Cognizant

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Making Value-based Technology Work For Your Organization

March 2017

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Imagine You are a CTO……

What Do You Need to Know to Support Value-Based Programs?

Tell me the requirements.

•What changes do we need to make? What new capabilities do we need?

•New Data Sources and Integrations

•Changes to Processing Workflows (care delivery, revenue cycle, etc)

•New Analytics

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Different Types of Payment Reform

How a CMO or VP- Provider Thinks…

- Accountable Care Organization
- Coordinated Care Organization
- Value Based Reimbursement
- Center of Excellence
- Patient Centered Medical Home
- Specialty Care Medical Home
- Retrospective Payment Bundle
- Prospective Payment Bundle
- Alternate Quality Contract
- Physician Incentive Program
- Value Based Hospital Purchasing
- Pay for Performance
- Pay for Quality
- Partial Capitation

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Different Types of Payment Reform

Focus on Requirements, Not Program Names…

- Program names do not convey the change in technology and workflow required
- For example, all of the following are PCMH programs in operation
  - Fee for service plus a quality based bonus
  - Differential rate schedule for care delivered within PCMH
  - Differential rate schedule based on performance in pervious quarter
  - Retrospective episode of care for diabetes care
  - Shared savings on total cost of care
  - Shared savings on diabetes care
  - Partial capitation
  - Full capitation

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Administering Payment Reform for Payers

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Different Types of Payment Reform

How to Categorize Payment Reform Programs…

- What is the role of claim?
  - FFS payments continue based on the claim stream
  - Claims still flow, but FFS payments are replaced by something else

- Both types have significant impact on
  - Provider payment
  - Other operations within the payer enterprise
  - Operations outside the payer enterprise that create requirements for the payer

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Supporting Tomorrow's Business with Today's Technology

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Impact on Provider Payment

The most basic tasks of payment reform is to change the way providers get paid

Changes to FFS process

- Pricing: New logic to determine allowed amount or rate schedule
  - May require paying claim at $0 to retain encounter
  - May require paying a multi-provider global case rate (prospective payment bundle)
  - New complex methods of paying a claim based on other claims or other data
- Accumulators: New logic for impacting accumulators
- Provider Lookup: New metadata about providers and relationships among providers
- Member Lookup: New relationships between members and providers far more complex than simple PCP assignment
- Reversals: Program operations change a payment long after processing – far more often

New "Capitation" Requirements

- New and more complex forms of typical capitation
- Plus, more complex methods for calculating PMPM payments on top of FFS, calculated externally
- Configuration updated far more often (monthly)
- A member can be included in multiple and changing populations that do not follow group lines
- Configuration management extremely difficult due to variance and complexity of new rules

The basic problem: to pay a provider, a claim and a contract is no longer enough

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Impact on Other Core System Functions

Payment reform is not limited to payment processing

Member Responsibility

- If claims paid differentially, what logic applies to benefit calculations?
- How to link new benefit payment logic to new provider payment logic?
- How to manage one payment reform program across many benefit designs
- Payment reform drives complexity and uncertainty that will greatly reduce payment collection at point of care

Product Design/Steerage/Transparency

- Proliferation of product designs based on payment reform
- More flexibility and modularity needed to model product designs
  - Cannot stay a BI / SAS exercise forever
- Greater capabilities to drive site of care selection based on payment reform
  - Provider even more important than payer

Clinical Edits, UM, and Authorizations

- Payment reform may require conditional processing of these features, based on program design
- For most plans, requires linkages among functions that are modular today

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New Functionality Needed

Provider payment that cannot be done by the core system

Shared Savings Reconciliation

- Spreadsheets are not a replacement for the attributes of a core system: workflow, auditability, integration
- Requires ongoing update and adjustment, not just a series of one-time calculations
- Increased transparency with providers (data & calculations) will be required over time
- If 10%, 20%, 50% of your spend happens here, workflow systems are needed that look like a core system

Population-Based Payments

- The claim is a fundamental atomic artifact in a payer enterprise
- Over time, payers are making increasingly larger payments for population care that is not directly connected to a claim
  - This breaks things that now work fine

