Let us start by stating emphatically that capitation is here to stay. We believe capitation will continue to grow, and ultimately, become the predominate means by which provider organizations and physicians are paid. Not only does the capitation payment methodology make good business sense, it is the only effective means by which insurers can ever hope to provide a comprehensive range of high quality and cost-effective health care services to their enrollees.

We have been in the health care business for nearly 30 years and business partners for the last 10 years. In that time, we have seen the managed care business model evolve through the various stages of its life cycle to what it is today – a business model and payment strategy in a state of transition. Managed care and capitation have experienced their share of difficulties. There are many who vehemently disagree with the concept and think that capitation is, at best, unfair and, at worst, a perverse and complex strategy that should be eliminated in favor of a less complex and more acceptable fee-for-service system.

Many of the skeptics believe that a single payor system is the answer. They say that, if we would only dismantle the managed care system and do away with capitation and other perverse cost containment payment strategies, then more money could be re-directed from overhead to patient care to help cover the cost of new technology, expanded benefits and the increasing needs of an aging population. Those who advocate the systematic dismantling of managed care and capitation view fee-for-service medicine as the preferred payment choice and the only rational payment option for the future. We firmly disagree on a number of fronts.

In the following discussion, we will take a hard look at capitation and the core issues surrounding it. We will also tell you why capitation is not going to die and challenge you to get ready for another round of capitation and aggressive cost containment measures.

**What is Capitation and How Does it Work?**

For this discussion let’s start with a simple definition of capitation:

Capitation: “a periodic prepayment amount for the provision of a defined range of health care services to a defined population of eligible members.”

Capitation is a financial payment system that appropriately reimburses providers based upon an economic model that provides a fixed level of reimbursement. This is a proven concept for many larger groups with extensive cost control measures in place. However, accepting a fixed fee from a health plan and paying fee-for-service to providers
without controls is a sure method to fail. It is only logical when revenue is finite, that health care expenses must be controlled and predictable. Many provider organizations have failed simply because they agreed to accept a fixed rate of reimbursement through the front door from health plans and then paid it all out to providers through the back door on a fee-for-service basis.

Capitation is typically paid to a risk-bearing organization (e.g. IPA, medical group or hospital) in the same month that eligible members are entitled to receive service. In most cases, health plans will pay capitation on an age/sex and copayment adjusted basis, so that capitation payments bear a direct relationship to the projected cost of care. Thus, if the eligible population is younger and copayments are higher ($10, $15, $20), capitation rates will be lower. Conversely, if the population is older and copayments are lower ($0, $5) capitation rates will be higher.

As experienced managed care professionals will attest, age/sex and copayment adjusted capitation rates do not always correlate well with costs. Acuity of care is a critical factor in the actuarial (rate setting) process. There is no substitute for a risk bearing organization knowing their cost of care and using that information in their health plan negotiations to assure that future capitation rates bear a high correlation to actual experience (after appropriate adjustments for changes in population mix, benefits, copayments, new technology and inflation).

Capitation is typically paid for commercial and Medicare Risk members on or before the fifteenth day of a given month of service. In some cases, Medicaid payments may be paid in the month subsequent to the actual month of service. Regardless of the timing of such payments, capitation is considered to be payment in full for the provision of all risk services as they are defined in the “Division of Financial Responsibility” (DOFR) exhibit of the applicable provider agreement.

In states where payors directly pay capitation to their risk bearing organizations, the risk-bearing organization typically has “fully delegated” responsibility to process and pay provider claims and sub-capitation, review and approve requests for specialty services, implement and monitor quality assurance, contract with providers, provide member services, manage MIS systems, perform accounting and statistical functions, and perform such other administrative services as set forth in the provider agreement. In other states, health plans will credit the capitation amount to a specified capitation account and process and pay claims and perform most other administrative services on behalf of the risk-bearing organization. In non-delegated or partially delegated sites, the risk-bearing organization will retain some control over the utilization management and quality assurance process, thereby allowing for the assumption of risk and the potential for incentive payments based on performance.

