Agenda

I. Managing Financial Risk: Sharon Hicks - Level Setting and Definition

II. Managing a Capitated Contract: Pamela, Chief Operating Officer, Acacia Network

III. Questions & Discussion
Managing Financial Risk
The Transition From Pay-For-Volume To Pay-For-Value

- Fee-For-Service
- Case Rates & Bundled Payments
- Capitation & Population Payments

Pay-For-Performance
Risk Is...

Possibility That Actual Results Will Differ From Projected Results
The Competing Goals Of Any Alternative Payment Model

The payer is hoping that the arrangement will lead to overall savings

The provider is hoping that their efficiencies can allow them to recognize excess revenue

Everyone is hoping that the effectiveness of services are improved

- Outcomes
- Quality
- Population health
- Burden of health problems on associated spending
Financial Risk Is Part Of An APA

Have you done an analysis of cash on hand?

How well do you understand your cash flow?

Can you negotiate pre-payments for the APA with a true up occurring later?

Do you have finance capability or simply accounting?

Determine how much risk you are willing able to take.

Remember that the higher the risk, the higher the reward... but the higher the risk!
To Manage Risk...

You need to understand the actual cost of delivering a service

- Activity-based cost management
  - An understanding of the activities that cause cost

- Target costing
  - Understanding the range of rates within your market
  - Developing a plan to track this range within your own organization

- Value engineering
  - Once cost drivers are identified, then processes can be reengineered to get closer to the market range
How Is Capitation Determined

- Basic Medicaid Example
  - People are separated into rating groups determined by age, illness, risk assumptions, etc.
  - Then actuaries determine the likelihood of medical services and medical expenses being incurred during a rating period.
  - For example, suppose that an insurer says that they will pay you $100 PMPM
    - That might mean that the population includes some people whose expected expenses is $400 and others who are expected to spend $20
  - When capitating an insured group, one assumes that some portion of the population won’t use any services
  - When capitating a group of users of service, one has to assume that the whole population is going to be using services
Financial Risk Management System

Key element is routine real-time clinical utilization and cost reporting (also, Incurred But Not Reported-INBR)

Overall cost accounting system
- Cost per unit of treatment
- Cost per course of treatment
- Cost per patient

Do you have cash to get through the transition
Do you have the systems to prove you’ve met your goals

Revenue Cycle focus is critical

Payments for APAs can be contested
Medical Expense Ratio

Ratio between costs incurred for services and premiums received

- Total premium received in month: $100,000
- Total cost for services + IBNR: $90,000
- MER = ($90K / $100K) = 90%

\[
\text{Medical Expense Ratio} = \frac{\text{Total premium received in month}}{\text{Total cost for services + IBNR}}
\]
Basic Principles

**Actuarial processes needs to be learned**

You pay for insurance in case something catastrophic happens and the insurance company prices you by using actuarial assumptions that determine how likely that is to happen.

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If I am older, then the likelihood that I will need care is higher. If I am younger, then it’s lower.

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But when you are looking at a population of people, then you need to think about volatility.

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Generally, the larger the number in your population, the lower the volatility.
Basic Statistics Principle: Bigger Numbers Are Better

N=500

Attempting to calculate average spending between 1 and 10.

Findings:

a. Mean score = 6.579
b. If my 501st person has a score of 9, my mean goes to 6.584

N=10 for the same assessment

Findings:

a. Mean score = 5.800
b. If my 11th person has a score of 9 my mean changes to 6.100

The smaller your population the more volatility you have...the more that one outlier is going to have a significant effect.
Example

There are 700,000 people with End-Stage Renal Disease (ESRD) in the U.S. and 242 million adults. So if you are insuring the whole population of the U.S., your chance of having someone in your population with ESRD is 0.28%.

- When the actuaries are determining if rates are adequate, they use these kinds of prevalence measures.
- If you have 1 million covered lives, you are expecting that you will have about 2,800 people with ESRD and if you have one or two more, you don’t have a big financial program.
- But if you have 10,000 or 5,000 covered lives and you have two extra ESRD members, you can lose lots of money.
Risk Bands

Think of risk bands the way that you think about standard deviation in statistics.

- Standard deviation (SD) is a quantity calculated to indicate the extent of deviation within a set of data
- Risk bands then are the range of estimates of expenditure that the actuary will provide
- As with SD, the larger the number in the population, the tighter the risk bands
- It’s important to understand both the size of the risk band and also the absolute dollar that is being proposed in any APA
Steps To Determine “Current Spending”

- The next few slides come from the principal of Compass Health Analytics in Portland Maine. Compass provided economic and actuary services to my past employer.

