11th National Pay for Performance Summit

Actuarial Issues in Value-based Contracting

February 18, 2016

Agenda

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- Drivers of Value-based Care Contracting
- How Value is Generated in VBC Payment
- Payment Model Options and Characteristics
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- Payment Model Development Process
- Looking Forward
- Q&A

Introductions

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Jim has been a Principal in Deloitte Consulting for 20 years. Jim has a specific emphasis in value based care, and medical care reimbursement in particular. He is the national leader of the Deloitte Consulting health actuarial practice, which includes more than 100 health actuaries. Through his reimbursement subject matter knowledge and role in assuring the quality of the work delivered by Deloitte's health actuarial practice, Jim has had the opportunity to work on dozens of projects related to hospital and physician reimbursement. Jim has led projects in provider reimbursement development, design of operations and financial arrangements for integrated health systems, development of benchmark utilization and cost data, health information analytics related to efficiency and quality. Jim has done work specific to all three major market sectors of commercial, Medicare and Medicaid. He has a 360 degree understanding of healthcare, as he has led projects for payers, providers, governmental entities and large employers. Jim is a Fellow of the Society of Actuaries and Member of the American Academy of Actuaries..

John Bertko, FSA, MAAA

Chief Actuary, Covered California; Former Director, Office of Special Initiatives and Pricing, Center for Consumer Information and Insurance Oversight (CCIIO), CMS
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John is an independent actuarial consultant working as the Chief Actuary with Covered California (California's Insurance Marketplace) and was the Director of Special Initiatives and Pricing at CCIIO in the Centers for Medicare and Medicaid Services (CMS), retiring from this position as of January 31, 2014. He served as a senior actuarial advisor on various private insurance initiatives, including risk adjustment, insurance programs and insurance oversight activities. He served on the Massachusetts Connector Board from October 2014 to March 2015. He formerly was the Chief Actuary of Humana Inc., where he managed the corporate actuarial staff. He has extensive experience with risk adjustment and has served in several public policy advisory roles. He serves on the panel of health advisors for the Congressional Budget Office and completed a 6-year term on the Medicare Payment Advisory Commission (MedPAC). He served the American Academy of Actuaries as a board member from 1994 to 1996 and as vice president for the health practice council from 1995 to 1996. He is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

Across the US healthcare spectrum, we are hearing that the shift from volume to value is a priority; it is not a question of if, but when…

1

Being in both FFS and VBC is like having one foot in each of two canoes

2

There is risk in building the wrong capability no matter how well you build it

1: Jackson, Laurie. *2 Canoes*. 2007. *www.CaptureThisPhotography.com*. Web. 14Jan2015.
2: Unknown. N.d. blog.iowahospital.org. Web. 15Jan2015.

Drivers of Value-based Care Contracting

The shift from volume to value is gaining traction, driven by major forces

Demand for value

Traditional payers, as well as engaged consumers, are demanding more – quality, evidence, and transparency – for few dollars

Status quo creates financial gap

Health care reform mandates, rising costs, and declining reimbursements are pushing earnings down, while populations are shifting towards segments with lower reimbursement (e.g., Medicare, Medicaid)

Government pronouncements and programs

The federal government has made their mark on health care through regulations and guidelines, such as the ARRA and ACA

Need to capture market value

Organizations will need to shift to VBC in order to maintain and capture market share in the face of increasing competition and new entrants

