"REAL TALK" FROM THE TRENCHES OF THE VALUE-BASED PAYMENT MOVEMENT

Wakely
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A synopsis of learnings from serving investors and providers

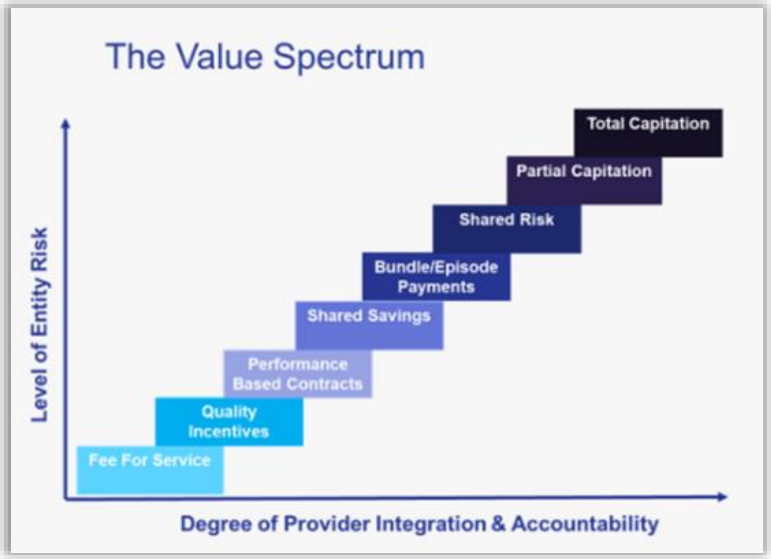
Over the past few decades we have observed and been a part of the noteworthy shift from fee-for-service (FFS) payments to value-based payments (VBP) across the US Healthcare Industry. This movement is characterized by an increasing emphasis on efficient health care spending on high quality services. Importantly, the movement to VBP has been jointly fueled by private company innovation and significant government program influence. In particular, the wide variety of models introduced by The Center for Medicare & Medicaid Innovation (the Innovation Center or CMMI), created by the Affordable Care Act (ACA), have ensured that the VBP movement is not just a passing fad. Rather, we are now on a bumpy, meandering, low speed limit (moving slowly), one-way road to VBP transforming how care is delivered and evaluated in our country.

The path to VBP has been paved with buzzwords, fancy black box "proprietary" tools, flashy PowerPoint presentations, and as of late, volatile company valuations. Based on our extensive experience supporting investors and risk-taking providers, the reality of the VBP movement is often far less glamorous.

VBP has taken on many shapes historically: e.g., private contracts with payers, Accountable Care Organizations (ACOs), the Medicare Shared Savings Programs (MSSP), the Direct Contracting programs, and the latest - ACO Realizing Equity, Access, and Community Health (ACO REACH). Through these numerous programs provider organizations have increasingly managed the financial risk of attributed patient populations.

We see the progression to VBP as happening along a spectrum for providers over time. From quality incentives and operational performance guarantees to bundled payment models; from one-or-two-sided risk sharing to partial or global capitation, the level of entity risk and degree of provider accountability tends to evolve over time and scale (Figure 1). The ACO REACH model is the latest public VBP program that has served as one of several notable catalysts for increasing investor interest in the VBP movement.

Figure 1



The path to VBP has been paved with buzzwords, fancy black box "proprietary" tools, flashy PowerPoint presentations, and as of late, volatile company valuations. Based on our extensive experience supporting investors and risk-taking providers, the reality of the VBP movement is often far less glamorous. Messy, disparate, heterogenous data sets abound. Pricing transparency between payers and risk-taking providers is often limited. Private contracts are often silent or insufficiently detailed on important matters such as pricing trend and margin assumptions, the definition of revenue components to which % of premium contracts are applied, liability for supplemental benefits, accountability for Medicare Star Rating fluctuations, accounting for Medicare Part D risk sharing programs, Risk Adjustment Data Validation (RADV) penalty responsibilities, etc.

