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## Improving Outcomes Through Incentives: Using a Global Budget with Risk Sharing to Drive Cost Savings and Improved Quality

*By Ed Cymerys*

In the past 50 years, health care costs in the United States have more than tripled, rising steadily from 5 percent of the gross domestic product in 1960 to 18 percent in 2012.

Driven by those increasing costs, commercial health insurance premiums have become dramatically more expensive. The average premium for a family of four is expected to hit 24 percent of the median family income in 2013, and rise to 30 percent by 2020. This affordability crisis in our industry is a central concern for Blue Shield of California, a non-profit health plan with a mission to ensure access to quality, affordable health care.

As rising medical costs threatened to quickly make our commercial health insurance products unaffordable in the California market, we developed our accountable care organization (ACO) initiative, designed to improve health care quality and reduce costs. Conceived in 2008, long before passage of the Affordable Care Act, our program is not part of the Federal Medicare ACO program. Our ACOs are collaborations with three-way risk sharing between

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# Letter from the Editor

By Kurt Wrobel



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I think Greger Vigen best summarized the intent of this edition of *Health Watch* when in his article he said, “We are in the middle of extraordinary times.” While the policy debates and media have mostly focused on the expansion of government programs, the mandate or tax to purchase health insurance, and the dramatic change in underwriting rules, we are also seeing a profound change in how payors compensate and incent providers. These initiatives will provide the focus for this edition of *Health Watch*.

In our opening article, Ed Cymerys highlights the work he and his actuarial team have done in developing an innovative accountable care organization (ACO) structure for Blue Shield of California. Going well beyond developing a simple capitation rate, the actuarial team actively engages their provider partners in a program that motivates all stakeholders to improve the quality and efficiency of care through a more effective incentive structure. By being front and center throughout the development of the program, the actuarial team showed how their skill set can be used beyond more traditional rate setting.

In an effort to frame the challenges and opportunities in provider payment programs, Vigen contributes a convincing argument on why system transformation and provider payment reform will succeed, even when and where other attempts were less successful in the past. As Vigen highlights, much of this work will rely on technical skills and enhanced technology and data that we have developed in other aspects of our health insurance work.

Continuing with the theme of highlighting programs that go well beyond simple capitation rate setting to improve the incentive structure for providers, Matthew Day and Jill Wilson discuss the detailed structure and organization of the Blue Cross Blue Shield of Massachusetts program. Like the Blue Shield

ACO program, they rely heavily on changing the existing provider incentive structure.

Along with these innovative private programs, several government programs have been developed to use a better incentive structure to encourage more effective and better coordinated care. Michael Cook and Shelly Brandel provide the details on a new dual-eligible program facilitated by the Medicare-Medicaid Coordination Office in the Affordable Care Act (ACA) legislation. By combining payment and assigning clear accountability, the Centers for Medicare and Medicaid Services (CMS) expect that health plans will provide more effective and efficient care. In addition, several leaders from the Health Section’s Medicaid subgroup highlight several states’ Medicaid innovations, including cutting edge payment changes based on episodes of care, patient outcomes, and quality metrics.

This edition concludes with an article that ties these initiatives by highlighting the significant change required to operate in these new payment models. As highlighted by the authors from Deloitte, this change requires the development of several new capabilities that go well beyond the skills necessary to operate in a fee-for-service model.

In total, this edition emphasizes that many innovative provider payment programs are starting to improve the incentive structure that providers have operated under for so many years. Based on the preliminary evidence, these structures have the promise to improve the coordination of care and provide more efficient care. As a profession, we are in a unique position to help promote and drive this change through our analytic capabilities as well as our broad knowledge of health insurance and the delivery system. ■

# Chairperson's Corner

By J. Patrick Kinney

Welcome to the 72nd issue of *Health Watch*, this time with an editorial focus on provider payment topics. In this month's Chairperson's Corner, I will talk about the ongoing efforts of the Health Section Council to support our membership as we participate in the major changes occurring within the U.S. health care system. I'll also expand the focus a little, and discuss our strategic approach to continuing education on health actuarial topics in general. And, I will encourage you to attend the Society of Actuaries (SOA) Health Meeting in Baltimore this June.

## Payment and System Reform

The SOA maintains a Web page of articles and information about many aspects of health system reform. This grew out of several related SOA and Health Section initiatives over the past several years. The work group for the SOA's strategic initiative "Untapped Opportunities for Actuaries in Health" identified potential opportunities to advance the actuarial profession in the area of provider payment reform. The Health Section Council now shares responsibility—along with section members—for developing actuarial talent capable of taking advantage of these opportunities. The Health Section Payment Reform Subgroup, led by Greger Vigen, has been one of our most active teams. Included in this strategic effort are a number of activities focused on accountable care organizations (ACOs) and similar provider initiatives, including SOA-sponsored webcasts and speaker placement at external conferences. The SOA joined the Brookings-Dartmouth ACO Learning Network, which has also hosted webcasts over the past few years. Notes from these webcasts are available for SOA members. These materials can be found via links on the Health Section website (<http://www.soa.org/Professional-Interests/Health/hlth-detail.aspx>). Click on "Untapped Opportunities" or "Payment and System Reform Subgroup" under the Resources area.

As is clear from even a cursory review of the content found on these Web pages, there is substantive activity on payment and system reform across the health care landscape. This includes major initiatives like ACOs, bundled payment pilots, and patient-centered medical homes, with nearly 1,000 federal and private sector initiatives. These are supported by a combination of new and old payment approaches, from shared savings to episode-based payment, that are moving the medical model from volume-based reimbursement to value-based rewards. Much of this work is happening now as payers and providers form alternative networks, create modified reporting systems, implement innovative payment contracts, and attempt to build and/or reshape long-term relationships between providers and payers. Decisions being made now will drive ongoing health care cost trends, product design for health insurance exchanges, and relationships between physician and hospital costs—in fact, most areas of health actuarial practice. It is critical for our members to keep up with developments in provider payment and health system reform. To help meet this need, the Health Section Council and the SOA this April offered a special seminar on these topics. This issue of *Health Watch* continues to support section members and other actuaries who want to learn more about industry changes.

## Continuing Education

The seminar and this topical issue of *Health Watch* are examples of the section council's strategic approach to continuing education. Led by Nancy Hubler, the council's continuing education coordinator, we have engaged in a long-range planning effort to identify and prioritize over a dozen emerging subject areas for continuing education (CE) development. Following a "stages of change management continuum" model, volunteer "champions" for each topic are creating specific plans to develop CE material for our members. Recognizing that members will have different educational needs, our plans include ideas for CE delivery rang-

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# Health Watch

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To join the section, SOA members and non-members can locate a membership form on the Health Section Web page at <http://www.soa.org/health/>

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ing from providing basic awareness of an issue, to moderate and in-depth levels of knowledge. Members should be able to access CE at a level and via a delivery mechanism most appropriate to their own circumstances. Delivery mechanisms include traditional face-to-face meetings and seminars, publications such as this one, short podcasts on particular topics, and the increasing use of webcasts to support interactive learning.

Examples of topics we are addressing include health care reform (with numerous subtopics such as actuarial value, essential benefits and risk adjustment), health economics, complexity modeling, predictive modeling, quality measurement, ERM and Medicaid issues.

Through these efforts, the Health Section is actively supporting the SOA's strategic goal to "foster career-long learning focused on technical excellence and business acumen."

## Health Meeting

Of course, the largest continuing education event for the section is the SOA health meeting, held in June of each year. The section council, SOA staff and numerous volunteer session coordinators and speakers all come together to provide an outstanding opportunity for professional education and networking.

This year's health meeting is being held in Baltimore, Md., at the Baltimore Marriott Waterfront hotel. The "waterfront" in this case is Baltimore's Inner Harbor area, which is a spectacular example of creating an urban destination for tourism—including business conferences. Herein I speak from experience, as I spent much of my childhood living in 1960s Baltimore. (I later read an H.L. Mencken essay titled "Baltimore in the 1860s" and I was struck by how familiar the city seemed, even a century later.) Since then I have followed its development from afar, visiting several times over the years, including during the inaugural season of Oriole Park at Camden Yards. This baseball stadium is now a classic, and I encourage you to take in a

game if you can—the O's will be in town during the health meeting, and the stadium is walking distance from the hotel! Close by you can visit Babe Ruth's birthplace—or Edgar Allan Poe's grave. If you are thinking of bringing your family along, I can report that there is plenty to do in the Inner Harbor area. My family took a trip down memory lane with me last April (yes, including an Orioles game), and they are clamoring to return. For the history buffs among you, I highly recommend a visit to Fort McHenry, a short water taxi ride across the harbor. This historic fort is the birthplace of "The Star-Spangled Banner" during the War of 1812. The kids loved it!

The health meeting itself will feature almost 100 separate sessions, covering topics across the spectrum of actuarial knowledge. Our special guest speakers will be Ian Morrison, internationally known author and futurist specializing in health care and the changing business environment, and David J. Brailer, M.D., Ph.D., the former National Coordinator for Health Information Technology. Join me in taking advantage of this opportunity for outstanding learning in a city steeped in history.

## Section Elections Coming in August

Each year the Health Section membership has the opportunity to elect new volunteer leaders as members of the section council. It is exciting and invigorating to have seen the impact that new members have had on the council during my tenure. When the section elections are held this summer, I encourage all members to vote for the actuarial leaders to join the Health Section Council for the next three years. Meanwhile, if you have ideas for our future success, along with energy and commitment to carry us forward, consider how you might be able to contribute as a volunteer. For more information, please contact me or any member of the Health Section Council. ■

the health plan (Blue Shield), hospitals and physician groups, and are designed to control costs while offering optimal patient care for commercial HMO members.

The role of Blue Shield's actuarial team has been central to the architecture of a strong global budget model for the program and to the development, implementation and operations of each of the nine arrangements we have initiated since the program began in January 2010.

## Background

When we developed the ACO program, we were looking to partner with providers on a solution that addressed the underlying cost drivers in a meaningful way. The main challenge we faced was that the health care delivery system creates an adversarial relationship where the health plan, hospital and medical group work in silos, unable to effectively or efficiently control costs and deliver optimal patient care.

In California, the payment model landscape contributes to this effect. While capitated reimbursements (per member per month) are widely used for physician services, hospital facilities are typically paid on a fee-for-service basis. Well known in the industry, the fee-for-service model means that incentives are not aligned—providers are encouraged to do more in order to get paid more. Blue Shield had long observed the effects of this phenomenon with our network providers: the more downward pressure we put on the price per unit of service, looking to keep our insurance products affordable in the market, the more upward pressure on utilization providers would assert.

In order to create real, sustainable savings and thus keep our premiums down, the challenge before us was to come up with a new model that would put all the players—the hospital, the physician group and the health plan—on the same side, with the same motivations and goals. Many of our network providers shared our concerns of remaining competitive, with the very real threat of losing patients to the integrated health care system Kaiser Permanente.

To effectively collaborate to reduce cost, improve quality and compete successfully with Kaiser, we needed a solution that would align incentives across the three parties. That solution also needed to be easily implemented and work within the current payment arrangements.

## Development of a Well-Constructed Incentive Model

Our model has succeeded in aligning the incentives for the hospital, physician and health plan through an annual global budget. The budget consists of total expected spending for the care of a set population of members, with an agreement to share risk and savings among the partners. We have initially focused our program on the commercial HMO population associated with our physician group partners, which allows us to avoid the challenge of member attribution common in the industry.

The model we adopted was driven first by business goals, which centered around delivering savings to our customers and members on their health insurance premiums. For each global budget arrangement, savings goals are set upfront, and are determined by the amount needed to keep premiums flat or to a minimal increase. Each organization agrees to contribute to the cost savings as well as to bear part of the financial risk if the savings goals are not met. The arrangement creates a global per-member-per-month target amount for the cost of health care, without changing the underlying payment mechanisms for physicians and hospitals. If savings targets are exceeded, the partners share in the savings; if savings are lower than the target, the partners write off this amount. This shared-risk arrangement motivates all parties to work together to reduce costs. Success depends on taking cost out of the delivery system, not by shifting risk to one of the other partners.

