Session 44, Transitioning a Health System from Separate Physician and Hospital Reimbursement to Global Payment

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2019 SOA Spring Health Meeting

Session 44: Transitioning a Health System from Separate Physician and Hospital Reimbursement to Global Payment

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Session Overview

- Three speakers today
  - Elaine Corrough, FSA, FCA, MAAA, Partner, AHP Portland
  - Stephanie Entzminger, FSA, MAAA, Consulting Actuary, AHP Temecula
  - David Axene, FSA, FCA, CERA, MAAA, Partner, AHP Temecula
- We will be using polling devices today in this session to get a real-time response to several questions.
- This is based upon a real client study that is ongoing, names of actual participating organizations have not been included
  - one academic medical center
  - two separate community acute care health systems
  - related IPAs and medical groups
  - Medicare Advantage focus

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Elaine Corrough is a partner at Axene Health Partners, LLC and is based out of the Portland, Oregon office. She has over 25 years of health actuarial experience. Her recent work has focused on the transfer and management of risk between health insurers and health systems/provider organizations for Medicaid and Medicare managed care populations. She particularly enjoys assignments requiring assimilation and documentation of new regulations, technologies, and data sources into existing actuarial processes and methods.

Prior to joining AHP, Elaine consulted on all aspects of health and welfare benefits for plan sponsors ranging from small public entities to Fortune 100 companies. In addition to traditional consulting activities such as pricing and claims analysis, her expertise includes actuarial analysis of legislative and regulatory developments; ROI assessments; health risk migration and mapping; and complex model design and development. In addition, she is a past Staff Fellow in health for the Society of Actuaries.

Elaine has presented at multiple industry conferences on a variety of health and actuarial topics. She is a Fellow of the Society of Actuaries, a Fellow of the Conference of Consulting Actuaries, and a Member of the American Academy of Actuaries.

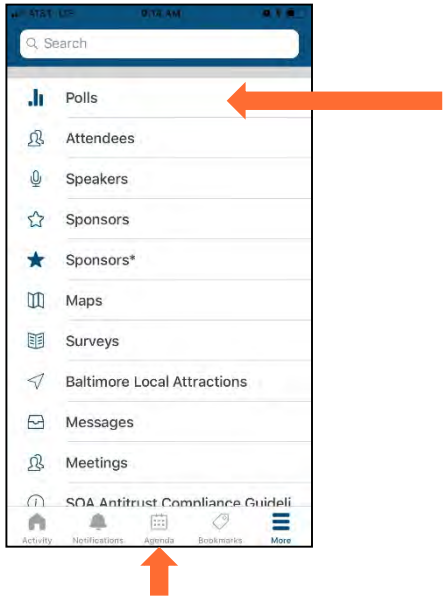
Elaine earned a Bachelor of Arts in Classics (with an emphasis on languages) from Washington University in St. Louis. She resides with her husband in the Portland area.

Context for Today's Presentation

- Three separate health systems are based in California and therefore, their desire to join together to take global risk is regulated under the Knox-Keene Act
- However, the issues they face are similar to those faced by systems nationwide looking to:
  - Get closer to the premium dollar by accepting global risk from health plans
  - Design financial incentives (e.g., value-based reimbursement models) to share funds across hospital and IPA providers
  - Defend against the incursion into the market of integrated systems (e.g., Kaiser)
- Next: polling questions to gauge your areas of interest

To Participate, look for Polls in the SOA Event App or visit **health.cnf.io** in your browser

Find The Polls Feature Under **More** In The Event App or Under This Session in the Agenda



