Session 23, A Common Vision of Value-Based Care: Case studies of Payer-Provider Collaboration

2019 Health Meeting

DAVID S HANEKOM, MD, FACP, CMPE

MAUREEN TRESNAK, FSA, MAAA

FAN ZHANG, MD, MHA, MBA

Session 023, A Common Vision of Value-Based Care: Case Studies For Payer-Provider Collaboration

June 24, 2019

SOCIETY OF ACTUARIES®

SOCIETY OF ACTUARIES
Antitrust Compliance Guidelines

Active participation in the Society of Actuaries is an important aspect of membership. While the positive contributions of professional societies and associations are well-recognized and encouraged, association activities are vulnerable to close antitrust scrutiny. By their very nature, associations bring together industry competitors and other market participants.

The United States antitrust laws aim to protect consumers by preserving the free economy and prohibiting anti-competitive business practices; they promote competition. There are both state and federal antitrust laws, although state antitrust laws closely follow federal law. The Sherman Act, is the primary U.S. antitrust law pertaining to association activities. The Sherman Act prohibits every contract, combination or conspiracy that places an unreasonable restraint on trade. There are, however, some activities that are illegal under all circumstances, such as price fixing, market allocation and collusive bidding.

There is no safe harbor under the antitrust law for professional association activities. Therefore, association meeting participants should refrain from discussing any activity that could potentially be construed as having an anti-competitive effect. Discussions relating to product or service pricing, market allocations, membership restrictions, product standardization or other conditions on trade could arguably be perceived as a restraint on trade and may expose the SOA and its members to antitrust enforcement procedures.

While participating in all SOA in person meetings, webinars, teleconferences or side discussions, you should avoid discussing competitively sensitive information with competitors and follow these guidelines:

- **Do not** discuss prices for services or products or anything else that might affect prices
- **Do not** discuss what you or other entities plan to do in a particular geographic or product markets or with particular customers.
- **Do not** speak on behalf of the SOA or any of its committees unless specifically authorized to do so.
- **Do** leave a meeting where any anticompetitive pricing or market allocation discussion occurs.
- **Do** alert SOA staff and/or legal counsel to any concerning discussions
- **Do** consult with legal counsel before raising any matter or making a statement that may involve competitively sensitive information.

Adherence to these guidelines involves not only avoidance of antitrust violations, but avoidance of behavior which might be so construed. These guidelines only provide an overview of prohibited activities. SOA legal counsel reviews meeting agenda and materials as deemed appropriate and any discussion that departs from the formal agenda should be scrutinized carefully. Antitrust compliance is everyone's responsibility; however, please seek legal counsel if you have any questions or concerns.

Presentation Disclaimer

Presentations are intended for educational purposes only and do not replace independent professional judgment. Statements of fact and opinions expressed are those of the participants individually and, unless expressly stated to the contrary, are not the opinion or position of the Society of Actuaries, its cosponsors or its committees. The Society of Actuaries does not endorse or approve, and assumes no responsibility for, the content, accuracy or completeness of the information presented. Attendees should note that the sessions are audio-recorded and may be published in various media, including print, audio and video formats without further notice.

A Common Vision Of Value-Based Care

Case Studies For Payer-Provider Collaboration

Objective

Through several case studies to discover best practices strategies of how to enable transparency and true collaboration, including the engagement of front-line clinicians, to the financial feasibility of value-based reimbursement arrangements.

Agenda

- ❑ Overview of Value-Base Care Transition
- ❑ Payer Provider Collaboration Challenges
  1. Attribution Methodology
  2. Financial Alignment
  3. Quality Metrics
  4. Physician Alignment
  5. Risk Coding
- ❑ Case Study – Putting it All Together

