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Value Based and Accountable Care

The Actuarial and Clinical Role in Building a Sustainable Model

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The Centers for Medicare and Medicaid Services (CMS) recently announced the addition of 106 new Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) for 2013. Add in the 116 MSSP ACOs from 2012 and the 32 Pioneer ACOs, let alone all of the activity happening in the commercial segment, and it's clear that value-based care (VBC) is becoming more prevalent. Although the VBC train has gained momentum, it's a long way to the destination. There are a number of stops between fee for service (FFS) and population health management.

It can be hard for a care system to operate in both the VBC and FFS environments. It's a pleasant surprise to see so many organizations taking a leap of faith to give this new business model a try. Some are doing it because they're already operating like an ACO and adding this wasn't a stretch. But, for the vast majority, every day means a new critical decision in risk areas they may not be prepared to assess, or a change of habits in the way care is provided.

What if the organization is wildly successful, moves the needle with quality metrics, and creates significant savings with the Medicare FFS population? Hooray! But this isn't simply about the MSSP ACO. This is about taking the entire organization and many population segments into this new VBC world. How will these newfound efficiencies affect the overall organizational finances, given those additional efficiencies are probably also affecting the significant majority of other patients under historical FFS contracts? Do fewer MRIs? The chief challenge is that these are high margin services. You just can't win!

Ultimately, it will require a collaborative, analytical approach to navigate through the risks, while increasing both quality and efficiency. We will need good clinicians and actuaries to get from the FFS station to our destination at population health.

A Little History Lesson Never Hurt Anyone

This isn't the first time that organizations have considered VBC. Since the era of capitation, reimbursement methodologies have run the gamut from FFS to full risk capitation, and any number of methods in between. With increased pricing pressures and countless health reform changes, hospitals, physicians and health plans are once again exploring risk/gain sharing financial arrangement scenarios.

When providers engaged in some form of capitation or risk more than a decade ago, some were successful and some were not. Not surprisingly, only the failures are remembered, causing significant hesitation among many. Of course, successful navi-

CONTINUED ON **PAGE 32**

… how can we drive toward a sustainable business model in this new world of VBC?

gation to value based reimbursement will require avoiding the historical challenges of managed care. That may have been impossible in the past, but now the data and tools are better, and the organizations are more capable. The table below summarizes the transitions needed to help move from FFS to VBC.

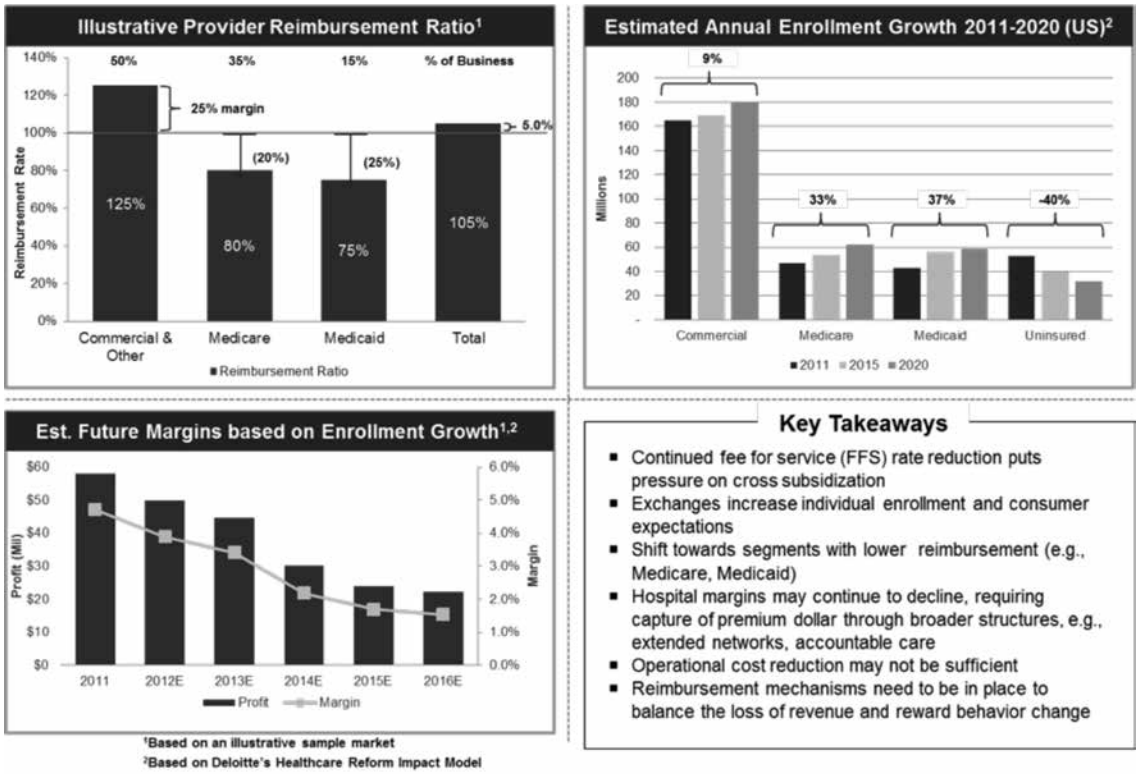
Fast forward to today. Health care systems are being reintroduced to VBC through test cases like the MSSP ACO or bundled payments and through new reimbursement strategies with payers. Our experience is that successful VBC organizations employ a multi-faceted, phased-in approach. It takes time to be prepared for full capitation. What role does actuarial and clinical support play? How do we integrate the value of refined analytics into capabilities discussions with clients? Most importantly, how can we drive toward a sustainable business model in this new world of VBC?

