White Paper

Recognizing Savings and Care Opportunities Drive Value-Based Reimbursement for Payers

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EXECUTIVE SUMMARY

Value-based reimbursement (VBR) and contracting is much more than a payment methodology. Embarking on an alternative payment methodology journey requires a payer to ask and answer several questions — beginning with the reason for pursuing VBR to determining how to handle operational issues such as the most efficient way to administer patient care, identifying opportunities for cost savings and improving care, and figuring out how to handle dual ways of pricing claims. Now that VBR is in its adolescence, early adopter payers have learned several lessons. This white paper highlights considerations payers must evaluate as they initiate the shift to VBR. It also highlights the experiences Blue Cross and Blue Shield of North Carolina (Blue Cross NC) had as it adopted VBR and the specific lessons learned with Cognizant and its end-to-end suite of tools.

> "We have a team of people working on this ... it's been a journey ... but in five years we achieved a 20% reduction in medical costs, lowered readmissions by 17%, and reduced complication rates by 4% with our joint replacement program."
> — Blue Cross NC

Answering the questions in this journey outlines developing a payer's maturity in addressing VBR, a complicated, new, and operationally disruptive process. These answers evolve over time and should be considered in total when identifying which methodologies and software to use.

IN THIS WHITE PAPER

This IDC Health Insights white paper presents key questions payers should answer when considering the operationally disruptive process involved when adopting VBR. These questions are derived from interviews with a provider network executive at Blue Cross NC regarding the deployment of one type of VBR, Episodic Bundled Payment arrangements using NetworX Payment Bundling Administration (PBA) software to design, implement, execute, and expand value-based reimbursement including use cases and best practices. This white paper is intended to offer insights into the business needs of payers wrestling with value-based reimbursement across the industry and is based on secondary research by IDC analysts and several briefings with Cognizant.

SITUATION OVERVIEW

According to IDC research, more than 50% of the financial transactions healthcare payers deal with will soon be done on a value-based system. Value-based reimbursement will require payers to evolve and adopt a new paradigm at the contract negotiation table with providers. To address the shift from fee-for-service (FFS) to VBR, payers should be prepared to face significant changes.

Value-based reimbursement will be organizationally and technically pervasive for payers. What is underestimated are the core procedural and systematic changes necessary in the middle and back offices to execute operationally under an environment where soon most payments will be value based. In addition, new paradigms in finance, product definition, contract and rate modeling, and workflow will be established and driven by direct changes in provider contracting, episode recognition, care coordination, and claims pricing and processing. There are multiple VBR methodologies that are possible to support, each with

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its own procedural and technical challenges. Payers need to decide what to support with contracting, provider relations, and technical support. Supporting all of these involves significant, sometimes overlapping, effort. Recognizing opportunities via analytics starts the journey; operationalizing the mechanics of reimbursement finishes the effort, with better patient outcomes as the overall goal.

The only certainty is that change will continue to shape the healthcare market. The successful payer will be able to meet that change head-on by having insight, procedural agility, and operational efficiency. Operationally, struggles will come with VBR – think multi-year, multi-project, and multi-division efforts. Payers can start now by examining the considerations discussed in the sections that follow.

Focus on the End Goal

Fragmented fee-for-service transactions result in providers rendering care under the context of which billing code is paid or how they are paid. Efficiency is not the goal under a fee-for-service paradigm, and medical spend continues to be a struggle for payers.

Look for the Most Efficient Way to Administer Care

Alternative payment methodologies/models (APMs) give providers the latitude to put the care delivery first and billing/revenue generation second.

Find Opportunities for Savings and Better Care

One way to understand opportunities is by using episode modeling software. Modeling claims into potential episodes is becoming a fine use for analytics. Running fee-for-service paid claims (many years to get trend) through episode rules identifies which hypothetical episodes will have the most impact on the population and calculates the risk- and severity-adjusted budgets for them.

Which episodes to adopt is one of the primary unknowns at the beginning of this journey. Episode recognition software can be leveraged to assign patient claims, representing their utilization of healthcare services, to clinically relevant episodes of care. Episode recognition is operationalized using software tools to provide a picture of healthcare utilization for relevant conditions over a defined period. Currently, most episode recognition software are developed to parse administrative claims data into episodes of care. This type of software can create hundreds of condition-specific episodes.

The creation of these episodes depends on the intricate decision logic that determines to which episode a claim should be assigned. Several commercial episode recognition software packages have been in use in the private sector for many years. These products are used by various stakeholders in various applications. For example, health systems have used these tools to examine prevalence rates for various conditions, incidence rates for various treatments, and complication rates to support internal quality improvement. Employers have also used this software to understand provider utilization and cost variation.

