WHITE PAPER

SOA Health Meeting Session 5A: Value-Based Payment Arrangements - Past and Future

Session QA Follow-up

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During the Society of Actuaries (SOA) 2021 Health Meeting that was held this past June, Wakely consultants hosted Session 5A titled Value-Based Payment Arrangements – Past and Future. Wakely partnered with two guest speakers, Chris Lassonde from Blue Cross Blue Shield of Massachusetts (BCBSMA), and Dan Elliott from eBrightHealth ACO.

This session was well attended and the topics discussed were met with great interest from the audience. Due to the time constraint of the session, we were not able to address all of the questions raised through the meeting chat channel. We have carefully reviewed the questions since the session and categorized similar questions to extract common themes in order to share our perspectives on as many of them as possible through this whitepaper. We thank our audience for your enthusiasm on this topic and hope to continue the discussion beyond the 2021 SOA Health Meeting.

Benchmarking

Several of the session questions related to benchmarking for setting financial performance targets in value-based payment arrangements. Below we provide our thoughts on the common themes of the questions coming from the session.

Question: For retrospective targets, how do you separate out provider performance from underlying trend?

Response: This is a great question. While it is not practical to conduct a controlled experiment in order to determine the true provider performance, it is possible to measure other factors that may influence the outcome and then adjust performance results for these.

Changes that happened between the base period and the measurement period which are outside of the provider performance scope need to be accounted for before measuring performance. Underlying trend

is one of them. The actuary or analyst can study the underlying trend by observing medical inflation and secular trends in the general population and adjust the benchmark for underlying trend between the base period and measurement period to account for this change. Other factors that may warrant adjustment include patient mix changes, provider fee schedule changes, new technology or policy changes resulting in service mix changes, etc.

The overriding principle is to try to account for known changes that are not attributable to provider performance, or where the provider is disproportionately impacted, before measuring performance.

Question: What is your feeling on arrangements that tie budget to what the payer is receiving, e.g. percent of premium?

Response: Percent of premium arrangements are becoming increasingly popular alternative payment models, especially within Medicare Advantage partnerships and within certain regions of the country. This payment mechanism implicitly sets a medical loss ratio target for the payer and providers, thereby passing a significant portion of financial risk from the payer to the provider. One key advantage to such arrangements is that provider incentives are optimally aligned with payer incentives. For example, a provider taking global risk from a payer in MA will receive more in their service fund if they are able to eliminate risk coding deficiencies and increase revenue for the payer. For the payers and providers to be successful in such arrangements, data sharing and transparency are essential.

Rate setting is critical in determining the premiums which will be used as the basis for the budget. Whenever possible, providers should work closely with their payer partners to ensure a rate setting process that appropriately accounts for the expected patient risk profile and medical inflation. Providers should have a seat at the table for influencing product design as well since they will be the primary risk bearers.

Within the commercial space, a complicating factor of percent of premium arrangements is the treatment of family contracts. The premium for a family (subscriber, spouse, children) is often the same across everyone, but each individual member could be part of a different provider risk contract.

For providers new to value-based payment arrangement, it would be advisable to start with a lower degree of integration and risk, and gradually move to higher degrees of risk as they gain experience. We often see payers set up multi-year glide paths for their provider partners starting out with a monthly capitation and eventually transitioning to global risk.

Question: For BCBS - how was the control group defined relative to the BCBS population, and was data normalized for demo/risk/benefit plan differences? Is the comparison on allowed or paid amount?

Response: The study[1] by Harvard Medical School researchers published in the New England Journal of Medicine describes in detail the comparison, including the selection of the control group.

[1] Health Care Spending, Utilization and Quality 8 Years into Global Payment, Zirui Song, M.D., Ph.D., Yunan Ji, B.A., Dana G. Safran, Sc.D., and Michael E. Chernew, Ph.D.

Question: Over time as costs go down the benchmarks are driven down. How do you then create incentives? Are providers penalized by their own performance?

Response: This is a common concern regarding target setting for value-based payment arrangements. If the benchmark is based on historical expenditures and provider performance is improving (i.e. expenditures are declining), it does feel like providers will be penalized financially for their strong performance. Mitigation strategies we have seen from the Center for Medicare and Medicaid Innovations (CMMI) as well as private carriers include using regional expenditures instead of plan-specific experiences for benchmarking, fixing the base period for a number of years, benchmarking against comparable groups, using other incentives such as bonus payments for specified measures, etc. Setting a reasonable medical expenses budget or target is definitely a key to success for any value-based payment arrangement.

In general, any given provider entity is not large enough to meaningfully move the network. If they are, it's prudent to consider carving them out of the network experience.

