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1 Improving Outcomes Through Incentives: Using a Global Budget with Risk Sharing to Drive Cost Savings and Improved Quality
By Ed Cymerys

2 Letter from the Editor
By Kurt Wrobel

3 Chairperson's Corner
By J. Patrick Kinney

10 Health Care 2.0—Massive Implications of System Transformation
By Greger Vigen

16 Massachusetts Payment Reform from an Actuarial Perspective
By Matthew Day and Jill Wilson

21 Payment Reform Under The Medicare-Medicaid Financial Alignment Demonstrations
By Shelly Brandel and Michael Cook

27 Payment Reform: A Medicaid Overview
By Rebecca Owen, Dave Neiman and Tom Carlson

31 Value Based and Accountable Care The Actuarial and Clinical Role in Building a Sustainable Model
By Mark Bethke, Cindy Hamilton, Amanda Holland and James Whisler

Improving Outcomes Through Incentives: Using a Global Budget with Risk Sharing to Drive Cost Savings and Improved Quality

By Ed Cymerys

In the past 50 years, health care costs in the United States have more than tripled, rising steadily from 5 percent of the gross domestic product in 1960 to 18 percent in 2012. Driven by those increasing costs, commercial health insurance premiums have become dramatically more expensive. The average premium for a family of four is expected to hit 24 percent of the median family income in 2013, and rise to 30 percent by 2020. This affordability crisis in our industry is a central concern for Blue Shield of California, a non-profit health plan with a mission to ensure access to quality, affordable health care.

As rising medical costs threatened to quickly make our commercial health insurance products unaffordable in the California market, we developed our accountable care organization (ACO) initiative, designed to improve health care quality and reduce costs. Conceived in 2008, long before passage of the Affordable Care Act, our program is not part of the Federal Medicare ACO program. Our ACOs are collaborations with three-way risk sharing between

CONTINUED ON PAGE 5

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the health plan (Blue Shield), hospitals and physician groups, and are designed to control costs while offering optimal patient care for commercial HMO members.

The role of Blue Shield's actuarial team has been central to the architecture of a strong global budget model for the program and to the development, implementation and operations of each of the nine arrangements we have initiated since the program began in January 2010.

Background

When we developed the ACO program, we were looking to partner with providers on a solution that addressed the underlying cost drivers in a meaningful way. The main challenge we faced was that the health care delivery system creates an adversarial relationship where the health plan, hospital and medical group work in silos, unable to effectively or efficiently control costs and deliver optimal patient care.

In California, the payment model landscape contributes to this effect. While capitated reimbursements (per member per month) are widely used for physician services, hospital facilities are typically paid on a fee-for-service basis. Well known in the industry, the fee-for-service model means that incentives are not aligned—providers are encouraged to do more in order to get paid more. Blue Shield had long observed the effects of this phenomenon with our network providers: the more downward pressure we put on the price per unit of service, looking to keep our insurance products affordable in the market, the more upward pressure on utilization providers would assert.

In order to create real, sustainable savings and thus keep our premiums down, the challenge before us was to come up with a new model that would put all the players—the hospital, the physician group and the health plan—on the same side, with the same motivations and goals. Many of our network providers shared our concerns of remaining competitive, with the very real threat of losing patients to the integrated health care system Kaiser Permanente. To effectively collaborate to reduce cost, improve quality and compete successfully with Kaiser, we needed a solution that would align incentives across the three parties. That solution also needed to be easily implemented and work within the current payment arrangements.

Development of a Well-Constructed Incentive Model

Our model has succeeded in aligning the incentives for the hospital, physician and health plan through an annual global budget. The budget consists of total expected spending for the care of a set population of members, with an agreement to share risk and savings among the partners. We have initially focused our program on the commercial HMO population associated with our physician group partners, which allows us to avoid the challenge of member attribution common in the industry.

