

PAYOR GLUE FOR VIRTUAL MEDICAL HOMES: INSURANCE STRATEGIES

By
Sandy Berkowitz, RN, JD
Willis Health Care Practice

Patient-centered medical homes (PCMHs or medical homes) are definitely the future, if not already the present, of health care redesign. They are the critical primary care front door of the Accountable Care Organization (ACO). Under the 2010 Patient Protection and Affordable Care Act (PPACA), partnering with medical homes is identified as a performance indicator for health plans that will be encouraged by the state health insurance exchanges. So what are medical homes and how might they affect a health plan's risk management thinking?

WHAT IS A MEDICAL HOME?

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967. In 2006, it was used in pilot programs for Medicare enrollees. The medical home's alluring potential to improve population-based outcomes and reduce long-term health care costs is supported in the 2010 PPACA, with new pilot program funding.

The medical home is a way of organizing primary care so that patients receive care that is: 1) coordinated by a primary care provider (PCP), 2) supported by information technologies for self-care management, 3) delivered by a multi-disciplinary team of allied health professionals and 4) committed to evidence-based practice guidelines. The goal of the PCMH is to deliver continuous, accessible, high-quality, patient-oriented primary care.¹

Why is the medical home so critical to the redesign of care delivery? Deloitte 2010 describes the PCMH as an "innovative model of primary care delivery that espouses coordination of care as a necessary



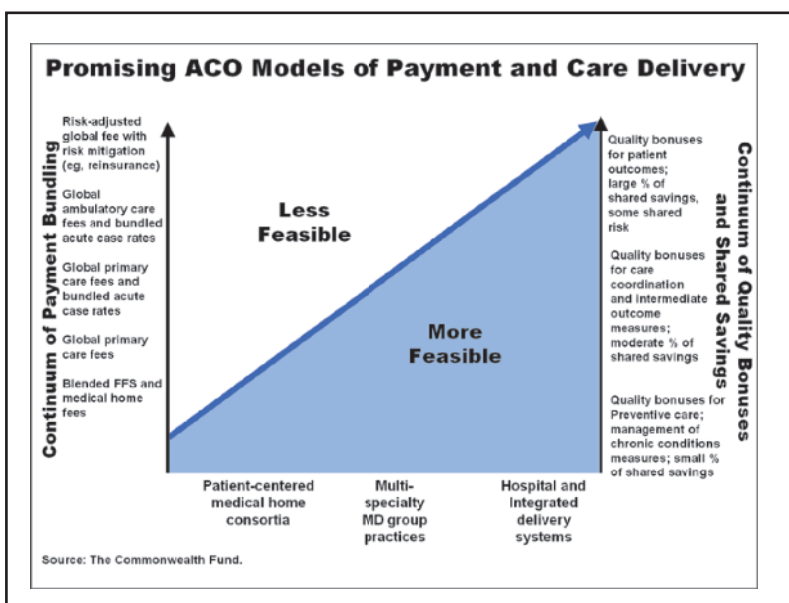
replacement for volume-based incentives that limit PCP effectiveness...and widely touted as a means of reducing long-term care costs associated with chronic diseases.”² The critical subtext of this sentence comprises these realities:

- A growing shortage of primary care physicians
- Fee-for-service (FFS) payment methodology that rewards volume without regard to outcomes
- 30+ million new insured persons entering our delivery system in 2014, many of whom present multiple, chronic and costly diseases
- These new insureds (and many of the currently insured population) are in need of accessible and ongoing treatment
- Over time, this treatment will cost less if we can build in accountability for clinical outcomes driven by patient-centered care plans

CHANGING PAYMENT METHODOLOGIES

The Commonwealth Fund Blog September 2010, expressing a widely shared view, promotes payment reform as key to PCMH sustainability.³ Most health insurers engaged in primary care redesign have adopted a three-part payment model:

1. Fee-for-service (FFS) payments
2. Fixed monthly case management fees per member (see left side of graph)
3. Potential bonuses based on clinical outcomes, characterized as **performance risk** (right side)



As the PCMH matures, it will likely take on global primary care fees (which the health plan sets based on the population assigned the PCMH). Factoring in acute care cost, accountability begins to resemble **insurance risk-taking** because the PCMH is exposed for services it does not control (left side). An important question for the PCMH taking global primary care fees is whether they are at risk for services delivered outside the medical home, including emergency room costs.

