



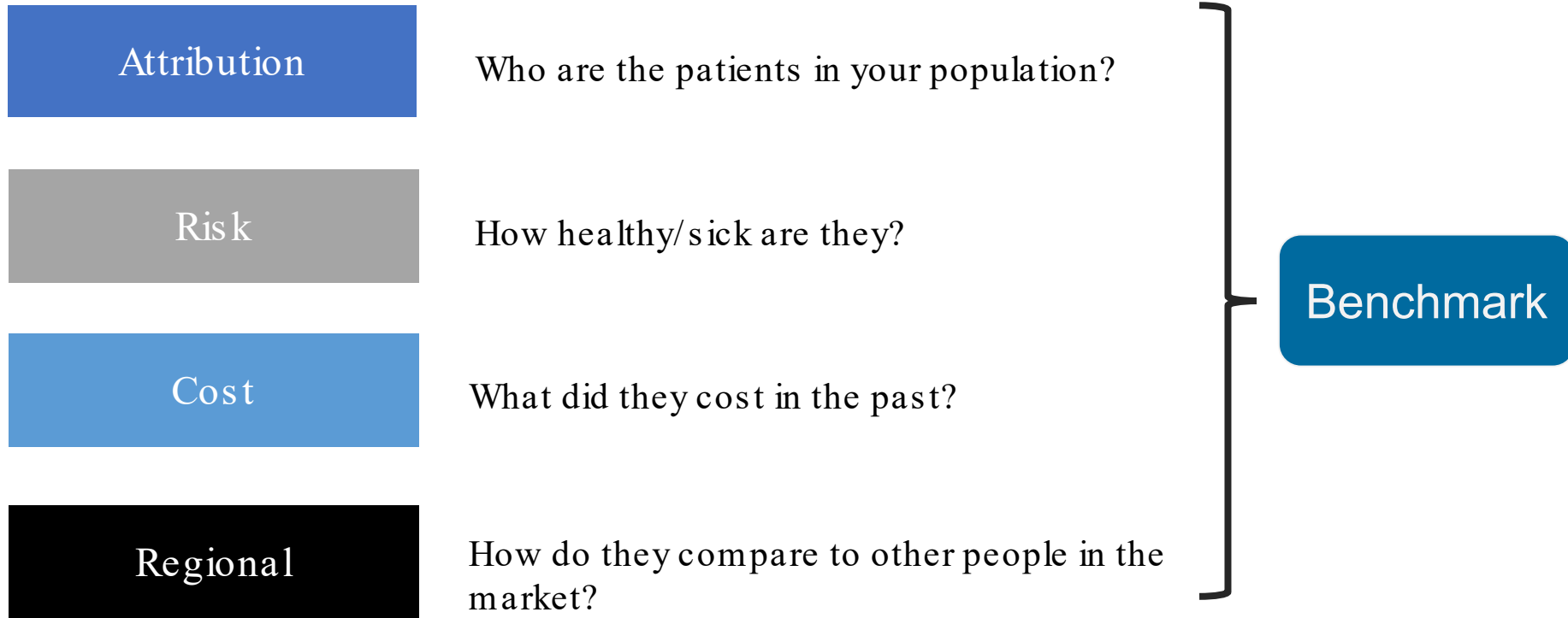
Expected Costs:

Principles of Benchmarking in Medicare, MA,
Commercial, and Medicaid

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Successful ACOs Beat Expectations - What goes into expected costs?



Benchmarks are updated yearly usually on two factors

1) Inflation

- a) Usually set at the market level roughly equating to a hospital referral region
- b) Can be prospective; however, we believe actual inflation is a better measure of value creation

2) Risk

- a) Several common models
- b) Models attempt to either predict next year's costs (prospective) - or -
- c) Attempts to account for this year's costs (concurrent)
- d) For commercial populations, we prefer concurrent models
 - i) HHS - HCC is publicly available and used in the health exchange market



Quality - The Other Side of the Value Coin

Measuring quality is difficult so focus on the most impactful measures is needed

5 Measures:

- 1) Blood pressure control for hypertensive patients - Saves the most lives
- 2) A1c control for diabetic patients - Biggest impact on co-morbidities
- 3) Risk adjusted hospitalizations - Prevention
- 4) Risk adjusted emergency department visits - Strong PCP relationship
- 5) Patient Reported Outcomes - Impactful on members
 - a) Musculoskeletal - Daily quality of life
 - b) Access to Care - Success in helping patients navigate their care
 - c) Net Promoter Score of the Practice - Member defining value



Risk and Reward - Utilize the Savings Rate to create the right incentives

An ACO can either just make investments in primary care and population health or it invest and take downside risk where it would cover a percentage of losses about the benchmark

