Session 8, Best Practices in Risk-Based Contracts

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2019 Health Meeting

Best Practices in Risk-Based Contracts

June 24, 2019

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Best Practices in Risk-Based Contracting

Value Based Care Evolution & Best Practices in Risk- Based Contracting	Joseph Heintzelman & Daniel Santmyer
Network Strategy	Joseph Heintzelman & Daniel Santmyer
Population Health Management	Dr. Mike Goran
Provider Perspective & Pain Points	Jennifer Leazzo
Q&A	

VBC Evolution Shift from Volume to Value

Number of beneficiaries in CMS MSSP ACO's has grown **~300% in past 5 years**[1]:

HISTORICAL PARTICIPATION AND PERFORMANCE

PROGRAM CHARACTERISTICS

Performance Year	ACOs	Assigned Beneficiaries
2018	561	10.5 million
2017	480	9.0 million
2016	433	7.7 million
2015	404	7.3 million
2014	338	4.9 million
2012/2013	220	3.2 million

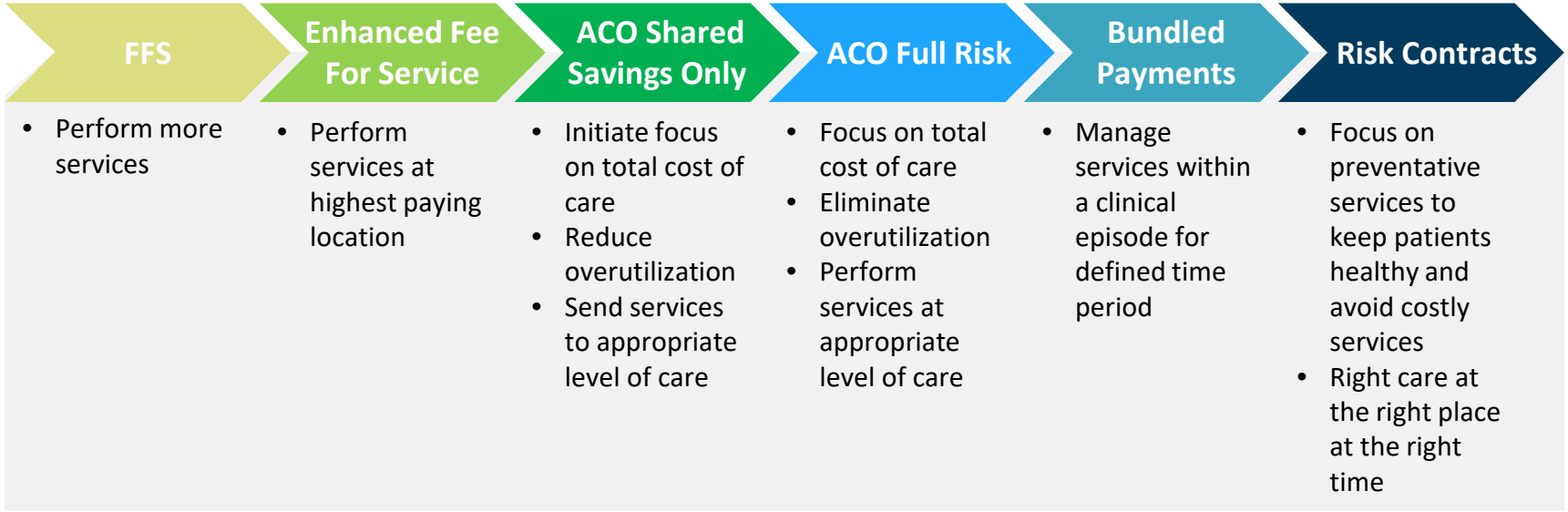
- CMS pushed ACOs into downside risk with Pathways to Success
- New CMMI programs (Primary Care First & Direct Contracting) will move FFS beneficiaries into population-based / capitation arrangements
- The number of members under value-based arrangements in MA and Commercial markets has grown significantly the past 3-5 years. → Capitation is no longer isolated to the west coast!
- Many states have made significant commitments to moving Medicaid payments from FFS to value-based
- **Managing total cost of care has grown in importance and markets continue to evolve away from FFS-based payments**
- **Yet, many providers lack the analytical capability to make data actionable, and many payers are isolated in managing their "silo" of the business**

[1] Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SSP-2018-Fast-Facts.pdf

VBC Evolution CMS Transition from FFS to FFV

FFS	Enhanced Fee For Service	ACO Shared Savings Only	ACO Full Risk	Bundled Payments	Risk Contracts
• Incents utilization, whether necessary or not • No oversight of quality for patient	• Increased Revenue to incent certain behaviors • e.g. Site of Service differential in fee schedules • e.g. MIPS/MACRA	• Provider manages cohort of members and their overall trend; if cost lower than target payer pays $ to provider • e.g. MSSP Track 1	• Provider pays back payer if cost is higher than target • e.g. Pioneer/Next Gen ACO	• Provider agrees to set payment for all services within a clinical episode for defined time period • e.g. BPCI-Advanced	• Provider accepts upfront payment and agrees to provide all services to members in arrangement • Shifts risk to new entity • e.g. MA contracts with carriers

VBC Evolution How Are Provider Organizations Profitable?



VBC Financial Risk/Opportunity transferred to providers

Risk-Contracting Examples:

Shared Savings

- Compares actual to projected medical expenses
- Shared savings settlement occurs after performance period
- Typically upside only, but can include downside risk
- Risk mitigation items typically included in settlement calculation

