Next Generation models of Care delivery Contracting to serve your Community

Creative Managed Care Solutions. LLC

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Current Relationship Models

Patient <Subscriber K> Payer <Mgd Care K> Provider

Patients & Providers are focused on the best care and outcome for the best value.

Payers, as rational for-profit companies - are focused on maximizing profits by retaining premiums.

Current Relationship Model

In this relationship model - you let the **Payer control** the way **your services** are sold to **your Consumers.**

You have no input into Plan Design & no Data to make improvements

- Product design options; HMO/POS/PPO
- Price your patients pay; **premiums + deductibles + cost-share**
- Benefit coverages and **limitations**
- Limited Incentives for **healthy lifestyles**
- Benefit exclusions; **some may surprise you**
- Patient financial responsibility levels; may depend on
    - Administrative burdens; Auth req's, Notice req's, Retro reviews, denials
- Data reporting challenges with Payer

Problems with Current Health Plans described by previous speakers

- **Self-Funded Plans: No Integration**

  Current plans offer limited coordination between the health plan, Providers, and the Members.
- **Fully Insured Plans: No Flexibility**

  Insured plans primarily have their interests in maintaining margins and not their customers.
- **Employer's Risk Management; Limited**

  Generic, superficial attention to prevention – window-dressing.
- **Cost Management: Limited Incentives**

  Limited to balancing funding and costs – costs and funding go up.
- **Discount Pricing: No Cost Basis**

  Solely dependent on the network's ability to secure competitive rates that are rarely cost based.
- **Health Management: Minimal**

  Most health plans don't engage the members health and utilization in a true and real form towards improvement.
- **Poor Customer Service**

Results

Ever-Increasing costs due to large claims & poor health care integration.

The only thing predictable is that an employer's costs will increase year after year.

Lets discuss some Solutions?

- ✓ A health plan that **EDUCATES** and involves the the customer on **ALL aspects of their care including Cost**.
- ✓ A health plan that **GUIDES your Patients towards Proactive, comprehensive Care**.
- ✓ A health plan that is **TRANSPARENT** and manages chronic illnesses and their large claims.
- ✓ **20% - 40% LESS COST** for administration, technology, and experience.
- ✓ A health plan that **ENGAGES MEMBERS** through population **Wellness** management.

Models we are seeing Develop across the US

- Clinically Integrated Networks (CIN)
- Accountable Care Organizations (ACO)
- Direct Models
- Risk sharing Models
  - Partial Risk
  - Full risk

Clinically Integrated Networks (CIN)

Becker's Hospital Review defines CINs as individual providers and health systems that are collaborating strategically to do 3 things:

1) improve patient care,

2) decrease the cost of care and

3) demonstrate their value to the rapidly changing market.

Clinically Integrated Networks (CIN)

According to the **U.S. Department of Justice**, CINs all share four defining characteristics.

In order to operate legally as a CIN, a network must:

1. **Have physicians play a key leadership role.**
   No matter how the collaboration between provider partners is structured, physicians must be part of the CIN's governance structure.
2. **Commit to comply with clinical guidelines.**
   Members of a CIN commit to improving care outcomes, increasing efficiency of delivered care and increasing patient satisfaction.
3. **Strategically use data and technology.**
   CINs need to prove how they are improving outcomes, increasing efficiency and reducing costs.
4. **Demonstrate its value.**
   CINs must show how they are delivering better care at lower costs to deliver on its value proposition.

Accountable Care Organizations (ACO)

What are the different types of Medicare ACO models?

- Pioneer ACOs
- Medicare Shared Savings Program (MSSP) ACOs
- Advance Payment ACOs
- Next Generation ACOs
- ACO Investment Model (AIM)

https://www.kff.org/faqs-medicare-accountable-care-organization-aco-models/

Accountable Care Organizations (ACO)

As of 2018, CMS reports that there are about 12 million beneficiaries attributed to a Medicare ACO, including 10.5 million in MSSP ACOs and 1.4 million in Next Generation ACOs.

CMS generally attributes beneficiaries to ACOs based on their primary care provider's affiliation with a Medicare ACO, but beneficiaries are free to seek services from any Medicare provider in or out of the ACO.

DIRECT MODEL SAMPLES EMPLOYER><PROVIDER

- ✓ A health plan that **EDUCATES** and INVOLVES the **CUSTOMER** on **Plan Attributes**
- ✓ Plans that combine the benefits of the large insurer's **COVERAGE.**
- ✓ **EMPLOYER** and **PROVIDER** now **Control** Benefits which leads to Improved Outcomes at Lower **Costs**
- ✓ **You** also **Control Your Data; that you use to Improve the Plan Design**
- ✓ Competitive provider reimbursements result in reduced Out of Network and **Balanced Billing** headaches.
- ✓ **20% - 50% LESS COST** for administration, technology, and experience.
- ✓ A health plan that **ENGAGES MEMBERS** through **Individualized Wellness** engagement.

Flexible Health Plans that You and Your Consumer Design

Numerous flexible plan options ensure the clients needs are met.

