

Session 92PD, Value-Based Care: The Role of the Health Care Provider Actuary

Moderator/Presenter:

Kelsey L. Stevens, FSA, MAAA

Presenters:

James P. Hazelrigs, ASA, MAAA

Aaron P. Jurgaitis, ASA, MAAA

Jeremiah D. Reuter, ASA, MAAA

Juliet M. Spector, FSA, MAAA;

2018 SOA Health Meeting

JAY HAZELRIGS, ASA, MAAA

Session 92 Value-Based Care: The Role of the Health Care Provider Actuary

Tuesday, June 26th



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Case Study:

Health System Value-Based Care (VBC) Growth Strategy

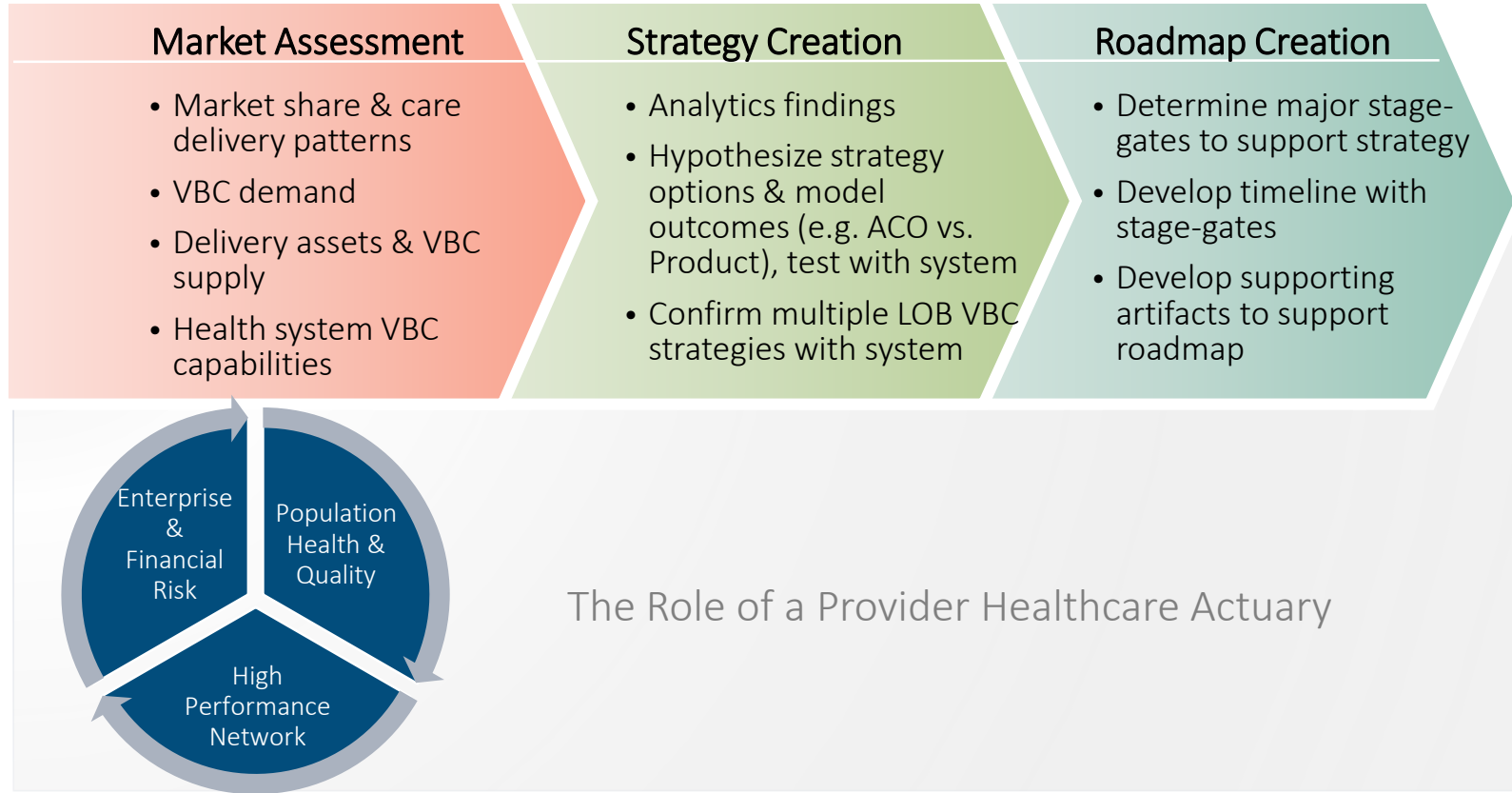
Objectives:

Analyze market and develop a VBC growth strategy and roadmap to enable organization to better compete in the near future and ultimately serve its mission

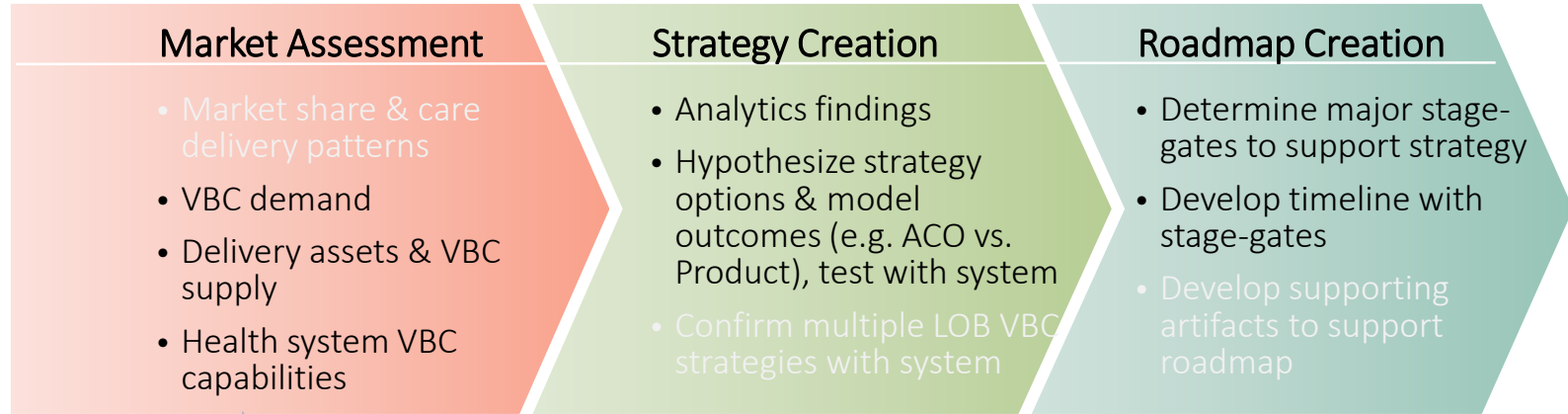
Organization Overview

Description	Challenges
<ul style="list-style-type: none">• Multi-facility/multi-geography health system with limited primary/specialty physician assets• Serves all populations (mission based)• Entire new leadership over past 24 months	<ul style="list-style-type: none">• Deteriorating payer mix, stagnate market share gains & revenues and eroding margins• Very competitive market (#3 health system)• Minimal investments in VBC capabilities
Main Contacts	Our Multi-Disciplinary Support Team
<ul style="list-style-type: none">• Chief Financial Officer• Chief Strategy Officer• Support staff: VP of strategy & single analytics person	<ul style="list-style-type: none">• Actuaries• VBC strategists• M&A specialists• Health econ analysts• Population health management specialists

