

Why Provider Organizations Should be a Proponent of Capitation

by

Russell Foster*

Senior Advisor, Mazars USA LLP

Sheila Stephens

Senior Advisor, Mazars USA LLP

Stephen Wilson

Director, Mazars USA LLP

Shawn Dunphy

Senior Manager, Mazars USA LLP

** corresponding author*

For the past 35+ years, we have been actively involved in the development, implementation, and operation of health care organizations that have received compensation for services rendered on a prepaid, capitated basis. As more and more health care organizations embrace the Triple Aim and payors coalesce around provider organizations that are capable of accepting greater levels of professional and institutional risk, the question remains: “Should provider organizations be proponents of capitation?” How does one assess whether or not capitation can work and, if so, what are the drivers of success that need to be understood and internalized?

Many organizations have performed exceedingly well under capitation while others have failed. Why is it that some organizations thrive when it comes to providing health care services on a capitated basis while others struggle to deliver on quality and cost? The reason(s) why some organizations succeed while others fail are often not easy to explain; it is complicated and often requires a deeper dive into the organization and its structure to find the answers. However, there are common themes at the root of most successes or failures relative to capitated agreements.

First things first – start with the definition of capitation. “Capitation” is 1) the payment of a fixed per member per month (“pmpm”) amount, 2) as payment in full, 3) for a given month of service, 4) for a defined population of eligible members, 5) for the provision of a defined range of services. Capitation is often referred to as a “budget-based” or “value-based” payment methodology or model. Regardless of what you call it, the inference is the same, i.e., it is a fixed amount of money that must be managed well to ensure the timely provision of high quality and cost-effective health care services and provide for a reasonable margin.

There are many places around the country where capitated arrangements exist and there are many different variations of the capitation model in play, depending on the level of sophistication of the provider organizations assuming risk. There are also places around the country that are still being paid solely on a volume-based, fee-for-service (“FFS”) basis where providers are not accepting any risk: some out of fear, some because the impetus for change has not arrived and others because they lack the necessary knowledge, expertise and administrative infrastructure needed to provide high quality, efficient, cost-effective services in a capitated environment. In some instances, health plans are generating significant margins annually under the existing FFS structure, which makes the transition to capitation less attractive to them at present.

Although there are many different payment models in existence, some of the most common models include (a) Budget-Based: incentive only, no downside risk; (b) Budget-Based: shared risk and incentives; (c) Full Professional Risk: with or without institutional shared risk, and; (d) Full/Dual Risk and Global Risk. A brief overview of each model follows:

Budget-Based: Incentive Only

This contracting method is used when a payor desires to begin a gradual transition of a provider organization from FFS to capitation. In the early going, for the first year or two, the focus is operating within a pre-determined budget goal that is established by the payor, with monthly or quarterly monitoring of positive and negative variances. This model may start with a capitation payment to the Primary Care Physicians (“PCPs”) and may include some minimal sharing of utilization and case management duties and responsibilities. In this model, the provider receives a small administrative allocation on a pmpm basis so that they can start developing their administrative structures, hire staff, and take initial steps toward the monitoring of quality and cost. Also in this model, the payor: processes and pays the claims and PCP capitation; performs most Utilization Management (“UM”), Case Management (“CM”), and Quality Management (“QM”) functions and; generates the utilization and cost reporting, including production of the year-end financial statement as well as PCP and specialty performance report cards, if any.

Budget-Based: Shared Risk and Incentives

In the Budget-Based Shared Risk and Incentives model, a payor and provider have agreed to share both gains and losses up to a pre-determined level (e.g., not to exceed some pmpm amount, percentage of revenue, or percentage of gain or loss). Similar to the Budget Based Incentive Only model explained above, in the Shared Risk and Incentives model the payor usually processes and pays claims and PCP capitation payments, performs most UM, CM, and QM functions and produces all utilization and cost reporting, including production of any year-end settlement statements, PCP and specialty performance report cards and other forms of reporting. In this model, however, the provider organization will take a more active role in the UM and CM processes and, in turn, may receive a higher administrative fee to help cover costs.