Percent of Premium

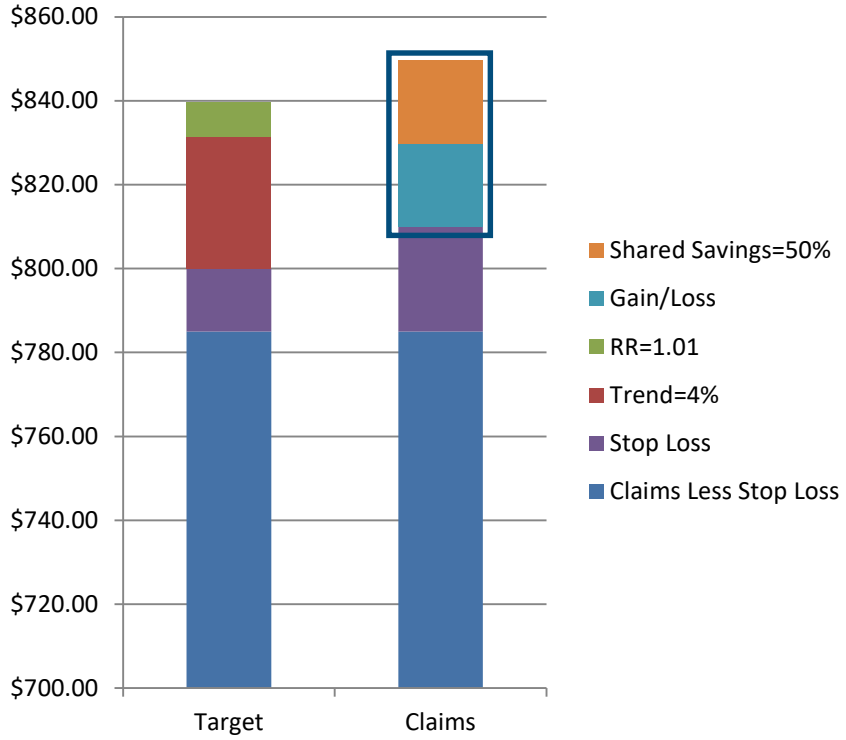
- Fixed estimated prepaid amount with future adjustments expected
- Initial monthly payments based on pre-performance period with post-performance period adjustments
- Multiple risk arrangements (e.g. upside only, full upside/downside, limited upside/downside)

Capitation

- Fixed prepaid amount, typically with no future adjustments
- Monthly payments based on pre-performance period calculation
- Includes both upside and downside risk
- Risk mitigation items not included in capitation and purchased separately

VBC Shared Savings Example

- Target / Baseline
  - Built using 2017 claims:
    - **2017 Claims = $800**
    - 2017 Stop Loss = $15
    - 2017 Claims Less Stop Loss = $785
    - 2017-18 Trend = 4%
    - 2017-18 Risk Ratio = 1.01
- Performance Year Claims
  - Calculated based on 2018 actuals:
    - **2018 Claims = $810**
    - 2018 Stop Loss = $25
    - 2018 Claims Less Stop Loss = $785
- Gain/Loss = $40
- Shared Savings = $20
  - 50% of Gain/Loss (aka “Gross Savings”)



Risk Based Contracting Outline

Providers

Patients

Targets

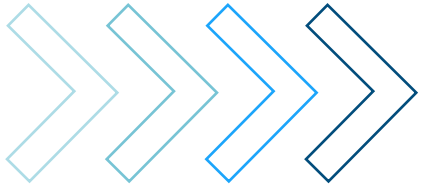
Other Considerations

Risk Based Contracting Providers

- **Who are the providers** at risk?
  - **CIN/ACO often decides** which providers are included in the “at risk” list
  - Sometimes based on Tax Identification Number (“TIN”), sometimes based on National Provider Indicator (“NPI”), sometimes the intersection of the two.

Risk Based Contracting Patients

- **Which patients**' costs are at risk?
  - Attribution can be done many ways. Broadly, could be based on **geography, patient choice, prospective claims, or retrospective claims**.
- **Which services** are at risk for these patients?
  - Usually some services are **carved out**. Could be because at-risk providers do not cover these services (dental, vision), or because services are high cost outliers (transplants).
  - Some contracts put PCPs and Specialists at risk only for **professional services and not facility-based services**
  - Other contracts are specific to **one type of service** (i.e. Mental Health)

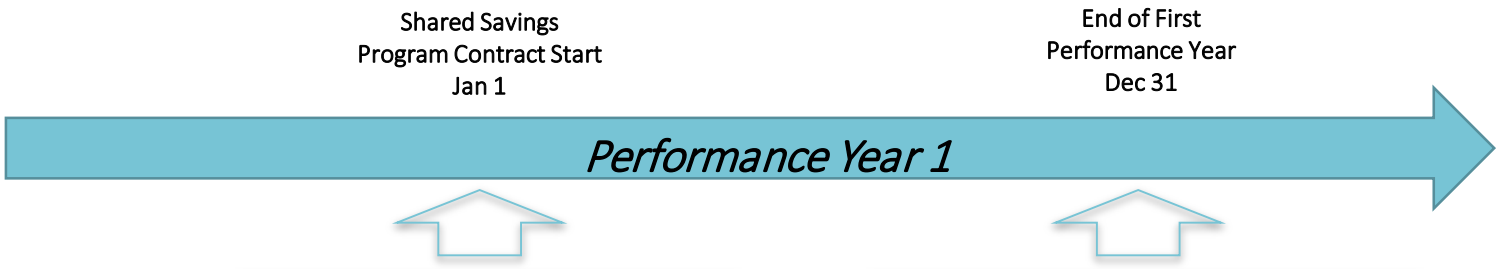


Risk Based Contracting Patients: Attribution

- **How are patients "assigned"** to a provider or group of providers?
- For MA and Commercial plans, **members select coverage** with a particular payer and associated network of providers.
  - Since an individual member could see many providers in the course of their coverage period, there **must be a method to match patients to providers**.
- **Claims-based attribution** is the most typical method. Often involves a set of primary care procedure codes and specialty types.
  - For example, CMS MSSP attribution allows specialists to attribute lives only if the patients did not have a qualifying visit with a PCP.

Risk Based Contracting Patients: Attribution (Cont.)

