Welcome to Milliman’s Health Webinar

- The briefing will begin in a few minutes.

13th October 2020
Virtual Meeting Best Practices

- Mute: As an attendee, you will be on mute automatically for the duration of the webinar.
- Video: Only presenters will be on video. Video is turned off for attendees.
- Q&A: Use the chat function within the meeting for questions.

Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00pm – 12:02pm</td>
<td>Welcome</td>
<td>Sinéad Clarke</td>
</tr>
<tr>
<td>12:02pm – 12:20pm</td>
<td>COVID-19 Update</td>
<td>Kevin Manning</td>
</tr>
<tr>
<td>12:20pm – 12:35pm</td>
<td>Data Analytics: Payer Value Chain</td>
<td>Joanne Buckle</td>
</tr>
<tr>
<td>12:35pm – 13:00pm</td>
<td>Data Analytics: Case Studies</td>
<td>Lalit Baveja &amp; Alison Counihan</td>
</tr>
<tr>
<td>13.00pm – 13.15pm</td>
<td>Q&amp;A session</td>
<td>Sinéad Clarke</td>
</tr>
</tbody>
</table>
COVID-19 Update
Irish and international experience

Kevin Manning
13 OCTOBER 2020
COVID-19 considerations for insurers

Caveats

- Rapidly changing environment and huge uncertainty when you try to model the future
- Time horizon – need to consider 2020, 2021 and longer term
- International comparability challenging
  - Different health systems
  - Different COVID-19 incidence
  - Different governmental responses
Direct COVID-19 Impacts

COVID-19 inpatient hospital admissions

Source: https://covid19ireland-geohive.hub.arcgis.com/

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Direct COVID-19 Impacts

COVID-19 ICU cases

- Pre-Covid ICU capacity: 225
- Temporary surge capacity: 354
- Current permanent capacity: 280
  - Before additional 17 ICU beds from winter flu plan

Source: https://covid19ireland-geohive.hub.arcgis.com/

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Indirect impacts of COVID-19 on insurer claims costs
Considerations for modelling future trends, international insights

Common themes from discussions with international colleagues

- Considerable levels of deferral of care
  - Deferred or Foregone?
- Bounce-back evident but current levels below normal
- Considerable variation by specialty
- 2021 position heavily dependent on potential course of the virus – vaccine, second wave
- Uncertainty over longer term impacts

https://www.commonwealthfund.org/
https://www.stratadecision.com/
Indirect COVID-19 Impacts

Outpatient visits – relative to baseline week (March 1-7)

Percent change in visits from baseline

Indirect COVID-19 Impacts

Inpatient admissions

Inpatient Admissions Daily Rate of Change: January and February Above Normal Before Nationally, Rates Plummeted as COVID-19 Surged


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Indirect COVID-19 Impacts

ER visits

Daily Emergency Visits Rate of Change: Nationally

Indirect COVID-19 Impacts

UK research


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Key challenges for health insurers

- Pent-up demand?
- Longer term impacts on health?
- Impacts for private hospitals?
- What to assume about the path of the virus?

DOCTORS

Where Have All the Heart Attacks Gone?

Except for treating Covid-19, many hospitals seem to be eerily quiet.
COVID-19 considerations for insurers

- Market risks on asset side
- Direct COVID-19 claims impact
- Non COVID-19 claims impact
- Death rates & lapse risks
- Lapses due to economic shocks
- Slow down in new business
- Expenses/operational impacts
- Payment holidays

Caveats

- Rapidly changing environment and huge uncertainty when you try to model the future
- Time horizon – need to consider 2020, 2021 and longer term
- International comparability challenging
  - Different health systems
  - Different COVID-19 incidence
  - Different governmental responses

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Indirect COVID-19 Impacts

Telehealth impact

Office Visit Telehealth Utilization

- Telehealth soared and filled a void during the pandemic and was utilized for almost 50% of office visits at the peak
- However, telehealth office visits have come back down to 11% reflecting the hands-on nature of healthcare

Note: Data from January 1, 2019 to July 31, 2020

For more information:


