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Is Your Integrated Delivery System Throwing Away Free Money?

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Controlling the pricing of both the delivery and the insuring of health care should be powerful. That is the theory behind an integrated delivery system (IDS), also known as a provider-sponsored health plan. However, after a decade of working with such systems, I have not seen them realize their potential and I will explain why.

Optimizing value in an integrated health care delivery system requires aligning the financial interests of the health plan and the provider. That is a big challenge. To understand why it is so difficult, consider this common scenario. Suppose you are part of a health plan's leadership, such as CEO, CFO or chief actuary. A hospital system owns your health plan and you are developing the annual pricing for Medicare Advantage (insurance for aged individuals). The hospital notifies you that it would like you to increase its payment rates by 5 percent to improve its financial results. As a leader, you know the financial performance of the health plan is an assessment of your managerial performance. The typical reaction of many health plan executives is that a significant reimbursement increase is bad for the health plan business. Given that, what fact-based analysis can you perform to know the true impact on your health plan business and on the integrated system? How should you frame the discussion to appeal to leadership at the hospital system?

The short answer is to have the right actuarial analysis framed in a way that answers the question, "What's in it for the hospital?" and more important, "What's in it for the integrated delivery system?"

WHO GAINS WHEN PAYMENT RATES CHANGE

An aggressive reimbursement contract (one that is either too high or too low) between a carrier and a hospital within an IDS does not always result in optimal financial outcomes for the system as a whole. In fact, improperly aligned incentives between the CEOs of the hospital and the health plan have led to adversarial negotiations and resulted in suboptimal margin outcomes

for both entities. The numerical example that follows is a highly simplified illustration of how integration of strategic direction in actuarial work can lead to win-win solutions.

By way of background, citizens aged 65 and up can enroll in Medicare benefits directly through the Centers for Medicare & Medicaid Services (CMS), which administers this program. Alternatively, they can purchase richer benefits at a lower cost through managed-care insurance companies. CMS uses a formula to determine how much any member would cost in health care services to CMS if the member were enrolled directly through CMS. The insurers develop a bid to insure members at a lower cost than what it would cost CMS. The lower costs are achieved primarily through care management that is largely absent in members enrolled directly through CMS and results in savings to CMS. CMS shares some portion of these savings with the issuer and the shared savings are called rebates.

Consider a health plan with the bid characteristics and plan financials shown in Table 1.

We have highlighted the key numbers in dark blue. The plan's claim costs for standard Medicare fee-for-service (FFS) claims are $525 per member per month (PMPM), which are funded entirely by CMS (in this example). The plan receives $140 PMPM in rebates from CMS, of which $122.50 is spent on supplemental benefits. The plan's overall margin is $30.83 PMPM.

If the hospital raises its rates such that the overall claims of the plan go up by 5 percent, then the following things would happen:

- Claims for standard Medicare FFS benefits increase by $26.25 PMPM (highlighted in yellow in Table 2). Since CMS funds these claims, the increased claims liability is passed on to CMS.

- Since it costs the plan more to provide standard Medicare FFS benefits now than it did before, CMS will reduce the rebates paid to the plan.

- Assuming the plan does not want to change its supplemental benefits to maintain its competitive positioning, it will still need the $122.50 PMPM to fund these benefits, plus an additional amount to administer these benefits. These numbers are highlighted in green in Table 2.

- To keep the benefits the same, the reduction in rebate revenue flows directly to the plan's margins (highlighted in dark blue in Table 2).

The details of these effects and the bid mechanics are shown in Table 2 on page 35.

Table 1
Example Health Plan Bid and Financials

Item	Formula	CMS Reimbursement Rate	Current Contract PMPMs
a		Standardized benchmark rate	$800.00
b		Risk score	1.000
c	a · b	Risk-adjusted benchmark rate	$800.00

Item	Formula	Plan Basic Bid	
d		Basic claims cost @ 1.0 risk score	$525.00
e		Administrative expenses @ 1.0 risk score	$50.00
f		Profit margin @1.0 risk score	$25.00
g	d + e + f	Standardized (@1.0 risk score) plan bid	$600.00
h	b · g	Risk-adjusted plan bid	$600.00

Item	Formula	Rebate Calculation	
i	c – h	Plan savings	$200.00
j		Plan rebate %	70.0%
k	i · j	Plan rebate revenue	$140.00
l	k · d / g	Supplemental benefit claims cost	$122.50
m	k · e / g	Supplemental admin expense	$11.67
n	k · f / g	Supplemental benefit profit margin	$5.83

Item	Formula	Plan Financial Impact	
o	h + k	Total Part C (MA) revenue	$740.00
p	d · b + l	Total Part C (MA) claim cost	$647.50
q	e · b + l	Total Part C (MA) admin expense	$61.67
r	o – p – q	Part C Margin PMPM	$30.83

Abbreviations: CMS, Centers for Medicare & Medicaid Services; MA, Medicare Advantage; PMPM, per member per month. For simplicity, we have assumed plan risk score of 1.0, $0 member premiums, and no Part D benefit. We also assumed a 4.5-star plan, which results in a CMS rebate payment of 70 percent.