- Attribution: Retrospective vs. Prospective attribution



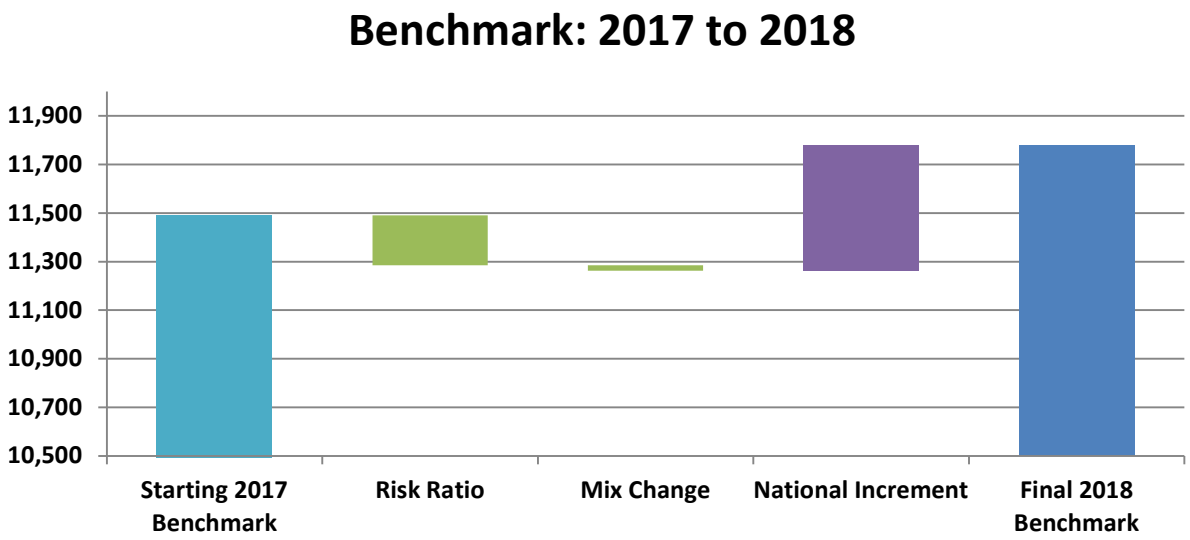
	Prospective Alignment	Retrospective Alignment
When Are Members Assigned?	Patients assigned to providers prior to the performance year	Patients assigned to providers after the performance year
Examples	Next Generation ACO	MSSP Track 1 ACO
How Does it Work?	Methods • Plurality of visits in prior year(s) with provider in ACO • Patient designates provider/ACO (attestation) • Payer designates provider • Geographic area assignment	Methods • Plurality of visits with providers in ACO during the performance year

Risk Based Contracting Targets

- How are “savings” quantified?
  - Risk-adjusted benchmark, based on some data.
    - Data
      - Comparison to “market” (similar geographic region / population / time period)
      - Comparison to trended historical costs
        - Using identical cohort for performance & baseline year(s) inherently eliminates end-of-life costs in baseline year(s)
    - Risk adjustment models
      - Many different models; intended to measure the health status and resulting expected cost of a population.
- There are a number of factors to consider in verifying the target population is similar / comparable to the measurement population.
  - Risk adjustment
  - Mix adjustments for proportion of new members, mortality, and how these variables change over time in each respective population
  - Credibility of population size in both target and measurement years

Risk Based Contracting Target Example

- Target example (MSSP ACO)
  - Includes target based on 2017 data and adjustments for change in population's risk, mix, and one year of trend.



Risk Based Contracting Targets: Risk Adjustment

Risk adjustment is intended to **normalize the health status of two populations** and/or how that could change over time.

- **Concurrent vs Prospective** risk adjustment
  - Concurrent will give incomplete results until the year is over, so any quarterly reports based on emerging data will have a misleading/incomplete risk score.
- **Risk adjustment models**
  - Public – CMS-HCC, HHS-HCC
  - Proprietary – MARA, Symmetry ETG/ERG
  - Academic – CDPS, Hopkins
- Different for **Commercial vs MA**:
  - Coding pays off in MA and **payer is incentivized to help providers** maintain accurate coding
  - Coding increases in Commercial agreements tend to benefit the provider, so **payer is less incentivized to provide coding assistance**
  - CMS estimates normalization changes for MA and MSSP/NG ACO programs, which impacts final settlement risk scores

Risk Based Contracting Targets: Trend

When using historical costs to develop a target, those costs must be **trended forward to the measurement/performance year**. What trend should be used?

- Regional or national?
  - How to define “region”?
- PMPM trend**%** or fixed PMPM increment**$**
  - Higher cost areas are typically disadvantaged by using a fixed dollar increment, as that often understates actual trend
- Regional **unit cost** trend%
  - Does not include utilization trend component; only includes changes to provider payment rates

Risk Based Contracting Other Considerations: Stop Loss

- Most value based contracts offer **truncation** of medical costs past a certain threshold. The idea underlying this truncation is that some very high costs at the member level (often $150k+, and often end-of-life costs) are not manageable and therefore should not be included in a value based arrangement.
- Some contracts completely **exclude** these “outlier” claims, while some contracts attempt to **reconcile** the proportion of claims over the threshold by creating a stop loss charge and calculating the stop loss payout.
  - The actuarial modeling of the stop loss charge and payout is often based on similar methodologies as **traditional stop loss / reinsurance**.
- More innovative stop loss arrangements include **risk sharing of shared losses**. For example, a reinsurer could choose to cover 80% of shared losses over a certain threshold in exchange for a monthly premium calculated by an actuary.
  - This evaluation would include estimating the probability of success in the value-based arrangement.

Risk Based Contracting Other Considerations: Quality

How is quality maintained when providers are incentivized to provide fewer services?

- The **measurement and impact** of quality varies among different types of contracts.
  - MA Star ratings
  - Medicare ACOs
  - Commercial ACOs
- Low quality scores are detrimental to value based payments.
  - Sometimes this is modeled as a **threshold**, in which risk share payments will not be paid unless a certain quality score is met.
  - Other times, quality determines the **% of the risk share payments that are paid** to the provider vs retained by the payer.

Risk Based Contracting Other Considerations: Mix Adjustments

Often, there are differences between the target population and measurement population that are not explained by risk adjustment. Some examples are included below:

- **Proportion of new members**: New members (those members with less than 12 months of data) typically have a lower risk score due to the lack of data used to assign risk scores. If the proportion of new members is significantly lower in the measurement period than the baseline period, the risk assigned to the measurement period population will be less complete, relative to the baseline period

- **Mortality %**: End of life care is costly. If the mortality rate is significantly lower during the baseline vs measurement period, measurement period costs will likely be higher than baseline.

