OPTUM™

Perspectives

Six strategies to improve your health plan's performance in 2012

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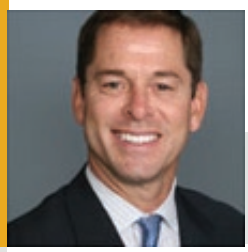


Welcome to Optum Perspectives!

For those of us energized by the opportunity to solve big challenges, this is an exciting time to be working in health care. Amid a raft of new regulatory concerns, uncertain economic conditions, and changing consumer expectations, each of us has before us an unprecedented opportunity to make decisions that positively affect the health of our communities and our organizations.

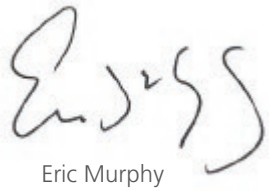
This is what keeps me, and I would bet many of you, awake at night. The good news is this: you are not in it alone.

At Optum, we not only share your passion for health care improvement, we are committed to being part of the solution. Further, we are dedicated to facilitating dialogue between stakeholders so that we can learn from each other's experiences and forge new partnerships to deliver better services to your members.

In support of these goals, we launched Perspectives. This inaugural issue offers industry experts' thought-provoking discussions—drawn from our recent webinar series—plus real-world examples of proven strategies for improving health plan effectiveness, profitability, and sustainability.

Please enjoy this edition of Perspectives and share it with a colleague or friend.

Regards,



Eric Murphy

PERSPECTIVES

Six strategies to improve your health plan's performance in 2012

Fall 2011

Changes to CMS' star payment system: **implications for plans**

To help plans improve their star ratings, OptumInsight presented a webinar evaluating the measures that were changed in the star program for FY 2012 and proposing best practices that plans can implement to succeed under the changes. The following information highlights some of the program changes and strategies covered in the webinar.

Presented Sept. 20, 2011

Expert presenters
Eric Cahow, Ph.D., Senior Director,
Government Program Management and Strategy,
OptumInsight

Scott Fries, Vice President,
Government Program Management and Strategy,
OptumInsight

Changing measures

The Affordable Care Act of 2010 directed the Centers for Medicare & Medicaid Services (CMS) to pay a quality bonus payment of 5 percent to Medicare Advantage organizations that achieve quality benchmarks. To qualify for the quality bonus payment (QBP), health plans need to attain four out of a possible five stars on the Medicare Health and Drug Plan Quality and Performance Ratings. This system, known as the star ratings system, is intended to focus the industry on quality improvement.

2015 payment will be determined by clinical performance in 2012

The first payments under the star system will be made to plans in January 2012. From 2012 through 2014, plans attaining fewer than four stars will receive partial payments—bonuses equivalent to 3–4 percent of revenue. In 2015, it will be all or nothing. Those earning three or fewer stars will receive no bonus payment, while those receiving four or more stars will receive a QBP of 5 percent.

On July 27, 2011, CMS released its 2012 star ratings measures, adding new ones and removing or recalibrating others. While there were few surprises beyond lower-than-expected Healthcare Effectiveness Data and Information Set (HEDIS) inflation, it still has a material impact on plans' strategies for monitoring, intervening, and improving performance

Best practices

Medicare Advantage plans can take many actions to improve their star ratings. OptumInsight has identified five critical domains that determine success in star improvement: organization and strategy, operations improvement, provider engagement, member engagement, and data and reporting.

Star Improvement Model

Organization and strategy

Many plans begin their star improvement programs assigning measures to individual owners, much like the chapter owners in an NCQA accreditation exercise. This can be limiting. OptumInsight recommends a more rounded strategy that begins by increasing the knowledge of the organization. Educate staff about the goals and processes of the star program. The strategy should also examine benefits design. With medication adherence measures and other Part D components making up a larger portion of star scores, it is important to carefully address drug tier levels and pricing. Finally, plans need to realize that not all measures are equal. Because they will be able to impact some, they should focus on a meaningful number of measures.

Operations improvement

Two areas can have a substantial impact on operational measures:

– **Member satisfaction surveys**—Don't be caught off guard. Use mock member surveys to better understand an ongoing process and detect variations.

– **PBM optimization**—Operational excellence is especially important for Part D, in which administrative measures predominate. OptumInsight recommends facilitating collaborative efforts with pharmacy benefits managers (PBMs).

Member and provider engagement

To close the clinical gaps in quality as well as risk adjustment, plans must focus on engaging providers and members. That can be done directly with mail, telephone or email interventions or by working directly with providers combining both interventions into a single contact.

– **Member engagement**—Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) measures appear to be particularly resistant to intervention by plans. OptumInsight recommends that clinical programs should be designed in alignment with the star system and take a regimented approach to getting members assigned to programs that improve care quality and satisfaction.

OptumInsight star provider/member engagement model		
Network stratification	**Provider approach**	**Member approach**
High volume, high Commitment	Collaborative partnerships	Through provider
Low volume, high commitment	Pay for activities	Through provider and then member direct
Low volume, low commitment	Remediation	Member direct
High volume, low commitment	Pay for activities	Member direct and then through providers

Using quantitative analysis to plot providers, groups, and their related membership into groupings that support logical outreach strategies, OptumInsight partners with plans and providers to develop customized provider incentive and clinical quality programs that fit the needs of the organizations and their marketplace.

