Provider MCO’s - What Are They?

- A provider organization which contracts with an HMO
  - On a capitated or risk-bearing basis
  - Or otherwise

- A provider organization which accepts risk directly from the purchaser
Examples: “Carve Out” MCO’s

- PBM - Prescription drugs
- BHO - Behavioral Health Organization
- Laboratory
- Radiology
- Capitated Specialties - e.g. Cardiology
- HIV/AIDS
Examples: General Providers

- Primary Care Physicians
- Multi-Specialty Group Practices
- Hospitals & Health Systems
Examples: Integrated Groups

- MSO’s - Medical Service Organizations
- PHO’s - Physician Hospital Organizations
- IDS - Integrated Delivery Systems
- PSO’s - Provider Sponsored Organizations
- Alphabet Soup - ISDN, CISN, PSN, etc.
Actuarial Roles - Provider MCOs

- HMO’s - Capitation Negotiations
- Employers - Direct Contracting
- HCFA - Medicare + Choice
- State DHS - Medicaid Program
- Insurance Department - PSO Formation
- Reinsurer
Capitation rate is calculated as:
- Utilization x Cost per Service = PMPM

Utilization rate assumptions taken from:
- Historical results
- Projected Managed Care improvements

Cost per service reflects provider costs and discounts
Managed care often shifts sites of care

Utilization decreases at one site, increases at another

*Service Intensity* often increases at both sites

Ideally, care is shifted to the most appropriate and efficient location
PHO Formation

- Hospital and Physicians form PHO
- PHO contracts with HMO’s or employers to accept risk on a capitated basis
- Entities within the PHO don’t always trust one another
- How do you divide the capitation dollar?
- How do you align incentives?
Negotiated process

Actuarial pricing model under various scenarios of reimbursement, utilization

Selection of assumptions is part of the negotiation

Comparison to market benchmarks
PHO: Aligning Incentives

Need to align incentives to:

- Put providers most at risk for the services they provide directly
- Put providers at risk for services they can influence directly or indirectly
- Encourage use of most appropriate site of care
- Reward providers for favorable results overall
Premium Funds Flow

Health Entity

Primary Care Pool
- 14%
- Includes:
  - Family Practice
  - Internal Medicine
  - Pediatrics

Secondary Care Pool
- 28%
- Includes:
  - All other physician services not included in primary care
  - OB/GYN

Hospital Pool
- 32%
- Includes:
  - Inpatient Hospital Expenses
  - Outpatient Hospital Expenses

Administrative Expenses
- 12%
- Includes:
  - Tertiary Care
  - Prescription Drugs
  - MH/SA
  - Home Health
  - DME
  - Ambulance
  - Out-of-Area
  - Transplants

Other Expenses
- 14%
PCP Pool Fund Distribution

**PCP Pool**
- Health Entity

**Withhold Pool**
- Specialist
- Hospital
- Offset Deficit

**PCP Bonus**
- 10% of Surplus
- 20% of Surplus
- Balance

**PCP Pool**
- 85% × Capitation
- 19% of Premium

**Physician A**
- 15% × Capitation

**Physician B**
- 20% of Surplus

**Physician C**
- 19% of Premium
Specialist Pool Fund Distribution

- **Specialist Bonus**: 20% of Surplus
- **Withhold Pool**: Balance
  - 50% of Surplus
  - Offset Deficit
  - 20% × Fee Schedule*
- **Physician A**, **Physician B**, **Physician C**: 80% × Fee Schedule*
- **Reserves**: 20% of Surplus
- **PCP**: 20% of Surplus
- **Health Entity**: 23% of Premium
  - 10% of Surplus
- **Health Entity**: Offset Deficit
- **Hospital**
Hospital Pool Fund Distribution

- **Hospital Bonus**
  - 40% of Surplus

- **Offset Deficit**
  - 20% × DRG Schedule*

- **Withhold Pool**
  - 10% of Surplus

- **Specialist**
  - 32% of Premium
  - Offset Deficit

- **Hospital A**
  - 80% × DRG Schedule*

- **Hospital B**

- **Hospital Pool**
  - 20% of Surplus
  - 10% of Surplus
  - 20% of Surplus
  - 10% of Surplus

- **Health Entity**
  - 32% of Premium

- **PCP**
  - 20% of Surplus

- **Reserve**
  - 20% of Surplus

- **Health Entity**
  - 10% of Surplus

- **Specialist**
  - 20% of Surplus
Competitive Capitation Pricing: Challenges for the Actuary

- Excess supply of providers/specialists
- HMO’s are using competitive bidding
- 300-500,000 lives to a single vendor
- Providers face gain/loss of market share
- Assisting these providers presents some challenges to the actuary
Competitive Capitation Pricing
Challenge #1: Data Quality

- HMO may provide only demographic data
- HMO does not want bids based on historical costs and utilization
- Challenge to identify normative utilization
- Challenge to identify “best practices”
- Will the provider be able to achieve the assumed utilization levels?
Competitive Capitation Pricing
Challenge #2: Unit Costs

- Marginal pricing may be appropriate for incremental volume
- Restructuring may be required to reduce costs - Can this be achieved?
- Can the provider serve all the members directly?
  - *If not, can they subcontract at the same unit price level assumed in the bid?*
Competitive Capitation Pricing
Challenge #3: Optimal Price

- Increasing capitation price bid:
  - Decreases likelihood of winning the bid
  - Increases risk of losing current market share

- Decreasing capitation price bid:
  - Increases likelihood of winning the bid
  - Decreases profitability if the bid is won

- Optimal bid price hard to determine
Competitive Capitation Pricing
Challenge #4: Documentation

- New standard of practice
- How do you document all of this?
- Not as simple as putting together a pricing model
Competitive Capitation Pricing
Challenge #5: Professional Risk

- Provider will lose market share if the bid is lost
- Provider is most likely to win the bid if costs are underestimated
- Many uncertainties in estimating the costs
- Need for appropriate communication with provider as to decision-making roles
Resources

- Relevant ASOP’s: 5, 8, 16, 23, 25, New
- BBA of 1997
- Medicare: Provider at Risk Rules
- NAIC: RBC for MCO’s
- This meeting: Sessions 98, 114, 133
For Further Information

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