JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

Session 3

Risk, Capitation, and Other Financial Issues in Managed Care

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Health Care Financing and Coverage in the US

	Population	Payment
Private Ins.	67%	44%
Medicare	10	16
Medicaid	9	14
Uninsured	14	-
Out-of -Pocket	-	16
Other	-	10

Who is “At Risk” For Cost of Care Provision

- **30% Self-insured employers**
- **25% For-profit MCOs**
  - **5% Gov. contracts**
  - **18% Empl. contracts**
- **20% Not-for-profit MCOs/IDSs**
- **13% For uninsured: safety net providers, government, patient**
- **12% Government programs**

Capitation: A Working Definition

A type of health care financing where a provider is paid a fixed per-capita fee for a pre-negotiated market basket of services on behalf of an enrolled group of consumers.

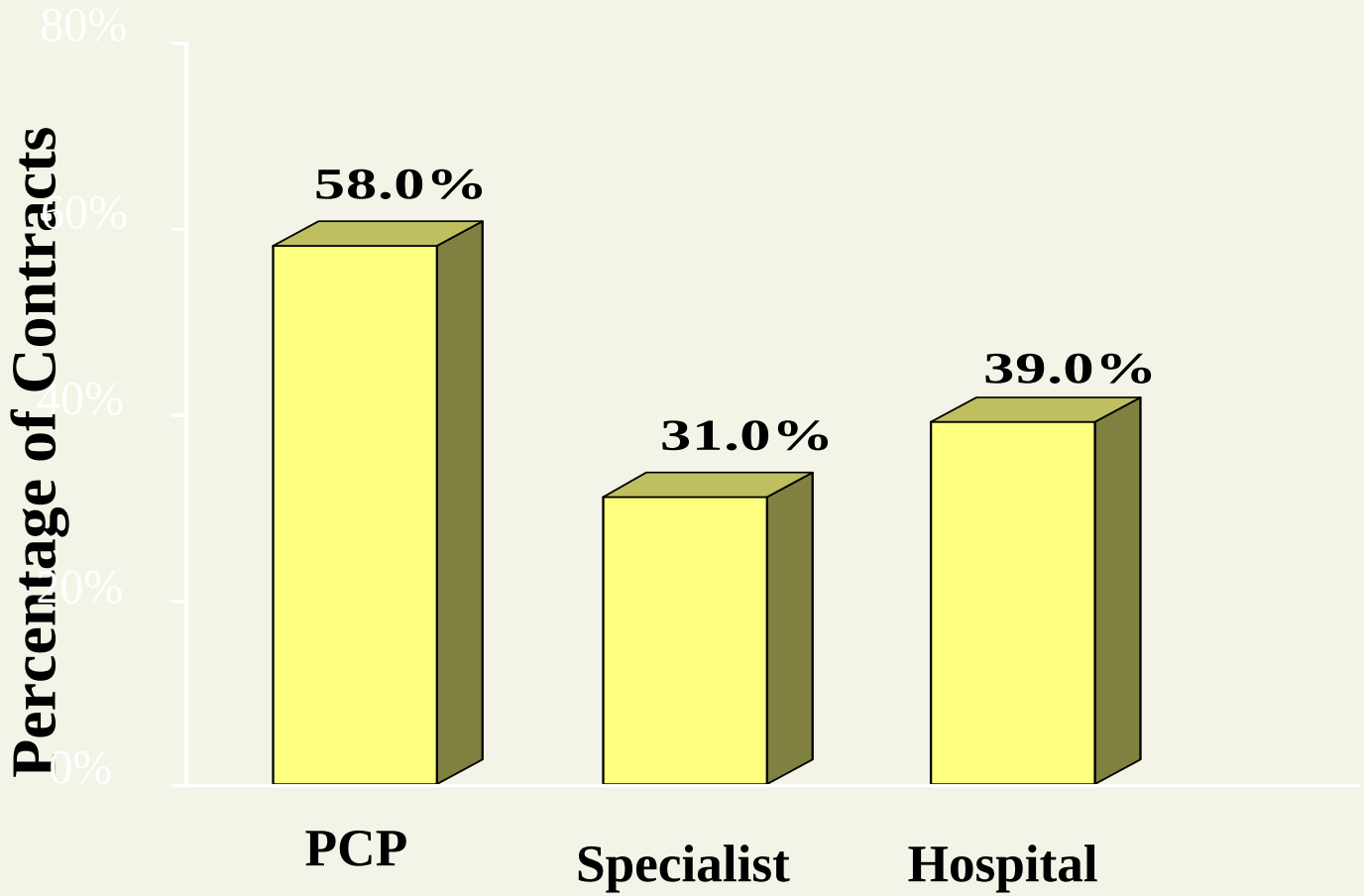
Potential Advantages of Capitation

- **Strong incentives for efficiency**
- **Fosters primary care and prevention**
- **Fosters “population orientation”**

