Session 109PD, Medical Cost Reduction Opportunities and Care Model Design

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2018 SOA Health Meeting

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Session 109, Care Model Redesign

June 27, 2018

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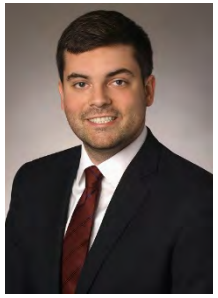
Panel Introductions

Chris Schmidt – Minneapolis, MN

Mr. Christopher A. Schmidt has over 16 years of consulting experience. Mr. Schmidt's focus has been in the area of health actuarial and data analytic services. He has worked with Federal, State and local government agencies, large national and regional health plans, and providers. He has expertise in a variety of areas including issues such as Value Based Care analysis, Value Based Care program design and implementation, payer/provider reimbursement analysis and contracting strategy, Medicaid capitation rate setting, and Medicare pricing and bid development.

Jeff Burke – New York, NY



Jeff Burke is a Manager in Deloitte Consulting's Health Actuarial practice. His current focus is in value-based care (VBC). He is involved in helping health plans and providers identify clinical areas with opportunity to improve efficiency and financial outcomes. He also works in economic modeling and contracting. Previously, Jeff focused in ICD-10 readiness specializing in its impact on reimbursements and risk scores.

Mike Van Den Eynde – Atlanta, Georgia

Mike is a Managing Director with twenty plus years of strategy, operations and care management redesign experience. Mike is the lead of our care management service line that helps our clients find innovative ways to better manage their medical cost trend and improve the quality of care. Mike recently led a care management vendor selection effort, design of a new health advocacy model, a medical management organization restructuring, the redesign of the medical management strategy for a national health plan and has led many medical management assessments.

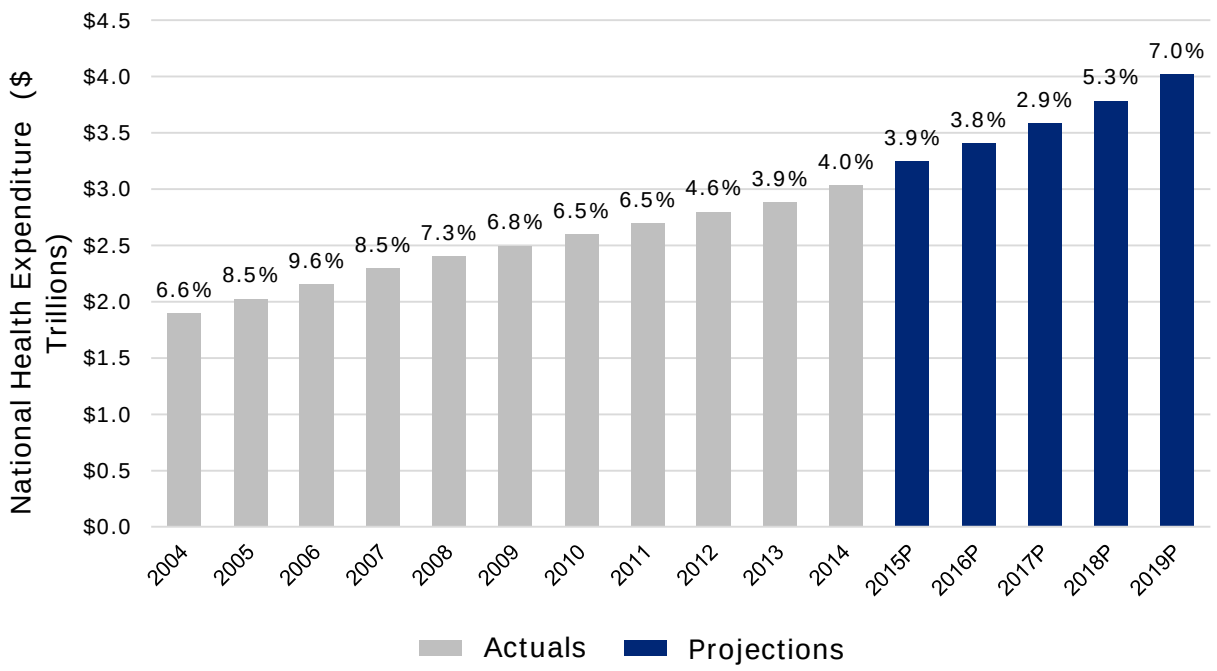
The Case for Care Model Redesign

Why is Affordability Important to Health Plans?

Escalating costs and decreasing affordability continue to pose the primary challenge in U.S. healthcare as cost pressures are increasing for all who pay for healthcare: health plans, governments, employers, and consumers

National Health Expenditures and Annual Growth Rates[1]

Actuals 2005-2014, Projections 2015-2019



Source: [1]Centers for Medicare and Medicaid Services (CMS) "NHE Tables" and "Historical and Projections 1960-2024"; [2] SNL Financial Benchmarking Data; [3] "The Facts on Medicare Spending and Financing," Kaiser Family Foundation; [4] "Medicaid's Share of State Budgets," MACPAC; [5] Kaiser/HRET Survey of Employer Sponsored Health Benefits

Impact on Health Care Payers

Health Plans

From 2010 to 2015, the average health plan medical loss ratio increased from 86% to 90%[2]

Government

The Medicare Hospital Insurance trust fund is projected to be depleted in 2029[3]

From 2010 to 2015, Medicaid's share of funded state budgets increased from 12% to 16%[4]

Employers

From 2010 to 2015, average employer contributions to employee premiums increased by 28% from $9,733 to 12,591[5]

Consumers

From 2010 to 2015, average employee contributions to premiums increased by 24% from $3,997 to $4,955[5]

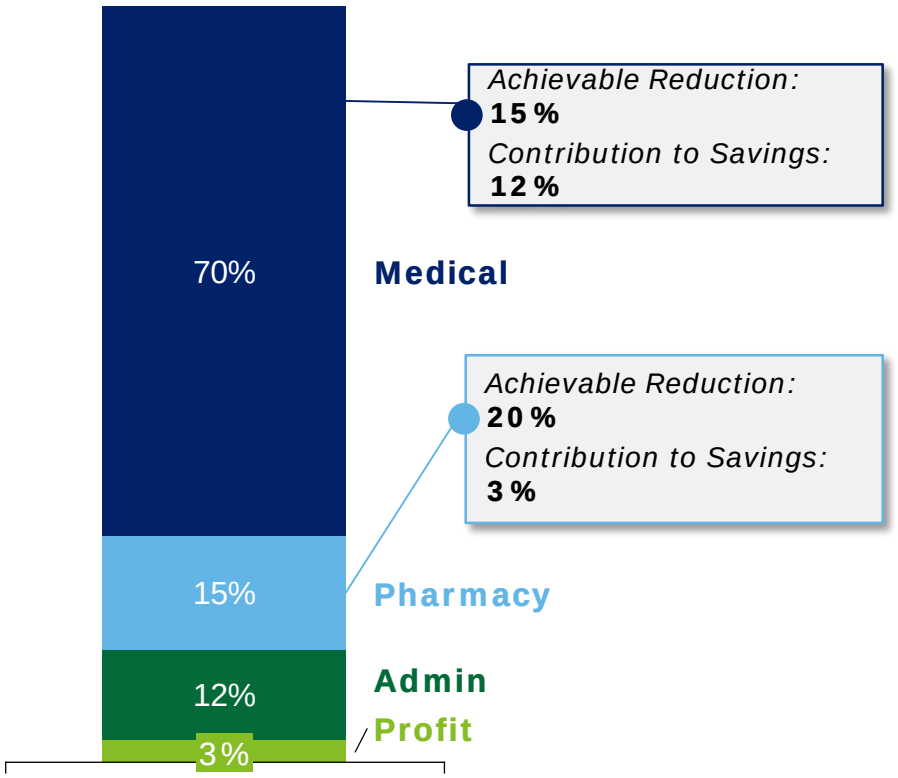
If industry actions do not meaningfully restructure the healthcare system to tame costs, there is a growing risk to the future of the viability of the standalone health plan business due to potential disruptive government policies that could lead to the disintermediation of the health plan value proposition and a shift to a less profitable book of business

