REIMBURSEMENT + ACTUARIAL DEFENSIBILITY

Module · Board-Grade Revenue Truth

THE PROBLEM NOBODY PUTS IN THE BOARD DECK

In reimbursement-dependent healthcare, program ROI is not a finance problem. It is an actuarial problem. Most enterprise contracts in care management, bundled payments, and value-based programs are signed on internally modeled savings claims. Those claims are presented to boards and investors as validated revenue.

They are not validated until an independent actuarial team says they are.

When that review happens — typically at year-one or year-two renewal — the result is binary: the program saves money on an actuarially defensible basis, or it doesn't. If it doesn't, no amount of operational success, member satisfaction, or clinical outcome data overrides the finding. The contract ends.

The companies that survive this review are the ones that engaged the payer's actuarial team during the buy cycle, not after go-live.

4 QUESTIONS YOUR ACTUARIAL ENGAGEMENT STRATEGY MUST ANSWER

Before you sign the enterprise contract:

1. **Who is the actuarial lead at this payer, and have they seen your attribution model?**
   Not the CMO. Not the VP of Value-Based Programs. The actuary. If you haven't named them and received informal sign-off on your methodology, your contract has an undisclosed structural defect.

2. **Is your control group methodology defensible under independent review?**
   Internal models almost always use comparison populations that favor program ROI. Payer actuaries use claims-based matched cohorts. If your comparison group and theirs would produce materially different savings estimates, you will lose the renewal conversation regardless of what your model shows.

3. **What is your minimum detectable effect at the contracted population size?**
   Small pilots are statistically underpowered to show savings. Actuaries know this and use it. If your pilot population is under 500 attributed members, you are not generating statistically defensible savings data — you are generating anecdote. Renewal criteria must reflect this, or they need to be renegotiated before go-live.

4. **Have you separated program effect from secular trend?**
   Healthcare costs trend independently of your program. If your savings model doesn't explicitly isolate the program effect from regional/national trend lines, an actuary will do it for you at renewal — and the number will be smaller than yours.

3 SIGNALS YOUR PROGRAM ROI WON'T SURVIVE INDEPENDENT REVIEW

1 Your savings model was built by your data science or finance team without actuarial input or external validation.
What good looks like: commission a peer review from an independent actuary before your first renewal conversation — not during it.

2 Your attributed population is defined by enrollment, not by claims-based risk stratification.
What good looks like: attribution methodology aligned with the payer's claims system during contract design, documented in the contract exhibit.

3 Your comparison group is a historical baseline rather than a prospectively matched or concurrent cohort.
What good looks like: a concurrent comparison cohort negotiated with the payer before go-live. Retrospective baselines are the most common point of actuarial dispute at renewal.

If any of these conditions are true, the risk is not theoretical. It is scheduled.

THE ENGAGEMENT MODEL THAT WORKS

The companies that consistently survive actuarial review share one pattern: they treat the payer's actuarial team as a co-designer of the measurement model, not an auditor of their claims.

- Actuarial engagement as a named procurement step
  Not a post-go-live afterthought — a named milestone in the enterprise deal process, with a counterpart identified by name.
- Methodology alignment documented in the contract exhibit
  The attribution logic, comparison cohort definition, and savings calculation method belong in the contract — not in a slide deck.
- Quarterly data-sharing cadence
  Gives the payer actuary real-time visibility into program performance against their own model. No surprises at renewal.
- A pre-agreed savings band
  The range within which both parties consider the program validated. Eliminates the "our model vs. your model" standoff at renewal.

This is not standard sales practice in healthtech. It is standard practice for programs that renew.

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I install board-grade revenue truth systems for VC and PE-backed healthtech companies that need commercial clarity before their next board meeting or raise.

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