Finance, Accounting and Solvency Requirements

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Goals

- Financial and non-financial elements in global capitation/risk
- Reviewing contract elements of global capitation/risk
- Issues facing Provider Organizations in a capitated environment
- Solvency requirements and other suggested metrics to monitor
- Success factors

Market Realities

- Physicians control cost & quality decisions
- Significant role for provider-driven organization in Managed Care
- Consolidation of providers will continue
- Regulatory intrusion will intensify
- ↑ Information Demands - Outcomes, Quality, Access, Satisfaction & Cost
- Provider Organizations are best positioned to undertake population management process

Market Realities cont.

- ↑ CMS and Payors looking for alternative reimbursement methodology
- ↑ Mixed Group/IPA Models
- ↑Purchaser/Provider Communication
- Managed Care moves into the Medicaid Market
- Pharmacy and Injectable cost inflation
- Health care is a people business
- Health care is a local business
- Commercial HMO members are more comfortable with MA choice when become eligible for Medicare

The Health Care Environment: A Paradigm Shift

From:

"Managing Sickness"

- Caring for Individuals
- Acute In/Out Patient Care
- Hospital at Center of Delivery System
- Maximizing Revenue
- Micro-Management of Utilization, Health Care Decisions
- Optimum Individual Provider Performance

To:

"Managing Health"

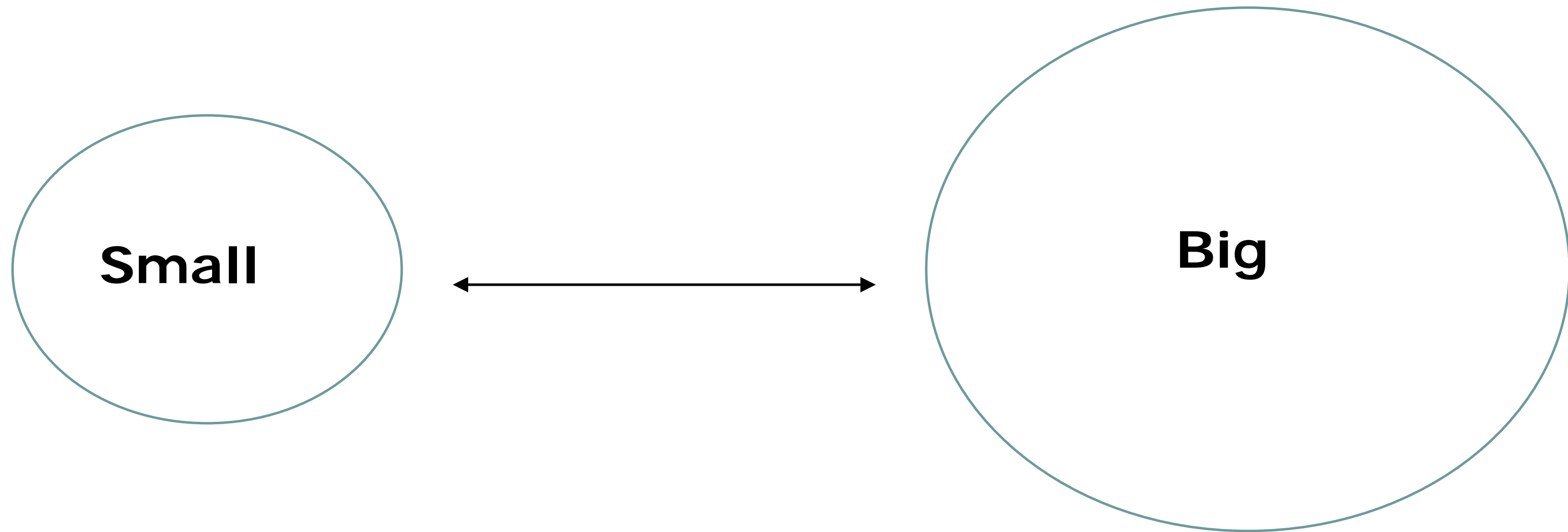
- Accountability for a Population
- Continuum of Care
- Primary Care Provider at Center of System
- Minimizing Expenses
- Provider Self Management Based on Shared Values, Shared Culture, CQI and Shared Incentives.
- Optimize System Performance