It was essential that the providers take downside risk as part of our ACO agreements, as incentive plans that use both “carrots” and “sticks” are more effective in engaging providers to work toward

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Our providers understand the affordability crisis, and they want to maintain their relevance and viability in the market.

desired outcomes. Our actuaries worked hand in hand with our attorneys to ensure that the incentive programs set up were legal and able to pass regulatory scrutiny. We have had considerable success in securing agreements by providers to take risk in the arrangement. Our providers understand the affordability crisis, and they want to maintain their relevance and viability in the market. Therefore, they are willing to take risk to retain important commercial health insurance patients that contribute substantially to their bottom line.

In determining the detailed breakdown of the shared-risk model, our actuaries understood that the most effective provider incentive models will rely upon the underlying provider reimbursement structures. Our model considers both who has more control over the services, and who should be rewarded proportionally should we exceed the target. For example, as shown in Table 1, the hospital provider partner can exercise a great deal of control over what happens inside their own four walls, so it is logical to put them at a greater share of the risk for that component (50 percent, in our example).

Likewise, should performance be under the target on hospital services, that partner is able to receive a higher percentage of the savings, which allows them to recoup some of their reduced revenue.

The actuaries also needed to carefully consider items that could unfairly impact the provider incentive results. For example, because our ACOs across the state vary in size, their ability to absorb large claims also varies, and the actuaries needed to take outlier thresholds into account in order to prevent providers from disengaging in the cost-controlling endeavors of the program produced by the adverse impacts of an individual catastrophic claim on the incentive pool. In addition, as we know that the population in the program will almost assuredly shift over time (for example, as Blue Shield writes new employer group business), the actuaries must pay attention to the underlying changes in the demographics of the population, in addition to potential changes in benefit mix. We do not want to unfairly penalize or reward providers in the incentive program for these types of changes.

It was also crucial that our actuaries engage in cross-functional collaborations to develop an end-to-end view that would ensure that the ACO arrangements benefited our members and customers. For instance, we purposely set incentive targets at stretch goals to ensure that meaningful savings were generated before incentive pay-outs would be made. We also re-evaluated our internal processes to make sure the expected cost savings were passed along to our customers and members through lower premium increases.

### Data Is King

Data is an integral part of the program collaborations from beginning to end, and that is why the actuary is uniquely positioned to add a substantial value to the work team and the overall program.

Understanding the reimbursement method of the various services being performed within the arrangement is crucial to understanding how cost savings can flow back to the health plan, and thus to customers, as well as how to best deploy incentive programs. For example, if reimbursement for

Table 1

Service Category	Target (pmpm)	Partner at Risk		
		Hospital	Physician Group	Plan
Hospital services (provider partner)	\$115	50%	25%	25%
Hospital services (non-provider partner)	\$25	20%	30%	50%
Physician services	\$90	20%	50%	30%
Ancillary services	\$10	20%	30%	50%
Pharmacy card	\$50	10%	45%	45%
Total cost	\$290			

inpatient services is based on DRG payments, then programs to reduce length of stay might benefit the hospital partner's bottom line, but would not typically flow back to the health plan. Likewise, if all services are currently capitated to the providers, then understanding the cause and effect relationship of how the savings flow is important. The actuary needs to carefully consider these relationships to ensure that the incentives for all parties are aligned.

Our actuaries working on the program learned to step out of their comfort zone. The industry has a long tradition of keeping information sharing to a minimum. While some of this is warranted in the protection of patient and contract confidentiality, Blue Shield realized that the affordability crisis and increasing competition demanded change. If we are going to ask providers to both better manage costs and take on risk if the expected improvement is not attained, then it is reasonable to expect that providers will want to fully understand the underlying cost drivers. The health plan is in the best position to provide this holistic view, and the actuaries are perfectly positioned to provide this information, validate it, and explain it to providers.

In our discussions with the providers, our actuaries and analysts are front and center, not only presenting the initial information to the providers to make our case for the program, but also engaging in the follow-up discussions as the collaborations move forward. Having the information experts at the table, able to proactively share an unprecedented amount of information, has resulted in a significant increase in provider trust. This trust, historically lacking in provider-health plan relationships, has been a critical building block for the success of the collaborations.

## ACO Operations: Actuarial Involvement from A to Z

In our ACO partnerships, each organization shares clinical and case management information to more tightly coordinate care for the program's HMO members. This allows the partners to identify where costs are unduly high and implement solutions to bring those costs down while improving quality. A

Blue Shield analytic team supports the process of developing the cost-saving clinical interventions on which the partners will focus their efforts. The analyst's role is central to this process. The analysts' ability to understand member population health and cost drivers, as well as to develop applicable benchmarks, provides clinicians with reasonable and appropriate tools for effective goal setting. Working with a dedicated project management and clinical intervention team comprised of representatives from each of the partners, our analysts help jump start the process by delivering two key items.

First, the analyst team develops a population health presentation comparing key metrics to a health-plan-specific local control group. Metrics include a range of utilization rates such as inpatient admissions, inpatient length of stay, risk scores and emergency room utilization. This initial report provides a current-state perspective on how well the partners are managing member care and identifies opportunities for improvements that will generate savings. In some cases, there are clear gaps between current performance and the benchmark standards, while in other cases we may choose to target improvement beyond the benchmark level.

Second, the analytic team converts the cost-control targets from the ACO agreement into high-level utilization targets. To do this, the team models several scenarios using local health-plan-specific and industry benchmarks, and taking into account provider mix and unit costs. The team also draws heavily on the provider partners' assessment of their operational challenges and opportunities for "quick wins" as well as longer-term change. Blue Shield's project management and clinical staff work with the provider partners to select a final scenario. Once the final set of operational targets is set, project teams are established to oversee each operational work stream.

The role of the actuarial analyst supporting ACO collaborations goes beyond what is traditionally expected of a health plan actuary. As part of the program team, the actuarial support is highly consultative in nature—from explaining developed risk-share incentives to providing projected experience

The role of the actuarial analyst supporting ACO collaborations goes beyond what is traditionally expected of a health plan actuary.

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Working with all parts of the health care delivery system to keep the cost of care down will be crucial for our continued success in the California market.

for both internal and external stakeholders—and includes on-site meetings and presentations to senior leadership from the health plan and providers.

Every ACO we have built has its own unique circumstances, requiring our actuarial support to be flexible. Early on, ad hoc provider data requests tend to be quite frequent and unpredictable, as we work to establish a relationship and build trust. Each set of provider partners may have a different set of concerns and interests requiring a deeper review. For example, we may be asked to look closer into the drivers of high pharmaceutical drug card costs or to analyze members' out-of-network facility costs for both emergent and non-emergent care. Our team works to respond to these requests quickly, and to have open dialogue with the providers about their concerns. Adding licensed clinical staff to our program team, to work alongside our actuaries and project managers, has also been helpful in continuing to build trust and credibility with providers.

As operations progress, the development, maintenance and production of both financial and utilization dashboards by the actuaries is key to monitoring the program's progress. The analyst is also best positioned to determine key change drivers when the dashboard metrics point to unexpected results. In addition, at the end of the contract period, the actuarial team will either perform the final incentive program calculation or oversee its production. They will also be at the table with the providers to think about the renewal terms as the journey continues.

## Successes and Lessons Learned

Blue Shield's first ACO, a collaboration between Blue Shield and certain providers in the Sacramento area to serve CalPERS HMO members, has yielded impressive results for its first two years. The program delivered \$15.5 million in savings for CalPERS in its first year in the form of an immediate premium credit, and the partners shared an additional \$5 million in savings above their targets. In two years, the ACO delivered \$37 million in savings to CalPERS, with the partners sharing an

additional \$8 million in savings. Much of the success was due to reductions in health care resource use—including a reduction in inpatient days, preventable hospital readmissions, and out-of-network service utilization for the members in the program. The program also addressed the overutilization of services, reducing the amount of unnecessary elective surgeries.

Blue Shield has since formed eight additional ACO arrangements throughout the state, and early success indicators are promising for these collaborations. For instance, two ACOs established in the San Francisco market in 2011 for the City and County of San Francisco (CCSF) have shown consistent results. In the first full year, inpatient days per 1,000 members dropped over 20 percent in one ACO and over 12 percent in the other. Readmission rates also dropped, showing progress toward the triple aim of improving health, improving patient experience and lowering health care costs. Perhaps most telling was the reaction of the CCSF Health Service Board, which gave the ACO team a standing ovation after their presentation of the results in a recent meeting. That's a very unusual customer response during a renewal meeting, and powerful feedback on the impact of the program.

As mentioned, much of the savings we have achieved through this program have been the result of reduced hospital utilization, which reduces revenue to our hospital partner. Our incentive model is designed to lessen some of this impact, but it is nonetheless true that revenue reduction impacts the hospital disproportionately. Together with our partners, we have implemented action plans and processes that repatriate patients into the participating facilities when they are admitted at out-of-network hospitals, such as through emergency rooms (based on Blue Shield claims data). While bringing patients back into the participating facilities helps the provider partner's overall bottom line, it also results in better care management for the member.

Another success is the evolution in providers' thinking on alternative reimbursement methods that has accelerated their adoption of such arrangements. With the improved controls and more effective delivery of care achieved with this program, we

are seeing the providers willing to take more risk, particularly through capitation on facility services. Many of our hospital partners have entered into sub-capitation arrangements with us as a result of our ACO collaboration. Our actuaries must in turn work to ensure that the cost reductions resulting from these methods serve to benefit our employer groups and members as well.

## Opportunities and Challenges Ahead

As we look to 2013 and beyond, we see numerous challenges and opportunities.

The most important program enhancement currently in the pipeline is the addition of an integrated technology system to connect the partners, allowing us to automate data sharing and give providers access to information that will increase clinical quality. In 2012, we signed an agreement to develop and implement technologies and other solutions that will allow doctors, hospitals and health plans to deliver evidence-based care that is more coordinated and personalized.

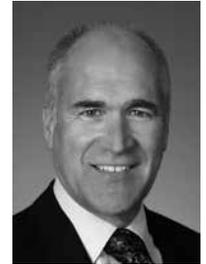
The technology platform will support data exchange across multiple provider organizations and will integrate clinical, financial and administrative data into a comprehensive medical history. The new system will enhance the member and provider experience by ensuring that the providers receive information in real time, allowing them to intervene quickly when their patient is still in the system (that is, admitted to the hospital), rather than after the fact. The system will also give the provider access to personalized evidence-based information for decision making on serious conditions, based on a constantly updated library. Overall, the solution should improve care quality and coordination and reduce costs. The new partnership launched in January, 2013 at the site of our newest ACO, where many of the aspects of the technology solution will be tested and refined.

In addition to technology, our actuaries will continue to monitor the results of our individual collaborations and to review our models for necessary adjustments and enhancements that will drive continued success. As we move forward, one key consideration will be the possibility of enhancing

our demographic adjustment approach with a more robust risk adjustment methodology. However, we must keep in mind that deploying any risk adjustment methodology concurrent with the ICD-10 implementation will require careful consideration.

Also, our initial focus was on our commercial HMO business, and we are now actively exploring expansion to our Medicare Advantage and PPO business. Besides the variety of regulatory issues these expansions will introduce, we need to find solutions to problems being faced by others in the industry, particularly in the area of member attribution, as well as customer funding arrangements other than the traditional fully insured business model. In addition, we will take our accomplishments to the next level by leveraging other strategic initiatives such as patient-centered medical homes and products that incorporate value-based insurance design. These opportunities will continue to make our work interesting and challenging, as well as innovative and important.

The full engagement of our actuarial and analytic staff—with their expertise and ability to find creative solutions—will be essential to tackling these challenges. We must continue to innovate in this area as we work to fulfill our mission to provide all Californians with access to high quality health care at an affordable price. Working with all parts of the health care delivery system to keep the cost of care down will be crucial for our continued success in the California market. ■



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# Health Care 2.0—Massive Implications of System Transformation

By Greger Vigen



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**W**e are in the middle of extraordinary times. Transformation of the health care industry is happening. Yet the transformation has been uneven. Activity is widespread; major initiatives are underway. A few organizations have **already** achieved major successes at the “three-part aim” of “better care for individuals, better health for populations, and reduced expenditures.” Others are still fighting inertia and have either stalled or settled for incremental changes.

There is widespread implementation of initiatives such as accountable care organizations (ACOs), patient-centered medical homes (PCMHs) and bundled payments. Progress is underway on “organization” and “care” such as improved quality on many pilots. “Accountability” (and the twin goal of affordability) is moving far slower.