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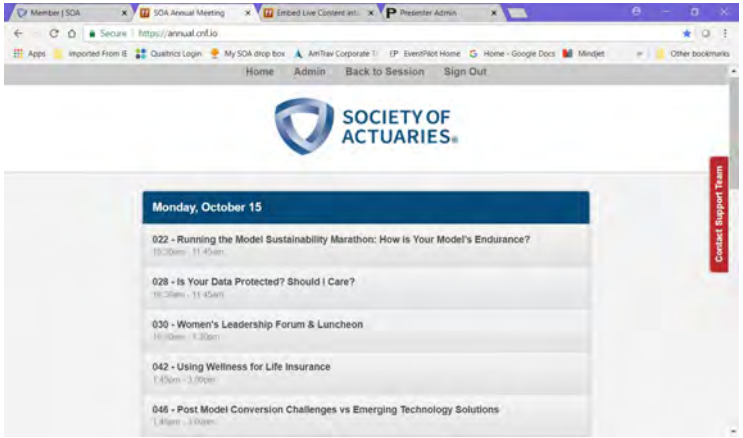

Polling Question: Do you work with providers, systems, or health plans in California?

- Yes, I work with providers, systems, or health plans in California
- No, I do not work with providers, systems, or health plans in California

Live Content Slide

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Poll: Do you work with providers, systems, or health plans in California?

Polling Question: Do you work with providers and systems to accept global risk?

- Yes, I work with providers and systems to accept global risk
- No, I do not work with providers and systems to accept global risk

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Poll: Do you work with providers and systems to accept global risk?

Polling Question: Does your work involve value-based reimbursement?

- Yes, my work involves value-based reimbursement
- No, my work does not involve value-based reimbursement

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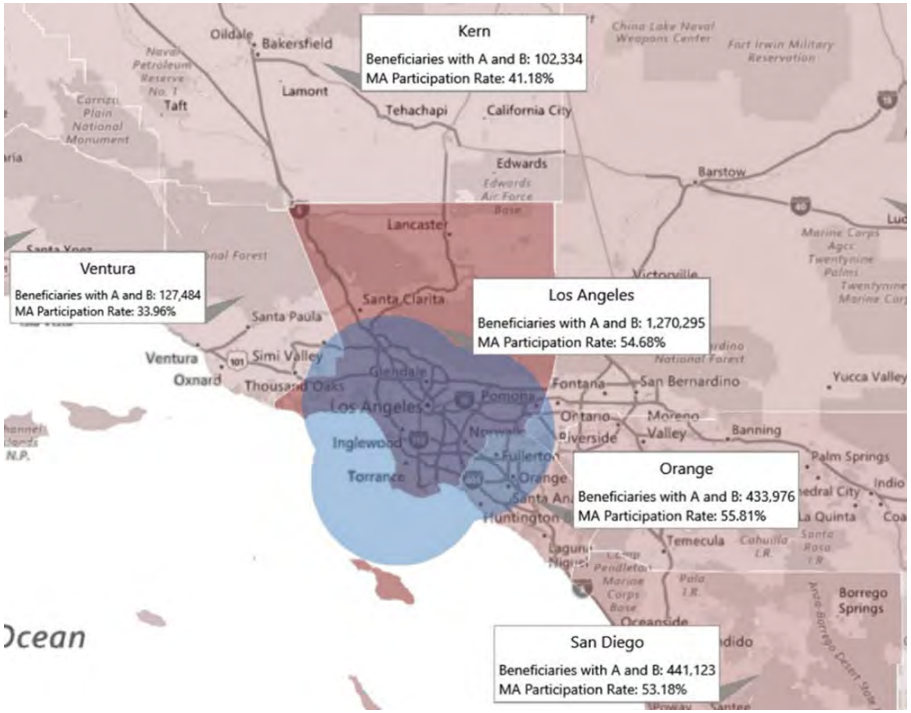
Poll: Does your work involve value-based reimbursement?

What is Limited Knox-Keene?

