St. Elizabeth Healthcare

- 1,187 Licensed beds
- 44,067 Inpatient Discharges*
- 10,168 OBS*
- 4,291 births *
- 198,903 ED visits *
- 493,433 Other OP Visits*
- 7,400 employees
- 300+ employed PCPs in 60 office locations
- Operating Revenue (budgeted) - $1,100 million

* CY 2013 actual as of 12/31/13 (unaudited)
How do Risk Contracts/FFS Differ?

Fee For Service (FFS)

• Payment rates are negotiated up front
• Payer holds the risk – they win if expenses < premium revenues
• The payer has incentive to invest in strategies that reduce expenses

Risk Contracting

• Total cost of care is negotiated up front. The payer (government, employer, etc) knows in advance what his cost of care will be.
• If expenses < premium revenue, the provider wins; if not, the provider loses
• Payments are typically made as a cash flow mechanism:
  1. As services happen at a ‘market’ rate
  2. As a series of regular, capitated payments
• Surpluses/deficits are tracked monthly, and a net annual surplus/deficit is settled at end of year plus 120 days +/-
• The provider has incentive to invest in cost control measures
Negotiating and Managing Risk

Risk contracting is a budgeting exercise

- **Revenues**
  - Do we understand?
  - Can we control?

- **Expenses**
  - Do we understand?
  - Can we control?

- Do we believe Revenues will exceed Expenses?
Negotiating and Managing Risk

For all variables under consideration:

• Assess the risk
• Ameliorate the risk as far as possible
• Make vs. Buy decisions
  • Clinical
  • Administrative
Negotiating and Managing Risk

Revenue Considerations

• Is revenue given or negotiable?
  • ‘% of Premium’ still leaves the MCO in control

• Can the provider affect revenue?
  • Can we affect the benefits and contribution strategy?
  • Can we raise revenue through better coding?

• How close are you to the actual payment source?
  • Using your own employees as an ‘at risk’ population is a good way to look at this problem
Projecting next year’s costs to get to a ‘revenue needed’ number

<table>
<thead>
<tr>
<th></th>
<th>2013 Cost</th>
<th>Cost/unit</th>
<th>Utilization</th>
<th>Final Future</th>
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</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$ 50.00</td>
<td>8%</td>
<td>2%</td>
<td>$ 55.08</td>
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<tr>
<td>Outpatient</td>
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<td>7%</td>
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<td>Professional</td>
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<td>5%</td>
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<tr>
<td>Total</td>
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<td>$ 254.90</td>
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</table>
Expense Considerations (three kinds of risk)

- **Price Risk**
  - Risk of paying too much for any given service

- **Utilization Risk**
  - Risk of paying for too many services on a per capita basis

- **Mix Risk**
  - Risk of substituting more expensive treatments or drugs for less expensive alternatives.
Assessing the Risk

• **Price Risk**
  - Are we able to know the ‘market’ price for each service?
  - Are we able and **willing** to negotiate for lowest price?

• **Utilization Risk**
  - Do we know which service lines are high vs. optimal?
  - Do we have an ability to ration care (through benefit, network, pre-authorization rules)?

• **Mix Risk**
  - Can we/ will we implement policies forcing our providers to practice as we see fit?
Ameliorating the Risk

• For each area of expense, set up a green/yellow/red grid showing level of importance/ level of control

• For each ‘yellow’ or ‘red’ item, you must have a plan B, or how you’ll manage around them

• Example – if we have no control of neurosurgical expense, we may sub-capitate that population to a specialty group.

• Example – if we have no transplant capabilities, we may carve those services out of the ‘at risk’ dollars entirely

• Under no circumstances do we accept risk for a yellow or red item without a Plan B
Humana MA HMO example