So, actuaries have an enormous opportunity and responsibility. Our existing expertise, combined with new analytic tools, when implemented alongside collaborative providers can make a major difference. It is time for our active engagement—to create accountable and affordable programs, and to forge partnerships with responsible providers.

This article outlines the direction of the industry leaders and massive forces driving change, and then identifies implications to health actuaries.

## Industry Direction

Industry leaders have agreed on two fundamental problems in the industry: the fragmented health system and the historic fee-for-service payment system that often rewards volume rather than value and results. Multiple initiatives are underway to address both problems in parts of the country.

There is a much larger toolkit of solutions, including new data sources, analytics and provider-based solutions. Various initiatives to implement and test these potential solutions are moving through a variety of pilots.

Government buyers have implemented many significant new programs. These include various fed-

eral (Medicare/CMS/CMMI) programs such as 259 federal ACOs with 4 million beneficiaries and over 400 hospitals participating in the bundled payment initiative.

In addition, there are hundreds of other additional PCMH programs and private sector ACOs.

Activity is high, but the health care industry is one-sixth of the economy. So, even though there is high potential, much needs to be done to implement solutions across the entire country.

The transformation across the industry is unstoppable. However, a transformed environment, by itself, will not create the results you or your organization want. Industry transformation does not mean that you or your organization will be successful. “Standing still” or incremental improvement means long-term failure; so, your active involvement is needed.

## Forces Driving Change

Transformation of the health industry is driven by the same powerful forces that have transformed other industries. Major innovations in technology and new competition create high potential for improved personal service and economies of scale. Then, financial pressures from buyers overcome inertia to drive implementation of innovations.

In a time of transformation, it is very important to understand the external environment and major new solutions and initiatives being tested. Each initiative under way has its own advantages and disadvantages. Some previous solutions will no longer be needed; others become far more powerful. And, a much wider toolkit of potential solutions is available when carriers and providers work together. We have seen industry leaders begin to integrate highly diverse elements into comprehensive programs, including:

- Deeper evidence-based management of hospital and acute care.
- Payment reform (provider reimbursements that pay for value and results).

- Major advances in measurement systems for quality and resource use.
- Major quality improvements in many recent pilots.
- High industry collaboration, especially among leading providers.
- Health information technology (patient-centric single sources of data).
- Member engagement (including increasingly customized web and multimedia tools).
- Personal responsibility (including value-based benefit design and less generous insurance coverage).

Additional resources are available to understand the key innovations and major players:

- An overview is at “The Opportunities During Transformation: Moving To Health Care 2.0”<sup>1</sup>
- The Society of Actuaries sponsored research on “Measurement of Healthcare Quality and Efficiency: Resources for Healthcare Professionals” by me, Ian Duncan and Sheryl Coughlin. The research provides an overview on many major programs and initiatives.

The following table outlines the major forces that are driving this transformation.

Element	What Is New	Force for Change
<b>Financial costs</b>	Health costs are a massive problem. Cost increases drive out other government services. “Family coverage equals the cost of a mid-sized car.”— <i>Milliman.com</i>	↑ Force
<b>Employer support</b>	Changed employer commitment, from formerly covering health plan cost increases, even if far higher than other compensation Higher contributions and more patient cost-sharing greatly change the engagement with employees.	↑ Force
<b>Visible consensus</b>	Widespread visible public discussion of financial problems and need for affordability More balanced objectives of improving quality and reducing premium increases Objective is total reform of health care delivery, not just a specific issue	↑ Force
<b>Leadership</b>	Innovation and change driven from the provider community Common, widely discussed policy consensus on problems and major concepts Many local initiatives	↑ Force

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Element	What Is New	Force for Change
<b>Inertia</b>	Inertia, as always, is a major obstacle	↓ Obstacle
<b>Delivery system</b>	Massive scope and energy in multiple voluntary pilots throughout the provider community Integration can lead to excellent performance, monopoly abuses, or both. The ultimate impact on affordability is yet to be determined.	↑ Force
<b>Expertise on system reform and value-based payment</b>	Many pay-for-performance programs over recent years More providers familiar with capitated Medicare Advantage (MA) in several parts of the country	↔ Mixed
<b>Analytics and metrics</b>	Substantive improvement in analytics and metrics (quality, resource use, episodes, prospective and retrospective risk adjustment) with continuing changes on the horizon Pilots underway for illness-specific metrics (such as complication-based risk sharing)	↑ Force
<b>Data availability</b>	Technical barriers to shared information mostly gone Short-term operational and political barriers remain	↑ Force
<b>Care management</b>	Major new data sources, systems support and successful illness-specific pilots including the various topics discussed earlier Implementation is still uneven, and some elements can be expensive to establish.	↑ Force
<b>Contractual arrangements</b>	Wide variation, but some key programs have sophisticated multiyear arrangements with more strongly aligned incentives In some cases, explicit transition arrangements are being developed.	↔ Mixed

Element	What Is New	Force for Change
<b>Aligned incentives (payment reform arrangements)</b>	<p>Deeper and more sophisticated payment reform options on the table, but implementation is just starting and/or uneven</p> <p>Builds on years of pay-for-performance programs</p> <p>Alignment across Medicare, Medicaid, and commercial under discussion</p>	<p style="text-align: center;"> Mixed</p>
<b>Expertise in provider community</b>	<p>Widespread sharing of information at least in the short term</p> <p>Deeper internal staff and external consultants in some locations based on pilots, pay-for-performance, or other programs</p> <p>Alternative provider-level compensation arrangements</p>	<p style="text-align: center;"> Force</p>
<b>Health information technology (HIT)</b>	<p>Major improvements in provider level HIT</p> <p>Widespread Web-based patient support</p>	<p style="text-align: center;"> Mixed</p>
<b>Member “backlash” and “entitlement”</b>	<p>Lower benefits (bronze plan) and higher contributions create “skin in the game”—especially very high dependent contributions.</p> <p>Provider fees and total premium far more visible</p> <p>Backlash is not automatic. During prior reform attempts, minimal backlash occurred in some locations.</p>	<p style="text-align: center;"> Impact unclear</p>
<b>Benefit design</b>	<p>Some innovations, for instance three-tiered pharmacy benefits</p> <p>More provider interest in channeling volume through benefits</p> <p>The major system transformation is behind the scenes, so the ultimate patient/member role remains unclear.</p> <p>Open issues remain, such as the balance between choice and efficiency (for example, choice of a primary care physician).</p>	<p style="text-align: center;"> Impact unclear</p>

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## It is very different this time!

The energy and environment are massively different this time: these major forces were not there in the '90s. However, inertia is still a challenge. Any behavior change takes effort, and, beyond the generic problems for any change initiative, the local memory of a failed health reform initiative from a decade ago can create obstacles throughout some communities. So, although major transformation is inevitable, the pace and impact in your community is up to you.

Many important financial, technical and policy questions remain.

- How hard should buyers push for financial results in the early years?
- How do buyers and providers create the right working arrangement?
- Does integration lead to great performance, monopoly power, or both?
- Do new payment reform arrangements lead to expense reduction and lower waste?



- In a transformed system, what is the appropriate role for the member?

## Implications to Health Actuaries

The many driving forces show that transformation is inevitable. This is easy to predict, since it is already underway. However, successful financial results are not inevitable. As mentioned, early financial results have been very uneven. Managing waste and creating affordable programs is tough. There are substantial trade-offs between short-term results and long-term system stability, and expert financial advisors are essential.

Health actuaries need to be the ones who bring solutions. As medical cost trends remain far higher than general costs of living, we must create opportunities for improvement. Status quo is not satisfactory in this new world. Regardless of your current position, it is essential to expand and deepen your role.

- For those connected to providers, you are at the forefront of a new industry.
- For executives, these major environmental changes offer new resources, create massive opportunities and risks, with major impact to your strategy and operations.
- Those with pricing responsibilities will need to quantify the future financial implications of these new approaches.
- For those with an analytic role, you will need to understand the new analytic tools and metrics.
- If you are new to the profession, major changes create massive opportunities, leveling the playing field between you and those with more historic experience.

Given the breadth and depth of changes, it is essential to track the external environment and be prepared to expand your role. For example, you should understand the following:

- How forces creating transformation are changing the ways the industry and actuaries work.

- The newest analytic tools and next generation of tools on the horizon and how they impact your job.
- New data sources, including clinical and patient data.
- Health system integration, including changes such as ACOs and PCMHs.
- Financial implications of techniques for attribution of patients.
- How providers can supplement your traditional toolkit.
- How to work with allies outside of your organization (whether providers, carriers, vendors).
- The strengths and weaknesses of new competitors.

During this time of change, the Health Section Council is expanding its continuing education content, including *Health Watch*, ongoing educational groups, webcasts and stand-alone seminars. Let me or other council members know your thoughts and suggestions.

The cost of health care is the burning issue for our times. For many of us, our core business is financial management of health care programs. We have the opportunity to create an improved and affordable health system for ourselves, family, friends, and the community as a whole. ■

#### END NOTES

- <sup>1</sup> [www.soa.org/library/essays/health-essay-2009-vigen.pdf](http://www.soa.org/library/essays/health-essay-2009-vigen.pdf)

The cost of health care is the burning issue for our times.

# Massachusetts Payment Reform from an Actuarial Perspective

By Matthew Day and Jill Wilson



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In 2009, Blue Cross Blue Shield of Massachusetts (BCBSMA) introduced a health care payment reform model called the Alternative Quality Contract (AQC) for managed care lines of business. The AQC employs a population-based global budget, coupled with significant financial incentives based upon performance on a broad set of quality measures. As of 2013, over 85 percent of the managed care business is under an AQC model, including over 700,000 members and their nearly \$4 billion in annual medical claims.

The twin goals of the AQC are to significantly reduce health care spending growth while improving quality and health outcomes. The spending goal of the AQC is centered on holding providers accountable for a global budget; providers are held responsible for all care delivered to their members, including hospital, pharmacy and specialty care. The quality incentives encompass a broad set of nationally accepted clinical process, outcome and patient experience measures. At its inception, the AQC stood in contrast to a landscape dominated by fee-for-service payment models where providers' earnings are based on the volume of services provided. Instead, AQC providers' earnings are based on a more comprehensive measure of value—the overall cost of their members and the quality of care delivered. This article will explore some of the actuarial issues present in the development and evolution of the AQC.

## Separating Risk from Incentive

Payment reform models like the AQC are based on the premise that the health care system will respond to financial incentives. Fee-for-service payment incents more volume, more expensive services and higher costs overall. Early pay-for-performance models used a few discrete measures of quality (e.g., diabetes testing) or cost (e.g., generic prescribing rate) and saw improvements in the measured areas, but little overall improvement in cost or value. The AQC, with its global budget and broad quality measure set, looks to make the incentives complete—measuring and compensating

providers for global results.

Countering this aim for a broad-based incentive model is the concept of financial volatility we will call insurance risk. Insurance risk is the variation in total health care costs for a population outside of the cost variation caused by the choices of health care providers. This volatility comes from changes in the population (health status), macroeconomic conditions, new government mandates, epidemics and other factors. As an example, the costs from a member breaking his leg in an accident would be insurance risk. The difference in cost if the member's PCP chose to order an MRI or x-ray would be an appropriate decision to target with incentives. The AQC does not aim to influence the behavior and choices of health care providers due to the volatility of insurance risk, but to offer the broadest incentive possible outside this risk.

The distinction between incentive and insurance risk is not a clear line. BCBSMA examined the results of each model feature as these contracts unfolded. That experience informed future contracts and the introduction of new or refined features. Many actuarial features of the AQC model have evolved over time to refine and improve this distinction.

We will explore a few cases of this process below.

## The Start of a Contract

BCBSMA considers it important that the starting budget for an AQC not demand immediate and dramatic savings from current spending levels. Capitation contracts that demanded such savings often resulted in member dissatisfaction and were seldom sustainable. The AQC looks to curb costs over time, by setting a slower rate of growth target.

With this structural goal in mind, the actuarial question remained: What was a fair measure of "current costs" on which to set this baseline? When first exploring this issue, the usual factors contributing to a stable base data set were considered: size of the population, number of years of experience, blending with a "manual rate," and truncating large claims.