Question: What risk adjustment models were used to adjust for health status before calculating the benchmarks or payout?

Response: In general, for the governmental programs (MSSP, DC, Next Gen, etc.), the CMS HCC model that is used within Medicare Advantage (MA) is used here as well. Some programs such as Direct Contracting (DC) will use a concurrent model (new for DC) for their high-needs population. The general consensus though, is to use the MA risk adjustment model.

A wide variety of other models could be used within private value-based programs as well. This would vary based on the entity rolling out the program. Some models include prescription drug data and some do not. Some include both demographic and diagnosis components while others include demographic components only. An important consideration is whether the risk adjustment model is predictive (as in MA) or concurrent (as with the individual ACA exchange market). A predictive model may do a better job matching risk-adjusted payments with claim expenses during the contract period; however, a concurrent model will be directly related to the expenses that occur during the performance/contract period. The key is that value-based targets should always consider changes in acuity.

Patient Attribution

Attribution represents the process that commercial and government payers use to assign patients to the physicians who are held accountable for their care. It is important to attribute patients with the providers who have control over the patients and costs assigned to them. Depending on the risk sharing arrangement or program, several methods exist; patient-selected, geographic-based, claims based, etc. Attribution can impact financial measurements as well as quality metrics. Several questions from the session focused on the idea of attribution and the challenges associated with it.

Question: Are you seeing challenges with attribution of members to ACO provider groups? Are you using retrospective or prospective approaches?

Response: Attribution methodology is arguably the most critical component of value-based contract design and every method comes with its own set of challenges. It is important to define what provider types are eligible for attribution, what metric determines the primary doctor (e.g. plurality of visits or plurality of costs), and how much historical data to utilize.

As for retrospective vs. prospective, this varies depending on the program. For example, MSSP ACO's can choose retrospective and/or prospective attribution methodology, while Direct Contracting Entities rely on prospective attribution. Both have advantages and disadvantages within their design. Attribution rules over the course of the performance year can fall within a spectrum.

On one end there are prospective attribution methodologies, where providers know the patients they are responsible for prior to the start of a performance period. Providers receive a list of attributed members at the beginning of the performance period and no new members are added during the period, but providers remain responsible for even those patients who move.

On the other end are retrospective patient attribution methodologies, where the at-risk population is determined after the performance period ends. While retrospective patient attribution is very commonly used as payers have the claims data needed to assign patients to specific providers, retrospective models present challenges to providers. The providers do not know who their measurement will be based on until the end of the performance period so it makes targeted care management and financial forecasting a bit more difficult.

In-between attribution methods are also possible. For example, under Direct Contracting, attributed members are determined prior to the start of the performance year, but members can join or leave the direct contracting entity during the performance year through voluntary alignment.

Question: Do the members need to select a PCP or do you use attribution models to assign a member to a PCP?

Response: We see significant variation from program to program. Generally, in governmental programs such as MSSP or Direct Contracting, members are attributed to PCP's using a claims based attribution methodology. We have also seen patient choice arrangements where members will select a PCP upon enrollment and therefore that PCP becomes their "assigned" PCP and is responsible for their care. The patient choice method is probably the simplest and is ideal if patients frequently see a particular provider, but it can be hard to enforce with all members/products as carriers do not usually require PCP selection. Additionally, low cost members may be skewed towards not choosing a PCP and patients may select PCPs that they do not use or see.

Quality Metrics

Another important component of a successful value-based arrangement is quality. While there are a myriad of opportunities to incorporate quality measures within the chosen model, most models will include metrics that can be measured and tracked. Often these metrics influence financial reconciliations. Some follow-up questions from the session pertain to these ideas.

Question: What metrics do you track to ensure the patients still receive the appropriate quantity and quality of care?

Response: Various metrics can be used to make sure that the quality of care patients receive is not falling short. If we think about HEDIS measures or other metrics found in Medicare star ratings, there are metrics around patient care surveys, follow-up visits, preventive care visits, etc. Each of these metrics are designed to make sure the members are seeing their PCPs, receiving the appropriate care and are satisfied with their care.

Question: How do you incorporate quality of care measures into the shared cost/savings calculation?

Response: A wide variety of approaches can be taken here. Depending on the strategy of the organization, quality of care measures can be used as an all-or-nothing threshold for distributing the shared savings to the providers or as a multiplier of shared savings. Some metrics may serve as informational metrics only while others will be included in financial reconciliation calculations. The quality strategy will be something the organization will want to review as they enter value-based arrangements.

