Episode-based Payment System

Response to Request for Information

Prepared for:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

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McKesson Health Solutions
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Component A: Episode Design

For each function described in Section 3, please describe (1) your current capabilities, (2) your proposed approach and solution; (3) new capabilities that you will need to build as a result.

Clinical Guidance

Current Capabilities:

McKesson Health Solutions’ clinical research staff (physicians, registered nurses, and other specialty-based healthcare professionals) have been researching and developing evidence-based clinical care guidelines, InterQual® Criteria1, in all areas of clinical care for 36 years. The authoring physicians’ backgrounds include experience or specialization in internal medicine, infectious disease, anesthesiology, occupational medicine and surgery. Additional clinical staff also hold advanced degrees, certifications (e.g., nurse practitioner), and/or case management certification. McKesson uses a multi-step standardized development process that actively reviews current medical literature and aggregates valid, relevant scientific evidence and real-world best practices into the InterQual Criteria to ensure that customers are getting unmatched clinical rigor and integrity.

McKesson capabilities include coding and claims management relationships with the CPT Editorial Panel, active relationships with national medical specialty societies, and consultative specialty specific relationships from a panel of more than 900 practicing physicians. McKesson medical directors have given presentations at major recent national conferences for Episode Management and have authored a number of articles on these topics in current trade magazines.

For 36 years, McKesson has delivered software, clinical content and services to the payer and hospital industries. We are committed to creating a healthcare system in which quality is higher, mistakes are fewer and costs are lower, and are proud of the success we have made towards that goal in partnership with our customers. We are #1 in providing clinical care guidelines. We are the industry-leading provider of 24/7 Nurseline services, currently servicing more than 24 million lives. We are an industry leader in providing claims performance software and services. We are #1 in providing care management workflow solutions. And we are #1 in providing business analytics solutions for healthcare management. This unique presence gives us a unique perspective that drives our ability to understand your needs, and a unique level of experience and expertise that helps us effectively address those needs.

Proposed Approach & Solution:

McKesson’s Clinical Content Team will provide assistance in developing and refining evidence-based episode definitions if pre-existing content is not adequate or appropriate for this initiative, and may be expanded to include clinical and business performance metrics and analytics, as required. Onsite clinical consulting and guidance from the Clinical Content Team is also available.

1McKesson Health Solutions’ InterQual solution is an evidence-based decision support product that helps payer and provider organizations share a common language when determining the right care at the right place and the right time for individuals, driving optimal financial and medical outcomes. InterQual Criteria cover over 95% of all reasons for admission to any level of care and over 95% of procedures and imaging studies, including inpatient and outpatient levels of care, behavioral health, imaging, procedures, molecular diagnostics and retrospective monitoring.
New Capabilities:

No new capabilities are anticipated to be necessary.

Episode Definition

Current Capabilities:

✓ Enabling Full Scale Bundled Payments

Health plans require sophisticated technology to enable full-scale, bundled payment solutions that automate and align the following core objectives of bundled payment strategies. The solution should include expert, customizable clinical content to meet episodes’ diverse care and reimbursement criteria, while streamlining administrative processes.

The solution must:

- Automate and streamline initial data analyses to target best practice for episodic care
- Automate episode authorization and payment
- Automate bundling and payments for different payment models, such as FFS with incentives or single lump sum payments (prospective or retrospective)
- Accommodate specialty-specific episode definitions

With these capabilities, health plans can optimize the medical savings derived from episode of care programs by combining and aligning decision support guidelines with payment decision rules. In addition, automation of the process from initial authorization to final payment will greatly reduce the administrative costs normally associated with all the manual efforts described.

McKesson’s Episode Management solution offers Arkansas Division of Medical Services (DMS) the ability to combine episode identification, management and reimbursement capabilities. The solution delivers high levels of customization to meet diverse care criteria, while streamlining and automating administrative processes. The solution is built on McKesson’s Total Payment™ platform, an existing, proven payer-facing and provider-facing claims transaction rules engine, which is used by leading health plans to return accurate claims payment decisions for approximately 74 million covered members. It offers episode of care and bundled payment rules that look across multiple providers and multiple dates of service to determine which services belong to an episode of care and how those services should be paid. The solution, which is generally available, has been deployed in production for a large health plan to support a prospective bundled payment pilot program.