CMS – MACRA 2015 & Payment Transformation

SOCIETY OF ACTUARIES®

CMS FFS Payment circa 2015

Medicare Payment Prior to MACRA

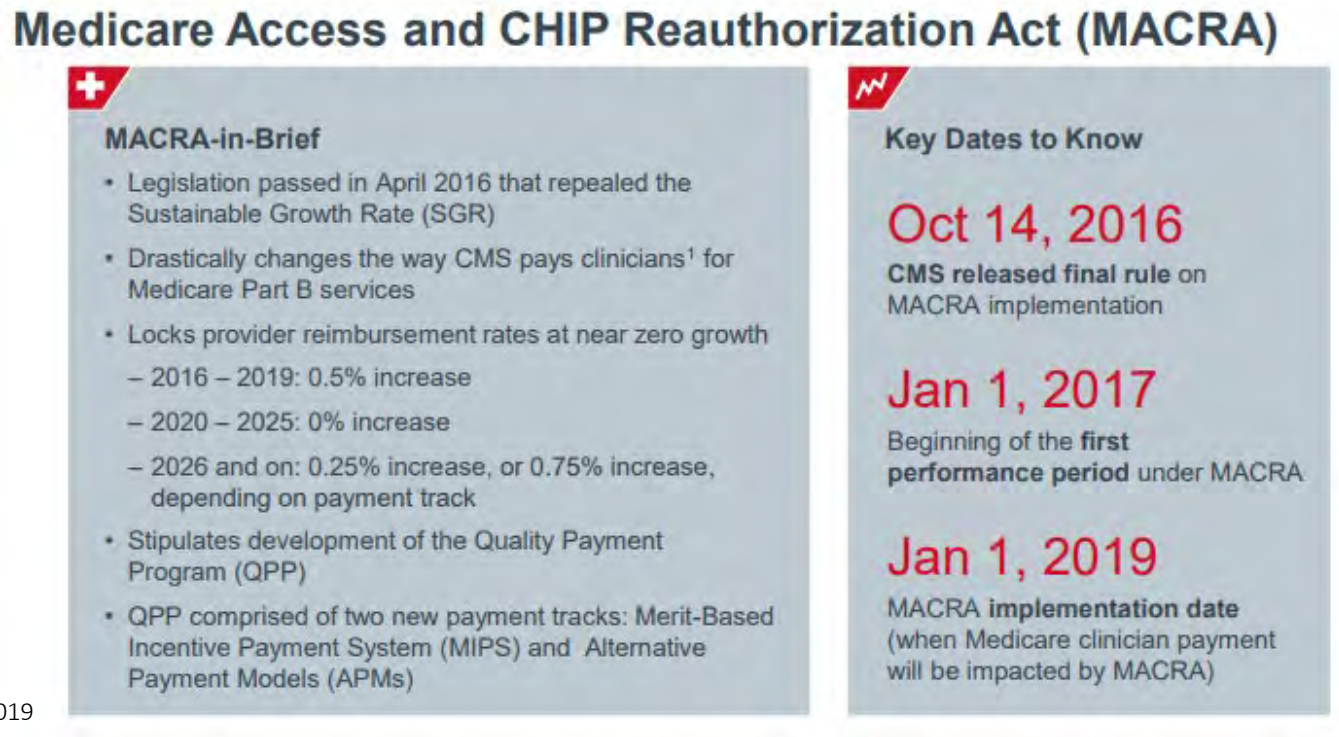
Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

MACRA 2015



www.advisory.com
Accessed May 6, 2019

QPP Strategic Goals

- Improve beneficiary outcomes
- Enhance clinician experience
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation

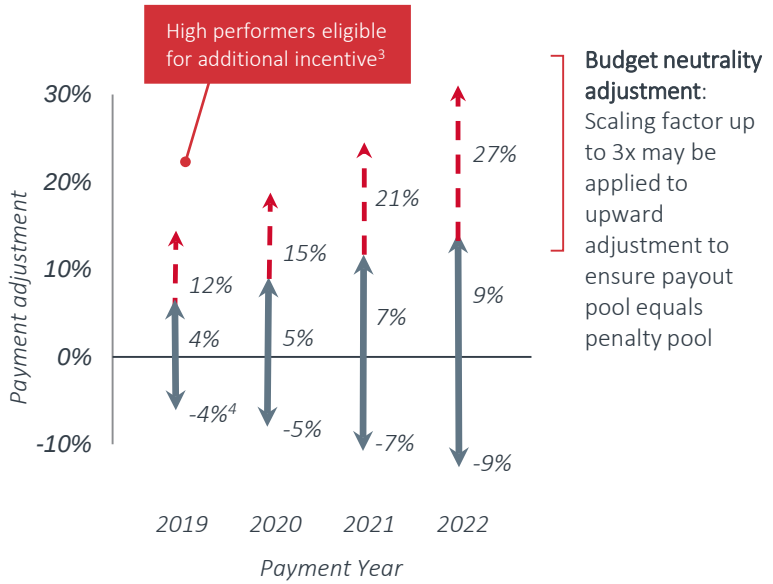
Quick Tip:
For additional information on the Quality Payment Program, please visit QPP.CMS.GOV

MIPS : Budget Neutral, Self-Adjusting FFS

Payment Adjustment Determination

1. Clinicians assigned score of 0-100 based on performance across four categories
2. Score compared to CMS-set performance threshold[1] (PT); non-reporting groups given lowest score
3. A score above PT receives bonus; a score below PT subject to penalty[2]

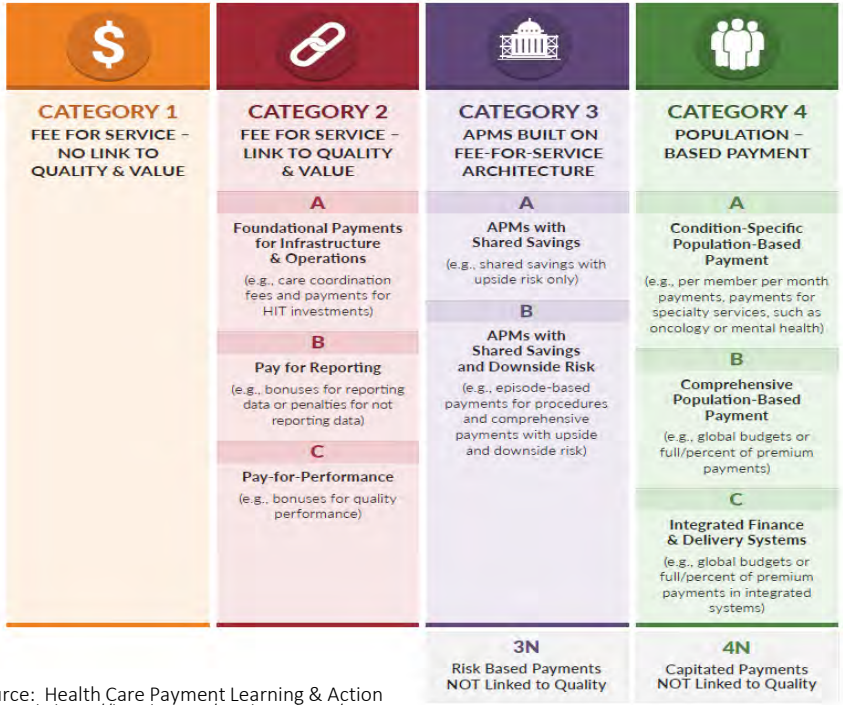
Maximum Provider Penalties and Bonuses



Budget neutrality adjustment: Scaling factor up to 3x may be applied to upward adjustment to ensure payout pool equals penalty pool

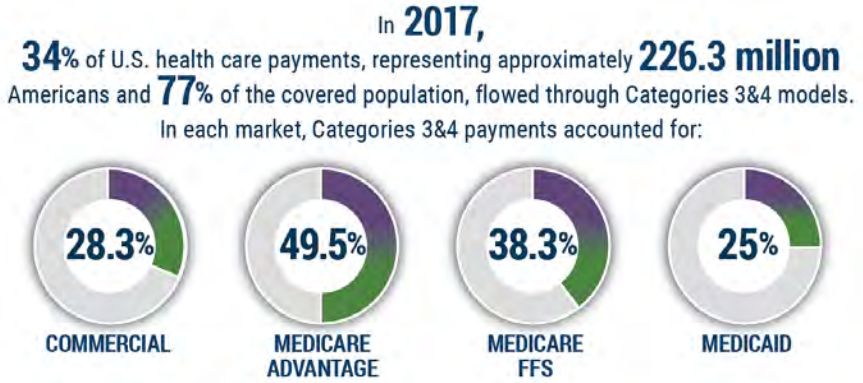
Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," May 9, 2016, available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf; Advisory Board interviews and analysis.