Risk Based Contracting Unique Contract Features by Line of Business

Medicare Fee-for-Service

- Programs/Risk Levels: MSSP ACOs, Next Generation ACOs, BPCI Advanced Bundles
- CMS provides more data to providers than most Commercial insurers
- Risk adjustment using CMS HCC methodology

Medicare Advantage

- Risk Levels: Upside only, Percentage of Premium, Full Capitation
- Covered services can be Part B only, Parts A+B, Parts A+B+D, etc.
- Division of Financial Responsibility (DOFR) specifies services on which provider takes risk
- High cost & unpredictable services (i.e. Transplants) are typically carved out of risk-based contracts
- Percent of premium capitation is common = a provider is paid based on a percentage of the payers' CMS revenue (minus some exclusions) for services included in the DOFR
- Risk adjustment using CMS HCC methodology

Risk Based Contracting Unique Contract Features by Line of Business

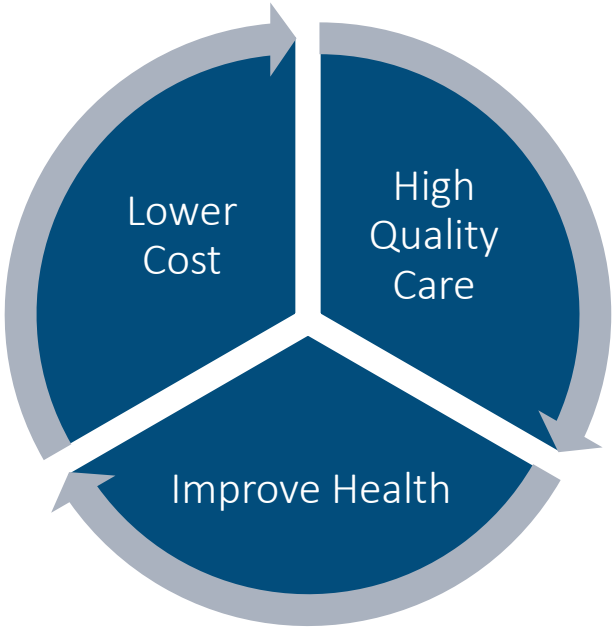
Commercial

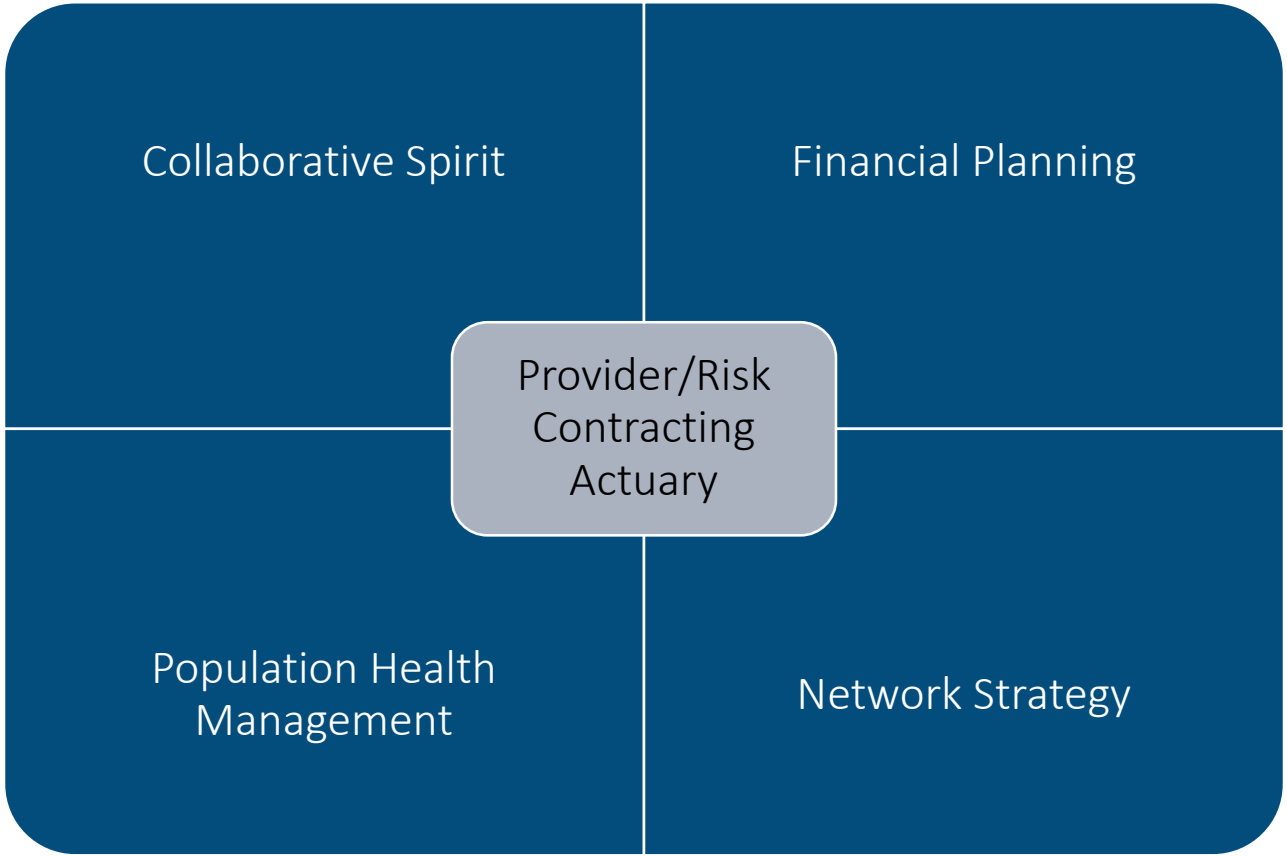
- Populations: Employer Sponsored, Employer Exchange, Individual Exchange
- High Turnover = Volatile Populations (employee turnover with groups, employers/individuals change payers)
- Benefits changes/variation within employer groups
- Significant portion of population with $0 claims
- Provider reimbursement within a payer and geographic region can vary significantly
- Payer Anti-trust/Competitive concerns = Commercial data is limited in provider identification and/or paid claims detail provided
- Risk adjustment and contract attributes are not standardized

Medicaid

- Populations: TANF Adults, TANF Children, SSI, Special Populations
- High turnover in TANF populations
- Benefits vary significantly by population and state
- Difficult to engage all members (frequent address changes, frequent PCP changes)
- Risk adjustment and contract attributes are not standardized
- Social determinants of health becoming prevalent in risk adjustment
- Behavioral health condition comorbidities and engagement are critical success factors

