HEALTHCARE TRENDS

PHYSICIAN ORGANIZATIONS: MANAGING THE RISK EQUATION

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Driven by an aging population, the development of new, high-priced pharmaceuticals, and the rapid expansion in coverage as a result of the Affordable Care Act (commonly referred to as “Obamacare”), more and more of the nation’s GDP is being consumed by the healthcare dollar. In response to these fiscally unsustainable trends, federal, state, and local entities, employer groups, and health plans and other third-party payors are mandating that the manner in which healthcare providers are to be reimbursed shall transition from a fee-for-service, or “pay as you go,” model to one founded on a risk-based, value-driven platform.

During this transition, it is worth looking at what is being pursued by California physician organizations, which have long been industry leaders in the development and implementation of various forms of risk-based healthcare delivery models. The capitated, delegated model is well embedded throughout the state, which has led to higher quality, more efficient, more measurable, and less costly delivery of health care, resulting in improved patient experiences and outcomes. In the Commercial, Medicare Advantage, and Medi-Cal HMO space, the shared risk contracting model, wherein professional services are capitated to a physician organization and a shared risk pool is designed to incentivize alignment between the physician organization and health plan in the management of hospital and ancillary (“institutional”) services, has been a part of the contracting fabric for decades. There are many instances, both past and present, of the success of this type of contracting model. Unfortunately, there is now empirical evidence that, despite the best efforts of all stakeholders, institutional expenses incurred under the shared risk model are increasingly exceeding budgeted dollars; in some cases, by double digit percentages.

The HMOs, many of which are for-profit entities, and thus accountable to their investors, are no longer willing to absorb losses year over year. Standard HMO financial pro formas are based on a targeted Medical Loss Ratio (MLR) being in the range of 83%–86% of the premium dollars, administrative and G&A expenses being in the range of 13%–15%, with profits margins in the 1.5%–3% range. When the MLR exceeds the top end of the target range, it places pressure on the bottom line. In the shared risk model, given that the professional services are capitated, and thus can be budgeted for, it is spiraling institutional expenses that are driving the losses. Although HMOs will continue to work with their physician organizations in an attempt to turn the tide of rising institutional expenses, their “turn-around” windows are becoming shorter and shorter before they decide to exit contracts, and eventually non-performing markets. For physician organizations, the impact of HMOs exiting their marketplace for Commercial, Medicare Advantage, and/or Medi-Cal products can be devastating. The membership related to these HMO arrangements can be in the tens of thousands, and even though best efforts are made to retain their membership through these transitions, disruptions are never a good thing. Members can choose to sign up with competing physician organizations, and then there is always the threat of Kaiser picking off its share of this affected membership.

In an effort to (i) keep HMOs from cancelling their contract or exiting their market, (ii) retain and expand their membership base, (iii) get closer to the top-line revenue source and thus better control the flow of funds, and (iv) exercise more control over the composition of the provider network, physician organizations are increasingly embracing the next evolution of the provider risk-based, value-driven platform, becoming Restricted Plans. Under this arrangement, the Restricted Plan becomes financially responsible for not only the professional services, but also the institutional services and, in rare instances, the costs of prescription drugs. Given that the Restricted Plan can now take risk for institutional expenses, it is now viewed as a “Plan.” The parties in this new “Plan-to-Plan” (Health Plan to Restricted Plan) arrangement negotiate a Division of Financial Responsibility (DOFR), which is a line item assignment of the professional, hospital, and ancillary services to be performed or provided. For undertaking the line times assigned to it, the Restricted Plan typically receives 83%–87% of the premium dollars, with the health plan receiving the balance of the funds to cover sales and marketing and those medical expenses for the services assigned to it in DOFR – services such as Out-of-Area, transplants, and prescription drugs.

Becoming a Restricted Plan does not come without its challenges. Firstly, the financial commitment can be very substantial, and far exceed the level of capital outlay that physician organizations are typically required to make as simply a risk-bearing organization (RBO). From an administrative perspective, the Plan’s organizational structure is not simply a “scaling-up” of its existing physician organization. Rather, it is a separate and distinct entity, with its own executive team, that oversees all of the delegated services and functions required under its Restricted Plan license. It must develop, and have approved, its own set of policies and procedures. In addition, the DMHC application process requires that the applicant complete numerous exhibits, with supporting documentation and various financial models, which describe in detail how it will develop, implement and execute on the clinical, operational, and financial functions for which it is now responsible. Given the breadth and depth of information submitted as part of the application, the review process on these applications typically run 6 – 9 months, but have taken longer on occasion. For Restricted Plans that later become interested in expansion outside their current service area, an abbreviated application process, known as a material modification, is submitted for each new service area and/or county.

Once a physician organization is armed with a Restricted Plan license, its ability to shoulder a bigger part of the risk equation
makes it a very valuable commodity in the eyes of health plans. Not only is it assured of maintaining its existing contractual relationship with health plans, it is highly likely to gain even more market share if/when health plans terminate under-performing, competing physician organizations and roll the membership into the Restricted Plan. From the health plan perspective, knowing it will be able to move into new markets with an existing, proven Restricted Plan partner will only enhance the relationship between the two entities, making the Restricted Plan an invaluable partner for the health plans in the long term.

As federal, state, and local entities, employer groups, and health plans and other third-party payors continue to mandate that the health care industry transition to risk-based, value-driven platforms for the delivery of health care, those physician organizations that have the vision, aptitude, and leadership to be on the cutting-edge of the next evolution of the risk equation, the Restricted Plan, will be well positioned for financial success and ensuring that their destiny is by choice, not by chance.

If not you, then who…your competitor? If not now, then when…when it is too late?

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