NEW CHALLENGES
NEW SOLUTIONS

The New Risk Bearing Providers

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TRIZETTO

TriZetto Market Position

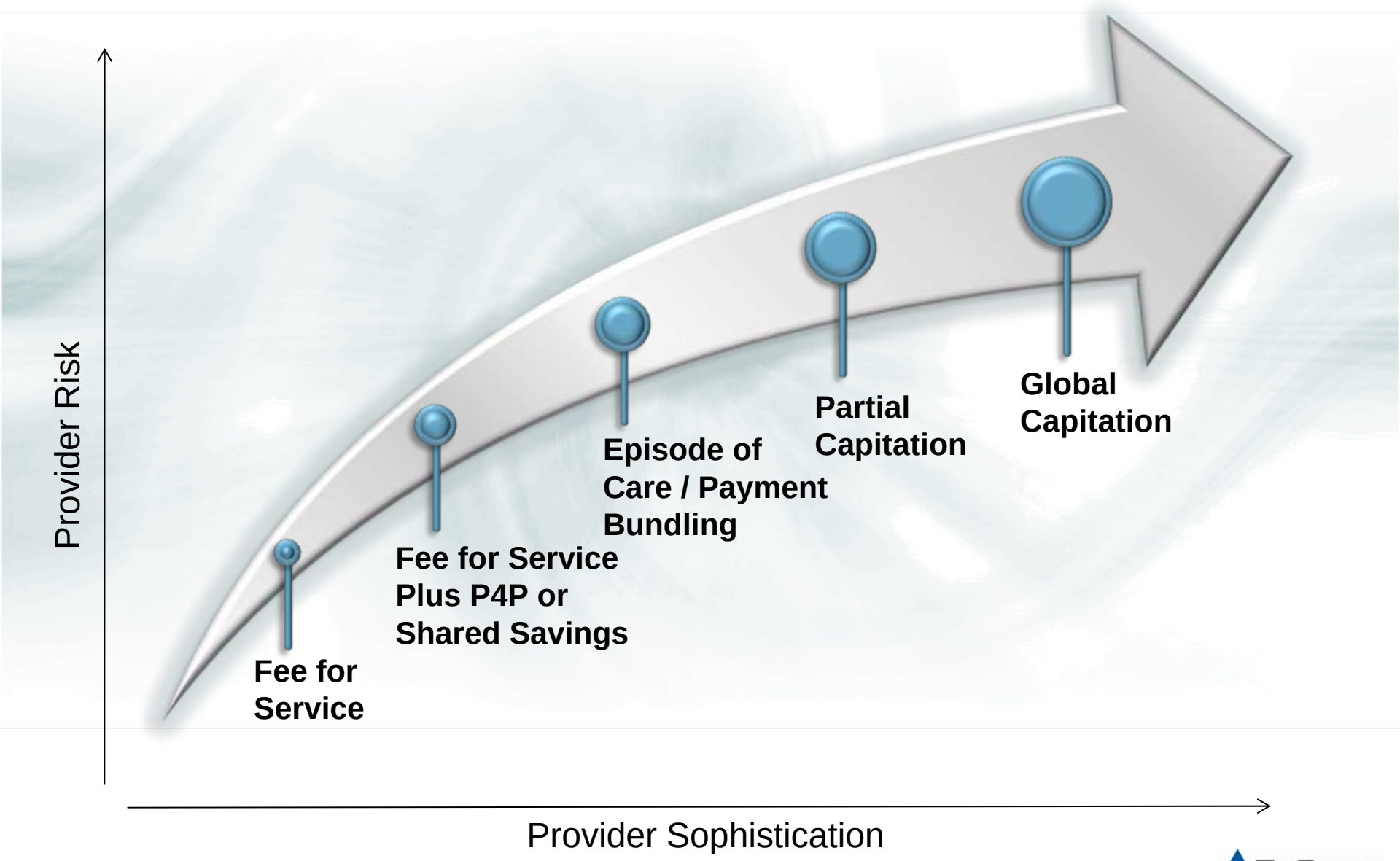
350 Payer organizations
representing over
180 MILLION CONSUMERS