It's important to evaluate which episodes of care will be supported. The concept underlying most of this software is the episode of care. Recognizing that there are varying definitions of an episode of care, the National Quality Forum's (NQF's) Episodes of Care Measurement Framework defines an episode as "a series of temporally contiguous healthcare services related to the treatment of a given spell of illness or provided in response to a specific request by the patient or other relevant entity ... these healthcare services can be administered by one or more providers over the course of the episode."

Using an episode-based approach to performance measurement can highlight the linkage of services provided in different settings and by different providers into an episode that otherwise may not have been considered together. There are two kinds of episodes:

- An *event-based episode* includes all services within a user-defined time window surrounding a trigger event (e.g., hospitalization, a significant outpatient procedure, or outpatient medical visits).
- A *cohort episode* includes services provided to patients who share a common condition, disease, or characteristic within a user-defined period (e.g., pregnancy and diabetes or eligible members of a wellness program).

Similarly, the Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model Framework and MACRA are aligned in the goal of moving payments away from FFS and into APMs that reduce the total cost of care and improve the quality of care. Both MACRA and the APM Framework establish designations for APMs that consider the extent to which payments are based on value (as opposed to volume).

Determine Which Methodologies to Support

Payers can define their VBR program in many ways. IDC Health Insights recommends that payers decide what methodologies they want to support to ensure technical competence in a coordinated way. After methodology selection, one (for most methodologies) needs to look at:

- **Episode window:**
    - How is the episode triggered?
    - How many days is the episode (pre, post, during)?
    - Do I want to consider look-back periods for comorbidities?
- **Inclusion or exclusion:**
    - What patients do I want to include or exclude in my analysis?
    - What services do I want to include or exclude in my analysis?
    - What providers do I want to include or exclude in my analysis?
    - Do I want to track leakage?
    - Do I want to consider narrowing networks?

- Prospective or retrospective methodologies:
    - Who receives payment?
    - What is the process for budgeting or sharing savings?
    - What risk level do I want to execute (full, upside only, upside/downside)?

Consider How to Handle Pricing Claims in Dual (FFS/VBR) Ways

As variables multiply as to how to pay for services, the enterprise workflow required to design and file products, configure rate schedules, alter network definitions, trace financial transactions back to their core administrative transaction, execute appeals, and quote proposals will need to be introduced or altered for different origination or approval processes. Noting that VBR is all about the financial implication, an auditable, traceable workflow now becomes required, not just nice to have. Consequently, payers must assess the strength of their workflow and make appropriate adjustments as needed.

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Consider the Flexibility of Member Benefits

Products must evolve with the transition to value-based reimbursement. It is common to steer patients to lower-cost, higher-quality providers participating in value-based arrangements through financial incentives and lower member cost share. Patient outcomes are improved within value-based care and there is a natural progression toward the providers through patient and provider recommendations. However, the quickest patient movement occurs when member cost share is positively impacted.

Examine How to Adjust Claims Workflows

Claims engines must be altered with embedded logic, or software must be appended to parse claims and encounters and route them to VBR and FFS engines in concert. Either as separate software or embedded within the claims engine, to execute VBR, basically each claim is priced twice – first, in the traditional FFS manner and, second, within the context of the VBR agreements applicable. A piece of software that identifies potential VBR transactions and routes them to calculation logic along with the appropriate general subledger interfaces is necessary.

Make Choices for Prospective and Retrospective VBR Claims Pricing Engines

To trigger real-time value-based payments in a *prospective payment* methodology, software must receive the claim, determine whether the claim is part of a bundled payment arrangement, and send back a response with a new price, if qualified for a VBR arrangement. This allows the payment bundling system to function as a rules-based, claims repricing engine, prospectively creating episodes of care in real time at the point of adjudication. When scaling a value-based program, automation is key to the expansion of successful programs and contracting arrangements. This type of pricing engine provides appropriate automation to sustain current auto-adjudication rates.

To reconcile *retrospective* bundled payments, paid FFS claims are evaluated by running the claims through software to provide reconciliation reports that aid you with bundled payment disbursement. This process will compare FFS payments with the target price so that "true-up" can occur. Unfortunately, more than a year might pass before physicians receive the incentive for current actions, so the math must be traceable and clear. Overall medical cost reduction and improvements in quality are realized at a slower pace with retrospective contracts because of the lag time between care coordination and financial reconciliation.

Figure Out How to Operationally Reconcile FFS and VBR Claims

The changing accountabilities between provider, payer, and member in the VBR paradigm will cause an increase in the number of "reconciliation" processes required in the finance; claims processing; waste, fraud, and abuse (WFA); and risk adjustment departments. In these departments, workflows will need to be introduced or altered, and payers need to decide which episode reconciliation workflow processes they should use.