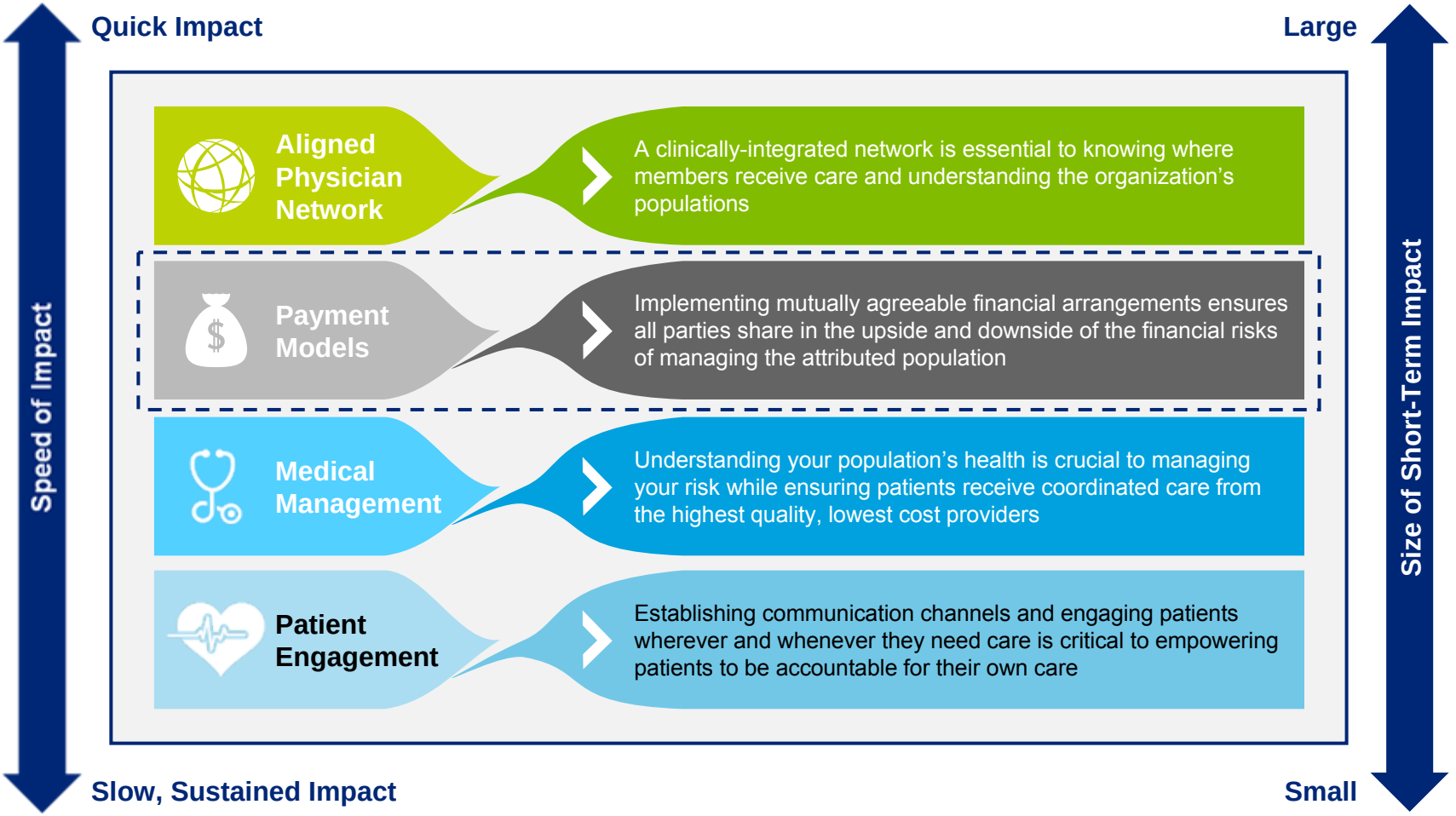
Capabilities are in place

From genetic breakthroughs and nanotechnology to digital health and the cognitive cloud, technology is changing health care

The industry is positioned to be able to bend the curve on healthcare costs, and value-based care payment aligns the incentives