- Knox-Keene Health Care Service Plan Act of 1975 – set of laws/statutes passed by the CA state legislature to regulate health care service plans, including HMOs, operating in California
  - Reference: California Health & Safety Code, Section 1340 et seq.
  - Administered by the Department of Managed Healthcare (DMHC)
  - Implemented, interpreted, and made specific through DMHC regulations (California Code of Regulations, Title 28)
- "Restricted" or "Limited" Knox-Keene (LKK) licensing – entity contracts with providers, but does not create its own insurance products and doesn't market the plans
  - Enables LKK entity to share funds across hospital and physician providers
  - Enables LKK entity to take on delegated administrative and care management activities from the health plan
  - May be more attractive to a health plan due to global risk acceptance
- **Significant effort, time, and investment is required to apply for LKK license**

Case Study: The Players

- System 1: A high-visibility academic medical center and IPA and other affiliated medical group
- System 2: A large community-based hospital system with IPA
- System 3: A smaller community system with IPA
  - Owns the LKK license



Case Study: Current Situation

- MA Plan Offerings: All three systems have existing contracts with a variety of MA plans
- All three systems have a range of contracting formats in place – varies by health plan and system
- Each system has their own Management Services Organization (MSO) and all have fairly sophisticated contracting and data analytics capabilities
- The three systems are exploring the opportunity to pursue global risk as an integrated network using System 3's LKK license

The Ideal LKK Entity

- Characteristics of the ideal LKK entity:
  - Active participation amongst all organizations in the LKK entity
  - Single contracting entity with each health plan
  - Contracts established with non-partner providers to round out the network (e.g., ancillary providers)
  - Single MSO handling delegated administration including care management efforts
  - Single funds flow model across entity (individual internal IPA models okay)
  - Clear path and strategy for funding requirements (e.g., TNE)
  - Consolidated financial and provider reporting
  - Common base capitation rate across the LKK entity – adjusted for RAF for each IPA's assigned population
  - Shared risk on items too risky for individual health systems

The Ideal LKK Entity: Reality

- Characteristics of the ideal LKK entity:
  - Active participation amongst all organizations in the LKK entity
  - Single contracting entity with each health plan
  - Contracts established with non-partner providers to round out the network (e.g., ancillary providers)
  - Single MSO handling delegated administration including care management efforts
  - Single funds flow model across entity (individual internal IPA models okay)
  - Clear path and strategy for funding requirements (e.g., TNE)
  - Consolidated financial and provider reporting
  - Common base capitation rate across the LKK entity – adjusted for RAF for each IPA's assigned population
  - Shared risk on items too risky for individual health systems

System 3 seemed disengaged

But the three systems want to keep their own MSOs

Systems want to reflect "contracting success" – want everyone to win

Systems want to maintain care within each system

Strategic Objective: Financial Value

- Discussions center around whether an LKK-based entity will generate improved **financial value** (increase in net revenue)
  - How much additional revenue do we expect to generate? *and/or* What efficiencies do we expect to gain?
  - What responsibilities and risks do we take on by pursuing each initiative?
  - Is the effort required reasonable, given the expected results?
  - Does using the LKK improve our chances of capitalizing on the opportunity, versus going it alone?

How Financial Value is Created

- Increase Revenue
  - Market expansion/growth in existing markets
  - DOFR additions
  - More delegated activities
  - Increased risk scores
- Increase Efficiency
  - Administrative efficiencies
  - Care management effectiveness
  - Optimizing site of service

Polling Question: In general, where is the most value in an LKK-type entity generated?

- Market expansion/growth in existing markets
- DOFR additions
- More delegated activities
- Increased risk scores
- Administrative efficiencies
- Care management effectiveness
- Optimizing site of service

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Poll: In general, where is the most value in an LKK-type entity generated?

