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

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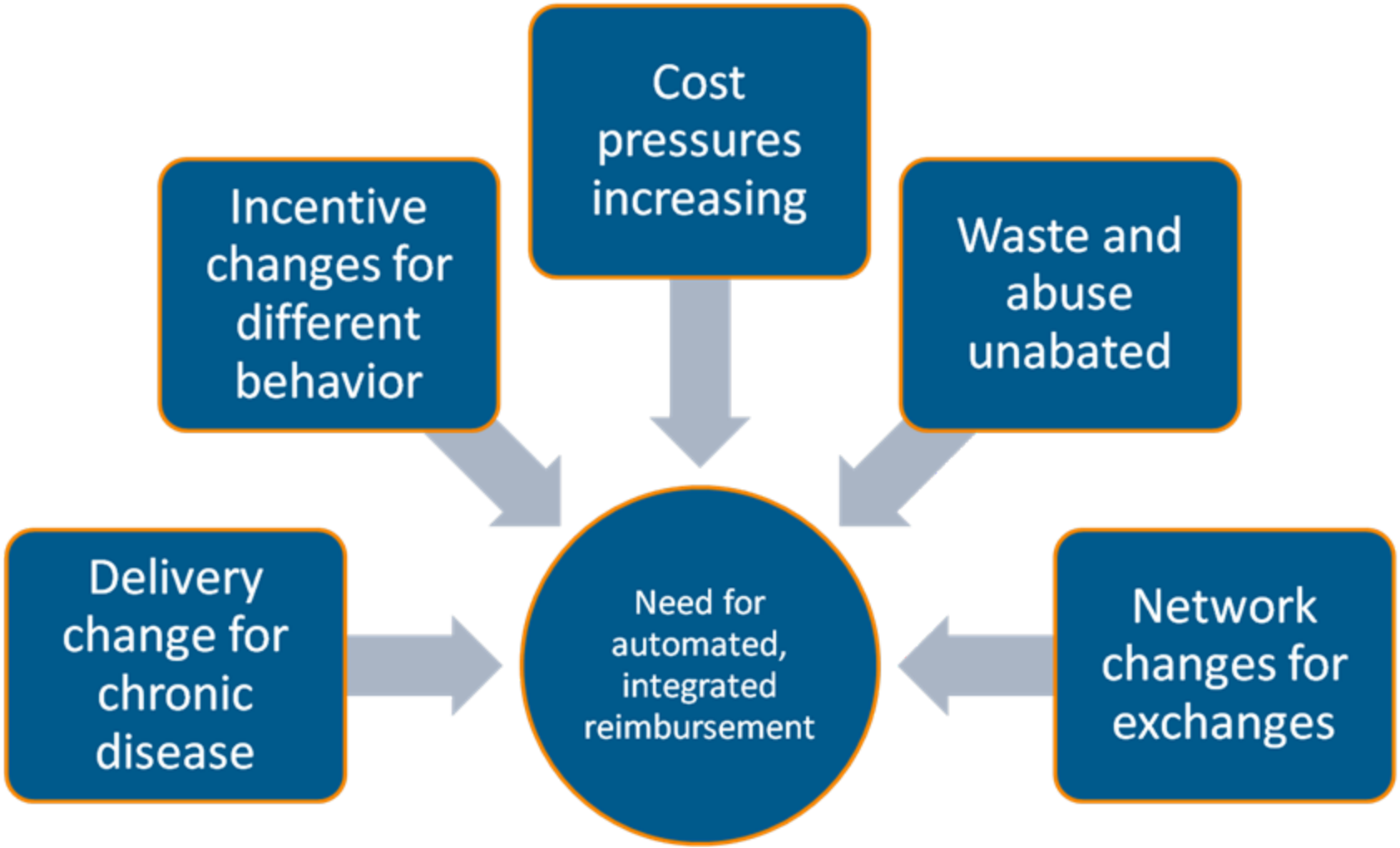
BUSINESS
CARE
CONNECTIVITY

Agenda

1. State of the Industry – Payer's Perspective
2. Steps to Transitioning to Value Based Arrangements
3. Value Based Reimbursement Core Competencies
4. Intelligently Automating from Contract to Payment
5. State of the Industry – Provider's Perspective
6. Value Based Transformation
7. Core Competencies and Automation

State of the Industry- Payer's Perspective



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

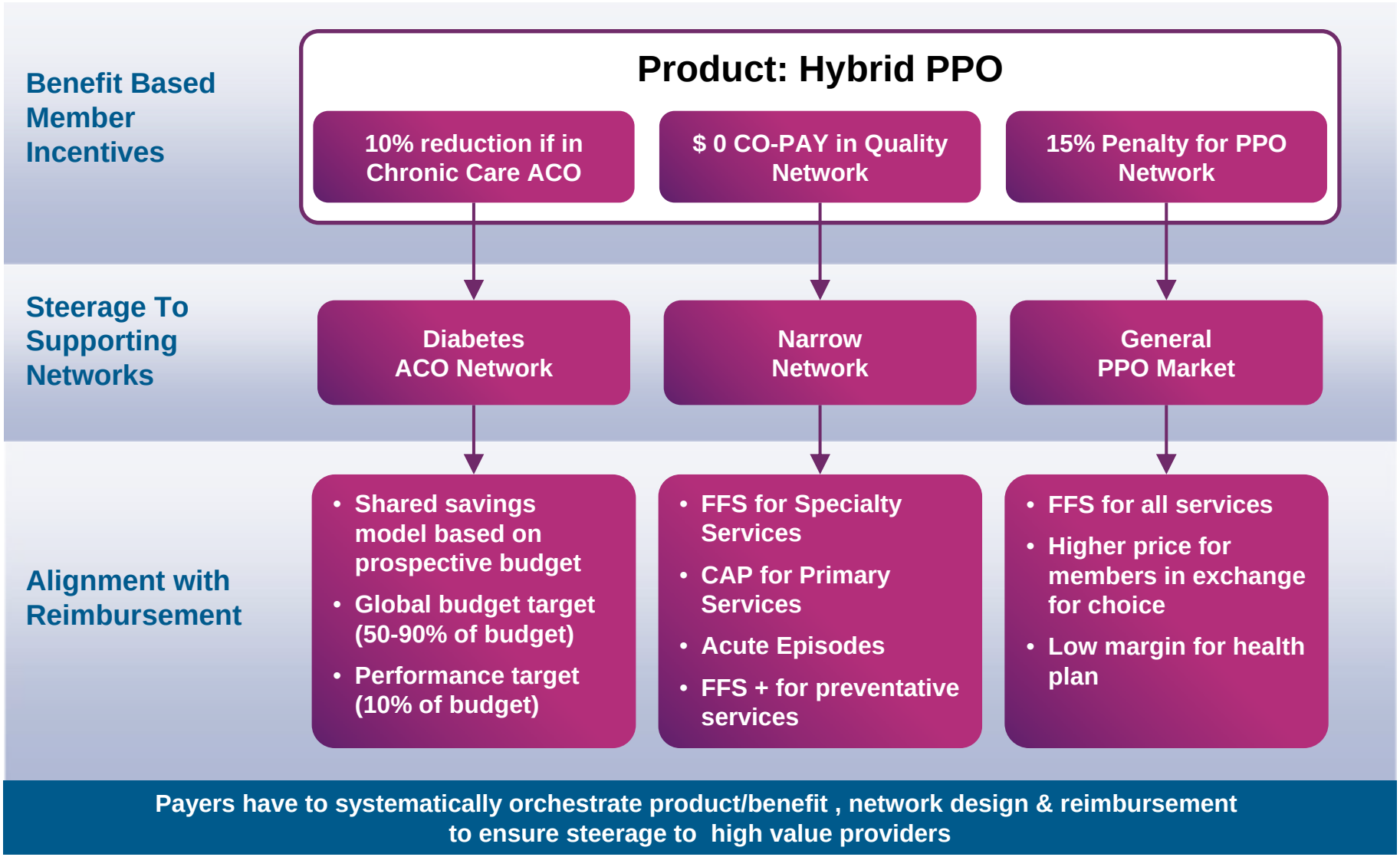
Diabetes medical home with enhanced reimbursement for specific services, and reimbursement for non-physician and non-office services

