HEALTH PLAN OPERATIONS AND POPULATION HEALTH SERVICES:

IDENTIFYING THE DEFINITIVE ELEMENTS FOR BUSINESS AND CARE DELIVERY EXCELLENCE

Transitioning risk from payers to providers and evolving payment models from volume to value requires a monumental shift. Providers taking on risk contracts and health plan operations need differentiated capabilities to manage traditional health plan functions. From the payer side, health plan operations must be redesigned to support remarkably improved business and care delivery outcomes. For health plans, health systems with delegated payer operations, or health systems wanting to become their own payer, turn-key outsourcing offers expert support to design, build, operate, measure, and optimize value-based health plan operations that can drive clinical and financial excellence, as evidenced by:

- Higher revenue
- Lower costs
- Higher market share
- Meeting mandates for medical cost ratio (MCR) contained in the Patient Protection and Affordable Care Act

DEFINING VALUE-BASED HEALTH PLAN OPERATIONS

In this Point of View, Lumeris offers a definitive formula for value-based health plan operations in shared-risk or global-payment models. Strategic investments in business transformation consulting, structure and implementation, value-based care services, and collaborative payer operations offer health plans and at-risk health systems opportunities to dramatically improve efficiencies and effectiveness. Return on this investment is evident through an organization's ability to meet the goals of the Triple Aim *Plus One*: better health outcomes, lower costs and improved patient *plus* physician satisfaction.

Lumeris offers a four-part framework to health plans and health systems looking to achieve high-rated operational success and as much as 30 percent lower medical costs compared to an unmanaged population.

Health Plan Operations and Population Health Services			
Component I Business Transformation	**Component II** Organizational Structure and Implementation	**Component III** Value-based Care	**Component IV** Collaborative Payer Operations
• Data-driven opportunity analysis • Financial modeling • Provider contract structure and incentives • Health plan benefit design	• Organizational or new company structure (PHSO) • Governance • Support to measure contract performance and evolve contracts and incentives • Operational resources	• Office management: – EMR, PM, Billing • Population health: – Data analytics – Quality management – Utilization optimization – Provider-based care management staffing – PCP engagement and behavior change	• Revenue cycle management • Enrollment • Plan administration • Claims processing • Customer service • Network management • Care management • Compliance • Contracting

IDENTIFY IMPROVEMENT OPPORTUNITIES TO ADDRESS BUSINESS TRANSFORMATION

ESSENTIAL GUIDANCE:
To rapidly create value, identify a value-based care business transformation expert that can help you identify opportunities to improve your performance. This opportunity analysis should be based on the aggregation of insights (claims/cost, EMR, lab, and pharmacy data) from across the health plan and provider network.

Transforming value-based health plan operations starts with a comprehensive qualitative and quantitative analysis of an organization's business and care delivery model. In order to maximize improvement, organizations must take a data-driven approach to uncovering opportunities to drive better clinical and financial outcomes. A solid strategic approach to business transformation begins with:

- Opportunity analysis: Gather and analyze data to uncover opportunities for provider groups to improve business and care delivery efficiencies with a focus on impacting quality, cost, utilization, and administration.
- Identify physician partners: Drive adoption and promote success by partnering with strong physician leadership within the provider organization.
- Financial modeling: Ensure an appropriate amount of risk is allocated based on the readiness of providers and more predictable margins and profitability.
- Contract structure and incentives: Design contracts that align providers' cost and quality incentives with the desired patient health outcomes.
- Health plan benefit design: Create products that remove barriers to care for patients while controlling cost and utilization through effective network management.

ORGANIZATIONAL STRUCTURE AND IMPLEMENTATION OF THE TRANSFORMATION

ESSENTIAL GUIDANCE:
Begin the transformation by deciding the structure that best supports physicians in value-based contracts. Implement the strategy within a subset of your business, and then apply newly developed capabilities and lessons learned to other lines of business, ensuring alignment with overall business objectives for improving revenue, managing costs and achieving health care reform initiatives.

After a business transformation strategy has been defined, organizations must structure and implement the plan. Several payers and health systems choose to establish population health services organizations (PHSO) to aggregate independent providers and share first-dollar risk. These new companies can provide governance, contracting, incentives, training, and needed resources to enable provider transformation from volume to value. Important tactics for implementing the transformation include:

- Structure for success. Create an organizational structure or a new company to serve as the PHSO, which can provide value-based care solutions that enable and empower providers to deliver high-quality, low-cost, satisfying care (for the provider and patient) with better health outcomes. Support providers as they assume clinical and financial risk and care for the total health of patients and populations.
- Start with a familiar, well-defined population. Select a population with which you are already involved — e.g., Medicare patients or your own employees — and can deliver credible, actionable information and insights at the population and patient levels.
- Communicate early and clearly. Involve teams across the organization early to gain buy-in for the strategy. Help them understand the objectives of deploying the PHSO and its proposed impact to current operations.
- Measure contract performance and evolve criteria with risk progression. As providers assume greater risk for the health of patients and populations, the PHSO should oversee changes to contract structure, success criteria and incentives to reward higher levels of performance on quality, cost and utilization measures.