Kevin Manning
kevin.manning@milliman.com
Data Analytics in Healthcare

Joanne Buckle, Lalit Baveja, Alison Counihan

13 OCTOBER 2020
Health Payer Value Chain

Joanne Buckle
# Health payer value chain & supporting analytical framework

## Health Payer Value Chain

<table>
<thead>
<tr>
<th>Financing and risk pooling</th>
<th>Care Management</th>
<th>Integrated Delivery System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning, Marketing and Distribution</td>
<td>Actuarial &amp; Operations</td>
<td>Member/patient Management</td>
</tr>
<tr>
<td>Pricing, budget setting &amp; liability estimation</td>
<td>Member engagement education &amp; information</td>
<td>Network development provider contracting</td>
</tr>
<tr>
<td>Provider reimbursement via &quot;claims&quot;</td>
<td>Appeals/ grievances</td>
<td>Provider reimbursement via case rates or episode costing</td>
</tr>
<tr>
<td>Enrollment &amp; eligibility</td>
<td>Member services</td>
<td>Provider relations</td>
</tr>
<tr>
<td>Billing</td>
<td>Management reporting &amp; analysis</td>
<td>Credentialing</td>
</tr>
<tr>
<td>Connectivity</td>
<td>Utilisation &amp; unit cost targets</td>
<td>Provider profiling</td>
</tr>
<tr>
<td>Distribution management</td>
<td>&quot;Standard&quot; payer analytics, eg revenue, outgo, expenses, membership</td>
<td>&quot;Standard&quot; payer analytics, eg revenue, outgo, expenses, membership</td>
</tr>
</tbody>
</table>

## Member engagement education & information
- "Standard" payer analytics, eg revenue, outgo, expenses, membership
- Basic clinical data & analytics
- Advanced power analytics, combining clinical and financial

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### Understanding low value care: The IOM\* framework

<table>
<thead>
<tr>
<th>Category</th>
<th>Sources</th>
<th>Estimate of Excess Costs</th>
<th>% of Waste in the US</th>
<th>% of Total in US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary Services</td>
<td>• Overuse beyond evidence-established levels</td>
<td>$210 billion</td>
<td>27%</td>
<td>9.15%</td>
</tr>
<tr>
<td></td>
<td>• Discretionary use beyond benchmarks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unnecessary choice of higher-cost services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inefficiently Delivered Services</td>
<td>• Mistakes, errors, preventable complications</td>
<td>$130 billion</td>
<td>17%</td>
<td>5.66%</td>
</tr>
<tr>
<td></td>
<td>• Care fragmentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unnecessary use of higher-cost providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Operational inefficiencies at care delivery sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excess Admin Costs</td>
<td>• Payer paperwork costs beyond benchmarks</td>
<td>$190 billion</td>
<td>25%</td>
<td>8.28%</td>
</tr>
<tr>
<td></td>
<td>• Payers’ administrative inefficiencies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Inefficiencies due to care documentation requirements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider prices that are too high</td>
<td>• Service prices beyond competitive benchmarks</td>
<td>$105 billion</td>
<td>14%</td>
<td>4.58%</td>
</tr>
<tr>
<td></td>
<td>• Product prices beyond competitive benchmarks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missed Prevention Opportunities</td>
<td>• Primary prevention</td>
<td>$55 billion</td>
<td>7%</td>
<td>2.40%</td>
</tr>
<tr>
<td></td>
<td>• Secondary prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tertiary prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fraud</td>
<td>• All sources – payers, clinicians, patients</td>
<td>$75 billion</td>
<td>10%</td>
<td>3.27%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$765 billion</td>
<td>33.33%</td>
<td></td>
</tr>
</tbody>
</table>

*Now called the National Academy of Medicine.

SOURCE: “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America.” Institute of Medicine (2013)

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Data Analytics: Case Studies

Lalit Baveja
Alison Counihan
Case study 1

Insightful analysis with limited data information
### Identify ways to improve profitability

#### Situation
- **Doubling of claim costs** in the last four years!
- What is driving this?
- Can this trend be slowed down?