Provider Support and Engagement

Several questions were related to provider support and engagement. The audience has shown great interest in this area and also identified it as an ongoing challenge for value-based arrangements.

Question: What reports do you share with various types of providers to help with their performance and how often?

Response: A key theme during the presentation was that data sharing is pivotal to the success of any value-based payment arrangement. If providers are well-informed with actionable data, they are most likely to succeed in achieving the goals of the program.

We have seen several challenges when it comes to data sharing within value-based payment arrangements. An example of a common data-sharing challenge is the timeliness of data sharing; delays in data sharing mean that the provider has a delay in monitoring patient claims, particularly those that occur outside of the provider organization itself. Additionally, allowed dollar amounts could give the provider insight into its competitors' insurer-provider reimbursement contracts, revealing highly confidential information.

Regarding what reporting we have seen payers share with providers, we have seen some payers share scorecards with their providers to summarize their financial and quality performance and to illustrate how

they compare to the rest of the organization. The reports we have seen vary widely, but often include pertinent information for that provider's given population such as member rosters, component level expenditures, diagnosis code capture, drug adherence, ER utilization, and any benchmark targets. Some of these reports offer drill-down capabilities allowing the provider to focus on the metrics at a patient-by-patient level.

Question: What types of interventions/programs or investments do you employ to assist low-performing providers? Do you "weed out" poorer performers?

Response: It is important to continually monitor performance by practice and, in some cases, at the provider level. One way is to employ network performance specialists who are present with the practices and teams on the ground. Providers generally respond well to constructive feedback and are usually willing to engage around performance. Oftentimes there are practice or population factors that may explain, at least in part, variations in performance. Often this is enough, just to understand and be aware of contextual factors. In other situations, financial incentives and penalties have been effective when it comes to aligning with key performance indicators and driving engagement. Resorting to measures that are more aggressive is usually not necessary.

Question: Programs such as the Medicare Shared Savings Program (MSSP) have the challenge that the benchmarks are not fully known during the performance year due to retro membership. Any advice to the providers as to managing their performance?

Response: One advantage of a retrospective assignment is that members assigned to the ACO under the MSSP program will necessarily be seeing those providers. While the PCP might not know if that member will ultimately be attributed to the ACO, they can treat the members they are seeing as assigned members and make sure they are getting the appropriate care they need. In addition, having timely reporting and information on all the patients the providers are seeing would be helpful in equipping the providers to manage the patients' care and costs. Sophisticated providers participating in APMs and contracts with retrospective patient attribution should run their own attribution calculation at the start of a performance period to help determine who is at financial risk under the model and estimate the costs associated with that population. Then, they should run an attribution calculation every quarter to update assignments and stay informed.

Question: For BCBSMA, how were you able to bring such a large proportion of providers into the program? Is your market share such that there is significant leverage on the health plan side?

Response from Chris: Two factors were critical in driving adoption. The first was significant executive backing in valued based care. From the inception, all levels of leadership were very clear with the network that participation and performance in valued based care was going to be the path towards enhanced reimbursement. Second, Massachusetts passed a cost containment and data transparency law in 2012. It had many facets, one of which was holding all payers and providers in the state accountable for keeping down the cost of healthcare, and making public information on how each entity was trying to achieve that goal.

Miscellaneous

Question: Do you think COVID-19 will lead toward more value-based payment arrangements?

Response: In our opinion, value-based payment arrangements will become more and more popular in general. The concept is to pay for value, not sheer volume. This concept is in line with the interests of various stakeholders, including health care consumers, payers, policy makers as well as providers over the long run. During the pandemic, we have seen a dramatic decline in health care utilization during one period and pent-up demand in following periods. Utilization patterns differ significantly depending on geography as well. Although unintended, value-based payment arrangements have helped some providers stabilize their revenue, avoiding drastic fluctuations. On the other hand, the pandemic also poses challenges in setting future benchmarks for such arrangements, due to the uncertainties surrounding a post-pandemic norm of health care consumption.

Question: As an actuary employed by a provider system to support value-based contracts, it can often feel isolating. Do you have any suggested resources or communities?

Response: As the market continues to shift toward value-based contracting, we believe new resources and communities will continue to emerge. The SOA Health Section just recently launched a VBC subgroup as a means for actuaries to gather and discuss emerging hot topics. This group is new, but may provide a helpful resource. In addition, here at Wakely we are learning a lot through our experiences supporting both payers and providers in this space. We are always available for discussion and support as needed.

Special thanks to our co-presenters Chris Lassonde and Dan Elliott. Please contact any of the abovementioned authors with questions, feedback, or to follow up on any of the concepts presented here.

OUR STORY

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