APM Framework



Source: Health Care Payment Learning & Action Network, http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

- APM Framework: payment models on a continuum of clinical and financial risk for provider organizations; represents payments from public and private payers
- Rapid growth trend: value-based payments are shifting to advanced categories (3&4)



New Payment and Service Delivery Models

The Center for Medicare & Medicaid Innovation, created under the ACA, has grouped 82 new payment and service delivery models into the following seven categories

Model Category	Active	Announced/ Under Development	Not Active	Total
Accountable Care	5		5	10
Episode-based Payment Initiatives	6		4	10
Primary Care Transformation	5	2	4	11
Initiatives Focused on the Medicaid and CHIP Population	1	1	4	6
Initiatives Focused on The Medicare-Medicaid Enrollees	4		1	5
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	23	5	2	30
Initiatives to Speed the Adoption of Best Practices	7		3	10
Totals	**51**	**8**	**23**	**82**

Source: The Center for Medicare and Medicaid Innovation

Industry Trends in APM Adoption

SOCIETY OF ACTUARIES®

Industry Observations

Government has been leading the innovation in value-based care models, not the private sector or national payers.

Value-based care transition has moved at a slower pace. The industry is in search of scale.

When moving up the risk continuum, scale and experience are critical for success.

A provider-driven clinical model actually works! However, it is critical to capture value from meaningful differentiation.

Hospital-less Integrated Delivery Networks (IDNs), activist employers, and government performance standards are the new disruptor.

Payer/Provider Collaboration in VBC Transitions

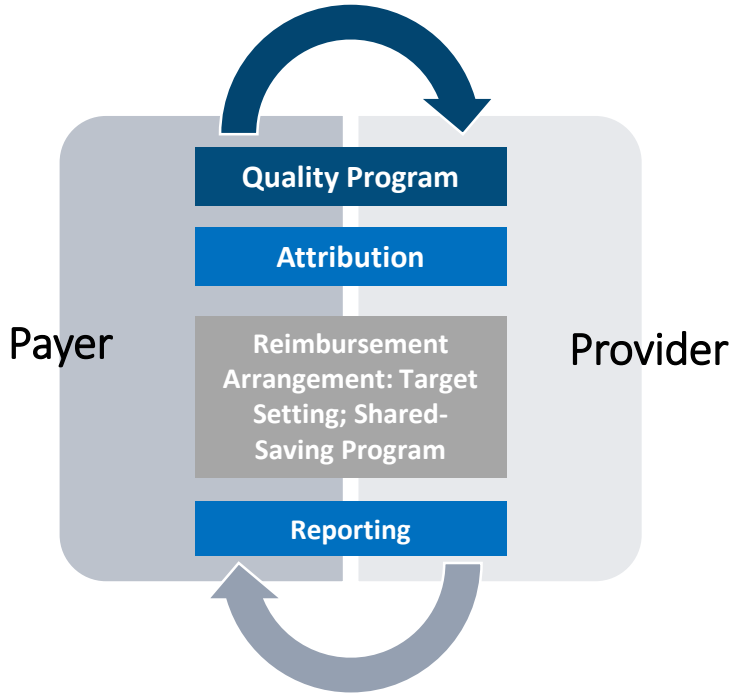
Traditional

Payer Identifies problem (cost)

Reimbursement Initiative from payer

Provider Change Reactively (Financial & Clinical Model)

