RISK strategies CONSULTING

Emerging Trends and Patterns in Various Healthcare Market Segments

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Overview

Payers and plan sponsors are typically concerned with the financial issues facing them over the coming plan year. As a result, they focus significant energy and resources around tools and approaches to offset the effects of trend. Offsetting trend requires affecting a combination of unit cost, the number of units utilized and/or the mix of units utilized. Typical strategies include various forms of either renegotiation of reimbursement levels and/or deployment of utilization management programs. While some of the products tied to these approaches may appear to be sophisticated, they are more tactical in nature. This category of products merely "resets the bar" on a one-time basis.

The market requires that a broad and deep set of new approaches which manage trend be developed and deployed. Managing trend means foundationally affecting the means and quality in which care is delivered to patients as well as the ways in which members are able to care for themselves while both inside and outside the healthcare delivery system.

Management of trend necessitates significant investments and innovation by payers and providers. It requires a comprehensive and integrated series of solutions that actively assess and manage the behaviors and practices of patients/members and providers. Success depends upon alignment and accountability among and between each of the critical stakeholders.

This document will examine and discuss a number of critical considerations which are linked to the changing marketplace. Items examined and discussed include, but are not limited to:

1. Recognition that the Federal and State Governments are the largest purchasers of healthcare. The purchasing power of Medicare and Medicaid directly affect the cost of care for commercial plans. The regulatory standards that have been put in place for payers and providers affect the delivery and cost of care for every American. Reimbursement levels for Medicare and Medicaid, as well as the resources to maintain regulatory compliance create significant investment and innovation challenges for both payers and providers.

2. Blue Cross Blue Shield litigation and resulting potential implications on the existing overall structure of the Association.

3. The Pharmacy Benefit Management (PBM) industry has undergone significant horizontal and vertical consolidation. There has been a simultaneous movement toward acquisition- based pricing, creation of needed clinical management strategies as well as the development and deployment of Total Medication and Therapy Management (TMTM) solutions. TMTM is designed to address coherency and continuity of care between medical and PBM based pharmacy management.

4. Vertical and horizontal consolidation of health care delivery systems within a growing number of geographic regions.

5. Simultaneous investment practices and valuations for and by the capital markets into technology platforms and digital applications as well as proven, successful traditional payers and other operators who plan to improve their value proposition through vertical and/or horizontal growth.

6. Entrance of new traditional and non-traditional players in various markets. A number of emerging local, regional, and national health plans are considering growth within and beyond their existing geographical and market segments. Several commercial and governmental payers are contemplating entry into each other's market segments. Non- traditional players such as Amazon and Google have begun their entry into a number of market segments as well.

7. Longtime existing national entities providing services in post-acute care, dialysis, radiology, anesthesia, neonatology, and lab services. Early-stage roll ups of imaging centers, dermatology,

cosmetic surgery, orthopedics, cardiology, and oncology with additional areas of medicine likely on the horizon.

8. The expansion and implications of Virtual and Digital Based Care developing into a "new norm".

9. The acknowledgement and recognition that the aggregation of competitive cost of goods is merely a starting point in the creation of needed future state value propositions.

10. The active decision by providers and payers to enter risk assumption/risk transfer arrangements and lines of business which will require active management. This includes, but is not limited to Medicare Advantage, Stop Loss, value-based reimbursements, capitation of specific types of care such as disability, workers compensation and voluntary benefits.

11. The growth of technology around transactional and non-transactional platforms. Discussion here will also include a focus on the depth and breadth of existing and needed emerging data sets along with their utilities and applications.

12. Development of a 360-degree view whereby network and plan configuration, clinical management, member engagement and provider profiling, as well as other critical functions, are all aligned and integrated rather than siloed and separated.

Payer Challenges – Developing Solutions Rather Than Building Network Products

Provider networks determine a payer's cost of goods in a given geographic market and are portrayed as the payer's primary value proposition. Negotiation for a competitive cost of goods is typically tied to the volume of goods being purchased. Payer market-share therefore often determines the value of negotiated terms. A lack of volume acts as a barrier to entry for entities attempting to build competitive networks.

Existing provider networks typically substitute choice/broad access for quality and/or outcomes. Payers are therefore typically acting as little more than aggregators of price rather than managers of financial and clinical risk. As with most aggregators, margins are attainable and sustainable but tend to be reduced over time. Aggregation is a necessary foundation but cannot be the entirety of a vendor's value proposition.

