

Capitation And Radiology: Ground Rules For Negotiating A Contract

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Citation

J Walbridge. *Capitation And Radiology: Ground Rules For Negotiating A Contract*. The Internet Journal of Healthcare Administration. 2000 Volume 1 Number 2.

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:

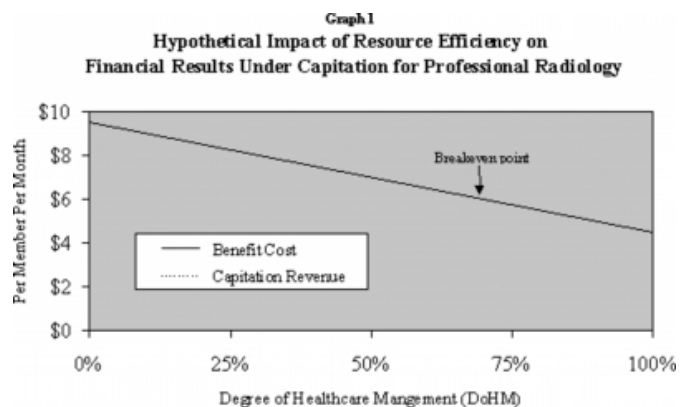
- **Capitation Rate:** a prepaid amount per member per month (pmpm) for an agreed-upon range of services. This payment transfers financial risk from the health play (payor) to the provider.
- **Capitation Risk:** the risk that the capitation rate payment is less than the “cost” of providing the services under the capitation contract.

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:

1. Target Population(s): The population should first be identified by type of coverage (such as commercial, Medicare, or Medicaid). The payer should be questioned to ascertain whether or not the membership reflects a typical (representative) cross section. In many cases, the population has notable bias. This bias can arise due to the nature of the payer (based on their marketing or enrollment strategies). It can also arise due to a selection bias attributed to which members are aligned or associated with your medical group (e.g., a subset aligned with particular specialists may attract the sicker individuals within that specialty).
2. Scope of Services: The covered scope of services should be carefully reviewed for both what is included and what is excluded. Risk is best transferred to the party that has the ability to affect financial outcomes. Thus, it is generally desirable to exclude risk for services due to out-of-area emergencies and for services not provided by the medical group.
3. Historical Cost: The best data to work from is the actual experience of the target population. In addition to capturing the historical cost pmpm, you will also want to know a) the cost basis (e.g., as a percentage of Medicare allowable), b) any incentive payments, c) reinsurance arrangements, d) impact of any large claims, e) period over which the data was gathered, f) the number of member months (credibility of experience), g) benefit plan provisions in effect, h) the extent to which the

experiences was “completed” (increased for incurred but unreported claims) and i) any circumstances which may differ from the proposed arrangement.

4. Changes Anticipated: Identify factors that have or will change. These factors include trends on cost (inflationary trends), the impact of new technologies and drugs, changes in the scope of services that are covered, and changes in any financial arrangements (e.g., insurance or risk sharing).
5. Financial Arrangements: Obtain details on any financial arrangements that are being offered or available for reducing risk and for participating in gain/losses. Reinsurance can typically be obtained to reimburse you for when the “cost” of services rendered for any member exceeds a defined threshold (referred to as Specific Excess of Loss Coverage)
6. Actuarial Benchmarks: Actuaries are able to develop models or benchmarks of costs pmpm. Actuaries have access to detailed claim data that allows them to project what a normative utilization and cost would be for a population in a particular region. Actuaries can also use risk simulation models to quantify the risk of the capitation payment being inadequate.

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:

- An overall actuarial cost of \$8.50 pmpm, for a moderately managed health system, with payments made at Medicare allowable.
- The cost varies with the demographics of the population. For example, the corresponding cost for a pediatric population ages 0 to 14 is \$3.00 pmpm, while for the older population (ages 60-64), it is \$22.00 pmpm.
- Milliman benchmarks for San Francisco indicate a range of +36% (\$11.50 pmpm) for loosely managed to -36% (\$5.40 pmpm) for well managed

delivery systems.

- Costs vary significantly by geographic region. For example, the costs in California’s central valley are substantially lower. For a moderately managed health system, we estimate costs of up to 35% less than in San Francisco (\$5.50 pmpm versus the \$8.50 San Francisco cost). This is a result of lower reimbursement rates in the central valley, as well as lower utilization rates there.

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:

1. Be wary of survey data. Information reported in surveys might lure you into a false sense of security around what constitutes a reasonable capitation level. Experts in capitation analysis are needed to examine the applicability of any survey results to your situation.
2. Consider the impact of variations from typical results. Look at more than just the average

reimbursement relative to a standard fee schedule (e.g., 120% of Medicare Allowable). Evaluate your risk position and your options for reducing your risk exposure.

3. Select a qualified consultant. When negotiating a capitation contract, work with someone who has experience in evaluating risk and capitation contracts. Many actuaries have easy access to detailed claim data to put a capitation proposal in perspective. Inquire into both the individual’s experiences in evaluating capitation contracts and the resources that they have available.

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

Author Information

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