Establishing a Baseline—Don't Forget to Mind the Gap!

A number of folks are claiming that the status quo is no longer sustainable. But how do you know unless you actually model this out? What might happen if a health system did nothing at all and continued business as usual? How will price compression, population shift and growth, and market competition affect your organization?

	Historical Challenges – Managed Care	Future Success Factors – Value-Based Care
Physician Alignment	Loose governance models enabled wide variation in treatment protocols	**Tighter governance through team-based multi-disciplinary clinical model** drives use of evidence-based, standardized protocols
Risk	Reimbursement models often forced providers to assume insurance risk	**Flexible reimbursement models with incentives aligned with objectives**; some models are risk-adjusted based on patient acuity
Patient Data	Disparate clinical and administrative platforms provided limited data with significant lag times	**Better patient data from interoperable health information technology** supports real-time monitoring and feedback
Primary Care	Gatekeeper focused on utilization and cost management	**Coordination of care** through medical homes, disease management, and preventive care

Sources: Deloitte Center for Health Solutions, *Accountable Care Organizations: A new model for sustainable innovation*; Webcast discussion by Latham & Watkins, The Camden Group, Intelligent Healthcare and Yale-New Haven Health System, *Accountable Care Organizations-Physician Hospital Integration*



The chart above illustrates one way to help assess a health system's future profitability by modeling the population growth by payer segment, and the resulting net system margin.

This should be the baseline to which future scenarios are compared. This upfront modeling can also be helpful in educating physician and organizational leadership so that buy-in can be gained, and establishing behavior change that may be necessary to migrate from the status quo FFS reimbursement. This type of baseline modeling, when done at numerous health systems over the last few years, has been interesting.

On one end of the spectrum, there are systems that are already starting out in a poor financial position (for example, negative net earnings), and five-year estimates of worsening results, leading to limited options. Given these bleak estimates, these systems can often begin exploring dramatic strategic decisions. We've seen this type of situation lead to an investigation of partnering, merger or acquisition options.

On the opposite end of the spectrum, there are systems that are still sitting strong financially and are the dominant provider in their market. Although these systems are still thinking through the strategy of a move toward VBC, they might ride out the status quo a little longer before completely moving away from their current position. As we have noted with some systems in the past year, if a health system is still able to command high FFS rates and there are not any imminent competitive threats to their market-dominating position, why rush into changing the business model?