Network configuration and construction strategies and tactics have been fairly static. Payer resources have been devoted to negotiating the lowest unit cost rather than creating, deploying, and demonstrating distinctive/differing provider selection criteria as well as quality of care metrics and measurements. There is little to no focus on identifying, quantifying, and managing clinical risk. Instead, the payers continue to default to providing the lowest unit cost as their value proposition. This has stifled investment and innovation, as well as the opportunity to grow or improve value propositions and margins.

Payers compete for market share through the benefits consulting community which acts as the distribution channel for payers to the plan sponsors. The objectivity of the consulting community, as well as their needed role in fostering innovation, has come into question in recent years. Rather than invest in data and analytics for driving and measuring results, consultants have a financial stake in the sale to/adoption of their Point Solutions and/or preferred vendors.

The selection of a network product is primarily a business-to-business (B2B) transaction. However, the users of the provider networks are individuals/members/patients as well as providers. This means success is contingent on the business-to-consumer (B2C) relationship. Payers have had limited experience in the B2C market. Their most significant experience has been through the public exchanges offered under the Affordable Care Act (ACA).

ACA is considered a commercial product. The ACA networks offered by commercial payers have typically been derivative of those payers' historic commercial networks. Within the ACA network provider reimbursements have been somewhat

reduced. Provider mix has been altered/designed to attract or dissuade certain types of individuals and/or risk characteristics. There has been little to no attention around building needed payer brand recognition and corresponding consumer stickiness.

A number of Medicaid payers, including many of whom are tied to provider health systems, have successfully entered the ACA market. Many of these payers have thrived in the ACA market. Their existing network composition/provider mix had historical success attracting and managing certain population risks. Their clinical management infrastructure, designed to tightly manage financial and clinical results, as well as their experience at managing B2C relationships, were already in place. For these payers it was also a matter of somewhat increasing reimbursement levels to their provider groups for their ACA product.

It is unclear how much commercial payers have learned from the Medicaid payers with whom they compete in the ACA market. The commercial payers should be utilizing this experience to build upon future state network solutions and strategies. We believe that it is a matter of time before some of the Medicare payers employ their learnings and enter the broader commercial payer markets as new competitors.

A review of the existing commercial provider networks shows that they are characterized in the following ways:

1. Reimbursement is typically on a fee for service basis with some one-way incentive-based reimbursement structures slowly entering the market - principally in regard to Primary Care services and providers.

2. Inpatient reimbursement is standardly on a DRG basis, thus minimizing the importance of clinical management and instead focusing efforts toward payment management.

3. Risk adjusted case rates, bundled payments, capitation, sub-capitation, and other forms of shared risk/risk transfer from payers to providers have begun to emerge slowly.

4. Network "effectiveness" is measured in terms of "attained" discounts calculated on a billed to allowed basis with consideration given also to the percentage of providers or claims dollars which are reimbursed on an in-network basis.

5. A number of emerging strategies have also been employed and deployed around the lowering of costs for use of out of network providers. These include the use of "wrap" networks such as PHCS and MultiPlan, advocacy services combined with "one off" negotiations with providers to avoid balanced billing or use of an established percentage of Medicare reimbursement to limit the plan's exposure.

Reconfiguration of Network Structure and Reimbursement

The market is in an early stage of a transition period. While the market remains focused on competitive unit cost and large friendly networks, there are a number of growing expectations for a more sophisticated set of strategies and tactics around network configuration and construction. For instance, we are beginning to see the creation of alternative and/or high- performance networks being offered in the marketplace. These network options are typically smaller in the number of contracted providers and have begun to deploy early stage/immature forms of outcomes-based risk sharing.

The Medicare Advantage market and corresponding network solutions are typically further along in the risk sharing space than their commercial counterparts. Not surprisingly, successfully managed Medicare Advantage plans utilize sophisticated patient centric care coordination tools and strategies to actively outreach and engage the patient. The Medicare Advantage market also employs more consistent and scalable risk sharing arrangements than their commercial payer counterparts.

Commercial payers need to utilize the lessons of the Medicare Advantage plans as they consider the evolution and thus scaling of clinical and financial risk transfer solutions. Key considerations slowing these types of innovations include:

1. A comfort for providers that fee for service reimbursement provides them a knowable revenue stream and mode which can be managed and manipulated to offset the financial results of changes and ill-effects in the reduction by government of traditional Medicare and Medicaid reimbursement levels. In addition, both providers and payers use fee for service as a safety net to offset/manage risks that would arise under alternative reimbursement models.