McKesson is actively developing the solution according to an expanded view bundled payments emerging as one of several Value Based Reimbursement approaches that align incentives across providers, health plans and patients to improve the quality of care and lower costs. McKesson’s vision for a comprehensive episode of care solution includes the components shown in Figure 1. This diagram represents the core competencies necessary to implement an effective bundled payment program. McKesson has assets in each of these areas that can be developed and integrated to automate manual tasks and scale up bundled payment programs in an efficient manner.
The first core competency is **Episode Initiation, Clinical Authorization and Patient ID**. This involves the identification of a patient who is eligible to enter an episode and the process of registering them for an episode. This ensures the patient and provider are aware of the episode and the expectations for outcomes and costs associated with the episode. Early awareness of an episode is critical in assisting providers in the management of the patient’s care according to the episode model and to the performance expectations for the episode. Ideally, patients and payers would be able to select a provider Center of Excellence based on published quality performance metrics and accurate pricing for an entire episode. Additional technology solutions include auto-authorization and registration capabilities.

The second core competency is **Care Coordination**, which allows the care team involved in an episode to manage the patient’s care effectively. This requires an understanding of the expected outcome of an episode and the longitudinal clinical pathway across settings of care necessary to achieve the expected outcome. In the simplest form, this competency requires education and training across all key stakeholders in an episode, such as the hospital, surgeon and rehabilitation services for a knee replacement episode. In more advanced models, clinical guidelines and alerts can be incorporated into Electronic Medical Records (EMRs) and care management software that proactively guides patient care and alert key stakeholders to implement appropriate interventions.

The third core competency is **Episode Bundling, Pricing and Payment**. This core competency allows a program to support provider and payer financial workflows using existing fee for service claims. Episode Bundling involves accurate payment of services associated with an episode and payment policies, which
may include a prospective lump sum payment to an administrative provider, partial payment to multiple providers with a reconciliation, or retrospective reconciliation of an episode for which services were already paid on a fee for service basis. In any model, it is important to support existing provider claims processes. McKesson has developed a solution to support all of these payment models using a rules based logic engine built on the Total Payment Platform.

- The fourth core competency is **Analytics**, which provides the ability to design and plan a bundled payment program and manage the program once it is underway. This competency includes the ability to model bundled payment programs using episode rules and historical data, create alternate models to study impacts of model changes and estimate episode costs. Analytics to support program management include payer and provider reports and dashboards of active and complete episodes, financial and clinical performance monitoring, and calculation of rewards and penalties.

- The fifth core competency is **Network Management**, which involves management of provider identification, contracts and reimbursement policies. This allows a plan to manage reimbursement policies including fee for service, pay for performance, episode payments, medical management fees and partial or full capitation and the ability to identify the correct provider, contract and payment policy efficiently.

**Building Episode Definitions**

McKesson has built and deployed episode rules to automate bundled payment programs in several different manners within the Episode Management solution. Our Clinical Content team, which creates and maintains InterQual Criteria, has engaged to create rules based on industry episode definitions like Prometheus and IHA (Integrated Healthcare Association). In addition, McKesson has authored definitions and is able to support custom definitions created by our customers.

When McKesson’s Clinical Content Team begins developing an episode definition and implementation plan, we utilize the Episode of Care Model shown in Figure 2 to help guide the process. This model shows the key components of a bundled payment program that need to be defined to build a complete view of an episode of care. The definition is converted to a set of specialized rules customized precisely to a customer’s specifications, permitting the flexibility at the claim line level to identify services that are included or excluded from an episode for accurate performance reporting.
A customer engagement begins with Program Definition Analysis. Delivered as a set of analytic services, the Program Definition Analysis assists payers in identifying target procedures and conditions for episodes of care based on factors such as high cost of care, high volume and high variance in cost and outcomes. Once target episodes of care have been identified, analytics can be used to identify providers who are active in these episodes to determine ideal characteristics of a Principal Accountable Provider and experience with their patient population. These services will utilize a clinical and financial analysis of claim histories. Once PAPs and episode definitions have been identified, modeling of the future program using historical data can be done to refine program design.
An example of a rule structure is shown in Figure 3. This diagram depicts a sample clinical course for a total knee replacement episode of care by services rendered. This episode was created following the prospective IHA episode definition for a total knee replacement and deployed to support a health plan’s participation in the IHA pilot in Southern California. The paths in this rule represent different components of an episode and reflect the kind of structure that can be built into an algorithm. Trigger claims, standard care, rehabilitation care and potentially avoidable complications can be identified automatically and used to determine appropriate compensation and capture provider performance within this kind of structure. The Episode Management rules engine provides the option to use switches to turn paths on or off. An example is the rehabilitation path, which can be turned on or off depending on the administrative provider responsible for an episode. This can be done within one instance of the rule and one implementation to allow administrative providers with rehabilitation services to bundle them into an episode and for administrative providers without these services to exclude them from the bundle.

