

Effect of Managed Care Strategies on Physician / Hospital Integration

**American Medical Group Association
National Conference on Physician Directed Healthcare
Las Vegas, Nevada**

- Physician / hospital integration was stimulated by the need to develop IDS that could manage “risk”
- Risk contracting became a means of redistributing healthcare dollars
- Initially, managed care represented incremental revenue
- However, it now represents a significant portion of most organizations payor mix
- Many hospitals and physician organizations to reevaluate their managed care strategies
- Meanwhile, we have lost differentiation among products in many markets (PPO products at HMO prices)

How can the “System” improve its price realization without advantaging one party at the expense of another?

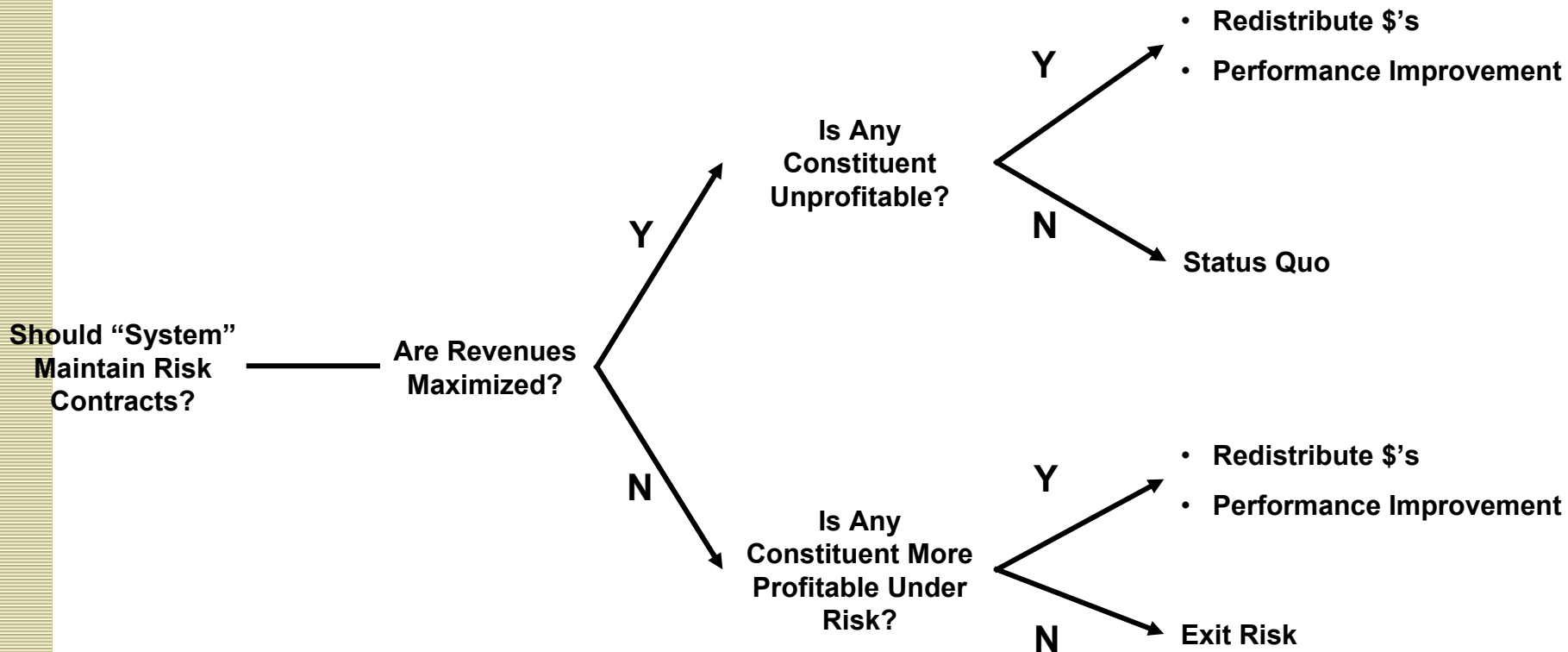
Conventional Wisdom...Exit Risk Based Contracting

- Two (2) potential problems:
 - Loss of market share to competitors
 - Disadvantaging one party at the expense of another

Today's Discussion

- Medicare Risk case studies
- Economics of FFS versus Risk - hospitals and physicians
 - Revenue
 - Contribution margin and physician compensation
- Alternatives:
 - Improve performance
 - Partial exit
 - Full exit