Base situation: ACO does not take downside risk

- 50 - 60% depending on level of quality

Risk: ACO accepts downside risk

- 60% to 75% depending on level of quality



Insurance vs Health Care Services Risk

Health care providers still do not become insurance companies when they form ACOs

- Downside risk should be motivating, but not ruinous
- Tying risk exposure to a percentage of health care provider revenue provides the right level of financial incentive alignment
 - Too much and the health care providers are incentivized to take risks with people's health
 - Too little and health care providers are rewarded on the upside without any real downside pressure



Sustainability in Accountable Care

- High performing health care providers should derive at least one third of their revenue through the ACO
- Benchmarks should reward both improvement over the ACO's historical performance and comparative performance against other health care providers
 - Over time moving to 50/50
- Benefits to members should incentivize strong PCP relationships
- Data sharing is a must from day one and should improve over time



Alternative Strategies to Transition to Value

- Pass - through
 - A percent of the premium dollar without regard to historical or relative ACO performance
- Conversion
 - Indexed off of historical fee for service payments
 - Converted to capitation (PMPM) or other non-FFS mechanism
 - Can be combined with total cost of care opportunities or not



The Premium Dollar - Where does the money to pay savings come from?

- Medicare
 - MSSP - Taxpayer and debt
 - MA - Taxpayer and debt passed through private companies
- Medicaid
 - Direct - Split between feds and state
 - MCO - Split between feds and state and passed through private companies
- Commercial
 - Fully Insured - Individual members
 - Self-Insured - Employers



How do owners of the premium dollar measure success?

- Federal Government
 - Academic savings
 - Public perception of value
- State Government
 - Lower budget line items
 - Public perception of value
- For-Profit Company
 - Maximize profits within regulations
 - Market perceptions
 - Customer perceptions
- Not for Profit Company
 - Maximize net revenue within regulations
 - Public perception
 - Customer perception



Medicare Advantage Incentives

- Premiums determined according to government regulations and guaranteed
- Regulations required 85 percent of premium on “medical expenses”
- 85 percent is at the plan level not at the ACO level
- Unique to Medicare Advantage the premium can increase due to ACO actions
 - Risk Adjustment
 - STARS ratings
- Setting Expected Costs
 - Natural pull towards the 80s due to the 85% regulatory requirement
 - Usually based on historical MLR experience for the MLR
 - Negotiations can drive the number up



Medicaid Direct Incentives

- State budget line item
- Varying capabilities to administer programs
- Maximizing the federal match is a confounding factor
- Setting Expected Costs
 - Attribution is particularly difficult
 - Open to unique arrangements
 - Risk adjustment is not as common



Medicaid MCO Incentives

- Insurance risk transferred from state to MCO
- MCO contracts can govern value contracting and delegation parameters
- Tying the premiums to the MCO to historical experience is particularly difficult
- Setting Expected Costs
 - Attribution is particularly difficult
 - Premiums vary by many factors and percent of premium is more difficult than in MA
 - Risk of adjustments by the state must be negotiated between the ACO and MCO



Commercial Fully Insured Incentives

- Insurers understand value-based care and take a longer term view on fully insured
- Small percentage of business for most compared to self-insured
- Only realize relative efficiency when patients switch from inefficient to efficient practices
- Setting Expected Costs
 - Historical improvement highly valued
 - May have different expectations about what is a sustainable level of increased revenue to support value
 - Risk adjustment is a thorny issue as they bear the direct cost of any coding intensity



Commercial Self Insured Incentives

- Savings payments show up as extra payments that have to be explained to employers
- Overlap between a given ACO's population and an employer's staff may be small
- Employers incorrectly assume many aspects value based care are in fee for service
- Highlighting the non-savings benefits of ACO work is critically important to employer buy-in
- More than any other setting savings are seen as costs here
- Payer may not benefit from lower total cost of care
- Setting Expected Costs
 - Predictability is more highly valued than normal
 - Regional efficiency as a sign of high value practices is valued but price sensitive
 - Historical improvement valued, but may not translate to savings to a given employer



Final Thoughts

- Always understand where your savings would go if not to you
- Historical improvement is valued more than relative efficiency by premium holders
- Insist on some recognition of relative efficiency for sustainability
- Start Negotiations by being on the same page about what a successful partnership looks like as a percent of overall providers revenue



Panel

- **Jamie Reedy, MD, MPH**
 - Chief of Population Health, Summit Health
- **Mike Barrett**
 - Vice President of Strategy and Development, Collaborative Health Systems
- **Karen Wilding**
 - Chief Value Officer, Nemours

