

# Capitation: Prepare For the Knock on the Door

**R**eforms in the nation's healthcare system are raising the pressure on managed care plans to capitate payments to physicians and hospitals, said David N. Schopp at the seminar "Understanding Capitation and Risk Sharing," held following the Catholic Health Assembly (pp. 33-59).

Insurance reforms, Schopp explained, will prevent a plan from using experience rating—that is, raising premiums when an employers' healthcare costs go up. Capitation shifts service and financial risks to the providers and aligns incentives of all parties in a health plan. Also, as health maintenance organizations (HMOs) get into Medicare risk contracting (and many are exploring this), they will often capitate the providers, said Schopp, who is the executive director of the Catholic Managed Care Consortium (CMCC), St. Louis, which cosponsored the seminar with the Catholic Health Association.

Schopp said CMCC is developing 10 to 15 indicators that providers can use to determine when capitation will have a significant impact in a particular community. But regardless of whether capitation seems imminent, providers should prepare now, according to seminar speakers, because it can happen quickly. Capitation is attractive to health plans and networks because it reduces incentives for overutilization of healthcare services.

## WHAT IS CAPITATION?

Capitation is a method of payment in which a provider is paid for services on a per member per month (PMPM) basis, receiving the same amount of money each month for a member regardless of whether the member receives services and regardless of the cost of services.

John L. Wolf, a consultant with CMCC, illustrated the part purchasers (generally employers), health plans, and providers (physicians and hospitals) have played in the evolution of capitation, in which the health plan pays the providers on a capitated basis.



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## HOW IS CAPITATION STRUCTURED?

Among the common capitation methods, Wolf explained, the simplest is for the health plan to pay the provider a flat PMPM rate. For example, the hospital might receive \$30 per month for a commercial member and \$150 for a Medicare member. This method works best, he said, when more sophisticated calculations are unnecessary because the patient mix and experience have been stable for some time.

A second method, the percentage-of-premium method, provides more protection to the payer, Wolf said, but the payment to the provider fluctuates with premium changes. Providers need to understand the plan's marketing and pricing strategies to be sure the mix of patients it is attracting does not increase the amount of risk that providers originally agreed to accept.

In the third method, in which the PMPM payment is age- and sex-adjusted, the provider must also be aware of the kind of patients the health plan attracts, Wolf cautioned.

## HOW ARE CAPITATION AGREEMENTS DEVELOPED?

Ideally, the health plan's budgeted revenue should be equal to the income it receives from premiums, but this is rarely the case, according to Wolf. An imbalance can occur when:

- Provider contracts do not coincide with group renewals.
- Regulatory requirements, such as reserve requirements or premium taxes, are not taken into account.
- Market competition forces lower premiums.
- Organizational goals are inconsistent—for example, shareholders in a publicly held company expect an unanticipated rate of return.

In developing a capitation contract, providers need to understand the payer's perspective, Wolf said. Payers base payments to providers on the medical budget, which is calculated after deducting a portion of the premium for administrative costs.

Two factors drive the premium—the plan's

membership and the benefits it covers—so Wolf advised providers to be sure the plan's capitation rates are appropriate for the population served.

As never before, capitation challenges providers to know the costs of the services they provide. These costs, he warned, determine the rate providers must require the health plan to pay them. For primary care physicians, this means estimating enrollees' annual utilization rates for services such as office visits, inpatient stays, office surgery, well-child visits, and laboratory/pathology tests. The annual rates are multiplied by the unit cost of each service and divided by 12 to determine a PMPM cost.

The plan also calculates a PMPM cost for referral services provided by specialists. This cost is determined by estimating frequency and average unit cost of items such as inpatient and outpatient surgery, radiology, maternity services, and emergency room visits.

Hospitals must determine a PMPM cost by calculating frequency and average unit cost of services such as inpatient days, emergency room visits, and outpatient tests.

Negotiations between providers and health plans begin when the payment offered does not support the provider's costs. In negotiations, Wolf advised providers to remember that the plan is negotiating from a different perspective than providers. The starting point for the plan, he noted, is the marketplace, whereas the provider is concerned with the anticipated volume and cost of services.

### HOW DO RISK-SHARING ARRANGEMENTS WORK?

The risk-sharing arrangement in the contract determines how financial results (good or bad) are apportioned among the plan and the providers. Service risks are those the provider assumes under the terms of the contract, and financial risks include the payment incentives in the contract. Unless risks are balanced for all parties, the relationship will deteriorate over time, Wolf said.

He listed the following components of equitable risk-sharing arrangements:

- Performance standards and goals
- Financial protections for physicians, hospitals, and payers
- Rewards for high-quality, efficient care

Risk-sharing arrangements spell out how pools of risk funds are established for providers. (These pools consist of a percentage of payment the plan

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withholds from physicians and returns if target costs are met.) In addition, risk-sharing arrangements answer questions about how surplus funds will be distributed among providers, how stop-loss recoveries are handled, who the risk-sharing partners are, exclusions from the capitation, and the provisions and timing of settlement.

To get a balanced contract, Wolf urged providers to ask questions, even if they do not know exactly what all the answers should be.

