eBOOK

4 Reasons to Start Preparing Now for a Future of Capitated Payments

Between the mid-1970s and mid-1980s Medicare introduced a program) that paid health maintenance organizations (HMO) a fixed monthly amount for each enrolled beneficiary. The program never took off because patients and providers perceived HMOs to be rationing care (and withholding necessary care) to remain profitable under a capitated system.

In an article published in the *Journal of General Internal Medicine* in 2001, author Thomas S. Bodenheimer, MD noted that only 30% of medical practices were making a profit from capitation, and both HMOs and physicians were rebelling against the program – with some physicians even refusing to accept capitated contracts.

It might have been tempting around the turn of the century to declare that experiments in capitated payment arrangements were done, and the payment model was not viable in the U.S. healthcare system. But capitation has seen a resurgence, and this time it's something that every healthcare delivery organization (HDO) should be taking seriously. There are four key reasons your organization should be preparing for a future that includes capitation payments.

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The ACA & CMS Bring Capitation Contracts Back

The passage of the Affordable Care Act (ACA) in 2009 and the subsequent efforts by the Centers for Medicare and Medicaid Services (CMS) to lower costs and improve quality have led us back to capitation. The latest programs coming from the Centers for Medicare and Medicaid Innovation (CMMI) – specifically the Realizing Equity, Access, and Community Health (ACO REACH) program – are all-in on the potential for capitated payments as one of the most viable alternative payment models (APMs) to fee-for-service payments (FFS).

What Do We Mean by "Capitation"?

There are many different forms that capitation payments can take today. As we talk about the importance of preparing for a future where capitation is a common APM to FFS, we are specifically talking about:

- **Primary Care Capitation Payments (PCCP):** A per-member-per-month (PMPM) payment to providers who offer a specific set of primary care services to aligned beneficiaries.
- **Total Care Capitation Payments (TCCP):** A PMPM payment made to an Accountable Care Organization (ACO) for all healthcare services provided to aligned beneficiaries – including primary care, specialty care, and hospital care. Other names for this include global capitation and integrated care delivery models.

1 Capitation is proving successful in lowering costs and improving care quality.

In the broad healthcare market, a significant number of payments are still fee-for-service based. However, more organizations are moving into APMs that include partially or fully capitated arrangements. There is growing evidence that primary care providers and specialists in global capitation models delivered higher quality care to aligned beneficiaries.

A 2020 study from UnitedHealth Group found that patients in capitated models were more likely to receive preventive screenings for things like breast cancer and colorectal cancer. Patients with diabetes were more likely to have blood sugar levels under control. They were also more likely to get eye exams and other preventive screenings to reduce the risk of complications common in diabetes patients. Providers in capitated models were also more likely to conduct medication reviews and complete functional status assessments for patients when compared to those in fee-for-service models.

One California Medicare Advantage insurance plan in a capitated payment model implemented an integrated care system with multiple care partners to manage patients with chronic health conditions. Outcomes data showed:

- 42% fewer hospital admissions compared to the national average
- 60% lower amputation rates for diabetic patients
- Pressure ulcer rates that were 30% of the state average for institutionalized patients

The same organization had significantly lower costs, averaging just $1,000 for intermediate-risk patients (compared to $1,500 statewide) and $2,250 for high-risk patients (compared to $3,500).

Capitated arrangements are also increasing at the state level, with 10 states currently participating in one of these models. For example, the Maryland All-Payer Model pays a predetermined amount to providers for inpatient and outpatient services (regardless of insurance plans). This global capitation model reduced:

- Medicare hospital costs by $429 million
- Preventable complications in hospitals by 48%
- All-cause hospital readmission rates by 57%

WHY IS THIS IMPORTANT?
Capitation is the APM of the Future

Value-based care initiatives and goals are not going away. Both CMS and commercial payers are leaning into new models that can keep costs low, maintain high quality standards, and address issues like access to care and patient satisfaction – and HDOs share the same goals. The sooner you become familiar with the models, the sooner you can put in place the necessary processes and find the right tools to shift payments from FFS to APMs when the time is right for your organization.

2 Capitation provides more stability and financial certainty for healthcare organizations.

Fee-for-service payments have dominated the U.S. healthcare system for more than 50 years. Healthcare stakeholders are familiar and comfortable with this method of payment that rewards volume over outcomes, which is part of the reason it's been so difficult to move to value-based care systems.

But when COVID-19 hit in early 2020 it sent shockwaves through healthcare financial departments. At a time when the cost of providing care was steadily increasing to meet the needs of patients sick with a novel virus, revenue went down dramatically. Procedures that typically provide the bulk of hospital and outpatient clinic revenue – things like elective surgeries and clinic visits – were down by 91%, partly due to a shortage of available hospital beds (because they were in use by COVID patients) and partly due to patients' fear of going to hospitals and clinics.