Common Vision



Arizona Care Network At-a-Glance

Primary Care | Community Specialists | Facility/ other

6,000 Providers

Care locations statewide

310,000+

Value-Based Lives

DIVERSE VALUE-BASED

Contracts

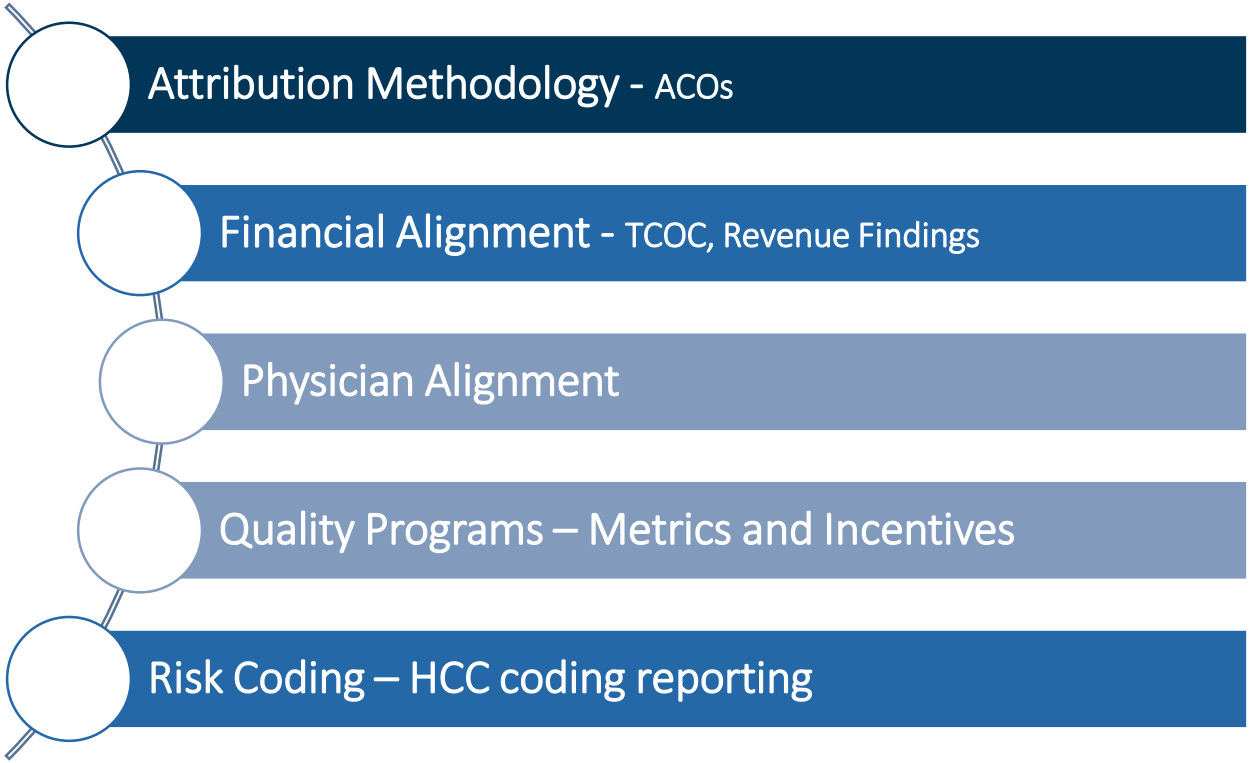
- Medicare
- Medicaid
- Commercial
- Direct to Employer
- Direct to Pharma

Quality outcomes achieving

$41 Million

Total Medical Cost Savings

Common Challenges in Payer Provider Collaboration



Challenge #1: Attribution Methodology

- Beneficiary attribution is critical under APMs, for risk transfer and benchmark setting

- Major types of attribution methodologies:
  - Member selection
  - Geographic determination
  - Visit-based (prospective or retrospective)

Challenge #1: Attribution Methodology

Considerations
• Shift from managing sickness to managing population health • Credibility and actuarial soundness • Increased administrative and financial burden for providers • Alignment of incentives

- How can providers engage with attributed beneficiaries that they may have rarely or never treated?
- How can providers manage new streams of information about their patient panel?

