Configuration of Network and Financial Management Systems to Support Multiple Value Based Reimbursement Models

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State of the Industry- Payer’s Perspective

- Cost pressures increasing
- Waste and abuse unabated
- Need for automated, integrated reimbursement
- Network changes for exchanges
- Delivery change for chronic disease
- Incentive changes for different behavior
Major Hurdles have been encountered
Each is required for long term success

**Reimbursement Model Design and Automation**
- Establishing the reimbursement model that most effectively supports the delivery system
- Modeling and testing changes
- Automating for scalable deployment

**Network Design**
- More payer-provider partnerships
- Movement away from “any willing provider”
- Providing tools for financial management
- Establishing networks for HIX

**Benefit Design and Member Experience**
- Making FFS benefit structures work with reimbursement initiatives
- Health incentives
- Increase access-how to lower overall cost of the benefit
- Easy to understand benefits

**Contract Management**
- Provider transparency for contracting
- Ability to adjust thousands of contracts
- Limit administrative burden
Efficiently Transitioning to Value Based Arrangements Proving to be Difficult

Business complexity is increasing…

- Providers merging and realigning
- Difficulty tracking provider relationships and attribution
- Demand from sales teams for narrow networks
- Networks and reimbursement adjusting to the influx of populations
- Contract intent and ability to operationalize
- Alignment of network, payment and reimbursement policies
- Manual efforts to support payment innovations

Resulting in the potential for more operational errors…

- Incorrect network affiliations and provider data
- Misinterpreted contract intent and configurations
- Mispayments and suspended claims

Solutions need to be flexible, automated and integrated
Establish reimbursement policies

Patient
70 yr. old man with diabetes, hypertension, and mildly elevated cholesterol levels

Program
Diabetes medical home with enhanced reimbursement for specific services, and reimbursement for non-physician and non-office services

Global Payment for Diabetes Services Provided within Medical Home

FFS for Diabetes Testing Supplies; FFS if member covered under PPO and Medical Home

Partial Capitation for Referrals to Cardiologist for Hypertension

Payers can leverage conditional logic on top of FFS reimbursement as a first step towards paying for value.
Align network design

**Benefit Based Member Incentives**
- **Product: Hybrid PPO**
  - 10% reduction if in Chronic Care ACO
  - $0 CO-PAY in Quality Network
  - 15% Penalty for PPO Network

**Steerage To Supporting Networks**
- **Diabetes ACO Network**
- **Narrow Network**
- **General PPO Market**

**Alignment with Reimbursement**
- **Shared savings model based on prospective budget**
- **Global budget target (50-90% of budget)**
- **Performance target (10% of budget)**
- **FFS for Specialty Services**
- **CAP for Primary Services**
- **Acute Episodes**
- **FFS + for preventative services**
- **FFS for all services**
- **Higher price for members in exchange for choice**
- **Low margin for health plan**

Payers have to systematically orchestrate product/benefit, network design & reimbursement to ensure steerage to high value providers.
Create benefits complementing reimbursement model

FS: requires a co-pay at each point of interaction or some % of payment to be rendered at each interaction point. Benefit systems must be adjusted to ensure the member doesn’t have to pay over and over- and there are incentives based on their enrollment in the program.
Set up contracts

**Contract 2**
Hospital A
- Shared savings (ACO)
- Membership panel
- PCP services contracted from Central Bucks

**Contract 1**
Family Practice
- Capitation for HMO
- Fee for service for other
- Pay for Performance
- Leverages orthopedic services from Abington

**Contract 3**
Hospital B
- Fee for service
- Episodic/Bundled for Total Knee Replacement

**MARY, 35 YR. OLD FEMALE**
Product: HMO
Services: Ear Infection Management

**SALLY, 50 YR OLD FEMALE**
Program: MH Program, ACO Panel
Services: Foot Exam

**SUSAN 60 YR. OLD FEMALE**
Program: MH Program, ACO Panel
Services: Insulin Sensitivity Test, Vertigo Consult

Given the increasing overlap of contracts, payers will need to develop sophisticated selection engines that understand the member, product, network and contract details.

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Medical Home: How do you apply the correct reimbursement policy?

Patient
70 year old female with diabetes, hypertension, and mildly elevated cholesterol levels

Program
Diabetes medical home with enhanced reimbursement for specific services including reimbursement for non-physician and non-office services

Reimbursement Policies

IF provider is contracted for medical home program AND is the patient’s medical home THEN reimburse at medical home rates (standard fee schedule + 5% for non-physician/office services)

IF patient is NOT in medical home program THEN do not reimburse for non-office medical home services

IF provider has both standard and medical home contract THEN reimburse at standard rates and not the medical home rates for all physician services

Leverage conditional logic on top of FFS reimbursement
These integrated and aligned systems must:

- Reduce manual interpretation & intervention
- Synchronize medical policy, payment policy, network design, and benefit design
- Apply hybrid and overlapping reimbursement policies
- Adjust reimbursement rates based upon member attribution to products, programs, and providers
- Model impact of new network & payment models
- Facilitate provider transparency
Value Based Reimbursement

Five Core Competencies

- Clinical Care Coordination
- Patient ID/Qualification, Clinical Auth
- Analytics
- Medical and Payment Policy, Pricing
- Provider Network Mgmt
Intelligently automating the contract to payment is critical to achieving the required efficiency.

**Contract Design and Setup**
- Networks & Provider Profiles
- Contractual Agreements
- Utilization Mgt and Authorization

**Contract Driven Claim Pricing**
- Claim
  - Payment Policies
    - "What to pay for"
  - Provider Selection
    - "Who & what contract"
  - Reimbursement Policies
    - "How much to pay"
- Contract Variations
- Network, Provider, & Contract Links
- Auto Authorizations
- Codified Contract
- Network, Provider, & Contract Links
- Waste and Abuse
- Bundled Payments

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State of the Industry – Provider’s Perspective

**Health Insurance Exchanges went live 10/1/13.**

Suddenly we have another payment mechanism in the market – completely new and virtually untested.