Accountable Care Triple Aim

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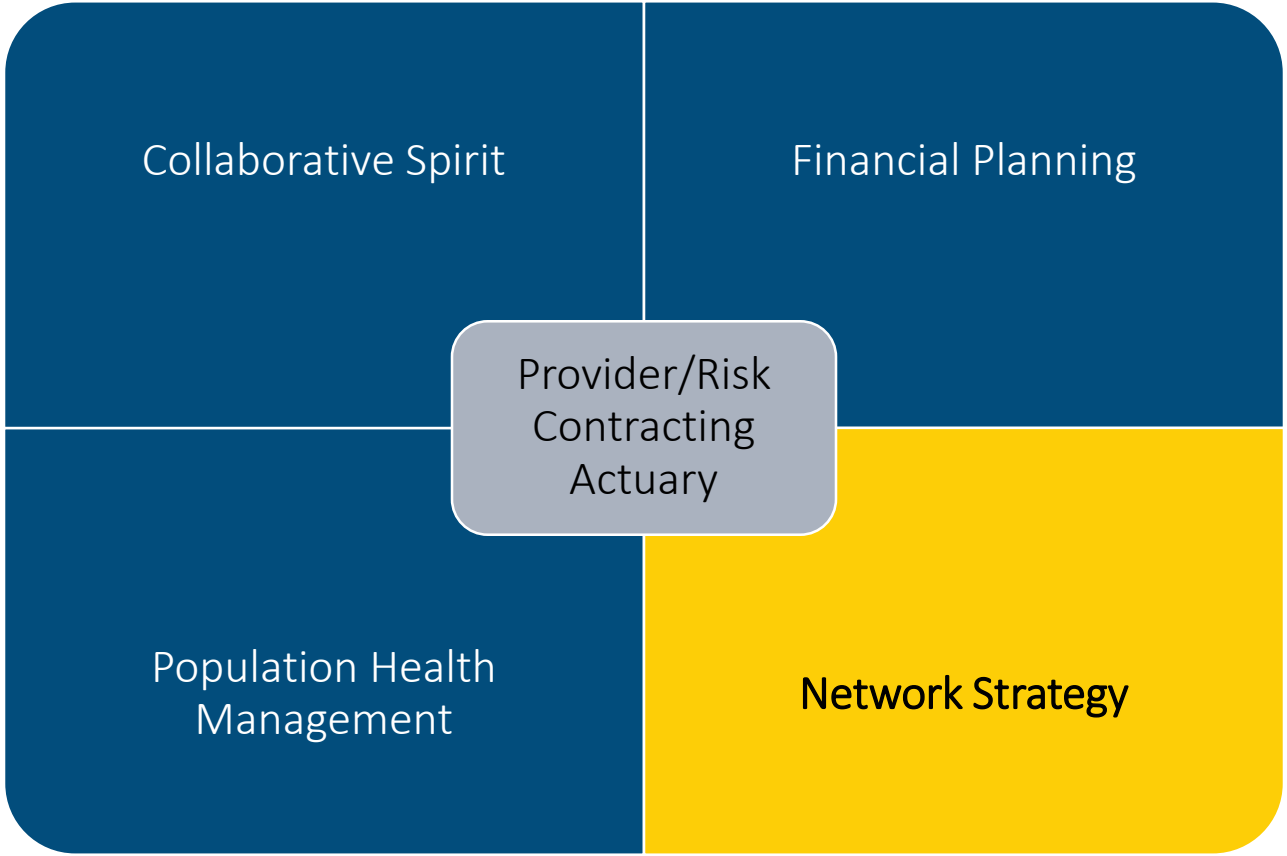
Financial Planning
Provider/Risk Contracting Actuary
Population Health Management
Network Strategy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Network Strategy

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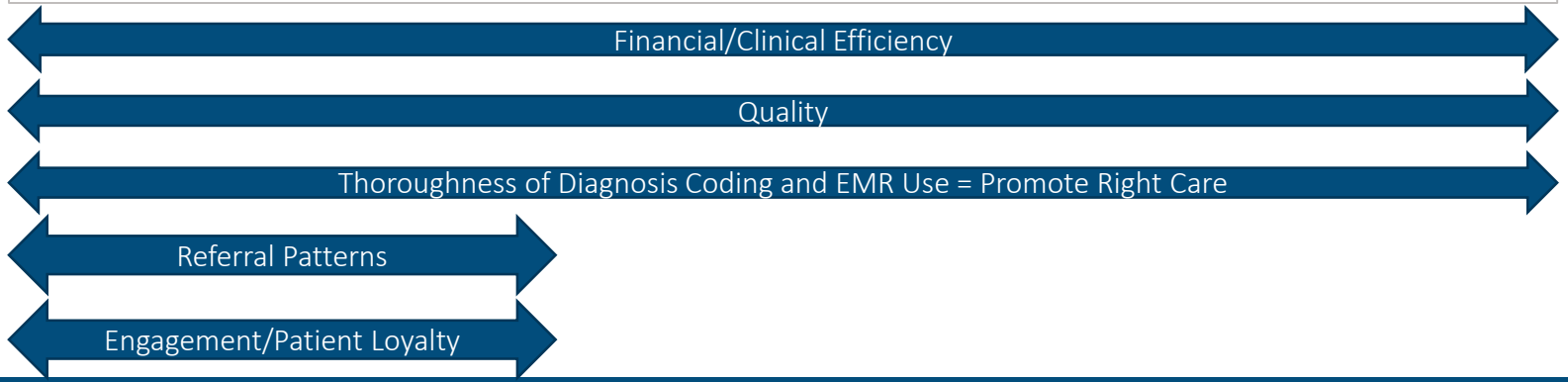
Network Strategy Network Evaluation

	Non-ACO Providers	
ACO Participants	Preferred Partners	Other
• Primary Care • Specialists • ACO Owned Facilities	• Affiliated Specialists • Preferred Facilities • Centers of Excellence	• Primary Care • Specialists • Facilities
Triple Aim Evaluation Measures		