Reimbursement Policies

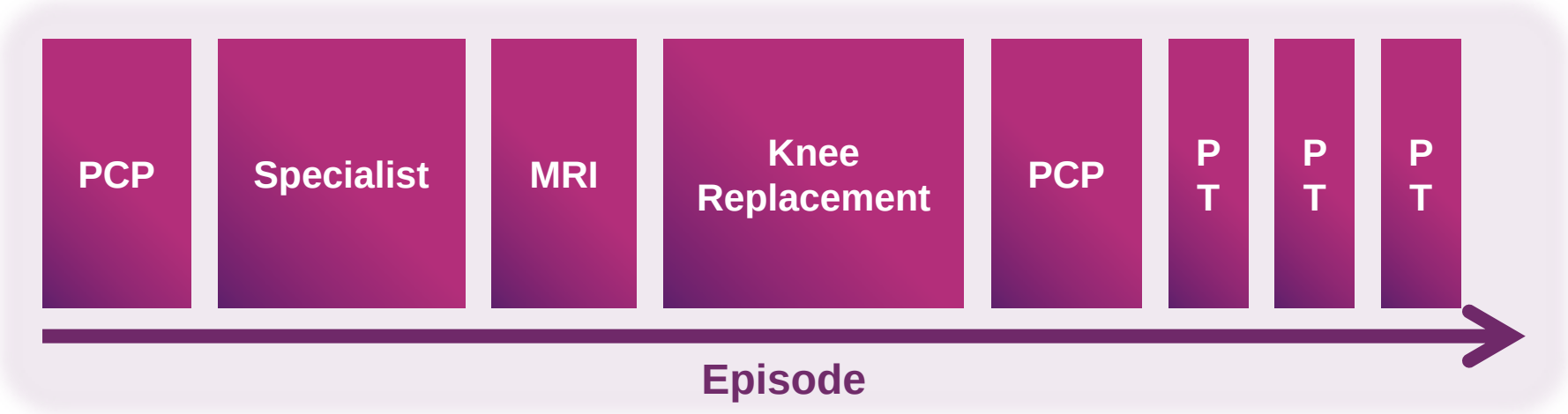
- **Global Payment for Diabetes Services Provided within Medical Home**
- **FFS for Diabetes Testing Supplies; FFS if member covered under PPO and Medical Home**
- **Partial Capitation for Referrals to Cardiologist for Hypertension**

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

Align network design



Create benefits complementing reimbursement model



FFS: 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

FFS PPO- standard deductible, % after	CDHP, Episode- HRA covers $100, 100% covered thereafter	Episode PPO- $100 flat fee for episode

Set up contracts

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.

