RECORD, Volume 23, No. 1*

Palm Desert Spring Meeting
May 21–23, 1997

Session 58OF
Physician Incentive Programs

Track: Health
Key words: Health Maintenance Organization (HMO)

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Summary: Panelists present various physical incentive programs, including withholds, bonuses, capitation, and other risk-sharing methodologies. Presenters comment on the implications of each type of program, including market acceptability, effectiveness in controlling care, and appropriate situations for applying each type of program.

Mr. Martin E. Staehlin: We are going to discuss provider risk absorption methodologies and appropriate situations in which they can be applied. We're going to have three presenters—Barry Shane from Healthnet/Qualmed, Larry Pfannerstill from Milliman & Robertson (M&R), and me. Barry is going to start by talking about an overview of physician reimbursement methods. We're going to go over some of the basic concepts. We're also going to talk about the Health Care Financing Administration's (HCFA) rules regarding physician incentive programs. I'm going to discuss some key factors for success and get into a few of the complicated issues that surround some of these physician compensation arrangements and how they are impacted by the organizational structure.

Mr. Barry M. Shane: I'm an actuary with Healthnet/Qualmed. We recently merged with Foundation Health Plan in California. Prior to that we were Health Systems International. It's hard to keep up with all the mergers these days. Healthnet currently has about 1.4 million commercial HMO members. The bulk of our

business is primarily managed care. Because of the merger with Foundation, we'll be adding some different lines of business within California, like individual business and CHAMPUS contracts for the government military programs. Our organization will have in excess of $5 billion of revenue a year. We're becoming a very large international firm.

In managed care, one of the key components of success for a managed care organization is how providers behave, so physician incentive programs are used to incent and change provider behaviors—often to reduce costs and in other cases to focus on quality issues. Incentives can take the form of penalties or they can take the form of rewards, and some key objectives of incentive programs are often reducing the cost for institutional and professional services. Controlling prescription drug costs is becoming more and more important these days because of the trends that we're seeing in the market. In California over the past year we saw prescription trends exceed 14%, and in some of our lines of business, they're approaching 20%. Passing some of the risk on to the provider to help control those costs is becoming a bigger issue.

From the Floor: Are you saying that prescription drug costs are 20% of total costs?

Mr. Shane: No, the trends in cost are approaching a 20% increase. Prescription drug costs still account for 12–13% of total costs in our plan.

We're promoting efficient delivery of care, quality delivery of care, and high-quality member services, and we are encouraging wellness. I am going to talk about preventive care programs and screening. Incentive data reporting is one of the things that I'm going to talk about as we get into more detail.

With incentive programs, there are many benefits that we hope to achieve if we can incent providers to behave in a certain manner. We also face some key challenges, and hopefully the benefits will outweigh these challenges. Lowering utilization and costs are obviously key challenges. With lower costs and utilization, we can be more competitive and add members to our plans. Promoting provider responsibility and partnership is important because of the focus on cost, particularly in California, over the past two or three years. I think developing partnerships with the providers has been a key objective of our company. It's not just the health plan hammering on the providers that were in a partnership to lower cost. The providers also benefit from managed care and to the extent that we improve results, it's not just the health plan that gains; the providers also gain. If you can encourage healthier lifestyles that result in a healthier population you can ultimately reduce your medical costs.

Health plans also look to reduce administrative costs by transferring certain administrative responsibilities to the providers, some of which are claims payments, member services, and utilization of management functions. In addition to the benefits that we see, we also face many challenges. One of the key challenges, at least in California where there is a highly capitated environment, is that it's really difficult to get quality encounter data. With providers not being required to submit a claim in order to get payment because they're getting paid monthly, regardless of utilization, we're just not seeing quality encounters, especially from fully capitated providers. I'll talk a little bit about what some plans do to incent that behavior, but the key issue is the provider groups seem hesitant or unwilling to dedicate the resources to providing that information if they don't stand to gain or lose by not providing them.

Maintaining provider financial stability is becoming a key issue. As providers take on more and more risk, they need to understand what risk they're taking on. Depending on the size of the provider and the magnitude of the risk, there needs to be mechanisms in place to help protect them from the risk they're taking. That's a key issue for HMOs to deal with because you don't want provider groups going bankrupt and thus disrupting members and upsetting employer groups.

Insuring quality of care. With providers taking on more and more responsibility for not only delivering care, but also utilization management, member services, and risk taking, it's important for the plans to aggressively monitor how providers are performing. This can be done through provider profiling and quality studies. Evaluating provider performance is a key issue because if your incentive program is going to be effective, the providers need to understand how they're going to be evaluated. If the program is overly complex or it's not administered in a way that they can understand, you're not going to achieve your desired results.

Also, maintaining incentives throughout the year is an issue we deal with. The way some incentive programs are set up, you get budgets that the providers are at risk of meeting, exceeding, or going below. If a provider is in a situation where it blows away its budget in the first quarter of the year and there are corridors limiting its risk, then it may have no incentive for the rest of the year to manage utilization. Sometimes plans look at things like quarterly budgets so that if they blow away their budget in the first quarter, it starts over in the second quarter and third quarter.

We're really trying to influence physician or provider practice patterns by using provider incentive programs. The impact of the way you influence the providers is based on what risk is transferred to them. For example, in a per diem arrangement, where you pay for each day of stay for a hospital visit, hospitals are encouraged to be very efficient in how they treat that member, but there's really no incentive for

them to control the length of stay because they're paid on a per day basis. Diagnostic related groups have the additional incentive of controlling the length of stay because they don't benefit from longer lengths of stay by receiving higher payments.

Case rates (such as maternity or transplants). The provider is really at risk for the overall care management of a condition, so this would pass on additional risk like complications in pregnancy. They'd have more incentive to try to do everything they can to prevent a C-section, for example, and have a normal delivery because their payment would not go up based on whether there are complications.