Potential Disadvantages of Capitation

- **Could offer incentives to skimp**
- **Incentives to avoid sick consumers**
- **Individual Patient and provider choices may be limited**

Avg % of HMO "Contracts" Reimbursed via Capitation by Provider Type (2005)



Source: Aventis 2006

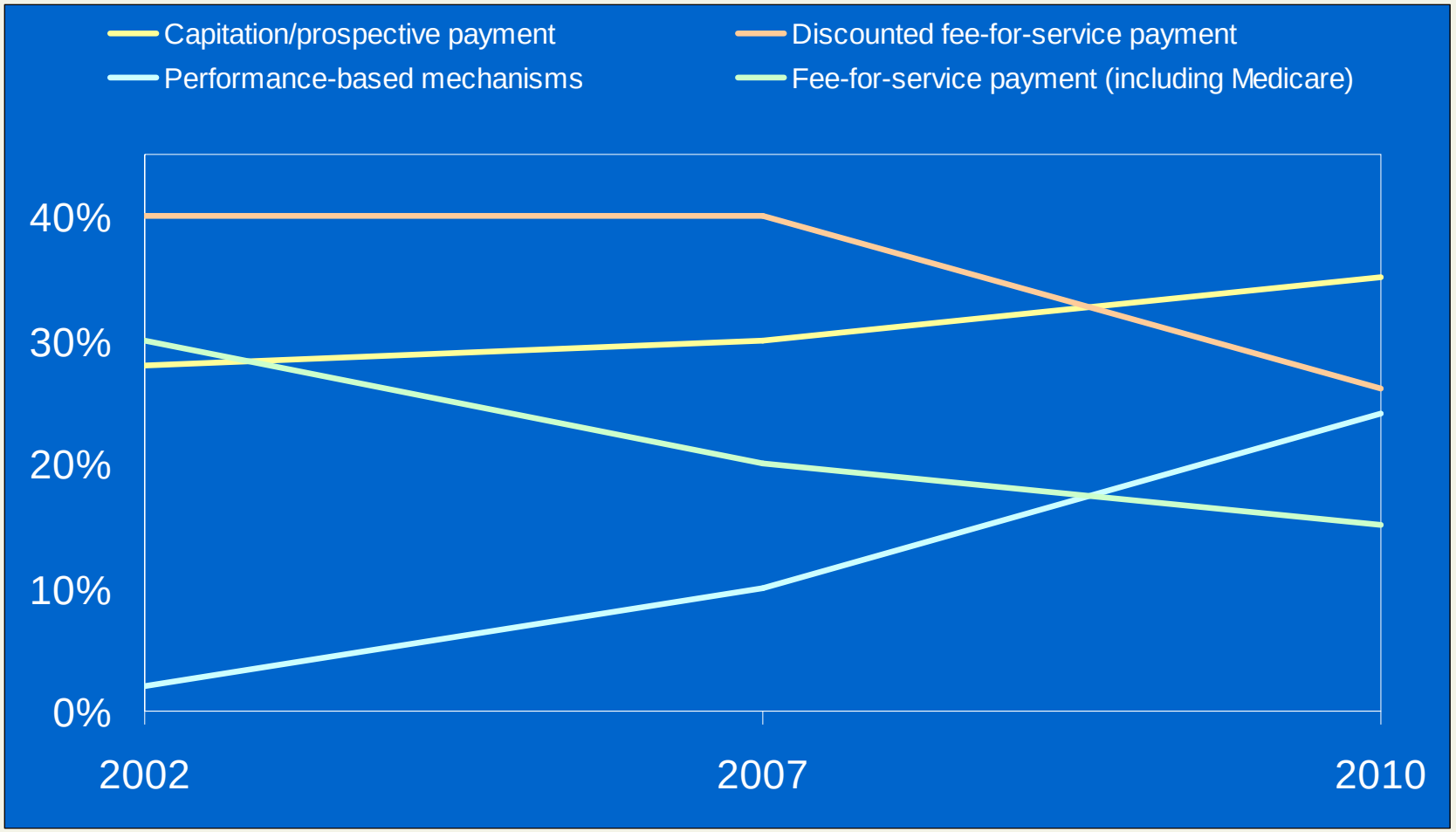
METHODS OF PHYSICIAN REIMBURSEMENT BY HMO TYPE (2005)