– **Provider engagement**—The selection, growth and alignment of high-performing providers has never been more important. OptumInsight recommends developing a customized provider incentive and clinical quality program that is aligned to the needs of the organization and marketplace. It must be realistic and align with financial and clinical objectives.

Data and reporting

Data collection, organization, and reporting allows for maximum impact of member and provider touch points. OptumInsight recommends evaluating current reporting and data sources and developing a reporting system that is integrated into a dashboard with other star data streams. This creates a management tool with the ability to drill down and understand poor-performing markets, provider groups, and measures. It should integrate data from utilization, pharmacy, risk adjustment, HEDIS, and operations.

Star performance monitoring needs to include internal measurement reports to track year-to-date progress of HEDIS performance, based on paid claims data.

Data analytics requirements need to:

- Identify members eligible for HEDIS measures
- Determine if eligible members are compliant with HEDIS measures
- Compare performance in current period to past periods
- Have drill-down capabilities to track member/provider engagement touch points and close rates

How OptumInsight can help

OptumInsight works closely with plans and providers to develop customized provider incentive and clinical quality programs that fit the needs of their organizations and marketplaces. Our solutions and expert consulting offer:

· A fact-based approach to member stratification
· Quantitative analysis that supports logical outreach strategies
· Collaborative partnership design

Want to learn more?

Visit www.optuminsight.com or call 800.765.6807 to learn more about the star payment system.

Presented Sept. 27, 2011
Expert presenters:
David Hochheiser, Vice President, OptumInsight

Claire Kapilow, Director of Regulatory Affairs, OptumInsight

Mike Sauls, Vice President, OptumInsight

Achieving ICD-10 financial neutrality—

fact or fiction?

The Oct. 1, 2013 deadline for implementation of the ICD-10 code set is rapidly approaching. As organizations prepare, many are wondering if the switch to ICD-10 will be financially neutral. In essence, will payments under ICD-10 be similar to ICD-9?

The answer to that question depends on many variables, including:

- Policies
- Information technology (IT) remediation
- Code translation and claim editing
- The use of hierarchical condition categories (HCCs)
- How ICD-10 impacts diagnosis related groups (DRGs)

Policies

Current coding policies and provider contracts are articulated in ICD-9 terms and will need to be restated in terms of ICD-10-CM/PCS.

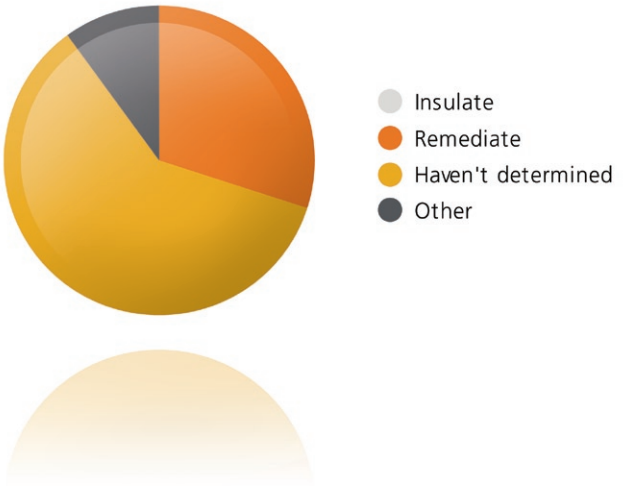
Trend analytics

Trend analytics also are based on ICD-9 claim data. "Organizations will still need to analyze historical claims using ICD-9 codes, but they will need to develop mapping strategies to compare ICD-9 claims with ICD-10 once the new code set is implemented," said David Hochheiser, vice president, payment integrity, OptumInsight.

Payment integrity

There is inherent payment integrity risk involved in the transition. For example, the monitoring algorithms looking for overutilization will have to change. Payers will need to monitor code creep and abuse that may happen during the transition.

Webinar attendees were asked:
"What type of remediation plan do you have?"



To prepare for ICD-10 implementation, there are three remediation approaches that organizations can take:

1. Insulate

- Process all claims in ICD-9
- Translate ICD-10 to ICD-9 for pre-processing
- Translate ICD-9 to ICD-10 for remittance

2. Process in native coded language

- Process ICD-9 received claims in ICD-9
- Process ICD-10 received claims in ICD-10
- In this approach, there is a need for flexible infrastructure and contracts
- May entail more IT work

3. Full remediation

- Process claims received Oct. 1, 2013 and later as ICD-10
- This is consistent with the federal government's approach

"In general, the insulate approach is not recommended, as an ICD-9 code may translate into multiple ICD-10 codes, which makes accurate mapping a challenge," Hochheiser said.

Code translation

Although provider organizations will be required to bill in native ICD-10 upon the Oct. 1, 2013 deadline, some payers will take different approaches. For example, the majority of federal and state payers, as well as many commercial plans, will process claims using ICD-10. However, other payer organizations will continue to process using ICD-9, which will require translating ICD-10 codes received from providers into ICD-9.

Code and claim editing

During the transition to ICD-10, organizations will need to adjust their coding practices, editing processes, and analytics. Many payer-specific policies that focus on clinical and other areas also will need to be updated. In addition, the government will need to update policies that focus on hospital-acquired conditions, the outpatient code editor (OCE), as well as national and local coverage determinations (NCDs and LCDs). However, the government has yet to publish any details about OCE, NCD, and LCD changes, which makes it difficult to prepare for them.