Next: Analyses to assess the opportunity

- Increase Revenue
  - Market expansion/growth in existing markets
  - **DOFR additions**
  - **More delegated activities**
  - Increased risk scores
- Increase Efficiency
  - Administrative efficiencies
  - **Care management effectiveness**
  - Optimizing site of service

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Stephanie Entzminger is a consulting actuary in the Temecula office of Axene Health Partners. She joined the firm in 2018 and serves clients with her expertise in Long-Term Care. She also provides a wide variety of actuarial services. Examples of these include:

- IBNR estimation
- Provider contracting, both on behalf of health plans and providers
- Health care analytics
- Strategic planning
- Assessment of Value determinations
- Dispute resolution

Stephanie previously worked in an insurance setting for Continental LTC, Inc. as a pricing actuary for their Long-Term Care business. She has also worked in a consultant setting for Towers Watson in their defined benefit pension group. She has Long-Term Care experience in the following areas:

- Preparing state insurance department rate filings for policies issued under pre- and/or post-rate stability regulations
- Conducting form analysis on individual and group blocks
- Compliance with statutorily-required filings, including annual rate certifications
- Experience analysis for assumption setting
- Modeling premium and claims projections

Stephanie earned a Bachelor of Science in applied mathematics from Loyola Marymount University in Los Angeles, as well as a Master of Arts in mathematics with a concentration in actuarial science from the University of Texas in Austin. She is a Fellow of the Society of Actuaries as well as a Member of the American Academy of Actuaries.

Stephanie lives in the San Diego area with her husband and their dog. They enjoy camping and hiking all around Southern California.

Section II: Analysis

- Three sets of analysis were performed
  - Inpatient length of stay
  - Financial responsibility for medical services
  - Financial responsibility for administrative activities
- All three health systems were compared across all metrics
- Goals included:
  - Ensuring no partner would “drag down” the others
  - Identifying opportunities for cost savings/revenue enhancement
  - Quantifying potential direct and indirect financial gain

Inpatient Length of Stay: Background

- Goal is to compare observed inpatient length of stay (actual LOS) to proprietary AHP length of stay benchmarks (ideal LOS)
  - The difference between actual LOS and ideal LOS is defined as "potentially avoidable days" of inpatient care
  - Hospitals with fewer potentially avoidable days are more efficient

AP-DRG	Description	Actual LOS	Ideal LOS	Potentially Avoidable Days / Claim
197	Peripheral & Other Vascular Disorders	6.25	4.51	1.74
198	Angina Pectoris & Coronary Atherosclerosis	1.50	1.87	0.00
199	Hypertension	3.25	2.48	0.77

- For each system, we analyzed LOS for CY18 MA and Medicare FFS
- One system had data by APR-DRG, others used MS-DRG

Polling Question

What length of stay improvements would you expect from a Medicare Advantage population moving to a more effective care management program? (assume current average LOS is 4.5 days)

A. < 0.5 days/case

B. 0.5 days/case

C. 1.0 days/case

D. >1.0 days/case

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Poll: What length of stay improvements would you expect from a Medicare Advantage population moving to a more effective care management program? (assume current average LOS is 4.5 days)

Inpatient Length of Stay: Results

Hospital A					
Line of Business	Admits	ALOS	ILOS	PAD/C	% of Actual
Medicare Advantage	6,605	3.66	3.62	0.50	13.8%
Other Medicare	5,994	5.07	3.98	1.26	25.0%
Total Medicare	12,599	4.33	3.79	0.87	20.0%

Hospital B					
Line of Business	Admits	ALOS	ILOS	PAD/C	% of Actual
Medicare Advantage	5,031	3.93	4.04	0.48	12.3%
Other Medicare	4,092	4.75	4.22	0.84	17.7%
Total Medicare	9,123	4.30	4.12	0.64	15.0%

Hospital C					
Line of Business	Admits	ALOS	ILOS	PAD/C	% of Actual
Medicare Advantage	1,113	4.94	4.61	1.04	21.0%
Other Medicare	21,491	5.24	4.66	1.05	20.0%
Total Medicare	22,604	5.23	4.65	1.05	20.0%

All Hospitals					
Line of Business	Admits	ALOS	ILOS	PAD/C	% of Actual
Medicare Advantage	12,749	3.88	3.87	0.54	14.0%
Other Medicare	31,577	5.14	4.47	1.06	20.6%
Total Medicare	44,326	4.78	4.30	0.91	19.1%

