Contract Alignment Payment Solutions (CAPS™)

A Value-Based Payment Model for Managing Professional Service Agreements (PSAs) for the Indigent Population in 2018 and Beyond

esi Healthcare Business Solutions

US Healthcare Costs

It is now apparent that **US Healthcare costs in 2018 and beyond can be summarized** under general themes

- Increases in insurance premium
- Increases in the number of uninsured
- Cuts in funding of Public Programs
- Continued increase in total healthcare costs

Equally certain on the **operations side of healthcare changes beyond 2018** include:

- Pay-for-Performance/Value-Based Payment schemes tied to cost, clinical outcomes and risk based contracting.
- Moving acute patient care to managing populations in a consumer-centric focus.
- Real-time clinical and business-data-knowledge availability that is transparent and auditable.
- Development of new technologies that go beyond the EMR and provide real-time value-add services with proven/auditable rate-of return.

The **Uninsured**

The uncompensated cost increases for the uninsured in 2018 and beyond will dramatically impact the providers that traditionally carry the burden for servicing the uninsured as a disproportionate percentage of their total patient population and corresponding disproportionate costs. Providers most at financial risk for the increases in uninsured patients are:

- **Academic Medical Center Providers**
- **America's Essential Hospitals (AEH)**

The costs and payments for services to the uninsured have traditionally created difficulty in negotiating Professional Services Agreements (PSAs) between the Hospital Entity and the corresponding Medical School Facility and/or Physician Group responsible for the clinical care component. In many instances the clinical care component will exceed 60% of the total cost of the PSA contract. This cost is so substantial that it is essential that the contracting parties pay particular attention to assure that the correct information is available for such an important long-term way to deal with uncompensated costs. Many of the challenges between the entities occur because in negotiating annual PSAs, the cultural and operating strategies of the parties are not properly aligned or negotiated with mutual business rules and data that is transparent.

Operational Implications

Professional Services Agreements (PSAs) between medical school/physician groups and corresponding teaching/safety-net hospitals **must be managed with real-time data.**

Physician entity providers **must be fairly paid-for-value to provide the clinical service component for uninsured patients under annual PSAs.**

Hospital entities **must assume the role of an insurer/payor for these clinical services.**

The hospital entity acting as payor for uncompensated care to physicians **must also provide the framework systems necessary to structure value-based PSAs** that:

- Substantiate the services and corresponding costs and payment metrics necessary for these agreements.
- Align operational and performance goals between hospital and physician entities through a data system that is able to capture, process, adjudicate and provide the timely data necessary to negotiate PSAs.
- Hospital/Physician PSAs must be negotiated with win/win agreements.

Negotiating PSAs for the uninsured requires agreement between the entities that this population cannot be managed in the same manner as that of the insured population. The requisite considerations to provide indigent care include the following:

- Understanding that uninsured costs on City, County, State and Federal Governments using "Tax Assessment-like" payment structures will potentially end or be substantially reduced.
- The ability to tack on extra fees to private insurance payors to assist in funding indigent care is no longer feasible.
- Understanding that both clinicians and executives participate in a mutual, respectful and open negotiations. Nothing should be done that projects a win/loss mandate.

Transition to Accountable, Value-Based Payment Models
for Negotiating PSAs for the Indigent Population

Traditional PSA Contract Models

Volume and value of services not well documented

- Lump sum or FTE-based payment models
- Little or no value-based incentives
- Poorly-defined performance expectations and priorities
- Clinicians are often left out in negotiating PSAs and many times PSAs come down from executives as mandates.