In a capitated environment, you pay the providers a monthly fee regardless of whether there's utilization or not, and this can take the form of professional capitation, institutional capitation, or prescription drugs. You can capitate other riders such as vision, dental, mental health, and substance abuse. You're basically passing on not only the risks outlined in the examples above, but also the incidence of illness risk. If no one is sick at all during the year, providers get their capitation. If there is extreme utilization, providers still have the same capitation which puts them at risk for everything, including incidence of illness. I've seen capitation withholds most commonly in point-of-service (POS) arrangements where you want to encourage the provider to limit out-of-network utilization.

I was at another session on POS, and they were talking about how providers can definitely impact whether a member wants to go in network or out of network by the type of service they provide to that member in network. If there are delays in referrals and delays in getting appointments, that member is more likely to go out of network. With the capitation withhold, you don't pay 100% of the capitation up front, and there's a settlement process whereby you would look at actual utilization out of network to see whether they get a portion of that withhold back or all of the withhold back. You're really just passing on a portion of the risk for nonnetwork utilization. You're not passing on all of the risk because the plan still retains some risk.

Service budgets are common with institutional claims. For example, you may capitate a provider for professional services, but on the institutional side set up a shared risk budget where they have a certain target for institutional claims. To the extent they exceed the target, they would make a payment to the plan and if they come in below the target, there would be a payment from the plan to the provider. Prescription drug benefits is also becoming an area where it's more common to have these types of budgets to just get the provider to also be at risk and have a vested interest in where claims are coming in.

Percent of premium capitation has the same risks as capitated arrangements, but it passes on the risk/reward opportunity of revenue increases or decreases. This is, as I mentioned before, the move toward partnership with providers. The providers feel as if the HMO is selling 5% increases, but asking the providers for rate passes. That doesn't go over too well, but if they feel as if they're in an equal arrangement where premiums are going up 3% and they're getting a 3% increase, at least there's some feeling of partnership there. This is fairly common in Medicare risk situations where the contracts are tied to HCFA revenue. It's also becoming more and more common in commercial arrangements.

I mentioned before that it's important to try to maintain provider stability to the extent possible while still maintaining competitive rates in the marketplace. Some of the areas that plans can use help, besides just education of the providers regarding general risk principles, is to make stop-loss arrangements available or purchase stop-loss through outside vendors to help limit their risk. They may want to share in the goals of managed care and share in the risk to have potentially larger profits, but they don't want to be at risk for catastrophic claims. We can have institutional stop-loss or professional stop-loss. One thing that has become fairly common is carving out very catastrophic high-cost illnesses such as acquired immune deficiency syndrome (AIDS) and transplants. Risk-sharing corridors can also be put in place where, in the settlement process, you may have a 50/50 gain share above or below a certain target, but there are corridors beyond which the plan rather than the provider is at risk.

With these reinsurance arrangements, it's fairly common to leave some percentage of risk with the provider so that once they get to their $50,000 stop-loss, they don't lose all interest in the case and say, "It's the plan's risk now, I don't have any interest in controlling care." Then plans have also often monitored provider financial statements just to make sure that they're on solid ground.

I want to go through an example of a provider incentive program. This one is what we at Healthnet call a shared-risk incentive program in which the provider is capitated for all professional services. There's a risk-sharing arrangement for institutional services and risk-sharing for prescription drugs where there are budgets in place for those components. Then there's also various reinsurance coverages available: professional, institutional, out-of-area reinsurance, AIDS, and transplants. I will describe an example of this.

In this example, we have the hypothetical HMO premium of $100 per month per member (PMPM). We're really following where that $100 goes in this professionally capitated arrangement. There is gross professional capitation of $38 and this could be a capitation number that was tied to some percentage of

premium, or it could be a capitation schedule that's PMPM based on and adjusted for age, sex, and plan design. The $38 is adjusted based on whether the provider is purchasing any reinsurance arrangements. In this example, they purchased professional reinsurance and AIDS and transplant reinsurance, so $2 is carved out to get to your net professional cap of $36 a month and $2 is put into your overall reinsurance pool. You also have the insurance premium feeding into that pool from the institutional side. On the institutional side, rather than having a capitation in this example, you have a gross budget of $33. You check to see whether the provider has selected any reinsurance. In this case, we show institutional reinsurance and out-of-area reinsurance, which costs $1 PMPM and feeds into the pool for a total pool of $4 PMPM. That would cover professional stop-loss, institutional stop-loss, AIDS, transplants, and out-of-area reinsurance.

Going down in the institutional line you get to your net budget of $31. That's really the key number for the shared-risk settlement. Once claims actually occur and you can have settlements that take place quarterly, semiannually, or annually, you're comparing actual claims to that $31. From the actual claims, you need to remove any of the stop-loss claims for which the plan has purchased reinsurance. For example, if net claims after stop-loss came in at $27 PMPM versus the $31 budget, you'd have a $2 payment PMPM go to the provider in this situation with a 50/50 gain share.

We also have a prescription drug budget in this example at $10 PMPM. The way that works is similar to the shared-risk settlement on the institutional side where, to the extent claims come in above $10, the provider would need to make a payment to the plan. Usually our drug budgets have corridors. There may be a maximum PMPM benefit of $1 that the provider would need to pay to the plans, limiting their risk. Then we have another category that would encompass other riders like vision, dental, and administrative expenses.

From the Floor: What was the stop-loss level for the professional $38? When did we go over the level for professional service? What is the stop-loss level?

Mr. Shane: I didn't define that. We have sliding scales based on what the provider wants. You're wondering when stop-loss claims kick in whether it's $5,000 or $10,000. There are sliding scales that can be made available to the providers based on how large they are.

From the Floor: If the drug budget goes over, where do the providers get the money? Is there a withhold?

Mr. Shane: That would come from provider funds. It could come in the form of reduced capitation in the future. It really depends on a provider-by-provider basis. They could pay a cash settlement based on their funds, but there's typically not a withhold of provider funds withheld to cover the prescription drug. It's usually through a reduced cap in the future or a one-time payment by the provider.

As I mentioned before, the budgets and the capitation amounts are typically age, sex, and plan adjusted. They can be tied to revenue if there are percentage-of-premium arrangements. Stop-loss arrangements include provider risk sharing in most cases, whether it's 10% of risk, 20% above the stop-loss levels, and settlements often include limits on the downside risk to providers. There is not always a limit on the upside risk.