Approaches to Improving Affordability

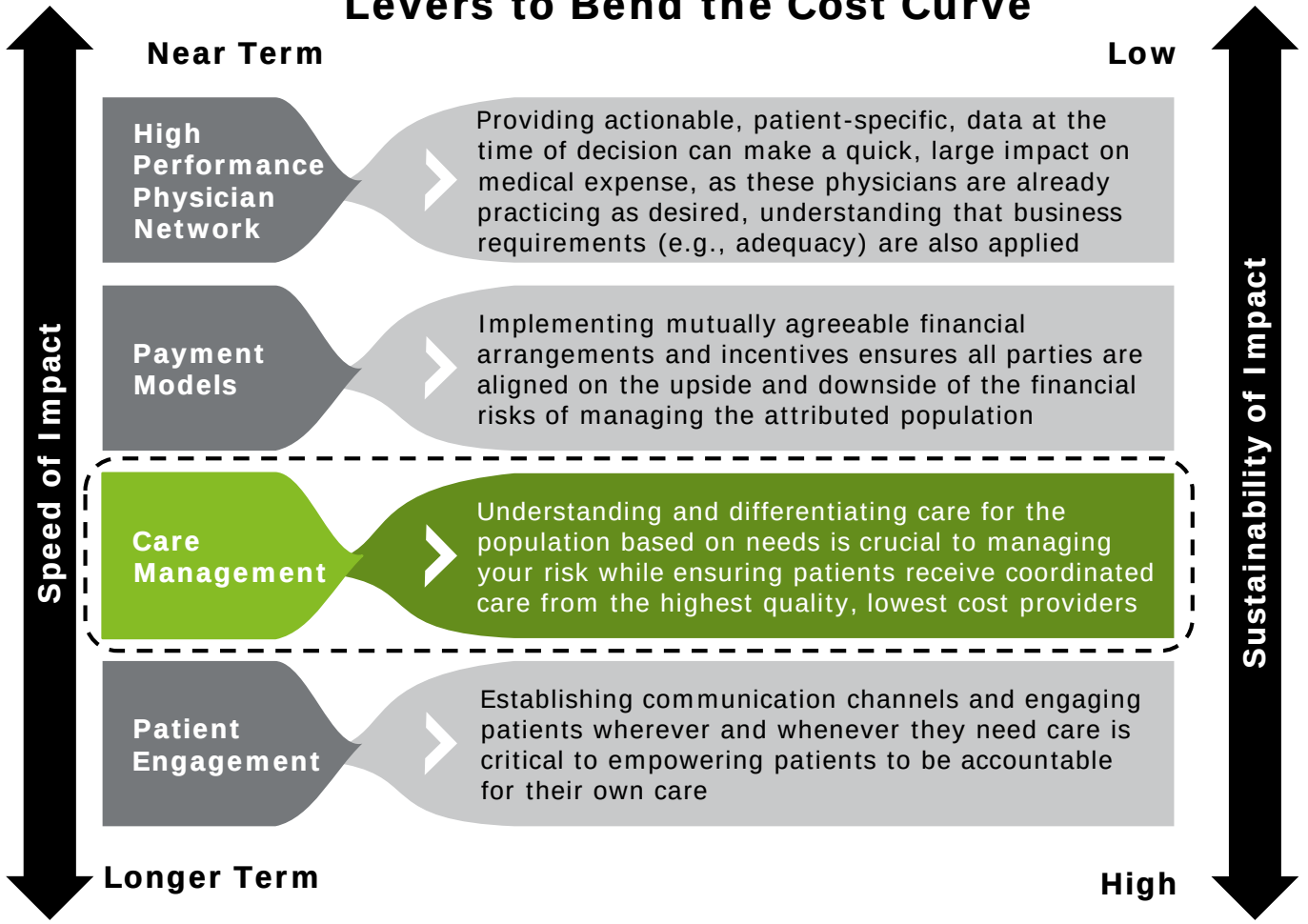
It's critical that Affordability focus on medical and pharmacy expense solutions across four main levers to bend the cost curve—Care Management will be today's focus

Where to Look for Cost Reduction

% Breakdown of Total Premium



Levers to Bend the Cost Curve



Case for Care Model Redesign

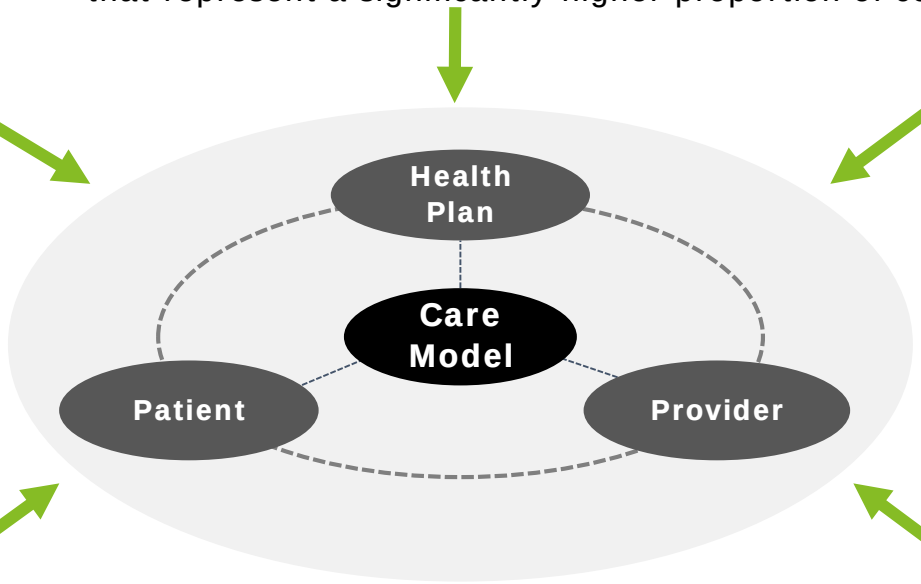
While health plans have practiced care management for many years, they are revisiting their approach due to external pressures and opportunities

Unsustainable Costs

Payers are continuing to push for reduction in medical costs through effective health management of whole populations; especially for senior chronic populations that represent a significantly higher proportion of costs

Digital & Analytics Advancement

Rapid advancement of analytics, digital and advanced interoperable technologies creates a significant opportunity for enhancing identification of care needs and the related care planning/coordination



Existing Gaps in Foundational Capabilities

Most providers and health plans still have gaps in foundational care management capabilities that need to be addressed; can provide opportunities to leverage strengths of providers and health plans

Consumerism

Patients demand care that is transparent with “no surprises”, cost-effective and creates a trusted patient-provider relationship

VBC Transition

Increasing percentage of risk business for is forcing provides and health plan partners to design care models that focus on quality and cost effectiveness

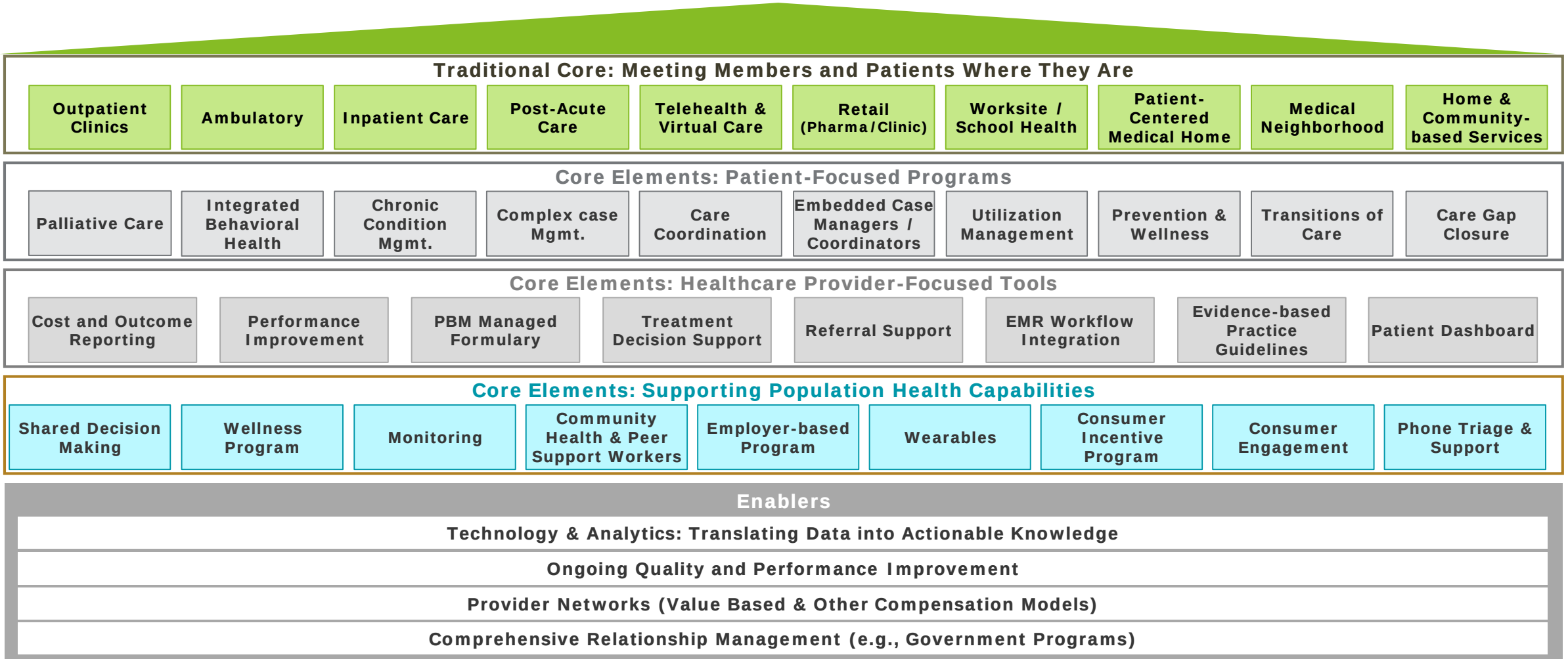
Increasing Regulatory Pressures

Expanding membership in the individual insurance market creates significant pressures on demand for Care Management; in addition, new government regulations (e.g., MACRA) increase the focus on quality and outcomes