Full Professional Risk: With or Without Institutional Shared Risk and Incentives

Full Professional Risk may be used when a provider organization has reached a level of sophistication and financial capacity to justify assumption of full risk for all professional services. Although full risk agreements can and often do exclude, i.e., carve-out, certain high cost services (e.g., out of area emergencies, high cost injectables, and certain transplants), the provider organization is at-risk for all losses incurred in the contract year.

In some states that have adopted the model of full delegation of risk and administrative services (e.g., credentialing, claims and capitation payments, UM and CM, provider relations services, contracting, finance, accounting and related services), the provider organization will either develop its own administrative infrastructure or outsource the delegated functions to a professional Management Services Organization (“MSO”) to be performed on its behalf. In other states, where

full delegation has not yet occurred, the payor's infrastructure is used by the provider and the provider pays the payor a management fee as a percentage of its professional capitation for those services. Depending on the specifics of the arrangement, reporting functions may be the sole responsibility of the provider organization, or may be shared with the payor.

In the Full Professional Risk model, payors and providers often enter into a separate shared risk/incentives agreement in which each party shares in the gains and losses associated with the provision of all or some institutional services (e.g., hospital inpatient and outpatient, skilled nursing facility, home health, durable medical equipment, ambulance and other carve-out services). Provider organizations that enter into shared risk arrangements are typically those with significant financial reserves that are able to cover their share of losses in down years. The assumption of institutional risk by provider organizations, in some instances, can trigger significant State licensing requirements or, at the very least, regulators can limit the risk being assumed based on the provider's financial viability to assume risk.

Dual Risk

The Dual Risk contracting method may be used when a provider organization and hospital partner together and enter into separate risk agreements to accept full professional and institutional risk, i.e., dual risk. Most often under a dual risk model, there is a shared risk incentive agreement between the provider organization and hospital to share gains and losses in the institutional risk pool. Dual Risk agreements most often include delegation of all or most administrative services, including processing of claims and capitation payments, UM and CM services, provider relations services and contracting, certain member services, finance and accounting and related functions. Reporting obligations are typically shared by the organizations.

Global Risk

Global Risk may be used when a provider organization enters into a risk agreement with a payor/Plan Partner whereby the provider organization accepts full professional and institutional, or global, risk. In this instance, the payor's hospital partner would remain on a diagnosis-related group, fixed per diem, or another discounted payment methodology and typically enter into an institutional shared risk-incentive pool agreement with the provider organization. Similar to the other full risk models, the Global Risk provider would also be fully delegated for all administrative services.

Global and dual Risk agreements exist in several markets around the country and are most prevalent with larger health systems or provider organizations that possess state licensure to operate on the same level as a health plan but that are not fully licensed as a health plan.

Capitation Support of the Triple Aim

For those organizations that believe in and support the Triple Aim—i.e. they are committed to (a) improvement in the health of populations, (b) enhancement in the individual experience of health care and (c) reductions in per capita costs—capitation supports these goals in several ways through: 1) continuous quality improvement and operational efficiency; 2) identification and assessment of health risks across the entire population of assigned members; 3) innovation and improvement in the delivery of health care services; 4) identification and management of marginal/poor performers; 5) reimbursement and incentive models that help promote appropriate utilization and costs; (6) detailed budgeting and variance analysis, monitoring and analysis of utilization and cost data, provider sub-capitation, and improved trend analysis and forecasting and; (7) increased member satisfaction.

To be successful, provider organizations must understand and embrace the Triple Aim, as well as *Live It, Sell It, Love It*, and do it all over again. In other words, it must become a way of life and not just another line of business.

Why Does Capitation Work for Some and Not Others?

While not every experience is the same, there are several reasons why providers often fail at capitation. The following are just a few of the most common reasons worthy of mention:

- *When provider organizations enter into a risk relationship, they often jump in too soon, without sufficient financial reserves, and without sufficient knowledge and expertise or advance planning to help improve their chances for success. To combat this deficiency, provider organizations must invest in data and data integrity, as well as the required organizational education to ensure thorough understanding and the import of the relationship of data management and effective management of risk.*
- *When the senior leadership of a provider organization accepts a capitation agreement but is happy with the status quo, they are typically unwilling to make the cultural shift from FFS to capitation that is necessary succeed. While younger physicians are more apt to embrace the change, older physicians may not be as willing to make the change and typically just want to “stay the course” until they retire. This typically requires extensive provider education, both initially and ongoing.*