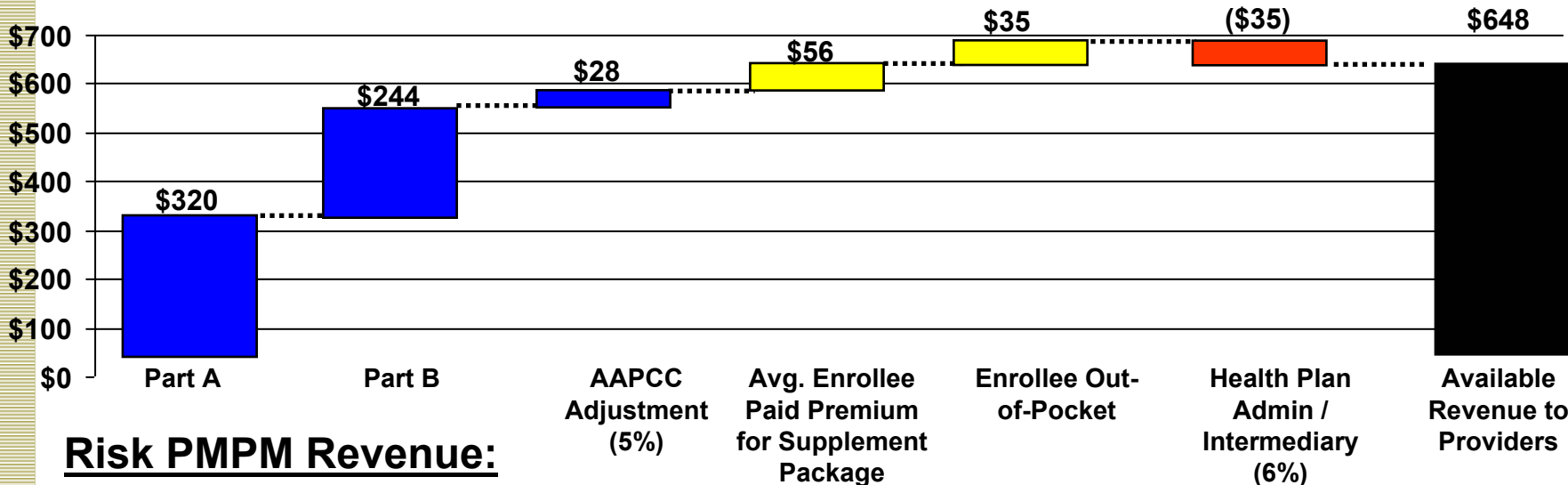
Payor Strategy Framework



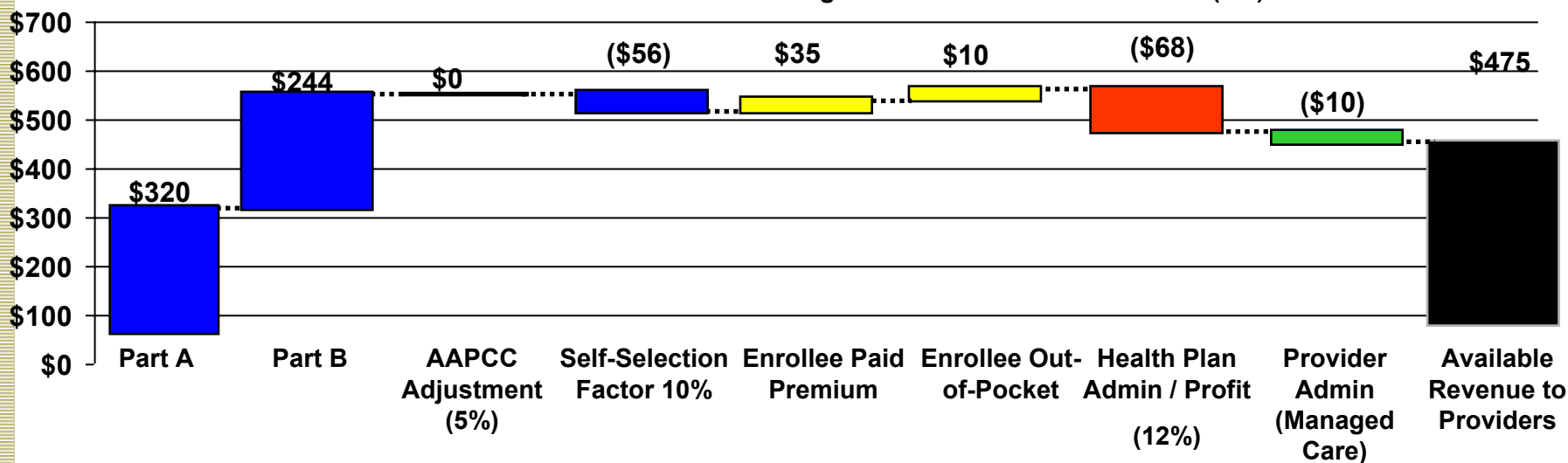
Performance by Product Type; Medicare FFS vs. Medicare Risk

ILLUSTRATIVE
SAN DIEGO

Fee-for-Service PMPM Revenue:



Risk PMPM Revenue:



Source: HCFA (2000 AAPCC). BDC Advisors, LLC analysis based on the performance of established IDSs.

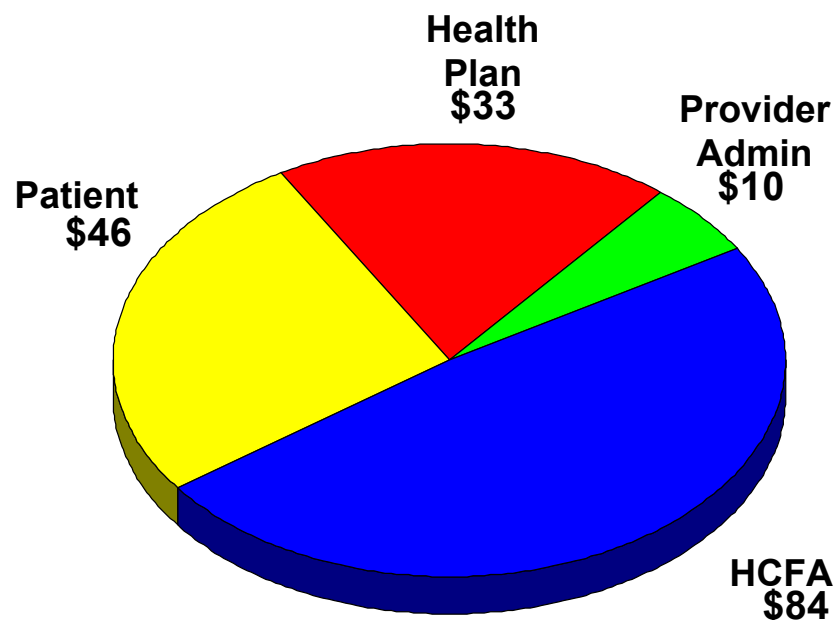
Performance by Product Type - Medicare Risk

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Sources and Uses

	FFS	Risk	Variance
<u>Sources of Funds</u>			
HCFA	592	508	(84)
Patient	91	45	(46)
Total	683	553	(130)
<u>Uses of Funds</u>			
Provider	648	475	(173)
Health Plan	35	68	33
Provider Admin	0	10	10
Total	683	553	(130)

Decreased Provider Reimbursement

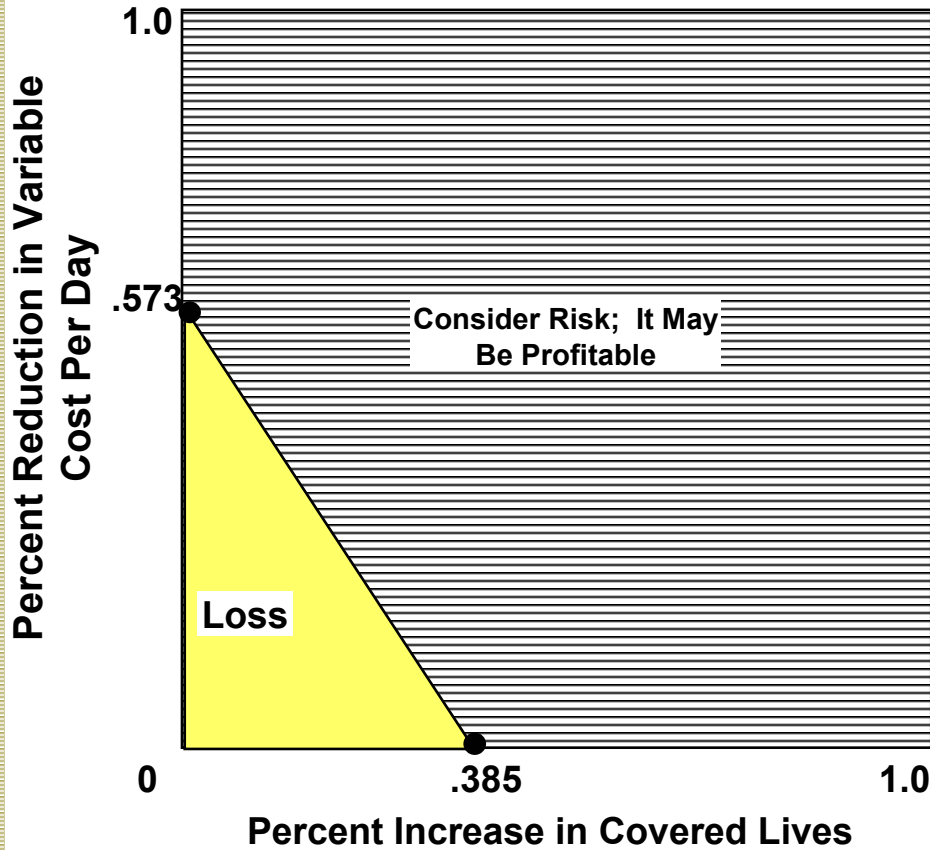


Provider Reduction: \$173

Alternative: Partial or Full Exit Considerations

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Indifference Frontier



Illustrative Market

Break Even Options:

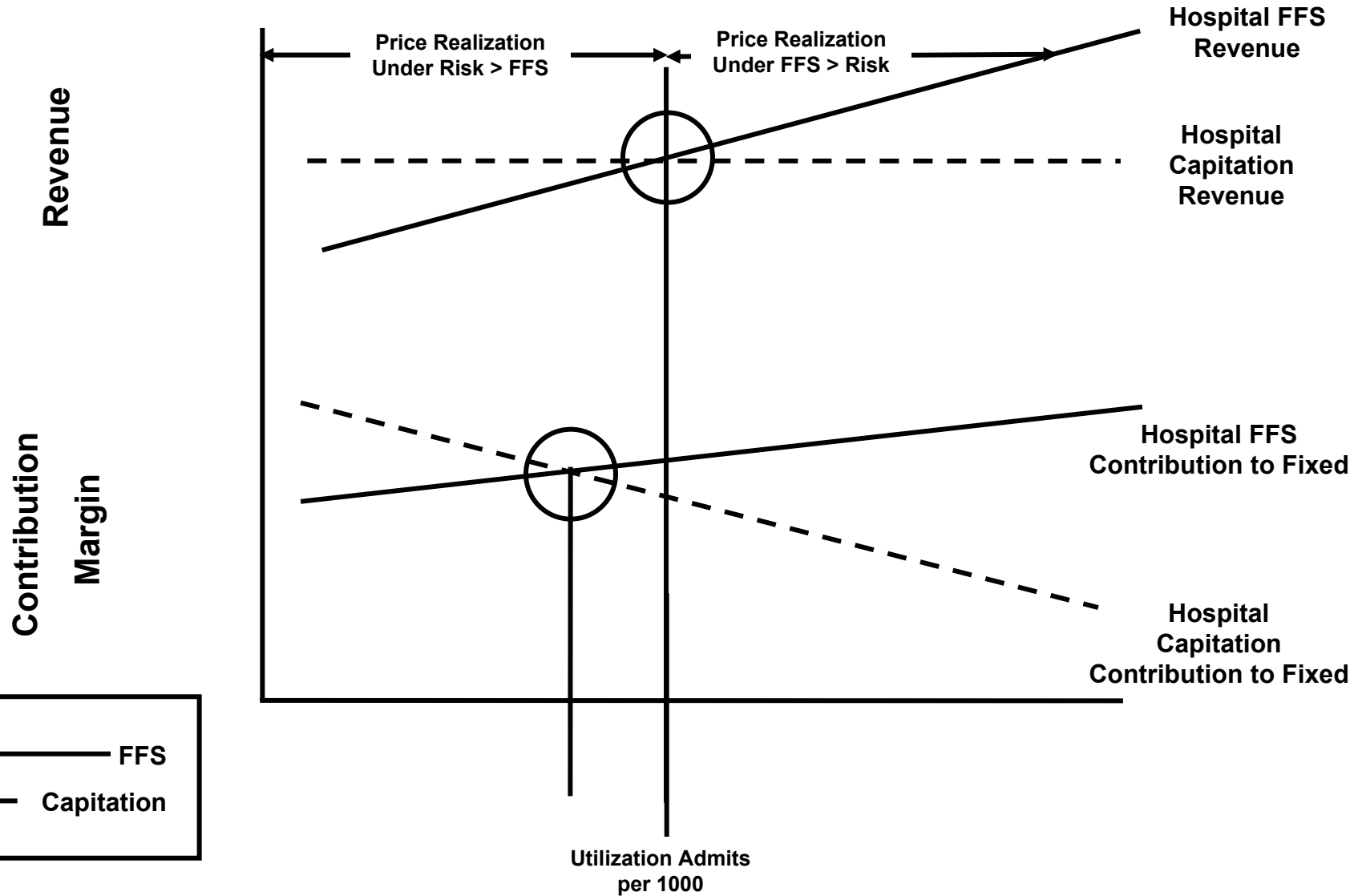
- Volume
 - Additional Enrollees 7,692
 - Percent Increase 38.5%

- Cost
 - Lower Variable Cost / Day⁽¹⁾ \$344
 - Percent Decrease 57.3%
 - Combinations of Volume and Cost Changes

(1) Assumed an initial variable cost per day of \$600

Source: BDC Advisors, LLC analysis

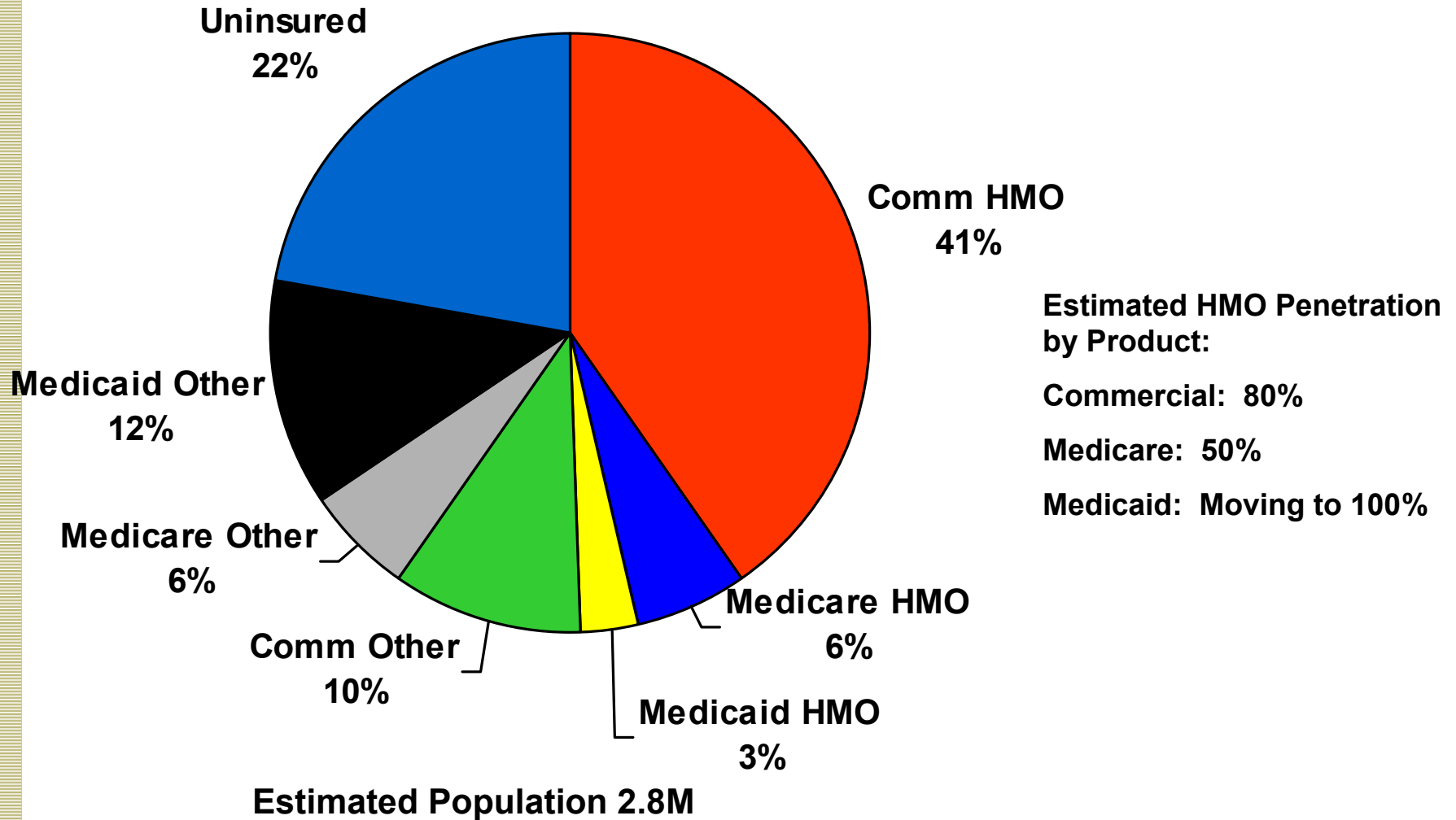
Medicare Risk Analysis - Decision Framework