ASO-Based Payment Requirements

- What logic to allocate a non-claim payment across multiple ASO customers?
- What administrative process to automate the “distribution” of non-claim payments back into the core system (and if not there, where?)
- Increased (and far more focused) transparency with ASO customers on the value of paying for care that was not delivered

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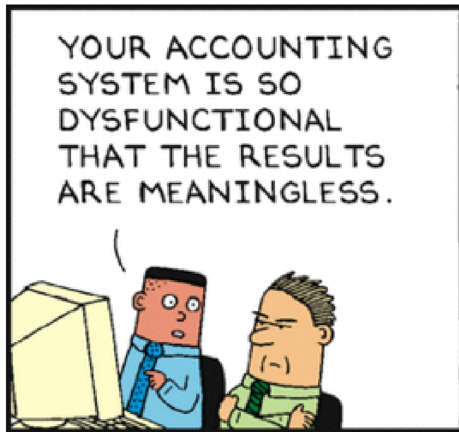
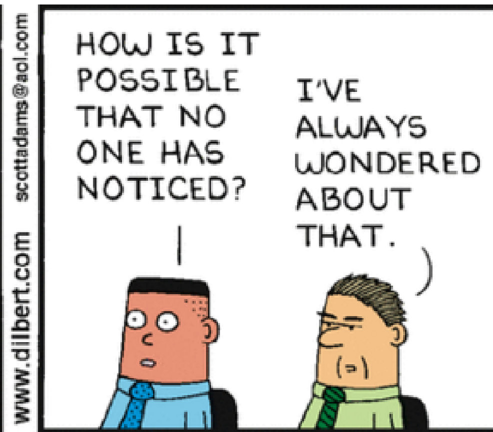
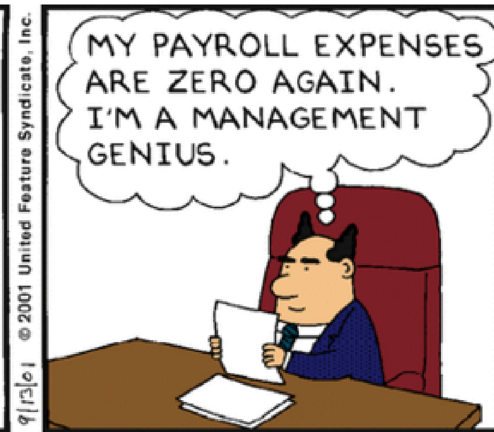
Who Knows What Was Actually Paid?

Thursday September 13, 2001







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New Sources of Truth on Provider Payment

Over time, these pain points only get worse…

The hard choice

- Make payments outside the core system
  - Lose the clear source of truth, break feeds to finance, make CSR and EDW either incomplete or far more complex, etc.
- Force non-claim payments back into the core system
  - Dummy claims, dummy members, and dummy providers makes it hard to have a smart process
- Only allow payments that can be natively processed by the core system
  - Legacy IT investment impeding the future of the company; brings significant increased complexity

Other considerations

- Payments to ASO or PCMH NewCo hard to relate to actual providers
- FWA and credentialing much harder to support
- Some programs break performance metrics like physician vs facility spend

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New Provider Roles and Relationships

Even if you view the provider as a vendor, things are now far more complicated

Multiple provider personas in a core system are not new …. But the volume and degree are much larger with payment reform

There are two areas of metadata now growing:

- New role of a provider entity:
  - A single physicians might bill as part of 5 – 10 different provider IDs or even tax IDs
  - NewCo organizations can represent aggregations of numerous providers, masking a clear view of basic concepts like specialty or even par / non-par
  - Difficult or impossible to connect the activity of a single actual provider across multiple and blended entities (if you want to stop doing business with a specific hospital or physician)

- New relationships among providers:
  - Care delivery becomes formal and informal associations among providers.
  - You may or may not have these defined for you. They will change frequently over time.
  - These “overlay” networks can be subsets of actual networks or can bridge across networks
  - The number and complexity of these many: many relationships greatly increases
  - It will be increasingly difficult to treat the core system as the source of truth about providers and their relationships, but PIMS systems struggle with this problem as well

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Supporting Payment Reform for Both Payers and Providers

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Difficulties of Payers and Providers Working Together

Fine, we'll compromise. I'll get my way & you'll find a way to be okay with that.

someecards
user card

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Increased Demand on BI Capabilities

What organization has surplus BI capacity looking for something to do?