McKesson has developed several different episode models, including the Prometheus definition for Coronary Artery Bypass Grafting (CABG) and a McKesson developed definition for Screening Colonoscopy. The retrospective DMS program would fit well within an algorithm defined in the Episode Management solution.

**Episode Management Rule Options**

**Total Knee Replacement**

- **Trigger Rule – claims Bundling Begins**
- **Readmission/Potentially Avoidable Complication Path – services included in global payment**
- **Rehabilitation Path – services included in global payment**
- **Warranty Period ends – claims bundling stops**

Figure 3. McKesson’s rule structure for a Total Knee Replacement.
Proposed Approach & Solution:

To assist DMS in building episode definitions to cover 75% of Medicaid medical expenses, McKesson will work with DMS to evaluate the procedures and conditions that account for the highest medical costs and those that can be effectively incorporated into an episode of care model. Once the list of potential episodes has been created, a Program Definition Analysis will be performed on a historical claims data set to identify clinical services most often associated with an episode. McKesson’s Clinical Content Team will use the results of the data set to identify the most common services and compare those to evidence-based criteria for the episodes in question to establish an episode of care model as outlined in Figure 2. This model will be reviewed with DMS to ensure the episode criteria are acceptable.

In general, episode definitions can be organized into two groups: event-based episodes involving a diagnostic or surgical procedure (e.g. cardiac catheterization, total knee replacement); and time-based episodes that involve medical management over pre-determined intervals (e.g. twelve months, congestive heart failure, diabetes) with adjustments for degree of illness. When an episode model is created, McKesson utilizes a rule template to capture algorithm logic containing categories for each aspect of an episode, such as included diagnoses, included procedures, potentially avoidable complications, etc. These categories are populated using the Total Payment Dictionary that contains lists of codified content such as ICD9 and CPT codes. This structure allows customers to quickly modify inclusion and exclusion criteria using the Dictionary. Experience with episode models to date is that many episodes have similar rule logic, and once a template is built for a procedure like CABG, it can be used as a starting point for new episodes with similar characteristics like coronary angioplasty. The template is modified for the new episode and Dictionary is populated with appropriate codes for the new episode. It is likely that 5-10 basic templates will be identified that will support the majority of the episodes needed for the complete DMS initiative, which will allow the program to be scaled up more quickly.

Our Episode Management solution is built on the Total Payment Platform. The service-oriented, n-tier architecture provides nearly unlimited scalability, high performance and interoperability to support your IT configuration. The platform is proven in the largest multi-site payer organizations, applying rules consistently for millions of edits per day.

New Capabilities:

McKesson may need to increase staffing to meet the DMS project timelines. Otherwise, no new capabilities are anticipated to be necessary.

Principal Accountable Provider (PAP)

Current Capabilities:

As part of the episode definition process, the McKesson Clinical Content Team determines which provider should serve as the administrative or Principal Accountable Provider. This is based on the provider who has primary responsibility and capability to effectively coordinate care within an episode to achieve quality and financial goals associated with an episode of care. This assessment includes use of clinical experience, available clinical evidence for an episode and an analysis of historical claims data for the episode in question. In McKesson’s existing rules, an administrative provider is identified using rules based logic to support a prospective lump sum payment. Similar logic could be utilized to identify the PAP to support the DMS retrospective model.
Proposed Approach & Solution:

DMS can evaluate McKesson’s current frameworks for PAP logic and the logic can be configured to meet specific DMS requirements. In addition, McKesson can create new logic to meet DMS requirements using our rules based structures.