Early discussions assumed that a very large population with at least two years of truncated data would yield the most stable starting point. The realities of the contracting process, however, pushed toward allowing smaller sizes and using only one year of data. To resolve this difference in approach, a Monte Carlo bootstrapping model was built to study the credibility of total medical expenses, adjusted for health status, at various provider group sizes. Contrary to expectations, that analysis showed that one year of untruncated, health-status-adjusted data was fairly stable at sizes as low as 5,000 members. As a result of this study and the prior experience, the preferred contract approach moved to one year of claims as a base budget (instead of more) from the year prior to the start of first performance period. This data becomes the basis for all budget calculations for the duration of the contract.

## The Budget Calculation

The starting budget is trended into the first performance period where it is compared against actual claims in that period to determine the surplus or deficit for a provider group. The first AQC's relied on fixed trends for this calculation, negotiated based on historic experience and prospective financial objectives. The fixed trends created tangible and known targets for providers, as well as some pricing predictability for the plan. However, toward the goal to separate insurance from incentive risk, adjustment provisions were introduced that would alter the fixed trend for factors that might be outside of a provider's control, such as benefit mandates and epidemics.

As experience unfolded, the multiple adjustments essentially negated the predictability of the fixed trend model. In fact, they led to a great deal of cost uncertainty as they were often only determined at final settlement, which occurs well after the close of a performance period. The original goal of the adjustments was to isolate elements of insurance risk that would move broad health care costs outside of the actions of any one provider group. The same goal could be achieved by moving from fixed



trend targets to one based on broad network trend itself. The AQC model thereby moved to trend targets based on a regional or statewide average across the entire HMO business. Data on trends could be shared with the groups regularly, adding back a certain degree of predictability. The new model separates incentive and insurance risk even more finely, greatly simplifies the contract and administration, while only minimally sacrificing predictability that was less than perfect to begin with.

Simplistically, the first budget is trended into the next year of the performance period and so on for the duration of the contract. More specifically, budgets are adjusted annually for more than just trend. Since the basis for the starting budget is total allowed claims over a one-year period, it is inherently representative of the at-risk members' health and benefit selection at a point in time; however, these are dynamic in any panel of patients. Each year, the budget calculation also looks at how the health status and benefits of the covered membership have changed since the prior year. This change is factored into the annual budget calculation so that the budget will continue to be representative of the population in each performance period. As the model

The twin goals of the AQC are to significantly reduce health care spending growth while improving quality and health outcomes.

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moved to network-based trends, the health status and benefit adjustments needed to not just consider the changes in the provider group, but normalize to the overall change in the network. This approach also neutralizes for any inherent inflation in risk scores year over year, a tendency we have seen in the underlying model.

All of these adjustments can account for various population shifts pertaining to the risk contract. These adjustments have also accurately handled large account losses or gains where the nature of the underlying at-risk population may drastically change in nature. Additionally, these adjustments have compensated for provider changes when a new medical practice with a moderate panel size is assumed or leaves an AQC group in the middle of the contract term. For very large changes in the provider group, such as a group that doubles in size due to a merger, the model looks at the claims experience of that new group explicitly and blends

it into the existing budget as if it were the start of a new contract. The terms of what is a large provider group change are specific for the group at hand since the underlying group size is critical.

## Moderating the Results

Each year, the budget with its trend and adjustments is compared against total medical and pharmacy expenses of members who have chosen a PCP within the AQC group. AQC groups must perform better than average to earn a surplus under the current model. This gross result of budget minus actual expenses can then be altered in several ways before determining the final net surplus or deficit result.

First, the actual claims can be modified by individual reinsurance-like adjustments. Health status models exhibit lower predictive accuracy at catastrophic claim levels; a reinsurance mechanism does a better job for these events. The early AQC groups mostly obtained third party reinsurance contracts to address this risk. This approach allowed for customized terms and a competitive bid process. On the other hand, this approach treated the catastrophic adjustment in isolation, not allowing it to work cohesively with other model elements. For this reason, later agreements have mostly dealt with catastrophic adjustments as an integrated part of the contract.

The second element to adjust the gross results is the percentage share of the result that is allocated to the provider. Higher risk share creates a stronger incentive for a provider to perform, but also minimizes the net savings available to lower premiums. Early contracts were most concerned with determining if care could truly be materially changed through an incentive model; therefore, the risk share was very high, even 100 percent in some cases. As the results came in, it became clear that change was possible with the right incentives, and later contracts began to lower the provider share and thereby create more net value. Additionally, the AQC model now determines the share based on the groups' quality performance, creating a triple effect of incentive, net value creation, and reinforcing the quality of care.

The final modification of the results is the application of an aggregate limit. Early AQCs were



commonly unlimited, again looking to create the strongest incentive for performance. As the model developed, the incentive goal was balanced by the idea of mitigating extreme circumstances. If all of the other provisions and adjustments in the model still resulted in a very large surplus or deficit, the parties would agree on the maximum allowable net result. This limits the ultimate financial risk to the provider, and also creates a maximum cost possible for the plan.

## Conclusion

While the focus of this article has been on the actuarial elements of the model, the many non-financial elements are also keys to success. Providers receive robust reporting and detailed claim extracts to focus and guide their activity. An interdisciplinary support team from BCBSMA meets regularly with each group to set goals, track progress, and collaboratively work through the unique challenges

of each group and population. The provider groups are also regularly brought together to share best practices and for focused user group discussions on specific subject areas.

To date, the results have been very encouraging. The AQC groups have delivered materially slower growth in their claim costs than non-AQC groups. Their quality has also increased faster and to higher levels than the broad network.

There is still a long road to make quality health care affordable to the entire population, but the AQC's progress to date has pointed toward a bright path forward. Maximizing incentives while minimizing the transfer of insurance risk has created a powerful yet sustainable model for change. Holding the twin goals in mind, while innovating and evolving the details, has allowed fast progress since 2009 and, hopefully, well into the future. ■

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# Payment Reform Under The Medicare-Medicaid Financial Alignment Demonstrations

By Shelly Brandel and Michael Cook

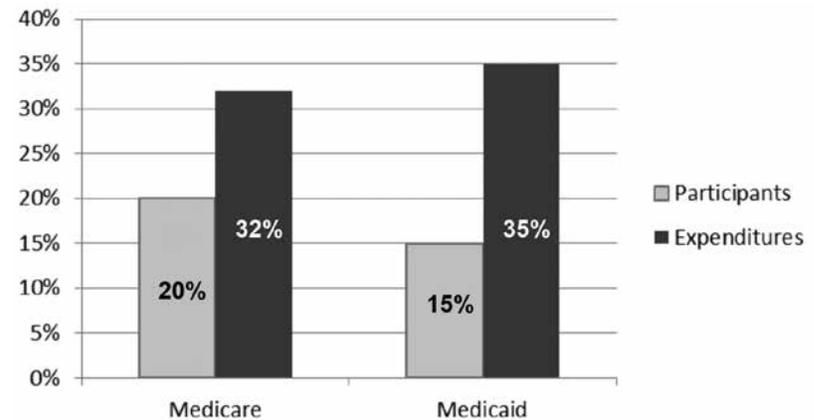
Nationwide, there are about 9 million people eligible for both Medicare and Medicaid benefits, whom we will refer to as “dual eligibles” in this article. These dual eligibles represent \$229 billion in medical spending in 2007.<sup>1</sup> Although dual eligibles represent a relatively small percentage of the combined Medicare and Medicaid population, they represent a significantly larger percentage of expenditures because they have more intense health care needs as a group than other Medicare or Medicaid populations. Figure 1 shows the proportion of individuals and expenditures represented by dual eligibles for Medicare and Medicaid.

Figure 1 shows that, nationally, in 2007 dual eligibles comprised 20 percent of the Medicare population and 32 percent of Medicare expenditures. They comprised 15 percent of the Medicaid population and 35 percent of Medicaid expenditures.<sup>2</sup>

Because Medicare and Medicaid largely operate as separate programs, it is difficult to coordinate care for dual eligibles using existing delivery systems that typically focus on only one set of covered services or are otherwise limited in scope. In addition, there is often a lack of financial incentive to actively manage care when only the Medicaid funding stream is capitated. However, some limited examples of such programs do exist:

- Some states include dual eligibles in their Medicaid managed care programs. These programs typically coordinate Medicaid services for dual eligibles but not their Medicare services. However, several states have designed programs that coordinate delivery of both sets of services.
- Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) have the potential to provide a coordinated provider network and schedule of covered benefits across Medicare and Medicaid for dual eligibles. The degree of Medicare-Medicaid integration varies significantly across states, and health plans may

**Figure 1:**  
Dual Eligibles as Share of Program Participants Vs. Share of Expenditures, 2007



or may not also be at risk for Medicaid-covered services under separate Medicaid contracts with the state. In all these cases, the Medicaid and Medicare revenue streams remain separate.

- The Program of All-Inclusive Care for the Elderly (PACE) provides fully coordinated, site-based care and funding for individuals over the age of 55 who are eligible for nursing home care. However, these programs are typically limited in the number of beneficiaries they can serve and are restricted to the subset of the dual-eligible population eligible for nursing home care.

The Affordable Care Act (ACA) created the Medicare-Medicaid Coordination Office (MMCO) with the goal of improving access to high-quality, fully integrated and cost-effective care for dual eligibles. In coordination with the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation, the MMCO is working with states to establish the Financial Alignment Demonstration, which will test delivery models that integrate care for dual eligibles. The authors of this article and their colleagues are assisting MMCO staff with various financial and policy-related analyses and review related to the demonstration.

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Medicaid-Medicare plans participating in the capitated model will need to pass an application process and readiness review addressing the enrollment process, access to care, and many other issues prior to participation in the demonstration.

## Financial Alignment Demonstrations

CMS originally provided design contracts to 15 states to design programs to provide fully coordinated care for dual eligibles. CMS then invited all states to submit proposals to test structures that align Medicare and Medicaid benefits under two different models. Both models are designed to achieve improved quality and financial savings associated with delivery system and payment reform:

- **Capitated Model:** This model includes a three-way contract between the state, CMS and participating health plans. The health plan receives prospective capitation payments that reflect anticipated program savings achieved through coverage of Medicare and Medicaid services, allowing the state and CMS to share in anticipated program savings up front. The health plan is responsible for providing fully integrated care for Medicare and Medicaid benefits for its members.
- **Managed Fee-For-Service (FFS) Model:** Under this model, the state is responsible for establishing programs to coordinate care for dual eligibles. In return, the state will be eligible to share in overall federal savings measured on a retrospective basis, as long as certain quality thresholds are met.

CMS received proposals from a total of 26 states (including the original 15 states) to participate in the capitated model, managed FFS model, or both. However, CMS does not expect that all proposals will be implemented. The proposed demonstrations are targeted to be effective in early to mid-2013 and 2014 with durations of about three years. Each state's program differs with respect to many factors, including:

- **Target population** (may include all full-benefit dual eligibles or a subset based on age, placement in nursing facilities, or other factors).

- **Geographic area** (can be statewide or limited to specific counties or regions).
- **Capitated model enrollment process** (generally passive enrollment is proposed for use, but the process used to phase in members, assign members to specific plans, etc. may vary).
- **Benefits covered** (generally covers virtually all Medicare and Medicaid covered services; but under the capitated model, states may carve out specific Medicaid services to be provided outside of the demonstration).

CMS is currently reviewing these proposals and working closely with each state whose proposal meets the demonstration standards and conditions to develop memoranda of understanding (MOUs) that outline key aspects of each state's program. As of the end of 2012, three states have established MOUs with CMS for their demonstrations (Massachusetts and Ohio under the capitated model and Washington under the managed FFS model). The remainder of this article focuses on the rate development and potential financial savings associated with the capitated model.

## Overview Of The Capitated Model

Medicaid-Medicare plans participating in the capitated model will need to pass an application process and readiness review addressing the enrollment process, access to care, and many other issues prior to participation in the demonstration. Once the plans are selected and beneficiaries are enrolled, health plans will receive separate capitation payments for Medicare Part A/B, Medicaid and Medicare Part D services. The capitation payments for Medicare Part A/B and Medicaid will be adjusted to reflect anticipated savings associated with care integration. A quality withhold will also be applied to the Medicare Parts A/B and Medicaid components. The Medicare Part D payment will not reflect any quality withholds or anticipated savings.

