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NJSOM 2014 Conference

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Agenda

- Introduction – Monique Hodge-Cowherd
- HHI – Julianne Pantaleone
- Horizon Medicare Blue Patient Center – Kevin Jennings
- Health Risk Adjustment – Kevin Jennings
- Network Relations Structure – Monique Hodge-Cowherd
- Q & A

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Horizon Medicare Blue Patient-Centered w/Rx (HMO)

9/2/2014

Horizon Medicare Blue Patient Centered w/ Rx (HMO)

Horizon will be launching new Medicare Advantage Part C HMO products on January 1, 2015 which promote the use of our Patient-Centered programs.

- These programs focus on actively improving care coordination, promoting preventive and wellness care, improving patient satisfaction, and reducing unnecessary costs.
- These products will utilize a subset of our Managed Care network and will tier medical cost share for Primary Care Physician (PCP) services.
- Patient-Centered Providers are Primary Care Physicians in Horizon's Patient-Centered Medical Home and Accountable Care Organization Programs.

Patient Centered Programs

- These Primary Care Physicians deliver a team-based approach led by a doctor to make it easier for patients to access the care, information and assistance when they need it.
- Members will receive more coordinated and personalized health care.
- Medical Cost share for PCP services will be tiered based on members pre-selection and use of a Primary Care Physician (PCP) affiliated with a Patient-Centered practice.
- Members selecting a Horizon PCP participating in one of our PCMHs or ACOs will have a lower copay for PCP services.
- Members selecting a Horizon PCP not participating in PCMH or ACO will have a higher copay.

Network Structure

- **Hospitals -** all participating hospitals are included.
- **PCPs -** Managed care internal medicine, family practice and pediatric providers are automatically included. The exception will be non-evaluated providers belonging to a mixed specialty practice not chosen to participate with this product.
- **Specialists -** will include a subset of the Managed Care providers; selection of the subset was based on cost efficiency metrics and county access need.
- **Non-Evaluated Specialists -** Managed Care providers with specialties outside of the 15 being evaluated will be automatically included in the product. Similar to the PCPs, the exception will be non-evaluated providers belonging to a mixed specialty practice not chosen to participate with this product.

Evaluation Methodology

Use ETGs to assess the efficiency of in-network practices:

Define efficiency vs. peer group by using ETGs

ETGs (Episode Treatment Groups) identify and classify an entire episode of care regardless of where the patient has received medical treatment. ETGs are case mix adjusted, accounting for differences in patient severity.

The efficiency of a practice on a particular ETG is determined by **comparing the actual costs of the practice to the costs of a peer group**. The lower the ratio between actual and peer group costs, the more efficient the practice.

Use direct costs only (exclude ER and hospital costs)

The following **categories of costs are included in the specialist analysis**: primary care, specialists services, radiology, lab and pharmacy.

Hospital and ER costs will not be used in the efficiency analysis.

The analysis will be based on **actual costs.**

Evaluated Specialties

- Allergy & Immunology
- Cardiology Invasive (Cardiology)
- Cardiology Non Invasive (Cardiology, Cardiovascular and Cardiothoracic)
- Chiropractic Medicine
- Dermatology
- Endocrinology
- Gastroenterology
- Neurology
- Ophthalmology
- Orthopedic Surgery

- Otolaryngology
- Podiatry
- Pulmonology
- Rheumatology
- Urology

Horizon Medicare Blue Patient-Centered Providers

- Practitioners participating with Horizon Medicare Blue Patient-Centered w/RX (HMO) will be indicated by a checkmark next to the plan name.

Checkmark next to plan name indicates plan is accepted.

- Practitioners who participate in our Patient-Centered Programs will be identified by the Patient Centered symbol.

Horizon Medicare Blue Patient Centered w/ Rx (HMO)

Key Features

PCP selection is required, however member will have lower out-of-pocket costs when visiting a PCP that is part of a PCMH or an ACO.

Referrals are required. Prior authorizations are required for some services.

Product Prefix

YKO

Network

Utilizes a subset of Horizon's Managed Care network.

No out-of-network benefits, except in an emergency.

No BlueCard access.

Horizon Medicare Blue Patient Centered w/ Rx (HMO)

Member Benefits

Preventive care – 100% with no out-of-pocket cost.

- **$10 or $15**: When member utilizes a **participating** Patient-Centered PCP.
- **$35**: When member utilizes a **non-participating** Patient-Centered PCP.
- **$50**: When member visits a participating specialist.

Reimbursement

Reimbursement will be at the Managed Care fee schedule.