New Capabilities:

No new capabilities are anticipated to be necessary.

Clinical and Business Exclusions

Current Capabilities:

As part of the episode definition process, the McKesson Clinical Content Team determines clinical and business exclusions appropriate for a particular episode of care. This assessment includes use of clinical experience, available clinical evidence for an episode and an analysis of historical claims data for the episode in question. Historical data analyses are particularly helpful in this area to be sure low frequency co-morbidities and clinical events are accounted for in the analysis. This assessment is closely related to creation of patient and provider level adjustments since many potential exclusions may identify an adjustment, such as a patient with Chronic Obstructive Pulmonary Disease (COPD) who undergoes a knee replacement.

Episode Management has a standard method for capturing clinical and business exclusions using a rule category to capture logic for exclusions. For instance, a list of provider IDs can be populated for providers who are not participating in a bundled payment program and any episodes associated with those providers can be excluded from the program. Clinical exclusions, such as Human Immunodeficiency Virus (HIV) in some of McKesson’s current definitions, can be identified using ICD-9 diagnosis codes and patients with excluded diagnoses will not have episodes activated. These are examples of the types of exclusions that can be implemented.

Proposed Approach & Solution:

McKesson will utilize rule categories within the DMS rule logic to populate exclusion criteria. These categories can be updated quickly by modifying the content of the categories. Potential exclusion criteria include, but are not limited to, patient age, gender, co-morbidities and frequency of services or services done close together, such as a colonoscopy done on the same day as an upper GI endoscopy. Potential provider exclusion criteria could include, but are not limited to, the address of the provider, a specific list of provider IDs or provider specialty. Updates to exclusion criteria through the Total Payment Dictionary can be completed quickly by updating the list of codified content in the exclusion category.

Built on the Total Payment platform, Episode Management’s architecture currently accepts more than 200 data elements on a claim form. Its flexible rules engine allows users to define rules that match their precise payment, medical and contractual policies based on any claim, provider or member attribute. All codes and rules are highly configurable, as is their firing order, providing highly granular editing and improved payment accuracy. Any one of these data elements can be used as a parameter in the expression of rule logic. Because of this, existing rules can be configured at a very granular level (e.g., provider, specialty, zip code, CPT code, etc.), and new rules can be created using any combination of data elements.

New Capabilities:

No new capabilities are anticipated to be necessary.
Patient- and Provider-level Adjustments

Current Capabilities:

As part of the episode definition process, the McKesson Clinical Content Team recommends clinical and business criteria that may be appropriate for a new classification within an episode. An example is a patient with COPD who undergoes a knee replacement. This patient will have a higher level of services expected than a patient without COPD, with a higher expected cost. This assessment includes use of clinical experience, available clinical evidence for an episode and an analysis of historical claims data for the episode in question. Historical data analyses are particularly helpful in this area to be sure low frequency co-morbidities and clinical events are accounted for in the analysis. This assessment is closely related to creation of clinical and business exclusions since many potential adjustments may identify exclusion criteria.

Patient and provider level adjustments are established in rule logic using different rule paths and rule switches to reflect the episode algorithm and identify the appropriate modifier or adjustment for a particular episode. Rule paths and switches are built as part of the rule’s decision tree with content categories that contain the codes that identify when a patient or provider adjustment applies to an episode of care. For instance, the patient mentioned above undergoing a knee replacement had COPD coded on the inpatient facility claim for the knee replacement. In this example, the patient’s claim received an adjustment code indicating the risk adjustment for COPD, while a patient without any relevant co-morbidities would receive a standard adjustment code. Unique adjustment codes can be established for any codifiable element reflected in data made available to the rules engine. Dictionary categories for these paths can be updated quickly as programs are refined.

Proposed Approach & Solution:

McKesson will identify recommended patient and provider adjustments utilizing clinical evidence, clinical experience and analysis of historical claims data to review with DMS. Once DMS approves the adjustments, rule paths and switches will be built within the rule logic to reflect the definitions, and Dictionary categories will be populated with appropriate content.