Other than the core system, the greatest IT impact of payment reform is the new demands created for BI support

- There is intensive BI activity before contracting that are poorly supported by legacy analytics tools
- There is intensive and ongoing BI activity after contracting to deliver ongoing visibility on performance and especially the reconciliation (or performance evaluation) process
  - This is only partially scalable or reusable over time

The number one complaint heard from executives managing payment reform is constraints on BI capacity

- Many departments have staffed their own BI within provider-contracting unit
- The areas of constraint are more than just availability or resources
  - Slow turnaround on requests
  - Cycle time when requesting a repeat of analysis with different terms
  - Lack of SME on the topics being addressed in payment reform programs
  - Lack of timely access to accurate data needed for quality performance evaluation

In many cases, BI-based approaches attempt to replace other requirements discussed here, but are neither scalable nor sufficiently accurate / contextual

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Payer Ability to Ingest Data from Providers

Point to point ETL for each provider cannot scale

Payment reform programs usually require data submission from providers

- Quality or performance results
- Clinical data
- Changes in provider organization

Existing data warehouse approaches seldom meet the requirements of payment reform

Existing software tools cannot effectively work with merged clinical and administrative data

- Clinical data requires context, unlike administrative data
- HIE (giant healthcare data library) approaches have not been successful

A primary barrier for payers is simply getting the data from providers

- Meaningful Use and closed system barriers
- Complexity of multiple end points, multiple interpretations of common formats, and over-reliance on CCDs

Some good news – once ingested, this data has multiple valuable uses

- HEDIS cost reduction, better CM/DM, reduce UM costs, better FWA

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Payer Support for Providers in Payment Reform

Their success is now your business. Providers are now your partners, not your vendors.

Overcoming Privacy and Security Issues

- Intractable tension between two messages
  - Coordinate care and share information among all needed parties
  - Protect the privacy of a member
- Legislative direction needed
- Until then, need ability to restrict or redact information based on constituent role and context

Coordination of Care Management Between Plan and Providers

- Shared data assets
- Shared care plans

Payer as the Supplier of Technology to Providers

The Need to Share Ongoing Performance with Providers

- Reducing latency
- Making the performance view specific to the terms for measuring the provider's performance

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Provider Ability to Ingest Data from Payers

Partnerships require trust and transparency is the coin of trust

The payer has a vital and exclusive role as aggregator of all utilization; no provider or community HIE can replace this

Utilization is a primary component of any payment reform program

- The switch from fee-for-volume to fee-for-value does not end the role of volume; it is still vital

Provider no longer want reports, they want the raw data

Generic quality or gaps in care reports have little value

- For both Payer and provider constituents, the reporting must be expressed in the specific terms of the agreement

Many legitimate barriers exist to sharing data

- Legal barriers
- Technology barriers
  - Few providers have technology to use claims data once sent
- Business competition barriers
- All of these must be overcome for payment reform to be successful