- Hospital C appeared to have much higher potentially avoidable days for Medicare Advantage compared to the other two systems
- Hospital C also had the lowest membership and the least credible data

Medical Service Financial Responsibility: Background

- Goal is to assess current contracts' Division of Financial Responsibility (DOFR) to identify areas where the Limited Knox-Keene entity could take on more risk
- For each system, we evaluated current contracts on a service-by-service basis to determine which entity was responsible for each category in the DOFR:
  - IPA
  - Hospital/Shared Risk Pool
  - Health Plan
  - Combination (e.g. out-of-area emergency = 80% health plan/20% hospital)

Medical Service Financial Responsibility: Results

			Contract													
Category	Subcategory	Cost Range	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Ambulance (out of area)		0.00% - 0.13%														
Audiology screening		0.00% - 0.00%														
Chemical dependence (detox/rehabilitation)	Facility	0.01% - 0.32%														
	Professional	0.00% - 0.00%														
Chemotherapy	Medications	0.11% - 3.60%														
	Outpatient facility	0.02% - 0.52%							-				-			-
	Outpatient professional	0.00% - 0.26%														
Diabetic management supplies		0.00% - 0.10%											-	-		
Dialysis	Facility	0.00% - 1.99%														
	Professional	0.01% - 0.18%				-	-	-								
DME		0.04% - 1.47%														
Emergency (out of area)		0.38% - 0.85%														
Hearing aids		0.00% - 0.01%														
Home health care	Agency visit	0.05% - 0.32%														
Immunizations		0.11% - 0.65%														
Mental health	Facility	0.11% - 0.47%														
	Professional	0.01% - 0.18%														
Nuclear medicine (outpatient)	Facility	0.03% - 0.49%														
	Professional	0.01% - 0.08%														
Radiation therapy (outpatient)	Facility	0.04% - 1.67%								-	-					
	Professional	0.01% - 0.24%								-						
Rehabilitation (occupational/ speech/physical)	Outpatient facility	0.04% - 1.18%														
	Outpatient professional	0.02% - 0.13%														
Skilled nursing facility	Facility	0.00% - 2.42%											-			
	Professional	0.19% - 0.75%	-	-	-								-			
Transplants	Facility	0.00% - 0.15%														
	Professional	0.00% - 0.16%														
Urgent care (outpatient in area)	Facility	0.00% - 0.00%										-				-
	Professional	0.00% - 0.00%										-				-
Contacts/frames	Related to cataract	0.00% - 0.00%														
	Not related to cataract	0.00% - 0.01%														

	IPA	1.9%	2.3%	4.2%	2.0%	5.1%	2.9%	3.7%	3.2%	2.7%	3.9%	3.2%	3.8%	2.9%	3.7%
	Hospital	3.7%	4.9%	3.0%	0.0%	0.0%	4.6%	3.7%	3.2%	0.0%	3.7%	2.9%	3.7%	0.6%	4.1%
	Shared Risk	0.0%	0.0%	0.0%	5.6%	2.5%	0.0%	0.7%	0.0%	3.8%	0.0%	0.0%	0.0%	4.0%	0.0%
	Health Plan	2.4%	0.7%	0.7%	0.7%	0.7%	0.7%	0.0%	1.0%	1.0%	0.7%	0.4%	0.8%	0.8%	0.3%
-	N/A	0.4%	0.4%	0.4%	0.1%	0.1%	0.1%	0.2%	1.0%	0.9%	0.0%	1.9%	0.0%	0.0%	0.2%

Administrative Activities Financial Responsibility: Background

- Goal is to assess current contracts' delegated administrative responsibilities to identify areas where the Limited Knox-Keene entity could take on more risk
- Analysis includes two-pronged review approach
  - Contract review (some contracts have a "delegated activities matrix" similar to a DOFR)
  - Phone calls with representatives from each system's internal MSO to discuss their operations