Hierarchical condition categories (HCCs)

The transition to ICD-10 will have a significant impact on HCCs since more than 1,000 HCC ICD-9 codes have more than one ICD-10 option. Complicating the issue further is the absence of government-released ICD-10 HCC lists. Organizations will need to consider and establish policies on when to use multiple codes and when to split codes for HCCs. Initially, more medical reviews may be required.

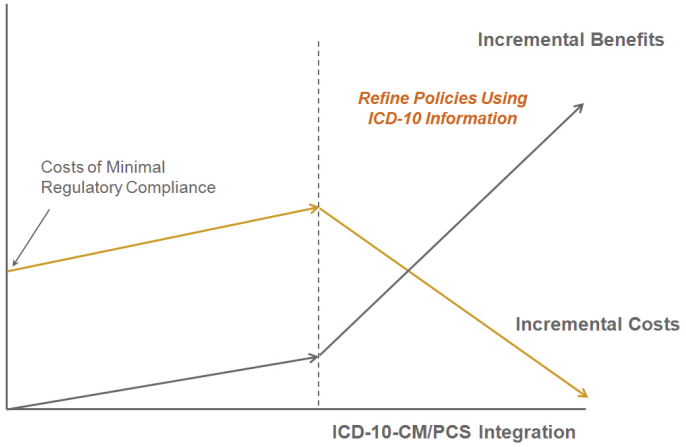
How ICD-10 impacts DRGs

In March 2011, Medicare published is first draft of DRG definitions for ICD-10. In the draft, DRG definitions, numbers, and logic remain the same, but the principal diagnosis code list is based on ICD-10. That means there are more choices, since there are fewer than 20,000 ICD-9 codes, and more than 140,000 ICD-10 codes.

"There are many circumstances when a patient who was discharged on Sept. 30, 2013 and coded with ICD-9 might not get the same DRG if discharged one day later on Oct. 1, 2013, when coded in ICD-10," said Claire Kapilow, director, regulatory affairs, OptumInsight. "A condition coded in ICD-9 may require combinations or clusters of ICD-10 codes to mean the same thing." These clusters may have unintended reimbursement impact.

Net impact of ICD-10

"Achieving budget neutrality—while desirable—is likely unachievable, but there are things that can be done to mitigate the risks," said Michael Sauls, vice president, consulting, OptumInsight. Payers will need to be flexible and look at short-term contracts and reconciliation mechanisms as they work with their provider network during and after the transition.



How OptumInsight can help

OptumInsight consultants help organizations with ICD-10 assessments, remediation, and transition, as well as business process optimization. We also offer numerous tools, tables, and training including:

- Worfklow application
- Proprietary crosswalk files
- Grouping and pricing
- Coding books

Want to learn more?

Visit www.optuminsight.com or call 800.765.6807 to learn more about ICD-10 financial neutrality.

Market transformation = **new opportunities for managing risk, improving engagement, and driving growth**

Presented Sept. 22 and Sept. 29, 2011

Expert presenters

Scott Guillemette, ASA, MAAA, Vice President, Risk Optimization and Growth, OptumInsight

Kevin Ashpole, Director, Risk Optimization and Growth, OptumInsight

> *Payers will need to become competent in working with different cultures, based on race, income, language and age*

Health plans are facing the most significant changes since the advent of Medicare, creating the need to re-think risk management, pricing, sales processes, and member interactions. To help health plans face these challenges, OptumInsight presented the webinar "Market Transformation = New Opportunities to Manage Risk and Drive Growth" on Sept. 22, 2011. An expanded delivery of this webinar was presented Sept, 29, 2011, entitled "New Opportunities for Managing Risk, Improving Engagement and Driving Growth." Both webinars provided demonstrations of market and margin modeling and how to apply lessons learned. The following information highlights some of the strategies covered in the webinars.

Employers and health plans need to prepare for extensive market changes as new regulations, subsidies, and tax credits are being implemented to transform the marketplace. Changes mandated by the Affordable Care Act (ACA) are anticipated to result in:

- **Program expansion**—A larger percentage of the population will be eligible for Medicaid, and the creation of health benefit exchanges (HBEs)—with substantial subsidies—will require the development of new plan offerings
- **Rating reforms**—Plans will be required to guarantee coverage and renewability, and not exclude coverage for pre-existing conditions. In addition, state departments of insurance and potentially the U.S. Department of Health and Human Services will review rate increases and strictly monitor medical loss ratios
- **Subsidies**—Small businesses will be eligible for tax credits, and individuals can receive subsidies when income is between 133 percent and 400 percent of the federal poverty level
- **Penalties**—Individuals may be penalized for not securing health coverage, and employers may be penalized for not offering minimum essential health coverage, or for offering benefit levels below minimum required levels
- **Unintended consequences**—There is potential for employer "dumping" of individuals, market churn between products, and a gaming of the system by employers and consumers

ACA - induced population shifts (in thousands)

