Value-Based Care Risk Financing:
Concepts and Case Studies

WELCOME!
Today’s agenda
Value-based care risk financing: Concepts and case studies

Presenters
Dr. Emanuel Lauria, KB Risk Solutions – primary presenter
David Robertson, Harden Insight – co-presenter
Jacob Brinkley, Harden Insight – co-presenter

Learning Objective
A continuation from the June session on *Demystifying Performance Based Risk*, this webinar will take a deeper dive into the methods and mechanics of how various financial risk mitigation programs work. Participants will gain a broad understanding and a working knowledge of these risk transfer solutions through case studies and practical scenarios.

Summary
Capitation agreements and two-sided payment models present opportunities and challenges to providers and payers of all types, whether directly to hospitals, physician groups and health plans, or emanating from bundled and networked arrangements. What we have is a classic risk/reward tradeoff: to assume the downside risk of individual medical claim severity and benchmarked population health management in exchange for potential upside incentives. Our session will continue the theme of presenting these solutions as an integral part of effective enterprise risk management.

Topics to cover
- Provider stop loss
- Hospital-based performance risk
- ACO reinsurance
Healthcare payment models: From volume to value
Evolution of alternative payment models
From Quantity to Quality: The Triple Aim of Lower Cost, Better Outcomes and Improved Experience

VALUE-BASED CARE

- Bundled or Episode-of-Care Payment
- Upside Shared Savings Programs
- Downside Shared Savings Programs
- Partial or Full Capitation
- Global Budget

VOLUME-BASED CARE

- Fee-for-Service
- Pay-for-Coordination
- Pay-for-Performance

increased financial risk under contract to providers
Financial risk tradeoffs: Shifting payment models

Source: R.F. Averill, Achieving cost control, care coordination and quality improvement, 2010
Capitation 101

What does it do?

- Shifts the financial risk assumed under contract from the payor to the provider
- Changes the revenue stream to providers from variable to fixed
- Accelerates the timing of payment for services - providers receive payment in advance of treatment and care being rendered
- Unlinks the cost or volume of services given to specific patients from the revenue received; funding not tied to volume of procedures, testing and visits
- Removes incentives to provide unnecessary care
- Brings increased focus to cost management, quality of care and illness prevention
- Increases profits as a result of more healthy patients
ERM in the Healthcare industry
Creating an effective ERM framework

Source: hfma, April 1, 2018

- TRM: **downside risk mitigation-focused**, and insurance-driven, with little to no consideration of upside value
- ERM: conceived to **advance the organizational contributions** of the risk management process
  - **Transformation** is the challenge: to align with value-based models while still living in a volume-based environment
  - **One-sided** models incur up-front costs but not back-end financial loss sharing
  - **Two-sided** arrangements expose providers to both shared savings and shared losses
  - Clinical and financial performance are **expressly linked** in value-based delivery
  - These new models are oriented toward **changing provider behavior** in managing patient population access and progression through the delivery ecosystem
  - Significant **dedication of resources** to care coordination, care management and catastrophic case management are critically important
From TRM to ERM: Downside / upside duality

Primary financial risk categories defined within payer/provider at-risk contracts
Value-based care risk solutions
# Medical expense downside risk solutions

Primary financial risk categories defined within payer/provider at-risk contracts

<table>
<thead>
<tr>
<th>LEVEL OF ANALYSIS</th>
<th>DOWNSIDE RISK</th>
<th>UNIT OF EXPOSURE</th>
<th>DURATION</th>
<th>NATURE OF RISK</th>
<th>DRIVERS</th>
<th>EXPENSE CATEGORIES</th>
<th>EXAMPLES OF CMS MODELS</th>
<th>FINANCIAL RM SOLUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>Catastrophic claim activity</td>
<td>Health plan member</td>
<td>Benefit year</td>
<td>Severity</td>
<td>• Cancers • Renal disease • Transplants • NICU • Sepsis • Gene therapy</td>
<td>• Institutional • Professional • Pharmaceutical</td>
<td>Capitated Medicare Advantage plans</td>
<td>Specific excess coverage: Provider stop loss</td>
</tr>
<tr>
<td><strong>Episodic</strong></td>
<td>Total claims expenses for a defined illness or condition</td>
<td>Set of procedures</td>
<td>Post-acute window</td>
<td>Severity</td>
<td>• Complications • Readmissions</td>
<td>CPT codes</td>
<td>Bundled Payments for Care Improvement – Advanced (BPCI-A)</td>
<td>Modified specific excess coverage</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>Total claims expenses measured against financial and quality targets</td>
<td>Attributed members</td>
<td>Performance period</td>
<td>Frequency</td>
<td>• Medicare enrollment type: Aged/Non-Dual, Aged/Dual, ESRD, Disabled</td>
<td>Medicare FFS</td>
<td>Accountable Care Organizations (ACO)</td>
<td>Aggregate cost protection: Shared losses reinsurance</td>
</tr>
</tbody>
</table>
Provider stop loss case study
Introduction to MPSL
Understanding the basics

- Physician group providers continue to, in increasing numbers, enter into contracts with health plan payors that expose them to “substantial financial risk” (as defined by CMS) of loss from large or catastrophic medical claim expenses.