New Capabilities:

No new capabilities are anticipated to be necessary.

Quality Metrics

Current Capabilities:

As part of the episode definition process, the McKesson Clinical Content Team determines potentially avoidable complications, expected levels of clinical services and expected durations for inpatient stays, rehabilitation services and overall episodes. In addition, McKesson’s analytics teams utilize evidence based and standard industry provider performance measures in building provider performance solutions. These assessments include use of clinical experience, available clinical evidence for an episode and an analysis of historical claims data for the episode in question.

McKesson has experience with establishing metrics and reporting on data from EMRs to track provider performance on patient status indicators, including lab values, functional scores and assessments. Through McKesson’s analytics capabilities, clinical metrics and financial metrics are combined to track individual provider performance and inpatient and outpatient facility performance. The McKesson Clinical Content team
responsible for InterQual Criteria will participate in the development of performance metrics and in incorporating them into episode algorithms to support episode reconciliation.

**Proposed Approach & Solution:**

McKesson will recommend quality metrics for each episode utilizing clinical evidence, clinical experience and historical claims data analysis and work with DMS to refine them as needed. Once DMS has approved quality metrics for an episode, they will be included in the algorithm to determine impact to rewards and penalties.

**New Capabilities:**

No new capabilities are anticipated to be necessary.

**Maintenance and Algorithm Updates**

**Current Capabilities:**

McKesson’s Clinical Content Team provides standard updates to content on a quarterly basis as part of an existing process. These updates include changes to content resulting from evidence based practice changes, codification changes and business changes. In addition to quarterly updates, rules and content can be updated on an ad hoc basis as customer requirements change. Turnaround times for changes vary depending on the nature of the change. Simple content changes such as adding procedure codes to an existing algorithm may be completed in several days, while changes to algorithms will take longer and will need to be assessed based on the nature of the requirements.

**Proposed Approach & Solution:**

McKesson will utilize the same approach described in the Current Capabilities section of this topic.

**New Capabilities:**

No new capabilities are anticipated to be necessary.

**Threshold Setting**

**Current Capabilities:**

McKesson can analyze DMS historical claims by running them through existing McKesson default episode rules as a starting point to understand potential costs associated with an episode. This data can be compared to any models DMS has already developed. Queries and reports can also be developed to reflect DMS requirements to analyze data and determine expected costs. Queries and rules can be modified to reflect different combinations of included and excluded services, different episode durations and different patient and provider adjustments to compare models. Once a model has been selected, DMS can use the results of the analyses to set budgets for each episode and adjusted categories within an episode.

It should be noted that McKesson does not set rates for clinical services, but McKesson can provide the data and analytics services to support DMS in setting rates.
Proposed Approach & Solution:

McKesson will provide DMS with analyses of historical data based on any combination of McKesson default episode rules, DMS rules that have been built in Episode Management, and queries on relevant data. Analyses will be refined as episode design progresses to show the potential impact of changes in episode design to support DMS in setting cost thresholds and establishing rewards and penalties.

New Capabilities:

No new capabilities are anticipated to be necessary.

If you have existing claims grouping algorithms and solutions, please indicate (a) whether your episode definitions include the following components, and if so, your clinical and economic rationale for how they are implemented

- Claims grouping
- Exclusions (e.g., co-morbidity)
- Risk severity adjustments
- Other adjustments
- Quality metrics
- Integration with non-claims data sources
- Payment thresholds

Please refer to the responses provided for Clinical Guidance, Episode Definition, Principal Accountable Provider, Clinical & Business Exclusions, Patient- & Provider-level adjustments, Quality Metrics, Maintenance & Algorithm Updates, and Threshold Setting.

(b) Indicate your willingness to publish the details of these episode to the provider community

McKesson is willing to publish the details of these episodes to the provider community.