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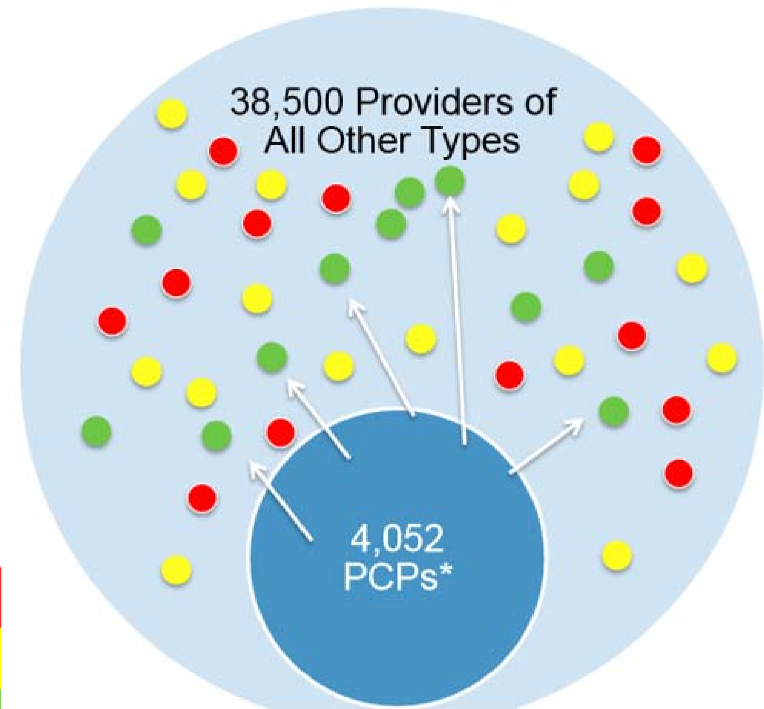
Sharing Data in Radical Ways - Example:
Disclosing Cost Outcomes Associated with The Other Guy

Panels Make "Buying" and Arranging Decisions Specialists and Hospitals Referrals

- No narrow networks are used
- PCPs refer where they believe they will get the best result
- Given the high percentage of admissions for common chronic illnesses, many have become convinced of the efficacy of referring to lower cost Specialists and Hospitals



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Rationalizing Provider Investments in Technology

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Leveraging Existing Assets

Forget about Meaningful Use – Make Your Use of the EMR Meaningful

The EMR as a primary workflow tool and as a system of record should be the primary technology solution for payment reform

- The EMR should be able to meet many of the primary technology requirements, such as
  - Identification of the patients in a program
  - Longitudinal information about a patient (including the content shared by other providers or a payer)
  - Differentiated workflows to administer the care of a patient based upon evidence-based methods to manage efficiency and improve quality
  - Coordination of care across all providers
  - Analytics and performance measurement needed for population management across multiple patents and providers

So, why is there a problem?

- Too difficult to configure EMR for payment reform and differentiated workflows, especially given multi-payer variation
- Lack of comfort having multiple standards of care or approaches
- Many locations require coordinated use across technology silos
- In some cases, EMRs do not yet have adequate capability

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What Are the Capabilities Needed?

If you cannot manage a risk population, you should not take risk

There are fundamental capabilities needed for payment reform programs

- Model a new payment reform contract before signing
- Analysis and identification of problems that can be fixed
- Identification of a patient in a program (at the right time and in all the right places)
- Longitudinal information about the patient care that drives the understanding of the patient risk
- Care delivery workflows that deliver value-based care (from beginning to end) based upon the program and the patient risk
- Coordination of care across all related providers, regardless of location or Tax ID
- Near-time visibility of performance measurements
- Management of utilization and management of quality (across different payers)
- Revenue cycle management that understands new payment methods …

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Impact on Revenue Cycle Management

Remembering fondly past days of a simple EoR

Provider RCM systems are completely unprepared for payment reform

- The extremely wide variety of payment reform programs makes this a hard problem to solve

The ability of provider systems to match an actual payment to an expected payment will decrease over time

- This will lead to more appeals and more claim status inquiries – some legitimate and some unthinkingly created by the provider systems
- The ability of both payer and provider to automate appeals will degrade over time, resulting in more CSR and phone time

The complexity of the appeals will increase

- New contracts are more complex and cannot be evaluated in an automated fashion by one or both parties
- New contracts are more subjective, using less precise data sources and less clear contract terms
- Payment reform “partnerships” are more open to business-based (a reasonableness standard) disputes which will be solved by BI analysts and business leaders, not claims adjusters

The need to actually pay other providers or be paid by other providers

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Additional Technology Challenges for Providers

How is the world really changing

Challenges of multi-payer programs

- A moving target of new management targets, payment methods, and reporting requirements

Management Across Other Providers

- The need to work across multiple EMR footprints
- The need to affect providers who are not part of the risk-based contract

How to Avoid or Embrace non-EMR Information/Workflow Systems

- The challenge and reality of portals
- How technology changes unchain us from the desktop