As usual, it's complicated, and most organizations are somewhere in the middle. For these systems, we often come up with a range of estimates that run the gamut of a worse case estimate (for example, what if the majority of payments are at Medicaid reimbursement levels?) versus a slightly more optimistic view of reimbursement trends, knowing it's likely somewhere in between. These are the organizations we've been spending the majority of our time with over the last two years. There is a lot of market positioning, as there are likely to be winners

CONTINUED ON **PAGE 34**

Although much is uncertain, one thing is clear: nearly all health care players are thinking through their strategic landscape, their status quo modeling, and considering how to react to this new health care world.

and losers in the VBC world as capacity is driven out of the system in some areas.

Of course, this baseline modeling should be done in the context of the system's market-specific dynamics and competitive landscape. Determining what the other physicians, hospitals and health plans will be doing in a specific market, and estimating how health reform may play out over the next three to five years, is a complicated task. It means considering everything from aging of the population into Medicare, to the impact of new state exchanges or managed Medicaid programs. Although much is uncertain, one thing is clear: nearly all health care players are thinking through their strategic landscape, their status quo modeling, and considering how to react to this new health care world.

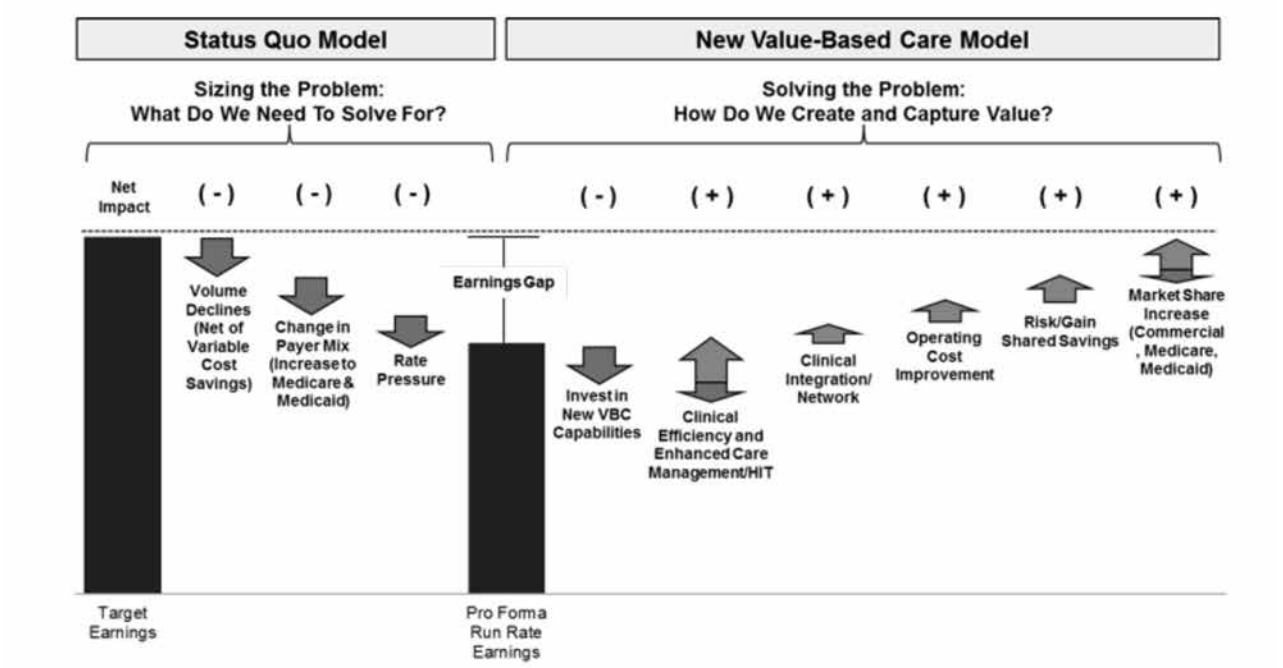
Closing the Gap and Defining the Future Business Model

After establishing a baseline model, the next step should be to determine what the future state VBC model might look like. How do the MSSP ACO and other VBC strategies factor into the overall business model? What are the major levers to pull? Are there any plausible scenarios that get back to a sustainable business model? Most importantly, what are the actions needed to mitigate the risks associated with the organization's strategic goals?