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

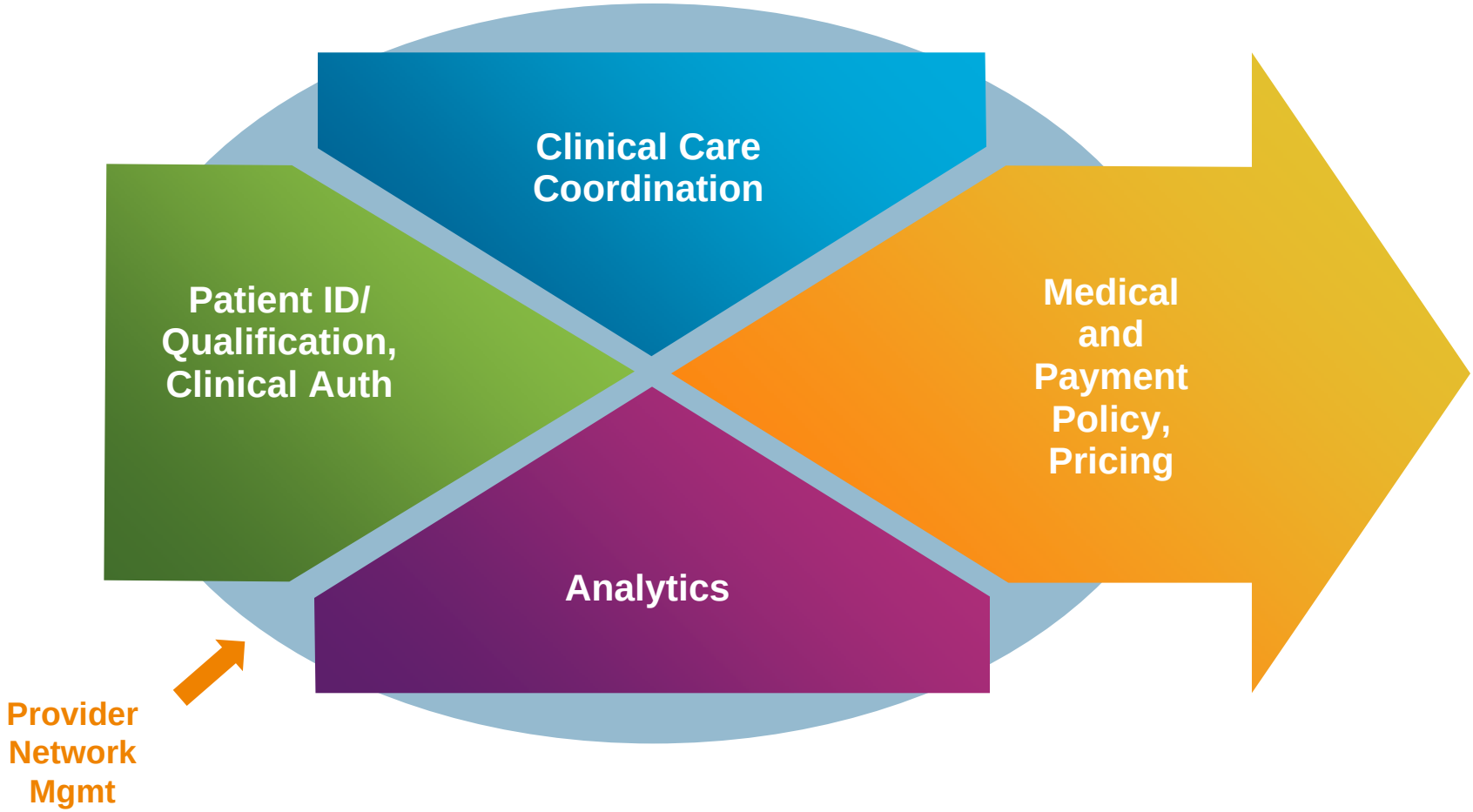
Leverage conditional logic on top of FFS reimbursement

These integrated and aligned systems must:

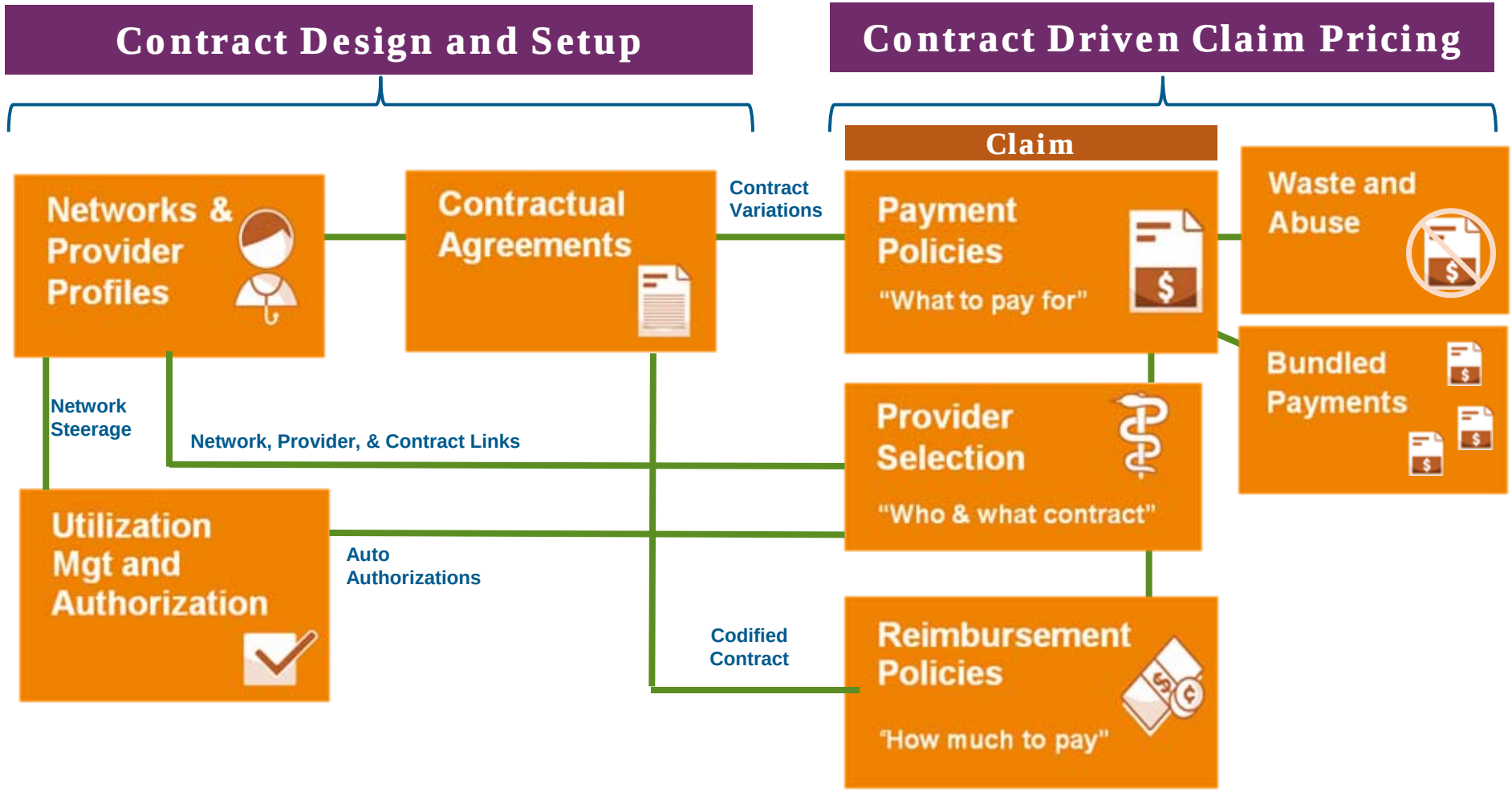
- Reduce manual interpretation & intervention
- Synchronize medical policy, payment policy, network design, and benefit design
- Apply hybrid and overlapping reimbursement policies
- Adjust reimbursement rates based upon member attribution to products, programs, and providers
- Model impact of new network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

Value Based Reimbursement

Five Core Competencies



Intelligently automating the contract to payment is critical to achieving the required efficiency



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

CBO projections 2/13

ACOs are HERE.