Lack of adequate systems to monitor performance

- Informal procedures and processes that are fragmented and ineffective
- Difficult to align physician performance with hospital quality, satisfaction, and patient outcome goals
- Physicians don't feel empowered to resolve operational issues

Value-Based Payment Model/CAPS™

Focus on the mutual benefits of the existing relationship

- Jointly identify and agree upon goals that benefit ***all*** parties through mutually developed business rules
- Use of real-time data
- Provide value to all stakeholders:
  Patient, Provider, Payor

Create a reimbursement model that supports joint goals and value to all stakeholders

- An accountable, measurable and equitable contract
- A market-based reimbursement model
- A payment model that provides transparency
- A model that informs physicians of all income – including subsidies – derived from their work for the uninsured

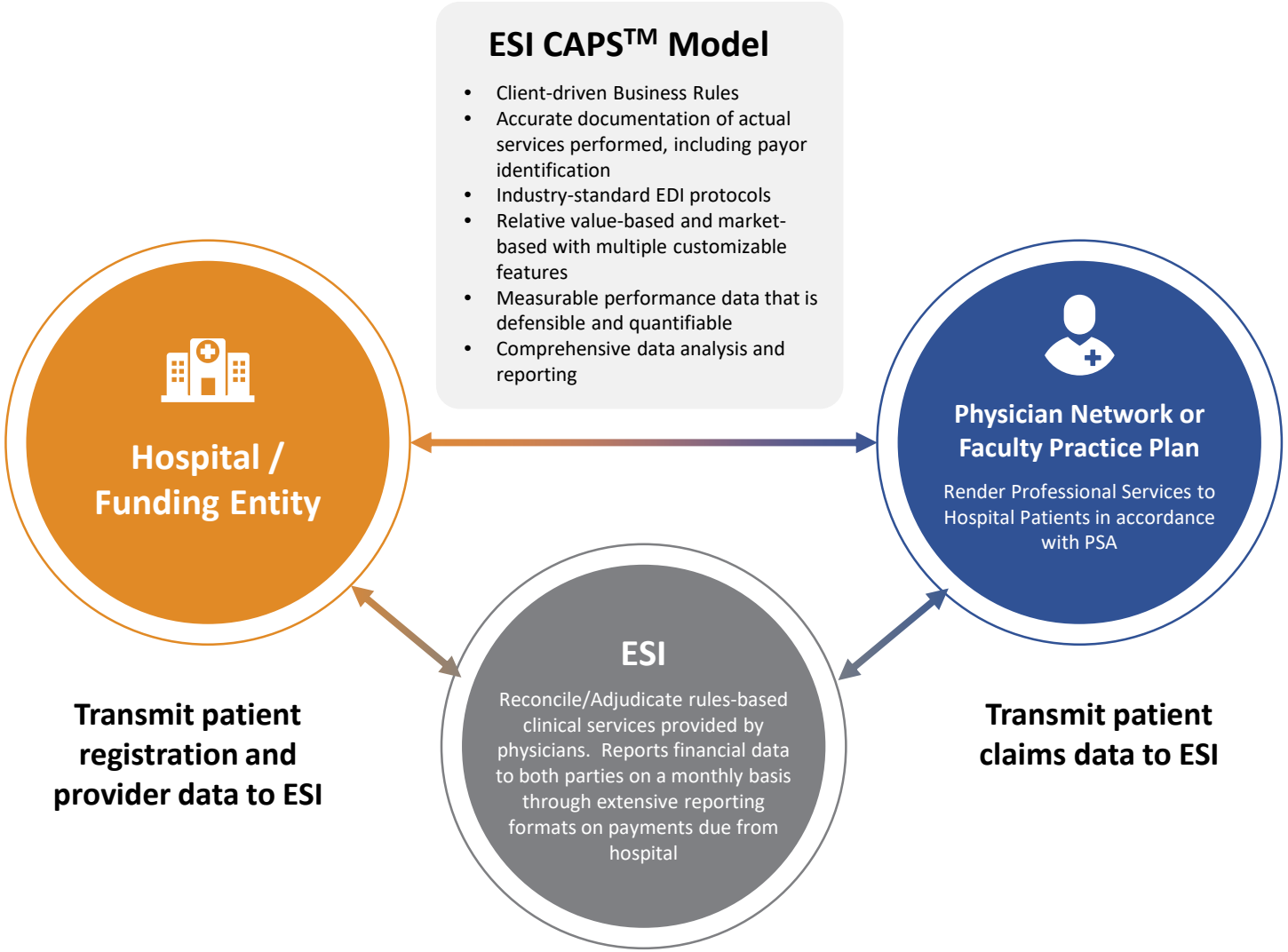
A Payment Model for the Uninsured Population