200K Physicians
representing over
400 PRACTICE MANAGEMENT/ EMR SYSTEMS

Processing
5 MILLION
Transactions per day
among

- PAYERS
- PROVIDERS
- CONSUMERS

Alternate Payment Methodologies (VBR)
A Continuum of Provider Risk



New Risk Bearing Providers

Hybrids Between Payer and Provider

All are established providers looking to develop new business models

None are payers today or have been taking any risk

Moving far beyond shared savings plans

New models require new ability to process (not really adjudicate) claims

All are leveraging their areas of strength as a provider (ability to deliver value)

All are winning the "land grab" among providers to determine management control

Three Examples

Selling Episodes of Care

- Provider builds their own network and sells episodes of care to a payer, taking carve-out risk
- Addressing administrative barriers for both payer and providers wanting to use episodes of care

Managing the Delivery of an Entire Specialty Area

- UM Provider takes control and the complete financial risk for all labs for a payer

Creating a Provider Owned Health Plan

- What is new about the providers creating their own plans

Selling Episodes of Care

Access MediQuip (AMQ) is a well-established company brokering medical implants to hospitals

Rather than passively waiting for margin to be compressed as hospitals and surgeons manage their own risk, AMQ decided to be proactive and take the risk themselves

AMQ occupies a middle position between payer and providers

- AMQ will look like a payer to the facilities, surgeons, and other providers they contract into their new network
- AMQ will look like a provider to the payer, taking episode-based carve-out risk

AMQ Sells Episodes to a Payer

Contracting with Providers

- Must build its own network
- Includes facilities, surgeons, anesthesia, outpatient PT, etc.
- Will cover all related services for members of a payer getting various procedures

Contracting with Payers

- Accepting carve-out risk for all members getting various procedures
- Must administratively and financially assure the payer that the payer will not pay for the same service twice

AMQ Sells Episodes to a Payer

Clearinghouse

- Facility: Payer ID= AMQPayer Billed Amt = $5,000
- Anesthesia: Payer ID= AMQPayer Billed Amt = $2,000
- Surgeon: Payer ID= AMQPayer Billed Amt = $3,000
- AMQ (Device): Payer ID= AMQPayer Billed Amt = $1,000

Facility

Anesthesia

Surgeon

AMQ (device)

AMQ Administration

Step 1
Providers send claims to clearinghouse, routed to a special payer ID

AMQ Sells Episodes to a Payer

Facility

Anesthesia

Surgeon

AMQ (device)

Clearinghouse

Facility: Payer ID= AMQPayer
Billed Amt = $5,000

Anesthesia: Payer ID= AMQPayer
Billed Amt = $2,000

Surgeon: Payer ID= AMQPayer
Billed Amt = $3,000

AMQ (Device): Payer ID= AMQPayer
Billed Amt = $1,000

AMQ Administration

Claims Exchange

Step 2
AMQ takes pre-adjudication claims off Clearinghouse using Payer ID

AMQ Sells Episodes to a Payer

Facility

Anesthesia

Surgeon

AMQ (device)

Clearinghouse

Facility: Payer ID= AMQPayer
Billed Amt = $5,000

Anesthesia: Payer ID= AMQPayer
Billed Amt = $2,000

Surgeon: Payer ID= AMQPayer
Billed Amt = $3,000

AMQ (Device): Payer ID= AMQPayer
Billed Amt = $1,000

AMQ Administration

Claims Exchange

NetworX Payment Bundling

Step 3
AMQ pre-prices claims based on the role in a complex epiode

AMQ Sells Episodes to a Payer

Facility

Anesthesia

Surgeon

AMQ (device)

Clearinghouse

Facility: Payer ID= InsuranceCo
Billed Amt = $0

Anesthesia: Payer ID= InsuranceCo
Billed Amt = $0

Surgeon: Payer ID= InsuranceCo
Billed Amt = $0

AMQ (Device): Payer ID= InsuranceCo
Billed Amt = $10,000

AMQ Administration

Claims Exchange

Step 4
AMQ send claims back to clearinghouse, priced to case rate. Payer processes claims, paying case rate and retaining encounter data