14%
now receive their care through an ACO.

488
ACOs are in operation, yet the future remains unclear.

9 *of* 32
pioneering ACOs opted out after seeing no projected cost savings.

20%
of all reimbursements are NOW value-based.

Administrative costs continue to soar

6,000+
Patient Centered Medical Home practices in operation TODAY.

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

http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx
http://www.ncqa.org

MHS Market Economics and Intelligence

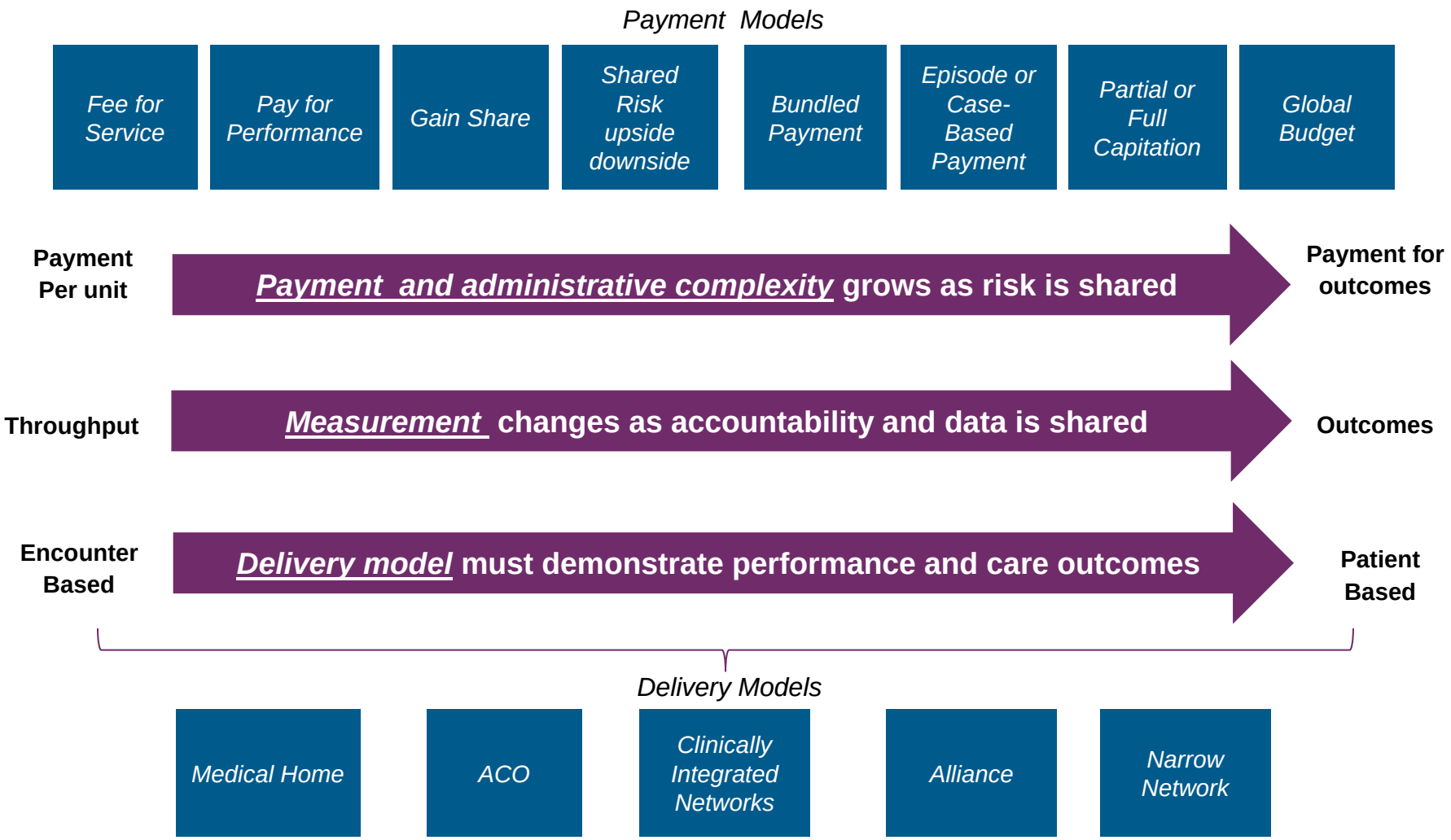
Providers are hesitant as traditional programs require expensive, manual resources

Payer Programs	Provider Involvement
Utilization Management	• Too much time spent requesting authorizations and/or reimbursement
Case & Disease Management	• Need care coordination tools • Need decision support tools
Network Referral Programs	• Lack of transparency
Complex Benefit Designs	• Struggling with administration
$74B spent annually[1]	$31B spent annually[2]