San Diego Market Overview

San Diego Market Composition

50% HMO Penetration, 64% Excluding the Uninsured

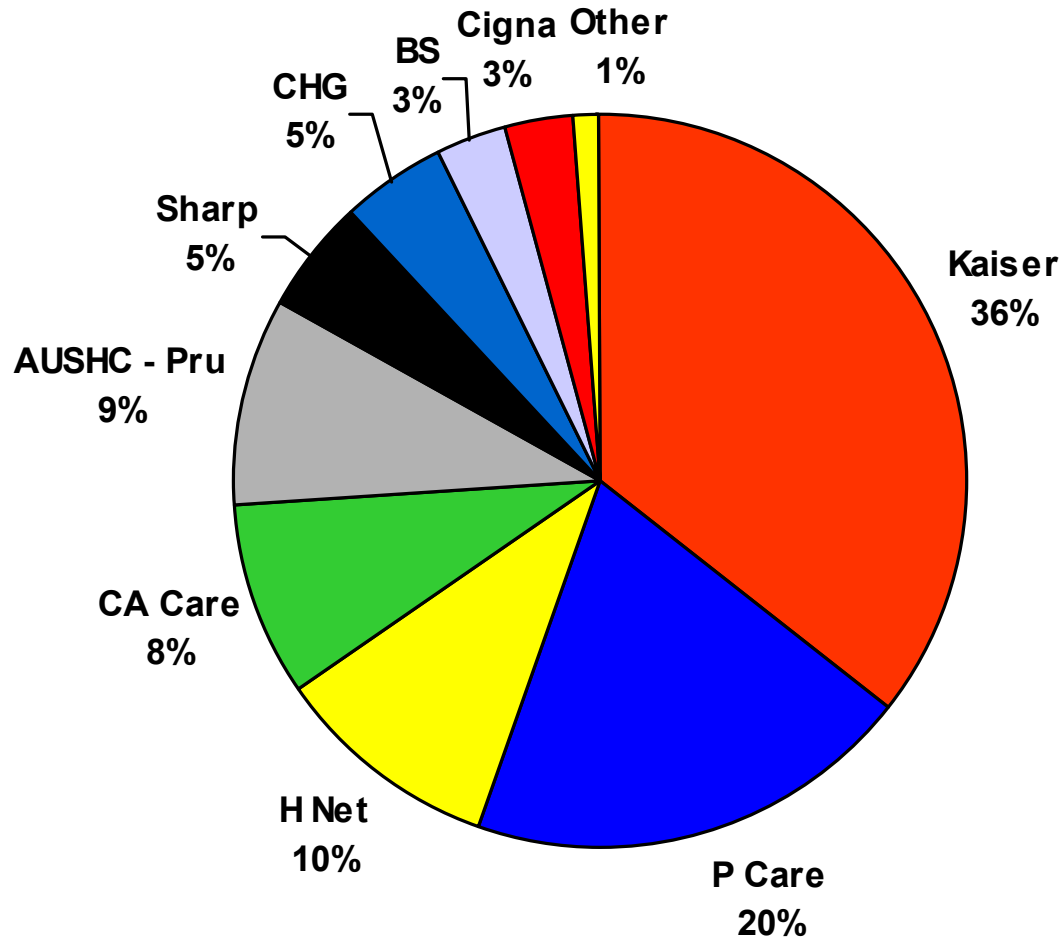


San Diego Rates and Health Plan MCR

- Most business sold at \$100 - \$110 PMPM
- Medicare AAPCC (\$564):
 - Part A: \$320
 - Part B: \$244
- Health Plan MCR (blended): 88%

San Diego Health Plans

Kaiser and PacifiCare are the clear market leaders, with market share relatively distributed among other competing plans.



Estimated HMO Enrollment 1.3M

Four (4) Major San Diego Health Systems

- **Kaiser:**
 - 1 Acute Care Hospital: 391 beds
 - Permanente Medical Group: 425 MDs
- **Sharp Healthcare:**
 - 4 Acute Care Hospitals: 1,290 licensed beds
 - Sharp Rees-Stealy Medical Group: 288 MDs
 - Sharp Community Medical Group (IPA): 637 MDs
 - Sharp Mission Park Medical Group: 60 MDs
- **ScrippsHealth:**
 - 6 Acute Care Hospitals: 1,400 staffed beds
 - Scripps Clinic: 320 MDs
 - Scripps Physicians (IPAs): 1,400
- **UCSD:**
 - 2 Acute Care Hospitals: 533 staffed beds
 - UCSD Medical Group: 400 MDs
 - UCSD Healthcare Network (affiliated community MDs)

- Market driven
- Alternative to Kaiser
- Competitive cost position
- Geographically distributed
- High physician access
- Focused specialty care campus (e.g., hearts, women's center)
- Focused physician strategy
 - Group
 - IPA

Medical Group

- > 85% of revenues derived through capitation > 10% of MD compensation derived from risk pools
- Medicare Risk one of most profitable product lines
- Thriving workers compensation business line
- Recently renegotiated risk sharing arrangement with Sharp Healthcare
- Competitive physician compensation

Hospital

- Evaluating capitation / risk sharing
- Evaluating competitors decision to accept capitation through a focused physician network
- Financial performance:
 - Losses through 1997
 - Small profit in 1998, 1999
 - Ahead of budget in 2000

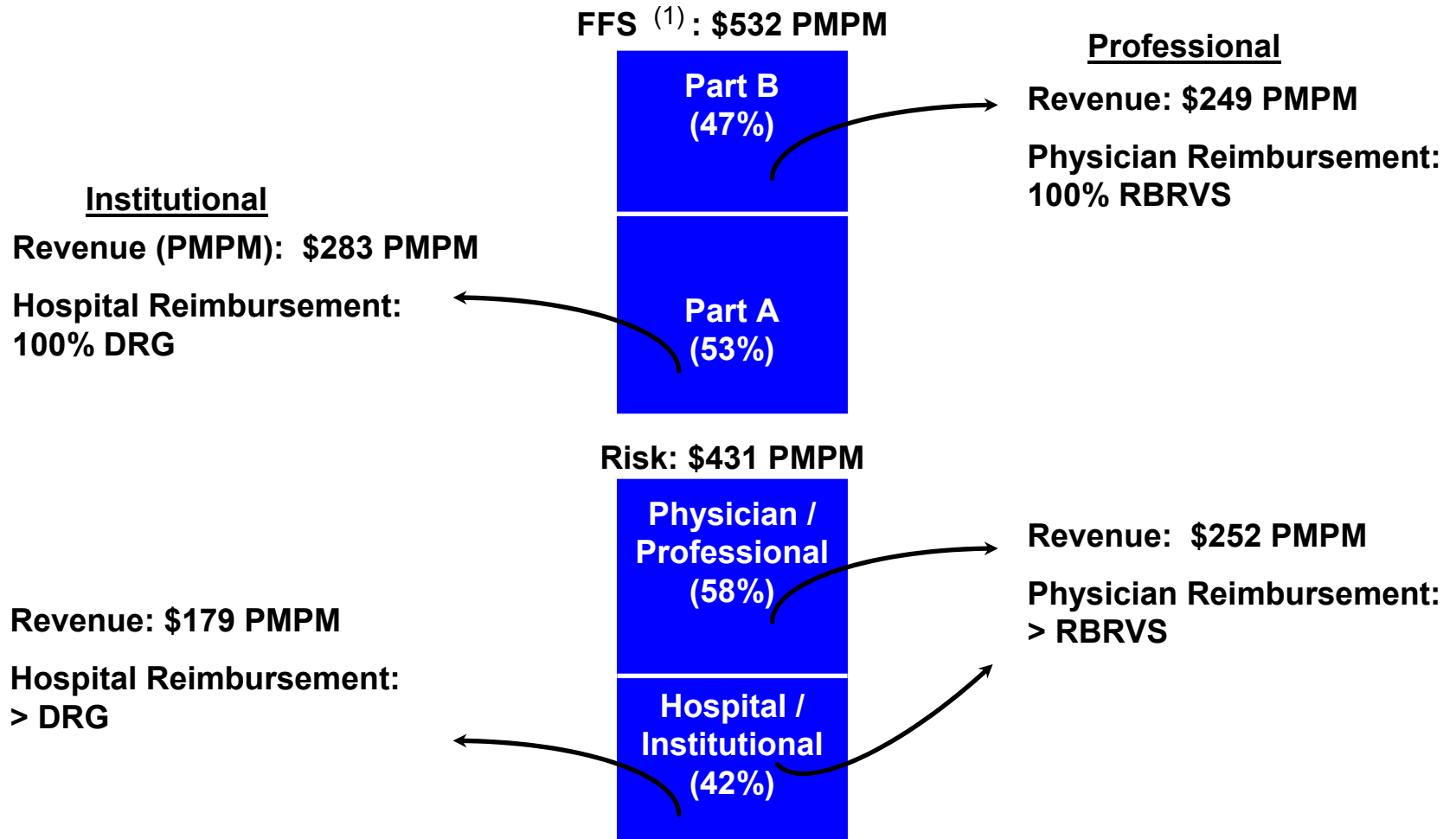
How should the Health System approach managed care /
capitation to maximize financial performance of the
“System?”