Provider Organizations
Why consider Risk-based Compensation

- Primary care organizations are best positioned to coordinate and manage population health
- MD's pen/PDA impacts almost all the costs
- PCPs control members
- All trends toward ambulatory care
- Direct purchaser/employer contracting potential
- Can manage and control the entire care
- Flexibility in selecting Hospitals/HMOs
- Entrepreneurial advantage/flexibility

Outcome Focus

Strategic Imperative



Benefits from Acting Big and Small:

<u>Big</u>

- Negotiating clout
- Strong central core competencies
  - IS
  - Finance
  - Managed Care Operations
  - Administrative Services
  - Marketing & PR
  - Communications
  - Disease Management Programs
  - Health Education
  - Human Resources

Benefits from Acting Big and Small:

Big

- Merger and acquisition expertise
- Capital
- New products
- Diversification of revenue
- Branding
- Industry and national recognition
- Self-insured opportunities
- Identifying & Replicating best practices
- Leadership and management depth

Benefits from Acting Big and Small:

Small

- Community relationships and focus
- Local team
- Sense of family
- Clinical outcomes
- Patient satisfaction
- Employee satisfaction
- Financial outcomes
- Local growth
- Specialists
- Hospital, SNF and other providers

Global Risk Contracting Issues

- Pricing global risk capitation/funding guidelines by LOB, by product, by benefit, by market
  - % of CMS revenues? Including MA member premium?
  - Definition of CMS revenues, does it include rebates?
  - How is it calculated for the dual eligible and retirees?
  - % of commercial premiums vs. fixed capitation by benefit and age/sex? Right to audit the premium? What is excluded (e.g. Mental Health, Vision, RX)? In case of % of premium, how is "split" enrollment calculated? Minimum PMPM capitation?
  - Risk adjusted capitation/funding for Commercial/POS and/or Medicaid members?
  - How are you paid for POS members? What is OON %?
  - Annual trend based on CPI, MCPI, premium increases?

Global Risk Contracting Issues cont.

- Health Plan Competency Level in the Areas of:
  - Sales & Marketing
  - Member Services
  - Member Education
  - Timely & Accurate Information (e.g. Eligibility, Enrollment, RAF)
  - Dispute Resolution - Member & Provider
  - Regulatory & Compliance Audits
- Growth plan, critical mass & minimum enrollment
- How the Benefits are changed? (e.g. Copays, Co-Insurances, Deductibles, Maximum OOP, MA member premium)
- Assigned or Open PCP (important for POS members)?
- Criteria for member transfers (especially high cost patients) and "block" transfers?

Global Risk Contracting Issues cont.

- Manageable DOFR (e.g. ability to manage OON, OOA & out of country care)
- Length of the Agreement - Long Term partnership vs. Short Term business relationship
- How often do you get to negotiate your arrangement? Can you terminate if not able to reach agreement?
- Network of Providers & Hospitals:
  - ➢ Who is included?
  - ➢ Who will be included?

Global Risk Contracting Issues cont.

- Who receives Coordination of Benefits and Third Party Liability recoveries?
- Any other protection (e.g. no-cost reinsurance) or incentives (e.g. Rx bonus or shared risk, OON sharing)? Is there any additional protection and/or compensation for "deferred" care in case of block-transfer from another PO?
- Participation in narrow network products (at what price?)

Global Risk Contracting Issues cont.

- Who pays what claims? If not paid by you, what are the bases of their claim adjudication (e.g. verifying authorization, reimbursement methodology, your "unique" contract terms)?
- How long for member "retro" deletion or addition?
- Utilizing your own Centers of Excellence vs their designated ones
- Requirements and consequences in case your are acquired or merged
- Freedom to hire your insurance agents or own an agency for MA enrollment

Global Risk Contracting Issues cont.

- Whose Disease management and registries is used?
- Are you able to access and use the plan's contracted rates for your contracted and non-contracted hospitals, SNFs and other providers?
- What is the process of adding new benefit plan or changing age/sex tables?
- What are other insurance requirements beyond professional liability?

Global Risk Contracting Issues cont.

- Ability to renegotiate financial terms in case of significant benefit change for MA (Medicaid?)
- No-cause termination timing and notice period
- What happens at the contract termination?
  - Continuum of care reimbursement?
  - If % of CMS revenues, future RAF payments?
  - Timing of reconciliation and payment of risk and incentive pools?
  - Timing of member communication & solicitation

Difficult Issues in Global Contracting

- Financial Withhold (during and at the time of contract termination)
- Financial and Administrative Compliance Criteria
- Consequences of non-compliance
- Sharing of Financial Statements
- Guaranteed participation in all of their HMO products and networks
- Application of the agreement in case of M&A
- Non-exclusive IPA PCP recognition

Difficult Issues in Global Contracting cont.