2. Despite its flaws surrounding clinical and financial management, the fee for service model allows for a simple and knowable method for calculating cost and trend – unit cost, number of units provided and mix of units provided. The challenges for alternative reimbursement modes surround the use of transparent and collaborative based predictive and prescriptive analytics and reporting. These analytics and reporting will need to demonstrate the realized short-term and long-term improvements in costs and/or clinical outcomes.
3. The primary focus for both payers and providers remains on unit cost. There is a lack of clarity, distinction, and differentiation around provider selection criteria. The same shortfall applies to quality-of-care initiatives, metrics, and outcomes.

4. The value proposition of existing value-based reimbursements/incentive pay (e.g., attribution and clinical management fees) has not yet been demonstrated. There has been an increase in the dollars charged to plan sponsors, outside the claim file on the historic "large and friendly networks". This has led to a tangible increase in costs (on a PMPM basis) with little, if any proven positive effect on trend.

Network Valuation Data Sources and Tools

The Uniform Data Submission (UDS) has been utilized for years to determine discounts and other aspects of network effectiveness. There are a number of flaws within the UDS structure that lead to significant concerns around the accuracy and findings for any given payer in any given market. Simply put, UDS "rolls up" each payer's claims by MSA to enable a basic discount analysis (we note that there is a second UDS submission to calculate PMPMs). UDS leaves some discretion to the payers around many of the details of their submissions. This discretion creates some inconsistency in the determination of value. In addition, the consulting firms which receive the UDS submissions each interpret that data differently.

Were UDS to take the necessary steps to narrow the inconsistencies of the submitted data sets and the interpretations thereof, there would still be some foundational limitations to the approach. The most significant shortfall ties to the fact that the data sets do not include information by NPI. This practice has been put into place to protect the proprietary nature of the negotiated arrangements between each payer and provider. However, it also creates a significant limitation whereby a recipient cannot calculate the needed analysis/ramifications of differing provider mixes among the payers. Other critical shortfalls tied to the submissions limit the accuracy and fullness of both case mix and service mix. In other words, due to the rolled-up and somewhat blended nature of the data, as well as the incompleteness/limits on the data elements, it becomes more than difficult to ascertain which payer is truly managing risk and cost on a more competitive basis in any given market.

While the UDS submission process is likely to continue, it will be either supplemented or surpassed in its nature and value in the near future. CMS (Centers for Medicare & Medicaid Services) has released a set of requirements for both providers and payers to publish price transparency for three hundred "shoppable services". Seventy of these services are pre- determined with the remaining 230 to be determined and displayed based upon highest volume. Providers are to show a breakout by payer. Payers are to show a breakout by health system/NPI. While there are some limitations to the CMS regulations, as well as some incentive for both payers and providers to attempt to employ allowable "masking" strategies, the release of this information will provide directional insight around unit cost competitiveness for both payers and providers in any given market.

We note that while CMS believes transparency will lead to a lowering of unit cost, history indicates that transparency tools often have an unexpected consequence of increasing costs. It is more likely that those payers receiving a deeper

discount will be asked to raise their price to a new market standard rather than payers with limited market share being able to negotiate down to a deeper discount.

Future State Models and Structures

In an attempt to obfuscate the completeness of price transparency, both payers and providers will be incented to develop more sophisticated reimbursement models with varying structures. This could take many forms including risk adjusted bundled payments, case rates, capitations, sub-capitations, and various forms of incentive-based pay.

We are likely to see a shift in the nature of payer/provider negotiations. We expect these two groups of players to begin focusing on investment moneys rather than reimbursement dollars. Investment moneys would not be calculated or included in the CMS shoppable services transparency requirements. It will be in everyone's shared interest to "partner" in new ways. We expect to see newly formed corporate structures such as joint ventures between payers and providers, separate incorporation of various provider system assets (e.g., physician groups, stand- alone infusion centers and stand-alone outpatient facilities) as well as joint ventures between and amongst provider groups. This could include differing examples of vertical and horizontal affiliation/co-ownership or revenue sharing. There are already examples of acute care and post- acute care facilities and providers working together under these types of arrangements.

The alternative reimbursement models and structures should both be driven by/link to first stage and later expected state Interoperability requirements as well as lead to improved alignment between payers and providers. If properly constructed, new strategies will help drive needed innovation. Providers will have known revenue streams which will allow for realignment of existing structures and resources into a more efficient delivery system which is less focused on inpatient revenue streams. Payers and providers will be allowed the needed time and means to collaboratively invest in necessary member centric and provider centric resources and technologies.