(c) for each supported episode, please provide the following

<table>
<thead>
<tr>
<th>Episode Name</th>
<th># Deployments</th>
<th># Payment Deployments</th>
<th># Production Payment Deployments</th>
</tr>
</thead>
</table>

For capabilities you will need to build, please describe how you intend to build those, the timeline for development, and how you propose working with DMS to develop your offerings in a manner that is suitable for Arkansas

McKesson has an implementation process for developing episode rules and analytics that will be utilized for DMS. A McKesson engagement manager will be assigned to the implementation, in addition to subject matter experts and clinical content experts, who will work with DMS representatives to develop requirements and a project schedule. The project schedule will be maintained in conjunction with DMS, along with an expected capacity plan for both organizations. Regularly scheduled project status meetings will be held to track progress and develop mitigation plans for any at risk deliverables.
Many of the capabilities described in the RFI already exist within current products. The need for additional capabilities will need to be determined based on more detailed DMS requirements. Episode rules and analytics algorithms will need to be developed within existing product frameworks to meet DMS program requirements. Through a widely deployed Total Payment solution line, McKesson has developed the ability to respond quickly to changes to rules and content. McKesson regularly deploys changes to default rules and purely custom rules for existing Total Payment customers. The timeline for rule logic changes depends on the nature of the change. Changes to rule content such as a new diagnosis code for exclusion criteria can be made in several days. The flexibility of Total Payment and Episode Management combined with the ease of making changes is one its primary benefits in performing claims auditing and episode bundling in a rules-based engine that is separate from core claims systems.

The timeline for the overall development effort will need to be discussed with DMS to ensure all program requirements are fully understood. However, it is expected that McKesson could support the DMS goal of implementing bundled payments for over 75% of Arkansas Medicaid medical costs prior to the 3-4 year timeline provided.

Please describe your proposed timeframe and capacity to scale up to reach 75%+ of medical spend within the next 3-4 years.

Episode definitions can be organized into two groups: 1) event-based episodes involving a diagnostic or surgical procedure (e.g. cardiac catheterization, total knee replacement) and 2) time-based episodes that involve medical management over pre-determined intervals (e.g. 12 months; CHF, COPD, diabetes) with adjustments for degree of illness. A staged implementation of an episode strategy is strongly recommended starting with event-based episodes that have well-defined included and excluded components, as well as clear starting and stopping points. This approach can support multiple concurrent operating project teams during implementation and stabilization of the system core competencies. More complex event based episodes (e.g., chemotherapy) can then be added on a specialty by specialty basis as each team progresses. Finally, time-based episodes can then be introduced, stratified for acuity of illness. McKesson anticipates that five to 10 episodes should be targeted in Year 1, 20 additional episodes in Year 2, and up to 30 to 50 additional episodes in Years 3 and 4. This approach assumes that an analytics based approach will identify and implement those episodes with the highest spend in that order. In other words, Year 1 will be devoted to a small number of high-volume episodes to get started; episode and rule definitions for these episodes are already available. This approach gives the software and planning teams lead time for the Year 3 and 4 deployments of a much larger number of lower volume episodes. McKesson believes that implementation of the medical management episodes will be the most difficult due to the variety of patients, co-existing clinical problems, and implementation challenges.

Please describe your approach to ensuring all design dimensions are made with sufficient clinical input.

McKesson’s Clinical Content Team is an integral part of Episode Management and would be involved in every step of this project as a key participant and owner of certain deliverables such as Episode Design, Patient Adjustments and Quality Metrics. In addition, the Episode Content Development Team has immediate access to every division within McKesson that has clinical expertise and existing product and service lines.

McKesson’s clinical research staff (physicians, registered nurses, and other specialty-based healthcare professionals) have been researching and developing evidence-based clinical care guidelines, in all areas of clinical care for 36 years. Physicians’ backgrounds include experience or specialization in internal medicine, infectious disease, anesthesiology, occupational medicine, and surgery. Additional clinical staff also hold advanced degrees, certifications (e.g., nurse practitioner), and/or case management certification. McKesson uses a multi-step standardized development process that actively reviews current medical literature and
aggregates valid, relevant scientific evidence and real-world best practices into clinical criteria to ensure that customers are getting unmatched clinical rigor and integrity

**Please compare your offering and capabilities to other solutions and vendors in the marketplace.**

Our Episode Management solution offers flexible rules, clinical content depth, proven and widely deployed MAA analytics solutions, and has an existing bundled payment production deployment for automating a large payer’s program. Bundled payments are an important part of the McKesson Health Solutions value-based reimbursement strategy, which is our approach to automating the entire process of contracting, pricing and paying for a continuum of reimbursement structures from fee for service to pay for performance to bundled payments and global payments and many iterations in between. McKesson brings deep expertise in all aspects of healthcare content and technology with payers and providers to support the success of customers implementing value-based reimbursement models.