- *When senior leadership sees the need and embraces capitation, but are unwilling to make the necessary infrastructure improvements to manage risk successfully, success is rare. The capitation model requires investment in systems and talent.*

- *If senior leadership is more concerned about preserving relationships and keeping their colleagues happy rather than confronting marginal/poor performers and focusing on improving quality and reducing cost, the capitation model will flounder. This model requires the ability to redirect referral patterns and establish, monitor, and report on agreed upon performance measures and benchmarks.*

- *This model is not productive if senior leadership does not establish and support the integral working relationship between quality and payment, which requires commitment to standards of practice or medical guidelines, performance measures, monitoring and reporting.*

- *The capitation model will not be beneficial if senior leadership of the provider organization does not deploy mechanisms to ensure accurate encounter data. Capitation does not require a “claim” for the provider to be paid; therefore, the submission of encounter information is critical as it is essential to managing capitation, provider performance, and the ability to collect and report specific and required elements for both the risk-bearing provider and health plan.*

Why be a Proponent of Capitation?

Those provider organizations that have made the cultural shift to capitation, or have embraced the need for change and are planning to move forward, capitation makes sense from several perspectives. A few of the advantages of making the switch include:

- *Capitation payments are predictable, paid monthly (usually by the 15th of the month), and help cash flow management.*

- *Accepting capitation can incentivize health plans to steer membership toward capitated networks, especially toward the dual risk and global risk networks, which increases membership and revenue growth.*

- *Local health care delivery and decision-making results in higher quality and improved member satisfaction.*

- *Local decision-making also results in greater physician satisfaction because physicians are more vested in the delivery system and are able to get answers to their claims inquiries, feedback on utilization decisions and resolution of disputes on a more timely and individual basis.*

- *Profits generated from the efficient and cost-effective delivery of health care services are retained at the local level, not shared with the health plans.*

- *Provider organizations that have made/are moving to embrace capitation position themselves to be the future of health care in this country. They will figure out how to make it work and become the market leaders of the future; it is time to lead or follow, your choice.*

Should Your Organization Choose to Embrace Capitation?

There is little doubt that risk-based contracting, *vis-a-vis* capitation or some other value-based model, is here to stay and already is the preferred care delivery model throughout the country. FFS as a preferred compensation model has actually been dying for many years, but the resuscitation effort continues in many places around the country.

While there are pockets of resistance around the country, continuing pressure from employers; government, including the Centers for Medicare and Medicaid Services (“CMS”); and health plans, which are all committed to the Triple Aim, will affect every provider regardless of location or readiness. Failure to successfully transition will have consequences far beyond the investments that need to be made to embrace it now. For many, holding on to the status quo will adversely impact the ability to compete and stay in business. Timing is everything, and now is the time to make the necessary investments to stay competitive.

As with every great endeavor, it takes time to establish the necessary systems and structures, and to learn how to manage capitation successfully, including implementing mechanisms to bring provider networks into compliance. Change starts with the first step, so it is best to step up and start now.

Where to start? It all begins with the Board of Directors and senior management team making the commitment to move toward risk-based contracting and learning this model of business. Embrace the change and start making the incremental changes that are needed, including development of a solid business plan that outlines goals, strategies, milestones and the willingness to work with health plans to develop mutually beneficial partnerships. Execute the business plan and ensure that the systems and structures are in place to support the success of that plan. Be prepared to manage dynamic and interlinking processes that require a focus on quality measures and outcomes, UM, data management, compliance with regulations, and fulfilling and monitoring contractual obligations.

Finally, choose wisely when developing or selecting medical guidelines, information and data retrieval systems, and staff. If a few senior leaders are standing in the way of needed change, consider asking them to step aside to ensure the success of the organization for the long term. Most importantly, a quality provider organization with solid leadership and a commitment to success has nothing to fear with capitation.

As Nike tells us, “Just Do It” and do not look back!

Additional Author Information:

Russ Foster can be reached at Russ.Foster@mazarsusa.com

Sheila Stephens can be reached at Sheila.Stephens@mazarsusa.com

Stephen Wilson can be reached at Stephen.Wilson@mazarsusa.com

Shawn Dunphy can be reached at Shawn.Dunphy@mazarsusa.com