The model we adopted was driven first by business goals, which centered around delivering savings to our customers and members on their health insurance premiums. For each global budget arrangement, savings goals are set upfront, and are determined by the amount needed to keep premiums flat or to a minimal increase. Each organization agrees to contribute to the cost savings as well as to bear part of the financial risk if the savings goals are not met. The arrangement creates a global per-member-per-month target amount for the cost of health care, without changing the underlying payment mechanisms for physicians and hospitals. If savings targets are exceeded, the partners share in the savings; if savings are lower than the target, the partners write off this amount. This shared-risk arrangement motivates all parties to work together to reduce costs. Success depends on taking cost out of the delivery system, not by shifting risk to one of the other partners.

It was essential that the providers take downside risk as part of our ACO agreements, as incentive plans that use both "carrots" and "sticks" are more effective in engaging providers to work toward

CONTINUED ON PAGE 6

Our providers understand the affordability crisis, and they want to maintain their relevance and viability in the market.

desired outcomes. Our actuaries worked hand in hand with our attorneys to ensure that the incentive programs set up were legal and able to pass regulatory scrutiny. We have had considerable success in securing agreements by providers to take risk in the arrangement. Our providers understand the affordability crisis, and they want to maintain their relevance and viability in the market. Therefore, they are willing to take risk to retain important commercial health insurance patients that contribute substantially to their bottom line.

In determining the detailed breakdown of the shared-risk model, our actuaries understood that the most effective provider incentive models will rely upon the underlying provider reimbursement structures. Our model considers both who has more control over the services, and who should be rewarded proportionally should we exceed the target. For example, as shown in Table 1, the hospital provider partner can exercise a great deal of control over what happens inside their own four walls, so it is logical to put them at a greater share of the risk for that component (50 percent, in our example).

Table 1

		Partner at Risk		
Service Category	**Target (pmpm)**	**Hospital**	**Physician Group**	**Plan**
Hospital services (provider partner)	$115	50%	25%	25%
Hospital services (non-provider partner)	$25	20%	30%	50%
Physician services	$90	20%	50%	30%
Ancillary services	$10	20%	30%	50%
Pharmacy card	$50	10%	45%	45%
Total cost	$290			

Likewise, should performance be under the target on hospital services, that partner is able to receive a higher percentage of the savings, which allows them to recoup some of their reduced revenue.

The actuaries also needed to carefully consider items that could unfairly impact the provider incentive results. For example, because our ACOs across the state vary in size, their ability to absorb large claims also varies, and the actuaries needed to take outlier thresholds into account in order to prevent providers from disengaging in the cost-controlling endeavors of the program produced by the adverse impacts of an individual catastrophic claim on the incentive pool. In addition, as we know that the population in the program will almost assuredly shift over time (for example, as Blue Shield writes new employer group business), the actuaries must pay attention to the underlying changes in the demographics of the population, in addition to potential changes in benefit mix. We do not want to unfairly penalize or reward providers in the incentive program for these types of changes.

It was also crucial that our actuaries engage in cross-functional collaborations to develop an end-to-end view that would ensure that the ACO arrangements benefited our members and customers. For instance, we purposely set incentive targets at stretch goals to ensure that meaningful savings were generated before incentive pay-outs would be made. We also re-evaluated our internal processes to make sure the expected cost savings were passed along to our customers and members through lower premium increases.

Data Is King

Data is an integral part of the program collaborations from beginning to end, and that is why the actuary is uniquely positioned to add a substantial value to the work team and the overall program.

Understanding the reimbursement method of the various services being performed within the arrangement is crucial to understanding how cost savings can flow back to the health plan, and thus to customers, as well as how to best deploy incentive programs. For example, if reimbursement for

inpatient services is based on DRG payments, then programs to reduce length of stay might benefit the hospital partner's bottom line, but would not typically flow back to the health plan. Likewise, if all services are currently capitated to the providers, then understanding the cause and effect relationship of how the savings flow is important. The actuary needs to carefully consider these relationships to ensure that the incentives for all parties are aligned.

Our actuaries working on the program learned to step out of their comfort zone. The industry has a long tradition of keeping information sharing to a minimum. While some of this is warranted in the protection of patient and contract confidentiality, Blue Shield realized that the affordability crisis and increasing competition demanded change. If we are going to ask providers to both better manage costs and take on risk if the expected improvement is not attained, then it is reasonable to expect that providers will want to fully understand the underlying cost drivers. The health plan is in the best position to provide this holistic view, and the actuaries are perfectly positioned to provide this information, validate it, and explain it to providers.