Project Scope Summary: Focus Areas

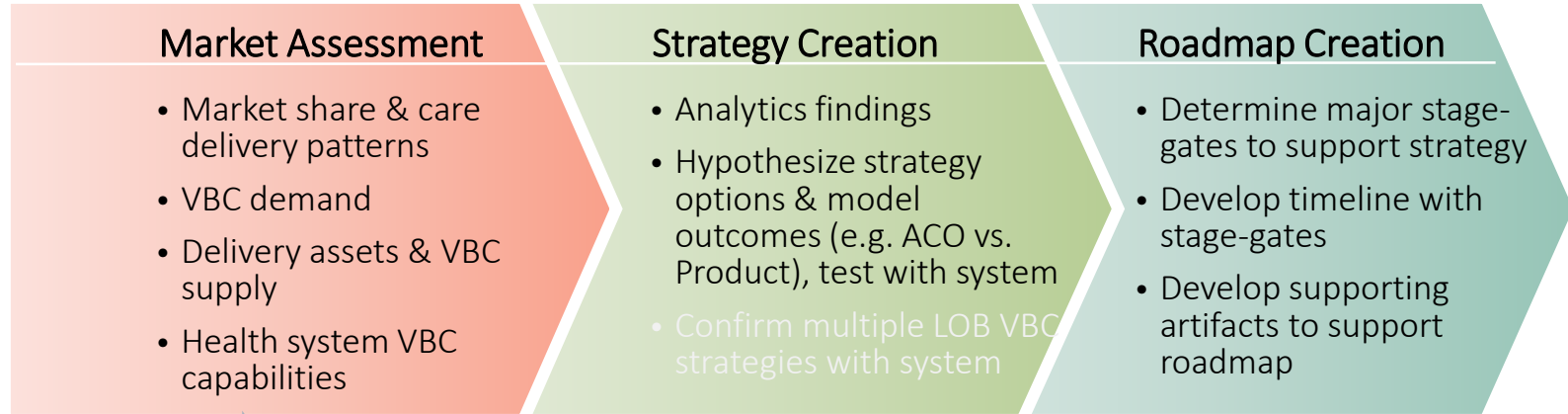


Project Scope Summary – Population Health & Quality Mgmt



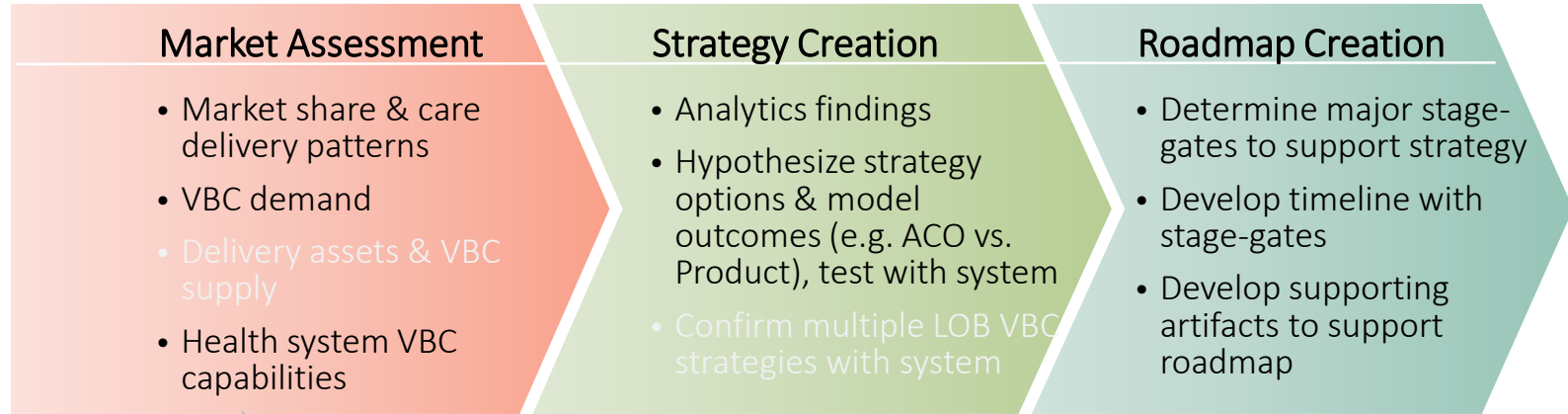
What are the major drivers of spend? What type of services do these patients need? Who are treating these patients currently? Does the health system have capabilities to analyze data to identify patient care management needs? What type of care management programs are being offered/should be offered to these patients? What are the health system resources that can be deployed to serve these patients? Do the patient needs vary by LOB? When do we need to have these capabilities deployed?

Project Scope Summary – High Performance Network Mgmt



What are the attribution levels for the various providers in the market (i.e. who controls the market share)? Which providers are the patients receiving care? How well do these providers delivery care? Does the system have capabilities for network performance management activities? Does the system need provider partners to support its strategy, if so, who are the optimal provider partners in the market? Does the target provider partners meet adequacy requirements for a product? Do we need to build/buy any provider assets?

Project Scope Summary – Enterprise & Financial Risk Mgmt



What type and how much are the VBC areas of opportunity in this market and by attributed provider? What are the economics/risks/opportunities for the various growth options? What capabilities does the system have for financial performance management? What are the value propositions for the target provider partners and/or the payer partners? How might the market stakeholders react/what are the potential implications of these actions? What are the product pricing requirements to pursue a product growth strategy?