- Contract terms in other markets
- Contract terms of acquired entity
- Recognition of acquired IPA/entity under the same term in case of IPA PCP belonging to other entities
- How to deal with a terminated IPA PCP
- Not utilizing their of Centers of Excellence
- Solicitation language at contract termination
- PPO/EPO participation

Success In Global Risk Requires

- Physician engagement (i.e. ownership, options, short & long-term incentives)
- Adopting a "Mini" Insurance company philosophy
- Understanding Revenue and Cost components
- Operationalizing your contract's unique Terms
  (Plan, Hospital & Provider)
- Managing sub-capitation including "leakages"
- Capturing/Reporting Meaningful Data
  - How to collect the data?
  - What do you do when you've got it?
  - How do you make it mean anything?

Success In Global Risk Requires cont.

- Ability to capture and track referral, utilization and clinical and financial metrics
- Analyzing your members (use of Predictive Modeling)
- Knowing your preferred specialists (use of ETG)
- Developing and monitoring P&L by LOB, by health plan, by market/region
- Identifying non-capitated services (e.g. W/Comp cases, experimental procedures, clinical trails care)

Success In Global Risk Requires cont.

- Having clear methodology to justify and monitor investment in clinical and administrative programs (e.g. Home visit, 24/7 UCC, after-hours member support center and triage program)
- Selecting the best outside providers based on quality, efficiency, access, satisfaction and coverage
- Tracking and analyzing your non-contracted provider reimbursement methodology, constantly assessing contracting opportunities
- Increasing your "exclusive" IPA PCPs

Success In Global Risk Requires cont.

- Use of Hospitalists and outpatient intensivists
- Creating effective and cooperative relationships with hospitals and their EDs and create win/win situation by using DRG, Cost Model or other reimbursement methodology
- Auditing "Their Data"
- Shifting cost from one bucket to another in order to achieve better clinical and financial outcomes
- Educating all of your staff (Provider and non-provider) regarding your metrics

Metrics by Line of Business
Entity, Market, Region, Clinic, PCP

- Admission P1000MPM
- Acute and sub-acute days P1000MPM
- Readmission % within 30 days
- OPS P1000MPM
- ED visit P1000MPM
- Weighted panel size per FTE PCP PM
- % of members with no visit in the last year
- RAF for MA members (and all members ?)

Metrics by Line of Business
Entity, Market, Region, Clinic, PCP

- Quality Metrics
- Patient Satisfaction (e.g. Completely satisfied)
- Specialist visit P1000MPM by LOB
- Specialist (employed and contracted) cost PMPY by LOB
- Member Disenrollment by LOB, by health plan PY
- Rx cost PMPM & % of generics
- Incentive bonus or pool information (comparison to the maximum potential and annual trend)

Regular review of:

- Monthly Financial Statements including BS, statement of cash flow and solvency requirements
- Monthly budget to actuals by market, region
- Budget to actual variances
- All of your quality, utilization, efficiency, satisfaction and financial metrics
- Regulatory and compliance metrics
- Catastrophic cases PMPM by LOB, by market, by region (need to be defined; cases with $75k hospital charges or above hospital Stop-Loss)

Regular review of:

- Hospital cost per day by LOB, by market/region
- All insurance experiences including malpractice
- Any self-insured programs
- Recent Program investments progress and ROI
- Strategic and Operational plan measurements
- Provider & employee satisfaction results
- Administrative costs and its components as % of total revenues

CA DMHC Required Solvency Criteria for Risk Bearing Organizations

- Positive tangible net equity (TNE)
- Positive working capital
- Minimum cash-to-claim ratio (.75)
- Adjudication (i.e. Pay, Contest or Deny) at least 95% of outside claims within 45 working days
- Reserves for IBNR claims liability methodology documented and calculated monthly
- IBNR estimate is reflected on the financial reports
- Submit annual audited financial statements

How To Create And Implement sub-Capitation Contracts

- Provider Orientation - When to refer
- How does the Eligibility & Benefit information is delivered?
- Knowing your experience and cost:
  - Whose Data you use?
  - How accurate a data source is it?
  - Actual vs. Actuarial?
  - Fixed Capitation vs. age/sex
  - What is covered and not-covered? Experimental Procedures, Out-of-Area
  - How to Pay for non-covered services?
  - How is the Capitation distributed in a single specialty group?