- Such Medicare Advantage and managed Medicaid contracts are governed by The Centers for Medicare and Medicaid Services (CMS) under 42 CFR 422.208, which has been completely revised effective January 1, 2019.

- CMS mandates that protection from excessive risk of loss in risk-bearing or capitated agreements must be in place, and establishes maximum deductible levels.

- This protection is known as STOP LOSS, which reimburses providers for individual member claim expenses above a selected deductible.

- Stop loss may be offered by the payor under its contract with the provider.

- In this case, the payor has complete control over pricing, terms and profit retention.

- However, commercial market insurance options are available that shift control of this protection to the provider group.

- These medical provider stop loss (MPSL) insurance products are admitted, A. M. Best ‘A’ rated policies, with negotiated pricing, terms and conditions and options for alternative risk transfer mechanisms.

- These options also enable multiple payor contracts to be covered under a single insurance policy.
Regulatory guidance from CMS
Under certain Physician Incentive Plan agreements, providers must evidence stop loss protection

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 417, 422, 423, 460, and 498

[CMS–4182–F]

RIN 0938–AT08

Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.
Regulatory guidance from CMS
Under certain Physician Incentive Plan agreements, providers must evidence stop loss protection

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Provider stop loss mechanics
Understanding the basics

• What’s covered?
  • Eligible services
    o Professional – physician – Medicare Part B (Outpatient: DME, home health, ambulance, preventive, therapy, mental health)
    o Institutional – hospital – Medicare Part A (Inpatient: SNF, home health care, hospice care)
    o Pharmaceutical – Medicare Part D and specialty tier (Note: some drugs can be covered by either Part B or D)

• How much is covered?
  • Claim valuation
    o Amount paid
    o Contracted rates
    o % of Medicare allowable
    o Sub-limits and per diems

• Amount of risk transferred?
  • Reimbursement
    o up to 90% of paid medical expenses (coinsurance),
    o which exceed the selected deductible,
    o up to $MM per member maximum per policy year

• Net cost determination?
  • Rate – per member per month
  • Retention – deductible per member
  • Reimbursement – amount above the deductible, recovered
  • Refund – based on favorable claims experience for the policy year

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>TRADEOFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>RETENTION</td>
<td>↑</td>
</tr>
<tr>
<td>RATE</td>
<td>↓</td>
</tr>
<tr>
<td>REIMBURSEMENT</td>
<td>↓</td>
</tr>
<tr>
<td>REFUND</td>
<td>[function of underwriting profit]</td>
</tr>
</tbody>
</table>
Provider stop loss coverage

How is it typically structured?

Example:

Reinsurance market stop loss plan

$150,000 per member deductible

- Claims below $150,000 are fully retained by the Provider, with no aggregate cap
- Claims above $150,000 are subject to 90% coinsurance with no aggregate cap, up to the $2,000,000 per member limit
- Claims above $2,000,000 are fully retained by the Provider
- Rates are expressed per member per month, or PMPM
- Premiums are calculated as:
  Rate PMPM x monthly population x 12
- Premium is paid on a monthly reporting basis
- Policies are subject to a minimum premium provision
- Experience refund options based on favorable experience are generally available
## ABC Physician Group
### Case study: 2018 Reinsurance market data