Comprehensive Suite of Care Management Capabilities

An innovative population health model manages defined populations across the continuum of care and requires each element to be integrated and performing effectively for the initiative to be successful

Provider-Led Population Health & Care Management Model



Continuum of Provider Model Options

Providers are at different stages in terms of readiness for advanced care management and therefore will be seeking care management initiatives that align with current business model and incentives

Level of Care Management Readiness

	Haven't Started	Evaluating Options	Taking on Risk	Already Transformed
Description	*Have resisted change; May be due to limited market demand, a lack of ability or resources to begin, or uncertainty of future*	*Beginning to consider opportunities to prepare for VBC and taking small first steps to initiate change*	*Have taken initial steps in taking on risk and have a high level plan to shift towards VBC*	*Integrated delivery system that have been functioning as a VBC-type entity*
% of Hospital Market	*10%*	*40%*	*45%*	*5%*
Solution Opportunity	• **Data analytics** • **Strategy support** • **Comprehensive health plan based model**	• **Data analytics** • **Telephonic and virtual options**	• **Data analytics** • **Reporting services** • **IT infrastructure** • **Embedded models**	• **Data analytics** • **Delegation support** • **IT infrastructure & services**

Care Management Model: Key Trends

While there are basic premises that seem relatively constant in care management, you should continue to monitor trends in the market and how they influence market priorities

Core Care Management

Care Management Across the Continuum

1. **A leading practice care model** that addresses all aspects of CM does not exist yet
2. **Utilization Management** is not going away
3. **Chronic condition management** remains critical but must incorporate new technologies
4. **Provider-based CM** has strong advantages, but requires multi-year efforts & tech investments
5. **Integrating Behavioral Health** remains a challenge across LOBs & markets
6. **Social determinants of health** are receiving greater attention
7. **Post acute care** has a significant impact on the total cost of care for some conditions
8. **Pharmacy** spend is fast growing & personalized medicine will drive additional focus for value

Key Outcomes

Focus on Patient Behavior

Demand for Quality & Outcomes

Effective Population Analytics

9. **Lifestyle behavior change** remains essential to address “rising risk” & “pre-diagnosis” patients
10. **Demand for quality and outcome reporting** will continue to increase and outcomes are becoming more transparent to the public (e.g., MACRA APM’s, MIPS)
11. **Providers seek not just data and tools, but actionable insights** on how to identify and manage medical spend

Key Future Design Concepts for Care Models

While there is no perfect model that will apply for every population, there are some key concepts that most health plans should try to incorporate into their models.

1 - Provider led

Integrating care management into a physician led model increases patient engagement substantially even when the program is delivered virtually

2 - Data driven prioritization

Prioritization of care management efforts is necessary to ensure an efficient and effective program. Deep analysis and benchmarking of historical medical costs help define the priorities for each managed population. Largely involves more immediate focus on the acutely ill and less investment in the existing well (especially in the first years)

3 - Care management delegation

There are components of care management that should rarely be delegated. Even when delegated, the health plan still has a significant role due to regulatory requirements and risk

4 - Continuum of provider model options

Because providers have such a diverse range of internal capabilities and strengths, health plans require a portfolio of care model options to support providers on their journey

5 - Build vs, buy

While care management should be a key skill set for most health plans and point of differentiation, health plans can still leverage purchased services to improve their impact and ROI

6 - Data & Analytics as a core competency

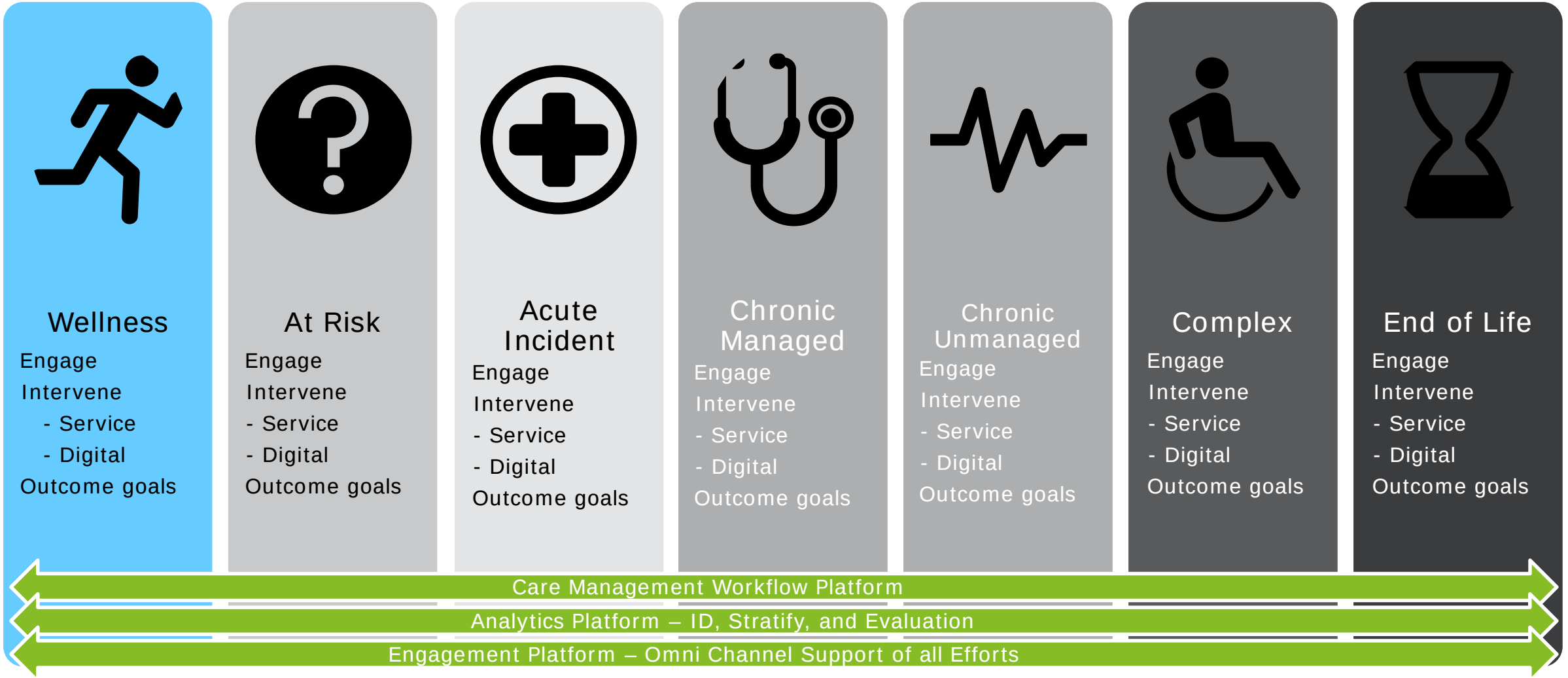
Regardless of the population, care model, provider collaboration setting, or use of vendors, a health plan with solid data and analytics capabilities is best situated to thrive

7 - Patient generated data

The future opportunity for patient generated data is significant, but there are many details to be worked out and unknowns to work through

Key Program components for a Standard Model

An organization may be able to leverage a single workflow platform and analytics (for ID, stratification, evaluation) but different populations will need different engagement and intervention approaches



Care Model Considerations

While a collaborative care model program can create value for patients, health systems, and plans, there are a number of key considerations that must be solved

Go-To-Market Strategy

- What is the approach to moving into MA and commercial markets?
- What is the collaborative's differentiation?
- What competitive advantages can the provider and plan leverage to enable lasting success?