How To Create And Implement sub-Capitation Contracts cont.

- How to deal with the scope to include Pediatrics vs. Adult
- Tracking & gathering encounter data
- Data Sharing - What to share with specialist to change behavior
- Termination Clause to deal with: Continuing Care Obligations, Communication to Members, Medical Record Transfer, not to compete.

How To Create And Implement Capitation Contracts cont.

- Low Enrollment Guarantees
- Reinsurance or Stop Loss for catastrophic cases
- Withholds and Incentive Pools (Referral Budget, Hospital Share Risk). Begin with incentive, then add negative risk
- Bonus Pools for Quality of Care, Patient Satisfaction & Administrative Compliance
- Coordination of Benefits, Third Party Liability & Eligibility Guarantee
- Policies for Use of other Specialists and Ancillary Providers

Required Components For Sub-Capitation Success

- Integrated Information Systems
- Comprehensive Utilization Management program
- Prudent experience
- Selected risk sharing partners
- Provider performance review process which should address:
  - Quality & Outcome measurements
  - Access & Availability
  - Patient Satisfaction
  - Degree of Compliance with Policies and Procedures
  - Evaluation of Specialists by Primary Care Physician

Required Components For Sub-Capitation Success cont.

- Geographic Coverage Including Hospitals
- Creation of Physicians Profile to Track & Monitor the Real Cost:
  - Referral to other Specialists
  - Utilization of Ancillary Services
  - Frequency of Procedures and Length of Stay
  - Use of Outpatient Facilities
  - Pharmacy Cost
  - Patient Complaints and Request for Second Opinion

How Does Capitation Affect Physician Practice Style

- Local solo practice become organized groups or networks
- Ties specialists to the payor (Group, HMO, PPO)
- Providers will manage health, not disease
- More willingness to work with Case Management, Ambulatory Care programs (hospital pre-admission program, Oncology Care Coordinator, Pharmacy Program) & Care Teams (hospital discharge planner, home health nurse)

How Does Capitation Affect Physician Practice Style

- Encourage specialists to act as true consultants to PCP
- Number of visits to primary care may increase while visits to specialists maybe significantly reduced
- Surgeons do fewer surgeries and specialists use less technology - dependent strategies to treat medical problems
- Use of physician extenders increases
- More emphasize on patient education, telephone care, e-visits and enhanced access to lower cost entry point

Alternatives To Capitation

- Discounted Fee-For-Service
- Fee Schedule (pay more for certain services)
- Case Rate- Fixed vs. Variable
- Fixed Budget - Distributed via percentage of charges
- Compensation included in Per Diem - Hospital based physician
- Compensation included in case rate - Cardiovascular Surgery, Outpatient Surgery, Emergency Room

Risk Based for PPO/EPO Patients ACO – maybe?

- Are the members fully insured or ASO?
- Will the members be attributed or enrolled?
- How are you getting paid?
- Are you responsible and/or incentivize for total/partial care or certain population (e.g. high risk members)?
- What is shared savings based on (e.g. actuarial, historical, historical with trend, benchmarks)?
- Value of exclusions and catastrophic cases
- Are you willing to take any down-side risk?

Risk Based for PPO/EPO Patients ACO – maybe?

- Understanding and analyzing criteria for utilizations (e.g. referral to specialist, imagine test, admission)
- Who are the specialists?
- Who are the other providers?
- How to apply your Disease and Care management?
- How available are utilization and cost data?
- Are you able to reduce costs by interventions (avoidable admissions, non-emergent ER visits, use of ambulatory OPS vs hospital-based OPS)

Necessary Components

- Data
- Governance
- More Data
- Leadership (MD and Non-MD)
- More Data

Final Takeaways

- Act as an insurance company by capturing and analyzing all the data elements
- Develop, discuss and finalize a long-term Strategic Plan and then communicate to all the stakeholders
- Have outside financial audit, develop annual "bottom up" budgets (operational & capital) with agreed upon assumptions, develop and update projections including cash flow projections
- Invest in Risk Management and Compliance
- Incentivize everyone based on financial, quality and patient satisfaction!