Determine How to Prove Results and Pay Providers

In VBR, a portion of the provider's total potential payment is tied to the provider's performance on cost efficiency and quality measures. While providers may still be paid a fee for service for a portion of their payments, they may also be paid a bonus or have payments withheld.

Fees paid to providers may also be contingent on the providers engaging in practice transformation to adopt technology and processes that alter the way they deliver care. Goals include:

- Accountability to the patients
- Nurse navigators providing a concierge level of interaction with the patients
- Automated processes to address prevention and wellness

So a baseline or benchmark for quality metrics, readmission rates, complications, and/or patient volume must be established and the variance off that baseline must be tracked, reported, and acted against with appropriate payment procedures.

Evaluate the Need for Contract Management Processes and Software Alterations

Traditionally, a payer initiated health maintenance organization (HMO) or preferred provider organization (PPO) contracts. Most of these contracts were very similar and contained provisions that established the services the physician was contracting to provide — the payment rates (capitation or fee for service). Standard contracts and fee schedules were the norm. Unless a physician was part of a large group, there was very little negotiation with the payer. The rates were the rates.

Contracting teams today must engage a provider in a discussion about the risks and benefits of value-based reimbursement. It is key for a contracting specialist to understand and communicate the underlying foundation of risk transference while thoroughly explaining the potential financial gain for the provider.

Explore Ways to Use Episode Reconciliation Analytics

As previously noted, analytics can be used to identify new episode opportunities (discovery), review provider performance, and monitor contracted episodes (execution) of care. Both report and visualization engines should cover the entire life cycle from discovery to execution.

FUTURE OUTLOOK

Where paper contracts and inefficient amendment processes sufficed before, payers will be running into providers coming to the contract negotiation table armed with analytics, models, and proposals for a variety of payment models, and payers must be prepared. Instead of merely haggling on fee-for-service rate increases, value-based contracting may spur complicated discussions on determining lump-sum payments, quality metrics to be used for bonuses or penalties, and arrangements for how shared savings should be split, which will be the new payment bargaining chips.

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COGNIZANT SOLUTION OVERVIEW: AN END-TO-END LONG-STANDING APPROACH TO REIMBURSEMENT

For years, Cognizant has creatively responded to the challenges of the new complications of reimbursement. What used to be a fairly direct "core administration" concept with a set of claims engines for all vendors has evolved dramatically as the "core" has necessarily exploded into specialties. Now, Cognizant's solution consists of a *platform* with three main products that, singly or together, automate often complex pricing scenarios to provide value to payers, providers, and patients.

With these products – NetworX Pricer, NetworX Modeler, and NetworX Payment Bundling Administration (PBA) – payer organizations have a platform driving enhanced provider reimbursement management and supporting regulatory compliance. The result is greater value for every healthcare dollar, from claims pricing and contract analysis to value-based reimbursement administration.

Products

Cognizant's significant product line shows the historical evolution of reimbursement at all payers as Cognizant offers multiple products, to design, implement, and execute reimbursement, in the Cognizant-TriZetto's NetworX Product Suite. Over the history of Cognizant-TriZetto's NetworX, the company supplemented its claims engines and introduced fee-for-service pricing and modeling flexibility with the following products:

- **NetworX Pricer:** This is a fee-for-service automation of pricing that streamlines configuration of FFS provider agreements.
- **NetworX Modeler:** This is a way to forecast contracts and expenditures without product, plan, member, or provider configuration to understand the "what-if" of rate change for FFS contracts.

Then, when value-based reimbursement became relevant, the company responded with the following offerings:

- **NetworX Payment Bundling Administration:** This rules-based engine automates *prospective* or *retrospective* episodic or value-based pricing agreements and is claims system agnostic. This solution aggregates claims from multiple providers into predefined episodes of care for qualification and pricing – evaluating claims during adjudication to determine whether a specific claim should be included in the bundled payment. Either prospective or retrospective, PBA is agnostic of claims platform via RESTful service and supports direct interfaces with both of Cognizant's claims engines (Facets and QNXT).

- **NetworX Payment Bundling Administration Analytics:** An extension of PBA (see previous bullet point), this solution allows users to analytically evaluate new episode opportunities and attributing providers (discovery/expansion phase), review provider performance, and manage contracted episodes of care (execution phase).