Learnings/Outcomes

Health system:

- Has broader and deeper understanding of its market position and growth opportunities for pursuing VBC contracts
- Is pursuing product oriented growth strategies by LOB
 - In discussions with its target provider partner, commercial strategy is stage-gated to develop primary network then approach payers via RFP for new product
 - In discussions with multiple payers for government related product strategies
- Understands its gaps for people, process and technology to support a successful VBC growth strategy, pursuing partner opportunities
- Implementing roadmap with major milestones for items such as network provider partner agreements, payer partners agreements (by LOB), population health mgmt. resource deployment, analytic capabilities, etc.

Oncology Value Based Care

JULIET M. SPECTOR, FSA MAAA

Value – Based Care: The Role of the Health Care Provider Actuary

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Cancer Care in the United States

- **\$87.8 BILLION** was spent on cancer care in 2014.
- Health Plans are trying to cut costs to be competitive.
- Reimbursement pressures on cancer centers.
- No consensus on how to measure the value of care.
 - Various definitions of value
 - Various treatment pathways

Oncology Value Based Care Organization description

- Large cancer center in the eastern US.
- Client contacts: CFO, managed care department, physicians.
- Physicians are employed.
- Performs high end cancer services as well as standard or core services.
- High Medicare Advantage penetration in the market.
 - Less interest in the Medicare FFS Oncology Care Model (OCM).
- Low commercial reimbursement.
 - Still need to attract top quality physicians.

Oncology Value Based Care Organizational Challenges

- Health plans and designated cancer centers do not have a widely accepted and objective measure to quantify the value of cancer services on a consistent basis in the commercial health insurance and Medicare Advantage markets.
- Payers think that the Cancer Center is too expensive. They believe it might be cheaper to send patients out of the community.
- Length of stay is longer on inpatient services.

Oncology Value Based Care Scope

- Understand the implications of emerging trends, especially alternative payment models.
- Assess current state by measuring and benchmarking reimbursement levels.
- Explore opportunities for changes to reimbursement models and funding levels.
- Identify and introduce corrective actions for where current payment models are not meeting stakeholder needs
- Prepare for growth in value-based funding arrangements, financially and operationally.

Oncology Value Based Care Modeling

- Rate to rate study

Method of Comparison by Service Category	
Service Category	Cancer Center vs Community
IP Medical + Surgery	Per Diem Rate to rate by APR-DRG and severity (excludes BMT)
OP Surgery	Orig Allowed as % of Medicare / Community Allowed as % of Medicare
OP Radiology General - Therapeutic	Rate to rate normalization by HCPCS
OP Radiology General - Diagnostic	Rate to rate normalization by HCPCS
OP Pathology / Lab	Rate to rate normalization by HCPCS
OP or Office Administered Drugs	Rate to rate normalization by HCPCS
Professional	Cancer Center Allowed as % of Medicare / Community Allowed as % of Medicare

- Longitudinal rate study

Organization wants to understand how they are delivering services across the continuum of care compared to those generally performed for the community and to peers.

Some institutions have demonstrated that, although they may be more expensive on a service by service basis, delivering higher quality care more efficiently can lead to a lower cost across the entire episode of care.

Oncology Value Based Care Data

Analyzed both commercial and Medicare advantage data

- Data from two major payers in the market
- Part A: 100% MedPar dataset for three years
- Part B Medicare benchmarks: Medicare 5% sample database for three years
- Proprietary commercial data
- Note Medicare Advantage benchmark data is not widely available so we relied on more robust Medicare FFS basis. In many instances Medicare FFS reimbursement is reflective of reimbursement under Medicare Advantage. Cancer center's current reimbursement is more of the exception than the norm

Oncology Value Based Care

Actuarial skills required

- Local market knowledge
- Product knowledge (both commercial and Medicare Advantage)
- Data sources
 - Benchmark availability
 - Cross references
- Reimbursement knowledge
- Medicare reimbursement and re-pricing
- APR DRGs
- Data integrity

Oncology Value Based Care Outcome / Take aways

Organization

- Understood market position better.
- Conceded to some pay cuts on the MA side.
- Able to prove services provided to value to the community.
- Learned payer perspective and how to analyze claims data.