Current Source of Coverage		Private Coverage Through Exchange			Private Coverage Out of Exchange		Medicaid and SCHIP (Excluding Duals)	Medicare, TRICARE & Other	Uninsured
		Employer	Individual with Subsidy	Individual No Subsidy	Employer	Individual			
Employer Workers and Dependents	148,922	11,645	6,235	1,895	125,028	156	3,356	12	595
Non-Group	12,040	312	4,499	321	775	4,560	902	0	672
Employer Retired	3,288	0	0	0	2,960	0	327	0	0
TRICARE	5,344	0	0	0	0	0	0	5,344	0
Medicare	32,852	0	0	0	0	0	0	32,852	0
Medicare Dual Elig.	8,796	0	0	0	0	0	0	8,796	0
Medicaid & SCHIP	45,229	487	2,253	0	1,048	6	41,425	9	1
Uninsured	51,631	2,059	9,480	1,349	5,398	0	13,838	0	19,508
Total	308,102	14,502	22,467	3,505	135,209	4,722	59,848	47,014	20,775

- Employer and Medicare coverage relatively untouched
- Exchanges pick up Non-group and Uninsured
- Medicaid grows substantially from uninsured shift

Anticipated shifts in membership and risk

As a result of these changes, health plans should anticipate substantial shifts in membership and risk. The introduction of HBEs is expected to reduce the number of uninsured individuals from more than 51 million to fewer than 20 million. Medicaid programs will expand by as much as 32 percent as many of these uninsured individuals join the program, and HBEs will pick up a substantial portion of individuals who are either uninsured or covered by non-group benefit programs. Throughout these changes, employer and Medicare coverage are expected to remain approximately the same, However, employers may experience significant "churn" within the segment. (See Table 1)

With the introduction of HBEs, demographics of the Medicaid population are expected to substantially shift to include more elderly individuals, as well as young and healthy men. This shift will significantly change the risk pool, challenging actuaries to develop pricing that can sustain the plans.

Beyond HBEs, states also have the option of creating their own federally subsidized basic health programs (BHPs) to provide coverage for low-income populations. These state-sponsored BHPs are expected to gain as many as 9 million members as they are implemented. "Only a handful of states, however, have announced that they will pursue this option, since the majority of states already have their plates full addressing regulatory and information technology challenges," said Scott Guillemette, ASA, MAAA, vice president, risk optimization and growth, OptumInsight.

Addressing the nation's uninsured population represents a $42 billion annual opportunity for payers that participate in HBEs and BHPs. Payers that participate in this market, however, should be prepared to manage lower-income populations, since an estimated 4.4 million new members will be between 138 percent and 200 percent of the federal poverty level. Additionally, a larger number of 19- to 24-year-old adults, are expected to join the exchanges. These individuals also have a much different morbidity rate than traditional Medicaid populations, which will require changes in pricing and plan structure.

For individuals joining HBEs and BHPs, the characteristics are divided among those who are eligible for subsidies, and those who are not. For example, the subsidy-eligible population will be less sensitive to price because of the subsidy. In contrast, individuals who are not eligible for subsidies will be more price sensitive when it comes to

premiums. Payers that enter these markets must be acutely aware of the population differences to appropriately price and manage their plans.

Another population shift is likely to occur in the small employer market. Payers that focus on this market have the potential to lose a substantial portion of members to exchanges.

A shift in marketing

Competition will increase as HBEs and BHPs develop programs to attract consumers. "The entities need to transition to consumer-driven organizations to attract and maintain members," said Kevin Ashpole, director of risk optimization and growth at OptumInsight. "These organizations need to leverage technology, such as patient portals, mobile/tablets, and custom apps, as well kiosks to create an interactive online experience for customers. Frequently, these electronic mediums are the initial point of contact with consumers."

The highly structured and regulated nature of HBEs and BHPs puts them at risk of becoming commodities within the marketplace. To differentiate themselves, plans need to become creative in their benefit design and network features and may want to consider the following elements:

- **Deliver value outside of medical insurance**—Value-adds may include discounts on non-covered procedures, health food stores, health clubs, as well as partnerships with community events
- **Offer additional products**—Dental, life, and vision benefits are still important components of the selling process
- **Create a brand**—Plans need to create and promote a brand that includes locations, ease of use, and whole health value
- **Manage churn**—Product portfolios and technology offerings will help maintain membership levels
- **Understand buying preferences**—Consumer-driven organizations are more like retail environments when it comes to buying preferences

Payer implications

As the market transforms, payers should ask themselves a series of questions to determine if, and how, they will participate in exchanges. "From an actuarial perspective, payers should scenario test to determine the impact of new members on the risk-pool and on the payer's medical loss ratio," Guillemette said.

New regulations, developed by the exchanges, will determine the criteria for payers to become qualified health plans (QHPs). These regulations, although they are still being defined, will require payers to participate in a 12- to 18-month accreditation process, submit their rates annually, and recertify as the regulations dictate.

Under these new market conditions, network structure is more important than ever. New Medicaid enrollees will stress provider capacity in rural communities and concentrated urban areas. In addition, taking on new segments of the adult population (e.g., younger adults, ages 19 to 24, and the pre-Medicare population, ages 50 to 64) requires a different configuration of specialists and outreach professionals. Within this population will be an increase in non-English-speaking individuals, so plans will need to expand the number of bilingual customer service representatives and marketing materials and even give special consideration to program names.