Contract Alignment Payment Solutions (CAPS™)

Our CAPSTM system provides hospitals and their clinician partners contracting support and technology platform to assist in managing complex PSA relationships. It is a fully-automated claim adjudication and reporting system that:

1. Collects, analyzes, reports, and trends business-data-knowledge for uncompensated professional services, including all clinical events performed by clinicians.
2. Considers the impact of value-based reimbursement, uncompensated care and other payor mix challenges.
3. Flexible interface capabilities to both the hospital and physician health information systems, along with compliant reporting capabilities.
4. Manages a wide variety of customized, client-specific contracts, business rules, and payment methodologies.
5. Establishes a framework for best practices plus quality and process initiatives as well as regulatory compliance.
6. Provides the mutually negotiated business rules under which the parties will operate in serving the indigent patients including, work units, payment for each work unit, and total amount owed and paid to clinicians on a monthly basis.

CAPS™ Model for Indigent Patient Care Payments



Results **You Can Expect with CAPS™**

- Detailed accounting of all clinical events performed by physicians including RVUs and reimbursement per RVU.
- Monthly financial reporting of monies due from hospital to physician.
- Increased transparency and operational efficiency.
- Improved Revenue Cycle with precise and timely reimbursement to clinicians attributable to accurate and consistent adjudication of professional services according to Business Rules.
- Prompt and accurate verification of patient eligibility, benefit plan and payor.
- Increased capture of payment from other third party payors.
- Value-added allocation of budgetary resources.
- Improved relationship with physician enterprise partners.
- Adherence to governmental compliance regulations.
- Defensible and quantifiable data for audit purposes.
- Accountability and documentation that leads to good business practices and successful contract re-negotiations.

CAPS™ **Sample Reports**

The reporting capabilities of ESI's CAPSTM System are very extensive and provides **the transparent, auditable, real-time and business-rules-based data that is necessary to support the value-based agreements to fairly pay clinicians for the agree-to services for the indigent population.** The following sample reports represent a small fraction of the reports available to assist in managing the PSAs.

Departmental Productivity Report

Sample Client
Claims Administration Payment Solutions
wRVU Summary
September 2011

REVENUE LOC/ DEPT	BILLED AMOUNT	RVU	FACTOR	ALLOWED AMOUNT	UNACCEPTED AMOUNT
ANESTHESIOLOGY & PAIN MANAGEMENT					
ANESTHESIOLOGY AND PAIN	$206,714.00	807.78973	33.9764	$23,055.20	$4,920.77
Department Total	**$206,714.00**	**807.78973**		**$23,055.20**	**$4,920.77**
CARDIOVASCULAR & THORACIC SURGERY					
CVTS CTS CARDIAC	$3,284.00	21.86211	34.9764	$595.96	$146.84
CVTS CTT THOR	$36,991.00	178.63462	35.9764	$5,205.17	$785.10
CVTS NON-SPECIFIC	$23,697.00	159.06032	36.9764		5404.2972
Department Total	**$63,972.00**	**359.55705**	37.9764	**$5,801.13**	**$6,336.24**
DERMATOLOGY					
DERMATOLOGY - SURGICAL ONCOLOGY	$2,622.00	16.52624	37.9764		685.5551
DERMATOLOGY	$159,393.00	1164.07235	38.9764	$27,911.80	$11,531.25
Department Total	**$162,015.00**	**1180.59859**	39.9764	**$27,911.80**	**$12,216.81**
FAMILY PRACTICE & COMMUNITY MEDICINE					
FAMILY MEDICINE	$153.00	1.85753	39.9764		66.9948
FAMILY PRACTICE NON-SPECIFIC	$25,377.00	302.62232	39.9764	$6,982.33	$3,299.68
FAMILY MEDICINE CLINIC	$197,915.00	1603.07886	39.9764	$50,518.05	$3,978.11
Department Total	**$223,445.00**	**1907.55871**		**$57,500.38**	**$7,344.79**
INTERNAL MEDICINE					
INTERNAL MEDICINE NON-SPECIFIC	$1,562,827.00	15674.77193	39.9764	$276,128.85	$253,153.26
ALLERGY	$6,101.00	53.54082	39.9764	$1,692.19	$126.93
ASTHMA	$4,267.00	36.38854	39.9764	$1,186.85	$49.50
CARDIAC LAB	$287,148.00	1928.68745	39.9764	$37,783.53	$24,285.41
CARDIAC REHAB	$26,880.00	166.0224	39.9764	$514.14	$5,126.71
CARDIOLOGY	$8,120.00	67.65001	39.9764	$2,009.21	$298.31
CHEST MEDICINE	$16,532.00	142.80062	39.9764	$4,234.33	$617.52
CHF CLINIC	$2,371.00	18.29733	39.9764	$199.02	$422.66
CVL ECHOCARDIOGRAM	$127,554.00	1066.08355	39.9764	$26,221.67	$9,568.60
DIABETES CLINIC	$11,378.00	94.24971	39.9764	$2,520.76	$681.50
ENDOCRINE	$24,766.00	206.30175	39.9764	$5,228.95	$1,780.44