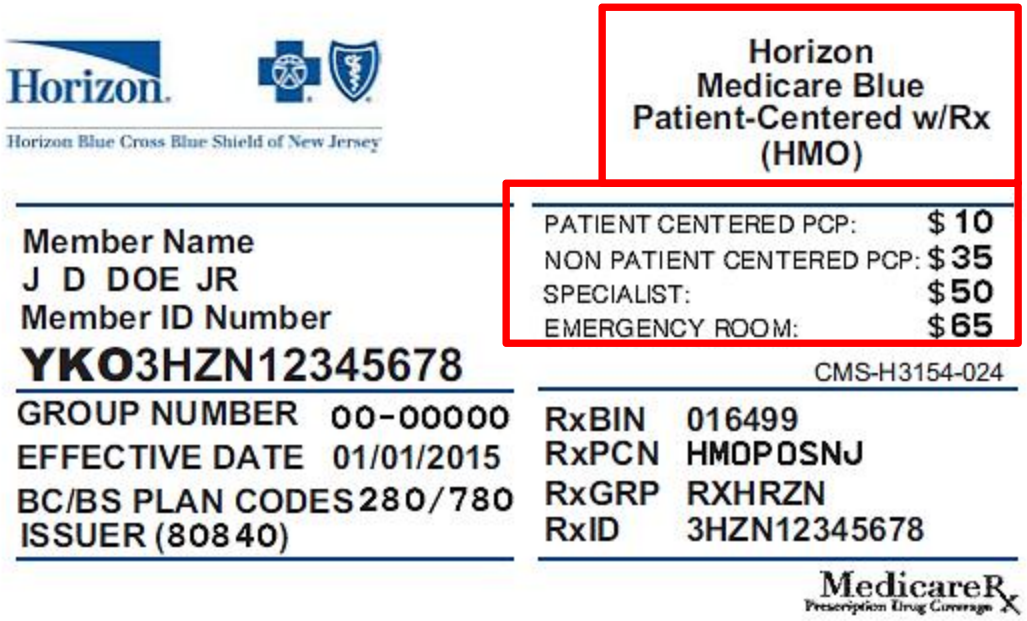
PCPs will be reimbursed based on their current (FFS or Capitation) payment methodology.

Capitated providers shall be reimbursed at existing MA rates.

ID Card

Member ID Cards will indicate:

- Product Name
- Member Copayments



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Health Risk Adjustment

Commercial Risk Adjustment Program

What is CRA?

- One of three new risk stabilization programs established by the Affordable Care Act (ACA) for the individual & small group commercial markets launched in January 2014.
- A tool used to compare healthcare costs based on the relative actuarial risk of enrollees.

What are the benefits of CRA?

- Minimizes the incentive to select enrollees based on their health status.
- Encourages competition based on quality improvements and efficiency, mitigating the impact of potential adverse selection and stabilizing premiums.

How does the CRA program operate?

- The U.S. Department of Health and Human Services (HHS) and CMS will be responsible for operating risk-adjustment models within New Jersey.
  - CRA - HHS
  - Medicare Advantage (MA) - CMS
- CRA - Insurers pay in/out based on the risk associated with their individual and small group enrollees.
- As a result, the risk-adjustment model redistributes revenue from insurers with healthier patient populations to those with sicker patient populations.

HHS's Model

Step 1:

Providers document each patient's demographic information and disease burden in the medical record.

Step 2:

HHS calculates risk scores by summing demographic and disease burden factors, using claims data.

Step 3:

HHS reviews and redistributes funds based on the calculated risk score.

Accurate Medical Record Documentation and Coding

Medical coding of patient encounters is only as good as the underlying medical record documentation.

Best Practices in Medical Record Documentation

- **Chronic conditions need to be reflected with every claim submission (e.g., report leg amputation status).**
- **Disabilities also need to be reported (e.g. autism).**
- **Medical records should be prepared according to CMS guidelines.**
- **Patient's name and date of service need to appear on all pages of the record.**

Best Practices in Medical Coding

- **Accuracy**
- **Specificity**
- **Thoroughness**
- **Consistency**

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Provider Practice Implications

If coding is accurate:

- Provider practices are minimally disrupted, allowing greater focus on other practice aspects.

If coding is inaccurate:

- There's a higher likelihood of requests for documentation to support accurate risk score submission by insurer.
- Additional medical record requests, by HHS or an insurer, means higher practice disruption and cost. Inaccuracies in coding require correction.

Why and How CRA Will Affect Providers?