Wakely has supported investors and providers in trudging through the hard, not-so-glamorous work of setting up organized data marts that enable consistent operational and financial performance reporting. Over time, such data frameworks enable robust analysis that steers growth and profitability. However, given the realities of today's provider data landscape, this work is NEVER easy.

We have experienced and understand the significant challenges of making important decisions based on less than optimal, less than timely, less than consistent data feeds from payer partners. Below, we share a few of the lessons learned on the road supporting health care investors and providers as they navigate the rapidly evolving "real" VBP world. While not par for the course, we would also be remiss to not acknowledge that we have observed instances of strong, collaborative, and transparent payer/provider relationships. Regardless of where your organization is on its VBP journey, there is potential for correcting missteps and improving transparency and analytic prowess. We hope to illuminate the way to help investors and providers avoid a few of the many potholes on the bumpy road to VBP.

Lesson #1 Do Not Expect Data to be Perfect

As actuaries we love working with data. We understand that we do not live in an ideal world and the data we work with will never be perfect. Yet we are still frequently surprised by the poor quality and lagged timing of the data sets our provider client partners receive. These are data sets providers rely upon to report financial performance and make important strategic decisions. Throughout our work with investors and providers, we have encountered a wide variety of data issues, some pesky annoyances, and others fundamental flaws that inhibit meaningful analysis. Below are a few common symptoms of bad data:

- Nonstandard data feed formats which vary by payer
- "Standard" CMS data files have been processed via algorithms that vary by payer
- Omission of important data fields
- Challenges in tying together longitudinal records (e.g., adjustments to prior claims/reversals)
- Duplicative records
- Missing records
- Internal inconsistency issues
- Inconsistent reporting lags by payer

Our lesson learned with respect to data is that one should not trust the data provided to them blindly. We cannot stress this point enough. To avoid pitfalls brought on by bad data, we suggest that VBP providers should:

- Allocate the time and resources to getting data marts organized on the front end of a risk relationship – do not underestimate the time and resources needed to make sense of disparate data streams.
- Always confirm which population(s) the data are intended to cover and ask for control totals to support validation. Is the data set reflective of the entire plan population? Is it associated with a specific population, e.g., beneficiaries afflicted with certain chronic conditions? Have contractual exclusion provisions already been applied or is the onus on the provider to apply such exclusions?
- Have another source of data to serve as benchmarks for reasonability checks – know what you are supposed to receive and have a rough range of expectations; when the data received does not fall within expected ranges, ask questions.
- Consider supplementing with public data for modeling and decision-making. This could help mitigate data quality issues as well as help with potential sample size concerns.

Lesson #2 Risk? What Risk

VBP Contractual terms can be complex and have unintended consequences. Oftentimes, the VBP provider may not fully understand the risk they are taking on and later be surprised by emerging results. Below we provide a few generalized examples of pitfalls from our experience.

In recent years, there have been a lot of vertical integrations between provider systems and health plans. Some have happened organically and others through acquisition. Such vertical integration typically involves risk delegation between the payer and provider organizations within an integrated system. Such risk delegation typically involves the establishment of financial targets - deviation from the target results in positive or negative financial settlements. For example, the target may be a fixed per member per month (PMPM) total cost of care or a target medical loss ratio (MLR). There are so many detailed factors in play for these kinds of risk deals, yet we have observed VBP providers that narrowly focus on a single target metric. VBP parties may fixate their negotiations and attention on the MLR figure, ignoring important and financially material details that define the basis to which the MLR will be applied - the premium amount. VBP contracts that are silent or vague on the details of how revenue is defined can expose VBP partners to unintended consequences that are completely outside of their control.

In VBP arrangements that involve Medicare Advantage beneficiaries, sometimes Part D is incorporated into the definition of revenue and claims, and other times it is excluded. But what about Part D catastrophic reinsurance, drug manufacturer rebates, coverage gap discount amounts, and risk corridor settlements? How are such Part D program provisions handled, which are often adjudicated at a level of granularity different from the VBP attributed risk population? How are such provisions shared between payer and provider? Oftentimes VBP contracts do not specify such details and unintended consequences that challenge transparency and trust emerge.