Administrative Activities Financial Responsibility: Results

Category	Cost (as a percent of premium)	Contract													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14
Claims processing and payment	1.00%														
Credentialing and recredentialing	1.00%														
Financial Accounting	0.80%														
Medical record review	0.30%														
Member appeals	0.40%														
Reporting	0.20%														
Utilization management	3.00%														
Complex case management	0.30%														

	Delegated service	6.7%	7.0%	6.9%	6.7%	7.0%	6.6%	6.6%	6.9%	7.0%	6.9%	6.6%	6.6%	7.0%	6.9%
	Retained service	0.4%	0.0%	0.2%	0.4%	0.0%	0.2%	0.5%	0.2%	0.0%	0.2%	0.5%	0.2%	0.0%	0.2%
-	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%

- Note that each MSO is already doing everything they can
- Opportunity to take on additional responsibility is minimal

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David Axene founded Axene Health Partners, LLC in 2003 with a unique vision to integrate actuarial science and the practice of medicine to improve the health care industry. He is an internationally recognized health consultant providing consulting to all types of health care organizations including:

- Health plans: HMOs, PPOs, managed care plans, BlueCross Blue Shield plans, insurance companies, etc.
- Healthcare providers: hospitals, medical groups, ancillary providers, etc.
- Various governments and government programs: federal, state and local, international, Medicare, Medicaid, CHAMPUS, social systems.
- Employer health benefit plan sponsors
- Healthcare innovation and technology companies
- Medical device and technology suppliers, etc.
- Dispute resolution services: expert testimony, arbitrator, mediator, etc.

David is recognized as a strategist and industry thought leader. He is a frequent speaker and writer on healthcare issues. He previously served as Chair of the Society of Actuaries Health Section Council and the Entrepreneurial Actuaries Section. He is a certified ARIAS-US arbitrator.

Prior to establishing AHP, David enjoyed a successful consulting career at Ernst & Young, LLP and Milliman & Robertson, Inc. While at Ernst & Young, he was responsible for the firm's health actuaries. He was an Equity Principal with Milliman & Robertson, Inc. (i.e., now Milliman USA) where he led their healthcare management consulting activities, including founding their Care Guidelines division.

His professional designations include: Fellow of the Society of Actuaries, Chartered Enterprise Risk Analyst, Fellow of the Conference of Consulting Actuaries, and Member of the American Academy of Actuaries.

In addition to his actuarial credentials, David earned a Master of Science in applied mathematics from the University of Washington, and a Bachelor of Science in physics and engineering from Seattle Pacific University.

David has served on multiple non-for-profit Boards including Azusa Pacific University, Town & Country Manor, The Awakening Church, the Benefits Board and the South Pacific District of the Christian & Missionary Alliance.

David is married and has three married children and 11 grandchildren. He and his wife reside in Southern California.

Polling Question

What is the most important reason why a health system would want to create a risk bearing organization to assume global risk for Medicare Advantage?

A. Increased gross revenue

B. Greater control of health care system

C. More attractive to health plans

D. Other

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Poll: What is the most important reason why a health system would want to create a risk bearing organization to assume global risk for Medicare Advantage?

So Why Would Health Systems and Related IPAs Want to Move to Global Payment?

- Increased revenues from health plans
- Moving up the food chain (getting closer to the premium)
- Increasing attractiveness to the health plans (assuming more risk)
- Indirect revenue increases from increased efficiency and reduction of potentially avoidable care (i.e., improved care management)
- Increased administrative cost pass-through

- In this project the client's primary focus was the potential for increased revenues and administrative cost pass-through
- Limited interest in considering increased efficiency and improved care management

Polling Question

How much total revenue increase is likely when moving from separate capitation rates for health system and IPA to a global capitation rate?

A. Less than 2%

B. 2% - 5%

C. 5% - 10%

D. More than 10%

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Poll: How much total revenue increase is likely when moving from separate capitation rates for health system and IPA to a global capitation rate?