Let's discuss what you might see for inpatient utilization in a commercial population under various reimbursement arrangements. Under an indemnity environment, it is 1.0. In fee-for-service HMOs, we've seen roughly half of indemnity utilization in the fee-for-service HMO environment. Our shared-risk population is where you're capitating the providers for professional services, but putting them at risk based on a budget for institutional. We've seen that come in about 10% lower than fee-for-service HMO or 45% of indemnity. Full risk is really the question, and I don't think anyone knows what is the true utilization in a full-risk environment, because you're not getting the encounter data to quantify. Unfortunately, it really is fairly consistent across all our co-risk providers that we're not seeing good data. Some submit absolutely no encounter data on the institutional side. Some are approaching 100 days per thousand and 120 days per thousand, which would seem unrealistic. They are really just some benchmarks for the consumer. Finally, much of the focus by employer groups, consultants, and HMOs does tend to be cost driven. Whatever we can do to lower costs is one of the key focuses with any company. It's also important to focus on quality issues to maintain competitiveness in the market and to differentiate yourself from other health plans.

Let's discuss a sample incentive program that focuses on three areas of quality. One is the data reporting issue, one is quality of service provided by the medical groups, and the last one is quality of care delivered. To even be evaluated in this type of program, the provider groups needed to submit a general quality improvement study of their choice that would be approved by the health plan, so they can be eligible for an incentive payout.

In this example, incentive pools provided by the health plan are evaluated in these three areas. For data reporting, the evaluation criteria is a minimum submission rate of professional encounter data. In this example, I think three encounters per member per year was considered a minimum standard that had to be hit. It is

monitored quarterly to make sure that they don't submit for half a year and then have claim system problems or don't allocate the resources. You don't want to get good data for part of the year and then bad data for another part of the year. Overall, they hit three. There's also a separate incentive for institutional encounters in this example. One thing I've seen implemented is a per dollar incentive just to get the fully capitated providers to submit an institutional encounter. It may be $50 or $75 per admit; but that's separate from this provider incentive. Then we require standard data submissions and a standard electronic format.

On quality of service, this is really evaluated based on member satisfaction surveys. The things focused on in the survey are access to care, skills and experience of physicians they dealt with and their opinion, the service they received, the outcomes of the care provided, and the overall satisfaction rate with their situation. They also take a look at the transfer complaint rate of members at various providers. If the provider has excessive transfers or complaints then that was part of the equation.

Finally, quality of care is based primarily on healthy people, 2,000 indicators looked at various screening rates for prenatal care, immunizations, mammography, pap smear, and so forth. This model really just looked at the three areas where the providers are profiled against one another, and on an annual basis there's a calculation that shows how they are profiled against other providers and the payout occurs. Results are communicated to the providers on a quarterly basis so that they now see what type of job we're doing in this area. They're allowed to submit data after they're given their progress report which helps them to get up to speed. I think that's about it for me. Larry's going to talk about regulatory issues.

Mr. Larry J. Pfannerstill: I'm with M&R in Milwaukee. For about the last four years I've been doing consulting on the provider's side dealing with incentive programs both for commercial members, Medicare, and Medicaid. I also have about 12 years experience on the insurance side, so I've kind of seen both sides.

What I'd like to do is just go over the basics of new regulations that have come out from HCFA that impact physician incentive programs. When I first saw these regulations, I thought, why are they doing this; why are they passing these regulations? There's a real perception in the marketplace, and it's growing, that these incentive programs are impacting the level of care that a person receives. In fact, just before the meeting I went up to switch materials and was looking through the TV stations and Gordon Elliott was actually interviewing people who had been declined for services by their HMO. One was a kidney transplant patient who was repeatedly denied and then had to go out and do fund raisers to get the money for the transplant. There was another woman also denied for a double lung transplant,

and even though she had lupus, it was determined experimental. Anyway, it was very one-sided. I don't think we'll get the other side until a health care actuary gets his or her own talk show.

There is a growing perception out there and HCFA decided to protect against improper clinical decisions made under the influence of strong financial incentives. They published and passed a new code of federal regulations that use physician incentive rules. It applies to those incentive plans that they have jurisdiction over—those that are with Medicare enrollees or Medicaid beneficiaries. It applies to any arrangements between a managed care organization and physicians or physician groups that base the compensation on some sort of savings or on the cost of services furnished to those patients.

The regulation was originally drafted and exposed in the *Federal Register* in March 1996. At the time it was released, there was not an outcry but then there were some grumblings from the industry which claimed there were too many questions in the regulation the way it was. As a result, they delayed implementation. It became effective January 1, 1997, or the subsequent renewal or anniversary of the group after that. Some parts are not effective until a little later than that, as we'll show, but there are still some questions outstanding, and we'll go over those as we go along.

The physician incentive plan. First, in order to be under the auspices of these rules, there has to be some compensation arrangement between the physician and the managed care organization. It has to directly or indirectly (and that definition is very broadly defined), impact the level of services provided. It only applies to Medicare beneficiaries or Medicaid enrollees.

This wasn't a change; they just reiterated that the managed care organization cannot offer specific payments to reduce necessary care and services. That restriction has always been out there, and I think we would agree that's not the real gist of physician incentive plans. The real gist of the rule is that if the incentive plan places physicians substantially at risk and that's defined in the regulation, there are several things that the managed care organization or plan sponsor must do. They have to conduct annual enrolling surveys. They have to ensure that some minimum level of stop-loss protection is in place for those services that are at risk, and they also must make disclosure either to HCFA or the state Medicaid agency in sufficient detail for them to determine whether your incentive plan is within the regulations. Some of that disclosure is required of every plan whether you are substantially at risk or not.

What is substantially at risk? First let's look at what it excluded. In Barry's incentive plan, he had a capitation for primary care services. If that capitation only put

physicians at risk for the services that they provide directly, they are not substantially at risk. It's only applied if the physicians are sharing in a risk pool for something or they're put at some sort of risk for services that they do not directly provide to patients. Also, if your patient panel size is greater than 25,000 members, then you are not substantially at risk. In other words, there are enough members that you'll see the fluctuations and expect to be somewhere around the norm.