In our discussions with the providers, our actuaries and analysts are front and center, not only presenting the initial information to the providers to make our case for the program, but also engaging in the follow-up discussions as the collaborations move forward. Having the information experts at the table, able to proactively share an unprecedented amount of information, has resulted in a significant increase in provider trust. This trust, historically lacking in provider-health plan relationships, has been a critical building block for the success of the collaborations.

ACO Operations: Actuarial Involvement from A to Z

In our ACO partnerships, each organization shares clinical and case management information to more tightly coordinate care for the program's HMO members. This allows the partners to identify where costs are unduly high and implement solutions to bring those costs down while improving quality. A Blue Shield analytic team supports the process of developing the cost-saving clinical interventions on which the partners will focus their efforts. The analyst's role is central to this process. The analysts' ability to understand member population health and cost drivers, as well as to develop applicable benchmarks, provides clinicians with reasonable and appropriate tools for effective goal setting. Working with a dedicated project management and clinical intervention team comprised of representatives from each of the partners, our analysts help jump start the process by delivering two key items.

First, the analyst team develops a population health presentation comparing key metrics to a health-plan-specific local control group. Metrics include a range of utilization rates such as inpatient admissions, inpatient length of stay, risk scores and emergency room utilization. This initial report provides a current-state perspective on how well the partners are managing member care and identifies opportunities for improvements that will generate savings. In some cases, there are clear gaps between current performance and the benchmark standards, while in other cases we may choose to target improvement beyond the benchmark level.

Second, the analytic team converts the cost-control targets from the ACO agreement into high-level utilization targets. To do this, the team models several scenarios using local health-plan-specific and industry benchmarks, and taking into account provider mix and unit costs. The team also draws heavily on the provider partners' assessment of their operational challenges and opportunities for "quick wins" as well as longer-term change. Blue Shield's project management and clinical staff work with the provider partners to select a final scenario. Once the final set of operational targets is set, project teams are established to oversee each operational work stream.

The role of the actuarial analyst supporting ACO collaborations goes beyond what is traditionally expected of a health plan actuary. As part of the program team, the actuarial support is highly consultative in nature—from explaining developed risk-share incentives to providing projected experience

CONTINUED ON PAGE 8

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for both internal and external stakeholders—and includes on-site meetings and presentations to senior leadership from the health plan and providers.

Every ACO we have built has its own unique circumstances, requiring our actuarial support to be flexible. Early on, ad hoc provider data requests tend to be quite frequent and unpredictable, as we work to establish a relationship and build trust. Each set of provider partners may have a different set of concerns and interests requiring a deeper review. For example, we may be asked to look closer into the drivers of high pharmaceutical drug card costs or to analyze members' out-of-network facility costs for both emergent and non-emergent care. Our team works to respond to these requests quickly, and to have open dialogue with the providers about their concerns. Adding licensed clinical staff to our program team, to work alongside our actuaries and project managers, has also been helpful in continuing to build trust and credibility with providers.

Working with all parts of the health care delivery system to keep the cost of care down will be crucial for our continued success in the California market.

As operations progress, the development, maintenance and production of both financial and utilization dashboards by the actuaries is key to monitoring the program's progress. The analyst is also best positioned to determine key change drivers when the dashboard metrics point to unexpected results. In addition, at the end of the contract period, the actuarial team will either perform the final incentive program calculation or oversee its production. They will also be at the table with the providers to think about the renewal terms as the journey continues.

Successes and Lessons Learned

Blue Shield's first ACO, a collaboration between Blue Shield and certain providers in the Sacramento area to serve CalPERS HMO members, has yielded impressive results for its first two years. The program delivered $15.5 million in savings for CalPERS in its first year in the form of an immediate premium credit, and the partners shared an additional $5 million in savings above their targets. In two years, the ACO delivered $37 million in savings to CalPERS, with the partners sharing an additional $8 million in savings. Much of the success was due to reductions in health care resource use—including a reduction in inpatient days, preventable hospital readmissions, and out-of-network service utilization for the members in the program. The program also addressed the overutilization of services, reducing the amount of unnecessary elective surgeries.