The development of future state models will both affect and be driven by the presently underway vertical and horizontal consolidation of health systems. In a growing number of markets, we are seeing the aggressive acquisition of physician groups, free standing outpatient centers and smaller hospitals by large regional systems.

In a typical geographic area, there are two to three large systems acquiring regional and community-based inpatient and outpatient facilities as well as physician practices. While these situations are being described as the creation of integrated delivery systems, they are often tied to an attempt to acquire or control market share including the broadening of geographic coverage. An analysis of results shows corresponding changes in billing, referral, practice and admitting patterns to better fit the needs of the health system rather than the needs of the patients. All too rarely are the health systems reconfigured for efficiency and effectiveness.

The cost of acquisitions by the providers has had undue effects on the market. The acquiring entities typically attempt to negotiate increased reimbursement levels from payers in order to offset the capital expenditures for the acquisitions.

When consolidations occur, the number of hospital beds generally remains at pre- merger/acquisition levels as do the number of outpatient facilities and assets. These mergers/acquisitions should result in a decrease of the former and an increase to the latter. The lack of clinical resource realignment and innovation has, however, recently been justified by the effects of the Pandemic. The hospital systems have publicly and regularly stated that they lack bed capacity to serve the high volume of patients requiring care. This reality leads to fear which will slow reduction in the number of hospital beds.

There are a number of existing "integrated delivery systems" that also operate as insurers/payers in both the Medicaid and Commercial markets. This first occurred in the 1990s with adverse results. A number of these health systems were unable to administer plans in regard to enrollment, eligibility, billing, and member services as well as pricing and management of financial risk. Many of these health system-based Commercial health plans closed or were sold off. A second round of this dynamic occurred when the Affordable Care Act (ACA) was put into law. Here also the market

experienced a number of the same issues as from the 1990s. The typical challenge for these structures is a focus on profitability of the health system rather than competitiveness of the health plan.

Consolidation of "integrated delivery systems" has left a number of providers/health systems seeking varying forms of partnership. No matter the size of the health system, it is apparent that there is a needed role for both the providers and payers. Foundational considerations around the creation of joint ventures traditionally include Regulatory Requirements, Corporate Structure and Governance as well as Capitalization including Reserves and Funding. These foundational considerations are then typically applied to the following:

I. Staged Approach to Risk Assumption
   - Fee for service with reconciliation
   - Value-based fee for service contracting reimbursement
   - Down-risk financial management/assumption
   - Full risk transfer/capitation

II. Duties as Assigned
   - Network configuration & contracting
   - Plan design and configuration for Medical, PBM and other coverages
   - Claims payment
   - Cash management & financial accounting
   - Delegated or non-delegated medical management
   - Compliance & regulatory reporting
   - Pricing

III. Data & Analytics
   - Designated datasets and elements to be shared and warehoused
   - Development of shared transparent clinical, financial, risk adjustment, and other predictive / prescriptive models and reporting
   - Distinctive quality of care metrics

IV. Successful Planning
   - Develop multi-year plan with milestones and measurements
   - Define goals and definitions of shared success
   - Migrate to mutually agreeable increasingly sophisticated risk and financial structure

Merging Network Configurations into Coherency: How Can Payers Distinguish Themselves?

Payers have historically sold their network products as the foundational/overall basis of their value proposition. The market in turn has purchased products based on the lowest common denominator – reimbursement levels. The payers' inability to demonstrate as well as assume risk on distinctive clinical, financial, and operational results has further reinforced this dynamic.

Payers view and market networks as a narrowly defined product rather than an integrated, coherent, and sophisticated multi-faceted solution. The failure to understand and explain the coherency/integration of provider selection, clinical management, member engagement as well as provider profiling and other critical functions has led the marketplace to seek answers elsewhere.

Plan sponsors have taken a series of steps in an attempt to solve for perceived and/or actual gaps. Innovative plan sponsors have attempted to drive change via two major routes. The first is to enlist or enroll in business coalitions and/or purchasing cooperatives that are designed to bring needed volume/mass to enable competitive cost of goods as well as drive innovation. This sometimes leads to forms of direct contracting. The second route is frequently marked by the purchasing of Point Solutions.