Advantages and Disadvantages of Capitation

There are several advantages and disadvantages of capitation. However, for this discussion, we would like to focus our attention on the following four.
One of the most fundamental reasons any person or company goes into business is to control their own destiny. With control comes the power to make the business decisions that drive the direction of the business and ultimately define its success or failure. Capitation is about power and control – the power to negotiate with health plans and other third party payors for equitable rates and delegation of administrative services; the power to set the organizations goals, objectives and budget; the power to negotiate fair and equitable agreements with providers; the power to implement its own utilization and quality management policies, procedures and standards; the power to hire and fire staff; the power to control claims data and other critical information needed to drive meaningful changes in behavior and to improve overall performance; and, the power to earn a profit for the benefit of the organization and its stakeholders.

No rational person goes into business to lose money, but many go into business unprepared and, in the process, lose everything. The risks of loss in any business venture are high (more than 70% of businesses fail in the first two years of operation). History tells us that most businesses fail because of under-capitalization, inadequate preparation and planning, ineffective leadership/management or a combination of all three. In any business, there are times when good old-fashioned luck is needed, but unfortunately luck is not a strategy and cannot be relied upon to carry a business through difficult times.

In health care enterprises, the risks are even higher because of the uncertainty associated with the health status of eligible members. The health care delivery system is also difficult to control given the significant number of providers involved in the process and the ability to maintain control over the utilization of service. Even when in-area costs are in check, out-of-network referrals and the associated loss of control over such patients in these settings can bury even the best organizations. In many cases, it is not risk that is the issue, but rather the amount and types of risk being assumed.

As we have traveled across the country and worked with many different types of risk bearing organizations, especially physician organizations, we have often found a notable lack of the following (essential) ingredients:

- Lack of a corporate mindset and strong business ethic
- Inability or unwillingness of physician Board members and medical directors to confront under-performing peers within the organization
- Lack of sufficient infrastructure to enable aggressive management of administrative processes
Lack of knowledge of the organization’s paid claims experience and the skills needed to utilize that data to negotiate appropriate rates

Inability to move quickly and decisively enough to make meaningful changes in a short period of time.

When the essential ingredients of success are missing, and the risk-bearing organization fails, capitation is often blamed (e.g. the capitation rate was too low, there was too much risk, providers failed to support the organization, membership was too low, the competition was too great, etc. etc.). Although some or all of the aforementioned conditions exist at some level within any managed care organization, the successful organization is able to recognize and act upon these issues in a timely manner and thereby can minimize the risks that cause others to fail.

Far too often, risk-bearing organizations fail because the physicians in charge try to run the organization in the same way they run their own individual practices – essentially, as a small business enterprise. Risk-bearing organizations are big business and generate millions of dollars in capitated revenues and expenses. The business principles that drive a successful physicians’ office will not work in a capitated environment. A capitated IPA/medical group will not be successful without a professional management team experienced in all aspects of managed care and capitation. It must have a dedicated and knowledgeable Board who are willing to make decisions based on what is best for the company, not necessarily what serves the best interest of any individual physician or particular group. And, there must be a strong administrative infrastructure that can deliver timely and accurate claims and sub-capitation payments, maintain positive working relationships with providers, patients, and payors; and, provide detailed analyses and information related to the organization’s ongoing performance.

Why are Patients so Dissatisfied with Capitation?

The reasons for provider and patient dissatisfaction are complicated but, in our opinion, have little to do with capitation. It is a rare occurrence indeed when a disgruntled patient is able to articulate the reason(s) that capitation is at the core of their frustration or upset. In our experience, patients say they dislike capitation because:

- PCP and other health care professionals tell them it’s bad
- Network access is more restrictive
- They believe there are more denials to specialists (than in the fee-for-service system)
- They believe that physicians are provided incentives to do less

Those of us who have spent years in the managed care business understand that patients become easily disillusioned anytime a request for service is denied or otherwise
challenged. The immediate assumption is that the plan, the IPA/medical group and/or the physician(s) are all saying “no” because such decision(s) will generate financial gain for the organizations involved, and that such decision(s) will always be to the detriment of the patient. Rarely is it understood or believed that a “no” decision may actually be the right (medical) decision and the most cost-effective financial decision may also be good care.