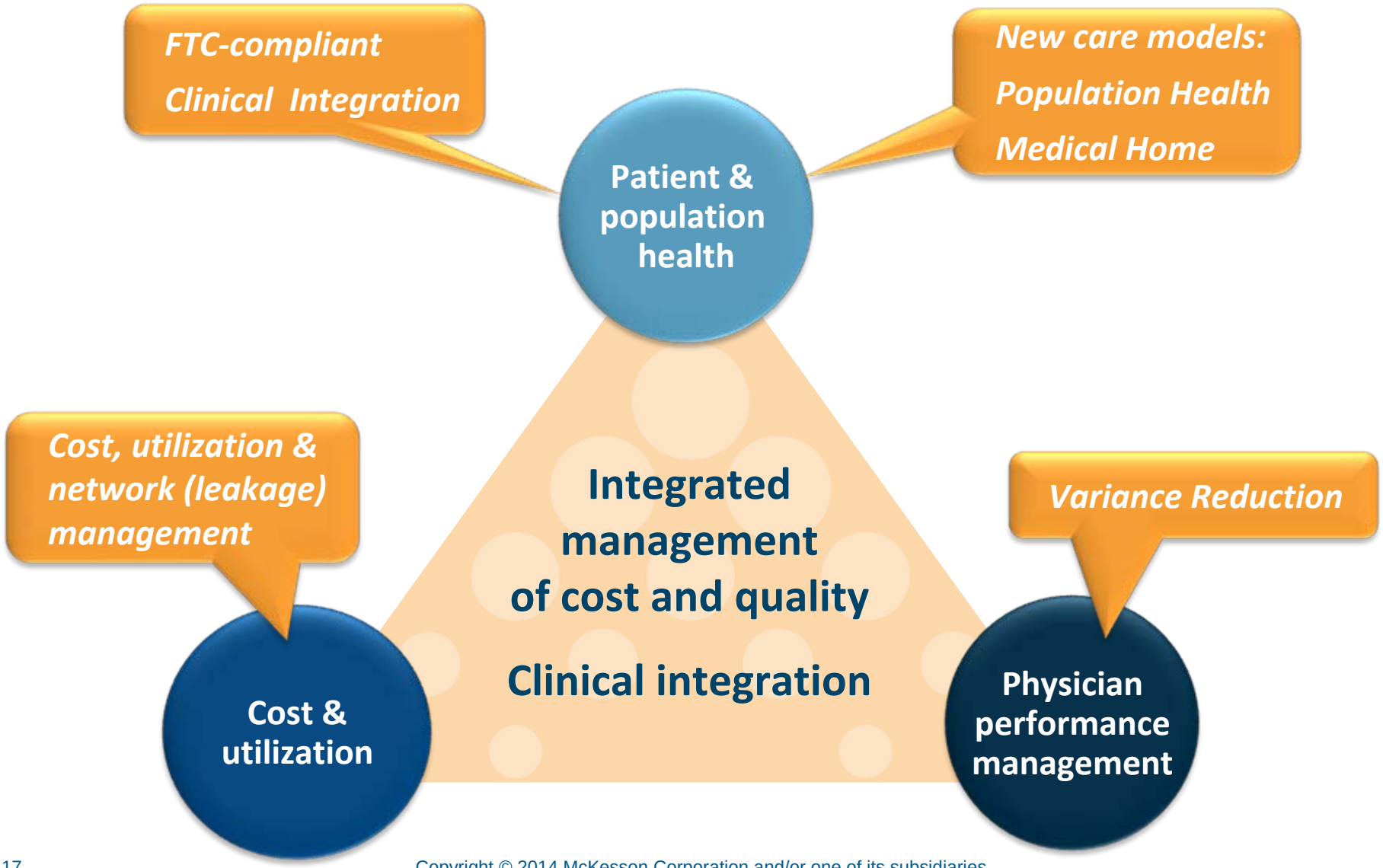
[1] Sherlock Expense Evaluation Report, BCBS Edition, 2010. *Calculated as average administrative costs as a percentage of premium dollars.*
[2] Health Affairs, What does it cost physician practices to interact with health insurance plans?, May 2009

Value Based Care Spans Current and Future Models

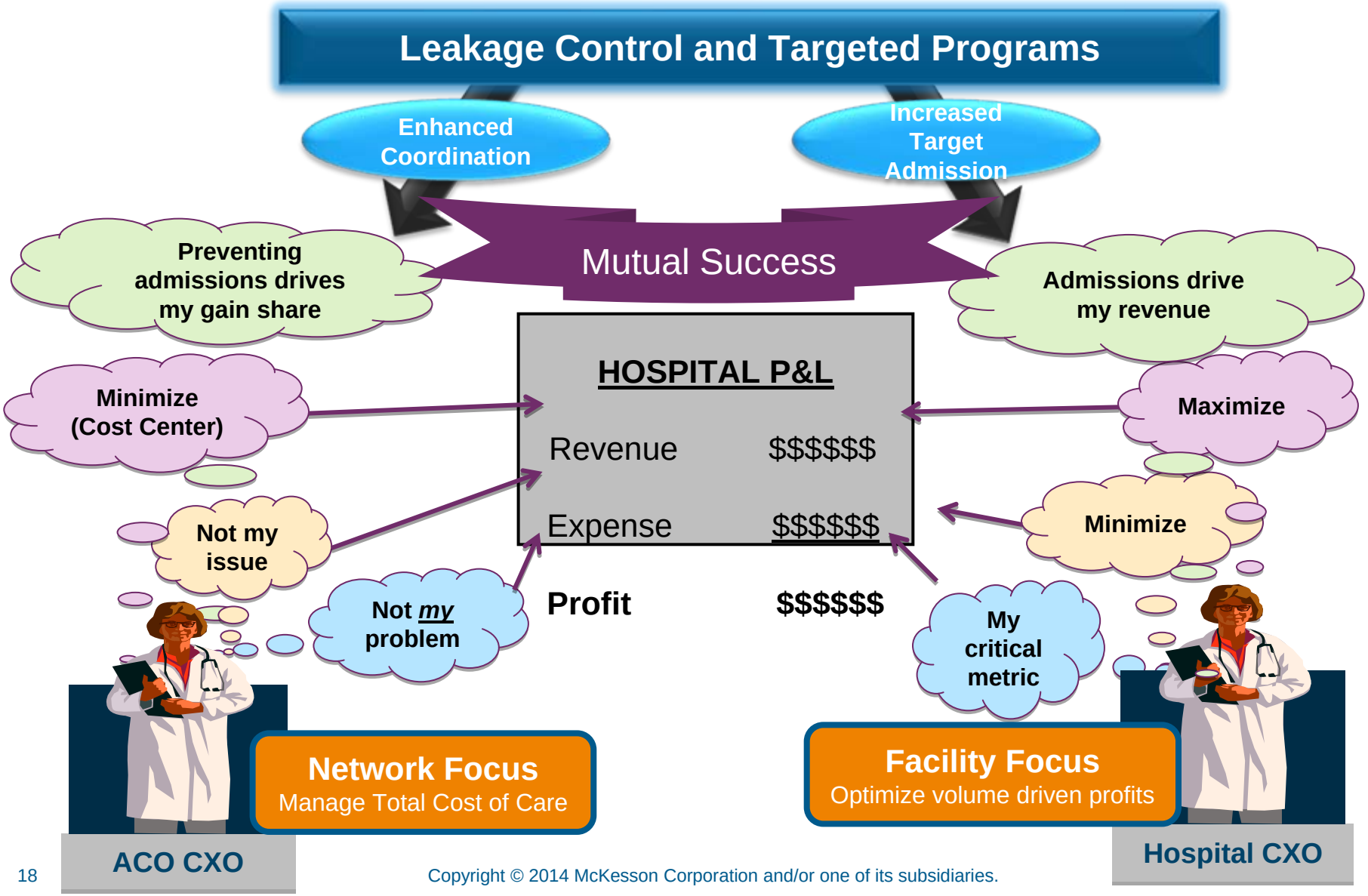
New payment & delivery models in use today create administrative complexity