Next steps

- Client presented to payer.
- Wants to continue updating the study with revised data. Partner with payer for real time analytics.

2018 SOA Health Meeting

AARON JURGAITIS, ASA, MAAA

**Session 92 Panel Discussion: Value-Based Care: The Role of
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June 2018



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Operational Readiness and Financial Feasibility

- Large West Coast academic medical center
- Highly competitive market with multiple large health systems in a major metro area
- Organization wanted to become more involved in value based care and contracting
 - Already engaged in multiple value based contracts

Operational Readiness and Financial Feasibility

- Main point of contact was director of payer strategies and value based contract management
 - Newly created position
- Objective: determine operational readiness of organization and help set strategy for future participation

Operational Readiness and Financial Feasibility

- Process (2-3 months)
 - Reviewed existing VBC contracts for key provisions and opportunities for success
 - Interviews with multiple stakeholders to measure views on VBC, identify communication strategies, and determine operational readiness
 - Chief Medical Officer, Chief Nursing Officer, CFO, care managers, IT, analytics, etc.
 - Modeled potential outcomes under future MSSP participation

Operational Readiness and Financial Feasibility

- Skills required included some actuarial, some non-actuarial
 - Financial forecasting
 - Contract modeling and review
 - ACO program knowledge
 - Critical thinking
 - Interviewing
 - Medical knowledge

Operational Readiness and Financial Feasibility

- Outcomes

- Uncovered issues that were known, but not an enterprise level priority
- Mix of patients impacted the way they delivered care
- Existing VBCs were unfavorable to client, ill-defined, and suffered from lack of useful reporting/data
- Continued participation in existing contracts, but with increased knowledge

Operational Readiness and Financial Feasibility

- Outcomes (continued)

- Savings under MSSP unlikely, but access to data and ability to engage in VBC with no downside had significant benefits
- Enrolled in MSSP program, new ACO for 2018
- Recommended avoiding downside risk contracts
- Need to build up analytics capabilities
- Push back in existing and future contracts for more favorable terms, greater transparency, DATA



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Cardiac Episodes: Acute Coronary Syndrome

JEREMIAH D. REUTER, ASA, MAAA, MS

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Acute Coronary Syndrome in the United States

- \$150 billion annually
 - 60-75% of cost on hospital admissions and readmissions
- 1.2 million discharges per year
 - Slightly more than half for STEMI, under the age of 65
- Focus on revenue as correlation with cost

Cardiac Episodes

Organization Description

- Large healthcare system with several acute care hospitals
- Client contacts: CPHO, CFO, COO, specialists, primary care, practice managers, other clinical staff.
- Large Medicare population, both FFS and Medicare Advantage
- Desire to participate in a greater spectrum of care for their patients and community through risk arrangements
- Specialist engagement through episodic accountability and bundle payments

Cardiac Episodes

Scope

- Unfold the future state clinical pathways for cardiac episodes of care
- Understand the interaction with other risk contracts
 - Carveout CABG/AMI?
 - Savings in a bundle need to be shared more with specialists than PCPs
- Increasing market share
- Understand the cost of managing more efficient episodes; relation to revenue
- Understand alternative payment models for STEMI/NSTEMI episodes.
- Assess current state by measuring and benchmarking STEMI/NSTEMI episodes.

Cardiac Episodes

Risk Identification

Utilization risk:

- Number of services within the episode

Technical risk:

- CMS Final Rule

- Accurate diagnosis coding to ensure proper severity is assigned to each episode

- Creating standardized care pathways/treatment plans

- Care coordination

- External partnerships (e.g., SNFs, Home Health Care)

- Gain-sharing incentives between physicians and hospitals

Insurance risk:

- Variance in medical expense relative to target price

- Complex cases

- Readmission risk/Post Acute Emergency Department Visits

- Keeping/not keeping pace with regional benchmarks

Performance risk:

- Communication (Provider-to-provider, Provider-to-patient, Discharge instructions, Longitudinal Care Advisor effectiveness)

- Quality

Cardiac Episodes Modeling

- Building Blocks
 - Population Health Management
 - Physician Provider Network
 - Risk Adjustment
 - Analytics & Reporting
- Clinical Workflow
 - Present at ED; Need integrated delivery team*
 - Care Pathway dependent on risk
 - Discharge; Need integrated delivery team*
 - SNF
 - SNU
 - Home Health
 - Home w/Observation
 - Home
 - Across continuum: Care Advisor; Case Manager; Role of EMR