Implications for hospitals?

Implications for physicians?

Medicare Risk Analysis - San Diego Case Study

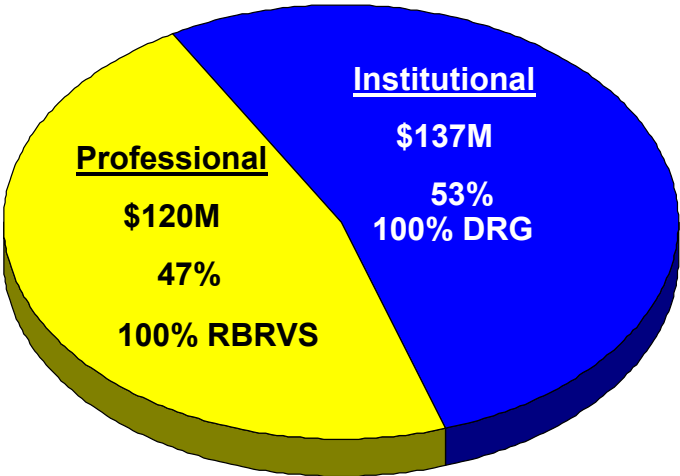
Advantage: Physicians and Hospital



Medicare Risk Analysis - San Diego Case Study

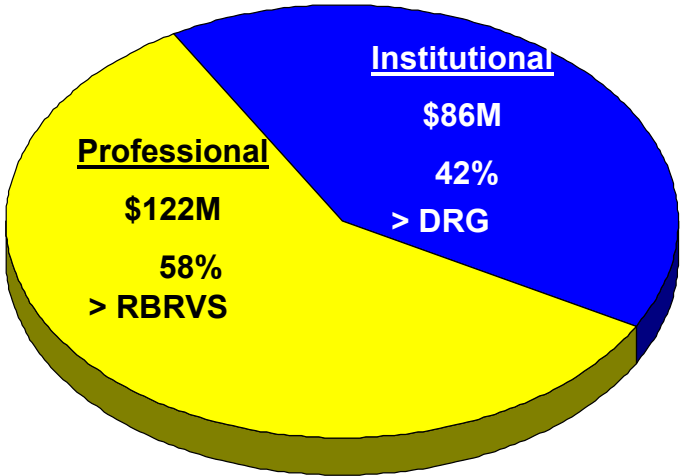
Constituent Impact Analysis 40,000 Members

Medicare FFS

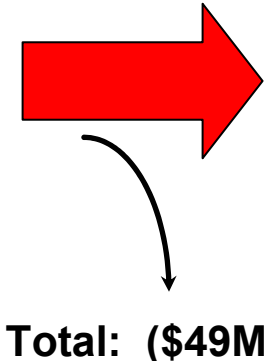


Available for Providers
\$257M

Medicare Risk



Available for Providers
\$208M



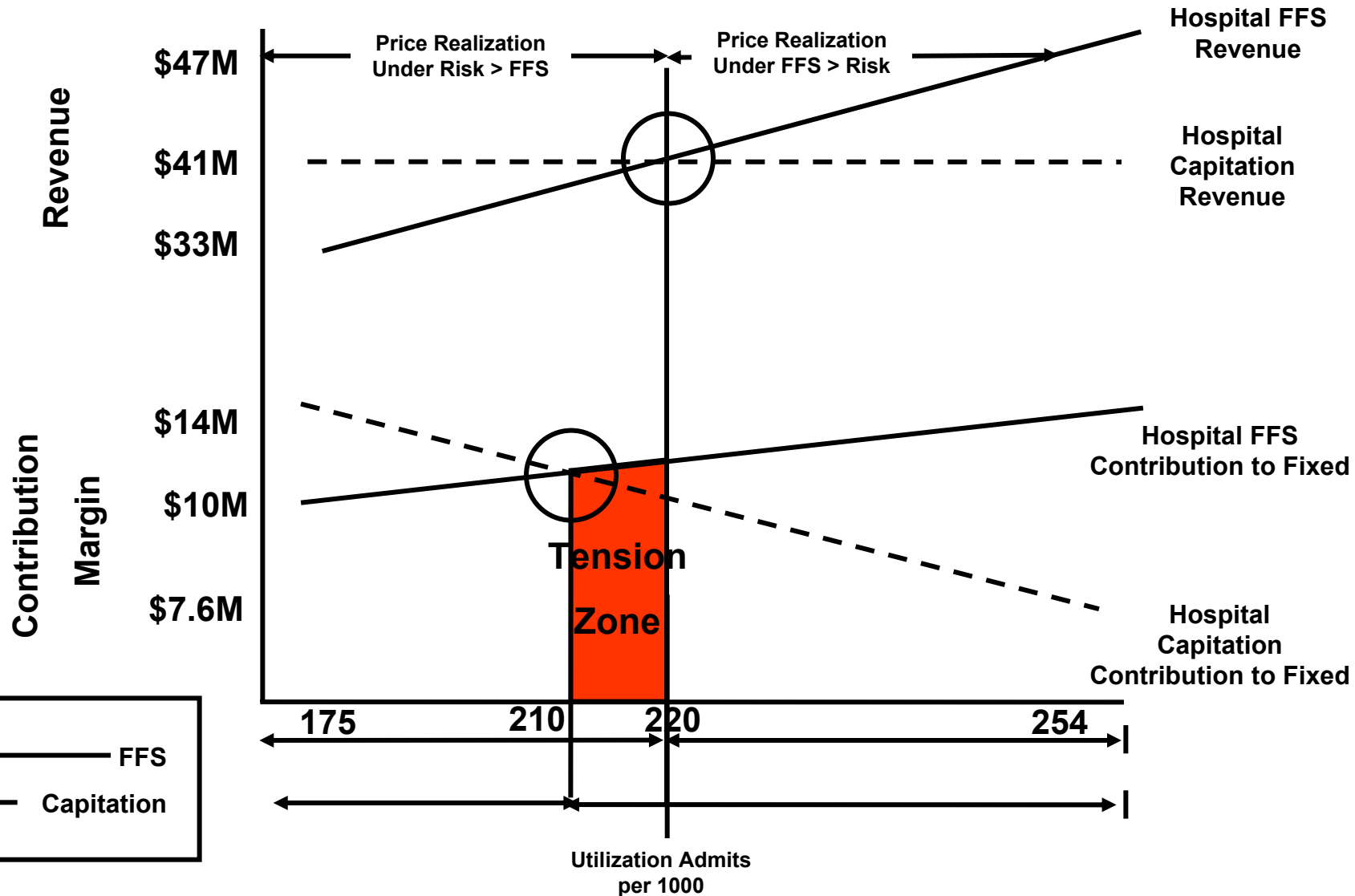
Source: HCFA 2000. Client data. BDC Advisors, LLC analysis based on 40,000 Medicare Risk enrollees.