## CAPITATION DEVELOPMENT

In concept, the capitation rates under the demonstration program (excluding Medicare Part D payments) are calculated using the following process:

1. Project baseline costs in absence of the demonstration.
2. Apply savings percentages.
3. Apply withhold percentages.
4. Apply any prospective risk adjustment mechanisms (for example, HCC Medicare risk adjustment model).
5. Apply any retrospective risk mitigation mechanisms (for example, risk corridors limiting health plan gains and losses or individual high-cost risk pool distributions).

Medicaid-Medicare health plans participating in the capitated model will receive three separate payments: Medicare Part A/B, Medicaid and Medicare Part D. Baseline cost development for each of these is described in more detail below.

### *Medicare Part A/B*

CMS will calculate the Medicare Part A/B capitation rate in each county based on the projected proportion of members enrolled from Medicare FFS versus Medicare Advantage. The component of the rate calculation associated with beneficiaries currently in the Medicare FFS delivery system will be based on the published county-level FFS payment rates, except that the demonstration rates will be increased to reflect any legislation removing the sustainable growth rate (SGR) physician rate reductions.

In addition, CMS may consider not applying the standard Medicare Advantage risk score coding intensity adjustment (3.41 percent downward adjustment to risk scores and revenue in 2013) in the early stages of the demonstration. In states where the majority of members are coming from Medicare FFS, plans may have limited initial ability to impact members' risk scores. In both Massachusetts and Ohio, CMS will not apply the coding intensity adjustment in calendar year 2013. The prevailing coding intensity adjuster will apply after startup.

The component of the rate calculation associated with members currently enrolled in Medicare Advantage will be based on estimated payments to Medicare Advantage plans in which members would have enrolled absent of the demonstration, including plan-specific assumptions regarding bid amounts, quality bonus payment-adjusted benchmarks, and rebate amounts for each county.

The Part A/B baseline projection will be a blend of the projections for individuals moving from Medicare FFS and those moving from Medicare Advantage. No additional adjustments for non-claim expense considerations will be made beyond what is already reflected in the baseline development for the Medicare FFS and Medicare Advantage populations.

### *Medicaid*

Each state, along with their contracted actuaries, will develop a projection of baseline Medicaid costs in absence of the demonstration. For states that currently include (or planned to include in the absence of the demonstration) dual eligibles in their Medicaid managed care programs, the baseline projection represents managed care capitation rates in absence of the demonstration (which may be based on health plan encounter data, Medicaid FFS data or other data sources). For other states, the baseline projection represents historical FFS experience projected to the appropriate time period of the demonstration.

The rate cell structure will vary by state but is generally expected to provide a financial incentive for plans to provide home and community-based services in lieu of institutional placement. For example, all beneficiaries certifiable for nursing home placement may be combined into one rate cell, regardless of whether they are utilizing a nursing facility or community-based waiver services. The rate would reflect the expected costs based on a historical relationship of the location of care provided. This allows plans to realize savings for delaying admission into nursing facilities through greater use of less costly community-based services.



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es. Alternatively, the state may use transitional rates and delay payment level changes for several months when members move from a community rate cell to a nursing facility rate cell or vice versa.

The Medicaid capitation rates may be further risk adjusted beyond rate cell definitions to account for variation in the mix of types of individuals participating in the demonstration (for example, institutionalized members and members receiving community-based waiver services).

The Medicaid baseline rate development must be approved by CMS with review from their contracted actuaries (Milliman and Actuarial Research Corporation). Similar to the Medicare Part A/B rate, the Medicaid baseline projection will be multiplied by the established savings percentage, withhold percentage, and other adjustments as applicable to determine the final Medicaid capitation rate under the demonstrations.

#### ***Medicare Part D***

The capitation rate for Medicare Part D covered benefits will be set at the national average monthly bid amount each year (\$79.64 for 2013). The Part D claims for demonstration plans will be subject to the same subsidies and end-of-year settlements as other Part D plans.

One item to note is that CMS is encouraging demonstration plans to buy down cost sharing below the standard low-income levels for its members without forfeiting the low-income cost-sharing subsidies. This option represents a competitive advantage over Part D plans not participating in the demonstration, as they must forgo the cost-sharing subsidy to the extent their benefit design is richer than the defined standard structure.

#### **SOURCES OF COST SAVINGS**

The sources of potential savings resulting from the capitated model vary depending on the type of service being provided:

##### ***Acute Care***

Acute care is primarily covered by Medicare, with Medicaid paying deductibles and cost-sharing amounts for dual eligibles. Therefore, under the current delivery system, there is limited financial incentive for Medicaid programs to better coordinate acute care because most of the resulting savings would accrue to Medicare. The demonstration program is anticipated to result in acute care savings resulting from efforts, among others, to:

- Coordinate treatment of multiple chronic conditions.
- Provide care in the most appropriate setting, emphasizing community-based care.
- Reduce or eliminate unnecessary tests or procedures.
- Better manage ambulatory sensitive admissions to reduce avoidable emergency room visits and inpatient admissions or readmissions.

##### ***Behavioral Health***

Financial responsibility for behavioral health services is currently shared between Medicare and Medicaid. Anticipated savings on behavioral health services are expected based on improved coordination between services covered by Medicare versus those covered only by Medicaid and emphasizing community-based care.



### ***Long-Term Care***

Long-term care services are primarily covered by Medicaid. For states where dual eligibles are not covered by Medicaid managed care programs, anticipated savings result from delaying members' entry into nursing home facilities through the increased use of home- and community-based waiver services, as well as discouraging unnecessary inpatient hospital admissions from the nursing facility. For example, financial responsibility currently shifts from Medicaid to Medicare and increases nursing facility payments to Medicare levels for the first 100 days after readmission to the nursing home. With health plans having fiscal responsibility for both Medicaid and Medicare services under the demonstration, they will have an incentive to modify contracting and coordination efforts with facilities to reduce inpatient hospital admissions from the facilities.

### ***Administrative Costs***

Administrative costs for managed care organizations in states with current Medicaid managed care programs may decrease on a per-member-per-month basis for a variety of reasons. One possible reason is increased enrollment over which to spread fixed administrative costs. Another is potentially reduced marketing costs, depending on the enrollment methodology for the demonstration and the competitive environment.

States may also request changes to administrative processes that reduce administrative costs or improve beneficiary experience (for example, integrating Medicare and Medicaid appeals processes), which can be incorporated into the demonstration with CMS approval.

### **SAVINGS DEVELOPMENT PROCESS**

The savings percentages applied to the Medicare Part A/B and Medicaid baseline projections will be established by CMS and each state. The general process is outlined below:

1. CMS will provide preliminary savings calculations developed by its actuarial contractors to each state. The savings calculations are based on a consistent set of assumptions derived from

an extensive literature review of the financial impact of care management activities on similar populations for each source of savings discussed above. These savings assumptions are applied to actual historical Medicare and Medicaid utilization and cost data for each group of individuals eligible for the demonstration in a particular state to calculate the preliminary savings.

The savings percentages have the potential to vary by state, depending on program characteristics, including:

- Populations included under the demonstration (for example, seniors not eligible for nursing home care, nursing home eligibles only, dual-eligible enrollees under the age of 65, etc.)
- Services covered under the demonstration and other program structure differences.
- Penetration of managed care prior to the implementation of the demonstration program.
- Historical acute care and long-term care utilization patterns of the targeted population.

2. CMS and each state will then establish the applicable savings percentages for each year of the demonstration, with the percentages expected to increase each year. In the capitated model MOUs completed for Ohio and Massachusetts, the savings percentages are 1 percent for the first demonstration year, 2 percent for the second year, and 4 percent for the last year.

3. The same savings percentages will be applied to both the Medicare Part A/B and Medicaid components of the capitation rates. Although the actual savings are likely to accrue disproportionately between Medicare and Medicaid services, the capitation rates in the demonstration are designed to allow both programs

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(Medicare and Medicaid) to share in the savings resulting from improved coordination. For purposes of the demonstration, CMS considers the existing Medicaid capitation actuarial soundness requirements to be flexible enough to consider differing efficiencies and savings that may be associated with Medicare versus Medicaid services. Therefore, CMS does not believe a waiver of Medicaid actuarial soundness principles is necessary.

#### QUALITY WITHHOLDS

The Medicare Part A/B and Medicaid capitation rates will be reduced by any quality withholds specified in the MOU. These withholds can be earned back by meeting certain quality standards. The withhold percentages and core quality measures will be consistent across all states, although some states may include state-specific quality measures in addition to the core quality measures.

### Monitoring And Evaluating The Financial Alignment Demonstrations

CMS has contracted with RTI International to monitor ongoing experience and evaluate the impact

of each state demonstration. This evaluation will include a review of health outcomes and beneficiary experience, service utilization, and financial impact measurement. Delivery systems and payment mechanisms determined to be effective may be considered for replication in other states.

*For additional details on the Financial Alignment Demonstrations, please visit <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>.* ■

#### END NOTES

- <sup>1</sup> Centers for Medicare and Medicaid Services, *Medicare-Medicaid Enrollee State Profile, The National Summary*, 1.
- <sup>2</sup> *Medicare-Medicaid Enrollee State Profile*, *ibid*.



# Payment Reform: A Medicaid Overview

By Rebecca Owen, Dave Neiman and Tom Carlson

The dramatic changes in health care delivery in the United States are providing most health actuaries with significant challenges that put our professional skills to the test, and there is no area where change is more extensive than Medicaid. The Affordable Care Act (ACA) extends Medicaid coverage to many more recipients, expands the coverage that recipients receive, and lays out a path for payment reform that is expected to increase quality of care and partially offset the increased costs of the expansion. This article focuses on the routes different states have taken to reform Medicaid, including payment reform and quality improvement initiatives.

The ACA has increased payment reform activity in a number of areas:

- There will be an increase in payments to primary care physicians, reflecting their expanded role in managing patient care. This increase will encourage providers to care for populations that have been historically underserved.
- The ACA funds studies, grants and demonstration programs focused on quality improvements and alternative payment and delivery methods.
- The ACA decreases Medicaid lump sum payments to disproportionate share hospitals—that is, those hospitals that deliver a higher proportion of care to low income patients who lack other insurance coverage (including Medicaid, Medicare and commercial insurance) in anticipation of fewer uninsured patients and less uncompensated care.

While these changes are federally mandated, it will be up to the states to implement them—or not. States can opt out of payment reform and Medicaid expansion, but those that do opt out will forgo all or part of federal funding. As of late January 2013, 10 states will definitely not implement ACA's Medicaid changes, five more states are unlikely to do so, five states are likely to participate, and 18 states plus

the District of Columbia will definitely implement ACA's Medicaid payment reform and expansion measures. Twelve states are still undecided. Of the 18 states that are definitely participating, four states—Massachusetts, Kansas, Arkansas and Oregon—are far enough along to give us an idea of what the Medicaid reform will look like, though the presence of health care exchanges in 2014 will add an additional level of complexity.

## Massachusetts

Massachusetts has new legislation to reduce costs based on alternative payment arrangements, and it will create new entities to oversee the change. Six years after Massachusetts' landmark legislation that reduced the commonwealth's rate of uninsured residents from 10.9 percent to 6.3 percent, Massachusetts introduced Health Care Reform 2.0. This bill, signed into law in August 2012, seeks to significantly curb the growth in health care spending while simultaneously increasing the quality of care. The legislation is far-reaching, impacting beneficiaries, providers, and public and private payors.

MassHealth, the state's Medicaid plan, is not exempt from the new requirements and responsibilities outlined by the law. The program will be accountable for achieving the spending growth targets applicable to the private sector (how the state will penalize itself is another question). Specifically, the legislation targets health care spending growth equivalent to the growth in gross state product (GSP) for the first five years, 0.5 percent below GSP for the following five years, and at a level equal to GSP thereafter.

The primary channel by which the state hopes to increase efficiency and lower Medicaid costs is through the transition from fee-for-service (FFS) payment arrangements to alternative payment methodologies (APMs). APMs may include shared-savings, bundled payments or global capitation arrangements. The legislation prescribes that MassHealth pays for 80 percent of its beneficiaries (excluding beneficiaries dually enrolled in Medicare) through an APM by July 2015.



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To ease the transition to the new payment system, the state has created two incentives for providers to participate in APMs. First, MassHealth will pay providers that demonstrate significant transition to APMs 2 percent higher rates (capped at \$20 million) for the time period July 2013 through June 2014. Second, MassHealth will give priority to certified, “model” accountable care organizations (ACOs) in its contracting process.