Technology

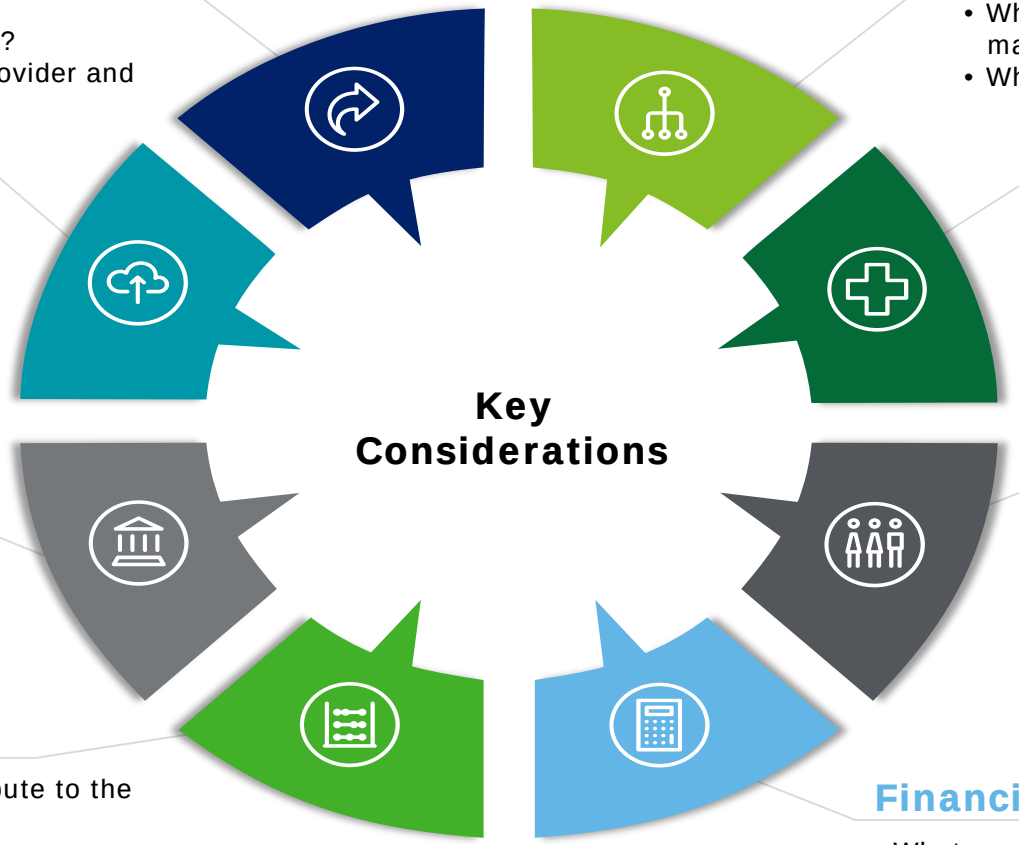
- What technology components are needed to implement the collaborative?
- What are the infrastructure requirements for provider and plan to integrate data?
- What additional technology vendors will be required?
- How can the collaborative utilize analytics to drive product performance?

Regulatory Management

- What are the critical regulatory requirements that need to be in place prior to launching the collaborative?
- What filings need to take place prior to launch? In the future?

Financial Pro Forma

- What assets will the provider and plan contribute to the collaborative?
- How will funds flow between the provider, plan, and collaborative?
- What are estimated revenue, costs, and net income look like for the collaborative over the next five years?
- What is the bassline budget for Administration for the collaborative?



Governance

- What are collaborative's guiding principles?
- What are the roles and responsibilities of collaborative's management?
- What is the decision making structure of the collaborative?

Care Model Development

- What clinical capabilities are needed?
- Are there current care model designs or pilots that can be leveraged to benefit the collaboration?
- What are collaborative's clinical priorities?
- What are the hypothesis of deriving value in utilization?
- How will the medical management platforms be integrated?

Operations and Network

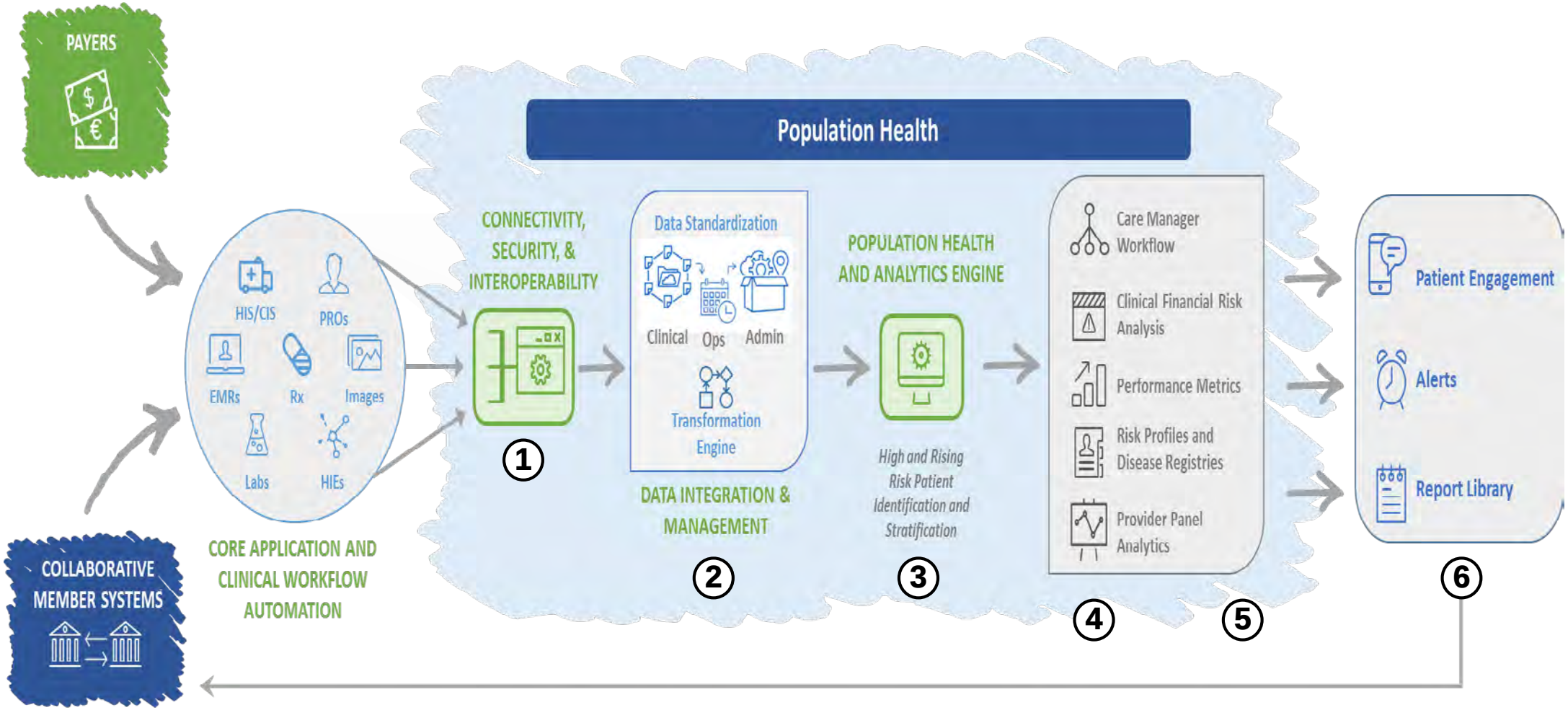
- Is the current provider network adequate to meet all the collaborative needs?
- How will existing administrative processes be impacted?
- What payment model will be used for in-collaborative network providers?
- What will be done to drive customers to collaborative products?

Financing and Pricing

- What are the target premiums that the collaborative should charge for its products?
- How can the collaborative target employers directly with competitive pricing?
- What risk management strategies can be used to differentiate its offerings?

Population Health Management Technology

Interoperable Health IT and Data Analytics architecture that reflects the overall operating model is a key input into the coordained program



Identification and Stratification Framework

Layering multiple core population health risk and need factors enables strategic insight. Central to the approach is defining the most salient available segmentation factors.

Segmentation Factors

Conditions

The chronic and other conditions the health plan prioritizes (e.g., CHF, CAD, Diabetes, Hypertension)

High Risk

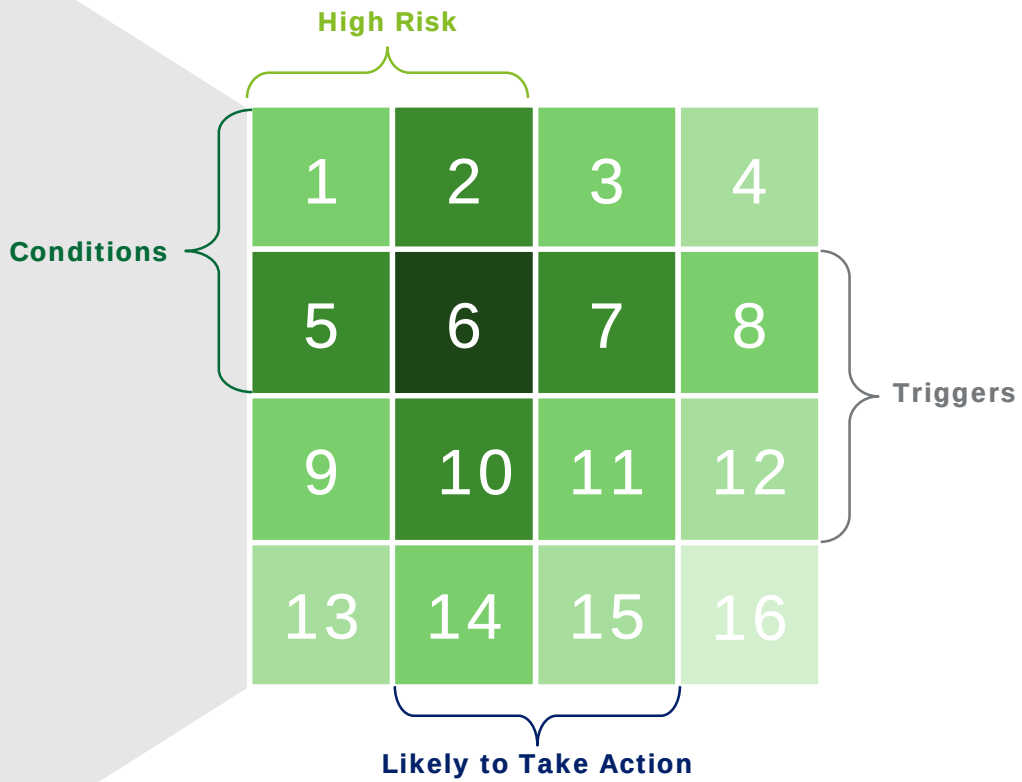
The members most likely to have large future health costs or other essential needs (e.g., Predicted High Cost, Likely Future Health Problems, Likely to Be Hospitalized)