AMQ Sells Episodes to a Payer

Facility

Anesthesia

Surgeon

AMQ (device)

InsuranceCo Pays

Facility: Payer ID= InsuranceCo
Billed Amt = $0

Anesthesia: Payer ID= InsuranceCo
Billed Amt = $0

Surgeon: Payer ID= InsuranceCo
Billed Amt = $0

AMQ (Device): Payer ID= InsuranceCo
Billed Amt = $10,000

AMQ Administration

Step 5
Insurance Co Pays
AMQ Global Case Rate

AMQ Sells Episodes to a Payer

AMQ Administration

Claims Exchange

QikLink

Facility ← Paid directly from AMQ Paid Amt = $3,000

Anesthesia ← Paid directly from AMQ Paid Amt = $2,000

Surgeon ← Paid directly from AMQ Paid Amt = $4,000

AMQ (device)

Step 6
AMQ pays associated providers their fee-for-service as contracted

Value AMQ Provides…

…to the Providers who join the Network:

- Volume / steerage
- Only minor change to administer program
- No member responsibility to collect
- No risk / challenge to hospitals trying to manage device cost

…to the Payer:

- Reduced medical costs
- No technical risk; cost per case now set
- No need to add complex IT software to administer claims into episodes
- Improved quality and patient satisfaction

AMQ Administration Requirements

Contracting with providers and payers

Managing UM and eligibility

- Handling eligibility changes
- Coordinating the status of the patient between the rendering providers and the payer

Collecting member responsibility

- Amount of member responsibility varies member by member and is unknown until InsuranceCo processes the Case Rate payment

Handling claims

- Process claims from providers, 835, EoB, 1099, 276, etc.
- Handling received claims that should not have been sent to AMQ
- Handling needed claims that went straight to payer by mistake

Process Summary

Administrator as a Rental PPO Network

- Obtain provider claim from clearing house
  - Send X99 response
  - Edit X12 format
  - HIPAA audit
- Ensure the claim belongs in the bundle
- Price the claims into what Administrator's customer (the actual payer) should pay (typically zero)
- Submit claim to customer for encounter data