> For optimization of the IDS margin to work, the board of the IDS would have to align the plan and the hospital CEOs' incentives with the IDS' value.

It may seem like the plan margin should only go down by the amount of the rebate revenue loss ($5.40). However, the bid mechanics and bid rules produce a leveraging effect that results in a situation where the plan margin must reduce by the stated amount to keep benefits the same. The details of the mechanics have been left out because they are highly complex and irrelevant to the discussion. The impact on each entity is shown here.

The net financial impact to the carrier = –$24.53 PMPM

The financial impact to the hospital = +$26.25 PMPM (equivalent to the increase in plan's claim costs)

The net financial impact to the integrated system = $26.25 – $23.53 = +$2.72 PMPM

Clearly, in this case there is a net benefit to the IDS of $2.72 PMPM that can be gained from the hospital increasing its reimbursement rates. Assuming the carrier cannot cut benefits without becoming uncompetitive, the plan will likely have to absorb the adverse financial impact (–$23.53 PMPM) in its margin. If the carrier has been running a positive margin of at least $23.53 PMPM, then there is a clear mathematical argument for sacrificing that margin in support of improving the integrated system's margin (by $2.72 PMPM).

We see some version of this example manifest in annual strategy meetings between payers and providers that belong to an IDS. In some cases, we watch the two entities leaving behind that $2.72 PMPM benefit in favor of protecting each individual entity's margin. In years when both the hospital and the carrier margins are positive, neither entity is motivated to rock the boat with such a conversation.

CONCLUSION

What gets in the way of maximizing the system value? The payer's and the provider's margins are generally negatively correlated, so why are so many IDSs attempting to maximize the value of both the payer and provider businesses separately and simultaneously? The financial incentives for the CEOs of the two systems are often based on the performance of their individual entity as opposed to the integrated entity.

For optimization of the IDS margin to work, the board of the IDS would have to align the plan and the hospital CEOs' incentives with the IDS' value. The board needs to understand that the hospital unit is benefiting at the expense of the carrier's margins (in the preceding example), but overall the system is better off. The system should enable the plan to offer competitive products while allocating financial assets (margin targets) between the payer and the provider business segments to maximize the combined returns. Maximizing the combined returns is

Table 2
Health Plan Bid and Financials After Hospital Raises Payment Rates by 5 Percent

Item	Formula	CMS Reimbursement Rate	Current Contract	+5% Contract, No Benefit Cuts	Difference
a		Standardized benchmark rate	$800.00	$800.00	$0.00
b		Risk score	1.000	1.000	0.000
c	a · b	Risk-adjusted benchmark rate	$800.00	$800.00	$0.00

Item	Formula	Plan Basic Bid			
d		Basic claims cost @ 1.0 risk score	$525.00	$551.25	$26.25
e		Admin expenses @ 1.0 risk score	$50.00	$50.00	$0.00
f		Profit margin @1.0 risk score	$25.00	$5.98	($19.02)
g	d + e + f	Standardized (@1.0 risk score) plan bid	$600.00	$607.23	$7.23
h	b · g	Risk-adjusted plan bid	$600.00	$607.23	$7.23

Item	Formula	Rebate Calculation			
i	c – h	Plan savings	$200.00	$192.77	($7.23)
j		Plan rebate %	70.0%	70.0%	0.0%
k	i · j	Plan rebate revenue	$140.00	$134.94	($5.06)
l	k · d / g	Supplemental benefit claims cost	$122.50	$122.50	$0.00
m	k · e / g	Supplemental admin expense	$11.67	$11.11	($0.56)
n	k · f / g	Supplemental benefit profit margin	$5.83	$1.33	($4.50)

Item	Formula	Plan Financial Impact			
o	h + k	Total Part C (MA) revenue	$740.00	$742.17	$2.17
p	d · b + l	Total Part C (MA) claim cost	$647.50	$673.75	$26.25
q	e · b + l	Total Part C (MA) admin expense	$61.67	$61.11	($0.56)
r	o – p – q	Part C Margin PMPM	$30.83	$7.31	($23.53)

Abbreviations: CMS, Centers for Medicare & Medicaid Services; MA, Medicare Advantage; PMPM, per member per month.

presumably one of the key reasons why the hospital entered the payer business in the first place.

To maximize enterprise value, the IDS needs to critically consider how each of its businesses fits into a rapidly evolving health care ecosystem. How does the system see its hospital portfolio evolving over the next five to 10 years? What type of investments or acquisitions does the system see itself making? How can the system incentivize investments in businesses and strategies that drive care delivery to the appropriate acuity level on the continuum (e.g., inpatient to ambulatory surgery centers)? Stale incentives tied to volume (for hospitals) and medical loss ratio that is a measure of profitability (for health plans) that cultivate the age-old tug-of-war are simply not going to cut it. IDSs need to clearly define long-term strategic goals and put the full force and capabilities of the combined enterprise in motion toward realizing these goals. ■

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