

Capitation And Radiology: Ground Rules For Negotiating A Contract

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Abstract

As capitation becomes a more prevalent payor mode for radiology the language of the actuary and the risks and potential benefits involved in a capitation contract need to be understood. This article reviews the terms, risks and benefits involved in a capitated contract

INTRODUCTION

If you have negotiated a capitation contract for radiology services, you probably have been challenged by a general lack of information to support that effort. You may also have found it difficult to know what information you are missing. To lay some groundwork for your discussions, this article provides a look through the eyes of an actuary into the development of a capitation strategy.

BASIC DEFINITIONS

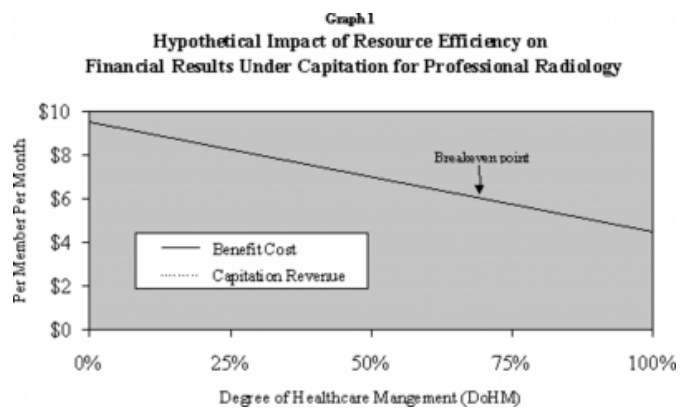
First, I suggest starting with the following basic definitions:

THE NATURE OF CAPITATION

A fundamental objective of physician capitation is the transfer of financial risk to the provider, who can best affect how efficiently resources are used to obtain appropriate care and financial outcomes. To put this efficiency in perspective, we use a measure called "Degree of Healthcare Management" (DoHM). At one extreme, DoHM=0% represents a virtually unmanaged population. At the other extreme, DoHM=100% represents a well managed delivery system with best current practices of medicine.

With improvements in medical management (increases in the DoHM), we anticipate a lower use of healthcare resources (lower cost). The effect of improved medical management differs by type of service. Presented in Graph 1 below is an illustrative view of the DoHM impact on costs and revenue pmpm for professional radiology services for a commercial population.

Figure 1



In the above graph the solid line represents hypothetical costs and the dashed line represents hypothetical revenue (capitation payments). The decreasing slope of the solid line shows the anticipated reduction in costs pmpm as a result of improved medical management. Where the two lines intersect (~DoHM=70%), revenue equals cost. If the DoHM is less than 70%, there will be inadequate revenue and a lower reimbursement schedule will be necessary to break even.

A FAIR AND ADEQUATE CAPITATION

How does one define a fair and reasonable capitation? From an economic perspective, the "appropriate" capitation is the range of dollar values for which both a) the provider is willing to take risk, and b) the payer is willing to transfer risk.

However, to find the threshold of these values as a medical group (below which you don't want to take risk) requires that you have adequate information. Adequate information

will allow you to find a minimum proposed capitation rate, commonly expressed as equivalent to a percentage of a common fee schedule such as Medicare allowable.

DATA REQUEST

In order to evaluate a capitation rate proposal, I recommend gathering the following information:

BENCHMARK DATA

For a general sense of the level of costs and variability, I have prepared the following illustrative costs for professional radiology services for a commercial population in San Francisco:

Hospital outpatient radiology costs are not reflected in these benchmarks. Such costs are comparable in magnitude to professional radiology costs, and have similar risk factors to

consider in a capitation analysis.

CAUTIONARY COMMENTS

A few comments of caution when contracting:

CAPITATION AT THE END OF THE DAY

Despite everyone’s best efforts, at the end of the day the capitation rate may be inadequate. This can be because either a) the underlying utilization and cost assumptions behind the capitation rate did not reflect the nature of the population, or b) the “roll of the dice” produced too many large claims.

There is nothing inherently right or wrong about capitation as a basis for reimbursement. However, before you choose to accept a capitation proposal be prepared to do your homework in assessing both the rate and the risk.

References

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