McKesson’s Episode Management solution is part of our evolving Integrated Reimbursement Management suite. It supports scalable episode programs with automated, prospective bundled payments. Leveraging the proven performance of McKesson’s Total Payment platform, the base software platform of the ClaimsXten™ solution, that is deployed by leading health plans to return accurate claims payment decisions for approximately 74 million covered members. McKesson Episode Management uniquely combines clinical support and financial transaction functions to promote quality care, reduce administrative and medical costs, and position plans to support full-scale bundled payment programs.

Additional components of the Integrated Reimbursement Management suite include Reimbursement Manager and Provider Manager. McKesson also offers Provider Manager, which can be used to define and manage narrow networks of providers involved in episodes of care, ACOs, medical homes, and other care models. Provider Manager includes capabilities to maintain extensive provider and practitioner specific information that facilitates the decision logic to make appropriate payments. It can track multiple affiliations between providers, which is required to support some advanced payment models.

This suite of modular solutions from McKesson Health Solutions is designed to support payer/provider collaborations that achieve care redesign to improve outcomes and lower costs. McKesson is focused on providing solutions that allow payers and providers to identify best practices, design care models and teams that can achieve program goals, and prospectively manage care and payment around the new models to ensure goals are met. Retrospective models are important to offer a step towards prospective management because they allow providers to participate in programs with minimal change to their billing systems. McKesson is also working with providers through an extensive provider technology business to build solutions for providers to better manage episodes of care and bundled payments. As payer and provider capabilities converge, full prospective models that manage clinical and financial aspects of an episode more comprehensively from the beginning of an episode can be realized. McKesson is committed to supporting customers in retrospective and prospective models and continuing to advance provider capabilities to help move our healthcare system towards improved quality and efficiency.

**A Trusted Partner**

Partnering with a vendor that can work with you for the long run is a critical success factor. McKesson Corporation is the nation’s oldest and largest healthcare company. McKesson has been in continuous
McKesson Health Solutions is a subdivision of McKesson Technology Solutions and is our payer-focused business. We deliver collaborative solutions with unrivaled clinical integrity that enable payers, providers, employers and consumers to come together to transform the business and process of patient care. Our vision is to help create a healthcare system in which quality is higher, mistakes are fewer and costs are lower. For 36 years, McKesson Health Solutions has been providing medical management and claim performance solutions with a 95% customer renewal rate. We are widely recognized as the leading provider and trusted partner in:

- **Point-of-care Decision Management Solutions** — clinical and financial solutions for all points of care allowing our customers to drive higher quality and lower cost of care by making their decisions smarter, more automated and more collaborative.

- **Care Management Solutions** — clinical solutions improving care quality and overall care experience for patients across the care continuum.

- **Finance and Network Solutions** — solutions designed for this fast-changing market to optimize claims performance by reviewing claims for policy compliance and fraud, waste and abuse, as well as analytics that provide a source of reporting for all stakeholders, create transparency, and provide clinically and financially relevant performance metrics. And, solutions supporting an Integrated Provider Management (IPM) Platform, which simplifies the designing, managing and servicing of provider networks, while orchestrating value-based reimbursement.

Our disease, case, and demand management solutions help customers improve outcomes and reduce unnecessary utilization. Our business intelligence and claims management tools help optimize business performance, and touch more than 160 million covered lives. Our solutions are used by:

- 100% of the top 10 health plans
- 96% of the top 25 plans
- Over 160M payment management lives representing over 250 clients
- Over 4,200 decision management clients (hospitals and payers)
- Over 50M care management lives
- Medicaid programs

McKesson is the best-suited vendor partner to address your Episode-based Payment needs for many reasons:

- **Financial Strength and Clinical Breadth** — With over $122 billion in annual revenues, McKesson is a financially sound, Fortune 14 company. Our solutions span the entire medical management continuum —from analyzing information to pinpointing areas for intervention, to identifying high-risk members for follow-up and managing their care, to measuring impact.
- **Proven cost-saving solutions that empower plans to accommodate reform** — For 36 years, McKesson has been providing medical management and claim performance solutions to healthcare organizations. No single vendor can match our breadth and depth of products and services.