Reports total reimbursement due to department for clinical work

ESI reports the unaccepted claims submitted by each department and provides insight as to what is driving these denials

Provider Productivity Report

Sample Client
Claims Administration Payment Solutions
wRVU Summary
September 2011

DEPARTMENT	BILLING PROVIDER	CFTE BENCHMARK	April-11	May-11	June-11	July-11	August-11	September-11	Report Total	Annualized	CFTE*
CARDIOVASCULAR & THORACIC SURGERY	Provider 1	5740						42.13	42.13	505.56	0.0881
	Provider 2	5740						5.96	5.96	71.52	0.0125
	Provider 3	5740					2		2	24	0.0042
	Provider 4	5740						46.17	46.17	554.04	0.0965
CARDIOVASCULAR & THORACIC SURGERY Total		5740					2	94.26	96.26	1155.12	0.2012
FAMILY PRACTICE & COMMUNITY MEDICINE	Provider 5	3937				6.32		9.45	15.77	189.24	0.0481
	Provider 6	3937				1.52	6.79	108.32	116.63	1399.56	0.3555
	Provider 7	3937		1.39	1.53	4.28	2.86	220.48	230.54	2766.48	0.7027
	Provider 8	3937		1.5				105.82	107.32	1287.84	0.3271
	Provider 9	3937						88.19	88.19	1058.28	0.2688
	Provider 10	3937		15.01				25.53	40.54	486.48	0.1236
	Provider 11	3937				5.69		94.73	100.42	1205.04	0.3061
	Provider 12	3937				4	1.5	84.38	89.88	1078.56	0.2740
	Provider 13	3937						117.17	117.17	1406.04	0.3571
	Provider 14	3937		8.06			8.34	32.88	49.28	591.36	0.1502
	Provider 15	3937			1.19	1.36	5.31	73.67	81.53	978.36	0.2485
	Provider 16	3937					0.97		0.97	11.64	0.0030
	Provider 17	3937					0.97	88.09	89.06	1068.72	0.2715
FAMILY PRACTICE & COMMUNITY MEDICINE Total		3937		25.96	2.72	23.17	26.74	1048.71	1127.3	13527.6	3.4360
INTERNAL MEDICINE	Provider 18	2969						6	6	72	0.0243
	Provider 19	2969			8.17			13.47	21.64	259.68	0.0875
	Provider 20	2969						26.3	26.3	315.6	0.1063
	Provider 21	2969						7.9	7.9	94.8	0.0319
	Provider 22	2969		1.28				11.25	12.53	150.36	0.0506
	Provider 23	2969		22.94				14.67	37.61	451.32	0.1520
	Provider 24	2969		10.27					10.27	123.24	0.0415
	Provider 25	2969		22.05		3.93	0.34	2.43	28.75	345	0.1162
	Provider 26	2969			4.27				4.27	51.24	0.0173
	Provider 27	2969					3.39	143.82	147.21	1766.52	0.5950
	Provider 28	2969		7.83			31.64	44.59	84.06	1008.72	0.3398
	Provider 29	2969						41.24	41.24	494.88	0.1667