HMO Type	SALARY	FEE-FOR SERVICE	BONUS PROGRAM	CAPITATION
IPA	4%	69%	10%	74%
NETWORK	3	72	15	73
Group	13	57	17	80
Staff	89	56	22	67
OVERALL	7%	68%	13%	74%

Source: Aventis 2006

How Physicians Will Be Paid

Share of Practice Revenue That Will Come From Different Payment Schemes

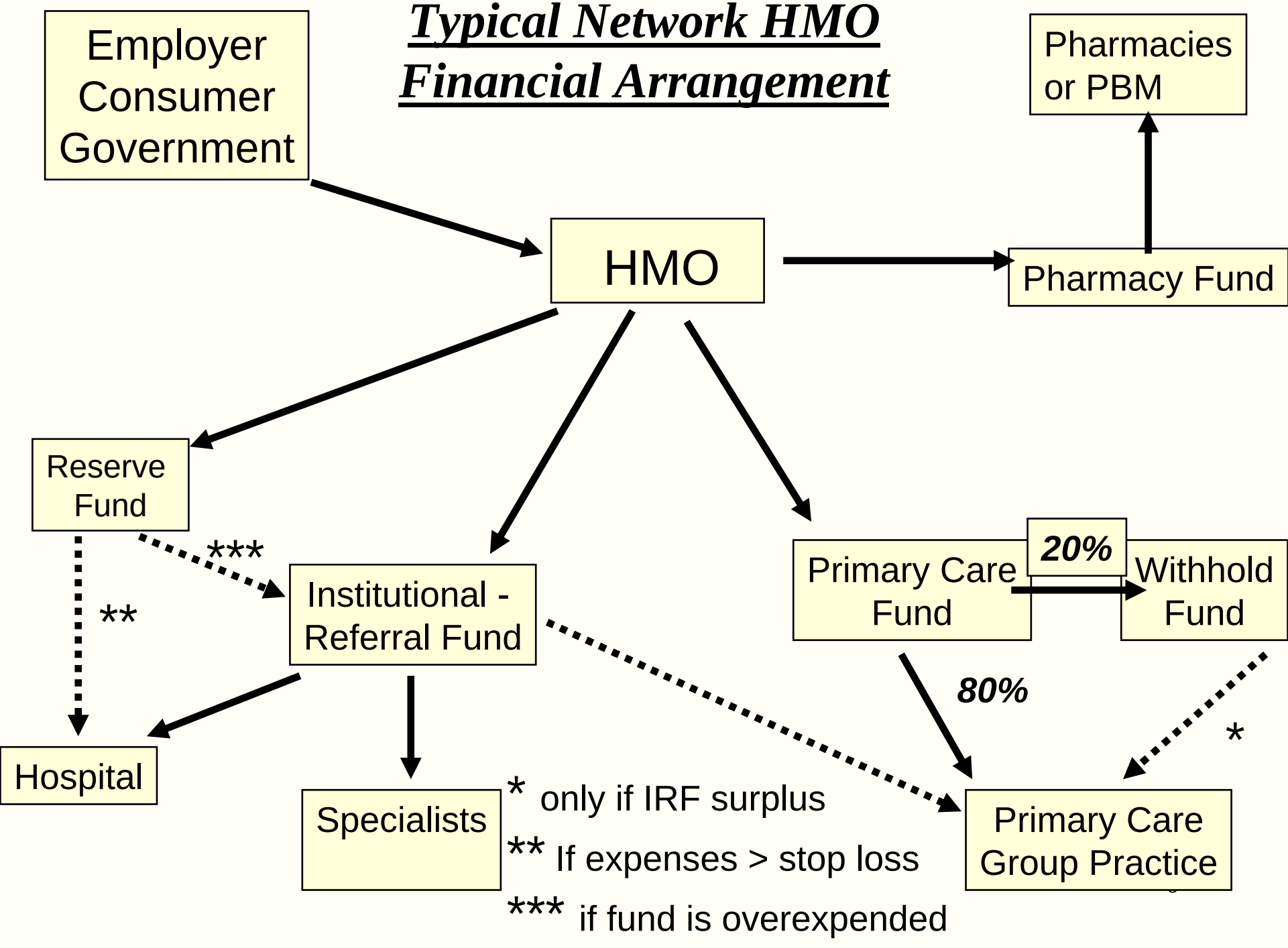


Source: Health & Health Care 2010: The Forecast,the Challenge. Institute For The Future, Menlo Park, CA, 2000

ABC Health Plan (Simplified) Premium Rate Development Spreadsheet for 2006

	Utilization per 1000	Unit Cost	PMPM Cost	Co-Ins. Adjust	Adjusted Cost	Cum. Total
INPATIENT						
Medical/Surgical	190	$1,200	19.00	0.57	18.43	
ICU/CCU/NNU	30	2,300	5.75	0.17	5.58	
Maternity	45	1,350	5.06	0.15	4.91	
Mental Health	15	650	0.81	0.02	0.79	
Nursery	20	700	1.17	0.04	1.13	
Subtotal	300					$ 30.84
PRIMARY CARE						
Office visits	4200	$ 35	12.25	1.75	10.50	
Immunizations	440	30	1.10		1.10	
Other	1200	15	1.50		1.50	
Subtotal	5840					$13.10
SPECIALTY CARE						
Surgeries	80	$ 1400	9.33		9.33	
Medical Specialist	650	100	5.42		5.42	
Radiologist	900	60	4.50		4.50	
Lab	2600	19	4.12		4.12	
Obstetrics	35	2200	6.42		6.42	
Psychiatric Care	160	60	0.80		0.80	
DME	40	150	0.50	0.08	0.42	
Physical Tx	140	60	0.70		0.70	
Subtotal	4605					$31.70
OUTPATIENT OTHER						
Amb Surgery	70	$ 1800	10.50		10.50	
ER	200	280	4.67		4.67	
Ambulance	50	120	0.50		0.50	
Subtotal	320					$ 15.67
TOTAL MEDICAL EXPENSE						91.31
Administrative / Care Management						24.00
Targeted Profit/Reserve						8.00
Total Required Revenue						$123.31

Typical Network HMO Financial Arrangement



Financial Management Definitions

- **PMPM - Per member per month. Specifically applies to a revenue or cost for each enrolled member each month.**

- **Medical loss ratio = (Medical Expenses/Premium)**

- **IBNR - Incurred but not reported. Medical expenses about which the plan does not yet know.**

Definitions – Cont.

Stop Loss: a form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. It may apply to an entire health plan or to a single component.

Risk Adjusted Capitation Payment

Risk adjusters redistribute dollars among health plans based upon the expected health status of the enrolled population in each health plan.

Why Risk Adjustment is Needed

% US Population	% of Health Care $
1%	30%
10%	72%
50%	97%

Why Risk Adjusted Payment is Necessary

- **To deter plans from selecting or marketing to healthier enrollees**
- **To protect plans from being selected by a costlier than average group of enrollees**
- **To facilitate plan's attempts to specialize in treating people with certain illnesses or conditions**

Methods of Risk Adjusted Payment

- **Reinsurance thresholds**
- **Prospective capitation adjuster**
- **High cost carve-outs**