VALUE-BASED CARE SERVICES THAT SUPPORT OFFICE MANAGEMENT AND POPULATION HEALTH

Providers often need assistance with day-to-day office management, and in caring for the total health of patients and populations. Outsourced value-based care services can range in maturity from office management functions (EMR, practice management and billing), to population health management functions (provider-based care management staffing, primary care-centric education on value-based care workflows and technology tools and reports that support population health management).

When organizations enable and empower providers with actionable information, powerful tools and effective incentives, they are helping providers become population health managers, assume upside and downside financial risk and deliver remarkably improved clinical and financial outcomes. For example, technology-enabled solutions that allow for more accurate documentation and coding help generate additional revenues that allow providers to appropriately care for patients and populations with complex health needs. Collaborative programs that provide support staff to physician practices, such as embedded care managers, can drive improvement in quality, cost and utilization measures. Education and training around value-based care workflows can also help practices optimize the patient experience and improve performance in shared-risk or global-payment contracts.

ESSENTIAL GUIDANCE:
Select a partner you trust with expertise in delivering value-based care services to providers. Health plans and health systems that offer the right mix of office management and population health functions will help providers succeed quicker in value-based payment arrangements. This strategic approach helps providers see value from their collaborative payer. It also positions providers for the eventual insourcing or funding of these value-added services once their success and maturity in value-based care is realized.

COLLABORATIVE PAYER OPERATIONS THAT OPTIMIZE BUSINESS PROCESSES

Today, driving profitability and performance for health plans requires improving the efficiency of collaborative payer operations. Transforming administrative functions such as revenue management, enrollment, claims processing, network management, care management, and customer service has a unit cost, but doing so is essential to a payer- or provider-owned health plan's ability to achieve optimal HEDIS and/or Star rating measures, higher CAHPS scores, more cost-effective care, and engaged and satisfied patients.

When health plans optimize business processes, they are able to manage costs, increase profitability and plan performance, increase membership, and meet mandates for MCR contained in the Patient Protection and Affordable Care Act.

ESSENTIAL GUIDANCE:
Choose a collaborative payer operations partner that has demonstrated an ability to achieve lower MCR while maintaining high levels of patient and provider satisfaction. Structure your partnership to share fee risk and financial reward based upon the success of the health plan.

EXPERTISE AND INNOVATION IN HEALTH PLAN OPERATIONS AND POPULATION HEALTH SERVICES FROM LUMERIS

Lumeris' approach to value-based health plan operations comes from our Collaborative Payer® Model, a care delivery innovation developed jointly by a payer and provider group. This model is built on a foundation of reciprocal accountability, aligned patient and provider incentives, cultural and data transparency, and information and technology tools that support continuous process improvement and behavior change. It favors the wellness of patients and fosters stewardship of health care resources in pursuit of the Triple Aim *Plus One*.

LUMERIS KEY DIFFERENTIATORS

Lumeris' Health Plan Operations and Population Health Services solution offers payers and at-risk providers turn-key outsourcing to design, build, operate, measure, and optimize value-based health plans. Lumeris partners with clients to share fee risk, and is compensated based on the financial success of the health plan. Our key differentiators include:

- Proven track record of operational excellence: Lumeris operates a consistently high-rated MAPD health plan known for 30 percent lower medical costs compared to an unmanaged population.
- Multi-payer expertise: Our seasoned team of experts have established more than 30 health plans in their careers, operate a highly-rated MAPD plan in St. Louis and provide transformative consulting services to health plans across the country.
- Value-based care experience: We have been effectively helping providers manage risk for more than 10 years and have established best practices that have resulted in high-quality, low-cost care while maintaining high levels of patient and provider satisfaction.

CASE STUDY: OPTIMIZING OPERATIONS FOR CLINICAL AND FINANCIAL ROI AT ESSENCE HEALTHCARE

Essence Healthcare has become one of the highest-rated Medicare Advantage Prescription Drug plans in its region by deploying Lumeris' full, turn-key business process outsourcing and management services. Results include:

- Compared to FFS populations, Lumeris' Accountable Primary Care Model℠ spends larger portions of health care expenditure on the healthier deciles of patients, with a focus on prevention, screening and managing gaps in care. Over time, Essence Healthcare's usage of this model has decreased potentially preventable readmissions by 40 percent compared to an unmanaged population.
- The Essence Healthcare network of PCPs makes better, value-based decisions and recognizes opportunities to close gaps in care for more than 40,000 MAPD members by using Lumeris' Accountable Delivery System Platform (ADSP)® tools and information, such as the integrated data picture of patient and population health. Over 97 percent of Essence Healthcare patients are seen annually and more than 80 percent of networked providers consistently rate that they are satisfied with their collaborative payer partner.
- Lumeris' Nine C's® Playbook of strategies and tactics to support provider behavior change helped Essence Healthcare achieve nearly 65 percent MCR (in 2013, before surplus distribution). Patients rated the overall health plan consistently above the national average in CAHPS surveys.
- Through Lumeris' Enhanced Encounter® Program, physicians ensure more accurate documentation and coding, resulting in more appropriate levels of reimbursement to manage patient care. Lumeris' prospective health assessment, supported by tools, engagement and education, has a near 70 percent completion rate among physicians participating in the program.