In general, if a plan places physicians at risk for more than 25% of the potential payments, they're substantially at risk. That's the general theory behind it. They go through a bunch of tests in the rules that you should apply. If you have withholds greater than 25% of potential payments, you are substantially at risk. If bonuses are greater than 33%, the same thing applies. It depends on if you're counting the bonus in the potential payment or not. If you have withheld less than 25%, but the physicians are potentially liable for services greater than 25% of the payments, then you are substantially at risk. You have withholds and bonuses. They tried to cover all the physician incentive programs that were out there, and they might have thought they had done a good job, but you'll see later that they didn't.

If you have a difference between the maximum and the minimum payment that a physician could receive and if it's more than 25%, that's determined substantially at risk. Even if you don't clearly explain what the maximum and minimum potential payments are, you could be determined to be substantially at risk. Any other arrangement that goes against the general philosophy of putting physicians at risk for greater than 25% of the payments will be determined to be substantially at risk.

If you're substantially at risk, what do you have to do? One of the first things is annual surveys. This is a quality survey. It has to include current members and also disenrolled members. Disenrolled members are not considered those that moved out of your plan area, but those that really stayed in and just disenrolled for some reason. They want to find out whether it was a quality issue that impacted their disenrollment. Again, you have to address quality of service and also the degree of access to those services. You have to do it within one year of the effective date and then every two years afterwards.

HCFA has offered, as an example, a survey to use and it's from the consumer assessment health plan study. HCFA is taking it upon themselves to assess or run this quality survey across a sampling of Medicare risk plans. If you're one of those people who are participating, that survey will suffice. You can also use it on your own. The only problem with that survey is that it doesn't have kind of a grid or questions for disenrolled members, so they are also going to come up with a sample survey for that. I don’t know whether it is available yet. HCFA is not saying when you have to conduct the survey. It just has to be within that year. You have to

report those results to several places—HCFA or the state (depending on which program you get in), Medicare and Medicaid, and to any prospective Medicare enrollees. In other words, you can use it as a marketing tool. It's another piece of information that will be available to the Medicare enrollee to determine which plan to select if there's a choice.

The second thing, if you are determined to be substantially at risk, you have to have some stop-loss coverage in place. One of the big problems with the original regulation for the stop-loss coverage was that it had a combined limit on all medical services. Then they realized that's not really the way many stop-loss arrangements are structured so they established separate institutional and professional limits that can be used instead of the combined limit. Or you can have aggregate coverage of 90% of the cost exceeding that which is determined to be 25% at risk.

Let's look at Table 1. The first row of the table is the 1–1,000 panel size. They publish limits but they put little asterisks on them. They believed, and it's really true, the panel size was really too small to put physicians at substantial risk. In addition, the stop-loss coverage prices in that range of enrollees is prohibitive. Two things you must do are conduct annual surveys and ensure that stop-loss is in place.

TABLE 1
STOP-LOSS PROTECTION
90% OF COSTS OF REFERRAL SERVICES THAT EXCEED:

Panel Size	Combined Limit	Institutional Limit	Professional Limit
1-1000	$6,000*	$10,000*	$3,000*
1,001-5,000	30,000	40,000	10,000
5,001-8,000	40,000	60,000	15,000
8,001-10,000	75,000	100,000	20,000
10,001-25,000	150,000	200,000	25,000
>25,000	None	None	None

*Panel size too small to put physicians at substantial financial risk .

The last one is disclosure. Again, you have to do it in enough detail so they can determine whether you are in compliance or not. One of the things you have to disclose is the type of incentive programs (withholds, bonuses, and caps, etc). There's really one thing before that. If you have an incentive program but it's just straight capitation to primary care physicians (PCPs), and they are providing all the services within that capitation, you have to disclose that if you're capitating the PCP but you don't have to disclose anything else. If you say yes, we have capitation, but

physicians are only at risk for the services they directly provide, you don't have to go through the rest of the list, but you do have to disclose that to the state. So every plan that has some compensation arrangement, other than fee for service, is going to have to disclose something to the agencies.

You disclose whether you're using a withhold or bonus, the percentage amount, the amount and type of stop-loss coverage that's in place. You must also disclose the panel size if it's pooled, and we'll go over what we mean by pooling later. For those capitated plans, you're also responsible for reporting the breakdown of payments made to the capitated physicians. If you had a plan that was under an incentive arrangement in 1996, this reporting requirement was due April 1. You also have to report the survey results.

The last disclosure item is to Medicare beneficiaries, and that's done upon request. As I said before, this could be another marketing tool to get Medicare enrollees into your plan. There's a little less that you have to disclose to them. You have to disclose whether you use incentives or not, what type of incentive arrangement there is, and that there is stop-loss protection in place (you might mention the amount) and then the summary of the survey results. If you think of it, the survey results could be used to your benefit. I describe this piece to potential enrollees as a marketing piece saying—hey, look at the survey results of our physicians last year. The people in our plan are very happy with our physicians. They can get care, they have good access, and they're quite happy with the care they receive. You could also use it to point out the deficiency of other plans. It's going to be public information.

With all of these, the annual surveys, the disclosure, and the stop-loss—the onus of the regulation is put on the overall managed care organization or the plan, not on the physician groups. Medicare or Medicaid has the contract with the managed care organization. That's what they can regulate, so it's up to the plan to ensure or attest that the stop-loss is in place, and that they're conducting the annual surveys. The physicians or the physician group does not have to directly report this to the state. It's up to the plan.

If the plan just passes off 80% of the premium to a physician hospital organization (PHO) or another health plan and walks away, then that health plan subcontracts for physician specialty services or pharmacy benefits. There are all these layers of subcontracting in there. What the rules really address are the physician/patient relationship. Are those medical service decisions being impacted by the potential compensation? The similar requirements of stop-loss protection and disclosure apply to the patient/physician relationship—not the relationship between the

managed care organization and the PHO in the situation where they just put all the risk on the PHO.