Triggers

Flags of recent events that may escalate urgency for the member or the plan (e.g., ED Visits, Hospitalization)

Likely to Take Action

Models or measures that indicate high receptivity to engage and take action (e.g., Predicted Receptivity, Lack of Key Barriers Such as Poor Access or Social Supports)



Identifying Care Management Focus Areas

Medical and Pharmacy Cost Saving Opportunities

Through claims data analyses, the universe of opportunities and actions can be narrowed down to the right combination of initiatives that will provide strong ROI in the near term

Deloitte's experience with health plans has indicated the following…

25-35% Of health care costs may be wasteful and harmful according to studies published by Dartmouth[1] and Rand[2]

20-30%[3] are typically identified as opportunities through the Opportunity Assessment

10-15% are deemed to be actionable during the next 3-5 years of implementing Affordability initiatives

3-5% are deemed to be achievable by health plans during the first year of implementing Affordability initiatives

…based on industry knowledge and observation

[1] Institute for Health Policy and Clinical Practice: "Reflections on Geographic Variations in U.S. Health Care"
[2] Berwick and Hackbarth: "Eliminating Waste in US Health Care"
[3] This is analogous to the 25-35% published by Dartmouth and Rand

Example Approach to Identifying Medical Opportunities

Different partitions of experience are better at isolating various "causes" of waste beginning with an aggregate and then executing deep-dive condition-specific analysis to refine key drivers

1. Aggregate Analysis

There is value at assessing the overall experience against comparisons to understand:

- The distribution of utilization and costs
- If there are population-agnostic areas with unusually high utilization

Sample Opportunities

- Septicemia: Certain facilities demonstrate high prevalence of sepsis (can be upcoding or poor quality)
- Joint Replacement: Physicians may "overprescribe"
- 1-Day IP Stays: Facilities may admit members prematurely
- Low ASC Usage: Infrastructure may not support shifting utilization to lower cost settings

2. Episodic Analysis

After broad-based issues are identified, experience should be differentiated by condition to refine and discern additional opportunities, which may include:

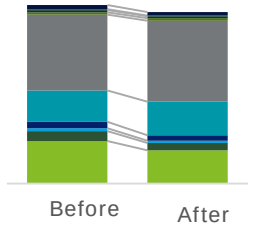
- Variability: Volatility will persist although variability can be an indicator of a low level of management, patient education, outcome-based medicine, etc.
- Proportion of Adverse Services: Some regions have consistently low costs, but favorable experience should have lower percentages of IP, etc.

Sample Opportunities

- Heart Failure: readmissions are too high potentially indicating members cannot identify "flair ups"
- Diabetes: one region has higher-than-average variability in the costs related to diabetic patients indicating a lack on chronic management
- Joint Replacement: Providers may not define preferred materials driving variation

Types of Opportunities Typically Identified

Utilization Reduction



Often plan focus on services that can be "removed" altogether. The opportunity can be largest if there is no "replacement" service, but many markets have fewer of these opportunities with UM practices nearly ubiquitous

Site of Service Optimization

Providers decreasingly focus on providing care in most expensive facilities and increasingly offer end-to-end services with all levels of care available. Health plans should support members and providers to identify the appropriate level of care

Population Intervention

Often a subset of the population requires intervention without a single type of utilization that requires targeting; resolution may be a combination of utilization reduction and site of service optimization

Medical Analyses Outcomes – Aggregate Analyses

Opportunity Assessments leverage different angles to identify probable drivers of costs and then narrow to the ones that are addressable

1. Process Data

Claims data is challenging because data varies between plans often driven by issues as fundamental as differing definitions of a "claim"

- Validate fields
- Group services into logical claims that are consistent with the client's treatment and comparable to benchmark data
- Adjust utilization using risk scores (e.g., CMS-HCC for Medicare data)
- Summarize data into actuarial models

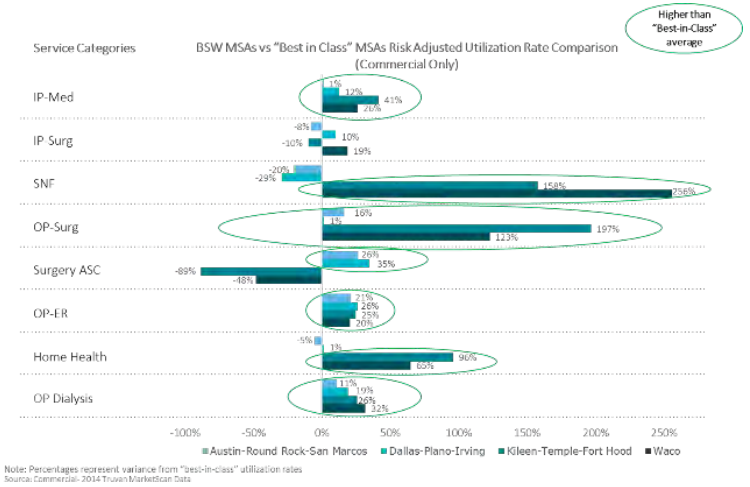
Service Category	Units / 1,000		% Diff.
	MSA	BIC	
IP – Medical	1,123.6	844.5	33.0%
IP – Surgical	464.0	404.4	14.7%
SNF	164.9	114.8	43.7%
OP – ER	408.5	367.6	11.1%
OP – Surgery	291.3	236.5	23.1%
Lab	10,073.5	11,746.0	-14.2%
Radiology	3,965.8	3,591.6	10.4%
CT/MRI	257.9	144.1	78.9%
Dialysis	1,575.3	1,388.8	13.4%

Note: Actual cost model is more detailed; this is a simplified depiction

2. Measure Opportunities at the Service Category Level

Identifying the major areas of opportunity and spend helps to narrow the scope where opportunity may be available

- Identify service categories that have (1) the greatest variances from benchmark and (2) meaningful unit cost
- This can be compared to an external benchmark or to the internal average (i.e., identifying regions with relatively poor experience)



Medical Analyses Outcomes – Aggregate Analyses (Cont.)

Opportunity Assessments leverage different angles to identify probable drivers of costs and then narrow to the ones that are addressable

3. Analyze Underlying Drivers

In order to make actionable, findings should be precise enough to reflect certain clinical areas, sites of care, providers, etc.

- Deep dives initially include analyses of DRGs and CPTs to identify clinical areas and sites of service to identify potential optimization opportunities

DRG	Description	Util/1000		Unit Cost	Savings Calculation		
		Plan	Benchmark[1]	Plan	Util/1000	PMPM	Annual
194	Heart Failure	9.02	6.05	$14,397	2.96	$3.56	$743,413
720	Septicemia & Disseminated Infections	8.66	7.64	$24,469	1.02	$2.09	$435,993
140	Chronic Obstructive Pulmonary Disease	5.05	3.85	$13,019	1.20	$1.30	$272,523
890	Hiv W Multiple Major Hiv Related Conditions	1.25	0.92	$42,459	0.33	$1.16	$242,740
133	Pulmonary Edema & Respiratory Failure	3.36	2.57	$15,555	0.79	$1.02	$214,188
053	Seizure	3.23	2.58	$14,585	0.65	$0.79	$164,633
460	Renal Failure	3.65	3.05	$15,601	0.60	$0.78	$162,227
662	Sickle Cell Anemia Crisis	3.36	2.38	$8,356	0.98	$0.68	$142,663
691	Lymphoma, Myeloma & Non-Acute Leukemia	0.26	0.18	$70,308	0.08	$0.47	$98,941
661	Coagulation & Platelet Disorders	0.13	0.09	$135,618	0.04	$0.46	$95,423
134	Pulmonary Embolism	1.09	0.76	$15,010	0.33	$0.41	$85,959
045	Cva & Precerebral Occlusion W Infarct	2.01	1.71	$15,522	0.31	$0.40	$83,286
892	Hiv W Major Hiv Related Condition	0.86	0.60	$17,931	0.27	$0.40	$82,885
282	Disorders Of Pancreas Except Malignancy	2.17	1.87	$10,832	0.31	$0.28	$58,013
690	Acute Leukemia	0.13	0.09	$66,251	0.04	$0.22	$46,616
052	Nontraumatic Stupor & Coma	0.70	0.50	$12,287	0.21	$0.21	$44,428
721	Post Operative, Post-Traumatic, Other Device Infections	0.93	0.80	$19,976	0.13	$0.21	$43,539
192	Cardiac Catheterization For Ischemic Heart Disease	0.61	0.42	$11,682	0.18	$0.18	$37,559
281	Malignancy Of Hepatobiliary System & Pancreas	0.45	0.39	$38,611	0.05	$0.17	$36,228
254	Other Digestive System Diagnoses	1.12	0.95	$11,473	0.17	$0.16	$34,199
693	Chemotherapy	0.99	0.92	$26,490	0.07	$0.16	$33,403
055	Head Trauma W Coma >1 Hr Or Hemorrhage	0.38	0.28	$16,461	0.11	$0.15	$30,564