Medicare Risk Analysis - San Diego Case Study

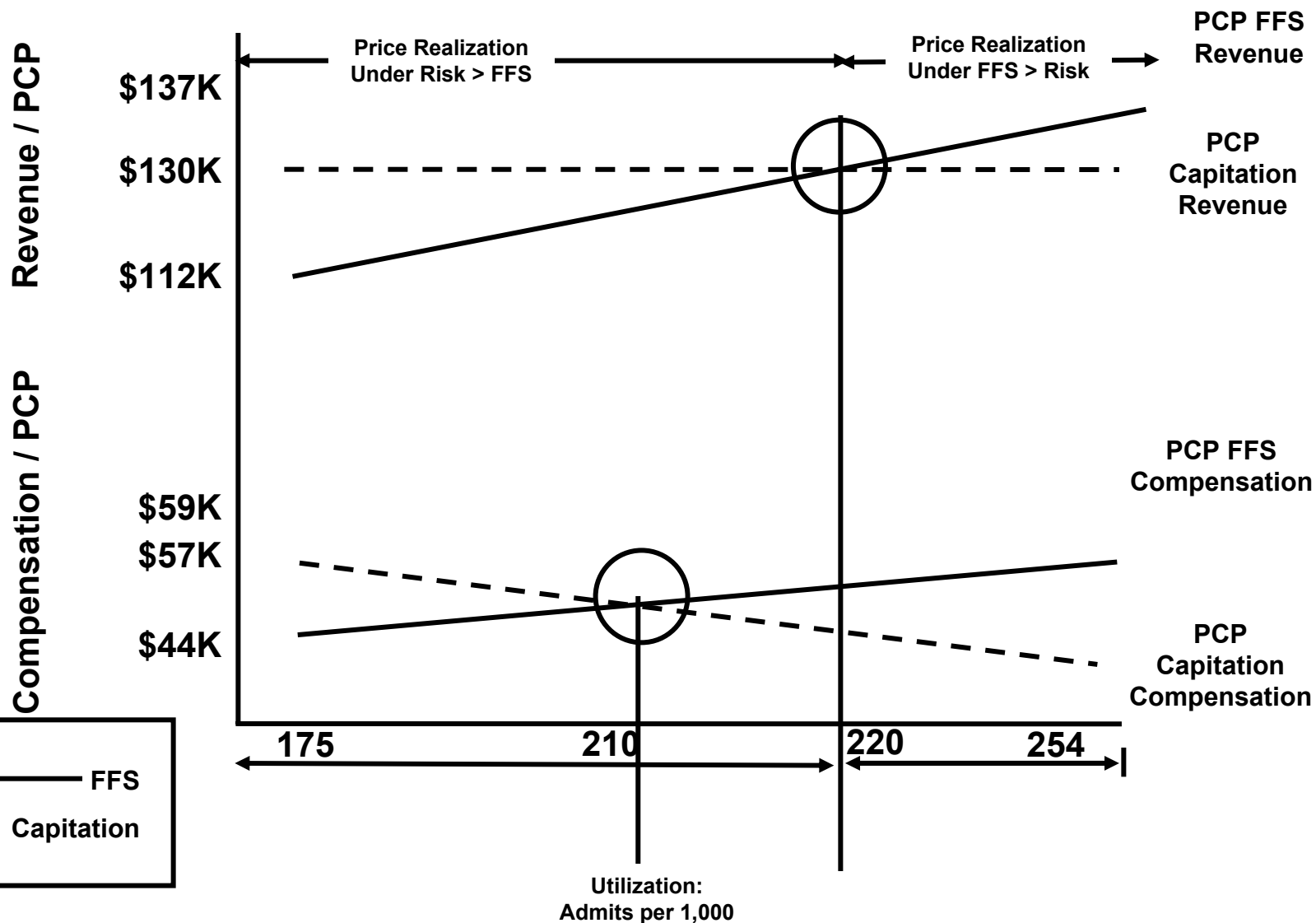
Summary

- Higher price realization achieved by both parties
- Due to:
 - Full commitment to risk by medical group
 - Restructured / aligned risk sharing arrangement
 - Use of risk assessment / demand management tools
 - Admits / 1000: 190 - 265
 - Length of stay: 3.1 - 3.4
 - Bed days / 1000: 900
 - Reduced variable costs / discharge
 - Reduced visits per member per year to MDs

Medicare Risk Analysis - Decision Framework: Hospital Impact



Medicare Risk Analysis - Decision Framework: PCP Impact

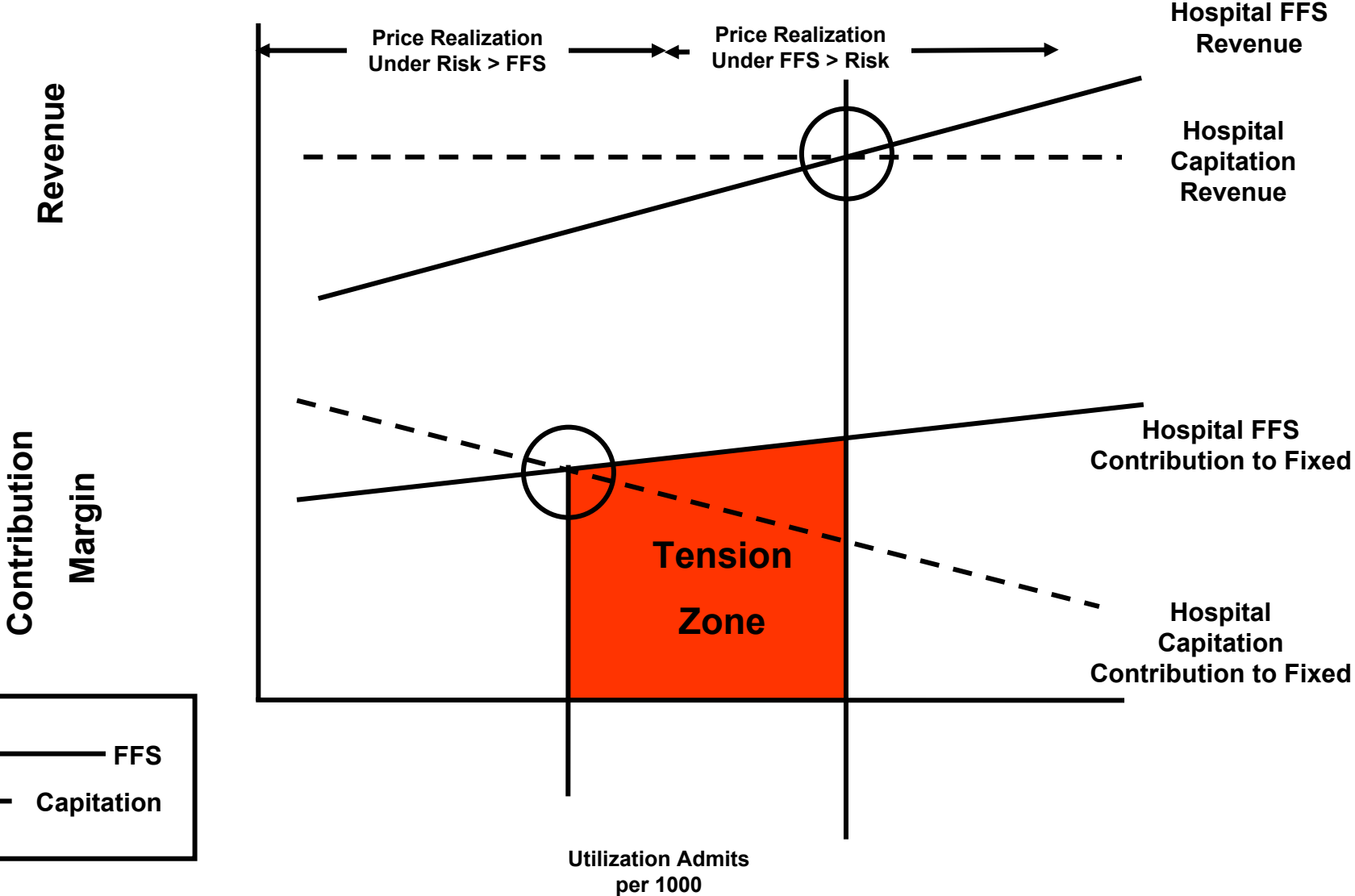


Source: BDC Advisors, LLC

Medicare Risk Analysis - Typical Finding

- Physicians advantaged under Medicare Risk
- Hospitals disadvantaged and considering exit
- Most frequent reasons:
 - Unfavorable hospital premium allocation
 - Low MD utilization rates per member per year
 - High hospital admits / 1000
 - High LOS
 - High hospital variable costs