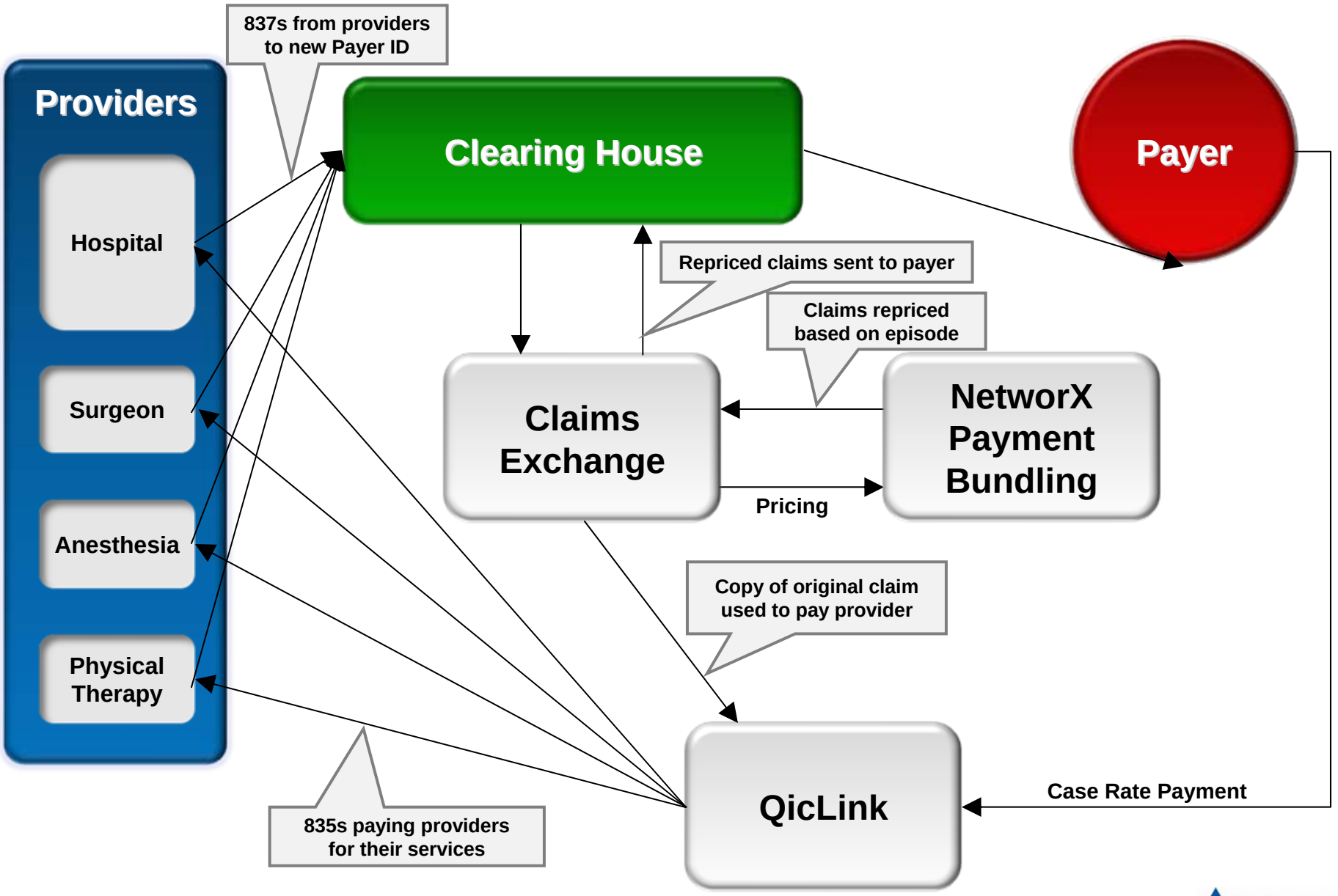
Administrator as a Provider

- Submit a claim for the episode
  - Use Administrator's NPI
  - May be an edited version of a claim from a provider
- Receive back the claim remittance
- Determine member responsibility and it's collection

Administrator as a Payer

- Accept claim from a provider
- Check the claim to see if it should be paid
  - Member match
  - Provider match
- Price the claim based on contract with provider providers
- Hold payment until ready for release
- Release payment, create EoB, 835, 1099, etc.

Episode Carve-Out Administration



Managing the Delivery of an Entire Specialty Area

Established UM delegation company believes it can manage even better than status quo under different financial arrangements

UMCo: (fictional name)

- contracts with payer to accept carve-out risk for all lab services
- builds its own network using many (not all) of lab companies currently serving payer
- is also in a middle position
  - UMCo accepts and “processes” claims from providers in its network
  - UMCo generates claims to the payer and gets paid on a reduced rate schedule

Contracting with the Payer

UMCo negotiates with payer for all lab services

- UMCo becomes the sole provider for labs accepted by payer
- Payer informs all existing lab companies to recontract with UMCo if they want to keep providing services
  - It is necessary that Payer have a dominant position in the markets
- UMCo contracts with payer as a provider, accepting a discounted fee schedule
- UMCo also agrees to reduce overall medical spend on labs

UMCo takes over UM function for lab services

- Since UMCo is the one receiving claims, they are now the entity to process UM and any clinical edits

Contracting with the Provider

UMCo negotiates with providers

- Leveraging payer's market power, UMCo signs up providers at even lower rate schedule
  - Not all providers will sign
- Providers also agree to new UM rules and processes
  - Designed to address inappropriate use of high-cost labs, such as unwarranted variations in genetic testing
- Providers do eligibility check and UM with UMCo; claims are sent to UMCo

Value UMCo Provides....