ACO Success – Multiple Strategies



Success Requires Paradigm Shift



Value based transformation

Focuses on value based delivery & performance

MEASURE

ADMINISTER

Value Based Payment

Value Based Shared Scorecard

MANAGE

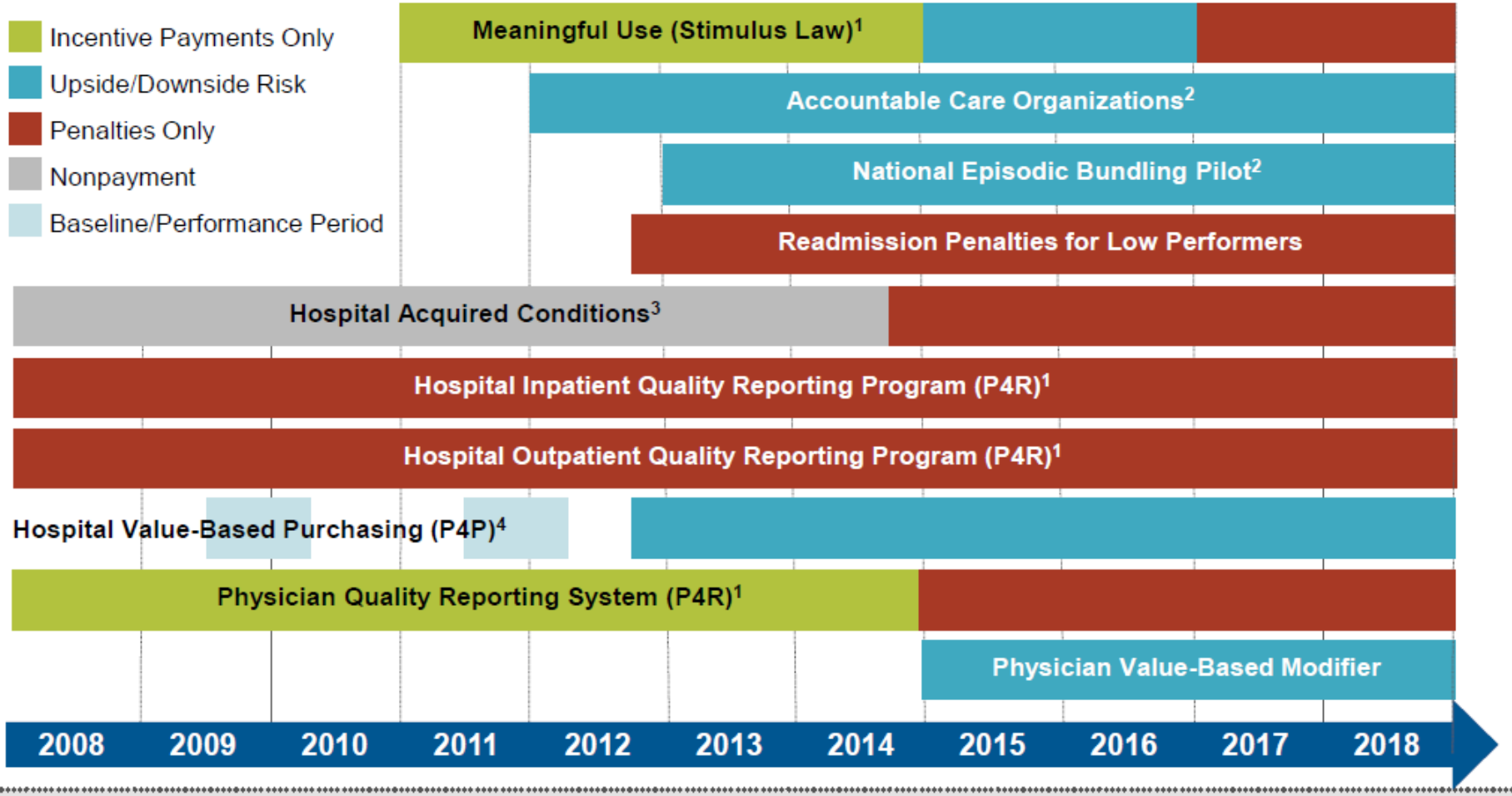
Value Based Delivery

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



Source: Centers for Medicare & Medicaid Services
1. Program is voluntary, but penalties are/will be in place for nonparticipants; 2. Program is voluntary; 3. Nonpayment for Hospital Acquired Conditions (HACs) began in 2008; HAC penalties of up to 1% of Inpatient payments begin in Fiscal Year (FY)2015; 4. The Hospital Value-Based Purchasing Program (VBP) begins in FY2013 by affecting payments for discharges occurring on or after October 1, 2012. The Baseline period for the program was from July 1, 2009 to March 31, 2010; the Performance period for the FY2013 program payment determination is from July 1, 2011 to March 31, 2012. The ACA mandates that the Secretary develop Value-based Purchasing plans for skilled nursing facilities, home health agencies, and ambulatory surgical centers

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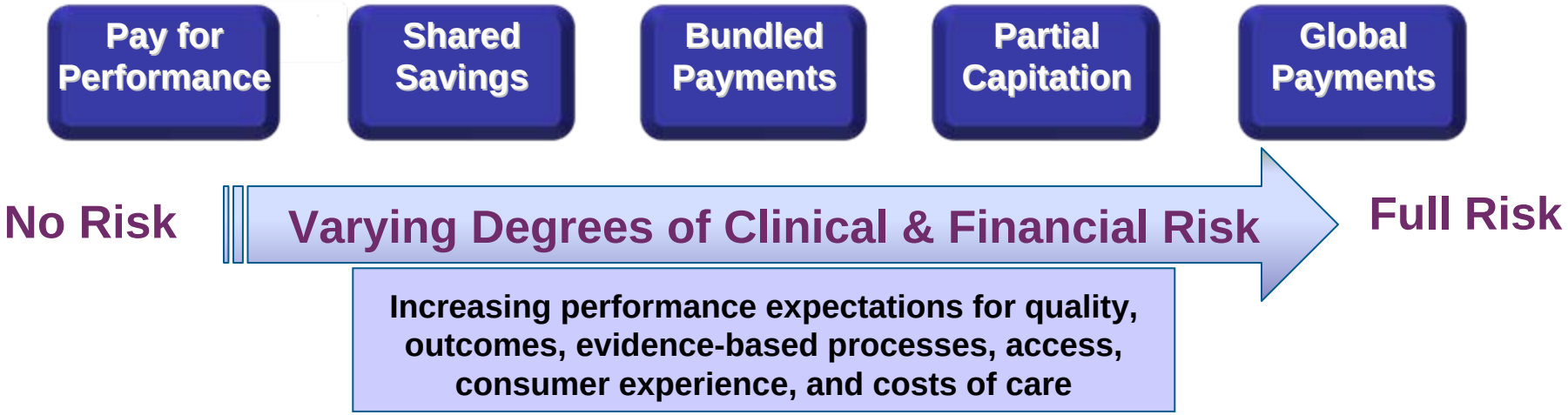
VBR Payment Models Spectrum