Below is an illustrative waterfall graphic of the types of levers available to a health care system.

To assess this new business model, an important step should be to establish an interactive financial model to sensitivity test the levers available and run multi-year scenarios for the organization. The financial model should be set up to help quantify and assess the following target questions:

- Is there room for improved clinical efficiency (for example, 10 percent of total "utilization")? Where are the opportunities for improvement (for example, admissions or average length of stay (ALOS), emergency room, lab/radiology, specialty visits, brand drugs, etc.)? What is the impact on operating margin in relation to current contracts (for example, how are doctors/hospitals currently paid)?
- What percent of revenue can be moved to VBC arrangements (for example, MSSP ACO, VBC contracts with payers, etc.)? How will those gains/losses be shared between the system and payers?
- Are fixed and variable costs well defined within the organization, and is it known what assets



exist and where? What percentage of fixed operating cost improvements can be made? How sophisticated is the organization in moving toward true cost accounting?

- What market share/revenue growth is reasonable, through steerage or new lives? Where will that market share come from and how will it be captured?

Any one of these questions can be a detailed assessment, and many organizations are already focusing on one or more of these areas. For example, fixed cost reduction efforts and managed care contracting strategy discussions are occurring at most of the systems we talk with. However, while most organizations are thinking about these areas in their silos, what is often missed is the linkage to bring them together as part of the broader strategic plan. The financial model is a tool to help facilitate this discussion by aggregating many of these assumptions, assessing how they interact with each other, and allowing for a directional view of which levers affect the business model that are achievable, which ultimately helps define where to begin.

To Achieve This New Value Based Care Model, Health Systems Require Key Capabilities

Before progressing any further with this new business model, an organization should be certain it has the required capabilities to achieve the organization's strategic vision and goals. This type of venture requires experience and collaboration with finance, the actuaries, technology, clinical and operations, and requires a leadership and governance structure that supports these functions. Sustainability in a value based marketplace should include the following six core capabilities:

Leadership and Governance

- Governance system of accountability
- Physician leadership decision making rights and responsibilities
- Performance measures to inform clinical and business decisions
- Communications and change management approach

Clinical Integration

- Care coordination and transition processes
- Clinical protocols and guidelines
- Tools/processes to support integration and care coordination
- Quality, safety, and outcomes
- Population health management/ care management/ disease management (vs. Case management)
- Patient engagement/satisfaction

Network and Physician Alignment

- High value network composition
- Physician alignment
- Community/public health programs and services engagement
- Provider evaluation and performance metrics
- Quality and performance reporting

Business Operations

- Process standardization
- Service operations
- Customer relationships
- Rating and underwriting
- Performance improvement
- Resource management
- Cost management
- Marketing and sales
- Legal and compliance
- Revenue cycle

Incentive Alignment

- Economic model
- Value based risk arrangements
- Distribution model
- Compensation and incentives
- Third party agreements