Blue Shield has since formed eight additional ACO arrangements throughout the state, and early success indicators are promising for these collaborations. For instance, two ACOs established in the San Francisco market in 2011 for the City and County of San Francisco (CCSF) have shown consistent results. In the first full year, inpatient days per 1,000 members dropped over 20 percent in one ACO and over 12 percent in the other. Readmission rates also dropped, showing progress toward the triple aim of improving health, improving patient experience and lowering health care costs. Perhaps most telling was the reaction of the CCSF Health Service Board, which gave the ACO team a standing ovation after their presentation of the results in a recent meeting. That's a very unusual customer response during a renewal meeting, and powerful feedback on the impact of the program.

As mentioned, much of the savings we have achieved through this program have been the result of reduced hospital utilization, which reduces revenue to our hospital partner. Our incentive model is designed to lessen some of this impact, but it is nonetheless true that revenue reduction impacts the hospital disproportionately. Together with our partners, we have implemented action plans and processes that repatriate patients into the participating facilities when they are admitted at out-of-network hospitals, such as through emergency rooms (based on Blue Shield claims data). While bringing patients back into the participating facilities helps the provider partner's overall bottom line, it also results in better care management for the member.

Another success is the evolution in providers' thinking on alternative reimbursement methods that has accelerated their adoption of such arrangements. With the improved controls and more effective delivery of care achieved with this program, we

are seeing the providers willing to take more risk, particularly through capitation on facility services. Many of our hospital partners have entered into sub-capitation arrangements with us as a result of our ACO collaboration. Our actuaries must in turn work to ensure that the cost reductions resulting from these methods serve to benefit our employer groups and members as well.

Opportunities and Challenges Ahead

As we look to 2013 and beyond, we see numerous challenges and opportunities.

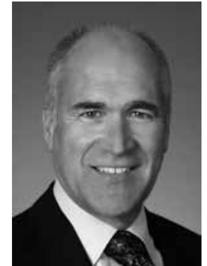
The most important program enhancement currently in the pipeline is the addition of an integrated technology system to connect the partners, allowing us to automate data sharing and give providers access to information that will increase clinical quality. In 2012, we signed an agreement to develop and implement technologies and other solutions that will allow doctors, hospitals and health plans to deliver evidence-based care that is more coordinated and personalized.

The technology platform will support data exchange across multiple provider organizations and will integrate clinical, financial and administrative data into a comprehensive medical history. The new system will enhance the member and provider experience by ensuring that the providers receive information in real time, allowing them to intervene quickly when their patient is still in the system (that is, admitted to the hospital), rather than after the fact. The system will also give the provider access to personalized evidence-based information for decision making on serious conditions, based on a constantly updated library. Overall, the solution should improve care quality and coordination and reduce costs. The new partnership launched in January, 2013 at the site of our newest ACO, where many of the aspects of the technology solution will be tested and refined.

In addition to technology, our actuaries will continue to monitor the results of our individual collaborations and to review our models for necessary adjustments and enhancements that will drive continued success. As we move forward, one key consideration will be the possibility of enhancing our demographic adjustment approach with a more robust risk adjustment methodology. However, we must keep in mind that deploying any risk adjustment methodology concurrent with the ICD-10 implementation will require careful consideration.

Also, our initial focus was on our commercial HMO business, and we are now actively exploring expansion to our Medicare Advantage and PPO business. Besides the variety of regulatory issues these expansions will introduce, we need to find solutions to problems being faced by others in the industry, particularly in the area of member attribution, as well as customer funding arrangements other than the traditional fully insured business model. In addition, we will take our accomplishments to the next level by leveraging other strategic initiatives such as patient-centered medical homes and products that incorporate value-based insurance design. These opportunities will continue to make our work interesting and challenging, as well as innovative and important.

The full engagement of our actuarial and analytic staff—with their expertise and ability to find creative solutions—will be essential to tackling these challenges. We must continue to innovate in this area as we work to fulfill our mission to provide all Californians with access to high quality health care at an affordable price. Working with all parts of the health care delivery system to keep the cost of care down will be crucial for our continued success in the California market. ■



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