*Integrated Delivery Team:

Responsible: Care Manager

Accountable: MD

Cardiac Episodes Modeling

- Provider Engagement
- Risk Stratification: points of insertion
 - ED → ACS Suspected
 - Cath Lab → PCU/ICU
 - IP Cardiac Rehab Initiation → Referral to OP CR
 - Post Acute:
 - Discharging home from any PAC site
 - Group orientation → Initial evaluation

Cardiac Episodes Data

Analyze commercial, Medicare Advantage, and Medicare FFS data

- Payer administrative claim data
- Medicare Limited Dataset; Future Qualified Entity (100%) dataset
- Proprietary commercial and MA data
- Hospital billing data
- Cost accounting

Cardiac Episodes

Actuarial Skills Required

- Provider cost allocation
- Product knowledge
- Risk stratification/Predictive modeling
- Reimbursement knowledge
- Ability to value clinical processes
- Bundle logic
- Data integrity

Cardiac Episodes

Outcomes / Take-Aways

- Accurate diagnosis coding is fundamental to success
 - Paramount to proper care management and resource allocation during admission
 - Ensures proper risk stratification during episode
 - Key driver of post acute care decisions
 - For Medicare, as target price more based on regional benchmark
 - Coding deficiency vs other regional providers results in lower revenue assignment
- Current episode cost and utilization driving episode costs must be analyzed against proposed care paths to validate opportunity for savings
 - Analysis of current costs must be based on actual episodic data
 - Make sure proposed care pathway does not create additional costs vs current pathway
 - If additional costs are created, determine if achievable and measurable ROI creates savings opportunity
 - Home Health Care and Medication Adherence preventing Readmissions are examples of increased costs that produce ROI

Cardiac Episodes

Outcomes / Take-Aways

- Identify Medical Savings Opportunities and Timing
 - Clinical experience indicates key savings opportunities for Cardiac Bundles in the episode period are found in Post Acute Care and Readmission//Emergency Department Visit Prevention
 - Opportunity analysis should be completed using regional and national benchmarks to identify areas of underperformance and/or competitive clinical advantage
 - Identify, design and agree upon actionable medical savings initiatives and associated episodic cost impacts
 - Timing of savings must be considered in light of availability of resources
 - Identify a leader who is accountable to execute as planned
 - Staffing must be aligned to achieve value based goals vs volume management

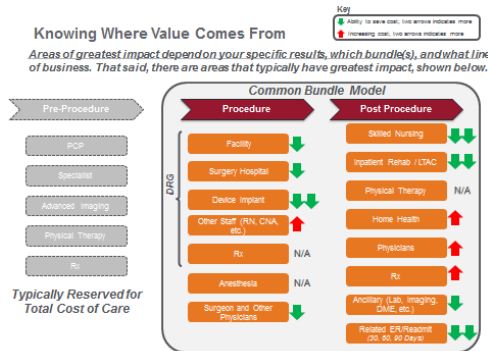
Example of Medical Savings/Internal Cost Savings:

- STEMI: Transition from ICU to PCU Days
- PCU Day is \$500 less expensive
- PCU Average Length of Stay is 1 day less than ICU

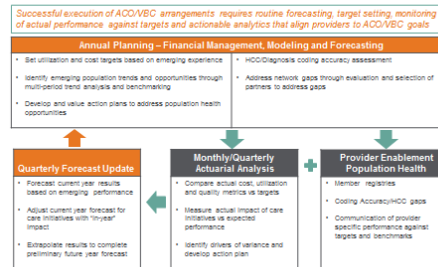
Cardiac Episodes

Outcomes / Take-Aways

- Analytics Available to Monitor Results
 - Frequent monitoring of performance against targets
 - Design actionable analytics that Identify emerging trends and actions needed to address adverse results
 - Create reporting that ties financial performance to operational and process metrics



Actuarial Analysis Cycle



Cardiac Episodes

Outcomes / Take-Aways

- Make Meeting Quality Measures High Priority
 - Patient Well Being
 - Should produce less variation for each episode type
 - Direct impact on savings opportunity through target price