The new legislation intends to increase access for MassHealth beneficiaries. Through the use of expanded “express-lane” eligibility renewals, the state hopes to decrease the enrollment churn associated with disenrollment due to administrative reasons. For qualified veterans, survivors or dependents currently enrolled in MassHealth, the state will investigate opportunities to improve access to the Department of Veterans Affairs’ benefits.

To implement and operate the changes required by Health Reform 2.0, Massachusetts created two new entities: (1) the Health Policy Commission (HPC) and (2) the Center for Health Information and Analysis (CHIA). The HPC will essentially oversee the implementation of the new legislation, including APM development, ACO certification, the review of health care cost growth, and the creation of benchmarks. The CHIA will collect payor data, develop

standardized quality reports, produce annual cost reports, and support the HPC with analytics.

More information is available at <http://masscare.org/about-mass-care/>.

## Kansas

The Kansas Medicaid program implemented KanCare to encourage quality and innovation. The new program is intended to move Kansas toward a fiscally sustainable health care program providing quality care. The KanCare program includes a pay-for-performance (P4P) component that is designed to provide financial incentive to reward quality and withhold reimbursement if quality metrics are not achieved.

The state will withhold a portion of each health plan’s monthly capitation for the health plan’s year-end assessment. A number of quality metrics are considered, and each metric represents a portion of the rate that is withheld. During the first year, 3 percent of the capitation will be withheld from each plan. The amount withheld will increase to 5 percent in subsequent years. Under current law, 5 percent is the maximum allowable withhold to be at risk for managed care organizations (MCOs). During the first year, six performance measures will be monitored. The state will use 15 performance measures thereafter. Each measure holds equal weight; so during the first year, each measure will be worth 0.5 percent, and in subsequent years, each measure will be worth 0.33 percent. A health plan will not be able to make up for missing a threshold in one measure with excellent performance in other measures.

The performance measures used for the first year are related to operations and put an emphasis on the transition to managed care. This focus will alleviate concerns about credible data not being available to measure quality in the first year. The performance criteria include claims processing measures, data submission compliance, grievances and other operational measures.

Quality measurement in subsequent years will include metrics intended to improve physical health (for example, certain HEDIS metrics), metrics relating to provider access and life outcomes for those



with physical or mental disabilities as well as those receiving substance abuse services, and metrics relating to how long-term care patients use skilled nursing facilities and home and community-based services (HCBS) versus hospitals. Performance targets are more rigorous than the standard contract requirements, and in general, the performance targets will increase by 5 percent per year. A list of the 15 measures can be found on the KanCare website.

More information can be found at [http://www.kancare.ks.gov/quality\\_measurement.htm#pay](http://www.kancare.ks.gov/quality_measurement.htm#pay).

## Arkansas

Arkansas has ranked near the bottom of measures of health outcomes and is a state with severe budget challenges. Medicaid beneficiaries have received care from a system that is fragmented and rewarded for volume rather than quality. Arkansas felt that small changes to payment were not sufficient enough to address the needs of the Medicaid population, and thus, embarked on a payment improvement initiative.

Arkansas worked with a broad range of payers, state agencies and providers to develop a payment method that will retain many fee-for-service (FFS) payment methods and also incorporate episode-based payments intended to incent and reward providers that deliver quality care. An “episode of care” is defined as the collection of all services and care to treat a medical condition for a given period of time.

The goal is to forestall payment rate cuts to providers by reaping the savings due to better coordination of care. The state will develop an average episode cost and measures for the quality of delivery during a set study period. Patient treatments will be clustered to an episode. Each episode will be attributed to a Principal Accountable Provider (PAP), who is deemed to have the most responsibility for each episode. At the end of a reporting period, the PAP will be rewarded or penalized depending on the cost of the episode relative to the benchmark for that episode. Providers who save money will be rewarded. PAPs whose episodes cost more than the benchmarks will pay for part of the excess.

This program went into effect in the summer of 2012, but it will take three to five years to fully develop the episode model. The first episodes measured are Upper Respiratory Infection, Perinatal, Attention Deficit Hyperactivity Disorder, Congestive Heart Failure, and Total Joint Replacement (Knee and Hip).

Arkansas is also embracing the concept of medical homes for coordinated care, emphasizing preventive care and the health of the patient based on a holistic view of a patient’s health care needs. Arkansas reform also addresses the need for better coordination of care for patients with mental health illnesses, developmental disabilities, and those with long-term-care needs.

More information can be found at <http://www.paymentinitiative.org/Pages/default.aspx>.

## Oregon

Oregon has a history of Medicaid innovation. For example, in 1993, Oregon adopted the concept of the Prioritized List, which ranked care by effectiveness and need, and then covered services as far down on the ranked list as budgets would allow. Also, when the Medicaid budget allowed for expansion in 2008, the state used a lottery method to choose 10,000 new beneficiaries out of 90,000 applicants for the pool. This method of expansion provides valuable early information and research opportunities on the impact that Medicaid expansion under the ACA may have across the country.

The state has had a large penetration of managed care organizations in the Medicaid population and had used a network of mental health organizations (MHOs) to administer mental health care. With a history of progressive changes to the delivery system, it is not surprising that the next phase of payment reform in Oregon would be dramatic and comprehensive.

In 2012, Oregon consolidated managed care plans into a network of 15 coordinated care organizations (CCOs) based on the medical home concept. The CCOs are local and community based, patient-cen-

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tered and team focused. They integrate community, county, MCOs and providers into an organized system of care. CCOs receive a risk-adjusted budget for each member, and while they must offer the basic benefit plan, it is expected that they will provide other community-based services to provide better access to care, coordinate care for members with chronic physical conditions, integrate mental and physical health care, and reduce disparities in access to care. CCOs are accountable for the outcomes of their member populations. The state reiterates that the desired outcome is to achieve what the Institute for Healthcare Improvement (IHI) has coined as the “Triple Aim”: improved patient experience (including quality and satisfaction), improved health of populations and reduced per capita cost.

While the CCOs are operational and most Oregon Medicaid members are now enrolled in a CCO, there is still work to be done to finalize how high-risk patients are integrated into the system, as well as how to better coordinate care for those with dual eligibility (that is, those with Medicare and Medicaid coverage). In an expectation of cost savings due to the new model, the initial budgets for the

CCOs reflected a 2 percent reduction in payments so the organizations will need to show improvements in costs from the inception of the program.

More information can be found at <http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx>.

These four states have responded to the challenge of payment reform in different ways, but they are all trying to achieve cost containment through an emphasis on quality, an expectation of improved performance, and some form of transfer of responsibility to the delivery system. States that have just begun the payment reform process are watching these efforts to see which are workable and effective. Some states have moved beyond these four states, while others are trying to build a consensus of what their future in Medicaid looks like. Each state has a different starting point for Medicaid transformation, and each state will implement reform slightly differently. Differing versions of the health care exchanges will complicate any changes to programs. At the end of the process of reform, Medicaid programs will still vary from state to state, and there will be disparities. ■

# Value Based and Accountable Care

## The Actuarial and Clinical Role in Building a Sustainable Model

By Mark Bethke, Cindy Hamilton, Amanda Holland and James Whisler



**T**he Centers for Medicare and Medicaid Services (CMS) recently announced the addition of 106 new Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) for 2013. Add in the 116 MSSP ACOs from 2012 and the 32 Pioneer ACOs, let alone all of the activity happening in the commercial segment, and it's clear that value-based care (VBC) is becoming more prevalent. Although the VBC train has gained momentum, it's a long way to the destination. There are a number of stops between fee for service (FFS) and population health management.

It can be hard for a care system to operate in both the VBC and FFS environments. It's a pleasant surprise to see so many organizations taking a leap of faith to give this new business model a try. Some are doing it because they're already operating like an ACO and adding this wasn't a stretch. But, for the vast majority, every day means a new critical decision in risk areas they may not be prepared to assess, or a change of habits in the way care is provided.

What if the organization is wildly successful, moves the needle with quality metrics, and creates significant savings with the Medicare FFS population? Hooray! But this isn't simply about the MSSP ACO. This is about taking the entire organization and many population segments into this new VBC world. How will these newfound efficiencies affect the overall organizational finances, given those

additional efficiencies are probably also affecting the significant majority of other patients under historical FFS contracts? Do fewer MRIs? The chief challenge is that these are high margin services. You just can't win!

Ultimately, it will require a collaborative, analytical approach to navigate through the risks, while increasing both quality and efficiency. We will need good clinicians and actuaries to get from the FFS station to our destination at population health.

### A Little History Lesson Never Hurt Anyone

This isn't the first time that organizations have considered VBC. Since the era of capitation, reimbursement methodologies have run the gamut from FFS to full risk capitation, and any number of methods in between. With increased pricing pressures and countless health reform changes, hospitals, physicians and health plans are once again exploring risk/gain sharing financial arrangement scenarios.

When providers engaged in some form of capitation or risk more than a decade ago, some were successful and some were not. Not surprisingly, only the failures are remembered, causing significant hesitation among many. Of course, successful navi-

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... how can we drive toward a sustainable business model in this new world of VBC?

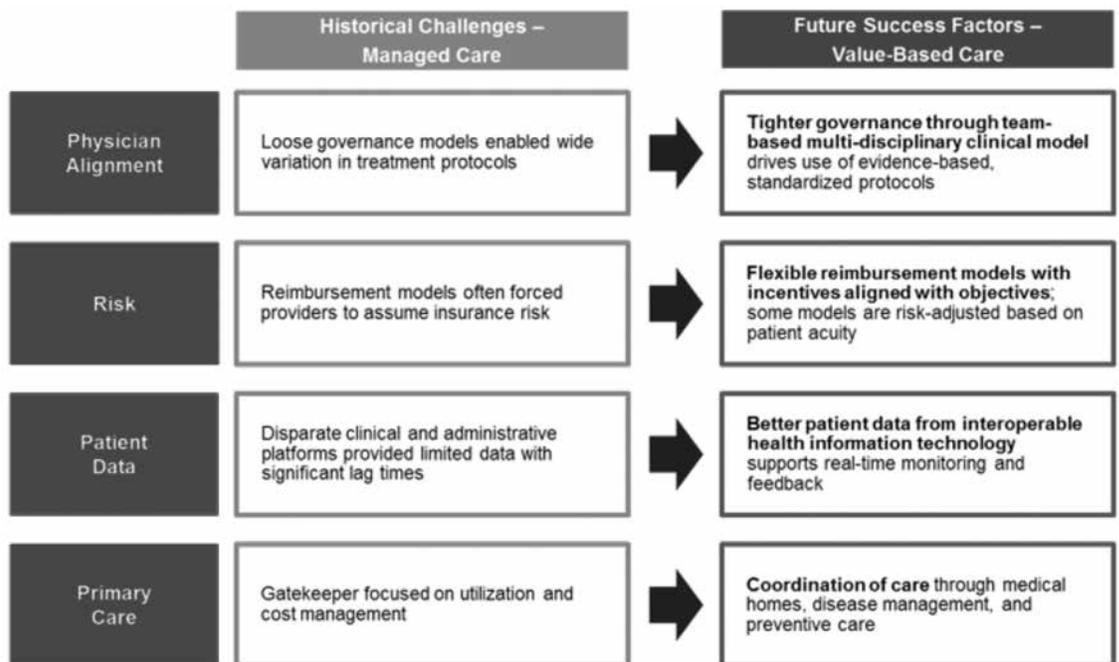
gation to value based reimbursement will require avoiding the historical challenges of managed care. That may have been impossible in the past, but now the data and tools are better, and the organizations are more capable. The table below summarizes the transitions needed to help move from FFS to VBC.