Network Strategy Results of Network Evaluation

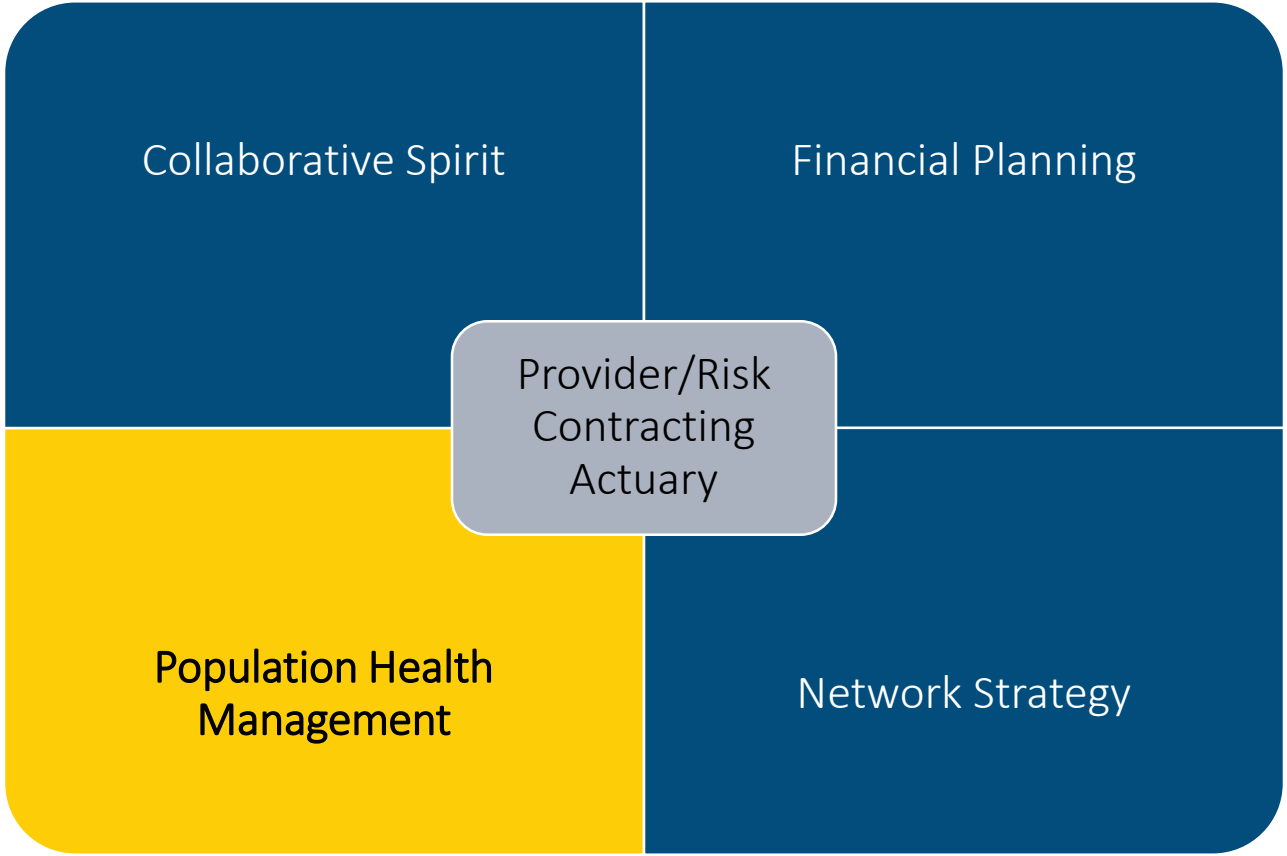
- Internal provider efficiency and clinical variance analysis
  - Identify “best in class” providers by clinical pathway
  - Provide peer education to providers that underperform across metrics
- Non-ACO Participant/Leakage Analysis
  - Claims to ACO = Revenue to Provider
  - What is the cause of leakage?
    - Member choice
    - ACO does not have capacity to provide service
    - Dual Admission privileges of ACO participants
    - Prior Provider Relationships
  - Leakage analysis can lead to pursuit of beneficial partnerships and avoidance of poor care
    - Identify high quality/efficient non-ACO providers
    - If provider not currently affiliated or preferred, recruit as a participant or preferred referral partner
    - If pursuing partnership, providers must “fit” with ACO’s culture

ACO Culture = Commitment to Efficient, High-Quality Care + Thorough Diagnosis and EMR Coding + Urgency to Identify and Enact Cultural Change

Network Strategy Network Evaluation – Cautions

- Difficult to achieve best in class network analysis
  - Data must be available
    - EMR only tracks claims “inside 4 walls” + EMR partners
    - Need EMR + paid claims data to see full picture of member care and leakage
  - Providers with small sample size
  - Algorithms are complex and subject to clinical scrutiny and disbelief
  - Analysis must be timely, actionable and consistent between time periods
    - Output and methodology must be effectively communicated to non-actuarial stake holders

- Technical Complexities
  - Application of risk adjustment
  - Identification of medically necessary vs. excessive vs. deficient levels of care
  - Understanding that an increase in some service lines is the best outcome
    - E.g. primary care visits, outpatient surgery alternatives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Population Health Management