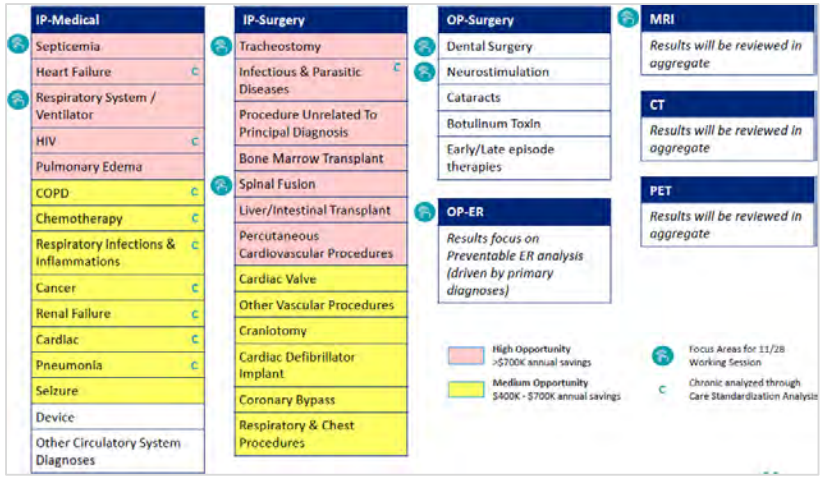
[1]Benchmark is the average across all regions. Utilization has been risk adjusted to be consistent with members for the given region

Focus Area | Moderate Opportunity | Minimal Opportunity

4. Prioritize Key Areas

Following the "mechanical" exercises, all results should be re-aggregated and reviewed so that they are clinically relevant

- Identify similar DRGs/CPTs, etc., with opportunity to aggregate in a clinically meaningful way
- Review findings with physicians to confirm the opportunities are valid and with the client to validate the experience and understand drivers



Medical Analyses Outcomes – Episodic Analyses

Grouping experience by episode and then analyzing experience by diagnostic category and stage allows us to understand drivers of costs specific to subpopulations

1. Group Data into Episodes

The key to this drill-down is the aggregation of related encounters into episodes isolating patterns of care to specific conditions

- The analysis should use standard logic that groups claims into episodes:
  - Chronic: All care provided to a patient over the course of a year related to a chronic condition
  - Acute: Triggered by an acute episode (e.g., IP stay, surgery) and include preparation, the acute episode, readmissions, rehabilitation, etc.

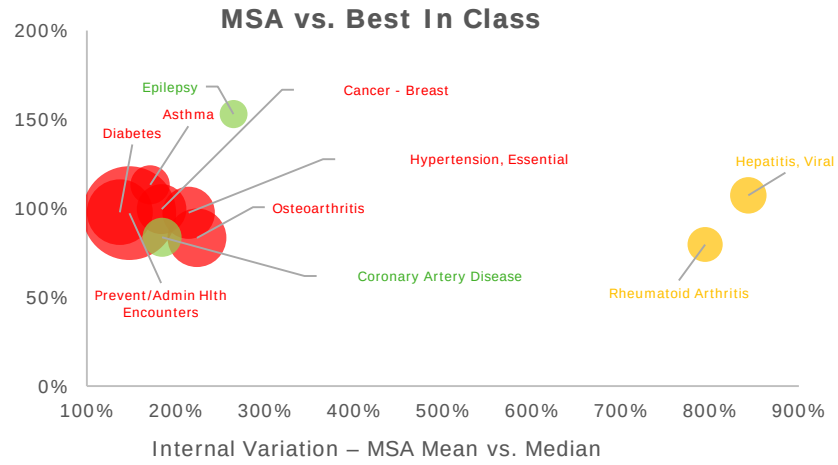
Acute Example

Herniated Intervertebral Disk	Office Visit Jan 10	X-ray Feb 28	MRI Mar 15	Hospital Apr 30	Office Visit May 8

2. Prioritize Diagnostic Categories and Stages

Costs are often driven by inconsistent care; diagnostic categories with high spend and variation are prioritized for examination

- The Mean:Median relationship does not directly calculate savings but it points us in the right direction (“where there’s smoke, there’s fire”)
- Leveraging benchmarks and spend help triangulate the opportunity



Medical Analyses Outcomes – Episodic Analyses (Cont.)

Grouping experience by episode and then analyzing experience by diagnostic category and stage allows us to understand drivers of costs specific to subpopulations

3. Identify the Services Driving the Variation

Analyzing the distraction of services relative to a benchmark help to understand what types of opportunities may be possible

- Regional differences may point to consistently higher or lower unitization but if certain areas have high variation, then the distribution cuts through those regional differences
- Additional metrics such as readmissions and avoidable ER visits help to identify key drivers

Service Category		Program/Region Util/1000 Episodes	Program/Region Paid per Episode	Program/Region % of Episode Stage Spend	Benchmark Util/1000 Episodes	Benchmark Paid per Episode	Benchmark % of Episode Stage Spend	% Difference Util/1000 Episodes
Inpatient	Medical	2.01	$10.55	1.86%	2.68	$12.64	2.08%	-25%
	Surgery	0.34	$1.63	0.29%	0.63	$3.94	0.65%	-47%
	MH/SA	-	$0.00	0.00%	-	$0.00	0.00%	N/A
	Rehabilitation	-	$0.00	0.00%	-	$0.00	0.00%	N/A
	Other	-	$0.00	0.00%	-	$0.00	0.00%	N/A
Skilled Nursing Facility		38.60	$6.83	1.21%	18.92	$3.59	0.59%	104%
Outpatient	Surgery – OR	3.69	$2.33	0.41%	3.15	$1.83	0.30%	17%
	Surgery – Other	22.16	$14.36	2.53%	19.40	$11.94	1.97%	14%
	MH/SA	-	$0.00	0.00%	-	$0.00	0.00%	N/A
	Emergency Room	344.75	$82.39	14.54%	244.28	$69.15	11.40%	41%
	Observation Days	1.68	$0.70	0.12%	1.58	$0.91	0.15%	6%
	Home Health	-	$0.00	0.00%	0.63	$0.06	0.01%	-100%
	Other	264.85	$20.18	3.56%	339.22	$25.54	4.21%	-22%
Physician	PCP	346.76	$16.02	2.83%	403.09	$17.76	2.93%	-14%
	SCP	834.51	$126.38	22.30%	1,374.86	$133.40	21.99%	-39%
	Other	1,191.68	$56.49	9.97%	1,386.85	$70.55	11.63%	-14%
Laboratory		482.04	$7.59	1.34%	483.52	$9.06	1.49%	0%
Radiology		256.13	$8.68	1.53%	325.97	$12.49	2.06%	-21%
MRI/CT/PET		41.62	$9.71	1.71%	38.16	$8.76	1.44%	9%
Rx	Generic	3,462.24	$79.68	14.06%	3,137.99	$77.80	12.83%	10%
	Brand	288.69	$96.20	16.97%	355.94	$117.65	19.40%	-19%
Ancillary	J Codes	69.15	$3.46	0.61%	78.54	$3.60	0.59%	-12%
	Other	177.58	$23.61	4.17%	187.51	$25.90	4.27%	-5%

Metric	Region	Benchmark
Readmissions	-	-
Total IP Stays	7	21
% Readmissions	0.0%	0.0%

Metric	Region	Benchmark
Avoidable ER Visits	845	1,273
Total Visits	1,023	1,541
% Visits Avoidable	82.6%	82.6%

4. Prioritize Key Areas

Variation is unavoidable with some conditions; assessing portion of care which is addressable helps to target the right population

- Conditions which have high relative proportions in addressable service categories tend to be prioritized
- As always, prioritization should be informed by clinical review
- The outcome—identified subpopulation and specific service areas utilization—is a high actionable target

	Focus Areas	Key Commentary	Priority (Low ↔ High)
Acute	Mental Health - Depression	• This could be a two-fold win: lower cost for behavioral health and medical • Potential for network and drug adherence improvement • Long-acting medication/injectables can improve adherence	
	Arthropathies/ Joint Disorders NEC	• Prior-authorization currently not required • No central initiatives currently in place • Ability to move to cheaper sites of service	
Chronic	Hypertension, Essential	• The Plan already has some intervention programs in place • Could be challenging as the Plan is already implementing education and other programs	
	Diabetes	• Area of focus for the Plan but high degree of difficulty to impact everyone • The Plan required by the state to have disease management program • The Plan providing significant amount of education to members	
	Renal Function Failure	• The Plan has investigated and determined this is an opportunity area • Rolling out an intensive care management program • Not sure if current all inclusive case rates are competitive	
	Cerebrovascular Disease	• Opportunity here but may not be low-hanging fruit • Conduct provider-level analysis	
	Mental Health - Schizophrenia	*(Similar commentary to Mental Health - Depression)*	
	Osteoarthritis	• Based on the Plan's experience, physical therapy has been one of the trouble areas, especially in the Dallas and Hidalgo area • Network optimization could be helpful	
	Chronic Obstructive Pulmonary Disease	• Part of standard care management program • Much already in place but could be improved	
	Coronary Artery Disease	• Opportunity to increase utilization management and pre-authorization, and improve network	