"Payers will need to become competent in working with different cultures, based on race, income, language, age, etc.," Guillemette said. "The shift will require more of a retail mindset, which is largely different than the market operates today."

Most importantly, participation in exchange programs will alter the underwriting cycle. The ACA creates forces and mechanisms that deepen and lengthen loss cycles. The opportunity to leverage gains, as a contribution to surplus, is limited by MLR thresholds and rebate aspects of the ACA regulations. Changing dynamics will make the filing and implementation of corrective pricing actions less certain and less timely. Although substantial opportunities exist, risk factors will certainly change, if not increase overall.

How OptumInsight can help

OptumInsight provides payers with a strategic approach to risk optimization and growth. This approach includes:

- Member movement scenario modeling
- Retail readiness assessments
- Competitive insights obtained via game theory exercises
- Enterprise alignment
- Strategic plan formulation

Want to learn more?

Visit www.optuminsight.com or call 800.765.6807 to learn more about market transformation.

Monitoring for post-implementation impact of ICD-10 conversion

Presented Oct. 4, 2011

Expert presenters

Dean Farley, Vice President, Consulting, OptumInsight

Carrie Cooper, Director, Associate Director, Health Care Operations and Technology, OptumInsight

The Oct. 1, 2013 ICD-10 implementation deadline is rapidly approaching, yet many health plans are already behind in their preparations. According to a poll taken by participants of the webinar, slightly less than 41 percent "were thinking about ICD-10 preparations," while only 27 percent stated that they "were actively engaged in remediation efforts." (See Figure 1)

Where is your organization in its ICD-10 efforts?

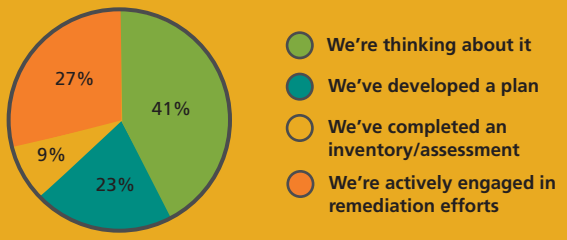


Figure 1

Evaluating ICD-10 challenges and impact

One of the primary challenges of transitioning to ICD-10 is that the industry has no practical coding experience with the code set, so there is no way to predict how provider coding practices will change after the implementation deadline. Health plans can, however, anticipate the areas that will be impacted by the ICD-10 transition, establish benchmarks, and predict potential outcomes.

These areas include:

- Claims operations
- Financial performance
- Call centers
- Provider network and provider relations
- Member management programs
- Member services
- Post-pay audit and recovery

"If you're not tracking data, how can you measure the future impact of ICD-10?" said Dean Farley, vice president, consulting, OptumInsight. "Health plans need to be asking themselves what the trends look like, and what are the acceptable limits for medical losses or autoadjudication rates? The time to ask these questions and build data models is now, not September 2013."

Pre-deadline ICD-10 considerations

Health plans need to assess a number of areas before the ICD-10 deadline to determine potential challenges, including:

- DRG drift—Are there changes in DRG assignment that impact reimbursement and contract categories?
- Coding risk—What is the spread of coding within any particular category?
- Fraud and abuse—Will ICD-10 help with more effective fraud and abuse detection?
- Reimbursement and clinical policy changes—Has the current reimbursement and clinical intent of policies remained neutral in the transition to ICD-10?
- Hard or soft cutover—How will either approach impact:
  - Compliance?
  - Trends, reserves, and lags?
  - CMS and state reporting?
  - Operational impacts?

In addition, health plans need to assess many operational areas, such as analytic capabilities and whether existing reports will still be functional when ICD-10 codes are introduced. Also, data warehousing needs may change since the ICD-10 code set contains significantly more codes.

Maintaining or improving service levels under ICD-10 can pose additional challenges. For example, plans that prepare for the dual processing of claims using both ICD-9 and ICD-10 may encounter claims backlogs, or even decreases in autoadjudication rates and financial accuracy. Other areas that may experience service-level deterioration include call centers and medical management, which may see a substantial increase in call volumes and talk times to resolve ICD-10 issues.

"Many consider the implementation of ICD-10 to be technological issue, much like Y2K, but it's not. It's a business-driven initiative," said Carrie Cooper, director, OptumInsight.

Leveraging ICD-10 to drive improvements

"ICD-10 is a cost that health care organizations will incur to stay in business," Farley said. "There's the initial cost associated with achieving minimal regulatory compliance, and the transition will extend beyond the Oct. 1, 2013 deadline. Organizations, however, will incrementally realize benefits in the time after the deadline." (See Figure 2 for more detail)

> *"ICD-10 is a cost that health care organizations will incur to stay in business."*

By leveraging ICD-10's unique benefits, health plans may realize several benefits:

- Enabling improved payment incentive strategies—ICD-10's increased specificity will allow health plans to develop payment incentives that better reflect the treatment delivered to members

- **Better calculating higher-weighted DRG payments**—ICD-10 codes increase the ability to substantiate the medical necessity of diagnostic and therapeutic services