Plan sponsors typically require payers to embed various Point Solutions into the administration of their covered populations. Oftentimes selection of these Point Solutions is driven by the consulting community which frequently has a financial stake in the adoption of the solution/vendor. There are a broad range and growing number of digital and non-digital based Point Solutions for areas such as data warehousing, analytics and reporting, member engagement, varying forms and types of care management and coordination, health advocacy and payment integrity as well as network contracting of specific types of care and/or scopes of service. Failure by the payers to demonstrate and distinguish their own expertise and value in these areas contributes to the perceived need for these Point Solutions.

The reconfiguration and reconstruction of payer/provider networks reflects a foundational change in the design and value proposition of current networks. The present models assume, or are embodied by, a siloed approach of functionalities within the payers.

1. Provider profiling typically excludes physician prescribing patterns in spite of the fact that total pharmacy benefits comprise up to 35% of PMPM costs.

2. The design and structure of PBM-based benefits and management is typically segregated from pharmacy benefits dispensed under the medical plan as well the overall management of the patient.

3. Provider contracting is typically focused on reimbursement level with limited integration to provider profiling and quality initiatives.

4. Quality initiatives and measures are created devoid of provider profiling and/or recognition of the specific dynamics of the health care delivery system within a given service area.

5. Administration of reimbursement strategies and practices are dependent upon poorly managed data housed in antiquated data warehouses which are not structured to ingest and integrate critical data elements (e.g., lab results).

6. Adjudication of reimbursement strategies is dependent upon outdated claims systems that are not foundationally designed or engineered for processing of value-based reimbursement.

7. Payment Integrity initiatives are often focused on a static grouping of pre-determined known revenue cycle enhancement practices. This includes a continued dependency on post payment onsite audit as well as recent efforts around pre-payment audit. Payment Integrity management results are often not included in provider profiling.

8. Clinical management of the member is customarily based on a specific claim, encounter, or episode rather than the underlying disease state(s) and ultimately the overall health status of the member. This often leads to the incomplete and/or inaccurate use of clinical criteria creating abrasion for the member and physician as well as suboptimal outcomes.

9. Member Engagement is under resourced with behavioral science and expertise being underutilized. There is a lack of understanding of potential learnings tied to considering health care as a consumer product good. There is an additional failure by the payers in being a key integration point for the member in both the management of their own health and relationships as well as with their relationships with their providers.

10. The “member journey”, including an understanding of the member’s administrative and clinical experience, is often not well tracked, or measured. Patient adherence, compliance and satisfaction are barely quantified and qualified leading to a lack of alignment and/or accountability. These shortfalls are intensified by the fact that existing member to provider attribution models are often incomplete or inaccurate.

11. Pricing models are limited in their effectiveness due to the siloed operational functions discussed within this section of the document. There is an inability to quantify, qualify and integrate key data elements tied to clinical and financial risk. The flow and integration of key data elements will need to be addressed in next generation solutions. In addition, future state pricing models will require the embedding of a broad array of non-traditional data sets and elements which enable a more complete view and understanding of each member and provider as individuals.

Change Equals Opportunities

The changing nature of the markets illustrates a broad array of opportunities for those with the needed resources and commitment to innovation. Despite their reliance on aged legacy technology, the major payers presently have the lead position due to their market share, volume, and breadth of traditional data, as well as knowledge of the industry. However, the resources and skills for true comprehensive change go beyond the payers existing skillsets.

There is a clear opportunity for non-traditional players to enter and affect the markets. Technology driven companies that understand and support B2C relationships, supply chain, and logistics are in a strong position to deliver differentiating value propositions. The depth and breadth of their non-traditional data sets and models potentially enables them to better assess and manage risk, as well as more completely understand and engage both members and providers.

Given the need for rapid, thoughtful, and scalable change, it is likely we will see traditional payers and new entrants simultaneously competing and collaborating. For instance, Anthem is building some of its own digital solutions, while also relying heavily on IBM. Highmark BCBS has announced a partnership with Google around population health management. EverNorth/ESI has partnered with Amazon on a discount pharmacy benefit card.

Amazon is clearly positioning itself across multiple places across the various healthcare markets. For instance, they are actively growing their position in the digitally based Durable Medical Equipment (DME) market. This follows the announced dissolution of Haven by Amazon, JPMorgan Chase, and Berkshire Hathaway. Haven was initially announced as a beachhead of innovation. There was an apparent misalignment of goals between the three owners, and each have since gone their own way.