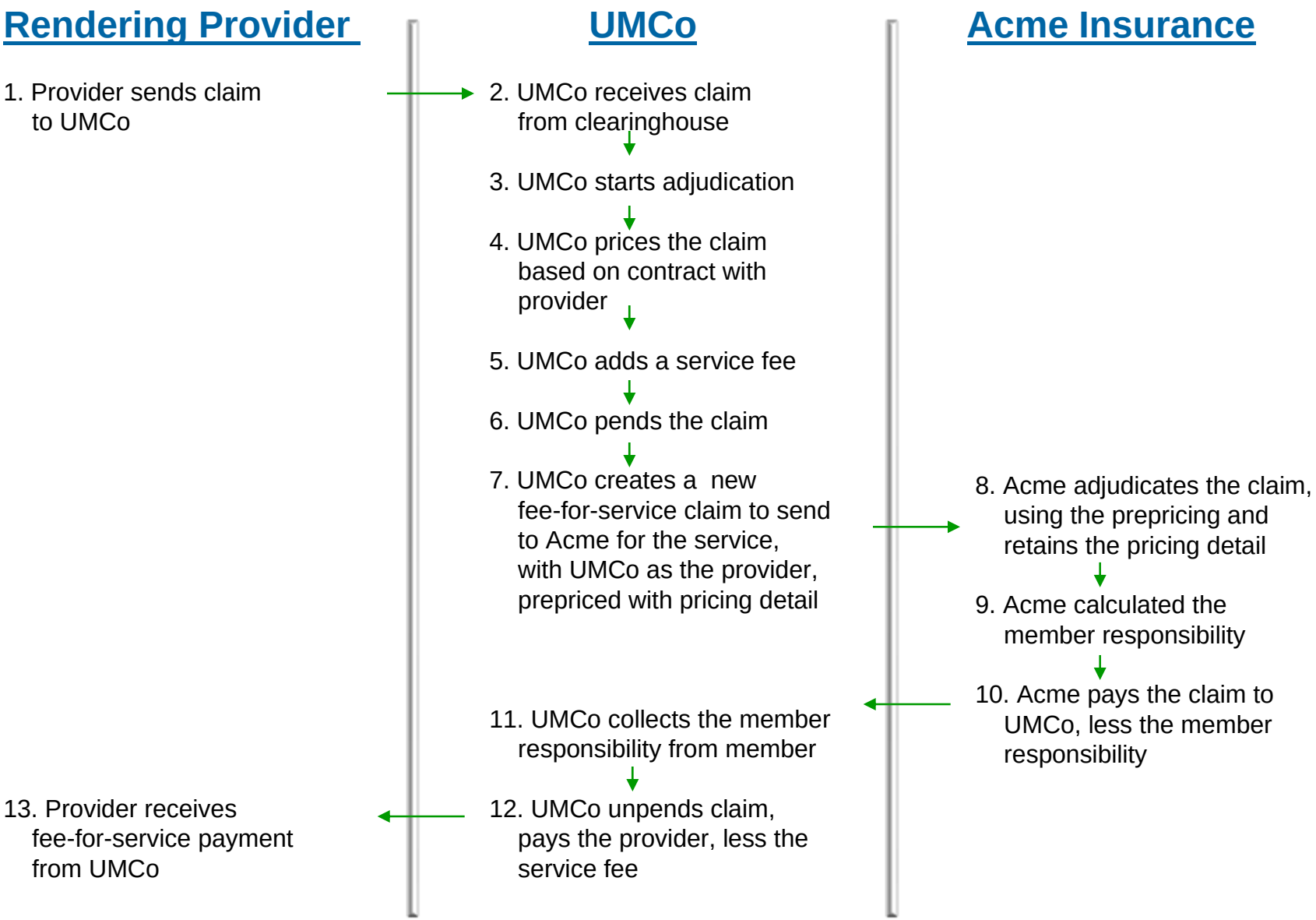
...to the Providers who join the Network:

- Volume – if they do not contract with UMCo, they lose a large number of patients
- Financial incentives for compliance
- No member responsibility to collect

...to the Payer:

- Reduced medical costs in painful area
- Reduced UM administration
- No need to add complex IT software