Shift from paying for volume to paying for value

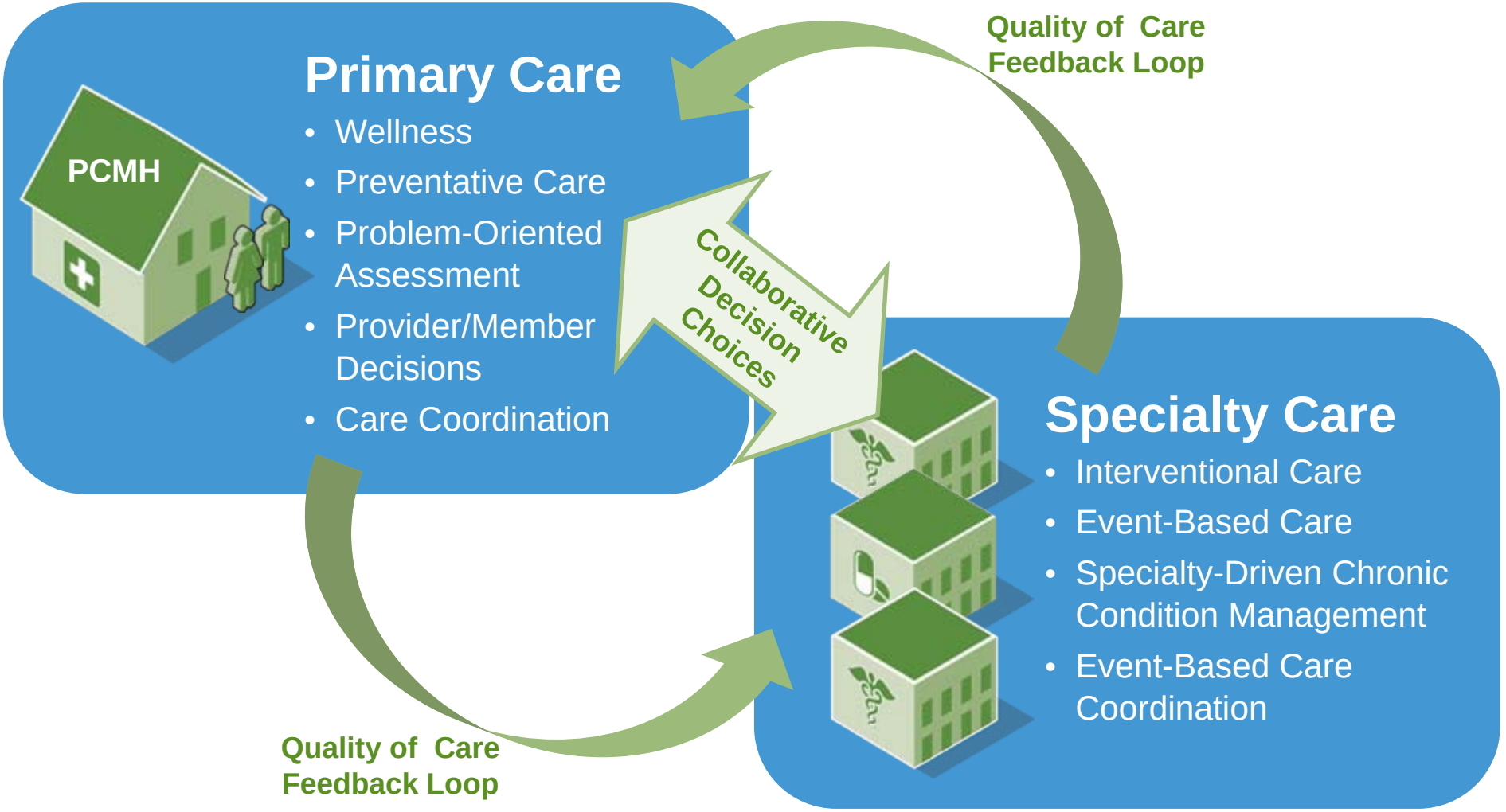


Keys to Success for the ACO

- 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

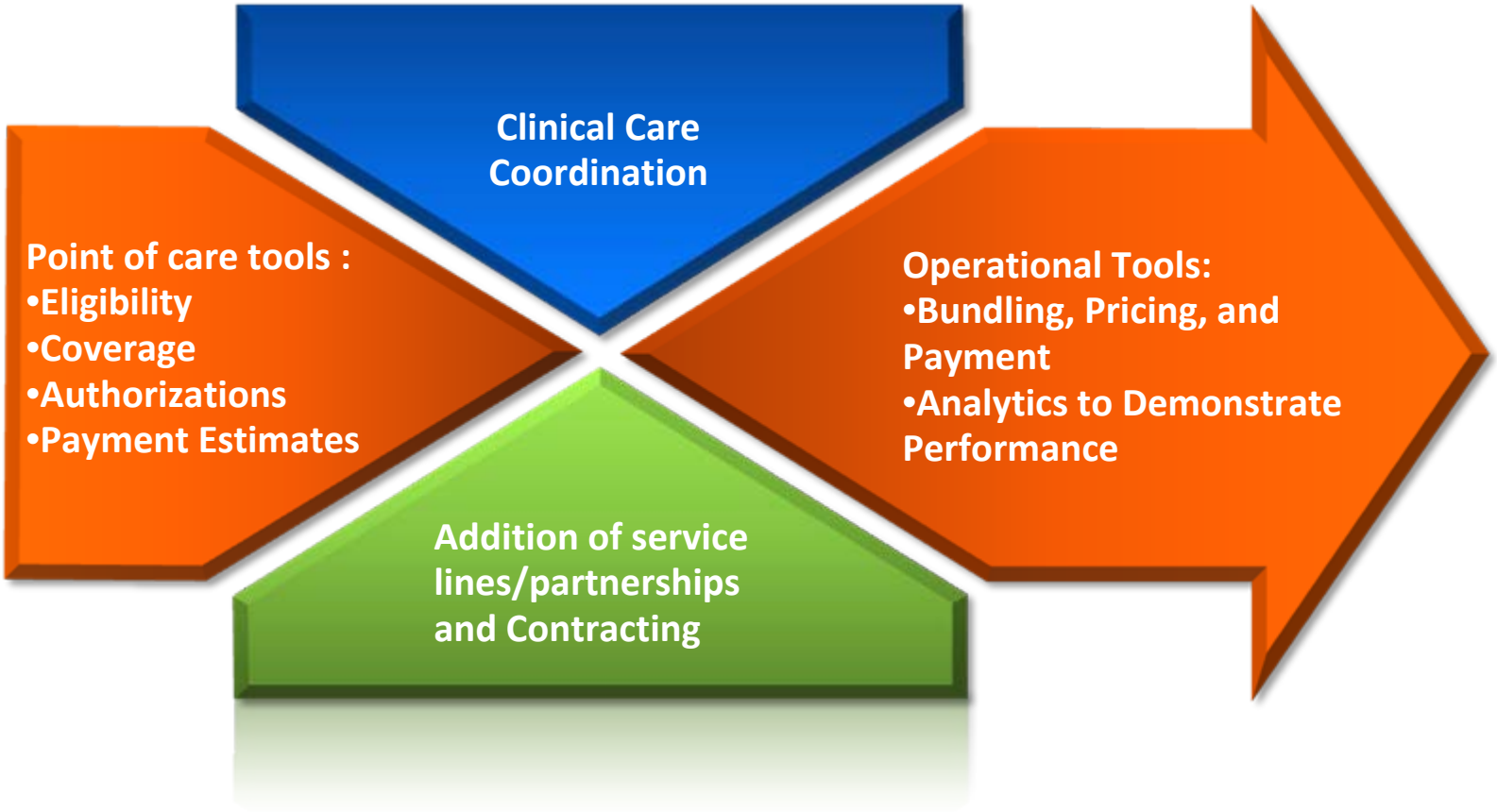