#### Challenge
- Limited opportunity for ongoing *premium pricing increases*
- **Strong provider community** difficult to negotiate
- Limited *digital data capture* or price/ cost information leading to manual processes
- Multiple *supply side changes* in private sector – growth in private sector providers

#### Action
- We performed an actuarial/clinical study focused on:
  - Analytics using basic clinical and financial data sets:
    - Diagnosis information (*ICD10 codes* for clinical grouping)
    - Surgery / procedure information (*procedure codes* for intervention grouping)
    - Dates of services
    - Financial information
  - Review of *provider / physician practices* for those common conditions:
    - utilisation
    - interventions
    - efficiency

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The overall increase in BC from 2013/14 to 2016/7 is around 26% p.a., i.e. approximately 1.88x increase or BC Lift.

A significant portion of this could be due to increasing policy duration or age / other population variables.

We focussed on specific medical conditions that have exhibited extraordinarily BC Lift.
Components of Trend

Cancer

- Cancer is significant driver of the high trend, contributing 5%~9% points for Product 1 and 3% points for Product 2.
Components of Trend
Calendar trend per GLM model after removing cancer claims and standardising for other factors

- GLM models used to standardise the impact of age, gender, family size, nationality and policy duration.
  - Product 1 is a new product launched in 2013; BC increases with policy duration and so increasing average policy duration of the portfolio has a significant impact.
  - Product 2 is a closed block portfolio and the increasing age of the policyholders has a significant impact. In particular, product 2 policyholders are older than for product 1, and BC increase with each year of increasing age is more significant at older ages.
  - MO policyholders are older than for FMU; the age adjustment has a larger impact on the MO products.
Gastritis cases currently contributes 5% to overall burning cost and the BC Lift is 3x.

56% of gastritis cases involve an upper GI gastroscopy. And of these 70% of gastroscopies are accompanied by a colonoscopy.

Doctors can have quite opposing practice patterns in terms of whether they use Upper GI scopes as a default line of intervention, and whether they also perform a colonoscopy at the same time. Current practice of most doctors appear to be to utilise scopes.

The doctors who perform high volumes of both Upper GI scopes and colonoscopies practice at two specific hospitals; both relatively new hospitals.
Physician profiling for Endoscopies

Top 20 Doctors who Have High Proportion of Scopes

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Knee Related
Increase in burning cost

- Currently contributes 4% to overall burning cost and the BC has increased 3x over the last 4/5 years.
- Increased BC came from two sources:
  - Existing private hospital with 3.3 BC Lift
  - Six newly established providers, contributing to 16% of 2016-2017 knee claims cost
- There are a handful of early claims each year (claims occurring within the first policy year). 85% of these cases come from Moratorium policies (with Early Claims).
- Further analytics warranted:
  - what extent they are they medically necessary
  - how is medically necessity defined.
  - How will this impact future BC trends.

**Burning Cost by Hospital Type**

- 2013/4:
  - 11 Total
  - 3 Lift: 0.73
  - 8 Lift: New Traffic
  - 3 P
  - 2 O
- 2016/7:
  - 33 Total
  - 26 Lift: 3.35
  - 2 Lift: New Traffic
  - 2 2 New O in 2016
  - 2 2 New R in 2016
  - 4 Existing R
  - 6 Existing P

P = Private Facility
O = Other Private hospital (clinic/ day care centre)
R = Public Facility

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Knee Related
Possible savings from unnecessary admissions/excessive stay?

- Only 22%-25% of admissions at private facilities (P and O) involve a procedure. 40% of admissions at public hospitals involved a procedure.
- The lengths of stay involved are very long; it may be worth reviewing whether these stays are in acute hospital beds and whether it is an efficient use of acute hospital beds.
- There are a handful of doctors generating significant burning costs from knee related claims.
Backache
Increase in burning cost

- Currently contributes **3%** to overall **burning cost**, i.e. 3% of overall medical spending is directed to treating backaches.