IDENTIFYING PCMH RISKS: ORGANIZATIONAL FORM MATTERS IN RISK ASSESSMENT

Medical homes are primary care delivery teams, made up of direct service providers who may be connected:

- Virtually (e.g., Community Care of North Carolina’s regional networks)⁴ or
- As employees of one legal entity (e.g., Kaiser model or a primary care practice that is freestanding or a subset of a multi-specialty practice)

A Harvard Medical School 2010 study of seven successful pilot sites, cited in Deloitte’s Medical Homes 2.0, listed these common elements, regardless of organizational form:

- Dedicated care managers
- Expanded access to health practitioners
- Data-driven analytic tools
- New incentives

These success elements present operational exposures common to *all* PCMH delivery models, including:

- Practice management
- Care management, demand management and utilization review
- Outcomes (mis)representation to enhance bonus revenue
- Financial incentive (bonus) distribution
- Performance of direct professional services: medical services, chronic disease management, counseling, nutritional counseling, health promotion, health fair screenings, home care
- New credentialing practices and ambiguity as to what standard of care a non-physician team leader – and team – will be held (NCQA Certification Standards 2011 defines PCMH Team leader as a physician, nurse practitioner or physician assistant)
- Network security and privacy violations
- Personal auto use at work by providers

Furthermore, while clinically integrated “virtual” PCMHs can negotiate and distribute fees to independent providers for antitrust, anti-kickback and self-referral purposes, they are not legally integrated and their ambiguous joint liability status creates additional risk. Does a “captain of the ship” doctrine apply when the treatment team’s care decisions are consensus-driven?⁵ Is the PCP standard of



care different for a nurse practitioner than for a physician team leader? Publicly, policy makers balance anti-kickback, self-referral, fraud and anti-trust violations against the promissory benefits of clinical cooperation. Privately, medical home sponsors may worry about old-fashioned finger pointing among PCMH team members.

RISK FINANCING SOLUTIONS

“Virtual” PCMH risks seem familiar and suggest group insurance program designs ranging from sponsored commercial insurance programs to group captives for both third-party professional liability and first-party capitation risks.⁶

Provider Excess of Loss (provider excess) is a line of coverage that emerged in the 1980s to protect providers entering into capitation contracts against medical loss cost risk (insurance risk) – but it was not enough to keep many groups from adverse selection, undercapitalization and financial impairment. Provider excess will return for those providers, including medical home providers, who want more upside potential than the modest upside “shared savings” CMS offers. Just as performance risk will belong to the PCMH team accountable for improving the health outcomes of the population assigned to it, ultimately the insurance risk for a population can migrate to the virtual PCMH and its ACO neighborhood delivery systems. If the PCMHs are joined in a legitimate captive insurance company, then “unrelated” (virtually integrated) parties can manage risk together – a group insurance solution. But for now, health insurers are not

ceding the insurance risk. Jeffrey Kang, M.D., chief medical officer of Cigna, puts it this way in an interview published on the Corporate Research Group blog:⁷

“...reform legislation is ‘completely silent’ on shifting provider payments from fee-for-service to fee-for-results. This is a big opportunity for health plans to innovate in the area of reform...Despite all the talk about medical homes and accountable care organizations, payment reform really boils down to incentives and measurements...Incentives should be around pay-for-performance, not for shared insurance risk...”

“We as health plans are better off continuing to hold that insurance risk because we have the actuaries and the capital...Health plans can then focus on really trying to create payment methods that give people incentives to improve quality, lower cost or penalties if they miss these targets.”

Bottom line: transfer of insurance risk to providers, including patient-centered medical homes, is being, and will continue to be, slowed by long memories and by health plans staking out insurance risk as theirs – until plans see their margins eroding by Medical Loss Ratio regulation or, dynamics on the provider side demand change. In other words, the insurance risk financing vehicle is on standby for pooling capitation risk among virtually integrated providers, but MLR pressure to fix medical costs may transform plan thinking once they evaluate 2012 performance.