How many times have we seen and heard about patients who have become suspicious of capitation and lost trust in their physician because of the existence of incentive arrangements between payors and physicians. Although incentive arrangements exist in every sector of the business world, incentives offered to a health care provider to practice high quality and cost effective medicine is automatically assumed to be a conflict of interest and therefore contrary to the best interests of the patient. Although conflicts of interest or aberrant behavior will always be present at some level, the percentage of physicians operating in this manner is quite low. The majority of the providers we have been associated with over the years have continued to practice the same high quality medicine regardless of how their services were ultimately paid. Even so, how many times have we heard about the financial incentives that have accrued to providers who have performed and billed for unnecessary tests and procedures on a fee-for-service basis in order to maximize their own reimbursement. Isn’t it ironic that patients can associate those (fee-for-service) abuses with high quality service when the highest quality of all may have been to do nothing! It is the same providers who over-utilize services in a fee-for-service system that must be monitored closely in a capitated environment to assure there is not an under-utilization of medically necessary services.

Even though patients have a right to participate in the decisions affecting their own health care, care decisions must remain within the context of the benefits the health plan provides. If capitation is to succeed, provider organizations must balance the rights and coverage limitations of the patient with prudent medical decision making and network constraints, with an eye on the best outcome and quality for the patient at the most cost-effective price possible. That is good health care and good business. Leaving patients out of the decision-making process will alienate them and their providers and lead to further distrust and dissatisfaction.

The public dialogue regarding consumer directed health care should not be misinterpreted to mean an abandonment of managed care principles, including capitation as the preferred financial vehicle. The challenge has been/will be to educate patients on the impact of their health care decisions on costs and the specter of rationing (care) as a means to control costs in the future. Cost containment would not be viewed by patients as something to dislike if they could come to understand the correlation between quality of care (the best possible outcome) and cost-effective delivery of health care services. Truly, the highest quality of care is also the most cost-effective. We believe that outcomes management and capitation are compatible and need not be an either or proposition.
**Why are Providers so dissatisfied with Capitation?**

When you look at capitation from a provider’s perspective, you see a completely different set of issues. Yes, patient care issues are high on the list of physician concerns in the capitation debate. However, at the very core of the matter, providers dislike capitation because:

- Providers resent the supposition that another physician, an IPA/medical group or a utilization management company could possibly know what’s best for their patient(s).
- Providers universally believe they already provide the highest quality and most cost-effective care possible and resent being told otherwise.
- Providers do not like taking risk for the cost of services they deliver or the services they refer to other providers.
- Providers view capitation as a paperwork nightmare that only increases office overhead and reduces their reimbursement.
- Providers are not willing to confront the inappropriate behavior of their peers because it would jeopardize their relationships and potentially affect the referral of new patients in the future. In effect, it’s safer to say nothing.

As health care professionals and consultants, we have had an opportunity to deal with capitation from the perspectives of health plans, IPAs/medical groups and hospitals. There is virtually nothing we have not seen in that time. Although there is some truth to all of the arguments providers raise about capitation, the provider’s perspective is only one side of the story.

It has been well documented that health care services rendered to HMO patients have been/continues to be among the very best available anywhere. This is true notwithstanding the few high profile cases that have been sensationalized in the media in recent years. One of the reasons that quality has improved is because of the integration of utilization review and quality assurance standards and the advent of quality review organizations, the most notable being NCQA and JCAHO. The adoption of standards by oversight organizations has given health plans and risk-bearing organizations the necessary tools to manage utilization policies and impact behavior with great success.

Providers resent the fact that another person or organization will be playing an active role in how health care services are delivered to their patients. Rather than looking at these professionals and professional organizations as partners in health care, each working together to identify the most appropriate care for the patient, providers often view the outsiders as intruders and an unnecessary waste of time and money. Contrary to this view, we believe the quality of care today is higher because these processes are in place and working.
Provider’s also dislike confronting aberrant patient behavior or getting themselves into uncomfortable situations with their best patients over such things as: (a) a specialty care referral decision (b) denial of care for a service that is not medically necessary (c) dealing with the perception that more service is better quality (d) network provider limitations or (e) any number of other patient driven concerns. Instead of dealing with the issues on a one-on-one basis, providers will often blame the system, the health plan or capitation for the perceived problem. Specialists know that often the referrals they receive from primary care physicians or self-directed patients are not medically necessary, but are unwilling to confront the behavior of the physician or patient because it is not in their economic interest to do so.