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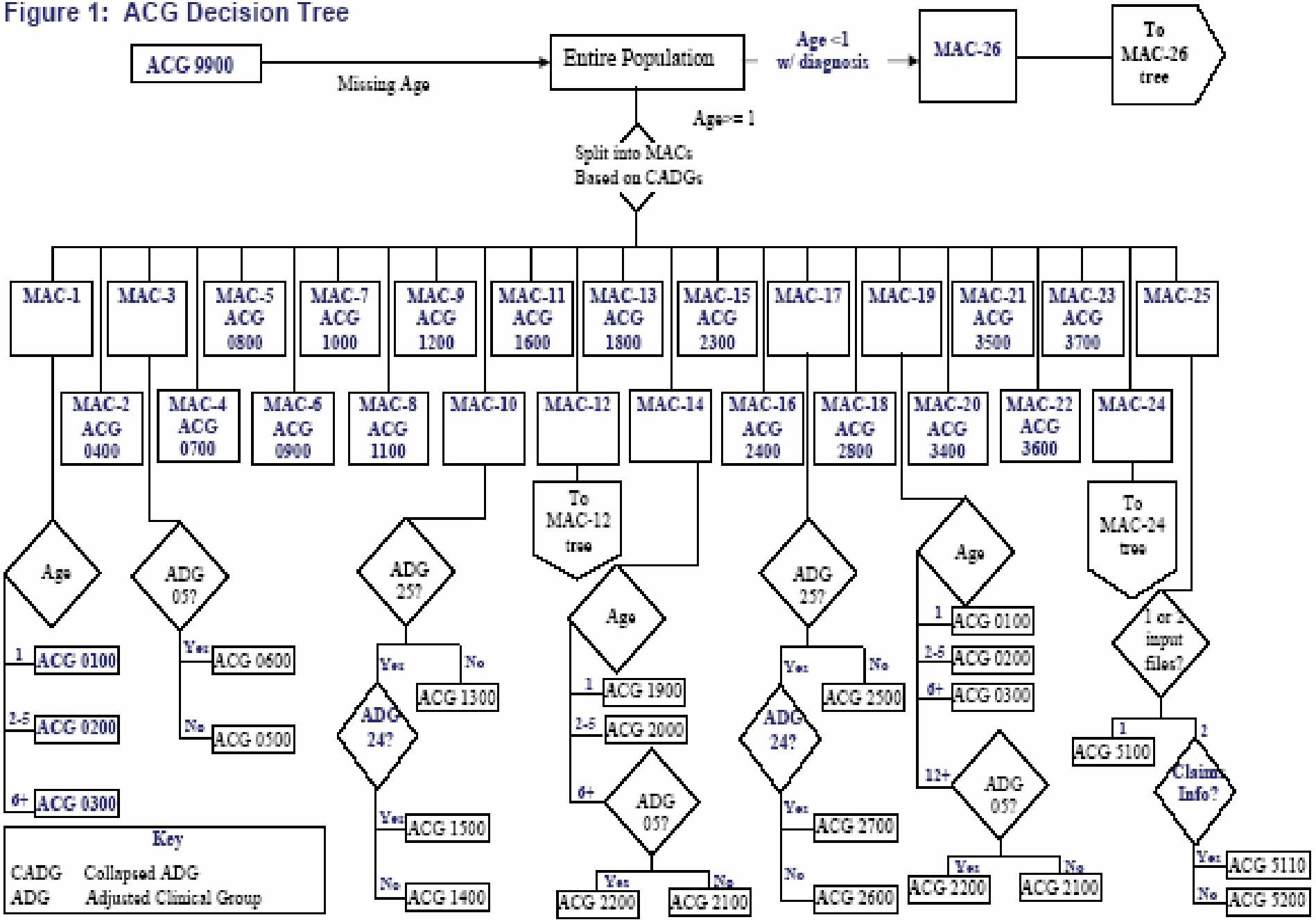
"Johns Hopkins ACG" Risk Adjustment/ Case-Mix Methodology

"Adjusted Clinical Groups", formerly Ambulatory Care Groups

See: www.acg.jhsph.edu

Figure 1: ACG Decision Tree



ACGs Lead to Fairer Payments

A comparison of demographic-based and ACG-based capitation payments to actual expenditures for healthier-than-average and sicker-than-average enrollee groups showed that ACG-based payments are much closer to actual expenditures:

Group Type	Payment system	Difference from "perfect payment
Sicker than average	Demographic	5.2% underpayment
	ACG	0.7% overpayment
Healthier than Average	Demographic	7.9% overpayment
	ACG	0.6% underpayment

Source: JAMA, 10/23/96

Other Non-Payment Applications of Risk Adjustment

- **Adjusting Performance (quality and efficiency) " Profiles"**
- **"Predictive Modeling" to identify high risk cases for Care / Disease Management**
- **Control and Stratification for Analysis, Evaluation, & Research**