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>SL Insurer 1</th>
<th>SL Insurer 2</th>
<th>SL Insurer 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$30,000</td>
<td>$30,000</td>
<td>$75,000</td>
</tr>
<tr>
<td><strong>Stop Loss rate PMPM</strong>&lt;br&gt;Fixed for policy period</td>
<td>$148.00</td>
<td>$158.57</td>
<td>$52.19</td>
</tr>
<tr>
<td><strong>Annual claim cost</strong>&lt;br&gt;Unadjusted 2017 data</td>
<td>$13,377,331</td>
<td>$13,377,331</td>
<td>$13,377,331</td>
</tr>
<tr>
<td><strong>Estimated S/L premium</strong>&lt;br&gt;Rate x total member months</td>
<td>$4,006,656</td>
<td>$4,292,807</td>
<td>$1,423,446</td>
</tr>
<tr>
<td><strong>Total claims expense</strong></td>
<td>$17,383,987</td>
<td>$17,670,138</td>
<td>$14,800,777</td>
</tr>
<tr>
<td><strong>Claim reimbursements</strong>&lt;br&gt;Unadjusted 2017 data</td>
<td>($2,242,210)</td>
<td>($2,242,210)</td>
<td>($1,262,430)</td>
</tr>
<tr>
<td><strong>Experience refund</strong>&lt;br&gt;Per proposed formula</td>
<td>n/a</td>
<td>($191,840)</td>
<td>-0-</td>
</tr>
<tr>
<td><strong>Total net claim expense</strong></td>
<td>$15,141,777</td>
<td>$15,236,088</td>
<td>$13,538,338</td>
</tr>
</tbody>
</table>
Hospital performance-based risk
The case study hospital’s recommended risk levels in this exhibit are indicated on a framework created to provide a basis for such an analysis. The framework encompasses risk continuums for eight key elements addressed within a commercial capitated contract, applicable to all provider types that might participate in such a contract. Provider types include:

- DRG hospitals
- Medicare Part A and Part B hospitals
- Ambulatory surgery centers (ASCs)
- Out-of-area (OOA) hospitals

Note: JOC = joint operating committee
To test the maximum risk profile assumptions, the hospital obtained a risk scenario analysis to evaluate each of the proposed options.

This analysis incorporated the projected capitation revenue and the related expenses for all inpatient and outpatient facility and professional services, including physician fees, laboratory and imaging costs, and more.

Expenses associated with disease management were itemized, because improving the management of care for chronically ill patients was a high priority for the organization as a requirement for effective population health management.

Also included were third-party administrator fees and stop-loss reinsurance, which would provide protection against large losses under each option.

The analysis found the hospital would have accepted risk for too large a patient population under Scenario A, and too small a population under Scenarios C and D (see the exhibit on page 50).

Scenario B, covering 15,000 members with a MLR of about $34 million, or 84.71 percent, was identified as the best option because it would allow the hospital to make its profitability targets both in terms of dollars as well as the desired percentage of revenue to expenses.
ACO aggregate reinsurance case study
An accountable care organization (ACO) is a network of physicians, hospitals and other healthcare providers and suppliers that coordinate efficient, high-quality lower-cost patient care while sharing financial and medical responsibilities.

The ACO alternative payment model has the goal of decreasing spending and improving care.

Eliminating the process of billing per procedure and instead providing incentives for care coordination aims to reduce unnecessary or redundant services.

An ACO can choose to participate in various risk-based contracts, beginning with zero risk, to coordinate the most appropriate care and best manage chronic diseases.

Predetermined levels of financial risk and reward are designed to inspire providers to meet the goal of ensuring the patient receives appropriate care to keep them healthy and out of the hospital.

Depending upon the type of risk contract(s) the ACO is under, members of the ACO can be rewarded with a financial bonus if they’re under the budgeted amount and might have to pay the difference if they exceed this amount.

There are also expectations for reporting data on performance, quality and savings benchmarks.
## ABC ACO
Track 3, Two-Sided Risk Model, January 1, 2019 – July 1, 2019

<table>
<thead>
<tr>
<th>PARAMETER</th>
<th>SSP TRACK 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Final Sharing Rate</strong></td>
<td>Quality score x 75%</td>
</tr>
<tr>
<td><strong>Minimum Savings Rate (MSR), MACO selection:</strong></td>
<td>Total updated benchmark expenditures x 2%</td>
</tr>
<tr>
<td><strong>Minimum Loss Rate (MLR), MACO selection:</strong></td>
<td>Total updated benchmark expenditures x -2%</td>
</tr>
<tr>
<td><strong>Performance Payment Limit</strong></td>
<td>20% of total benchmark expenditures</td>
</tr>
<tr>
<td><strong>Shared Savings</strong></td>
<td>First dollar once MSR is met or exceeded</td>
</tr>
<tr>
<td><strong>Shared Loss Rate</strong></td>
<td>(1 – Final Sharing Rate)</td>
</tr>
<tr>
<td></td>
<td>• Subject to 40% minimum/75% maximum</td>
</tr>
<tr>
<td></td>
<td>• First dollar once MLR is met or exceeded</td>
</tr>
<tr>
<td><strong>Loss Sharing Limit</strong></td>
<td>115% of updated historical benchmark expenditures</td>
</tr>
<tr>
<td><strong>Truncated Assigned Beneficiary Expenditures</strong></td>
<td>99th percentile of annualized expenditures by Medicare enrollment type</td>
</tr>
<tr>
<td><strong>SNF 3-Day Rule Waiver, MACO selection:</strong></td>
<td>Yes</td>
</tr>
</tbody>
</table>