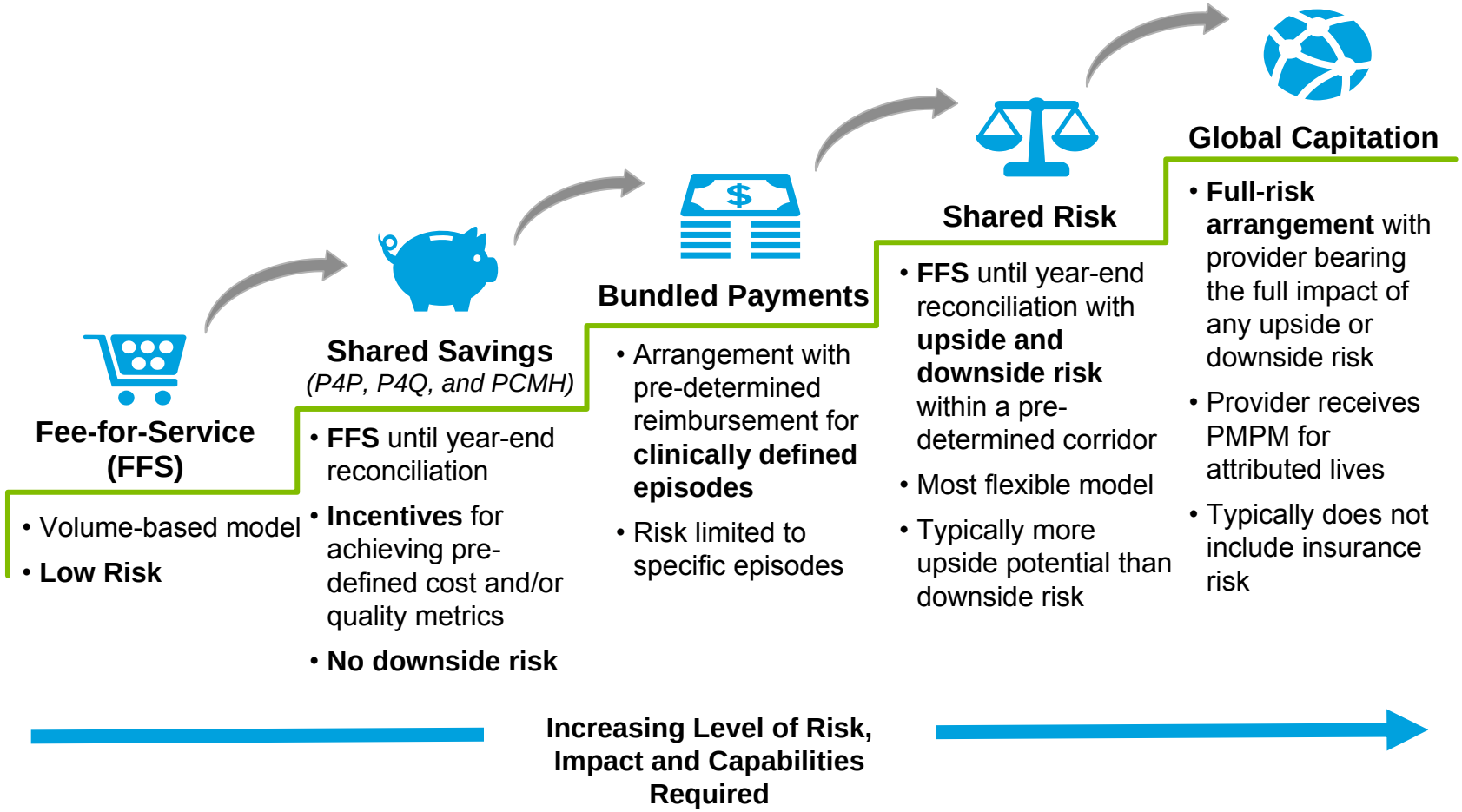
How Value is Generated in VBC Payment

Successfully bending the cost curve will hinge upon the success of the organization's network, medical management, patient engagement, and payment models