It is also worth noting JPMorgan Chase is the largest investment banking firm in the healthcare space. Successful future state payers, plan sponsors, health systems and those entities providing services to them will need to embrace a strong culture of change and innovation. Multidisciplinary/cross functional thinking and operational structures are critical success factors. These organizations will need to develop a series of integrative technology platforms which encompass the future state capabilities and functionalities outlined within this White Paper. Such platforms would perform all needed B2B and B2C functions and transactions. Existing technology and product ecosystems are complex and disconnected. As a result, these platforms will need to be able to support, supplement, simplify, connect and/or replace legacy systems.

The technology platform(s) will be linked to and fed by an Enterprise Data Warehouse (EDW). The EDW will ingest, cleanse, enrich, and integrate key operational and non-operational data sets. It will perform sophisticated and dynamic modeling which produces needed predictive and prescriptive models, analytics, and reporting. Successful future state service providers will be operating within and across the payer, governmental, plan sponsor, and individual consumer marketplaces.

Critical Success, Considerations and Opportunities

There are a broad number of critical considerations and opportunities. Each of these has standalone importance but are also best addressed through a synthesized approach.

1. **Adoption and Enhancement of Digital and Virtual Care** – The Pandemic has dramatically increased the need for and use of Digital and Virtual Care. The existing industry leaders for Virtual Care include Teledoc and Amwell (formerly known as American Well). The value of these companies has suddenly and dramatically increased, while their IT infrastructure and functionality have remained in an infancy stage.

   It is clear that Virtual Care will expand beyond Primary Care into other categories of medicine. In order to ensure quality of care, substantial investments need to be made around data ingestion and transfer, provider profiling and selection criteria, addressing of emerging payment integrity issues as well as the deployment of technologies such as facial recognition and corresponding natural language tools to ensure diagnostic accuracy, optimal care, and patient satisfaction/engagement.

   As with Virtual care, technology is driving the adoption of a broad range of Digital based solutions. These are far-ranging in nature. Often times they are "wearables" and or applications available on members' personal devices allowing for "real time" access. These Digital applications are also a continuation of traditional "Point Solutions" that have long existed in the market. These Point Solutions have been designed to address, augment and/or replace perceived or actual shortfalls of services offered by the payers. These Point Solutions take on a broad range of capabilities, including but not limited to, advocacy, member service call centers, both broad based and condition specific network solutions, as well as a host of clinical and care management capabilities.

   The selection and adoption of Point Solutions requires careful thought and execution. Adding and/or "complicating" a health plan and/or plan sponsor's ecosystem can lead to administrative complexity, data and technology integration concerns, deteriorated member experience, and a lack of clarity around return on investment.

2. **Care Extenders** - Contracting and integration of "Care Extenders" designed to broaden needed treatment options, thus ensuring access, efficacy, quality, and satisfaction. Examples include retail primary care centers (e.g., Walmart and Minute Clinic), midwives, a broad array of in home post-acute professionals such as EMTs, a fuller spectrum of licensed Behavioral Health professionals, holistic medical providers, etc.

3. **Care Coordination on Complex Care Cases/Disease States** – Proactively addressing the physical and Behavioral Health needs of severely ill patients and their families/caregivers. In order to optimize care and outcomes for the patient, as well as avoid downstream ill - effects on caregivers and family members' coverage and contracting strategies need to be reconsidered.

   Severely ill homebound patients with degenerative and/or individuals diagnosed with multiple and/or complex disease states require varying degrees of in-home care which oftentimes may appear to be designated as (not presently covered) custodial care. Broadening coverage and contracting in this area will likely improve patient adherence as well as lessen the burden on non-professional caregivers (e.g., family members), thus avoiding the degeneration of health status for all involved. Initiatives in this area would include integration of Behavioral Health specialists to examine and monitor the status of the patient and the non-professional caregivers.

4. **Behavioral Health** – The foundational recognition and valuation of the direct relationship between behavioral and physical health status is a critical success factor. Integration of Behavioral Health professionals and care should improve compliance/adherence, hasten recovery times, optimize clinical outcomes, and avoid recidivism.

Operationalizing integration of behavioral and physical health and care will require the redesign of clinical, data and process workflows. Comprehensive treatment teams and clinical protocols will need to be developed, along with corresponding individualized treatment plans. Patient information will need to flow on a real-time basis between and amongst the payer and all the designated caregivers. For instance, a recovering addict would likely need primary care, to be determined specialty care, prescriptions of non- addictive Behavioral Health medications, Behavioral Health therapy and services, physical therapy, and nutritional support, as well as dental care.