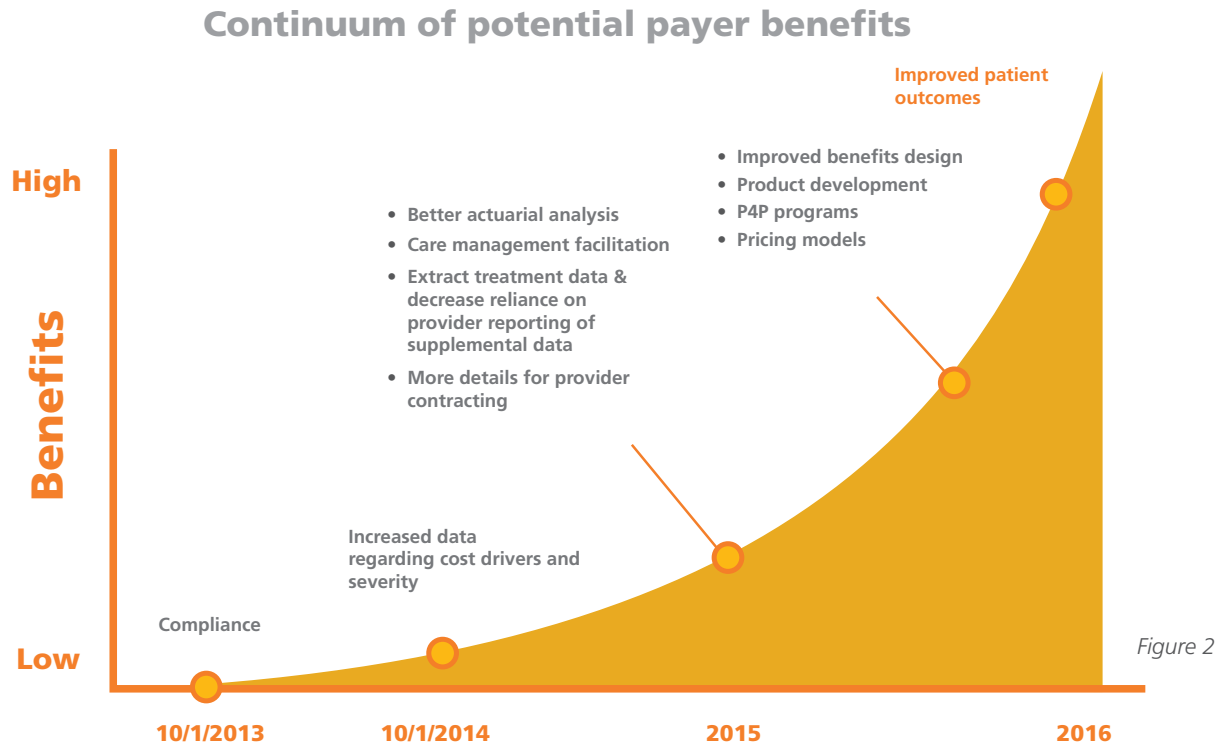


Figure 2

- **Improving quality measurement definitions**—The greater clinical accuracy of ICD-10 enables health plans to create more accurate quality measurements that better reflect patient conditions and clinical procedures
- **Provide better information for adjudicating beneficiary quality of care complaints**—The greater specificity of ICD-10 will contribute to more accurate and timely determinations
- **Developing better quality improvement strategies**—Using ICD-10, quality organizations will be better able to recognize trends, patterns, and dependencies not previously identifiable with ICD-9 codes
- **Providing more accurate information to support health care decisions**—ICD-10's improved ability to identify and track health outcomes will lead to more accurate information on health plan effectiveness for consumers to use in decision making

Administrative simplification impacts payers and providers—and ICD-10 can be a win-win for all if we use the codes in the best fit possible.

How OptumInsight can help

OptumInsight consultants help organizations with ICD-10 assessments, remediation, and transition, as well as business process optimization. We also offer numerous tools, tables, and training including:

- Work flow application
- Proprietary crosswalk files
- Grouping and pricing
- Coding books

Want to learn more?

Visit www.optuminsight.com or call 800.765.6807 to learn more about ICD-10 conversion.

Many payers are migrating toward initiatives that continuously monitor provider network performance. Armed with this information, payers can then steer members toward the highest-performing providers. OptumInsight presented a webinar Oct. 6, 2011 to help organizations develop these initiatives. The following information highlights some of the materials covered in the webinar.

Real-time provider network management

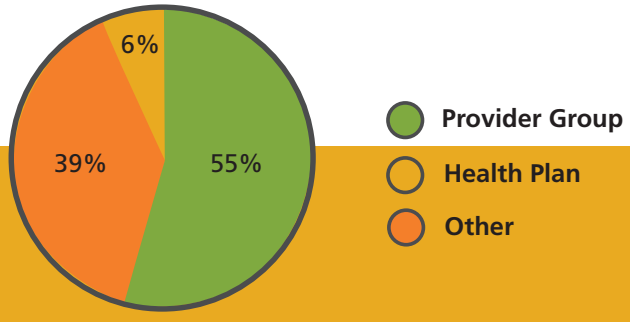
A variety of health care reforms and initiatives are engulfing the industry in a perfect storm that is driving an increased focus among payers to improve their provider network management. The factors contributing to the storm include escalating costs, new government regulations, increasing consumer choices, and rising technology adoption rates.

Presented Oct. 6, 2011

Expert presenter

Benton Davis, Senior Vice President, Clinical Community and Networks, OptumInsight

What we know: network is a key variable



"Upwards of 85 percent of care and costs occur at the provider level," said Benton Davis, senior vice president, clinical community and networks, OptumInsight. "To manage this, payers are moving toward more progressive relationships with providers."