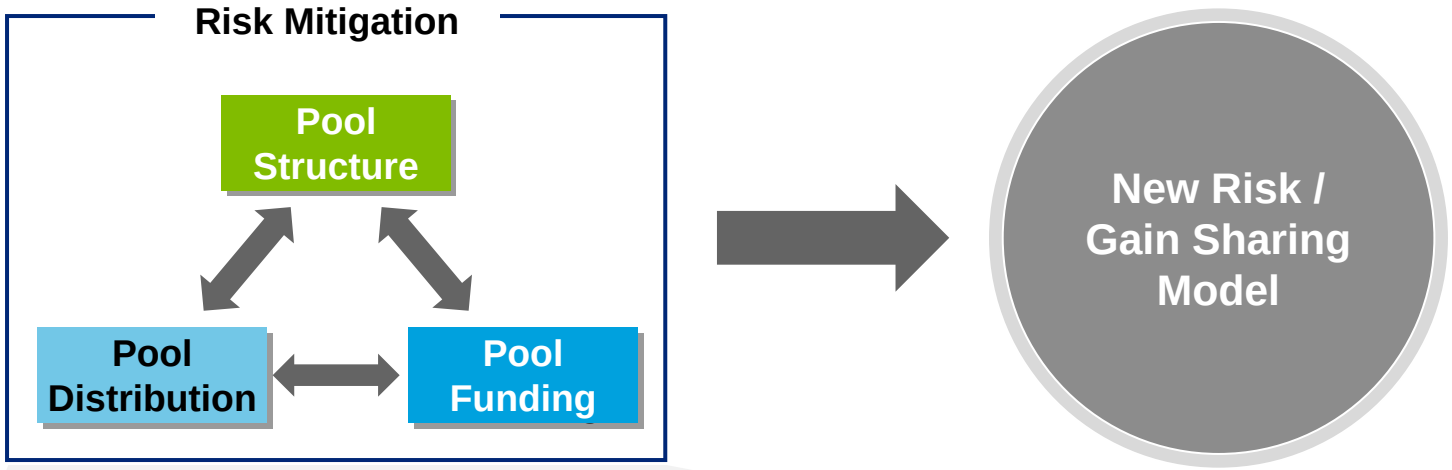
Payment Model Options and Characteristics

Value Based Care payment arrangements come in many flavors. The right selection is dependent on the purpose and capabilities



Payment Model Options and Characteristics

The selected payment models will form a new shared risk model structure



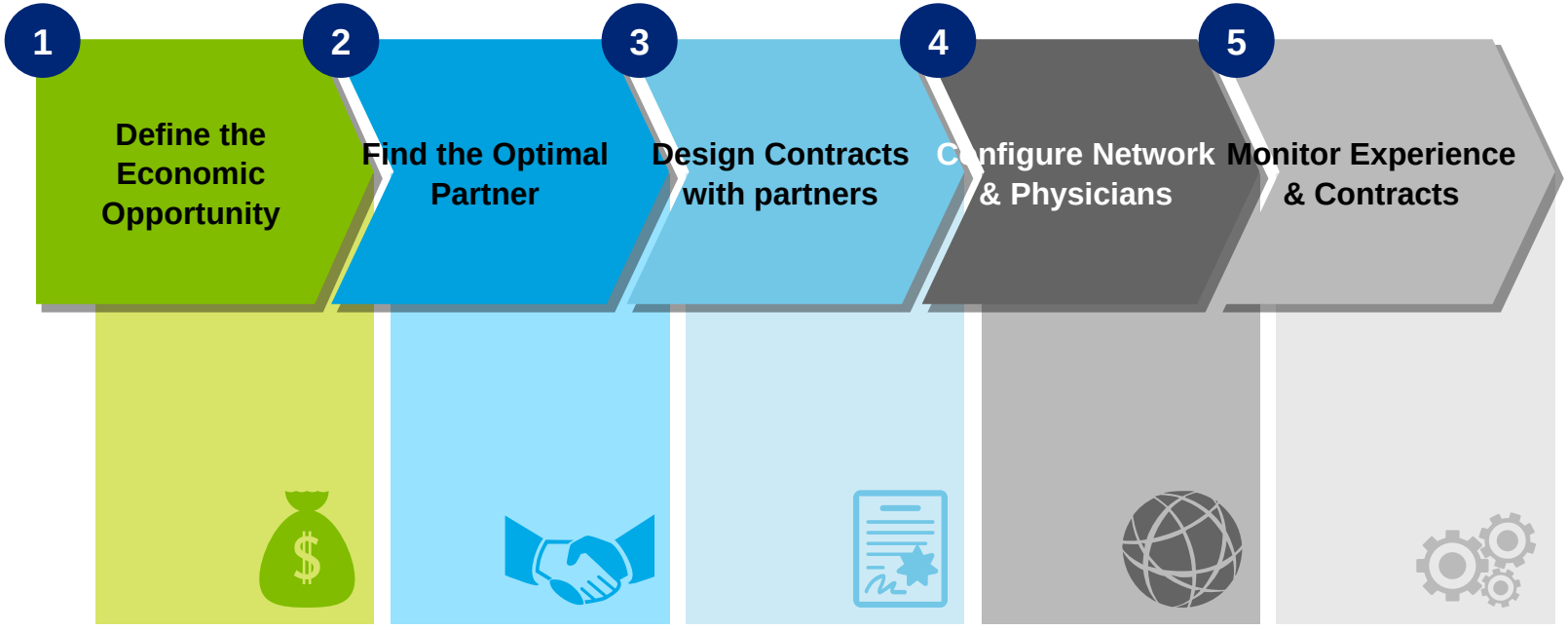
Pool Structure	**Define the different categories and / or responsibility centers for revenue allocation**
Pool Funding	**Determine the portion of the revenue allocated to each pool**
Pool Distribution	**Define how funds are drawn from the pools to cover services and how surpluses / deficits are distributed**