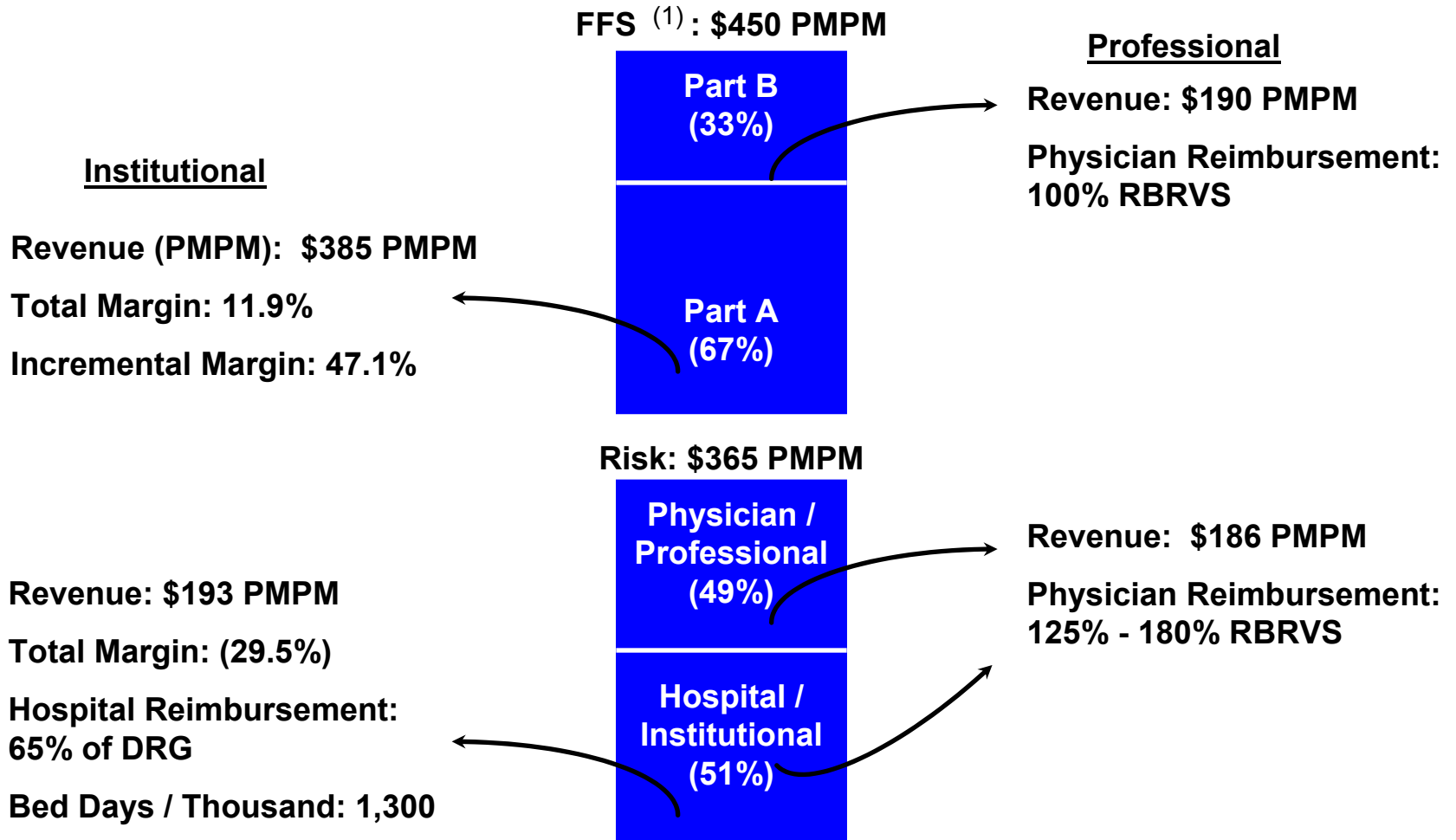
Medicare Risk Analysis - Decision Framework: Hospital Impact



Source: BDC Advisors, LLC

Medicare Risk Analysis - Northern California Case Study

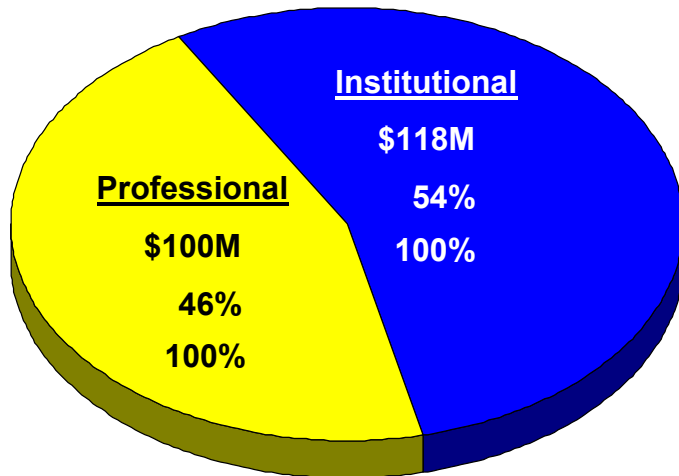
Advantage: Physicians



Medicare Risk Analysis - Northern California Case Study

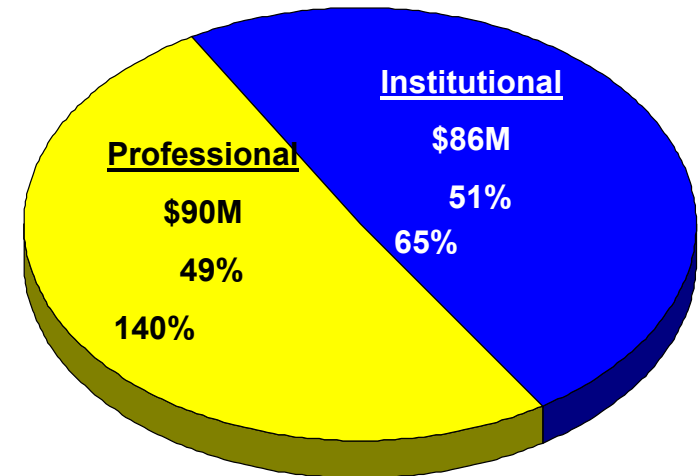
Constituent Impact Analysis

Medicare FFS

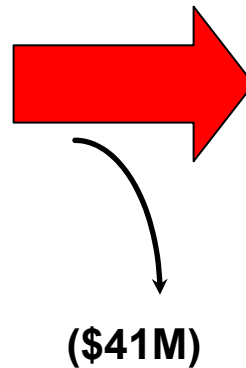


Available for Providers
\$218M

Medicare Risk



Available for Providers
\$176M



Summary

- Physicians significantly advantaged while the hospital receives fewer absolute dollars and lower price realization
- Due to:
 - Fragmented physician channels managing risk
 - High bed days per thousand: 1,300
 - High hospital variable cost structure