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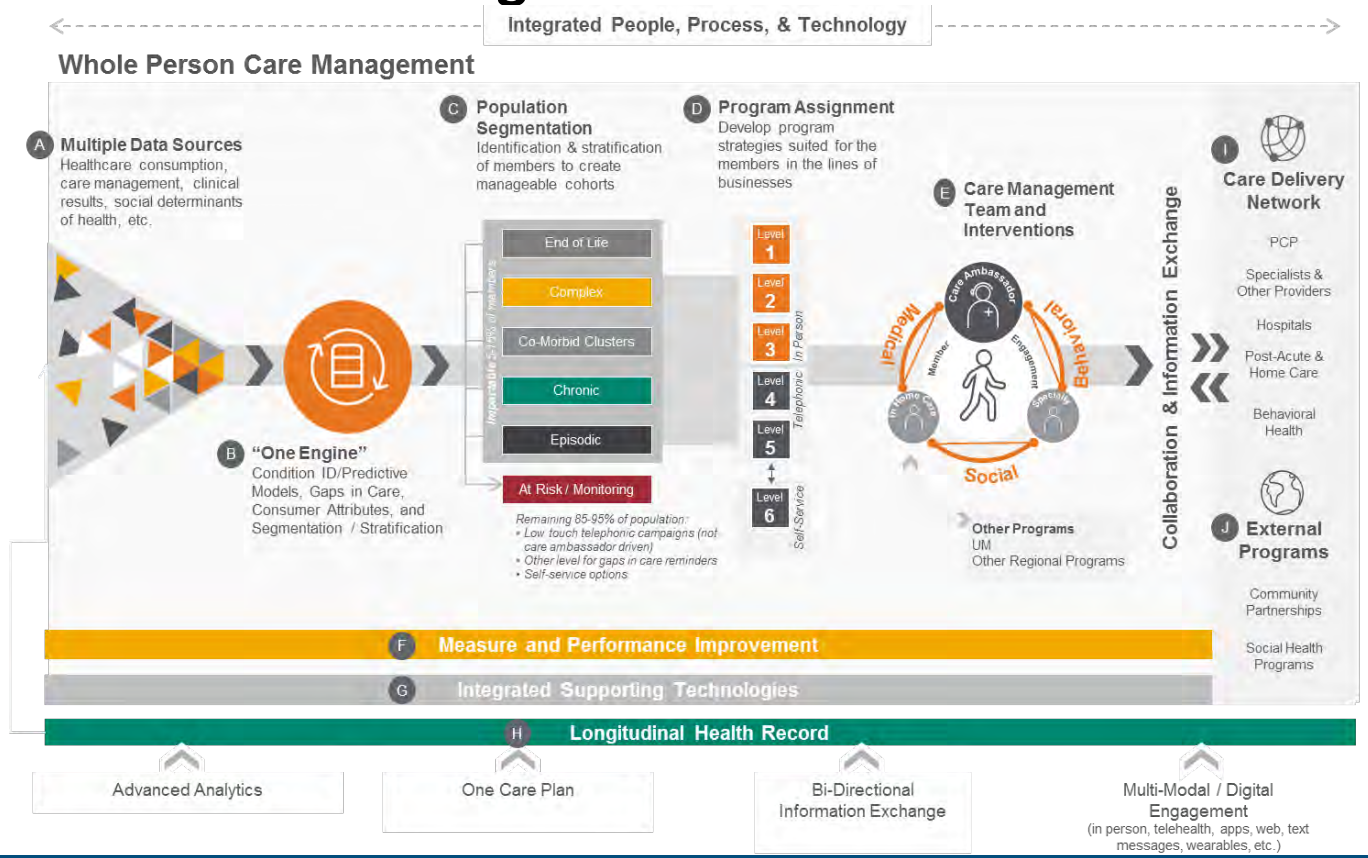
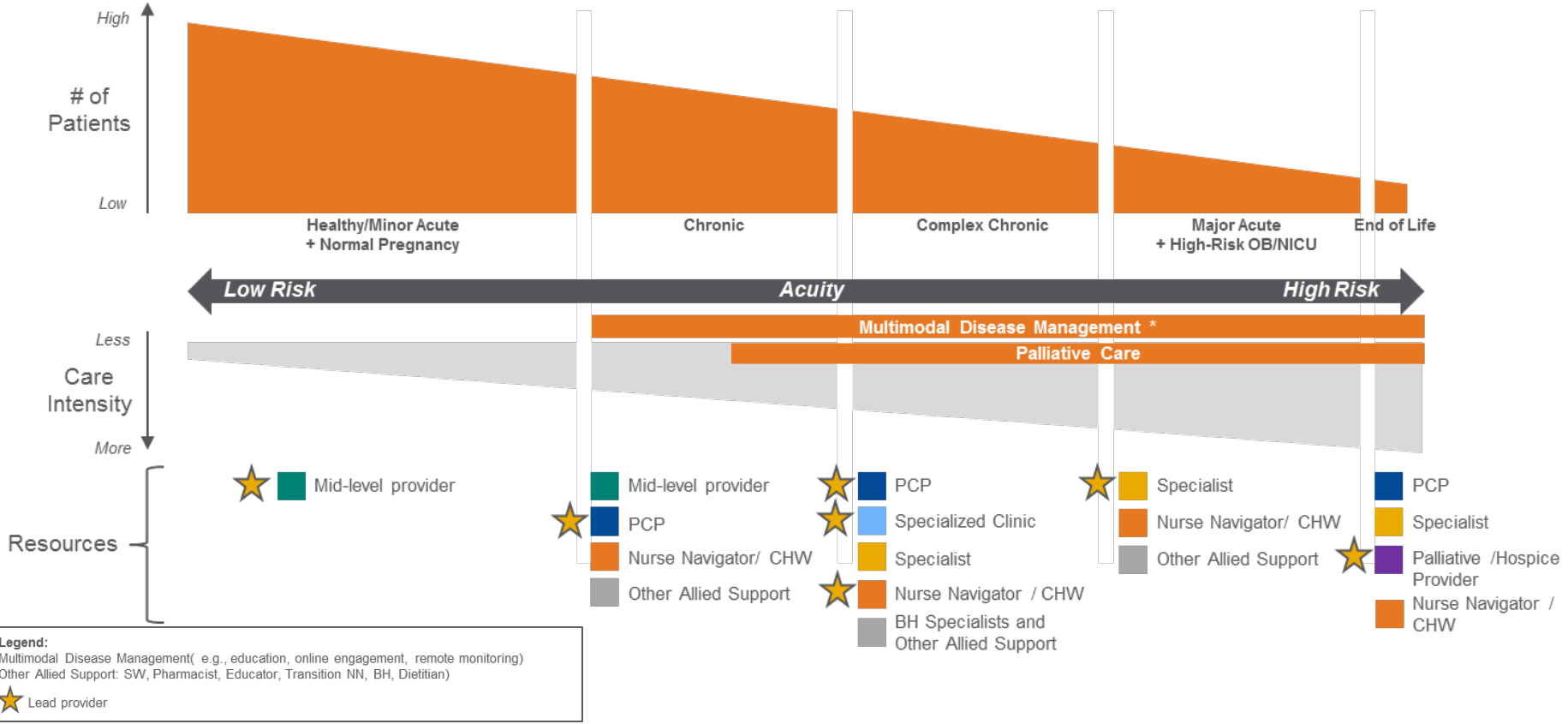
Population Health Management: Whole Person Care Management