Information and Integration Services

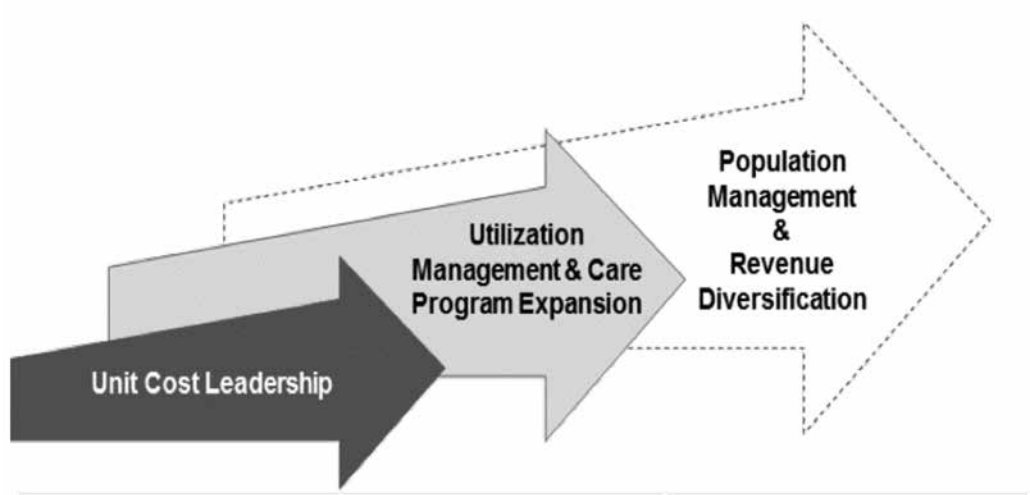
- Clinical information systems
- Data warehouses
- Analytics and business intelligence
- Interoperability and data sharing
- Population health reporting
- Secured health information

After establishing any capability gaps and a game plan to close them, an organization can then focus attention back on the levers that assist in a move toward a sustainable VBC business model.

CONTINUED ON PAGE 36

Achieving Efficiencies through Actuarial Data Analysis and Clinical Improvements

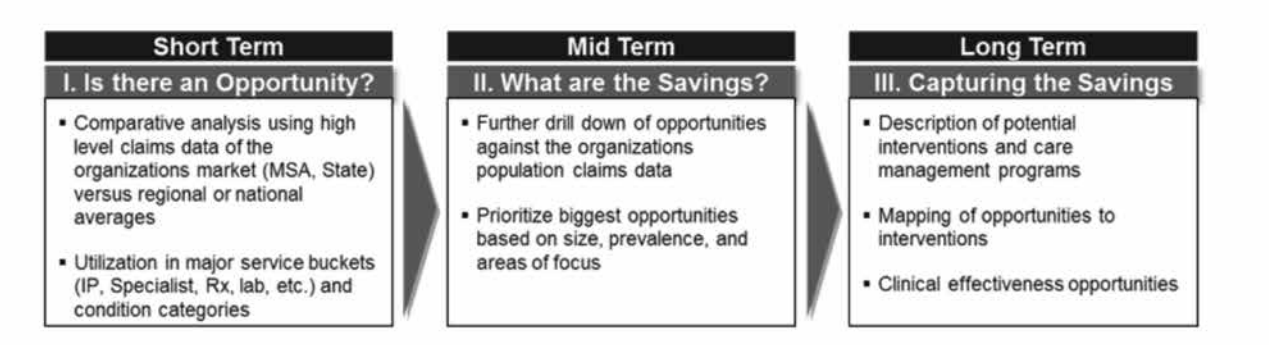
The real importance to VBC is increasing efficiency and quality at the same time! Actuarial support and work product, supported by clinical and technological insight, is often the springboard into important qualitative and quantitative information. For most organizations making this transition to VBC, the following life cycle illustrates the evolution of efficiency and clinical improvement:



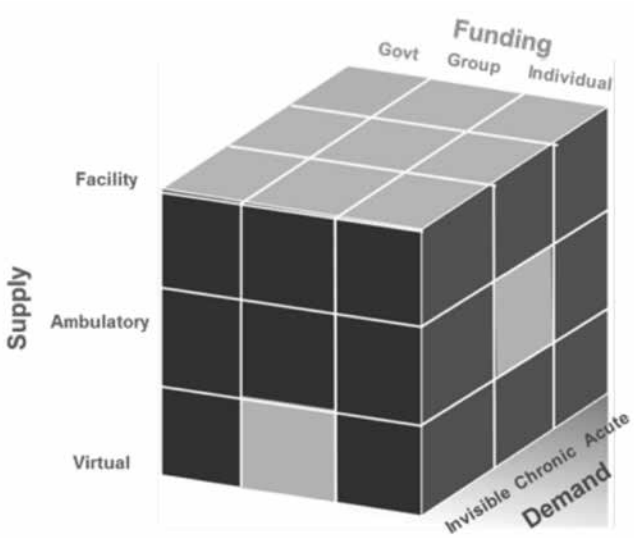
Use scale and select partnerships to help lower the cost of service, while maintaining superior quality	Utilize integration to help improve health, reduce need for care / use of expensive resources, and assume risk for delivering value based care	Leverage brand, reputation and relationships to extend into new products and services
▪ Top quartile performance or better in unit cost and quality ▪ Profitable at/close to Medicare reimbursement	▪ Dominant local provider in terms of market share ▪ Implementing new programs to improve costs and revenue performance	▪ Revenue base shifting towards global or fixed payments over time ▪ Developing relationships with new customers/segments