Alternatives

- Improve Performance

- Partial Exit
Hospital FFS
Group Capitation

- Full Exit

Requirement

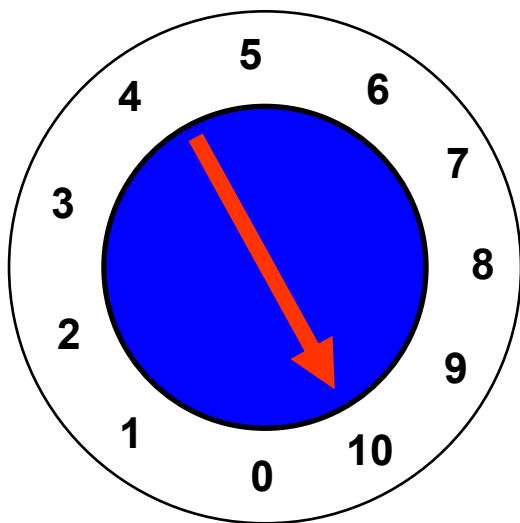
Ability to execute
Ability to reduce fixed costs /
manage capacity

Hospital or health plan
administered risk sharing
arrangements

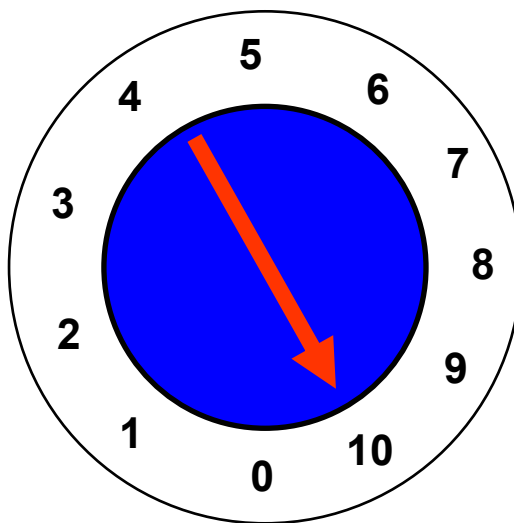
Next generation risk sharing
models

Health Plan Contractual & Operational Relationships

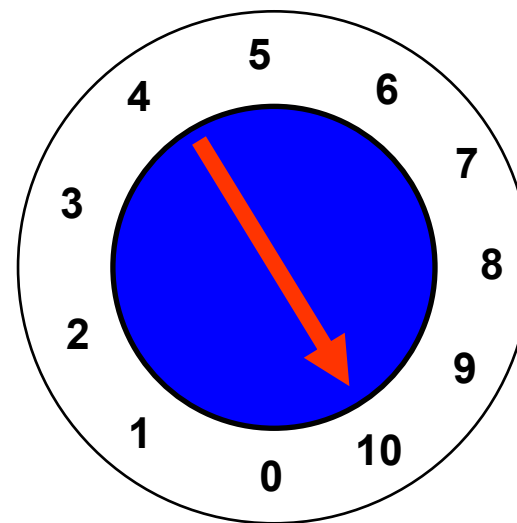
Network Design



**Outcome Based
Compensation**



Care Management



**Feedback
Systems**

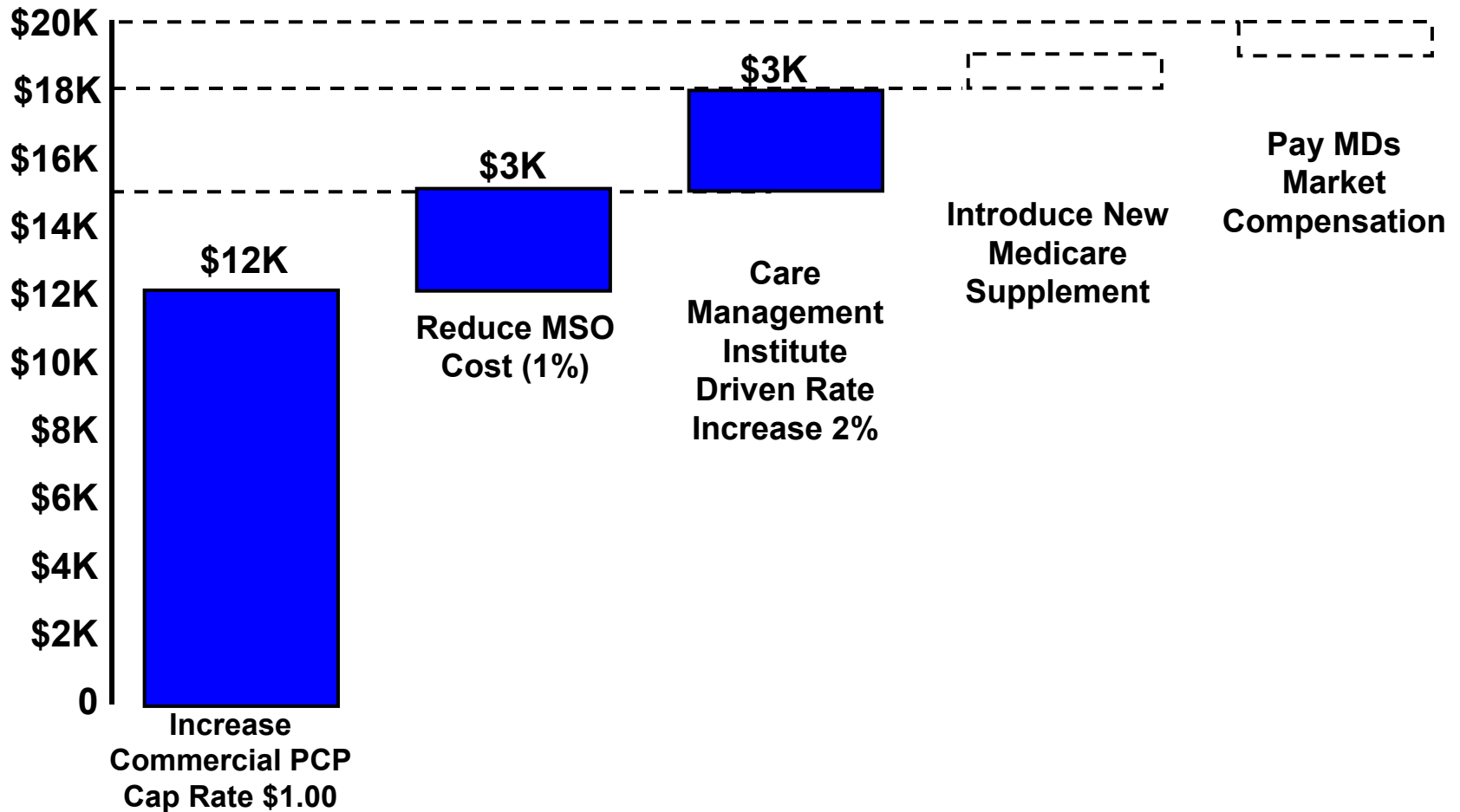
Alternatives: Partial Exit

- May improve price realization to hospital while maintaining current medical group price realization
- However, requires that the “System” push hospital downside risk to the health plan
- And, the ability to fully recover FFS revenues is lost (\$49M and \$41M from case studies) due to continued requirement for health plan and provider administrative costs

Alternative: Full Exit - Reallocating Re-Captured FFS Dollars

- Revise MSO division of financial responsibilities (return services to the hospital)
- Revise commercial premium allocation
- Develop a care management institute to improve quality
- Introduce new Medicare supplement with expanded benefits
- Pay physicians market compensation, regardless of reimbursement mechanism (requires Foundation model)

Reallocating Re-Captured FFS Dollars Replacing PCP Risk Pool = \$20K



Alternative: Full Exit - Additional Considerations

- Fully exiting Medicare Risk does not automatically guarantee a return to previous FFS revenue levels
 - Increasing hospital revenues may require increases in admits per thousand
 - Increasing physician revenues may require increases in patient visit rates

Summary

- Thoughtful analysis
- Economics different in every market
- Goal is to maximize “system” performance
- Redistribution of dollars may be required

Next Steps