Again, the rules place responsibility on the plan. This is one of those areas that perhaps was not well thought out. We're going to have some follow-up regulations or statements of opinion. What level of proof is required? In the situation where you're subcontracting, is it just OK to have the PHO tell the managed care organization, "No, we're not putting our physicians substantially at risk. We'll also attest that we are putting them substantially at risk, but the way we're doing it is OK because we're doing everything else that the regulations require. We're conducting the surveys and we're disclosing information." Remember, the plan is responsible for filing with the state or with HCFA. What is really not clear yet is what level of proof and what types of documentation HCFA or the states will review.

There could be greater disclosure of the subcontractor's practices. In this instance where they're subcontracting for prescription drugs, you might actually have to disclose the arrangements for that prescription drug subcapitation, which could be considered proprietary information. Once all this is filed, it's public information.

Let's go back to stop-loss. In Table 1, there were three columns—combined limit, institutional limit, and professional limit. There's a little footnote that says you can have aggregate coverage. In some of the arrangements I've seen, aggregate coverage just doesn't fit in. There's also confusion if you're just subcontracting again for pharmacy benefits. Where does that fit in? In the professional benefits? The stop-loss limits might not be appropriate.

Let's go over a very, very simple example. This is a primary care capitation of $10 with a 10% withhold. In other words, every PCP gets $10, but we hold back $1 or 10%. Then, at the end of the year, I'm going to rate the doctors based on quality of service, degree of access, and things like that, and we'll rank them into quartiles. The first quartile of physicians get none of their withhold back. They just get $9. The top quartile will get $3. This example is not unlike what I've seen in PHOs or hospital groups or plans that do this. You have a minimum potential payment of $9 (that's capitation minus the withhold), and the maximum that the very good doctor, the one who is meeting all the criteria, is going to get is $12. Let's go down the list of tests to determine whether this is considered substantially at risk or not.

The withhold, that dollar, is less than 25% of potential payments. We don't have a bonus so that's fine. The PCP is liable for a maximum of $3, which is substantially at risk because the regulation is written as less than or equal to 25%. The last one, the difference between the maximum and minimum payment, the $9–12 is 25% of

the maximum. That's really the main test in this example. Again, as long as the difference is not 25% or more, you're not substantially at risk.

This was a very simple example. In the workshop that dealt with these issues, many other arrangements came up. It is not based on dollars that you could compare, where you can tell whether something is the maximum or minimum the physicians would get. It was based on risk sharing with performance of different pools such as hospital inpatients, bed days, and so on, and it adds all kinds of confusion. I don't know whether that was considered when the regulations were drafted. I'm expecting that some follow-up opinions and instructions will be coming along.

What can we expect the impact of these rules will be? Stop-loss protection was probably out there before, unless the plan was a very large plan, but now minimum coverage is defined by setting that maximum stop-loss trigger. Some plans may be less prone to put a large amount of risk on the physicians to avoid the definition of substantially at risk. Again, once the survey results become available to the public, it could be used as an enrollment tool or marketing tool.

One of the other things that we were talking about at a workshop was that this applies to Medicare and Medicaid enrollees. What's to stop the states from saying it sounds like a good idea and enforcing this on commercial plans as well? This can limit the upside potential of reimbursement to physicians. If they have an open-ended contract where they get whatever savings they can generate or share in, it will definitely put them substantially at risk and the plan does not want to deal with the administrative problems of doing the enrollees' surveys, stop-loss protection, and reporting the distribution of payments. They might change that. They might change the plan.

If you're looking for more information on this, I would suggest three sources: the original rules, the March 27, 1996 issue of the *Federal Register,* and the American Association of Health Plans also published a letter of instructions on the risk contract. That was dated December 20, 1996. You can contact them to get a copy of that. HCFA published an operational policy letter dated December 3, which really gives a concise definition of the new rules because you don't have to read the old rules and the policy letter. You can just read the policy letter, and it will give you a very good description of what the rules are.

One of the best things I've found is a question-and-answer session published by HCFA dated December 30. It went through many examples on disclosure, substantially at risk determination, subcontracting requirements, and things like that. It kind of gives a sense of where they might be going. Last, *the Bureau of National Affairs Report* also published something on December 30 that was very good. It

gave a very good description of the rules, in everyday language, and the impacts of them.

Mr. Staehlin: You first heard an overview of some of these physician incentive programs. Then you had a fairly detailed review of some of these regulations that HCFA is putting in place. I'm going to interject a number of other sources. Every day, I try to either read some newspapers or get on the Internet and read American Health Line or Dow Vision or health care stories, because I'm trying to keep current. Larry started to talk about why one should worry about this. I don't do Medicare and Medicaid. The December 26 issue of the *Baltimore Sun* says, "These HCFA regulations are a response to growing unease nationwide about the rise of managed care programs and in their zeal to curtail burgeoning health care costs, their impact on patient care." They're worried that you're going to start to restrict services. They go on to say, "The policy on financial incentives applies to Medicare as well as Medicaid. However, it does not extend now to private health plans, but it should set the way the rest of the industry would conduct itself." Whether you believe that or not, you might be ready to start to act. The new policy establishes certain limits to discourage physicians from declining to provide or refer services.

Part of the issue is, it's probably going to be something that's going to impact all of managed care, so I'd like to talk a little bit about some of the key factors to be successful in these programs. Although they interrelate to one another, I'm going to try to divide them into comments on the structure of your programs, comments on effectiveness in controlling care, and then comments on market acceptability of the products that you have with another note about measurement of quality impact. I want to stress those four areas as I go through this presentation.

In talking about the overview of structural models, this quote applies to Barry's company. This is April 20, *First Option Health Plan,* "New Jersey's only provider-sponsored HMO (Red Bank-based First Option Health Plan) agreed last week to take a $50 million shot in the arm. Observers said the bailout should not be viewed as an indictment of provider-sponsored HMOs, but rather a lesson in what is required to run a serious managed care business." There are people who are having problems with these issues and some of it might be due to the structural model that you have. Here I'm talking about both ownership and governance. Somebody could own 100% or 90% of an organization, but they could have shared governance in the control of clinical protocols, so you don't get the organization telling people how to deliver care. They have an ownership or vested right in how the dollars flow, but there are other 50/50 governance issues that you're going to approach.