UMCo Claim Handling



Understanding the UMCo Opportunity

1. **Not traditional population-based carve-out risk – UMCo is sending FFS claims to the payer**
2. **UMCo is acting as both a delegated UM entity and an "services aggregator"**
   - Contract with payer lowers rates
     - UMCo lives on margin it can negotiate with a slightly narrower network
   - Incentive contract with payer to reduce unwarranted utilization
3. **Why it works now**
   - Member willingness to accept a slightly narrower network
   - Payer frustration in addressing misutilization by providers
   - Confidence UMCo has in its ability to address unwarranted variations in utilization

Creating a Provider Owned Health Plan

With CMS ACO you can:

- Comply with significant new process and requirements
- Try to reduce medical costs (fewer heads on beds?)
- Receive a small portion of overall compensation in shared savings revenue

With your own commercial insurance company you can:

- Find a good use for capital
- Leverage your high-value brand
- Try to reduce medical costs
- Build a high-value network with providers you select
- Keep all of the savings/profit from success in reducing medical costs

"I love the A and the C, but the O scares me" - *Insurance Company CEO*

TriZetto Health System Clients

TriZetto supports 36 Hospital Owned Clients processing 5.3M Lives

TriZetto serves payers, providers and consumers driving efficiency and effectiveness to improve the business of healthcare and promote better health for everyone.

What Has Changed?

In the Past	Now
Basis of plan was hospital as employer with self-funded employees needing care	Participation in Duals, Medicaid expansion, Medicare Advantage
All about volume as a provider (maximize heads on beds)	Somewhat about fee for value (still struggling with heads on beds)
The provider owner wants profit and financial performance	The provider owner wants help transforming the provider's operations into fee for value (use my plan to prepare me for CMS changes)
Grow slowly	Grow very fast
Most failed or were acquired	Most will fail or be acquired

Why is this Hard?

Outside of owner issues, not really that hard

Many consulting or systems companies helping with the launch of many new health plans

Culture shift for the provider / owner

- Transition from volume to value
- Transition from hospital system-centric to entrepreneurial
  - Central purchasing buys a core system like buying soap
  - Hospital leadership opposes contracting with providers not owned by hospital
  - Hospital IT expects everything to rotate around hospital EMR
- No real understanding of risk…

Payment Reform is Not Magic Pixie Dust

If Payers Can Manage Risk, How Hard Can It Be?

Important Message on Accepting Risk

First: **determine what risk you can manage**

What are the unwarranted variations of care that exist?	**Implantable pricing**	**LOS and complications for mildly diabetic patients receiving surgeries**
What clinical interventions can you make to address them?	**Reduce vendors and use a "first pull" approach**	**Implement tight glycemic control peri-operatively**
What other providers must align with you to achieve this?	**Ortho surgeon, cardiac surgeon, interventional radiologist**	**Anesthesiologist, endocrinologist**
How will you measure and manage the risk and your changes?	**Track physician compliance with first pull and vendor policy; track implantable costs directly to patient**	**Intensive tracking of glucose levels; measure LOS, step-down utilization, and post-op infections on 100% of patients in the program**

…only then should you contract with a payer

But I Have an EMR (EHR)....

- **Forget about meaningful use…**
- **Is your use meaningful?**
  - Does it tell you which of the patients you see are in the risk group?
  - Would you even notice?
    - How is care different if a patient is in your risk group?
  - Does it know the evidence based guidelines for a patient?
    - Do you follow these today?
    - Are you relying on the “magic pixie dust” effect to make this change?
- **How will your workflows change for patient in new payment methodologies?**
  - Do you know how to do that?

You are Now a Payer

- **Payers accept technical and incident health care risk and manage it**
- **Payers can - can you?**
  - Acquire members (attribution)
  - Take on only risk they know and understand
  - Manage risk (UM, benefits, etc)
  - Build networks
  - Make payments

Conclusion

These are all new opportunities being created by:

- Healthcare and payment reform
- Massive shift in Line of Business in the payer world
- Transition from volume to value

New companies filling a vacuum

They are first to market to address needs resulting from change

All about Provider-to-Provider relationships

- The days of Any Willing Provider are ending
- Who will do the managing and who will be an expense others are managing

These all translate new value to the industry

The whole point in all three is how to reward providers willing to take risk successfully

Questions?

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