- Define: “Incurred But Not Reported” or IBNR
  - The dollar amount the MCO assumes it will pay in the future for services already rendered but for which claims have not yet been submitted by providers
  - Authorizations and historical paid claim patterns are used to calculate this figure
Recent claim data provides a very limited picture, so actuarial calculations help predict true costs in the future.
Projected Growth Rate & Current Spending

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Program Adjustments & Current Spending

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# Capitation Holds the Highest Risk

## Some examples of common alternative payment methods

<table>
<thead>
<tr>
<th>Risk Model</th>
<th>Revenue Description</th>
<th>Level of Risk</th>
<th>Clinical Volatility</th>
<th>Patient Volume</th>
<th>Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation: Global</td>
<td>Providers receive a fixed sum, usually prepaid monthly, designed to cover the cost of delivering all or some of the services of the patients within their care, which may be supplemented with incentive payments for achieving quality goals.</td>
<td>High – Full risk for all services agreed to under the capitation arrangement</td>
<td>Low</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Value based purchasing</td>
<td>Provides financial incentives to hospital and physicians for providing higher quality care at an efficient cost predominantly through clinical protocols and incentives</td>
<td>Medium/High – Combination of fixed payment and Fee for Service payments with incentives/penalties for meeting quality benchmarks and for lowering utilization and costs</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Bundled Payments</td>
<td>Providers receive a fixed payment to cover all of the costs of services delivered during a hospitalization or episode of care (knee replacement or heart failure) or to treat a particular disease for a defined period of time (Diabetic Patient).</td>
<td>Medium – Full risk for specific services. Monitoring of costs and outcomes easier for a subset of the larger population</td>
<td>Low</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>Capitation: Routine Care</td>
<td>Providers receive a fixed sum; usually pre-paid monthly, designed to cover the cost of delivering preventative services of the patients within their care.</td>
<td>Medium/High – Full risk for preventative services agreed to under the capitation arrangement</td>
<td>Low</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Gain Sharing</td>
<td>Hospitals and providers collaborate and share cost savings as a reward for quality and efficiency improvements. Gain sharing targets device and supply usage within a specific service line (e.g., orthopedics or cardiology) whereas shared savings targets specific patient populations (e.g., diabetics or asthmatics).</td>
<td>Low/Medium – The incentive to reduce supply usage in conjunction with a quality outcome leads to efficiency gains. Risk increases in conjunction with the complexity of services rendered (i.e., traumas)</td>
<td>Low</td>
<td>Low</td>
<td>Low/Medium</td>
</tr>
</tbody>
</table>

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Infrastructure Requirements

- Necessary elements to manage risk include:
  - Technology infrastructure: systems to aid in streamlining administrative operations (i.e., registries, callback systems, data systems)
  - Reporting and analytics: data mining to identify areas of risk, including outliers, patient demographics, and risk factors
Helpful Hints

Determining spending is complex. Beware of simplistic answers.

Populations with 100% of people who are users of service will have very high per member per month (PMPMs) and very high costs. Don’t be lulled by the total dollars.

Every APA will have ways to game the system (e.g., case rates can see more discharges and then reopening of a case as a new case, population management can see agencies selected the lower risk members of the population and refusing to treat the higher risk members, etc.)

When in doubt, go outside of your organization for expertise.
Managing A Capitated Contract

Pamela, Chief Operating Officer, Acacia Network
Clinical Perspective on Managing Capitated Contracts

Acacia Network
Pamela Mattel LCSW
Chief Operating Officer
What is the Value of Volume?

- Attribution Size Matters
  - Competitive Position
- Opportunity to Impact Population
- Understand Population Profile
  - Trends, Social Determinants
- 80/20 Rule
  - 20% will use 80% of care resources
Clinical Transformation

- Risk Stratification’s Impact on Care
  - Drill Down to Understand Risk Variables
  - Redesign System of Care for Risk Profiles
  - Detail Staff Roles and Responsibilities
  - Re-Imagine Team
- Empanelment as Design Advantage
  - Team Based Care and Ratios
- Workflow Efficiency and Waste Reduction
- Patient Satisfaction = Outcomes
Clinical Challenges

- Inactive Captitated Patients Affect Quality Scores
- Claim Denials for Patients Seen in Other Practices
- Staffing Resources for Data and Quality Report Card Monitoring
- Outreach/Peer Recovery Staff for Engagement, Continuity of Care, Wellness and Recovery
- Professional Development Demands
Clinical Documentation

- Outcome Focused Progress Notes
- Detail vs General
  - Diagnosis + Intervention = Outcome
  - Maximize Coding to Reflect Metrics
  - Note Every Intervention
  - Chart Review for Supplemental Data to locate documentation that is not in reportable EMR fields
- Identify Linkage to Other Services
- Supports Rate Setting
- Pathway to Quality Incentive Payments
Quality and Measurement

- Preventive Approach
- “Raise the Bar Daily” Culture
- Persistent and Continual Scanning
- Focused Efforts using Root Cause
- Rapid Cycle Change
- Learning Culture
Revenue Cycle and Finance

- Invaluable Feedback to Clinical
  - Coding Trends
  - Identify Services Outside Capitation for Reimbursement
- Interdependent with Clinical
  - Managed Care Contract
  - Revenue/Billing
  - Clinical Care
- Finance
  - True Cost of Care
  - Cost Drivers
Key Activity

- Identify Revenue from Capitation versus FFS
- Visit Cost = positive or negative balance
  - e.g. Higher Visit Volume → Financial Loss
Managed Care Relationship

- Plans are Engaged and Monitored
  - Must Perform Qualitatively
- Better Quality = Preferred Provider
- Partnership to Learn Together
  - Use their Tools
- Ask for Help
Questions & Discussion
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