Care Model Redesign

A real world example

Case Study Assessment of the Provider Clinical Capabilities

The provider had a significant lead over most Integrated Delivery Networks (IDNs) in its ability to meet the clinical requirements of population management

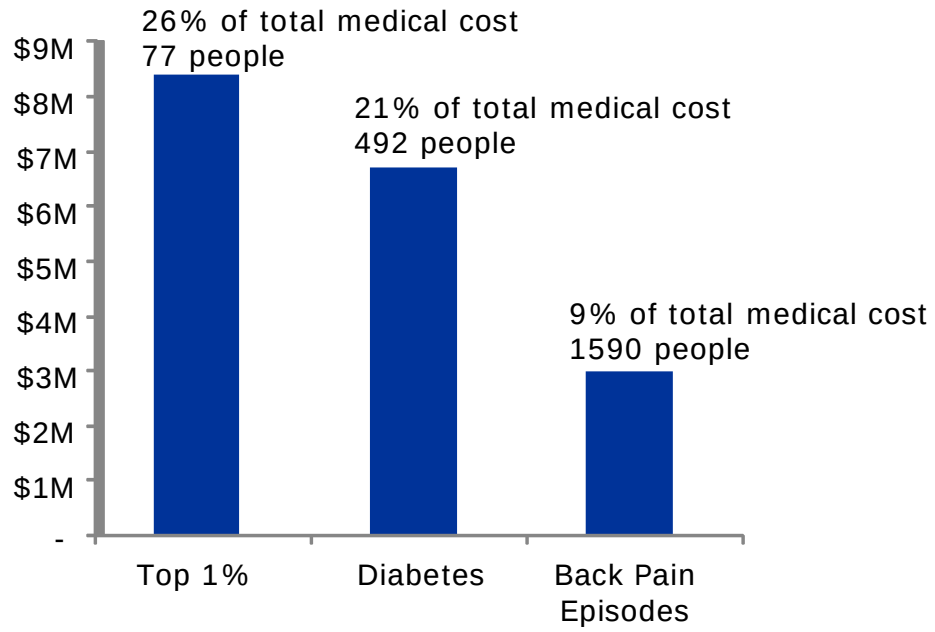
Capability	Assessment vs. Other IDNs		Population Management Gap	
System Connectivity		• Leading practice to have 100+ physicians and the hospital on the same CIS/EMR system		• The case management system under development now (Allscripts) will be key moving forward • Will need more analytics, high risk case identification and identification of gaps in care moving forward
Physician Leadership		• Ownership of half of the admitting physicians opens up a lot of possibilities to align incentives		• Need a new level physician leadership to build a culture based on wellness and shared responsibility for patients across the continuum
Inpatient Care Management		• Have a comprehensive quality and inpatient program in place		• Will meet future needs by continuing to implement the defined programs
EBM and Protocols		• Have an extensive set of protocols in place and utilized		• Will need to extend a number of condition protocols to include an extensive ambulatory component
Ambulatory Care Management		• The existing clinics and navigator roles are a significant foundation for future efforts		• Will need a major shift to have resources accountable for patients across the continuum

The existing clinical capabilities and some expansions would allow the provider to contract **immediately** to gain some of the cross continuum value they were generating

Sample Actuarial Analysis: Key Findings

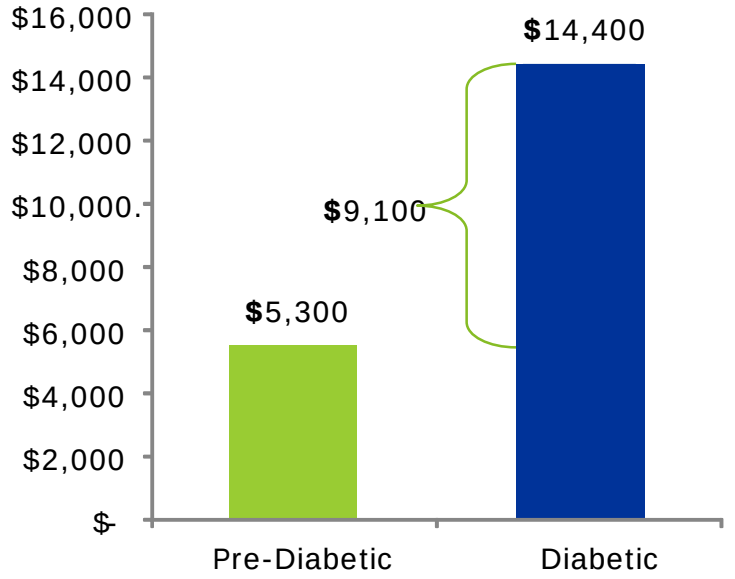
Key Findings from Actuarial Analyses Led to Selected Business Case Opportunities

Top Drivers of Medical Costs



- **The top 1% of the clients Members incurred $8.4 million dollars in medical costs in FY 2010, represent 26% of total medical costs**
- **Diabetes related treatment represents 21% of the total medical costs**
- **Back pain episodes represent 9% of total medical costs; the top 17% of these cases represent 75% of the costs**

Preview of Preventative Care Opportunity



- **Currently, 6% of the client member population is diabetic**
- **Another 20-40% of the client member population (1,500 – 3,000 individuals) is pre-diabetic**
- **Preventative care for this diabetic population could save $9,100 per pre-diabetic the client member**

Sample Actuarial Analysis: Business Case for Opportunity Areas

Based on the claims analysis and care management assessment, several initiatives could improve the quality of life for the provider's insured population and lower the overall cost of their healthcare

	Goal	Short Term Impact	Long Term Impact
Heart Failure Clinic Expansion	• Expand the existing heart failure clinic to increase the reach and timeliness of interventions	• Reduce re-admission rates to match national averages (now 20% and going to 16%)	• Avoid a 3% reduction in CMS reimbursement due to re-admission rate penalties
✓ Ambulatory Case Management	• Support the client members with complex needs and coordinate their care across the continuum	• Attempt to reduce the cost of treating most acute the client members by 10% or $840K	• Establish initial infrastructure in preparation for population management (full risk)
✓ Diabetes Management	• Expand outpatient management of diabetes to prevent complications of diabetes in the client population	• Lower costs and improve the health status of the diabetic the client members	• Establish a program to be sold to local employers and payers
Back Pain Prevention and Treatment	• Create a training program that will help prevent back injuries on the job • Manage the care of those with uncontrolled pain	• Reduce the prevalence of back injuries for employees (840 employees)	• Establish a program to be sold to local employers and payers
Wellness and Health Program Expansion	• Develop a leading practice wellness solution that will have more impact on employees and allow the client to grow a wellness revenue stream in the near future	• Prove the the client wellness model works • Attempt to stop the progression of pre-diabetes in the the client population	• Create a new revenue stream by selling a wellness offering to local employers • Stop the progression of pre-diabetes in the population

✓ *- Programs that were initiated*

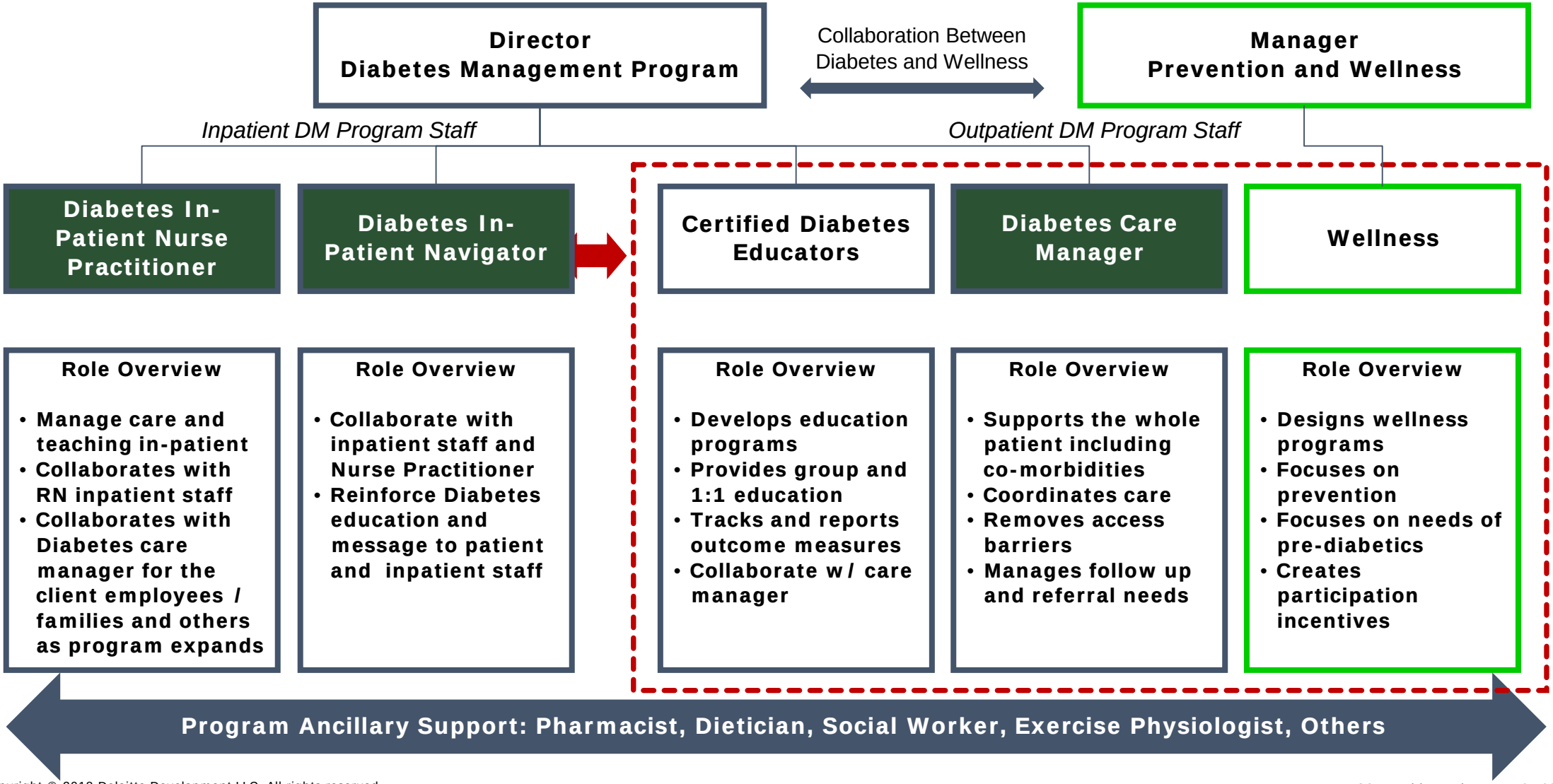
Sample Actuarial Analysis: Rationale for Programs