Population Health Management Population Segmentation



Legend:
Multimodal Disease Management(e.g., education, online engagement, remote monitoring)
Other Allied Support: SW, Pharmacist, Educator, Transition NN, BH, Dietitian)

★ Lead provider

Population Health Management Gaps In Care

Gaps in Care Opportunities to reduce discrepancy between recommended care and actual patient care

Patient Experience & Access

Getting Timely Appointments
Access to Specialists
Shared Decision Making
Stewardship of patient resources
Health Promotion and Education

Prevention

Cervical Cancer Screening
Breast Cancer Screening
Colorectal Cancer Screening
Tobacco Use Screening and Cessation
Body Mass Index Screening and Follow-up

Utilization / Coordination

Utilization & Cost / Overuse
- Use of imaging studies for low back pain

Care Coordination/Patient Safety
- Medication Reconciliation

Comprehensive Diabetes Care

HbA1c
Hemoglobin A1c
Eye Exam
Foot Exam
Medical Attention for Nephropathy

Cardiovascular Care

Controlling High Blood Pressure
Persistent Beta Blocker Treatment post Heart Attack
Ischemic Vascular Disease: Use of aspirin or antithrombotic

Add'tl Condition Management

Pulmonary Care
- Medication management for people w/ Asthma
- Avoidance of antibiotic treatment for adults with acute bronchitis

Behavioral Health
- Depression remission at 12 months

Population Health Management Total Knee Replacement Example

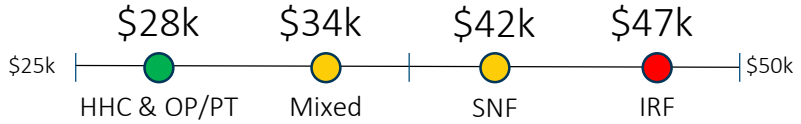
TKR Cost Variation Insights

- Costs are anchored (fixed costs) and variable costs
- Care redesign can enable quality outcomes and low costs
- For example, SNF and IRF costs can be supplemented with Home Health Care, PT / OT or other costs to reduce overall episode spend

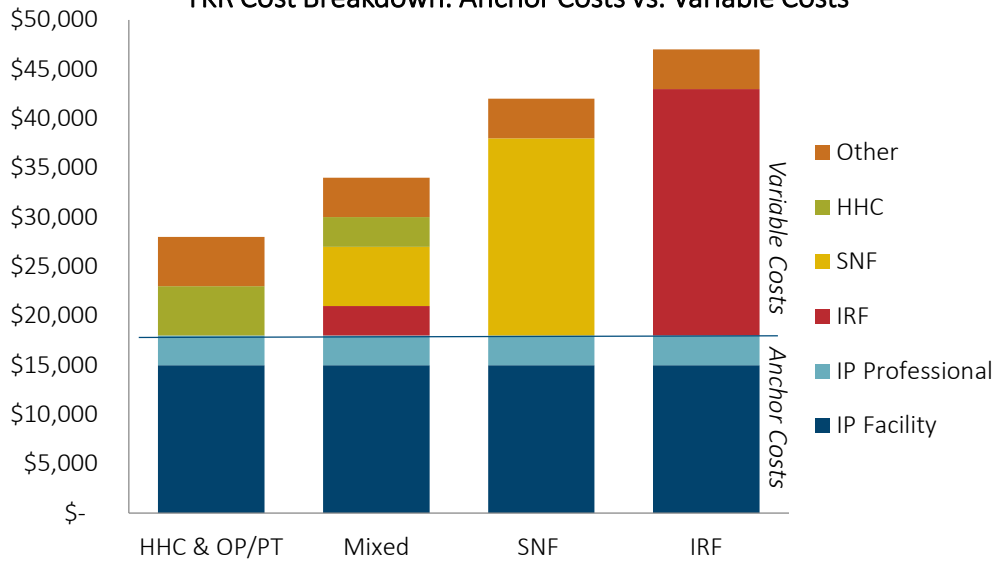
Strategies for cost reduction and care redesign include:

- Orthopedic surgeon buy in
- Care pathways use
- Reduction in practice pattern variation
- Patient/care giver education, engagement, preparation
- Preferred partners for services (OP PT, HH, SNF)
- Alignment with IP care, discharge planning and transitions teams

TKR Cost Variation Example



TKR Cost Breakdown: Anchor Costs vs. Variable Costs



Provider Perspective & Pain Points

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Provider Perspective Provider Pain Points

Data	•Providers lack infrastructure to ingest & analyze the data that carriers take for granted •Commercial carriers may not be willing to share cost information or have data quality issues themselves •Many diagnoses, procedures, facilities, providers masked (e.g. MH)
Using the data	•Power in combining clinical data from providers with paid claim data from carrier… but significant cost involved to harness that power and who pays for that cost •Physician can see things that patient doesn't share with PCP albeit ***lagged*** •ACOs can study patient behavior and provider practice patterns
Cohort Attribution	•Retrospectively assigned patients may not allow time to manage to cost target •Patients can disengage with providers in prospective attribution model •What time period is appropriate? •How to engage with patient

Provider Perspective Provider Approaches to Success

Eliminate excess utilization

- Implies ACOs with historical waste can initially make a lot of money
- Emphasize preventative services
- Interoperability helping reduce true duplicates
- Data Transparency

Site of Service

- HIP -> HOP
- OPS -> ASC
- ASC -> Office based
- ER -> Urgent Care

- For Medicare, these relationships hold true
- For Commercial, additional layer of cost differential within buckets

Patient/Provider Engagement

- Encouraging PCPs to engage with Patient; HMO encourages Patient engagement
- Patient may not stay with same job and carrier; must keep patient to collectively win
- Paid Claims data from carriers helpful to study patient selection patterns as well as provider practice patterns – requires data infrastructure

Provider Perspective Providers and Carriers Have to Agree Upon

Measure of success	•Cannot continue to reduce own ACO costs year over year; maximum efficiency •Does $ PMPM or % trend need to be better than peers? •What about random fluctuation?
Risk Adjustment	•“Black box” •Coding differences/inflation
What is outside Provider’s control	•Facility cost increases outside •Patient Choice •New drugs/procedures made available at high cost; stop loss
Cash Flow Timing	•Investments needed immediately to be successful, but shared savings paid later •Increased fee schedule or Care coordination fee up front to cover; may have to pay back


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