Opportunities to Improve Care Practice

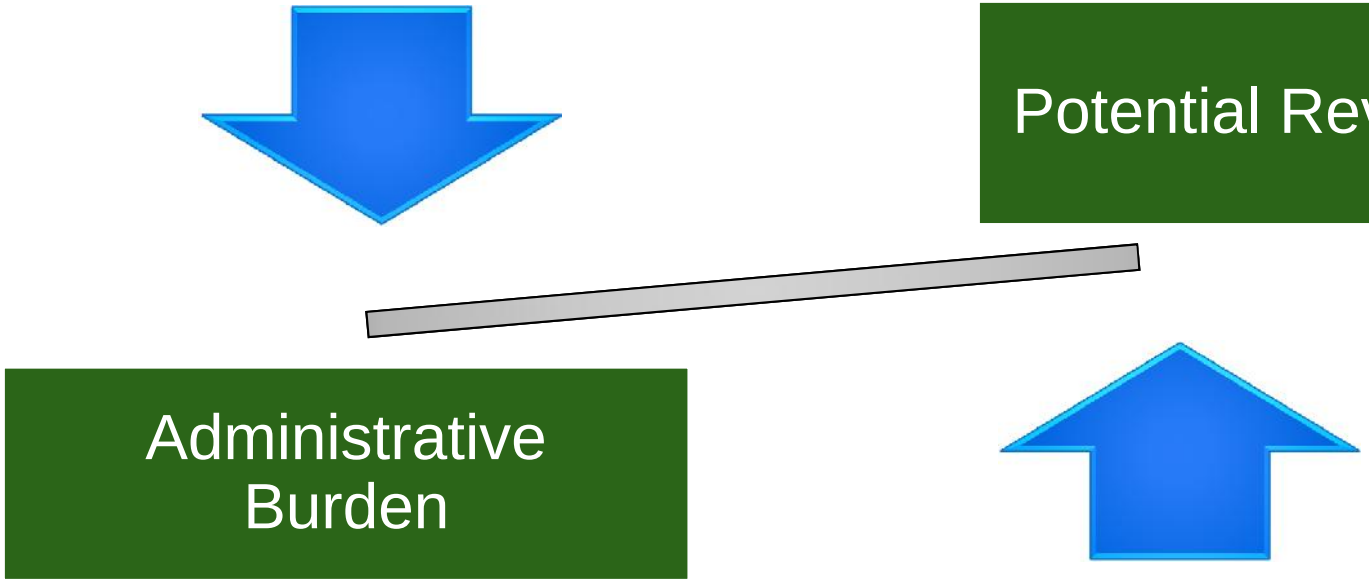
- Accurate risk capture improves high-risk patient identification and the ability to reach patients in disease and care management programs and care prevention initiatives.
- It also helps in the endeavor to identify practice patterns and reduce variation when clinically appropriate.

Financial Health of Your Practice

- Accurate medical records reduce the administrative burden of adjusting claims.
- More accurate payments and reflection based on the severity of illness burden for providers involved in risk-sharing arrangements.

The Financial Health of Your Practice:
Understanding the Risk of CRA

Claims submitted without all presenting and underlying diagnosis codes could result in potential resubmission to plans which could cost the provider, on average, between $15 and $25 per claim to make corrections.



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Source: BCBSA insurance carrier research and investigation of Medical Group Management Association resources.

How Can Providers Best Prepare for the New CRA and Risk Adjusted Environment?

Engage clinicians...

Engage coders and office staff...

Adopt technologies...

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Horizon Medical Record Requests

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Verisk Health

- Horizon will initiate medical record retrieval through Leprechaun/EMSI to collect provider chart information.

- Leprechaun/EMSI will reach out to the provider via letter to retrieve the medical records.
  - If medical records are electronic, providers can send the records via their medical management company/system
  - Fax/scan or mail hard copy medical records to Verisk Health.

Out-of-State Medical Record Requests

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Verisk Health

- The Home Plan will initiate medical record retrieval through Verisk Health to collect provider chart information.

- Verisk Health will reach out to the provider via letter to retrieve the medical records.
  - If medical records are electronic, providers can send the records via their medical management company/system
  - Fax/scan or mail hard copy medical records to Verisk Health.

Key Points to Remember:

All diagnosis codes should be included in every claim/encounter submission.

Medical records should be prepared according to CMS guidelines.

Failure to follow these standards will result in multiple, burdensome audits.

Network Specialist

New Jersey Counties	Network Specialist Name	Network Specialist Phone
Atlantic	Ann Marie Coles	1-973-466-7561
Bergen	Monique Hodge	1-973-466-8219
Burlington	Jay Thomas (covering)	1-973-466-5540
Camden	Maria Siravo	1-856-638-3224
Cape May	Ann Marie Coles	1-973-466-7561
Cumberland	Ann Marie Coles	1-973-466-7561
Essex	Jill Clark	1-973-466-4831
Gloucester	Ann Marie Coles	1-973-466-7561
Hudson	Monique Hodge	1-973-466-8219
Hunterdon	Kevin Jennings	1-973-466-7102
Mercer	Janet Denlinger (covering)	1-856-638-3414
Middlesex	Jay Thomas	1-973-466-5540
Monmouth	Janet Denlinger	1-856-638-3414
Morris	Kevin Jennings	1-973-466-7102
Ocean	Janet Denlinger	1-856-638-3414
Passaic	Kevin Jennings (covering)	1-973-466-7102
Salem	Ann Marie Coles	1-973-466-7561
Somerset	Jay Thomas	1-973-466-5540
Sussex	Kevin Jennings (covering)	1-973-466-7102
Union	Jill Clark	1-973-466-4831
Warren	Jill Clark (covering)	1-973-466-4831
New Castle County, Delaware	Maria Siravo	1-856-638-3224
Bronx, Kings, New York, Orange, Richmond, Rockland and Westchester Counties, New York	Jill Clark	1-973-466-4831
Bucks, Delaware, Monroe, Northampton, Philadelphia and Pike Counties, Pennsylvania.	Maria Siravo	1-856-638-3224

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Q&A