- **Innovative and Comprehensive Solutions** — McKesson continues our quest to offer our clients best-in-class solutions for their business needs. Whether through our own internal product development or through our strategic partnerships with other healthcare companies, we are committed to offering our customers the most innovative and comprehensive software solutions in the market today.

McKesson looks forward to working with DMS to provide clinical and financial expertise in developing Episode-based Payment solutions that will promote quality care, reduce administrative and medical costs, and position DMS to support full-scale bundled payment programs.
Component B: Administration/Infrastructure

Please describe your approach, capabilities, and experience for each of the following:

- Executing technical episode algorithms (designed internally and/or by 3rd parties) and input results to payment system of record

McKesson’s Episode Management solution is designed to capture an episode definition, including exclusion criteria and patient and provider adjustments, and apply a recommendation and adjustment code to identify the type of service a claim line represents within an episode of care. This model can support a retrospective reconciliation such as DMS has implemented or a prospective bundled payment program such as McKesson’s current clients are utilizing. In a retrospective model, the output from the episode algorithms in Episode Management are output to McKesson Analytics Advisor™, powered by MedVentive, which calculates the overall cost of an episode of care and compares it to established thresholds for the episode. Once the episode is complete, the financial performance for the episode is calculated relative to the thresholds and a recommended payment or penalty can be sent to a payment system of record in a standard format, such as Excel, CST, PDF or HTML. In addition to calculating financial performance, non-claims data can be utilized to adjust the recommended payment based either on reporting status or on achieving a specified quality metric, such as functional scores after knee replacement. The Analytics Advisor data flow model is shown in Figure 4.
Figure 4. McKesson Analytics Advisor data flow is designed to meet retrospective or prospective bundled payment models.

- **Generating reports that highlight performance and define payment (batch / real-time)**

  Analytics Advisor generates reports in a web-based, real-time, non-batched format for customers. Reports will be developed to represent provider financial and clinical performance within DMS episodes of care. These reports are typically generated as standard on a monthly basis depending on customer requirements. Sample reports are shown in Figures 5 and 6 for reference.
Figure 5. McKesson Analytics Advisor’s Quality Dashboard identifies opportunities that drive improvements in quality and adherence to care guidelines.
Figure 6. Analytics Advisor Provider Profile Graphs offers risk adjusting profiling for primary care physicians (PCPs) and specialists to identify opportunities specific for improvement.

- **Integrating non-claims data into episode algorithms**

  Analytics Advisor currently incorporates non-claims data, such as HgA1c values for measuring provider performance, from EMRs and other sources via data integrations. A similar integration could be developed to the DMS provider portal. Analytics Advisor financial, clinical, utilization, and performance measures are used to measure provider performance in a defined standard P4P process to reward/incent providers who meet acceptable performance levels. This method can be used to capture episode of care metrics and incorporate them into performance algorithms to determine appropriate rewards and penalties.

- **Administering rewards payments and penalties**

  Analytics Advisor’s Pay for Performance Adjudicator determines dollar and point rewards for providers who meet acceptable performance measures. This tool can be used to calculate recommended rewards and penalties according to DMS algorithms and output recommendations to the payment system of record.

Please describe how many relevant deployments you have:

- **Total**
McKesson Episode Management has one production deployment for Aetna. Please refer to the following press release:

**Aetna and Hoag Orthopedic Institute Collaborate with McKesson on Innovative Automated Bundled Payment Initiative**

*McKesson’s Episode Management Solution Provides Critical Technology Framework, Aetna First to Automate Integrated Healthcare Association Bundled Payment Program*


- **In production (vs. pilot)**
  
  Please see prior section for response to this question.

- **Number of providers in production**

  McKesson Episode Management has three surgeons in production contracted with Aetna for the IHA program. McKesson Analytics Advisor has more than 1,500 providers in production.