“NO FINGER-POINTING” SAVES MONEY, CREATES “GLUE”

Can professional liability joint defense (channeling) programs benefit virtual medical homes?⁸ Our insurance toolbox contains a range of professional liability group solutions, depending on the mutual vision – and trust – between a health plan and its provider network. The boldest and also most common in the provider malpractice world since the malpractice crisis of the mid 70s, is the

use of a captive as an alternative financing vehicle to commercial insurance. Here, a group captive serves as a financial integration vehicle (i.e., “the glue”), in part capitalized by the health plan in an echo of 1990s’ hospitals capitalizing risk vehicles to hold tight their attending, but not employed, physicians. This **first** option could sit in a segregated “cell” within a captive already established by a sponsoring health insurer. The **second** option is less bold but also a 1990s echo: the health insurer sponsors (and the medical home providers pay premium to) a commercial group program to compensate members harmed by the virtual medical home’s joint managed care errors and omissions and medical professional liability exposures. A **third** familiar design is a sponsored excess and difference-in-conditions (DIC) program that sits over individual primary program limits so that the professional liability coverage is broadened to include such managed care activities as care management and utilization review, credentialing and direct medical services for both bodily and purely economic injury – even if not covered by the individual provider’s primary policies.⁹

Why the focus on broadened group protection? Because:

- Direct service providers’ professional liability policies are NOT currently broad enough to cover:
 - Claims for injury with no “medical incident” trigger
 - Regulatory claims and private actions alleging economic injury, such as anti-kickback, antitrust violations and unfair business practices
- PCMHs will be bound to both Medicaid and Medicare health plans that in turn are caught between rising medical costs and shrinking government reimbursements. We see why health plans might consider a professional liability/managed care errors and omissions channeling program – as some hospitals do for voluntary medical staff. But unlike the hospital sponsored captive offerings, the plan can also reinsure the medical homes for provider-assumed medical loss cost (insurance risk) excess of negotiated provider risk corridors. Why go to the trouble of helping the medical homes **collectively** take medical loss cost risk? The use of a captive creates a focal point that makes medical cost control for the plan’s entire medical home (or ACO) membership – not just one PCMH’s population – a transparent and shared endeavor among all the health plan’s medical homes. The captive, as an insurance company, forces the accumulation of surplus in proportion to the insurance risk assumed by the provider policy holders. And the captive legitimately takes the risk of some negative medical loss cost trend off the plan’s books, preserving plan capital.

Short term, plans may want to ensure treating medical home professional liability exposures in an insured group program structure, with group-imposed risk management measures. Longer term we see group programs’ potential to expand beyond the financing of third-party liabilities to smooth capitation risk’s medical loss cost volatility. Enlarging the risk pool – and enforcing risk mitigation strategies that control unnecessary utilization of acute services – is Insurance 101 in support of bending the health care cost curve.



MEDICAL HOMES ARE NOW

Many medical homes are in pilot project status and are listed at www.pcpcc.net, the website of the Patient-Centered Primary Care Collaborative, a Fortune 500 employer, provider and multi-payer-sponsored coalition promoting an integrated approach to chronic disease management of populations as well as individuals. A sampling of the risk managers at health plans hosting medical homes reveals that these risk managers are often unaware of their organizations' sponsorship of this evolution in primary care delivery. This suggests that the health plan risk manager needs to amp up his/her office's scan of environmental business risk, analyze post-reform change in the host organization's operational exposure, consider the implications for the plan's own insurance program, then support business strategies with insurance solutions: here, the strategic question is the health insurer's appetite to sponsor a network-wide virtual medical home (or ACO) group program that increases the virtually integrated providers' opportunity to succeed.

The potential savings are not insignificant. In the Hospital Professional Liability world the estimate of savings available by using a joint defense starts at 20% of the total defense costs. The result of shared risk mitigation incentives and control of finger-pointing through joint defense provisions in professional liability claims will inevitably emerge in the drive toward clinical integration. Once providers see that their power of collaboration in defending liability claims produces both synergy and cost reductions, the quest for other risks that benefit from collaboration begins.

Our recommendations to health plan risk managers:

- Be certain to plug into operational changes in your organization resulting from PPACA, including the sponsorship of virtual medical homes
- Be proactive in recognizing the new risks – and also the new opportunities – that emerge as providers partner with plans to control costs
- Recognize that sponsored insurance programs for third parties, whose success is critical to your success, are not new, just new for you (and new to every other health insurer)
- Crawl/walk/run: Research your plan's appetite for DIC/sponsored commercial group program/captive strategies, starting with the most conservative options first

True, providers have historically rejected liability programs sponsored by plans. You won't know if post-reform change is truly afoot unless you, the risk manager, take the risk of asking how health plan insurance strategies can support business necessities. We think the times they are a'changin'.



Short term, plans may want to ensure treating medical home professional liability exposures in an insured group program structure, with group-imposed risk management measures. Longer term we see group programs' potential to expand beyond the financing of third-party liabilities to smooth capitation risk's medical loss cost volatility. Enlarging the risk pool - and enforcing risk mitigation strategies that control unnecessary utilization of acute services - is Insurance 101 in support of bending the health care cost curve.