Historically, a starting point for data analysis has been health plan claims. These claims can provide information about chronic disease prevalence, medical reimbursement by service category, and basic quality measures like readmissions for an entire population (not just a health system view). This health plan population data is aggregated and reviewed on a comparable per-member-per-month (PMPM) basis. However, data analysis can only take you so far. When embarking on a detailed exploration of clinical opportunities, it is crucial to blend both clinical and actuarial competencies to explore the areas of opportunities (usually against a "benchmark") and to overlay that with the clinical programs in place to determine the areas of greatest need/investment.

For health systems, a population viewpoint of claims data has not been readily accessible. Many systems start with the claims history for the organization's employee population as a proxy to assess care management trends for the enterprise. The data can provide a cross continuum view of the costs by site of service and by condition category, using both a top-down (benchmarking) and bottom-up (assessment of treatment decisions) review. Eventually, if taking on risk with a payer, it is advisable to have the same information the payer uses in order to collaboratively answer the following questions:



The result of actuarial collaboration with clinical and technology experience is recommendations to address opportunities across the dimensions of supply, funding and demand (see graphic to the right). For example, we've seen diabetes identified as a cost driver, and expansion of a diabetes program via outpatient management lowering associated costs over time, while also serving as an expansion program for other segments. Another example is an analysis of the historical readmission rates to provide a roadmap for broad care management/discharge planning to avoid penalties and get on the road to quality bonus payments. The identification of the opportunity and qualification of the benefits can be achieved through a detailed actuarial claims analysis in tandem with a clinical assessment of the care.



Ultimately, these analyses need to relate back to the overall financial model and tie to how these clinical opportunities affect revenue based on current contractual arrangements. For example, a DRG payment affects revenue when an admission is avoided, but it doesn't when ALOS is reduced. Assuming a significant proportion of a system's costs are fixed and the payment environment remains largely FFS, the result is often an expanded "gap" after capturing these improvements, as displayed in the following illustration.