Payment Model Relationships – Lessons Learned

Monitoring should be in place to recognize successful payment models and enable continuous improvement across the network and spectrum of models

Payment Model Development Process

Identifying and operationalizing value from the payment models should follow an integrated development process

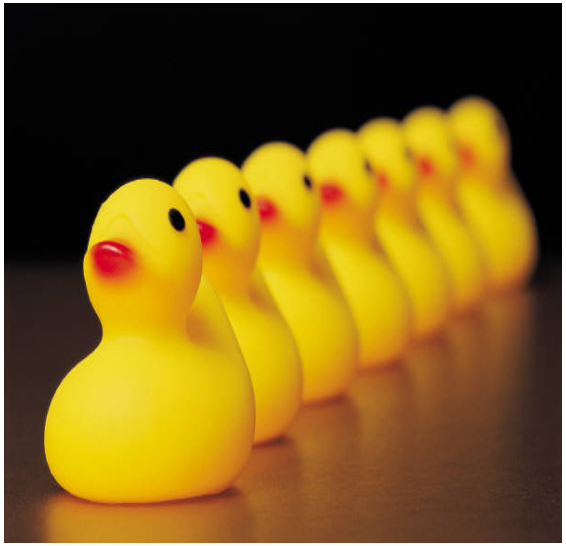


What Does a Health System Need to Adapt to Value-Based Contracting?

- Motivation
- Staff Capability
- Data – and lots of it
- A good Value-Based Contracting model
- A “trust-worthy” partner – the payer
- Capital (what Insurers call surplus)

Motivation

- Competitive Environment
  - Hospital systems or large medical groups competing to serve communities
- Community Health Improvement
  - Commitment to improving public health
  - Recognition that the status quo is unstable
  - Need for savings and greater quality
- Corporate Sponsor
  - Respected senior physician
  - If a hospital included, then executive partner



Staff Capability

- Physician leadership
  - PCPs
  - Certain specialties
- Financial analysts
  - CFO's support (even if "grudgingly")
- Data, data, data
  - Right data
  - Timely (near "real-time")
  - Analysis unit (unless you want to pay to outsource it)
    - Experience with "big data," not just use of Excel, OR
    - Out-source to a specialty firm (report production, not consulting)

A Good Value-Based Contracting Model

- How are you going to play this?
  - ACO (most popular currently)
    - Almost 500 Medicare-sponsored pilots
    - Nearly as many insurance company sponsored
    - How do you get into this game?
  - Bundling
    - Mandatory CMS joint program, starting in 2016
    - For <65 enrollees, more limited opportunities
      - Can oncology episodes follow joint replacement as the “next big thing?”
  - PCMH
    - How many successes?
      - Some for Medicaid programs
      - CareFirst appears to be having success
  - Other . . .

A “trust-worthy” partner – the payer

- Which payers are involved?
  - CMS for Medicare
  - States for Medicaid
  - Insurer
    - Regional
    - National
  - Large employer or coalition
- Payers role
  - Agree on risk-sharing mode and keep to it
  - Supply data in the right form and at right time
  - Isn’t too “greedy” about savings
- Employers role – join “scalable” models
  - Not “one-off” models

Need for Capital (or “surplus”)

- Surplus is needed to manage the “ups and downs” of claims cashflow from risk contracting
- How much surplus is needed?
  - What services are in the risk contract?
    - Physician
    - Hospital
    - Drug
    - Out of area
  - What is the population?
    - Medicare
    - Commercial (under 65)
    - Medicaid

Questions? Observations?

Are you up for the challenges?

How “foggy” is the road ahead?

When does Medicare’s Trust Fund run out?