COMMONWEALTH FUND BLOG 2010 ON PAYMENT METHODOLOGIES

Global primary care fee is in lieu of fee-for-service compensation. Such a global primary care fee would need to be risk-adjusted for the patient population served by the PCMH.

Global ambulatory care fees covering both primary and ambulatory specialist care, as well as bundled fees (*bundled payment is a single payment for clinically related services, also known as an episode of care payment*) for inpatient physician services, would be particularly suitable for multispecialty physician group practices. *(Parenthetical material not in original.)*

With the right partnership with other providers or payers, such practices also might accept a **bundled case rate for hospital and post-hospital acute care**. For example, Medicare could continue to pay hospitals and post-acute care facilities under its current rules and deduct those payments from the bundled acute case rate paid to the group practice. **With reinsurance or stop-loss** provisions, this approach would eliminate major downside risks for the practice.

Large hospital systems or integrated delivery systems with their own dedicated physician group practice or employed physicians might be willing to enter into **risk-adjusted global fees (or capitation)**, if they have the necessary risk-mitigation support from Medicare and Medicaid claims payment for services provided outside of the system.

¹ Deloitte 2010, Medical Home 2.0: The Present, The Future

² Ibid

³ Davis and Shoenbaum, Toward High Performance Accountable Care: Promise and Pitfalls, Commonwealth Fund blog, September 14, 2010

⁴ <http://www.ama-assn.org/amednews/2010/08/02/gvsa0802.htm>

⁵ Statements of Antitrust Enforcement Policy by the FTC and the U.S. Department of Justice, State 8, <http://www.ftc.gov/reports/hlth3s.htm#8>

⁶ **Captive insurance** companies are **insurance** companies established with the specific objective of financing risks emanating from their parent group or groups, but they sometimes also insure risks of the group's customers as well. Using a captive insurer is a **risk management** technique by which a business forms its own insurance company subsidiary to finance its retained losses in a formal structure. http://en.wikipedia.org/wiki/Captive_insurance

⁷ <http://blog.corporateresearchgroup.com/2010/04/20/the-way-forward-for%20health-plans>

⁸ **Channeling** A hospital insurance program that provides medical professional liability insurance coverage to nonemployed hospital physicians. The objective of this means of insurance coverage is to increase the number of patients being admitted to the hospital by tying staff physicians to that particular hospital through this insurance plan. This insurance strategy could lead to lower premiums resulting from loss control programs and joint legal liability defense programs. (The hospital and physician jointly defend against a patient's liability claim rather than each party retaining an attorney, which would increase expenses and develop an adversarial relationship between hospital and physician.) This program can be implemented through a joint hospital and physician program insuring both hospital and physician under the same insurance policy or the hospital can purchase a separate insurance policy for the physician. Barron's Insurance Dictionary, cited at <http://www.answers.com/topic/channeling>

⁹ DIC insurance provides coverage designed to close specific gaps in standard insurance policies and is usually available only for larger industrial or commercial risks. It allows coverage to be customized..., according to the insured's needs. DIC coverage may be provided by means of a separate insurance policy or it may be added by endorsement to the basic policy. <http://www.coverageglossary.com/explanations/dic.htm>

CONTACTS

For further information, please visit our **website** on **willis.com** or contact any of the following:

Mary S. Botkin
Practice Leader
Houston, TX
713 625 1146
mary.botkin@willis.com

Jacqueline Bezaire
Los Angeles, CA
213 607 6343
jacqueline.bezaire@willis.com

Frank Castro
Los Angeles, CA
213 607 6304
frank.castro@willis.com

Ken Felton
Hartford, CT
860 756 7338
kenneth.felton@willis.com

Deana Allen
Atlanta, GA
404 302 3807
deana.allen@willis.com

Pamela Haughawout
Chicago, IL
312 288 7394
pam.haughawout@willis.com

Neil Morrell
Chicago, IL
312 288 7478
neil.morrell@willis.com

Sandy Berkowitz
Malvern, PA
215 498 6594
sandy.berkowitz@willis.com

Paul A. Greve, Jr.
Nashville, TN
615 872 3320
paul.greve@willis.com

Brad Norrick
London
44 203 124 6738
brad.norrick@willis.com

The observations, comments and suggestions we have made in this report are advisory and are not intended nor should they be taken as medical/legal advice. Please contact your own medical/legal adviser for an analysis of your specific facts and circumstances.