The circumstances of the population and other stakeholders should be carefully considered to understand which interventions will be most effective and align to the goals of the enterprise

	Ambulatory Care Management	Diabetes Management
Rationale	• The provider had 77 members that incurred costs of $8.4M in 2010 - 26% of total medical costs • Outcomes for high risk members can be improved with care coordination and support • the client wants to create a foundational infrastructure for population management	• 6% of the provider's self-insured population have diabetes based on 2010 claims data • Medical costs for members with diabetes accounts for nearly $6.7 million (21%) of total medical costs • Existing diabetes management program needs to expand to effectively educate and support client employees and their family members • Prevalence of diabetes in Eastern region of the state is 12 to 14% compared to the national average of 7.5%
Expected Benefits	• Decreased utilization and costs for the client's self-insured population • Better coordination of care and improved outcomes • Overall improvement in population health including member self-management • Foundational infrastructure for population management	• Improved quality of life for diabetic employees through more effective diabetes self-management • Reduced medical costs • Decreased employee absenteeism due to diabetes complications • Reduced prevalence of type 2 diabetes in the client's employee population
Program Impact	• **Short Term:** Reduce the cost of treating the most acute client employees/family members by 10% • **Long Term:** Establish initial infrastructure in preparation for population management	• **Short Term:** Lower costs and improve the health status of the diabetic client members • **Long Term:** Establish a program that can be marketed to local employers and payers

Sample Actuarial Analysis: Design for Integrated Diabetes Management

The combination of the opportunity analysis and capabilities assessment provided input into the structure of the care management program



Care Model Redesign

Operationalizing

Monitor and Refine: Increasing Affordability in a Coordinated Program

It is critical the savings are addressed with a programmatic approach to designing, implementing, and monitoring the appropriate initiatives tailored to the specific opportunities

Step 1: Identify Opportunities

Initially, health pans should conduct deliberate and coordinated analyses to ensure all costs are being evaluated without redundancies and coordinate with Affordability leadership to identify areas to target reductions

Identify Opportunities Activities

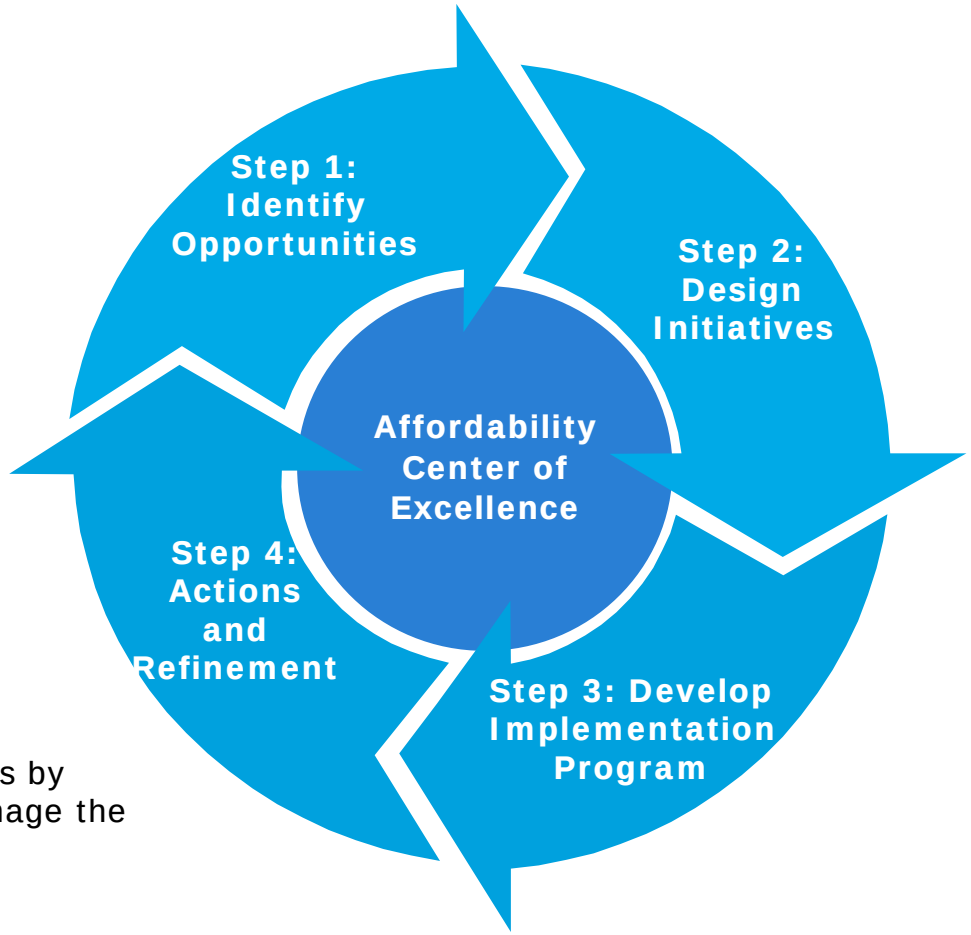
- Review claims data
- Perform Cost of Care performance improvement analysis
- Incorporate clinical input

Outcome:

- Identified achievable and actionable savings and opportunities

Step 4: Savings Actions and Refinements

Maximize the use of health plan resources by amending its current processes, and manage the program to success



Step 2: Design Initiatives

The initiatives should be tailored to opportunities identified, nuances of the health plan and covered population, and resources. Leverage cross-section subject-matter advisors to tailor solutions

Design Initiatives:

- Run additional analysis to dig deeper into data to explore root causes
- Deep dive session w/ key stakeholders to develop proposed action plans
- Refine savings amounts and timing
- Develop high level roadmap

Outcome:

- Assignment of goals and responsible parties

Step 3: Develop Implementation Program

A system with well-defined ownership, oversight, and incentives is critical to keep initiatives on track and meet the goals as defined by leadership. Initiate early-stage development of the governance structure, goal-setting process, etc.

Medical Opportunity Assessment Dashboard

Strong IT and analytics enable reporting tools and dashboards can provide long-term performance improvements tailored to various audiences within a health plan or provider

Sample Dashboard

Utilization Analysis

- UM departments may want to explore the overall utilization of key areas identified by the opportunity assessment to gauge whether there may be benefits from adding pre-authorization requirements, retrospective review, etc.

Episode Analysis

- Analyses tailored toward episodes and specific conditions will most benefit teams such as: Population Health, Case Management, Disease Management, etc.
- Ongoing reports will help measure the impact of these population-based interventions and further refine where additional focus will be most effective increasing quality and increasing efficiency

Sites of Service Analysis

- Networking and Contracting teams may benefit from analyses geared toward utilization at the appropriate site of care and inform: upcoming negotiations, network expansion and/or refinement
- Members may continue to seek care at non-optimal sites; this report may trigger those responsible for member engagement and benefit design

Potential Dashboard Audiences

- Executive Leadership
- Affordability Governance Leadership
- Medical Groups
- Health Systems
- Disease Management
- Network
- Care Management (Utilization, Disease, Care management)
- Contracting
- Member Engagement
- Wellness/Population Health
- Actuarial
- Finance/Budgeting

Given the wide variety of audiences and nuanced characteristics of every health plan, dashboards should be customizable

Questions?

Deloitte.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