Blending PCMH Models and Bundled Payments

Seamless Primary and Specialty Care

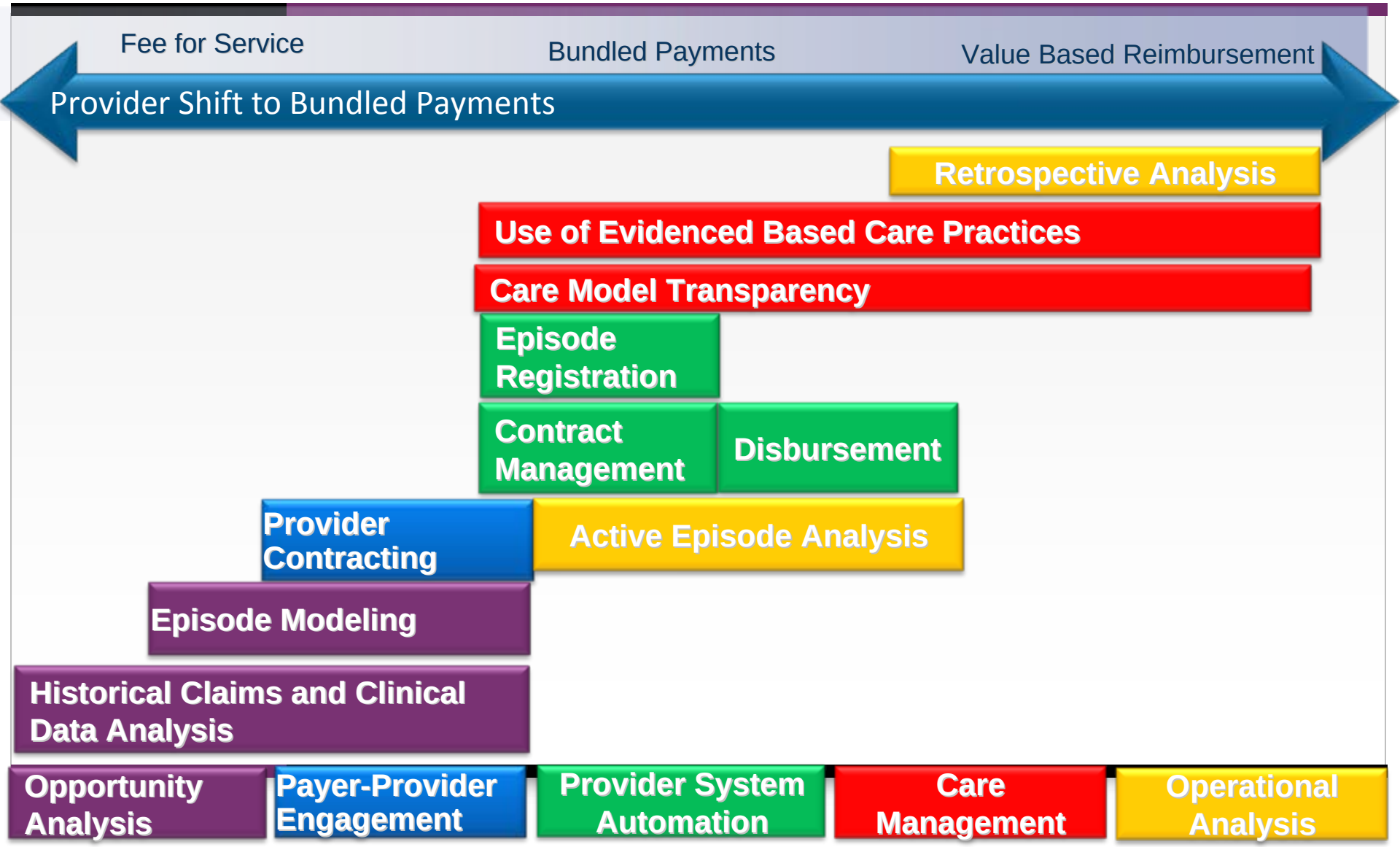


Automation Key to VBR Survival

Core Competencies Needed



Bundled Payment Automation for Providers



Questions