ESI reports the total clinical full-time equivalent physicians within each department based on their relative value units

Departmental Productivity Report
by Provider

Claims Administration Payment System (CAPS)
Department/Division Summary by Provider
Sample Hospital and
Sample University Health Science Center MSA
Service Dates 3/1/2018 through 3/31/2018*

Division Name	NPI	CHARGE	RVU AMT	AMT
	PROVIDER 1	$8,994.00		$2,141.03
	PROVIDER 2	$302.00		$67.68
	PROVIDER 3	$4,695.00		$1,157.60
	PROVIDER 4	$3,258.00		$700.03
EMERGENCY	PROVIDER 5	$4,353.00		$1,050.91
MEDICINE	**Total**	**$21,602.00**		**$5,117.25**
	PROVIDER 6	$1,059.00		$313.86
	PROVIDER 7	$1,821.00		$718.71
	PROVIDER 8	$2,446.00	15.6075	$834.07
FAMILY MEDICINE	**Total**	**$5,326.00**	**15.6075**	**$1,866.64**
	PROVIDER 9	$5,280.00	40.8019	$1,886.65
	PROVIDER 10	$27,374.00	223.2389	$10,165.91
	PROVIDER 11	$10,466.00	60.6228	$3,494.92
	PROVIDER 12	$1,597.00	30.8003	$1,105.40
	PROVIDER 13	$1,995.00	12.2975	$775.78
	PROVIDER 14	$20,609.00	136.9205	$7,287.86
	PROVIDER 15	$528.00	6.7458	$288.67
	PROVIDER 16	$104.00		$54.53
	PROVIDER 17	$11,043.00	88.6147	$4,122.91
	PROVIDER 18	$9,906.00	65.5477	$3,595.10
	PROVIDER 19	$14,029.00	104.4709	$5,374.47
INTERNAL MEDICINE	**Total**	**$102,931.00**	**770.0610**	**$38,152.20**
	PROVIDER 20	$3,987.00	28.2453	$1,449.60
	PROVIDER 21	$1,052.00	12.1048	$435.33
	PROVIDER 22	$2,621.00	23.7738	$1,085.67
NEUROLOGY	**Total**	**$7,660.00**	**64.1239**	**$2,970.60**
	PROVIDER 23	$12,135.00	29.4202	$3,421.91
	PROVIDER 24	$7,951.00	88.4924	$3,185.69
	PROVIDER 25	$42,271.00	315.1073	$15,836.67
OBSTETRICS & GYNEC	**Total**	**$62,357.00**	**433.0199**	**$22,444.27**

Denied Services Impact Report

Sample Client
Claims Administration Payment Solutions
Claim Edit Impact Report

CAR Code	Description	Potential Allowed	Service Lines	RVU AMT
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	$ 4,151.10	41	115.8793
177	Payment denied because the patient has not met the required eligibility requirements	$ 145,541.80	1225	517.4273
18	Duplicate claim/service.	$ 5,645.60	44	4055.894
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	$ 2,100.23	1	43.66391
26	Expenses incurred prior to coverage.	$ 30,988.32	243	829.0456
31	Claim denied as patient cannot be identified as our insured.	$ 47,127.01	454	1315.0534
38	Services not provided or authorized by designated (network/primary care) providers.	$ 5,453.45	61	152.238
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	$ 3,199.41	11	89.3122
96	Non-covered charge(s).	$ 4,886.25	16	136.401
97	Payment is included in the allowance for another service/procedure.	$ 5,118.39	52	142.8751
B14	Payment denied because only one visit or consultation per physician per day is covered.	$ 235.92	3	6.5858
GRAND TOTAL		**$ 254,447.48**	**2151**	**7404.37561**

ESI reports savings from inappropriately billed claims and identifies which claims can be corrected for resubmission and which claims can be submitted to other third party payors for reimbursement.