Reference: CMS Fact Sheet, Updated July 2017
# CMS ACO internal stop loss mechanism

Track 3, Two-Sided Risk Model, January 1, 2019 – July 1, 2019

### 2017 FEE-FOR-SERVICE EXPENDITURE TRUNCATION THRESHOLDS ($)

<table>
<thead>
<tr>
<th>MEDICARE ENROLLMENT TYPE</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESRD</td>
<td>431,369</td>
<td>431,369</td>
<td>438,842</td>
<td>438,842</td>
</tr>
<tr>
<td>Disabled</td>
<td>127,739</td>
<td>127,739</td>
<td>132,827</td>
<td>132,827</td>
</tr>
<tr>
<td>Aged/Dual</td>
<td>186,528</td>
<td>186,528</td>
<td>188,547</td>
<td>188,547</td>
</tr>
<tr>
<td>Aged/Non-Dual</td>
<td>119,631</td>
<td>119,631</td>
<td>122,128</td>
<td>122,128</td>
</tr>
</tbody>
</table>

### Notes:

- National FFS expenditures from the CMS Office of the Actuary, which represent the sum of total Medicare FFS Part A per capita and Part B per capita expenditures. Expenditures for each year include a three-month claims run-out. A claims completion factor of 1.013 is applied to expenditures to account for expected remaining Parts A and B claims run-out.

- OACT truncation thresholds are at the 99th percentile of FFS per capita expenditures for the applicable enrollment type (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible) and are applied to annualized expenditures from the benchmark and performance years. The negative of the truncation threshold is also applied.

- OACT completion factor is applied to expenditures with 3-month run out.
ABC ACO
Projection of 2019 annualized expenditure exposure above CMS benchmark

Reinsurance layer

2% corridor

CMS maximum

Loss Sharing Limit, %

$ Million

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## Economic benefit of program

<table>
<thead>
<tr>
<th>A.</th>
<th>B.</th>
<th>C.</th>
<th>D.</th>
<th>E.</th>
<th>F.</th>
<th>G.</th>
<th>H.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Losses in 2% Corridor</td>
<td>Net Losses in Gap from Corridor → Attachment</td>
<td>Reinsurance Premium</td>
<td>Net Coinsurance Participation in Reinsurance Layer</td>
<td>Total Reinsurance Program Cost</td>
<td>Gross Corridor Losses + Net Reinsurance Layer Losses</td>
<td>Reduction in Loss Exposure with Reinsurance</td>
<td>Residual Exposure Above Reinsurance Layer</td>
</tr>
<tr>
<td>102% to 107%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NOTES:
- 624.6MM to 612.4MM
- No sharing
- 40% share
- No gap
- 5.5 bps x Aggregate benchmark
- 612.4MM x 0.0055
- 655.3MM – 624.6MM
- 40% share, 10% coinsurance
- A. + B. + C. + D.
- 12.2MM + 40% share of 655.3 – 624.6
- F. – E.
- 704.3MM – 655.3MM
- 40% share

### Annualized:

<table>
<thead>
<tr>
<th></th>
<th>Jan 1 2019 – Dec 31, 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. + B. + C. + D.</td>
<td>$12,200,000</td>
<td>0</td>
<td>$676,000</td>
<td>$1,228,000</td>
<td>$14,104,000</td>
<td>$24,480,000</td>
</tr>
</tbody>
</table>

### Six-month pro rata:

<table>
<thead>
<tr>
<th></th>
<th>Jan 1 – Jul 1 2019</th>
<th></th>
<th></th>
<th></th>
<th>-----</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$6,100,000</td>
<td>$614,000</td>
<td>$7,052,000</td>
<td>$12,240,000</td>
<td>$(5,188,000)</td>
<td>$9,800,000</td>
<td></td>
</tr>
</tbody>
</table>

### Notes:
- Estimated attributed members: 42,000 assigned + 12,000 newly acquired = 54,000
- Projected CMS benchmark for 2019: $11,340/beneficiary x 54,000 = $612.4 million
- Reinsurance loss recovery: 90% coinsurance

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Thank you for your time and attention!
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