As with the treatment of physical disease states, the proper/accurate Behavioral Health diagnosis becomes the basis for treatment. Also, as with the treatment of physical ailments, Behavioral Health patients must receive care from a professional trained to treat that patient's specific diagnosis. Psychiatrists, psychologists, social workers, and other counselors are each trained in or have experience in specific areas of Behavioral Health care. one size does not fit all. Network contracting requires the inclusion of all needed areas of Behavioral Health Specialty.

A critical step to effectively embedding Behavioral Health into a treatment plan will require the de-stigmatization of Behavioral Health conditions to many of the covered members and their families. This will require both a broad-based and proactive communication strategy/process. It will also require an understanding that different Behavioral Health providers as well as alignment with the members' existing group of providers.

In order to optimize the opportunities presented by integrated Behavioral Health, the payers will need to undertake pro-active engagement strategies which identify potential at-risk and of-need individuals. Success in identifying this population segment will require the use of sophisticated predictive and prescriptive analytics and reporting. These tools will utilize a broad set of traditional and non-traditional data elements which will enable modeling of a specific individual's circumstances and potential conditions.

While the potential benefit of integrated physical and Behavioral Health is clear, the payers will need to foundationally change their approach to Behavioral Health. The payers have overmanaged and/or mismanaged the use of Behavioral Health services. A significant number of psychiatrists are not contracted on an in-network basis. This leaves prescribing authority to non-properly trained professionals. In addition, there is also typically a pre-existing/predetermined standard for a number of allowed visits to a Behavioral Health professional based upon specified diagnostic codes.

The historical approach of the payers is tied to a singular view of the cost of Behavioral Health conditions. This view fails to consider the overall health status of the patient, ignores the chronic nature (and therefore ongoing need for services) tied to some Behavioral Health diagnoses, and a lack of ability to quantify/qualify optimal clinical results. The default position has been to rely on the prescribing of Behavioral Health drugs. As a result, a high percentage of Behavioral Health patients remain on the same prescribed drug regimens for extended periods of time with little to no offset/use of professional services. This approach establishes an insufficient level of care.

The opioid epidemic, which we continue to face, can be viewed as an outcome of the care management flaws outlined above. The epidemic was likely foreseeable and somewhat avoidable based upon the available data. The same is true of the emerging Behavioral Health crisis tied to the Pandemic. The payers should be planning for this likelihood.

It is in the best interest of all stakeholders that the payers develop prescriptive and predictive analytics and reporting containing needed metrics and measurements to quantify and qualify the return on investment for integration of Behavioral and Physical Health. Success will enable proper innovation and resource allocation, which will include but not be limited to:

- Design and deployment of a comprehensive and integrated Behavioral Health platform/solution which considers and utilizes the full spectrum of Behavioral Health types of coverage and benefits, models, professionals, and modalities of care (e.g., ranging from EAP to inpatient services).

- The development, deployment and sharing with providers of predictive models which identify at-risk and at-need patients, including those with the likeliness of addiction and/or overdose.

- Proactively identify, assign, and integrate Behavioral Health resources/professionals with needed specified expertise designed to match the needs of various patient segments and types. For example, acknowledging and addressing the needed service providers for depression and anxiety tied to patients receiving significant, acute, and chronic care.

- Development and coordination of sophisticated provider profiling, which embeds the prescribing patterns of all providers. Utilize this opportunity to operationalize the management of Behavioral Health prescribing authority to properly trained clinicians.

5. Specialist Driven Network Configuration – Traditional focus has been on Primary Care provider contracting strategies and corresponding incentives. There has been a long debate with both conflicting and contrasting views around the strength and efficacy of the Gatekeeper. A review of rendering services as displayed within any significant data set illustrates that the majority of the cost of care emanates from Specialists. The Specialist overwhelmingly determines the majority of services rendered (inpatient and outpatient) as well as the course of care through the care continuum. Optimal clinical and financial outcomes, as well as successful reimbursement can only be realized through incorporation and cooperation of the various Specialists.