### HOW CAN PROVIDERS MINIMIZE RISK?

Health plans should create an actuarial model of PMPM charges at achievable target utilization rates and adjust charges for the services covered in the plan, Randall P. Herman explained. Then the average PMPM capitation rate should be compared with the PMPM charges. Periodically a plan should compare actual experience to its target utilization.

Herman, a principal with Reden & Anders, Minneapolis, advised providers to accept capitation only for services they can control. Services commonly "carved out" (exempt from capitation) include out-of-area emergency, out-of-network services in plans that allow members to use nonnetwork providers, mental health and substance abuse, and vision and dental care.

The contract should clearly define covered services, Herman said. If relying on the health plan to process claims, providers should make sure the processing system coincides with the terms of the contract. "Know how the system is interpreting what you're at risk for," Herman advised, "and maintain the right to audit what the plan is paying out."

### HOW ABOUT REWARDS FOR HIGH QUALITY?

In most capitation models, primary care physicians receive no additional compensation for providing higher levels of quality care. But David G. Foshage reported this may be changing. A few HMOs have decided to reward physicians for quality, said Foshage, senior consultant with CMCC. U.S. Healthcare, an HMO in the East, has added a "quality factor" that influences a physician's payment in addition to the traditional measures of utilization.

The HMO wants to reward physicians with a commitment to the organization and to managed care. It includes in the "quality factor" how many plan members the physician treats and the physician's cooperation with the HMO in patient

management. The factor also takes into account the physician's available office procedures, scheduled office hours, internal practice coverage for when the physician is unavailable, member opinions and transfer rates, and the percentage of patients receiving preventive care.

In this HMO, hospitals, too, get rewards for high quality. Criteria include participation in a nurse case manager program, electronic communication, participation in capitated programs such as radiology, cooperation with the HMO in patient management, member survey results, and complication rates. The HMO also adjusts payment rates on the basis of case mix and severity-adjusted length of stay, Foshage said.

#### WHAT MAKES A GOOD INFORMATION SYSTEM?

When Foshage asked the 140-member audience if their current information system would support their needs in a capitated environment, only two people answered yes. Unsurprised, Foshage advised participants to work toward getting information systems with the same capabilities as those of insurance companies and managed care plans. He pointed out that the hospital may not be the appropriate organization to acquire and operate the information system. Rather, a healthcare system, physician-hospital organization, or community-based network might run the system.

Essentially, he said, the system must answer the questions, Who do we get paid for? and, Did we

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get paid the right amount? (see **Box**). Documenting and reporting patient encounters and service utilization is one of the most important tasks, he said, because it enables hospitals to identify efficient providers and variance in medical practices. "You can't make decisions without these data," Foshage insisted. "Reporting patient encounters and utilization of referral and hospital services is the basis for all cost-reduction efforts.

"I haven't yet seen one system that can do all of this" he continued. "For a while we'll be cobbling together systems with different capabilities."

#### HOW DO YOU SPELL SUCCESS? H-E-A-L-T-H

A mind-set that focuses on keeping people healthy is the key to success for providers, Foshage said. That means thinking about people beyond the walls of the hospital and providing alternatives to inpatient care, he said. Hospitals have been focusing on treating patients efficiently once they walk in the door, but under capitation providers are "at risk for patients' health" and have a stake in keeping them healthy so they need fewer, not more, services. "The Catholic healthcare mission really fits with capitation," he said.

The focus on health means redirecting capital investments away from new beds, expensive hospital renovations, and high-tech equipment, Foshage added. Instead, he recommended investing in physician organizations, information systems, vertical integration, and medical office buildings for primary care physicians.

Resources should also be directed to discharge planning and case management, he said. "We don't do as much as we need to on the social side," he said, such as building support structures for patients so they can be discharged earlier.

Preparation and planning, especially assessing where the providers and the community stand on the continuum from fee-for-service to capitation, are essential to success. "The worst time to learn to do this is the day a health plan knocks at your door and you don't know if you and your community are ready," Foshage warned.

—Judy Cassidy

## INFORMATION SYSTEM REQUIREMENTS

David G. Foshage, senior consultant with Catholic Managed Care Consortium, noted that an effective information system for managed care must be able to:

- Identify enrolled individuals and determine these members' eligibility and benefits
- Make payments to subcontracting hospitals, physicians, and ancillary providers (who may be paid by capitation; by fee schedule; by per diem; or by usual, customary, and reasonable charges)
  - Track admission and referral authorization
  - Document and report utilization review and quality assurance activity
  - Administer risk-sharing arrangements by calculating risk pool surpluses or deficits and calculating the amount of withheld funds (withholds) to be returned to individual providers
  - Identify and track stop-loss data
  - Flag noncovered services
  - Document and report patient encounters and service utilization

For more information, contact David Schopp at PO Box 45998, St. Louis, MO, 63145 (314-253-6874). CHA members will receive A Workbook for Understanding Capitation, developed by CHA and the Catholic Managed Care Consortium, later this summer. For more information on CMCC, see Health Progress, December 1993, p. 70.