Reduced Services Impact Report

Sample Client
Claims Administration Payment Solutions
Claim Edit Impact Report

Dept	SERVICE LINES	Allowed Prior to Reductions	Discontinued Service Reduction	Reduced Service Reduction	Co-Surg Reduction	BL - 2ND LINE 50% Adjustment	BL - + 150% Adjustment	BL- 2ND LINE $0 ALLOWED	MULT PROC 50% Adjustment	Final Allowed	SAVINGS
ANESTHESIOLOGY & PAIN MANAGEMENT	18	$ 1,094.24	$ -	$ -	$ -	$ -	$ 486.92	$ -	$ (60.20)	$ 1,520.96	$ (426.72)
CARDIOVASCULAR & THORACIC SURGERY	2	$ 884.18	$ -	$ -	$ -	$ -	$ 181.50	$ -	$ (260.59)	$ 805.09	$ 79.09
DERMATOLOGY	6	$ 450.28	$ -	$ -	$ -	$ -	$ -	$ -	$ (225.14)	$ 225.14	$ 225.14
FAMILY PRACTICE & COMMUNITY MEDICINE	1	$ 49.74	$ -	$ -	$ -	$ (24.87)	$ -	$ -	$ -	$ 24.87	$ 24.87
INTERNAL MEDICINE	156	$ 38,171.54	$ (445.37)	$ (2,543.66)	$ -	$ -	$ 225.76	$ -	$ (16,874.81)	$ 18,533.45	$ 19,638.08
NEUROLOGICAL SURGERY	5	$ 3,949.24	$ -	$ -	$ (585.70)	$ -	$ -	$ -	$ (1,193.68)	$ 2,169.85	$ 1,779.38
NEUROLOGY	4	$ 768.64	$ -	$ (208.56)	$ -	$ -	$ 228.68	$ -	$ (109.10)	$ 679.67	$ 88.98
OBSTETRICS/GYNECOLOGY	53	$ 15,653.92	$ (59.56)	$ (683.05)	$ -	$ -	$ 325.46	$ -	$ (6,947.31)	$ 8,289.46	$ 7,364.46
OPHTHALMOLOGY	15	$ 9,606.53	$ -	$ -	$ -	$ (535.13)	$ -	$ -	$ (4,268.13)	$ 4,803.26	$ 4,803.26
ORTHOPAEDIC SURGERY	77	$ 32,106.55	$ -	$ -	$ -	$ (796.05)	$ 963.72	$ (2,305.79)	$ (12,859.34)	$ 17,109.09	$ 14,997.46
OTOLARYNGOLOGY	31	$ 11,470.12	$ -	$ -	$ (1,171.41)	$ (1,411.15)	$ -	$ -	$ (3,304.87)	$ 5,582.69	$ 5,887.43
PHYSICAL MEDICINE & REHABILITATION	9	$ 896.01	$ -	$ -	$ -	$ (76.08)	$ 222.70	$ -	$ -	$ 1,042.63	$ (146.62)
PLASTIC SURGERY	39	$ 23,900.78	$ -	$ -	$ -	$ (514.90)	$ 1,195.41	$ (3,410.10)	$ (9,632.22)	$ 11,538.97	$ 12,361.81
RADIOLOGY	74	$ 8,324.39	$ -	$ (280.77)	$ -	$ (490.89)	$ 51.85	$ (679.74)	$ (3,070.06)	$ 3,854.78	$ 4,469.61
SURGERY	71	$ 30,598.37	$ -	$ (1,146.80)	$ -	$ (753.64)	$ -	$ (240.62)	$ (13,569.42)	$ 14,887.90	$ 15,710.47
UROLOGY	21	$ 3,941.62	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,970.81)	$ 1,970.81	$ 1,970.81
TOTAL	**582**	**$ 181,866.14**	**$ (504.94)**	**$ (4,862.84)**	**$ (1,757.11)**	**$ (4,602.71)**	**$ 3,882.01**	**$ (6,636.25)**	**$ (74,345.69)**	**$ 93,038.63**	**$ 88,827.51**

ESI reports savings according to mutually-agreed programmed edits documented in the Business Rules.

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