Fast forward to today. Health care systems are being reintroduced to VBC through test cases like the MSSP ACO or bundled payments and through new reimbursement strategies with payers. Our experience is that successful VBC organizations employ a multi-faceted, phased-in approach. It takes time to be prepared for full capitation. What role does actuarial and clinical support play? How do we integrate the value of refined analytics into

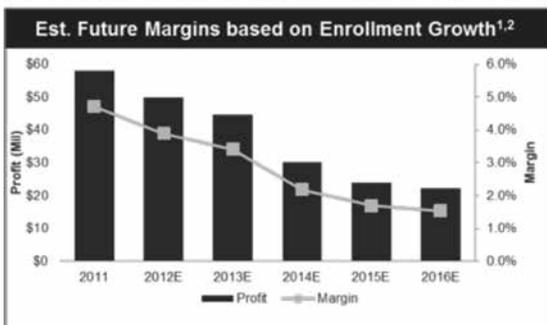
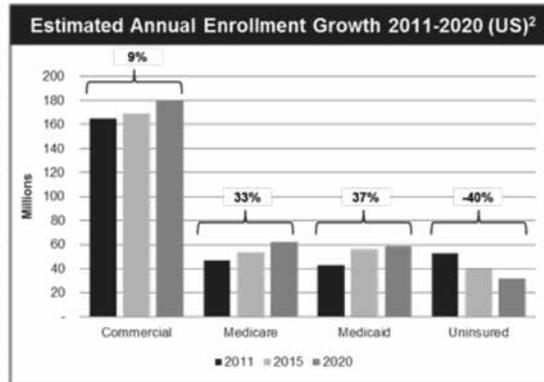
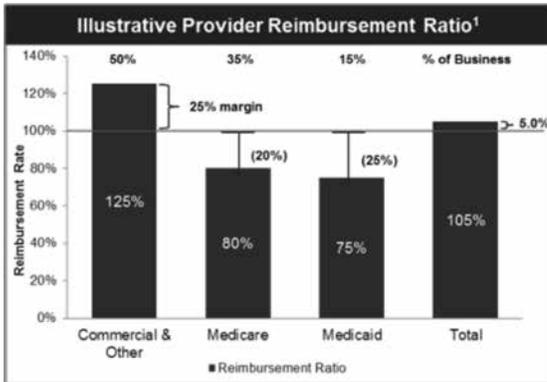
capabilities discussions with clients? Most importantly, how can we drive toward a sustainable business model in this new world of VBC?

### Establishing a Baseline—Don't Forget to Mind the Gap!

A number of folks are claiming that the status quo is no longer sustainable. But how do you know unless you actually model this out? What might happen if a health system did nothing at all and continued business as usual? How will price compression, population shift and growth, and market competition affect your organization?



Sources: Deloitte Center for Health Solutions, *Accountable Care Organizations: A new model for sustainable innovation*; Webcast discussion by Latham & Watkins, The Camden Group, Intelligent Healthcare and Yale-New Haven Health System, *Accountable Care Organizations-Physician Hospital Integration*



- ### Key Takeaways
- Continued fee for service (FFS) rate reduction puts pressure on cross subsidization
  - Exchanges increase individual enrollment and consumer expectations
  - Shift towards segments with lower reimbursement (e.g., Medicare, Medicaid)
  - Hospital margins may continue to decline, requiring capture of premium dollar through broader structures, e.g., extended networks, accountable care
  - Operational cost reduction may not be sufficient
  - Reimbursement mechanisms need to be in place to balance the loss of revenue and reward behavior change

The chart above illustrates one way to help assess a health system's future profitability by modeling the population growth by payer segment, and the resulting net system margin.

This should be the baseline to which future scenarios are compared. This upfront modeling can also be helpful in educating physician and organizational leadership so that buy-in can be gained, and establishing behavior change that may be necessary to migrate from the status quo FFS reimbursement. This type of baseline modeling, when done at numerous health systems over the last few years, has been interesting.

On one end of the spectrum, there are systems that are already starting out in a poor financial position (for example, negative net earnings), and five-year estimates of worsening results, leading to limited options. Given these bleak estimates, these systems can often begin exploring dramatic strategic decisions. We've seen this type of situation lead to an investigation of partnering, merger or acquisition options.

On the opposite end of the spectrum, there are systems that are still sitting strong financially and are the dominant provider in their market. Although these systems are still thinking through the strategy of a move toward VBC, they might ride out the status quo a little longer before completely moving away from their current position. As we have noted with some systems in the past year, if a health system is still able to command high FFS rates and there are not any imminent competitive threats to their market-dominating position, why rush into changing the business model?

As usual, it's complicated, and most organizations are somewhere in the middle. For these systems, we often come up with a range of estimates that run the gamut of a worse case estimate (for example, what if the majority of payments are at Medicaid reimbursement levels?) versus a slightly more optimistic view of reimbursement trends, knowing it's likely somewhere in between. These are the organizations we've been spending the majority of our time with over the last two years. There is a lot of market positioning, as there are likely to be winners

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Although much is uncertain, one thing is clear: nearly all health care players are thinking through their strategic landscape, their status quo modeling, and considering how to react to this new health care world.

and losers in the VBC world as capacity is driven out of the system in some areas.

Of course, this baseline modeling should be done in the context of the system's market-specific dynamics and competitive landscape. Determining what the other physicians, hospitals and health plans will be doing in a specific market, and estimating how health reform may play out over the next three to five years, is a complicated task. It means considering everything from aging of the population into Medicare, to the impact of new state exchanges or managed Medicaid programs. Although much is uncertain, one thing is clear: nearly all health care players are thinking through their strategic landscape, their status quo modeling, and considering how to react to this new health care world.

### Closing the Gap and Defining the Future Business Model

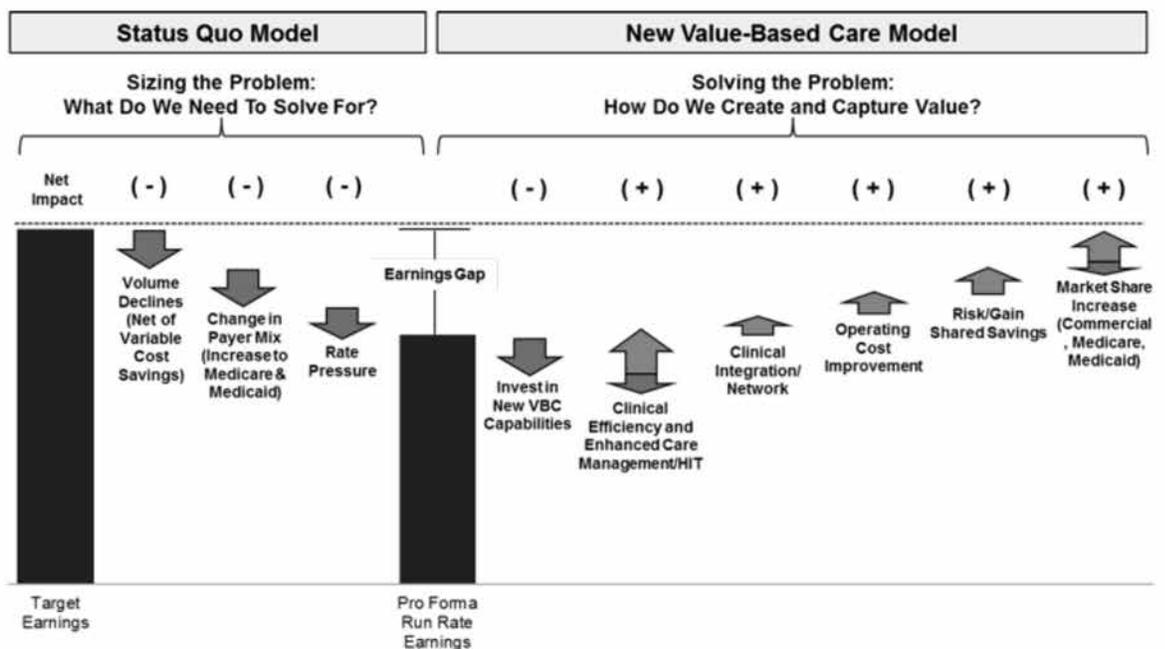
After establishing a baseline model, the next step should be to determine what the future state VBC model might look like. How do the MSSP ACO and other VBC strategies factor into the overall business model? What are the major levers to pull? Are there any plausible scenarios that get back to a sustainable business model? Most importantly,

what are the actions needed to mitigate the risks associated with the organization's strategic goals?

Below is an illustrative waterfall graphic of the types of levers available to a health care system.

To assess this new business model, an important step should be to establish an interactive financial model to sensitivity test the levers available and run multi-year scenarios for the organization. The financial model should be set up to help quantify and assess the following target questions:

- Is there room for improved clinical efficiency (for example, 10 percent of total "utilization")? Where are the opportunities for improvement (for example, admissions or average length of stay (ALOS), emergency room, lab/radiology, specialty visits, brand drugs, etc.)? What is the impact on operating margin in relation to current contracts (for example, how are doctors/hospitals currently paid)?
- What percent of revenue can be moved to VBC arrangements (for example, MSSP ACO, VBC contracts with payers, etc.)? How will those gains/losses be shared between the system and payers?
- Are fixed and variable costs well defined within the organization, and is it known what assets



exist and where? What percentage of fixed operating cost improvements can be made? How sophisticated is the organization in moving toward true cost accounting?

- What market share/revenue growth is reasonable, through steerage or new lives? Where will that market share come from and how will it be captured?

Any one of these questions can be a detailed assessment, and many organizations are already focusing on one or more of these areas. For example, fixed cost reduction efforts and managed care contracting strategy discussions are occurring at most of the systems we talk with. However, while most organizations are thinking about these areas in their silos, what is often missed is the linkage to bring them together as part of the broader strategic plan. The financial model is a tool to help facilitate this discussion by aggregating many of these assumptions, assessing how they interact with each other, and allowing for a directional view of which levers affect the business model that are achievable, which ultimately helps define where to begin.

## To Achieve This New Value Based Care Model, Health Systems Require Key Capabilities

Before progressing any further with this new business model, an organization should be certain it has the required capabilities to achieve the organization’s strategic vision and goals. This type of venture requires experience and collaboration with finance, the actuaries, technology, clinical and operations, and requires a leadership and governance structure that supports these functions. Sustainability in a value based marketplace should include the following six core capabilities:



<p><b>Leadership and Governance</b></p> <ul style="list-style-type: none"> <li>▪ Governance system of accountability</li> <li>▪ Physician leadership decision making rights and responsibilities</li> <li>▪ Performance measures to inform clinical and business decisions</li> <li>▪ Communications and change management approach</li> </ul>
<p><b>Clinical Integration</b></p> <ul style="list-style-type: none"> <li>▪ Care coordination and transition processes</li> <li>▪ Clinical protocols and guidelines</li> <li>▪ Tools/processes to support integration and care coordination</li> <li>▪ Quality, safety, and outcomes</li> <li>▪ Population health management/ care management/ disease management (vs. Case management)</li> <li>▪ Patient engagement/satisfaction</li> </ul>
<p><b>Business Operations</b></p> <ul style="list-style-type: none"> <li>▪ Process standardization</li> <li>▪ Service operations</li> <li>▪ Customer relationships</li> <li>▪ Rating and underwriting</li> <li>▪ Performance improvement</li> <li>▪ Resource management</li> <li>▪ Cost management</li> <li>▪ Marketing and sales</li> <li>▪ Legal and compliance</li> <li>▪ Revenue cycle</li> </ul>
<p><b>Information and Integration Services</b></p> <ul style="list-style-type: none"> <li>▪ Clinical information systems</li> <li>▪ Data warehouses</li> <li>▪ Analytics and business intelligence</li> <li>▪ Interoperability and data sharing</li> <li>▪ Population health reporting</li> <li>▪ Secured health information</li> </ul>