In newer programs like ACO REACH / Direct Contracting, there are elements that are not widely understood, leading to unexpected consequences. For example, the Direct Contracting program documents did warn about potential benchmark rate adjustments if actual experience turned out to be materially different from CMMI's expectations when setting up the regional rates. However, the industry was surprised by the magnitude of high single digit % downward adjustment for interim 2022 benchmarks. Related, there are REACH ACOs that are surprised to discover that second-year risk scores are capped for continuously voluntary aligned members (and are also subject to the coding intensity factor).

In short, risks are real and need to be better understood and studied in the VBP space.

Lesson #3 The Devil is in the Details

A very recent lesson we have learned on the ACO REACH program is about the participant provider list configuration. REACH ACOs are probably all familiar with the importance of the participating provider list on determining the aligned population and contributing to benchmarks. With the newness of this program and the exhausting details of program elements (financial, operational, product and compliance), it is very easy to miss the requirements of the participant provider list configuration to be submitted. And omissions may have unintended consequences in other aspects of the program.

According to the "PY2023 Participant and Preferred Provider Management Guide" released by CMMI in June of 2022, in order for an institution or facility provider to be included for financial calculation purposes (e.g. determining the Total Care Capitation (TCC) amount if the REACH ACO chose the TCC), the organization NPI and the CMS Certification Number (CNN) need to be submitted on the participant provider list. Without these identifiers, the institution or facility's expected claims will not be included in the TCC calculation.

This requirement is a detail among so many details underlying the ACO REACH program. Missing this can mean a significant deviation of the Total Care Capitation amount from the entity's original expectations. And the entity will have to wait until the next performance year to fix it.

When it comes to VBP, the devil is in the details.

Lesson #4 Math at Work

Below are a few vignettes inspired by historical project work highlighting the importance of detailed analyses.

MA Revenue Growth Overstated An investor is assessing a target Medicare Advantage entity for investment. The entity provides its historical revenue increases and expected market share growth for future years. If history repeats itself, the entity will have a modest PMPM revenue increase across a growing membership base. Isn't that fantastic? Unless…there is selection bias in calculating the historical revenue increase. Only persisting members were included in the year-over-year revenue increase calculation. The entity's ongoing risk adjustment coding accuracy operations have borne fruit - these members' risk scores (a primary driver of Medicare Advantage revenue) are showing steady improvements. However, with the entity's planned expansion, the influx of new members (a considerable portion newly Medicare eligible) will not have benefited from its coding accuracy initiatives. Assuming a similar revenue increase on new members would overstate the entity's top line opportunity.

Making an Impact? A private equity (PE) firm is evaluating a specialty care provider that manages populations with a severe chronic condition. Slicing and dicing the data reveals significant cost reductions from one year to the next. The cost reductions are associated with the specialty provider's interventions on the sub-population with the highest costs in the first year. However, after evaluating cost of the entire population afflicted with the same chronic condition, medical costs reductions dwindled considerably. Such a pattern may be attributable to regression to the mean at work – the sub-population with the highest costs had most likely experienced certain acute events resulting in high costs in one year. Those events may not repeat themselves in the next year, thus medical costs would come down naturally, without any interventions. To assess the value and impact of a specialty provider intervening, more robust matched cohort analyses and/or broader population cost analyses may be needed.

Lesson #5 The VBP Marathon Continues

We have no doubt we will keep learning along with our client partners as we trudge through health care investment and VBP journeys. We look forward to sharing additional lessons learned from the road periodically.

We also welcome you reaching out to share your lessons learned!

Please contact Ivy Dong (ivy.dong@wakely.com) and Tim Murray (tim.murray@wakely.com) if you have any questions or want to discuss.

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OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

Learn more about Wakely Consulting Group at www.wakely.com