Why am I using a St. Louis, Missouri example? A number of the quotes I'm using are from the February 1997 *Integrated Health Care Report*. It talks about three

marketplaces where the HMO penetration is more than a third of total lives—more than 33% is in HMOs or tightly managed care, and the growth rates of managed care are more than 30%. The four markets cited are St. Louis, Tampa, Florida, and Pittsburgh. I want to use this lest you think you have a lot of time to learn. In a six-month period, all of this consolidation and integration happened. Then I want to talk a little bit about what structure has to do with clinical delivery. Let's go to the first model.

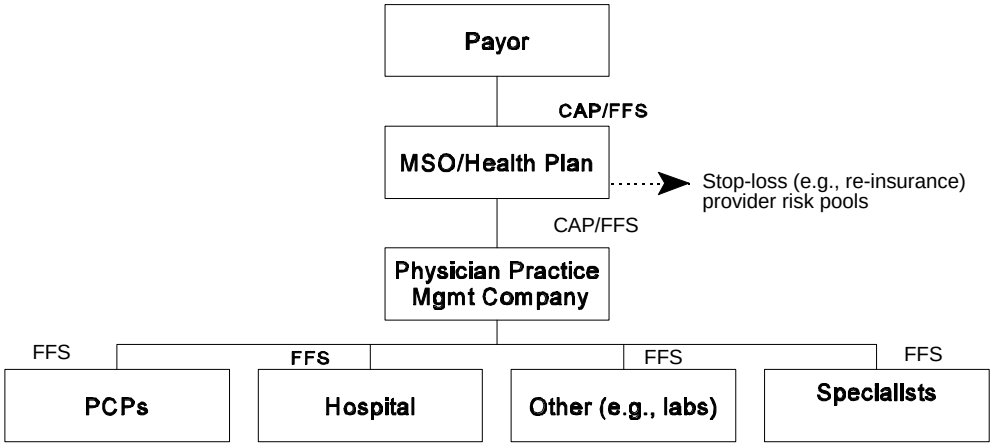
In the interest of time, there are six of these models. The boxes are similar. In Chart 1, there is a payor at the top moving to a management service organization, managed care organization (MCO), PHO, or whatever structure is in that box, through a physician practice management company. They actually may be in the same box, but they don't have to be. Then the physician practice management company works with all other groups—PCPs, specialists, hospitals, and others. The point is, you need to go through the financial modeling that Barry used in his example and figure out how this money is going to flow. You'll not only figure out how it flows through the chart, but how it flows through the risk pools, how it flows through the corridors, and what impact reinsurance has on this. Do you need one chart or four charts because you have Medicaid, Medicare, commercial that you're used to, and POS. If you start to aggregate and think you're doing well, we actuaries all know that you really have to bear down and find out where the problems are. This gets really complex.

The point I want to illustrate is about physician incentive programs. There are many disadvantages in this section. You'll find many comments on this model about incentives. There are not strong enough financial incentives. Why? Well, there's capitation flowing from the top, but everybody is fee for service, so unless this physician practice management company is much smarter than the rest of us, there's not going to be a way to make this whole thing work. It's difficult and expensive to control utilization. Many people are trying to get out of utilization management. Much of the data analysis is required, and there's no incentive to providers to produce good service. There are many problems with incentives on Chart 1.

What I want to talk about is some of the other partnerships that are going on that impact structure. This is an article from May 20. Medpartners, Inc. announces acquisition of Piedmont IPA because it enhances the company's ability to negotiate statewide managed care contracts. By bringing together Piedmont, Cardinal Healthcare, and NC Medical Associates, they have affiliated physicians ready to care for 32,000 prepaid lives. Medpartners is the nation's largest physician practice management company. The company develops, consolidates, and manages health care delivery systems. They manage the whole thing. Although they are a physician practice management company, they manage everybody as opposed to

other companies you may have that only manage PCPs, or specialists, or facilities, or pharmacy, or mental health. There are many different niche players right now, but you have to make sure you can control the whole cash flow to be successful.

CHART 1
RISK MODELS FOR CAPITATED POPULATIONS:
FFS FOR PCPs, HOSPITAL, SPECIALIST



Advantages:
1. PPM directly manages utilization and provider practice patterns.
2. Proven administrative and claims system available to handle FFS products.
3. Administratively simple and easily understood (e.g., accounting process is simple and uncomplicated).
4. Providers have experience with FFS products.

Disadvantages:
1. Not strong enough financial incentives.
2. Difficult and expensive to control utilization.
3. A lot of data analysis required—expensive.
4. Most budgetary deficits occur in this model.
5. No incentive to providers to produce good service.

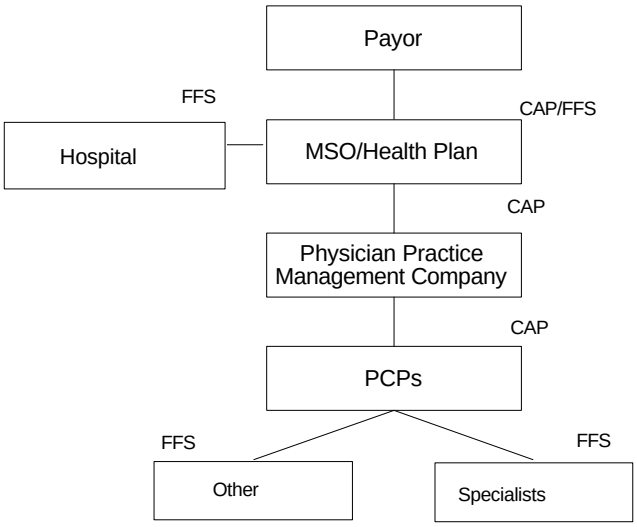
Issues:
1. Build incentives through withholds and variable fee schedules to control utilization.
2. Need to re-insure catastrophic claims.
3. Critical need to determine a mechanism to share budgetary deficits and surplus.