How to Connect to the Patient

How to Align Physician Income with Health System Income

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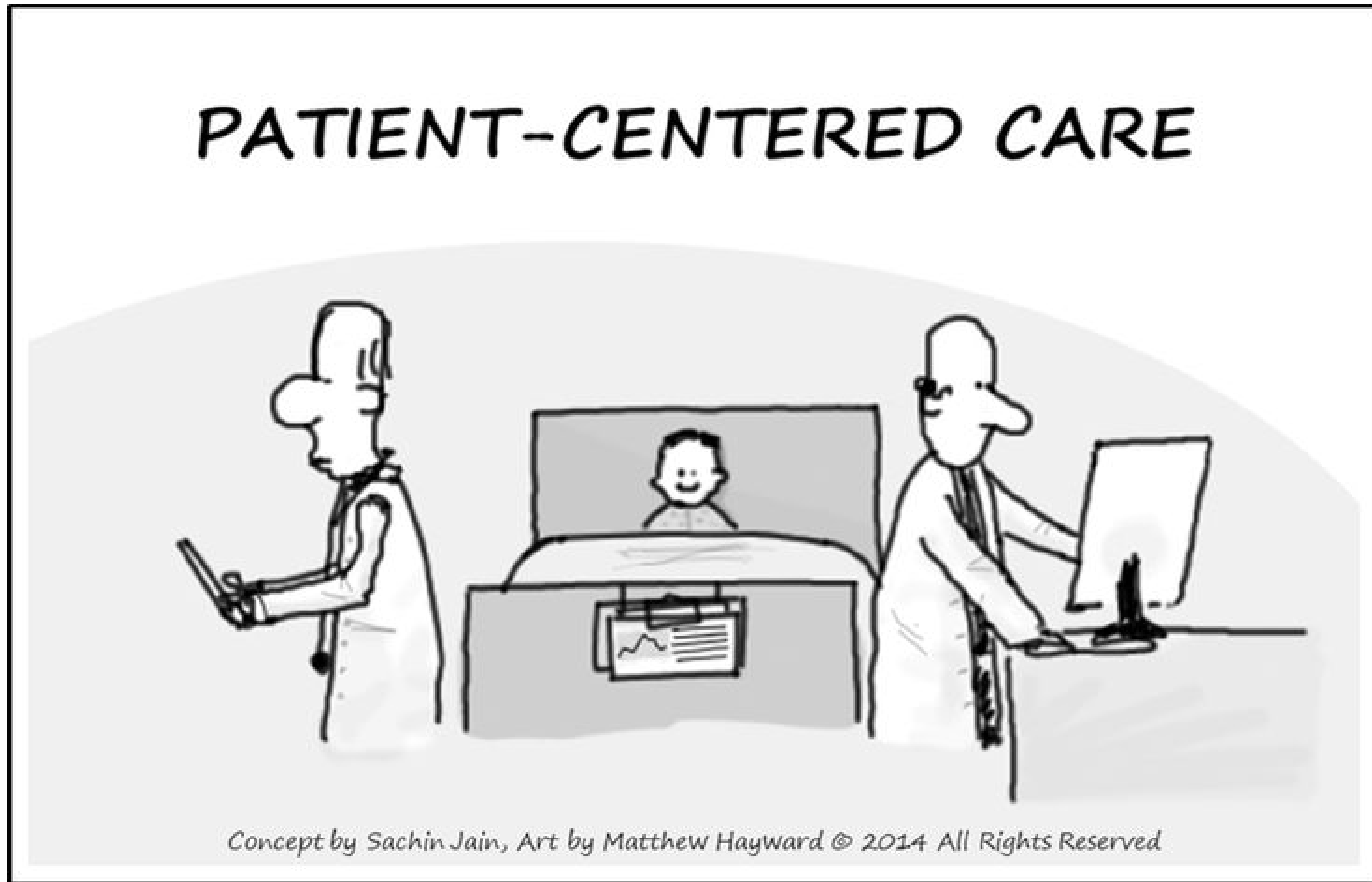
Keeping Technology in Perspective



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Thank You

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