- **4 - 7 MILLION**
  - new consumers in 2014
- **13 MILLION**
  - new consumers in 2015
- **24 MILLION**
  - new consumers by 2016

**ACOs are HERE.**

- **14%**
  - of all reimbursements are NOW value-based.
- **488**
  - ACOs are in operation, yet the future remains unclear.
- **9 of 32**
  - pioneering ACOs opted out after seeing no projected cost savings.

**Administrative costs continue to soar**

- **-30%**
  - Our cost base must be reduced by almost 30% - practically overnight.

**Patient Centered Medical Home practices in operation TODAY.**

- **6,000+**
  - new consumers in 2014
- **13 MILLION**
  - new consumers in 2015
- **24 MILLION**
  - new consumers by 2016

CBO projections 2/13

http://www.ncqa.org

MHS Market Economics and Intelligence

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Providers are hesitant as traditional programs require expensive, manual resources

<table>
<thead>
<tr>
<th>Payer Programs</th>
<th>Provider Involvement</th>
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</thead>
<tbody>
<tr>
<td>Utilization Management</td>
<td>• Too much time spent requesting authorizations and/or reimbursement</td>
</tr>
<tr>
<td>Case &amp; Disease Management</td>
<td>• Need care coordination tools</td>
</tr>
<tr>
<td></td>
<td>• Need decision support tools</td>
</tr>
<tr>
<td>Network Referral Programs</td>
<td>• Lack of transparency</td>
</tr>
<tr>
<td>Complex Benefit Designs</td>
<td>• Struggling with administration</td>
</tr>
<tr>
<td>$74B spent annually(^1)</td>
<td>$31B spent annually(^2)</td>
</tr>
</tbody>
</table>


\(^2\) Health Affairs, *What does it cost physician practices to interact with health insurance plans?*, May 2009
Value Based Care Spans Current and Future Models

New payment & delivery models in use today create administrative complexity

**Payment Models**

- Fee for Service
- Pay for Performance
- Gain Share
- Shared Risk upside downside
- Bundled Payment
- Episode or Case-Based Payment
- Partial or Full Capitation
- Global Budget

- *Payment and administrative complexity* grows as risk is shared

- *Measurement* changes as accountability and data is shared

- *Delivery model* must demonstrate performance and care outcomes

**Delivery Models**

- Medical Home
- ACO
- Clinically Integrated Networks
- Alliance
- Narrow Network

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ACO Success – Multiple Strategies

- FTC-compliant Clinical Integration
- New care models: Population Health Medical Home
- Cost, utilization & network (leakage) management
- Physician performance management
- Variance Reduction

Integrated management of cost and quality
Clinical integration
Success Requires Paradigm Shift

Leakage Control and Targeted Programs

Enhanced Coordination

Increased Target Admission

Mutual Success

Preventing admissions drives my gain share

Minimize (Cost Center)

Not my issue

Not my problem

HOSPITAL P&L

Revenue $$$$$$

Expense $$$$$$

Profit $$$$$$

Network Focus
Manage Total Cost of Care

Facility Focus
Optimize volume driven profits

ACO CXO

Hospital CXO

My critical metric

Admissions drive my revenue

Maximize

Minimize

Increased Target Admission

Mutual Success

ACO CXO

Hospital CXO

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Value based transformation
Focuses on value based delivery & performance

Value Based Payment

ADMINISTER

Value Based Shared Scorecard

MEASURE

Value Based Delivery

MANAGE

Administration and Reimbursement Based on Shared Metrics

Shared Data, Metrics, Analytics to Measure Value

Demonstrable Performance Based on Shared Metrics
Medicare is piloting many VBR models to remain viable
VBR Payment Models Spectrum
Shift from paying for volume to paying for value

Keys to Success for the ACO
- Collaboration with payors – around payment method
- Access to data (clinical & financial)—that both parties trust
- Data Transparency - agreement on methodology
- Use of multiple models to support goals
- Ongoing performance tracking

Increasing performance expectations for quality, outcomes, evidence-based processes, access, consumer experience, and costs of care

No Risk | Varying Degrees of Clinical & Financial Risk | Full Risk
Blending PCMH Models and Bundled Payments
Seamless Primary and Specialty Care

Primary Care
- Wellness
- Preventative Care
- Problem-Oriented Assessment
- Provider/Member Decisions
- Care Coordination

Specialty Care
- Interventional Care
- Event-Based Care
- Specialty-Driven Chronic Condition Management
- Event-Based Care Coordination

Quality of Care Feedback Loop

Collaborative Decision Choices
Automation Key to VBR Survival

Core Competencies Needed

Clinical Care Coordination

Point of care tools:
- Eligibility
- Coverage
- Authorizations
- Payment Estimates

Operational Tools:
- Bundling, Pricing, and Payment
- Analytics to Demonstrate Performance

Addition of service lines/partnerships and Contracting
Bundled Payment Automation for Providers

Fee for Service

Provider Shift to Bundled Payments

Bundled Payments

Value Based Reimbursement

- Retrospective Analysis
- Use of Evidenced Based Care Practices
- Care Model Transparency
- Episode Registration
- Contract Management
- Disbursement
- Active Episode Analysis

- Provider Contracting
- Episode Modeling
- Historical Claims and Clinical Data Analysis
- Opportunity Analysis
- Payer-Provider Engagement
- Provider System Automation
- Care Management
- Operational Analysis

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Questions