A couple of comments about FPA Medical Management. FPA Medical Management signed a ten-year capitated provider agreement with Pacific Care and Family Health Plan nationwide. They've done it to reduce costs, enhance member satisfaction, and expand quality improvement programs. FPA Medical is a national physicians' practice management company that organizes and manages PCP and hospital emergency departments. Unlike Medpartners that does it all, it does only PCPs and hospital outpatients. Again, people have different strategies, depending on the different structure. FPA obviously has to have partnerships to manage all the other components of health care.

Let's look at model four, Chart 2. We talked a little bit about full professional capitation. I don't have the risk pools on some of my slides so you'd have to go

back to some of Barry's comments, but the hospital is fee-for-service. That's going to generate a result, but you have the full cap going to PCPs managing all the doctors. Why am I talking about structure? That's not going to work where you have a specialty-dominated physician hospital organization board. There's going to be so much tension, you can't make this work. The structure that I was talking about that involves ownership and governance also talks about the structure within your provider community. If you have a PHO, who owns it? Who says what's going on? All of that is going to impact whether you're successful in structuring the financial arrangements to make all these dollars flow in a fashion that's going to make you successful.

CHART 2
FULL PROFESSIONAL CAPITATION



Advantages
1. Less Risk for PCPs.
2. PCPs manage specialists
3. Attractive to PCPs.

Disadvantages
1. Assumes that PCPs can manage risk and utilization effectively.
2. Quality issues - referrals delayed by PCPs.

Issues
1. Can MSO/Health Plan systems manage data to support this.
2. Can PPM manage data, distribution and monitoring.
3. Safeguards against under-referral to specialists and incentives to control inpatient care requires.

I have another comment from the *Baltimore Sun:* "Assembling a complete integrated system allows providers to accept and manage global capitation contracts." That's a true statement. It doesn't necessarily allow you to be successful, so you're trying to get the complete system so you can control the

monetary flow. You still have to take another step to make sure you understand how you're going to be successful in this arrangement.

There are different structural models about how some of these fit together. There is Baltimore-based Helix Health Care and what it's talking about is the managed Medicaid population. Maryland is one state in which it's letting provider-sponsored networks become an HMO and it'll work on the capital arrangements. In this environment, you have three hospital systems that have called themselves MCOs, and you have three HMOs. I don't know whether the footing is equal, but again you have to understand that structure and how it impacts your marketplace and the delivery of care to understand whether you're put at a financial disadvantage against the people with whom you're competing.

Let's discuss St. Louis. The St. Louis area market has been condensed so quickly and you have to understand the market in which you're operating. From a health system perspective, you have Barnes Hospital, Washington University, Jewish Hospital, and Christian Hospitals going together to make BJC Health Systems. This article characterized the marketplace as three years ago having had 36 independent hospitals. That's just three years ago. This is what they have now: BJC—33% market share; Unity—29%; STLHCN (St. Louis Healthcare Network)—20%; and Deaconess/Incarnate Word/Tenet—8%. They add up to 90% of the market share and if you're not with them, you're going to have many problems. Everybody knows about market share and the ability to make things work because you have the ability to operate. There's not much room for operation in there. Tenet is out there working right now to find a relationship to increase market share because it's No. 4 and it wants to stay in the market and not have the other three squeeze it out.

To have a network, you have to have coverage. I found out by working in St. Louis that it has some very different areas. We have downtown and that's where Barnes/Jewish is—there is a high population of Medicare and Medicaid people. You have the West County people. The West County people don't come downtown, so you want to find a way to cover them. There's no Northwest County presence. There's no South County presence. They're nowhere except downtown. The point to be made is everybody has to have additional partnerships so you provide access to the people who are in your network, but as this article points out and as we can talk about, some of these arrangements are getting to be exclusive. They say that in certain marketplaces you can contract with everybody. The time is coming, in some marketplaces—which may be very soon for St. Louis—where they'll go to physician groups and they'll say—no, no, you sign up with us. You decide which of the four groups you are with (or which two of the four). The issue is really being forced. Again, you must understand the whole dynamics to be successful before you enter into a deal. We just talked about a ten-year deal—that may constrain you

in inappropriate ways. An article said, "St. Louis University signaled late last week that it wants to sell all or part of its academic medical center of St. Louis University Hospital." And who's there? For profit Tenet Health Care and not-for-profit Unity Health Systems are in there to buy.

Again, trying to figure out where you should be, what your market share is, and what the other people are doing is going to say whether you're successful. I'm talking about structure in a broader sense—the structure of your organization, facility, and physician partnerships. The structure of your location and then the structure of the managed care dynamic in your marketplace are all going to impact how successful you are.

To look at it from the health plan perspective, the numbers in Table 2 represent managed care percentages in St. Louis, and it's supposed to be 40%. I think the numbers refer to the whole state of Missouri and Alton, Illinois. In any case, the numbers are all relatively appropriate. What do they say? It says—United Health Care through its merger of GenCare and PHP, is the leader in managed care right now with 25% of the market. Coventry has 13% and then plans trail off. There's Humana, there's Blue Choice. Partners HMO is owned jointly by BJC and Washington University. As a matter of fact, I think Aetna may no longer even be the administrator of that plan, so BJC is buying its own HMO. If you read the press coverage, BJC and Blue Choice were trying to merge. Now we have the fourth and fifth largest health plans merging with the number one health system. There are many things they would have to work out in the for-profit and the not-for-profit entities. It's getting very complicated. The degree of consolidation and integration is just extremely rapid.