Challenge #2: Financial Alignment

Performance Risk

- Inefficiency and suboptimal quality of the delivery of health care services
- **Example: Quality performance, care management performance**

Technical Risk

- Inappropriate structuring of contract elements to match covered population to provider-specific circumstances
- **Examples: Attribution methods, cost target development, trend assumptions, risk adjustment**

Utilization Risk

- How the payment model is affected by the known changes in utilization.
- **Example: Reduced utilization under risk-sharing arrangement will reduce FFS revenues and potentially overall revenue**

Insurance Risk

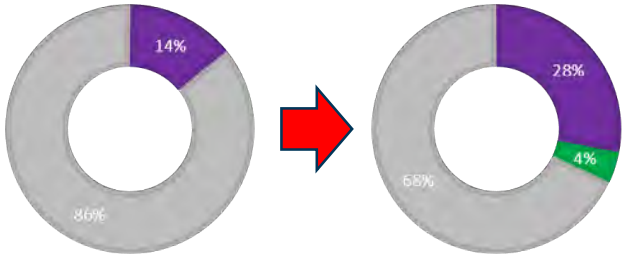
- Risk associated with the unknown variation in the utilization and cost of services.
- **Example: Variations that cannot be predicted such as acuity level**

Challenge #2: Financial Alignment

Considerations

- Transparency of target benchmarks
- Timely information / data analytics
- Risk mitigation strategies
- Cost savings / efficiencies

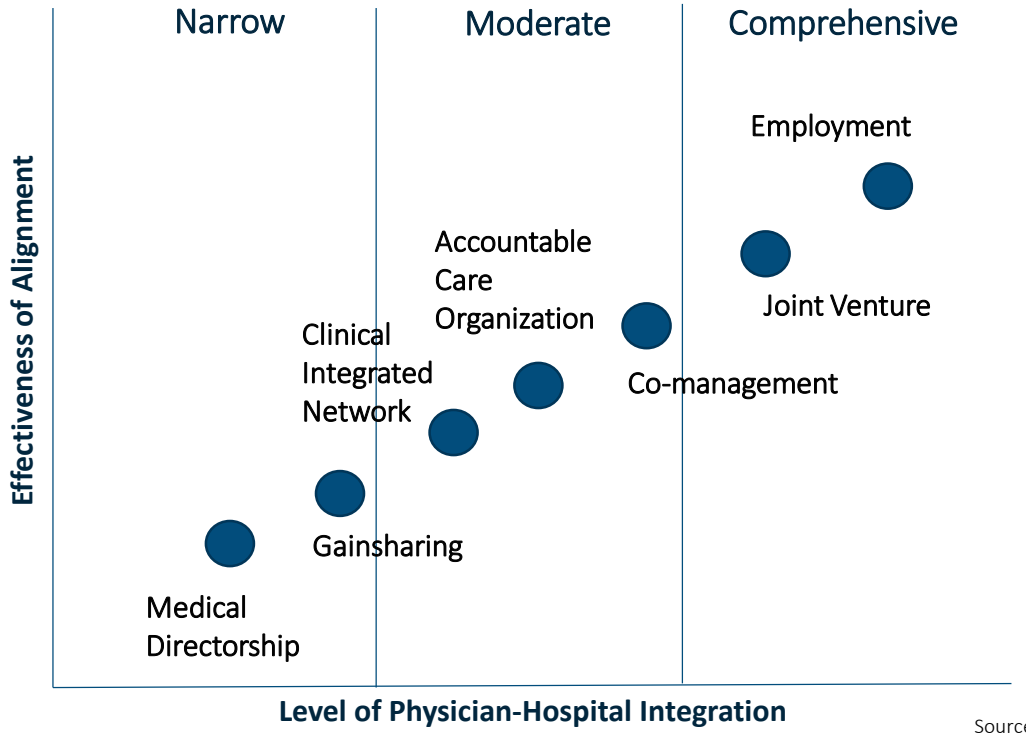
- How can Payers and Providers address the risks in the new financial arrangements?
- How can providers, particularly hospitals, manage as more and more of their revenue is tied to total cost of care risk sharing arrangements?