6. Integrated Medical Plan Based Pharmacy Benefit Management – As stated previously, pharmacy benefits comprise up to 35% of plan costs when including both medical and PPM based dollars. The existing broad range of issues on the medical based pharmacy side include:

   - Clarity and consistency of coverage rules for drugs and services under the medical plan vs those under the PBM

   - Coordination and consistency of formularies/preferred drugs among and between varying facility-based providers and PBMs in order to address inconsistent treatments/drug regimens experienced by individual patients based on the dispensing site of service

   - The negotiated cost of medical based pharmacy goods

   - The accuracy of the number of units billed by the provider and adjudicated by the payer due to the limitations of medical claims systems

   - Site of service optimization

   - Deployment of “brown bag” and “white bag” strategies

   We believe that the capitation and/or sub-capitation of specific Specialty drug classes would begin to address many of the above issues. The entity which assumes the financial risk would be in the best position to drive alignment, optimization, and overall resolution. In addition, the capitation/sub-capitation would eliminate the cost of Specialty drugs from existing medical payer/provider reimbursement outlier clauses thus improving overall financial results.

   The leading PBMs are already working with health plan payers to help address the outlined site of service as well as the brown bag/white bag issues. Cost of goods for these PBMs are typically 30 – 40% lower than that charged by facilities to the medical payers. The same PBMs are also oftentimes assuming risk/charging

capitation on rare, high cost “lightning drugs”. We suggest combining these strategies by going “downstream” to cover a broader array of Specialty drugs with costs of goods at specific target levels (e.g., treatments of $200,000 or more).

7. **Development of a “next generation” Blue Card type solution with increased functionality –** This solution would link various individual/independent health plans to one another should they decide to create their own multi-site/national account capability. In addition to linking the plans the platform would support each plan on an individualized/as needed basis for a broad range of critical functionality including but not limited to pricing, provider profiling, care management, member engagement/services, claim adjudication, contracting, pharmacy management, data and analytics and other supporting services.

8. **Creation of a Group Purchasing Organization (GPO) for various payer types –** Services could include leveraging the combined purchasing power of otherwise competing entities in order to negotiate an optimized cost of goods for network and other payer needed resources. The GPO would also link to and offer services available through the previously mentioned future state administrative technology platform(s) and EDW.

9. **Development of Dynamic Modeling Capabilities -** Enable the accurate valuing/assessment as well as comparative results of proposed clinical and financial solutions. Key analytical functionality would include perspective and retrospective valuation of various Point Solutions, digital and non-digital engagement tools, quality of care metrics, network configuration, and value-based reimbursement criteria.

   The platform would enable accurate risk adjustment and pricing, designed to the individual/personal level, with “roll up” capabilities. Corresponding full transparency and data sharing between payers and providers, would be embedded, thus driving, and supporting value-based reimbursement, capitations, and other forms of risk sharing.

   The dynamic modeling would begin with the ingestion and integration of multiple data sets and elements. The first data sets would be “traditional” such as eligibility, medical and pharmacy claims (including lab and genome results), EMR, clinical, member services, disability, workers compensation and provider profiling. However, success would depend upon the adoption and integration of “non-traditional” data sets. The value of these data sets would be realized through the deployment of complex Behavioral Science applications and tools.

   The non-traditional data sets would provide information on individual financial health, purchasing habits and history, lifestyle, social media activities as well as socio-economic status and other social determinants. We realize that the potential combining of these data sets bring into question some limitations around HIPPA that would need to be addressed.

10. **Risk Assumption Opportunities -** The combination of the data set/data warehouse and administrative platforms enables the thoughtful entry into risk assumption and management. There is an opportunity to realize both information-based and process- based assessment and management of risk. Potential risk-based products could include Medicare Advantage, Medicaid, disability, workers compensation, stop loss, capitations and sub-capitations, value-based reimbursement, reinsurance to provider groups and smaller payers as well as voluntary benefits.

Conclusion

This white paper has attempted to lay out key short term and foundational issues and considerations around the healthcare marketplace. We have examined the status quo including a detailing of the attributes of present-day solutions and structures along with both corresponding shortfalls and potential improvements.

The marketplace is undergoing rapid change due to a broad range of forces including unsustainable increasing costs, increased regulation, new technologies, demand from consumers (both plan sponsors and members) for clarity around clinical and financial impacts, as well as other foundational issues.

It is clear that foundational and significant change is inevitable. Successful management of clinical and financial risk is dependent upon the ingestion and ordering of broad and deep data elements into information along with actionable insights. The duality of healthcare as a B2B and B2C enterprise has begun to be addressed. We are at the beginning of a series of fragmented changes. The successful players will be those who put the pieces together through simultaneous member centric and provider centric analytics, reporting and actions.

Editor's Note:

This white paper was developed in 2021 under Cambridge Advisory Group before acquisition by Risk Strategies in 2022. Read the press release here.

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