- Compliant Benefit Plan Designs and ACA compliance reporting
- Pricing Solutions for full RBP plans as well as Out-of-Network Pricing Solutions
- Examples of custom plans and solutions to meet clients' needs:
  - PEO/Association plans
  - Narrow Network and 3-Tier plan designs built around existing narrow networks or assist a local partner in the development of a local/regional provider network
  - White Label plan development in partnership with Providers (hospitals and/or provider networks), and Employers

Narrow Network and 2 or 3-Tier plan designs

Can be designed to:

1. Work with existing entities or
2. Develop new local/regional provider-sponsored entities

> Focused on retaining the responsibility of meeting local health care needs locally

Some examples next:

Two Tier or EPO plan design

Limits providers available for Tier 1 services (lowest cost to member)

Allows members to choose determine what they're willing to pay to secure services from Narrow Network providers or other providers

Tier 1: PIH Preferred Provider Network		Member Cost
• Hospital(s)	• Owned/Sponsored Contracted Provider Network	$
• Owned/Sponsored Physicians & Affiliates	• Owned/Sponsored Operated Pharmacies	
• Owned/Sponsored Urgent Care Centers	• Owned/Sponsored Specialty Clinics	
• Other Contracted Participating Providers*	• Affiliated IPA (if applicable)	
Tier 2: Out-of-Network*		
• **Value Based Pricing (VBP) for All Services:** - Hospitals, Ambulatory, Ambulance, & Dialysis	• **Value Based Pricing (VBP) for All Services:** - Physicians, Ancillary Providers	$$$
• **X% of Medicare**	• **X% of Medicare**	

** Determine if Hospital and its narrow network partners is large (depth and breadth) enough to warrant a true EPO set-up which would not include any out-of-network benefits unless services are not available in the PIH combined entity.*

*** Restricted to those services not provided by Sponsor Hospital Network/Facilities**

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Benefit Summary: Open Member Liabilities	**Tier 1** **PIH Network**	**Tier 2** **Out-of-Network**
Deductible	$500 Per Person	$2,500 Per Person
Maximum Out-of-Pocket	$1,000 Per Person	$10,000 Per Person
Office	$15 Copayment Per Visit	50% Coinsurance After Annual Deductible
Hospital	10% Coinsurance After Annual Deductible	50% Coinsurance After Annual Deductible
Emergency Room	$125 Copayment Per Visit	[illegible]0% Coinsurance After Annual Deductible
Other	10% Coinsurance After Annual Deductible	50% Coinsurance After Annual Deductible

SAMPLE

3-Tier (Triple Option Tier Structure)

Allows members to choose the providers they want to receive services from and the amount they're willing to pay out-of-pocket to choose non-Narrow Network providers

Tier 1: Provider Sponsored Preferred Provider Network		Member Cost
• **Hospital(s)**	• **Owned/Sponsored Contracted Provider Network**	$
• **Owned/Sponsored Physicians & Affiliates**	• **Owned/Sponsored Operated Pharmacies**	
• **Owned/Sponsored Urgent Care Centers**	• **Owned/Sponsored Specialty Clinics**	
• **Other Contracted Participating Providers***	• **Affiliated IPA (if applicable)**	

Tier 2: In-Network (for example, PHCS Network & VBP)		
• **PHCS Professional Providers**	• **PHCS Ancillary Providers**	$$
• **Value Based Pricing (VBP) for:** - Non-Tier 1 Hospitals and Ambulance & Dialysis Providers		

Tier 3: Out-of-Network		
• **Value Based Pricing (VBP) for All Services:** - Hospitals, Ambulatory, Ambulance, & Dialysis	• **Value Based Pricing (VBP) for All Services:** - Physicians, Ancillary Providers	$$$
• **X% of Medicare**	• **X% of Medicare**	

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Risk Sharing Models

- Partial Risk
  - Accept financial risk for the portion of care under Providers control
  - Must invest in infrastructure to proactively manage care
  - Plan retains risk for rest of Patient's care

- Full risk
  - Assume care & financial risk for all Patient Care and Outcomes
  - Need greater infrastructure investment & resources to identify opportunity patients, communicate proactively, and measure results

How would you get started?

Plan Development/Process Steps

1. See if your Leaders, Clinical & Executive would like to develop new options to serve your community and are sustainable
   - Discuss how willing they are to invest in developing programs to serve your community & sustain your health system

2. Benchmark with similarly situated Providers
   - Determine investment needed to generate ROI

Building Your Plan

3. Assess viability of Your Network,
   - determine gaps in coverage
   - by Specialty / Provider Type & by Geography
   - Determine responsibility for contracting gaps

4. Determine market with plan options and benefit levels
   - Products and tiers
     - Driven by what options are available in Market
   - Assess competitors and their benefit plan structures in your market
   - Evaluate/identify additional providers necessary to fill out provider network
   - Determine payer services you could do better than current (Prior Auth/UM function)

Building Your Plan

5. Obtain Underwriting/ Stop Loss/Reinsurer input
    - rating of products and reimbursement established

6. How would you design products to best serve the sectors of your community competitively?
    - Focus on one sector.
    - Use lessons learned to grow, improve, expand

Discussion/Questions?

If you are fed up with your **current** payer **relationships** - what are you willing to do about it to make it better for **Your Community**?

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