CONTINUED ON **PAGE 38**

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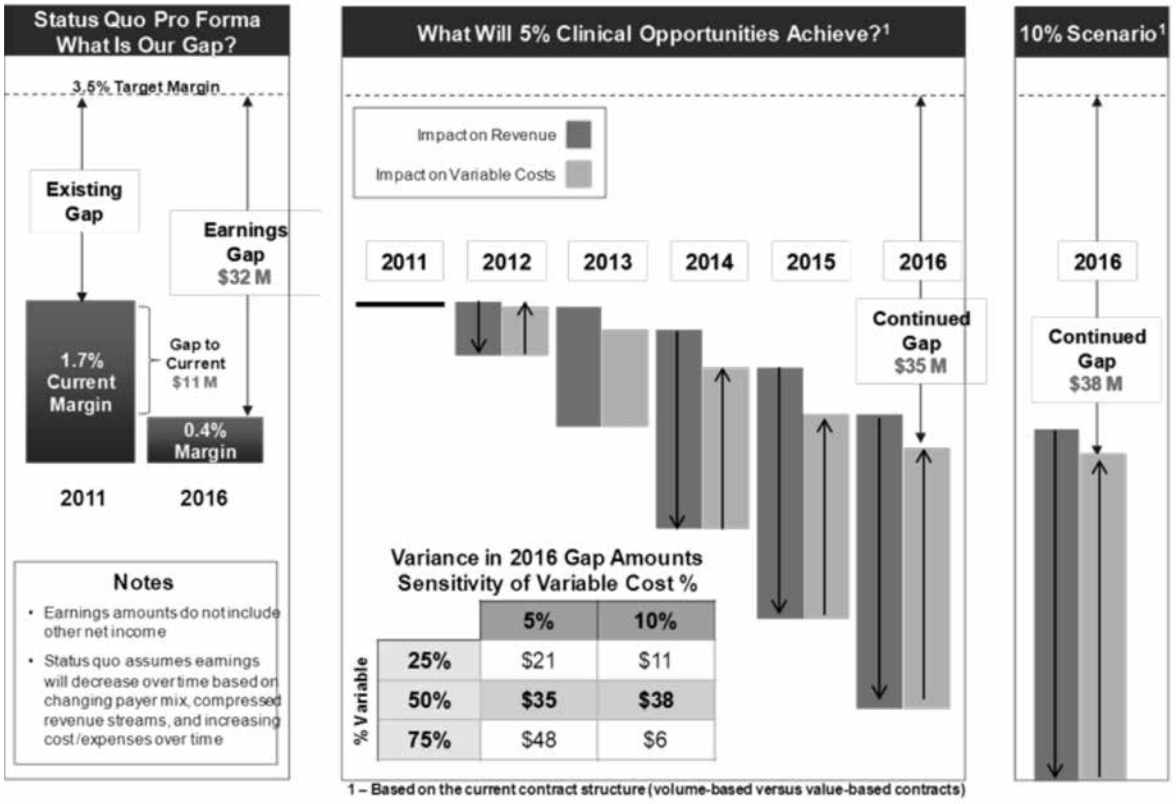

Given that clinical efficiencies in a FFS world often result in an even larger financial gap, it is imperative to explore how these types of clinical changes should be incorporated in the context of value-based reimbursement.

Moving from Volume to Value and Capturing Market Share

Each organization is often serving numerous population segments under varying payment terms. In order to incent real changes in clinical patterns, the areas of opportunity should be aligned among the targeted populations and contractual arrangements. To jump start these transitions to VBC, organizations are exploring various on-ramps to build up capabilities over time, including:

- Medical homes
- Bundled payments
- CMS MSSP/Pioneer ACOs
- Self-insured ACOs

As health systems begin to shift from volume to value, the current market environment should be considered along with knowledge of current market share and identification of desired future market share. Ultimately, there will be winners and losers; there simply have to be. As VBC takes hold in each market, it can free up capacity. The successful organizations will be able to capture more market share through the efficiencies inherent in their products. Consumers will be in the driver's seat. This means that organizations should become more efficient, achieve higher quality and become more user-friendly. Those that are not able to fill their excess capacity may have a difficult path forward.

Aligning the opportunities with the potential populations, potential payer/provider contractual relation-

ships, a competitive market environment, a timeline for achieving the required organizational capabilities, and a strategic three-to-five-year road map can allow for a strong chance to achieve the desired sustainable business model.

Redefining the Marketplace

Although we all try, no one can predict exactly how health reform will play out over the next five to ten years. The old idiom will remain true that health care is local and each market distinctive. What works for one system in one market will not necessarily work for another system in another market. But we do know that the health care market will continue to change dramatically into the foreseeable future through mergers and acquisitions, payer/provider collaborations, increased technology application, changing population demographics and changing reimbursement methodologies. We also know that individual consumers are gaining influence, and they have high cost and quality expectations. Those that do not change with the market may find it difficult to capture future market share to determine their own destiny.

Navigating this new VBC world requires organizations to develop and align capabilities to help capture the market. Collaboration can be key, with actuarial and clinical involvement being a significant cornerstone to making wise decisions about risk, efficiency and quality of care. The status quo may no longer be an option, not just for the health systems, providers and plans that we work with, but also for the actuarial and clinical professionals operating within it. It's an exciting new world—let's continue growing with it.

Information regarding Deloitte and solutions for value-based reimbursement can be found at the following site:

www.deloitte.com/us/acs.

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