational shifts, and whole-person, value-based approaches to healthcare are moving the needle toward a more integrated, planned journey with mandated paradigms. In this environment, payers are trying to reduce risk by deploying APIs based on demand and implementing data replication strategies as a general course of action. Simultaneously, regulators are also embracing APIs that need to be factored into planning.

An enterprise approach cannot be achieved overnight. To effectively manage the risk associated with all this change, payers need to ask about all deployments:

- What can we do today?
- What positions us for the future?
- Where do we want to go?
- What are we waiting for?

Payers should gather mandate requirements into an overall structured strategy and leverage outside needs to evaluate and deploy.

Considerations

To move from a one-off mandate compliance model to an enterprise operating model approach that incorporates mandate compliance, organizations should consider the following questions:

- Does the overall solution and its phasing consider capabilities from both the provider and payer perspective, given that payers are moving toward payvider models to solve the cost-of-care challenge?
- With interoperability as an ongoing priority, are the payer-to-payer data exchange solutions under consideration intended to be implemented by the organization, or will they require similar implementation by provider partners as both parties evolve?
- Will providers and other data partners (e.g., social determinants of health or SDOH sources) embrace the chosen solution, or will they wait for standards that allow them to implement one solution for all payers?
- Can the Member-360, claims, enrollment, and care management systems integrate seamlessly with the implementations planned in the mandates space?
- Can the organization handle the complex rules of prior authorization within equally complex value-based payment contracting?
- Will the organization's prior authorization solutions enhance its care management applications or sit as a one-off requiring further integration to compete?
- Will the environment being established allow for spinning up innovative applications such as:
    - Collecting, curating, and managing data to use in developing and testing AI for prior authorization, risk assessment, fraud/payment integrity, and population health
    - Merger/acquisition data and workflow consolidations
    - Taming high-volume data tsunamis from remote monitoring, care anywhere management, and genomics
    - Conversational and generative AI and the associated transparency and governance needs
    - Real-time adjudication of claims and authorizations
    - Expansion of member/patient engagement and experiences

Trends

A multi-mandate, multi-faceted operating model must also consider the following trends.

- Payers are implementing solutions that can support today's needs while also being future focused and integrating with the solutions that the providers eventually choose, instead of the other way around.
- Payers have eliminated data walls. The interoperability mandates and the need for SDOH, equity, census, and care data has opened data architectures to include many sources and potential business partners.

- Payers and providers are working together in payvider models such as:
  - Healthcare providers creating their own insurance plans
  - Payers and providers joining forces, including Aurora and Anthem (Well Priority), Banner Health and Aetna, Cleveland Clinic + Oscar, MVP HealthCare and the University of Vermont Health Network, and Cigna's EverNorth buying MDLive for virtual care
  - Insurance companies shifting to being a healthcare provider that offers insurance
- Intelligent automation is unifying AI, robotic process automation (RPA), and patient engagement technology to perform common, repetitive, manual tasks the same way a human would.
- AI also determines when and how to perform workflows.

Conclusion

For payers, establishing an overall vision and road map of where the enterprise approach is going with its mandates journey, then modularly implementing sections of the architecture seems the most appropriate path. Pulling back from the "check the box" or "avoid the fine" mindset also seems prudent. Payers should move in a modular fashion toward an enterprise operating model that optimizes consistency, flexibility, and cost while addressing compliance with mandates.

About the Analyst

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Jeff Rivkin is Research Director of Payer IT Strategies for IDC Health Insights. In that role responsible for research coverage on payer business and technology priorities, constituent and consumer engagement strategies, technology and business implications for consumer engagement, front, middle and back-office functions, value-based reimbursement, risk, and quality-based payment and incentive programs, among other trends and technologies important to the payer community.

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Health information networks depend on InterSystems to make comprehensive health data available for nearly 160 million US citizens. InterSystems interoperability and FHIR capabilities are the backbone for the QHIN eHealth Exchange, which links to 75% of all U.S. hospitals.

Health insurers leverage the Member 360 capabilities of InterSystems longitudinal health record, HealthShare, as the foundation for value-based care insights, performance measurement, and collaboration. The company also delivers provider data management capabilities, a digital front door platform, and low-code FHIR-based automation functionality.

As you evaluate your approach to addressing regulatory mandates like CMS-0057-F, while furthering your enterprise data strategy, InterSystems payer services for interoperability, prior authorization, and care management offer a flexible path to value – whether you need a single API to support provider to payer data sharing or a comprehensive solution.

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