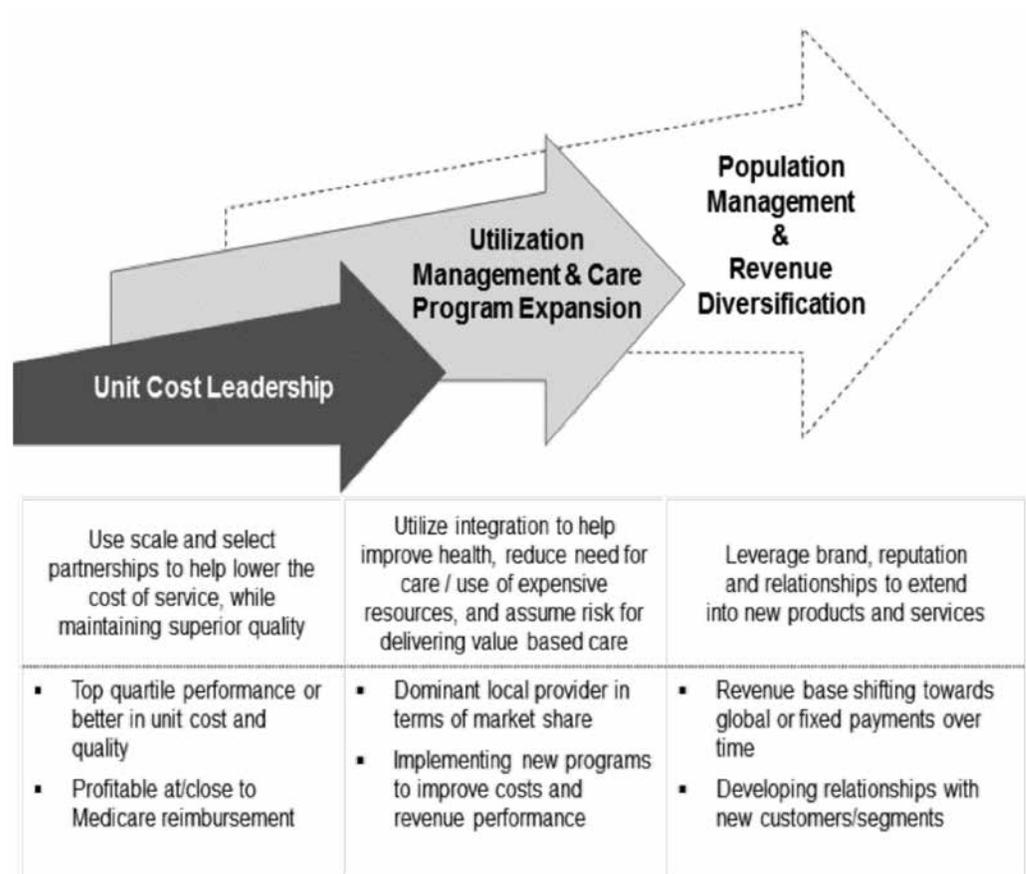
<p><b>Network and Physician Alignment</b></p> <ul style="list-style-type: none"> <li>▪ High value network composition</li> <li>▪ Physician alignment</li> <li>▪ Community/public health programs and services engagement</li> <li>▪ Provider evaluation and performance metrics</li> <li>▪ Quality and performance reporting</li> </ul>
<p><b>Incentive Alignment</b></p> <ul style="list-style-type: none"> <li>▪ Economic model</li> <li>▪ Value based risk arrangements</li> <li>▪ Distribution model</li> <li>▪ Compensation and incentives</li> <li>▪ Third party agreements</li> </ul>

After establishing any capability gaps and a game plan to close them, an organization can then focus attention back on the levers that assist in a move toward a sustainable VBC business model.

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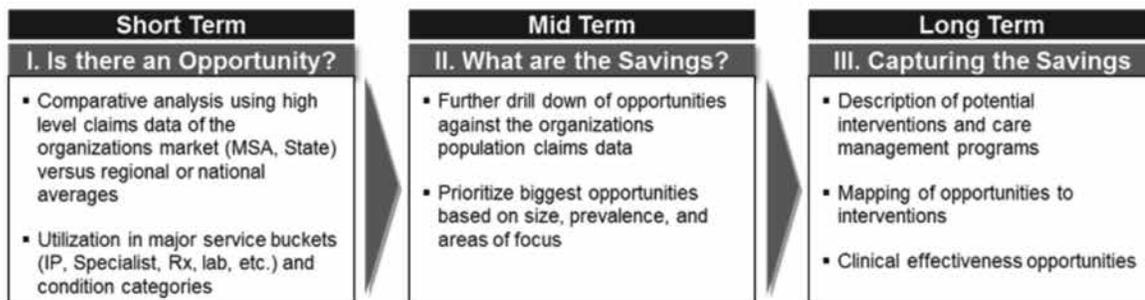
## Achieving Efficiencies through Actuarial Data Analysis and Clinical Improvements

The real importance to VBC is increasing efficiency and quality at the same time! Actuarial support and work product, supported by clinical and technological insight, is often the springboard into important qualitative and quantitative information. For most organizations making this transition to VBC, the following life cycle illustrates the evolution of efficiency and clinical improvement:



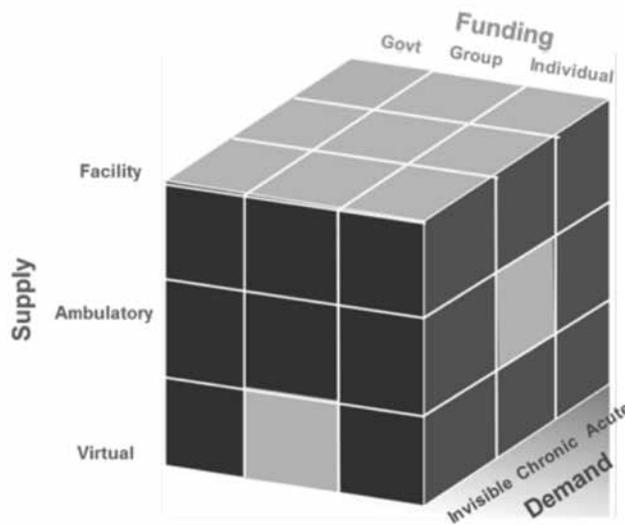
Historically, a starting point for data analysis has been health plan claims. These claims can provide information about chronic disease prevalence, medical reimbursement by service category, and basic quality measures like readmissions for an entire population (not just a health system view). This health plan population data is aggregated and reviewed on a comparable per-member-per-month (PMPM) basis. However, data analysis can only take you so far. When embarking on a detailed exploration of clinical opportunities, it is crucial to blend both clinical and actuarial competencies to explore the areas of opportunities (usually against a “benchmark”) and to overlay that with the clinical programs in place to determine the areas of greatest need/investment.

For health systems, a population viewpoint of claims data has not been readily accessible. Many systems start with the claims history for the organization’s employee population as a proxy to assess care management trends for the enterprise. The data can provide a cross continuum view of the costs by site of service and by condition category, using both a top-down (benchmarking) and bottom-up (assessment of treatment decisions) review. Eventually, if taking on risk with a payer, it is advisable to have the same information the payer uses in order to collaboratively answer the following questions:



The result of actuarial collaboration with clinical and technology experience is recommendations to address opportunities across the dimensions of supply, funding and demand (see graphic to the right). For example, we’ve seen diabetes identified as a cost driver, and expansion of a diabetes program via outpatient management lowering associated costs over time, while also serving as an expansion program for other segments. Another example is an analysis of the historical readmission rates to provide a roadmap for broad care management/discharge planning to avoid penalties and get on the road to quality bonus payments. The identification of the opportunity and qualification of the benefits can be achieved through a detailed actuarial claims analysis in tandem with a clinical assessment of the care.

Ultimately, these analyses need to relate back to the overall financial model and tie to how these clinical opportunities affect revenue based on current contractual arrangements. For example, a DRG payment affects revenue when an admission is avoided, but it doesn’t when ALOS is reduced. Assuming a significant proportion of a system’s costs are fixed and the payment environment remains largely FFS, the result is often an expanded “gap” after capturing these improvements, as displayed in the following illustration.



CONTINUED ON PAGE 38



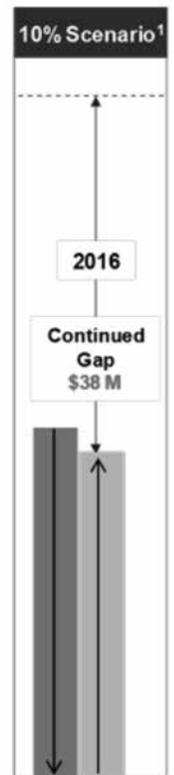
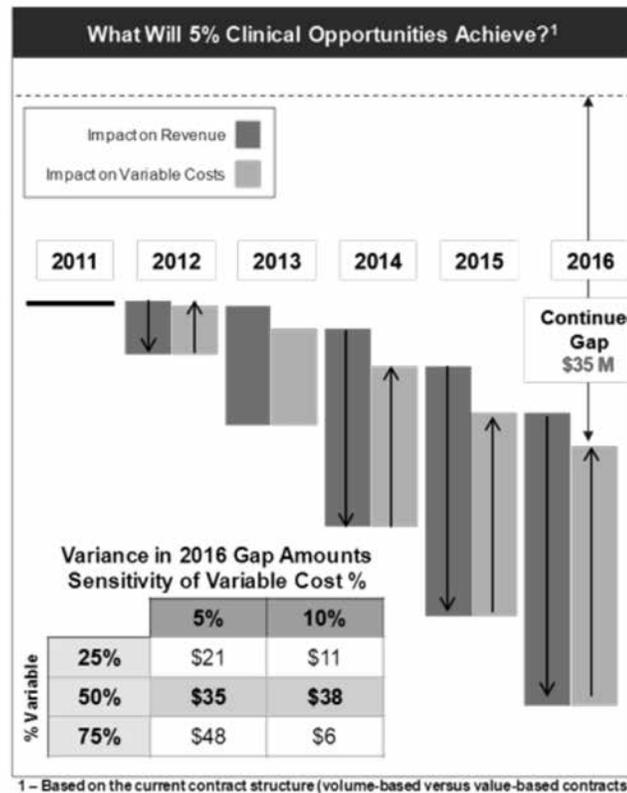
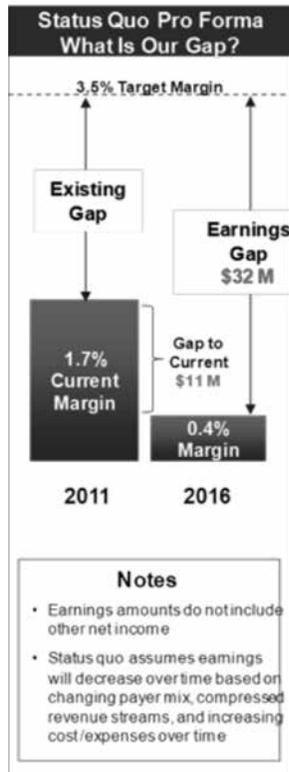
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Given that clinical efficiencies in a FFS world often result in an even larger financial gap, it is imperative to explore how these types of clinical changes should be incorporated in the context of value-based reimbursement.

## Moving from Volume to Value and Capturing Market Share

Each organization is often serving numerous population segments under varying payment terms. In order to incent real changes in clinical patterns, the areas of opportunity should be aligned among the targeted populations and contractual arrangements. To jump start these transitions to VBC, organizations are exploring various on-ramps to build up capabilities over time, including:

- Medical homes
- Bundled payments

- CMS MSSP/Pioneer ACOs
- Self-insured ACOs

As health systems begin to shift from volume to value, the current market environment should be considered along with knowledge of current market share and identification of desired future market share. Ultimately, there will be winners and losers; there simply have to be. As VBC takes hold in each market, it can free up capacity. The successful organizations will be able to capture more market share through the efficiencies inherent in their products. Consumers will be in the driver's seat. This means that organizations should become more efficient, achieve higher quality and become more user-friendly. Those that are not able to fill their excess capacity may have a difficult path forward.

Aligning the opportunities with the potential populations, potential payer/provider contractual relation-

ships, a competitive market environment, a timeline for achieving the required organizational capabilities, and a strategic three-to-five-year road map can allow for a strong chance to achieve the desired sustainable business model.

## Redefining the Marketplace

Although we all try, no one can predict exactly how health reform will play out over the next five to ten years. The old idiom will remain true that health care is local and each market distinctive. What works for one system in one market will not necessarily work for another system in another market. But we do know that the health care market will continue to change dramatically into the foreseeable future through mergers and acquisitions, payer/provider collaborations, increased technology application, changing population demographics and changing reimbursement methodologies. We also know that individual consumers are gaining influence, and they have high cost and quality expectations. Those that do not change with the market may find it difficult to capture future market share to determine their own destiny.

Navigating this new VBC world requires organizations to develop and align capabilities to help capture the market. Collaboration can be key, with actuarial and clinical involvement being a significant cornerstone to making wise decisions about risk, efficiency and quality of care. The status quo may no longer be an option, not just for the health systems, providers and plans that we work with, but also for the actuarial and clinical professionals operating within it. It's an exciting new world—let's continue growing with it. ■

Information regarding Deloitte and solutions for value-based reimbursement can be found at the following site:

[www.deloitte.com/us/acs](http://www.deloitte.com/us/acs).

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