- The BC has **increased 3x** over the last 4/5 years and can be expected to continue to increase rapidly with the aging of the policyholders and portfolio.

- **Private hospitals** are the major contributor to backache claims.

- There may be a problem with **early claims** (claims occurring within the first policy year). In 2017H1 alone, there were 22 cases, which we estimate contribute $5 to the BC.

---

**Burning Cost by Hospital Type**

<table>
<thead>
<tr>
<th>Type</th>
<th>Cont.:</th>
<th>Lift:</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>85%</td>
<td>2.72</td>
</tr>
<tr>
<td>O</td>
<td>8%</td>
<td>2.00</td>
</tr>
<tr>
<td>R</td>
<td>7%</td>
<td>2.00</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Increase in burning cost**

P = Private Facility

O = Other Private hospital (clinic/ day care centre)

R = Public Facility

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Top five doctors contribute 40% of the backache claims cost in 2016-2017, i.e. over 1% of overall claims.

Average cost of backache claims from these doctors range from $13,000 to 40,000.

Burning cost lift going from 2013-2014 to 2016-2017 could be due to:
- New traffic (from 9 doctors in 2013-2014 to 56 doctors in 2016-2017)
- Increase in number of backache claims (from 15 claims in 2013-2014 to 272 claims in 2016-2017)
Recommendations based on analysis

• Product design modifications to engage customer financially
• Standardise underwriting and ensure autochecks at Preauth/ claims
• Preauthorisation to steer patients to better providers
• Rigor at claims stage to identify suspect claims and monitoring
• Improve data capture, setup monitoring reports and trigger for checks
• Focussed investigations for specific conditions, providers and physicians
• Provider profiling with naming/shaming; incentives; monitoring deterrents
• Network management with medical policy in contracts
Case study 2
A journey towards automated claims adjudication
Patient suffers from chest pain and is diagnosed with a heart condition.

Hospital billing department sends Authorization request to Claim dept.

Claim Assessor receives request

Automated process
- EDI with validation checks
- Pay for reporting (Coding)
- Enabling tools (Coding)
- OCR (Coding)

Manual process
- Rules Engine/ API Services/ Policy system, provider management system, claims system

Workflow changes, process standards and tools/checklists

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Automated Claims processing (1)

Patient suffers from chest pain and is diagnosed with a heart condition.

Hospital billing department sends Authorization request to Claim dept.

Claim Assessor receives request

Coding tool enables quick diagnostic/procedure coding

Data points captured

| Member age |  
| Member gender |  
| Product/ plan ID |  
| policy inception date |  
| diagnosis code | Ischemic heart disease = I25  
| procedure code | Angioplasty with stent = 027034Z  

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Automated Claims processing (2)

Clinical, underwriting, contractual, utilization and financial rules/ edits

Auto adjudication Rules/ API Services

Claim Assessor sends API to Rules Engine on cloud, other checks from UW or provider info

Rules Library

- age appropriateness rules
- gender appropriateness rules
- diagnosis procedure rules
- avoidable admissions rules
- day care procedure rules
- permanent exclusion rules
- preexisting disease list rules
- waiting period conditions rules
- LOS benchmarks

PASS
PASS
PASS
PASS
PASS
PASS
FAIL
PASS
PASS
PASS
PASS
FAIL

Auto pass

Refer for manual intervention (clinical)

Refer for manual intervention (non-clinical)

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Minimum Data requirements for autochecks

For inpatient hospitalisation claims adjudication.

- **Member details:**
  - Unique ID
  - age
  - gender
- **Policy details:**
  - product ID
  - inception date
- **Clinical details:**
  - Date of services
  - diagnosis
  - Procedure
- **Provider details:**
  - Provider ID
- **Billed amounts**