Extent of Projected Revenue Increases

- Unlikely to get more than a 1% - 2% increase in % of plan revenue
- Very limited administrative pass-through (actually a net loss, more responsibility without funding from health plan)

Polling Question

Based upon a potential of at least a 0.5 days reduction in average LOS, how much overall health cost savings would you expect with a Medicare Advantage population?

A. < 5%

B. 5% - 10%

C. 10% - 15%

D. >15%

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: Based upon a potential of at least a 0.5 days reduction in average LOS, how much overall health cost savings would you expect with a Medicare Advantage population?

Projected Impact from Improved Care Management Practices

- Completed actuarial analysis of historical inpatient experience
  - FFS Medicare: 1.1 potentially avoidable days producing >19% savings
  - Medicare Advantage: >0.5 potentially avoidable days producing > 14% savings

Causes of Avoidable and Potentially Avoidable Days

Category	Description
1	AD-Understaffed for patient census
2	AD-Lack of weekend or night time services
3	AD- Delays in carrying out orders
4	AD-Physician decision making
5	AD-Patient does not meet admission criteria and could be treated in an alternative setting such as observation, or home if pt has a medically safe home
6	AD-Delay in writing orders for appropriate recovery stage of the illness in the hospital
7	AD-Patient not discharged to next level of care when clinically stable and a medically safe level of care is available
8	AD-No adequate Respiratory therapy
9	AD-No Home Health availability
10	PAD-Lack of adequate payer contracted vendor i.e. pharmacy, home care, SNF, Hospice
11	PAD-No medically safe home or alternative setting to discharge to.
12	PAD-CPS issues. No alternative setting to discharge to until CPS issues resolved
13	PAD-No medically safe home
14	PAD-No alternative or step-down care
15	PAD-Social – Family not comfortable with discharge plan, transportation issues, etc.
16	PAD-Teaching – delay in patient/family education (may be due to family availability or ability to learn or staff delay)

Projected Impact from Improved Care Management Practices

continued

- Combining inpatient savings with anticipated savings in other areas, projected realistic reduction in overall health costs is in the range of 10% - 13%.
- This becomes the largest opportunity for performance improvement, yet the sponsors show limited interest in this.
- This improvement is a net revenue enhancement, not a gross revenue enhancement. The sponsors are focused on gross revenue improvements.

Selection of Partner Issues

- Multiple partners are required to provide reasonable geographic coverage in a market
  - Single hospitals aren't adequate
- How many are needed?
  - Resource planning issue
  - Modeling by type of provider
    - Basic or community providers (i.e., the simpler things: OB, General Surgery, Orthopedics, etc.)
    - Medium or specialty providers (i.e., the harder things: cardiovascular, nervous system, cholecystectomy, etc.)
    - Tertiary/Quatenary providers (i.e., the most difficult things: complex cardiovascular, transplants, complex cancer/oncology, etc.)

Polling Question

What is the most important consideration for choosing a health system partner when pursuing Global Risk?

A. Similar mindset towards care management
B. Willingness to adopt similar reimbursement and incentive model
C. Similar referral patterns (especially for tertiary care)
D. Strong existing local provider relations (IPA, medical group)
E. Established administrative practices
F. Prior experience taking health care risk
G. Limited overlap of service area

Live Content Slide

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Poll: What is the most important consideration for choosing a health system partner when pursuing Global Risk?

Selection of Partner Issues *continued*

- Who makes a good partner?
  - Similar mindset for managing care
  - Willingness to adopt similar risk model (i.e., VBR)
  - Similar referral patterns (i.e., especially for tertiary care)
  - Strong existing local provider relations (i.e., IPA/Medical Group)
  - Established administrative practices
  - Strong analytics capabilities
  - Prior experience taking health care risk
  - Limited overlap of service area
  - Demonstrated commitment to “the plan”
  - Similar contracting history (i.e., similar health plans)

Q&A