Service Offerings

In addition to its products, Cognizant has two service offerings:

- **Discover Your Path to Episodes of Care:** To see its products in an active sample, Cognizant offers a consulting engagement combining the NetworX PBA and PBA Analytics into a program called Discover Your Path to Episodes of Care. Under this program, a payer can submit its *historical claims* to Cognizant to see how its claims would react (discovery) in an episode of care or bundled payment contract. Results are shared via a business intelligence tool to provide drilldown and drill-through views.
- **NetworX Payment Bundling as a Service (PBaaS):** Once the VBR program is operational, for those payers that would prefer to outsource their operations Cognizant offers another service called NetworX Payment Bundling as a Service. This is a recurring services engagement to operationally handle the *retrospective operational life cycle.*

CHALLENGES/OPPORTUNITIES

Cognizant has over 350 clients, and through the course of meeting with clients to discuss their readiness for VBR, the company noted some common payer challenges. When there is no immediate mandate from a regulatory agency or other stakeholder, there is no clear timeline for making VBR a priority in provider contracting. In addition, payers don't have insight into which are the most effective episodes of care to adopt during the initial pilot stage. There are questions around which providers are in the best position to accept a risk-sharing arrangement of the magnitude that moving to VBR entails. And finally, payers are unsure of what infrastructure is required within the organization to support the level that payment innovation VBR requires.

All payers and vendors face challenges when transitioning from interfacing with a sole core FFS platform to a VBR paradigm. This journey carries with it a requirement to educate staff and line-of-business executives about VBR's development, operation, and use. Even in the case of the core running in a managed service environment, it is necessary to ensure sufficient training as the appended or embedded VBR platform is deployed. An advantage Cognizant has over other VBR companies is its long-standing credibility in the claims processing industry and its ability to go beyond core reimbursement solutions and bring in offerings across the entire payer functional landscape with its suite of Cognizant-TriZetto Healthcare Products, infrastructure, and IT application services.

BEST PRACTICES IN VALUE-BASED REIMBURSEMENT

To illustrate the best practices in value-based reimbursement facilitated by the functionality of the NetworX platform, IDC Health Insights spoke with a payer that has used the Cognizant products to achieve its goals in establishing bundles.

Making Strides to Achieve a Seamless VBR Vision in a Migrating Claims Environment at Blue Cross NC

At Blue Cross NC, Director of Network Pricing and Expense Analysis Jake Yount and his staff use the NetworX Product Suite to achieve flexibility in provider contracting. This payer has been migrating membership to the Cognizant product suite over the past few years, with a transition from legacy claims processing to the claims engine Facets and a concurrent deployment of NetworX Pricer, Modeler, and Payment Bundling Administration (PBA). Since the products are core agnostic, they have been leveraged with Blue Cross NC's legacy claims system and Facets to maintain business continuity.

Yount reports that the movement to a prospective episodic bundled payment program with a focus on reducing medical expense and improving patient outcomes necessitated a rethinking of modeling, pricing, and reimbursement in a total approach for Blue Cross NC. This approach includes strong technology partnerships, a phased program implementation, and a marketing engagement plan that informs members and ASO clients of the program.

Yount and his staff implemented Pricer, Modeler, and PBA about five years ago. Hosted at Cognizant, the PBA software recognizes episodes of care and automates real-time bundled payments during the claims adjudication workflow. Before implementation of this software, bundled payment claims would be put in a pending status and exception procedures abounded — for each episode type and for each contract.

When asked about the ROI of this effort, Yount is clear, "We just couldn't do prospective bundling at scale without the right tools for value-based reimbursement." He quickly adds that the plan has averaged over 20% medical expense savings when comparing the fee-for-service costs with the bundled payment episode costs, 17% reduced readmissions, and a 4% reduction in complication rates in their joint replacement program and finishes by saying that with PBA, new opportunities are being considered. He adds that these considerations are now proactive, where in the past Blue Cross NC was reacting to contract requests from local health systems.

In summary, contracts with different calculations can be configured and reconciled with his team working closely with its vendor partners. Yount believes the infrastructure the plan has established will allow for future scaling of the episodic bundled payment program.

ESSENTIAL GUIDANCE — ACTIONS FOR PAYERS TO CONSIDER

Actions for payers to consider include:

- Recognize why you want to execute value-based reimbursement. The Blue Cross NC case study shows how care and/or cost are drivers toward VBR. Recognize and quantify measures of success for whichever motivation applies.

- Understand your long-term opportunity. Blue Cross NC states that in five years it averaged medical expense savings over 20%, readmission rates reduced by 17%, and a 4% drop in complication rates was noted with their joint replacement bundled payment program. Look long term and don't be fearful.

- Be proactive, not reactive. Don't wait for a mandate. It is understandable that payers wait for a state Medicaid mandate or a large self-insured employer or a major health system to usher them into value-based paradigms. Plan to be proactive instead of reactive.

- Recognize that an FFS-based system with manual workarounds will not scale; eventually, the drain on staffing resources will mandate automation to grow and expand.

- If considering outsourcing of VBR processing, remember all the internal organizations that need interface and ensure that the outsourcer can handle all interfacing organizations.

- Submit your historical claims for evaluation of potential risk-sharing arrangements and return on investment.

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