<table>
<thead>
<tr>
<th>Rule type</th>
<th>Fields required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan exclusions</td>
<td>Plan name&lt;br&gt;Diagnosis (ICD9 or 10)&lt;br&gt;Procedure (CPT, ICD9PCS or ICD10PCS)</td>
</tr>
<tr>
<td>Plan waiting periods</td>
<td>Policy inception date&lt;br&gt;Date of admission&lt;br&gt;Plan name&lt;br&gt;Diagnosis (ICD9 or 10)&lt;br&gt;Procedure (CPT, ICD9PCS or ICD10PCS)</td>
</tr>
<tr>
<td>Personal medical exclusions</td>
<td>Member ID&lt;br&gt;Claims Diagnosis&lt;br&gt;Personal medical exclusions codes</td>
</tr>
<tr>
<td>Pre-existing conditions</td>
<td>Plan name&lt;br&gt;Diagnosis (ICD9 or 10)</td>
</tr>
<tr>
<td>Gender appropriateness of diagnosis</td>
<td>Gender&lt;br&gt;Diagnosis (ICD9 or 10)</td>
</tr>
<tr>
<td>Age appropriateness of diagnosis</td>
<td>D/O/B or Age&lt;br&gt;Diagnosis(ICD9 or 10)</td>
</tr>
<tr>
<td>Is the treatment claimed appropriate for the claimed diagnosis?</td>
<td>Diagnosis (ICD9 or 10)&lt;br&gt;Procedure (CPT, ICD9PCS or ICD10PCS)</td>
</tr>
<tr>
<td>Is hospital admission appropriate and is the length of admission appropriate?</td>
<td>Diagnosis (ICD9 or 10)&lt;br&gt;Procedure (CPT, ICD9PCS or ICD10PCS)&lt;br&gt;Date of Admission&lt;br&gt;Date of Discharge</td>
</tr>
<tr>
<td>Is the cost of treatment within reasonable and customary guidelines?</td>
<td>Billed amount, diagnosis, procedure codes</td>
</tr>
<tr>
<td>Identify duplicate claims</td>
<td>Member ID, Date of admission, date of discharge, Diagnosis, procedure, billed amount, provider ID</td>
</tr>
</tbody>
</table>
## Overall summary of analysis

- In most payer systems, Inconsistencies in claims adjudication due to people training, experience and expertise
- Productivity pressures does challenge rigor in processing – leakage for many contractual and personal exclusions
- Relevance and opportunities of data quality not very apparent, often compliance due to regulatory requirement rather than business value
- Data focus approach can provide significant process efficiencies, effective provider and portfolio monitoring with a clinical and a wider business focus

### Overall Summary of results

<table>
<thead>
<tr>
<th>Claims Profile</th>
<th>Count of claims</th>
<th>% Total claims</th>
<th>Sum of Paid Amount</th>
<th>% Total paid amount</th>
<th>Average of los</th>
<th>Average claims cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total claim lines</td>
<td>29,669</td>
<td>100.00%</td>
<td>$258,397,619</td>
<td>100%</td>
<td>2.4</td>
<td>$8,709</td>
</tr>
<tr>
<td>Age diagnosis conflict</td>
<td>2</td>
<td>0.0%</td>
<td>$5,733</td>
<td>1.7%</td>
<td>1.3</td>
<td>$2,866</td>
</tr>
<tr>
<td>Gender Diagnosis conflict</td>
<td>1</td>
<td>0.0%</td>
<td>$4,879</td>
<td>0.0%</td>
<td>7.0</td>
<td>$4,879</td>
</tr>
<tr>
<td>Avoidable admission conflict</td>
<td>155</td>
<td>0.5%</td>
<td>$801,806</td>
<td>0.3%</td>
<td>2.5</td>
<td>$5,173</td>
</tr>
<tr>
<td>Diagnosis LOS Conflict</td>
<td>951</td>
<td>3.2%</td>
<td>$10,907,006</td>
<td>4.2%</td>
<td>7.8</td>
<td>$11,469</td>
</tr>
<tr>
<td>Procedure LOS Conflict</td>
<td>843</td>
<td>2.8%</td>
<td>$17,881,696</td>
<td>6.9%</td>
<td>5.0</td>
<td>$21,212</td>
</tr>
<tr>
<td>Permanent exclusions conflict</td>
<td>399</td>
<td>1.3%</td>
<td>$1,689,337</td>
<td>0.7%</td>
<td></td>
<td>$4,234</td>
</tr>
<tr>
<td>Pre existing disease conflict</td>
<td>1,360</td>
<td>4.6%</td>
<td>$10,800,233</td>
<td>4.2%</td>
<td></td>
<td>$7,941</td>
</tr>
</tbody>
</table>
Case study 3