It is true, in the majority of cases, that physicians are not eager to be risk-takers when it comes to their own practice and, ultimately their livelihood. Although physician decisions drive the cost of medicine, they do not like to be held accountable in a financial sense for the decisions they make. Capitation forces providers to confront their decisions and behavior as well as those of their patients. Both circumstances are equally distasteful, but necessary, if there is to be true cost-containment and patients are to have access to affordable health care in the future. Eliminating necessary controls, abandoning standards, and returning to a fee-for-service payment system is a prescription for disaster that neither educated providers or patients should want to occur.

**Is Capitation Going to Come Back Strong?**

The simple answer is that capitation is going to come back strong because it must. There is no other strategy that will work as well as capitation at controlling costs and improving quality. Consumer-driven health care, single payor systems and other fee-for-service payment options currently available (e.g. HMO, PPO, EPO, self-funded) do not align provider incentives nor link quality outcomes with cost containment. Capitation does both and will therefore prevail.

What are the signs that capitation is going to come back stronger than ever in the future? Consider the following:

- Health plans and other payors want to pass risk to organizations that have the structure and business expertise to make it work. Managed care organizations that can demonstrate their ability to deliver high quality health care services in a cost-effective manner will be the organizations driving health care into the future. Essentially, they will have the majority of the patients.

- Patients will follow the trend toward systematic, well-organized health care. For some, it will be a matter of affordability, because capitated delivery systems will offer the best value for the health care dollar. Other patients will select capitated networks because these networks will be able to measure quality objectively and systematically rather than assuming that all providers and networks deliver equal quality. When data
is presented to the patients, it will become clear which system(s) offer the best overall value.

- Providers want to belong to a successful business enterprise and will actively support the organization(s) that offer them the best opportunity to succeed. They will make their decisions based on the following criteria:
  - corporate structure, physician leadership and governance
  - administrative support and commitment to participating shareholders and members
  - reimbursement supported by experience data
  - open communications
  - commitment to ongoing education and training
  - commitment to quality of care/adherence to pay-for-performance standards
  - financial viability
  - organizational integrity
  - assurance of knowing their organization will be there to support them over the long-term

**Conclusion:**

There is no crystal ball about the future. However, the past often seems to be a reasonable predictor of the future. What we do know is that health care costs are increasing at an unacceptable rate. We know that the number of uninsured continues to grow daily. We know that national health insurance is down the road, if at all. We know that self-directed health care will have some positive impact on costs for those patients selecting that option. But, we also know that for the majority of Americans, HMOs will continue to be the backbone of the health care system. For the reasons cited earlier, health plans will pass risk to the organizations most prepared to manage risk, IPAs/medical groups will pass risk to their providers who actually deliver the care, and patients will ultimately learn that such a system is their best choice for quality and value.

Our recommendations are as follows:

- Invest in infrastructure, don’t destroy it
- Educate and train providers, help them to understand the business
Recruit the best and brightest providers into the organization and get them involved

Set high quality standards for the conduct of your business (this will be your best weapon in protecting yourself against unacceptable risk)

Demand personal integrity at all levels

Pay your providers fairly, and hold them to a measurable standard

Monitor individual performance regularly against the standard

To those risk-bearing organizations operating in states where health plans refuse to delegate administrative responsibility, do not accept risk without delegation. What business can succeed if they let another company write out of their checkbook? While health plans are powerful organizations, they cannot succeed without physicians.

Not every physician organization or risk-bearing hospital has what it takes to manage capitated dollars successfully. If you don’t know how, don’t do it. The risks are too great. Rather, join and actively support an organization that does know how to manage risk because they will be your future.

Capitation is not dead and it truly is wishful thinking on the part of those who think it is. Lessons are expensive, but we all learn through failure. Use your experiences (good or bad) to make the managed care delivery system better. Don’t run away from managed care, rather embrace it, make the changes that are needed and be a part of the future of managed care.

We know that our position is not a popular one for many patients and providers. Some providers have taken extraordinary steps to avoid associating with capitated systems for economic, philosophical or other reasons. Some providers have actually moved away from highly penetrated managed care markets to states or rural areas with little or no capitation. To you we say, it’s coming to a city near you. Your patients want health coverage and that is going to drive the decision whether capitation succeeds or fails in your area. You can be part of the solution, so get involved.

We look forward to your reaction to our position and are interested in engaging you in a discussion about the future of capitation in your area. Please share your opinions and predictions about the future with us. We’d like to hear from you.