Managing provider networks is about more than access and unit cost. It's the single best place to improve quality, revenue (e.g., through the star rating system), cost, and membership selection.

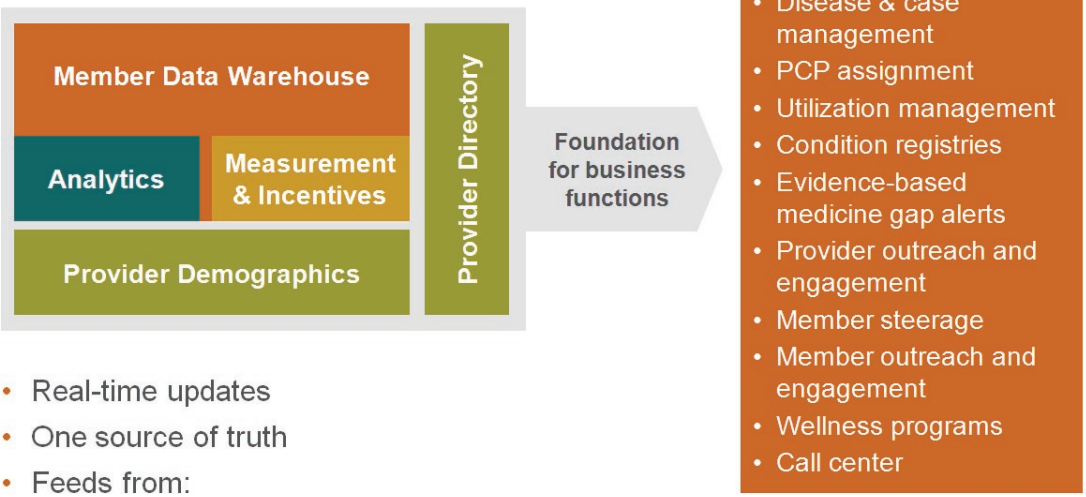
Many focus their efforts on improving financial results by reconfiguring their current networks for improved results, expanding networks for extended competencies in ambulatory care, employing selective use of new network vehicles such as ACOs, or finding significant opportunities to remove administrative costs. Others may focus on creating a competitive advantage by managing explosive growth in Medicaid and Medicare while facing decreasing revenues, maximizing growth through exchanges, or driving competitive advantage in retail markets.

The key is finding a way to improve financial results while creating a competitive advantage. But how?

Elements of real-time management solutions

In an effort to optimize their provider networks, payers are looking to implement solutions that enable real-time network management. With real-time information, payers can identify trends quicker before costs or quality are severely impacted. Real-time provider management solutions leverage data from multiple sources to assist with decision support. Data sources include claims, surveys, prescriptions, labs, provider credentialing, patient demographics, clinical data from electronic health records, and more.

ACA - induced population shifts (in thousands)



To create a foundation for real-time provider network management, payers can employ several quality, revenue, and membership-selection initiatives. These initiatives include:

- Reconfiguring current networks to improve results
- Expanding networks to extend ambulatory care competencies rather than directing patients to hospitals for care when it is unnecessary
- Leveraging new network vehicles, such as accountable care organizations (ACOs)
- Decreasing administrative costs wherever possible

"Provider relationships matter and are worth investing in. The payers that achieve the first-mover advantage will be the ones that have strong relationships with their providers," Davis said. "Most importantly, payers need to emphasize that they can no longer conduct business with providers in an analog way, such as phone, fax, etc. Relationships need to be linked electronically to exchange administrative and clinical data."

A more collaborative, data-driven approach

"The evolution to real-time network management starts with identifying providers who have a willingness to partner, improve care, and reduce costs," Davis said. "Payers need to design their programs so they are creating ways to help providers improve performance, instead of creating policies with a lot of 'gotchas' that are used to terminate individuals."

Evolving to real-time network management

Current approaches	Evolved approaches
Arms-length, business-to-supplier relationships with providers	Collaborative partnerships around shared objectives in improving individual and population health
Fee-for-service reimbursement	Reimbursement based on outcomes and health status
Annual review of selected provider's cost and quality performance	Monthly review of every provider in the network, as well as real-time feedback to providers on their cost and quality performance
Paper-based provider cost and quality reports via mail	Registries and evidence-based medicine gaps in care indications delivered into provider's workflow
Payer insights into members' health status come from claims and health surveys	Payer insights into members' health status come from claims repositories that are enhanced by EHR data, ultimately improving predictive risk models, evidence-based medicine, and registries
Broad, homogeneous networks	Narrow, high-quality, cost-efficient networks
Providers can't connect their withhold/bonus share to their performance	Providers receive regular and continuous feedback on open activities and their effect on reimbursement
Closest providers get the volume	Best providers get the volume

How OptumInsight can help

OptumInsight helps health plans build and manage more effective provider networks through:

- Expert contract modeling and design
- Market-leading analytics and network accessibility technology
- Best practices in provider behavior change
- EHR and HIE technology to improve provider practice
- Systems and processes to upgrade, measure, monitor, and continuously improve networks
- Provider demographics and the industry's largest outsourced credentialing operation

Want to learn more?