TABLE 2
MISSOURI HMOs MARKETSHARE—JANUARY 1, 1996

	Enrollees	Market Share
GenCare Health Systems (United)	237,125	14%
Physicians Health Plan of Greater St. Louis (United)	185,579	11%
	422,704	**25%**
GHP (Coventry, Nashville)	180,932	11%
Health Care USA, Missouri (Coventry, Nashville)	49,050	3%
	229,982	**13%**

TABLE 2—CONTINUED

Humana Prime Health Plan (Missouri/Kansas)	137,900	8%
Blue Choice (BCBS of Missouri/RightChoice)	88,178	5%
Partners HMO (BJC-Formerly Aetna)	**54,448**	**3%**
Prudential HealthCare HMO - St. Louis	46,508	3%
MetraHealth (Principal Health Care of St. Louis)	32,027	2%
Principal Health Care of St. Louis (Principal)	22,154	1%
HealthLink HMO, Inc.	11,445	1%
Mercy Health Plans of Missouri, Inc.	**11,310**	**1%**
CIGNA of St. Louis, Inc.	8,220	0%
Total	**1,717,562**	

What's the point of the structure's impact on clinical decisions? Again, it's the difference between accepting and managing risk and being successful. "Struggling with red ink, the HMOs in St. Louis must be receptive to global risk capitation arrangements. Passing the global risk onto providers appears to be more attractive when HMOs are losing money. The dominant systems in St. Louis also have the key components for managing the risk." Again, trying to pass off global risk, letting the providers manage it, as this quick integration is happening, and it's really hard to have data to say exactly where you are and who's winning. This is another quote from the article I referenced earlier—*Integrated Healthcare Report*, February 1997. "We no longer see ourselves as simply in the hospital business . . . For us to appropriately provide care, it has to be the full continuum of care/preventive care, ambulatory care, care in the office, home health, and nursing home care." I encourage you to read the article to see a picture of what might come. As I said, the same type of article is going to be done on Pittsburgh and Tampa and maybe other communities.

Let's talk about effectiveness in controlling care. Again, now we're trying to control the care and get a favorable managed care result. There are four points: the structure and the clinical operations that you have, your product, and finally, network. Price comes later, so in controlling care it's the network and how strong it is.

The first issue is structure. Again, we have the St. Louis article saying, "As the marketplace continues to mature, we think it is highly likely that a greater number of physicians will link with the dominant systems in tighter, more secure, and possibly exclusive relationships." This is almost a forced issue. Somebody has also

said that Unity and STLHCN are going to merge together because they're both Catholic based. You can read a great deal of information about the parochial systems. Catholics and Lutherans are two of the dominant religions that have gotten into health care historically. If those two merged, they'd have a 50% market share, and if Tenet and BJC merged, it would be 50/50. There are two players. Clearly when there's two players, you can bet there's going to be some exclusive relationships. You're either going to be aligned with one network or you're going to be aligned with the other. But you really have to be careful, the way this is going, and structure will clearly have an impact on your success in this marketplace.

The next success factor is clinical operation. This was a quote, "We no longer see ourselves as simply in the hospital business. For us to appropriately provide care, it has to be the full continuum of care—preventive care, ambulatory care, care in the office." You have to understand care. People are now saying—let's let the providers do their thing and we'll be in the back doing the risk. In some markets that still may be a viable strategy. If you don't understand what the people at the front line are doing, you're going to have some problems understanding why you're successful, how you're successful, and how you ought to change.

The third success factor is effectiveness in controlling care. Another quote: "Kansas City Plan Close to Buying a Provider Network. Blue Cross and Blue Shield of Kansas City (BCBSKC) is moving toward acquiring Preferred Health Professionals, a local provider network of 16 hospitals and 2,500 physicians. By combining the strengths of PHP and BCBSKC, we'll keep more health care decisions right here in Kansas City." Again, people may be looking to move into Kansas City and do some different things, but you want local presence. You want the understanding of your local area. Then your network could get more buy-in of where you're going and again, how you're going to be successful.

Now move to market acceptability as a success factor. It's very important that in doing all this, you don't take your eyes off the market. It's clear that the people with market share are in a big fight now. You can remember in St. Louis market share was a third, and everybody else is trailing behind. Tenet/Deaconess has a long way to go to get up to play with the other three. I'm not making a prediction. I'm just saying that it's hard to make leaps in market share without a clearly defined strategy, but you have to remember the market expects some things, and you have to keep those market expectations in the forefront of what you're doing or you're not going to be successful as you try and capture this market share.

There was a big article in *Contingencies* in the May and June 1997 issue. It dealt with how there are more and more POS products because markets are not willing to go straight to HMOs. You have some managed care markets that must slog through

POS. Maybe they don't really need to, but the market that we just talked about is not ready for HMOs. They have to go to POS first to convince the consumer, then go to the HMO.

An article from the *Capitation Newsletter* said a fee-for-service HMO is what the Houston market needs. I don't really understand how it works, but it's called a fee-for-service HMO. It has a little bit different twist on the way things are being delivered.

A May 16 article said, lest we think we want quality, a recent survey says affordability is still number one. We don't care as much about access and quality. We care, but affordability is still number one so you have to really keep your eye on price.

There are quality impact measures, like Barry had, that explain what you can do for at-risk compensation. You can give providers a score. This was a teaching hospital so the residents are going to rate the doctors. You have member surveys, and you have outcome modifiers based on length of service and some quality measures. You have to have your office open at certain times, and there are standards for performance and credentialing. All of those can be incorporated into this structure to affect the compensation.

I apologize for racing through some of my comments, but I wanted to give you a feel for some of the things that are going on because we think we understand traditional medicine and everybody was in love with gatekeepers because that's what managed care was. You'd go to a gatekeeper and the care is managed and we make sense of it. I've got three articles in the last couple of weeks on Oxford Health Plans. They have a big program now that they're developing specialty care teams. You no longer come through a PCP; you go into your special team. One article says, "The company says the specialty care team approach can lower cost (remember the number one concern) by up to 20% per case in 11 high-volume specialty areas." The areas include behavioral, oncology, orthopedics, obstetrics/gynecology, and cardiology—all the big ones. You come to the specialty team rather than the PCP and they take care of you.

Twist it a different way. I read something recently that says that we don't need specialists to treat certain types of chronic illnesses. There are really good protocols. We come into the PCP, and that PCP can manage the whole episode of chronic care. That's exactly opposite of what Oxford is doing. There are many different models. You have to understand which one is going to work right for you and which one is going to work in your marketplace. I think we really have to be aware of severity-adjusted outcome measurement. You don't go in and say you're

doing a great job by just measuring everything to that $100 PMPM. If you should have had $200 PMPM instead of $100, then you should get a bonus if you come in at $150 even though the average for your area is $100 because you're treating all the sick people and getting great relative outcomes.

There are many different things that you have to keep aware of as you structure these models because, as Barry said at the beginning, you want to incent appropriate behavior.