Challenge #3: Physician Alignment

Physician alignment is critical to enable a successful transition to value-based care

- Identify optimal strategies to align physicians and other providers
- Design compensation models that incent physicians to support health system goals
- Narrow alignment offerings to models that most effectively represent physician interest
- Focus on a limited number of arrangement options in order to most efficiently and effectively evolve in a mutually beneficial way within all relevant rules and regulations.



Source: Vizient

Challenge #3: Physician Alignment – Collaboration

Collaboration Areas

- Physician services outsourcing
- Contracting
- Risk sharing with physician practice
- Telemedicine
- Value-based arrangements between payers and providers will impact physician alignment choices:
  - ACO
  - Pay for performance

- What are some leading indicators for potential success associated with degree of clinical integration?
  - Effective Physician Governance
  - Well defined Care Model

Challenge #4: Quality Programs - Challenges For Providers

Metrics Overload

- Many risk arrangements with hundreds of quality metrics
- Same quality metrics applied to different populations for different payers
- Same quality metrics with different definitions
- Standard & non-standard metrics between CMS and commercial payers
- Different data sources needed to collect the quality metrics
- Different timelines between reporting and financial impact

Unclear Financial Impact

- CMS Inpatient program FFS adjustment:
  - Hospital acquired conditions
  - Readmission reduction
- Commercial programs' bonus structures:
  - Metrics thresholds
  - Percentage schedules

Connecting Clinical and Financial Metrics

- Financial value for quality metrics need to be tracked and fully understood
- Quality metrics should be more standard
- Quality metrics should link to outcome and performance
- Quality metrics in risk arrangements should support clinical decisions and population health management

Challenge #4: Quality Programs – Collaboration

Collaboration Strategy
1. Identify quality metrics that are standardized 2. Collaborate with providers to identify metrics that are indicators for performance 3. Building a clear scoring methodology to link quality metrics and financial incentives 4. Create a transparent reporting system 5. Evidence-based approach 6. Physician incentives

- How to establish a standardized set of quality metrics that can truly measure performance?
- How to collaborate with payers to negotiate mutually agreeable quality metrics?
- How to motivate physicians to improve the performance under quality incentive programs?
- How to build a systematic risk quality approach to link risk revenue and clinical goals together?

Challenge #5: Risk Coding

- HCC coding impacts value-based arrangements in several ways
  - Medicare FFS VBP, Hospital Acquired Condition (HAC) and Hospital Readmission Reduction programs
  - Bundled payments
  - Capitated arrangements
  - Total Cost of Care targets in risk sharing arrangements
  - Adjustments to quality metrics targets

Challenge #5: Risk Coding

Collaboration Areas

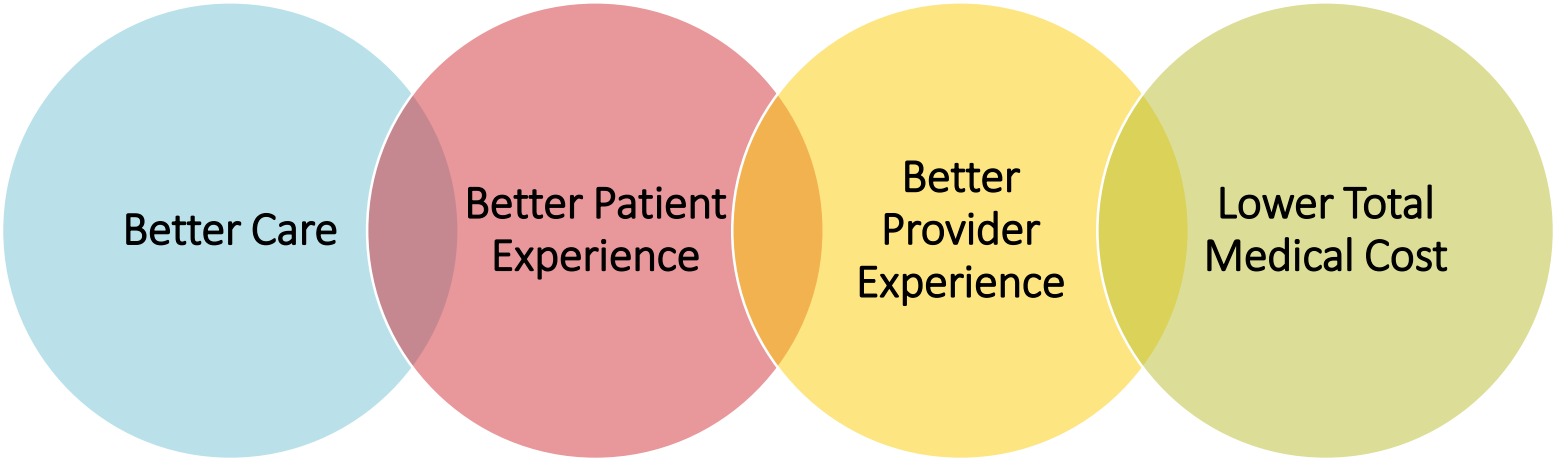
- Gap analysis
- Measure the impact across all arrangements to prioritize efforts and investment
- Investments
  - Physician education
  - Financial alignment
  - Process flows
  - Information and technology