Journey to value-based payment mechanisms

From DRG to Pay for performance adjustors

- Provider quality management and ranking system
- Provider cost and specialty differentials
- Policy direction and priorities
The Middle East context

**Universal Health Coverage:**
- Governments cover the cost of healthcare for citizens in full, currently depending on oil revenues to fund benefits
- Healthcare for expats is generally through Private Health insurance - may or may not be mandatory

**Falling oil revenue combined with high healthcare cost inflation:**
- Governments are looking to control healthcare expenditure and improve efficiency of services

**DRG reimbursement mechanisms are at various stages of consideration/implementation across most GCC countries**

Source: 2014 BMI data on GCC government health spending
Health system transformation to achieve value-based healthcare

Transition from the traditional payment model

- Improve population health
- Reduce per capita healthcare cost
- Improve experience of care

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Requirements for a value-based healthcare system

1. Data and coding standards
2. Quality data available for analysis
3. Value-based reimbursement mechanism

4. Quality monitoring framework
5. Provider profiling system
6. Payment mechanism linked to provider profile and quality outcomes

Saudi Arabia
Dubai; Qatar
Abu Dhabi
Payment Adjustors
A DRG based payment system allows for adjustors to introduce payment differentials

Payment calculations

- **Base Rate**: Usually a monetary value and is the same for all DRGs
- **Cost Weight**: Relative measure that reflects the relative use of resources linked to a specific DRG compared to other DRGs
- **Payment Adjustors**: Adjustment factor to adjust the payment to reflect the specific cost/quality differential that would be specific to a healthcare provider.
- **DRG payment**: Multiplier to the DRG price

Example for illustration

<table>
<thead>
<tr>
<th>AR-DRG</th>
<th>AR-DRG Description</th>
<th>Relative Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>B01Z</td>
<td>VENTRICULAR SHUNT REV</td>
<td>7.01</td>
</tr>
<tr>
<td>B02A</td>
<td>CRANIAL PROCEDURES, MAJC</td>
<td>2.19</td>
</tr>
<tr>
<td>B02B</td>
<td>CRANIAL PROCEDURES, INTC</td>
<td>1.04</td>
</tr>
<tr>
<td>B02C</td>
<td>CRANIAL PROCEDURES, MINC</td>
<td>0.75</td>
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<tr>
<td>B03A</td>
<td>SPINAL PROCEDURES, MAJC</td>
<td>8.82</td>
</tr>
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<td>B03B</td>
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Possible reasons for applying adjustors to prices

Adjustors allow for payment differentials based on cost differentials of patients and providers or to support policy objectives

Possible adjustors based on features of the patient:
- Paediatric patient adjustors
- Indigent population adjustor

Possible adjustors based on features of the provider:
- Size of the facility
- Geographical location
  - By region
  - Rural vs urban
  - Remote locations
- Undersupplied services
- Critical infrastructure
- Medical education
- Level of accreditation
- Type of facility:
  - Day clinic, single specialty hospital
  - Multi-specialty hospital

Adjustors used as incentives or penalties
- Quality metrics
  - Clinical outcomes
  - Patient safety
  - Patient experience
  - Efficiency and cost reduction
- Penalties for adverse experience
  - Unplanned readmissions
  - Hospital acquired complications
- Electronic health records

Changes in reimbursement to drive changes in behaviour

Changes in reimbursement to reflect cost differentials

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Implementation considerations

- Identify the goals of the process
- Decide how the transition will be managed
- Engage with stakeholders
- Assess possible inadvertent implications

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For more information:


Joanne Buckle
joanne.buckle@milliman.com

Lalit Baveja
lalit.baveja@milliman.com

Alison Counihan
alison.counihan@milliman.com
Q&A session