Visit www.optuminsight.com or call 800.765.6807 to learn more about real-time provider network management

Proactive business performance strategies that drive results

With continued margin pressures, health plans need to develop end-to-end payment cycle management strategies to lower costs. OptumInsight presented a webinar Oct. 11, 2011 to help organizations with these initiatives. The following highlights some of the materials covered in the webinar.

Presented Oct. 11, 2011

Expert presenters

Mike McDermand, Vice President, OptumInsight

Terri Lowe, Vice President, Operations, Physician Plus Insurance Corporation

Marshall Rosenfeld, Senior Director, OptumInsight

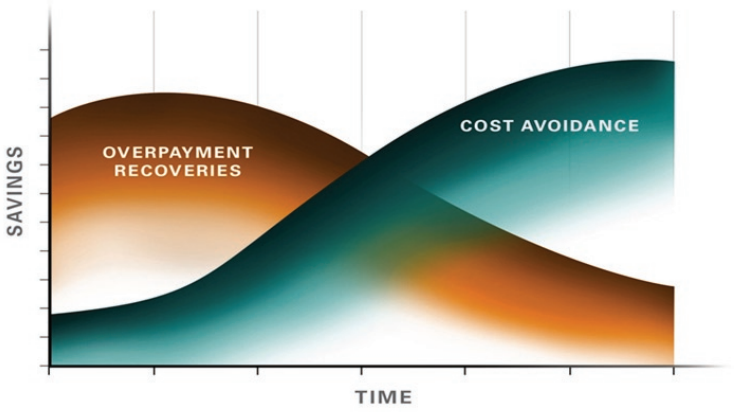
Improving payment accuracy is the single biggest opportunity for health plans to realize reductions in costs and improvements in provider relationships. "It's much more effective for health plans to proactively catch and correct errors before payment occurs than it is to retrospectively identify errors that require reconciling with providers," said Mike McDermand, vice president, OptumInsight.

For payers to improve payment accuracy, they must transform their analytics to better manage administrative costs in four key areas:

- **Data**—Having access to comprehensive data sources—including external data sources about professionals, members, and facilities—allows for advanced analytic discovery and testing
- **Matching**—State-of-the-art matching capabilities maximize connections between professionals, members and facilities
- **Detection and recovery analytics**—Predictive models help prioritize investigations and recovery efforts based on the likelihood of success
- **Retraining**—A closed-loop process needs to be implemented to continuously improve model performance by integrating investigative and recovery outcomes into rules and models

As health plans improve their payment accuracy, they will begin to notice an initial increase in recoverable overpayments thanks to better detection capabilities. However, these overpayment recoveries will taper as plans improve their error prevention. Ultimately, overpayments will dwindle, allowing plans to focus their efforts on payment accuracy—paying the right claims at the right time and at the right price.

Improving payment accuracy increases savings and reduces provider friction



Physicians Plus improves payment accuracy

Physicians Plus Insurance Corporation provides insurance to more than 110,000 members in south-central Wisconsin. Terri Lowe, vice president of operations, said the organization leverages a variety of pre- and post-payment accuracy strategies. It continues to educate and partner with providers to get claims paid accurately the first time—resulting in savings for all.

Physicians Plus uses OptumInsight for both pre- and post-payment subrogation. In 2010, Physicians Plus realized savings and recoveries of $2.47 per member per month in third-party liability claims with the OptumInsight services—which was nearly four times the previous rate.

Payment cycle challenges

Health plans face many similar challenges. "We find that there are a variety of clients who share common themes, and their challenges cut across various dimensions of their organizations, ranging from business complexities and government regulations, to economic pressures," said Marshall Rosenfeld, senior director, OptumInsight. Outlined below are some of those challenges and suggested solutions.

Payment cycle challenges

Problem	Solution
Provider contract carve-outs add complexity to system configuration but may not be effective	• Evaluate effectiveness with frequency distribution • Modify contracts as appropriate • Move evaluation upstream before contracts are negotiated
Overpayment recoveries add significant administrative overhead	• Evaluate • Determine root cause • Modify configuration and/or move edits upstream to detect potential issues earlier in the payment cycle
Third-party administrative arrangements (e.g., MH, Rx) add complexity to managing member out-of-pocket costs	• Develop real-time data exchanges to maintain synchronization between systems
Inaccurate, incomplete claims adjudication desktop policies and procedures cause unnecessary payment errors	• Integrate knowledge library with core administrative system to make current/historical policies and procedures available on a real-time basis

Focusing efforts to improve payment accuracy

For health plans to improve their payment accuracy, they should implement the following three practices:

- Evaluate business strategy and tactics in the context of business and technical capabilities, as well as market demands to establish a long-term plan and the greatest return
- Modify or eliminate obsolete business practices and processes for the quickest return
- Leverage technical innovations including editing and pricing to improve performance and gain a mid-term return

These proactive strategies will drive continuous improvement resulting in peak performance and improved provider relations.

How OptumInsight can help

OptumInsight offers a comprehensive set of prospective and retrospective solutions that inform and improve the entire claims management cycle. We can help your organization:

- Simplify claims processing
- Achieve accurate payment
- Improve provider relationships

Want to learn more?

Visit www.optuminsight.com or call 800.765.6807 to learn more about proactive business performance strategies

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