- What are some ways that provider burden can be alleviated?
- How are providers able to share information across sites of service?

Case Study : Arizona Care Network

SOCIETY OF ACTUARIES®

Quadruple Aim as Basis of Cultural Alignment

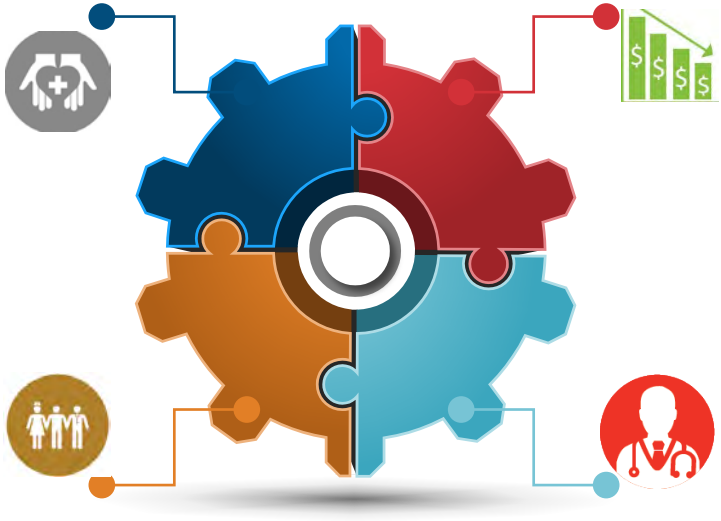


Aligning Clinical & Business Goals

Exceeding the needs of our customers

High-Reliability Clinical Care Delivery

Market-leading
Clinical Outcomes
Preferred network for
patients and payers



Value Creation

Cost of Care < Price of Care
Radical delivery cost reductions
Optimal, affordable healthcare
delivery

Growth

Value-based Patient Populations
Aligned Payer Relationships
Loyalty-Enhancing Patient
Technology Platform

Market-leading delivery network

Largest, high-performing Primary Care
Network in Arizona
High-volume, network-and hospital-
aligned Physician Referral Network

Building Trust & Demonstrating Commitment

- Data & Performance Transparency
- Clinical Care Model Alignment
- Network Model Alignment
- Division of Responsibilities
- Operational Alignment
- Governance
- Defining Value Together
- Financial Model Alignment

Creating a Win-Win for all Stakeholders

- Achieving the Quadruple Aim
- Capturing greater market share from competitors
- Growing a new market in marketplace through the launch of new products
- Diversifying and growing revenue stream through new programs, services, or products

Q&A

Maureen Tresnak
Maureen.Tresnak@Terrygroup.com

Fan Zhang
Fan.Zhang@Terrygroup.com

SOCIETY OF ACTUARIES®


SOCIETY OF
ACTUARIES®