The end result was dozens of hospitals and healthcare facilities going into bankruptcy or financial strain forcing mergers with other healthcare systems. Hundreds more healthcare systems operated with negative margins for multiple months (or even years).

WHY IS THIS IMPORTANT?

Capitation Can Improve Financial Viability

Under capitated payment arrangements, organizations get a PMPM payment for each beneficiary. These payments are not paid for a specific procedure or service. In the event of a dramatic change in healthcare (as with COVID-19), providers and payers can find innovative ways to continue meeting the needs of each patient and won't lose revenue simply because of a change in care delivery methods.

From a revenue cycle perspective, capitated models also make more sense than FFS. Healthcare organizations know in advance what their PMPM payments are, and the approximate size of their aligned beneficiary population. They can plan accordingly and count on a reliable monthly revenue stream. While total beneficiary counts can fluctuate as patients move or get assigned to other providers, these shifts usually have only a minor impact on total revenue each month (and having tools that help keep beneficiary lists up to date can improve accuracy in forecasting monthly revenue).

A recent analysis from the National Association of ACOs examining gains and losses in direct contracting entities (a capitated payment program through CMS) showed that organizations spent about 90% of capitation payments on Medicare-covered services. They received **10% more capitation revenue than they would have otherwise received under a FFS payment system**. It's compelling evidence that capitation can be profitable and is a viable way forward for organizations that want more financial stability.

3 CMS is going all-in on capitation with ACO REACH.

More than a decade after the Affordable Care Act, CMS remains committed to improving care quality, lowering costs, and enhancing patient experience. They continually launch initiatives and evaluate progress toward those goals. Most of the programs to date – such as MSSP and upside-only risk arrangements – have not provided broad and sustained cost savings and quality improvement, but CMS isn't giving up.

In 2023 CMS launched ACO REACH with stated goals of:

- Promoting health equity and address healthcare disparities for underserved communities
- Continuing the momentum of provider-led organizations participating in risk-based models
- Protecting beneficiaries and the model with more participant vetting and monitoring and greater transparency

Under the ACO REACH model, participants can choose from two capitated payment models for compensation:

- **Professional:** A primary care capitation model with risk-adjusted monthly payments for primary care services and lower risk-sharing arrangement that caps savings or losses at 50%
- **Global:** A total care capitation model with risk-adjusted monthly payment for all covered services, including specialty care and higher risk sharing arrangement of 100% savings or losses

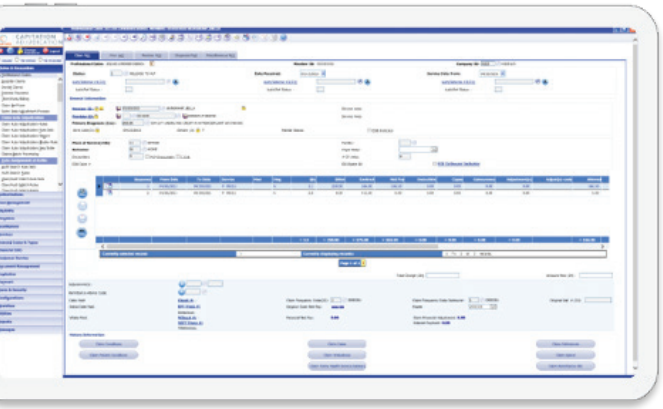
WHY IS THIS IMPORTANT?

Not Preparing for Capitation Puts You at a Disadvantage

There are about 200 organizations participating in ACO REACH for the performance years 2023-2026. When it ends, CMS is likely to roll out professional and global capitation on a larger scale to more healthcare payers and providers. Those that haven't put the pieces in place to accept capitated payments will find themselves at a disadvantage compared to healthcare systems that are prepared for the shift.

4 The tools are available today to succeed in capitated payment contracts.

One of the key reasons APMs like capitation underperformed in the past was a lack of tools available to help organizations manage the risk inherent in these contracts. Higher-risk patients – such as those with chronic health conditions or terminal disease – will require more care and incur higher costs. Limiting that care leads to poor outcomes and runs counter to value-based care goals of providing the highest quality care at the lowest possible costs. But technology today has the power to accurately measure and predict risk and adjust payments accordingly.



WHY IS THIS IMPORTANT?

The Tools You Choose Can Make or Break Capitation Success

Organizations that participate in APMs need software that:

- Is comprehensive and scalable to meet all different types of capitated payment arrangements
- Automates key tasks to minimize the risk of errors and eliminate manual work for revenue cycle team members
- Can be configured with specific features and functionality based on the parameters of a capitated payment contract
- Empowers users with cost-effective and self-service tools that improve everyday workflows
- Facilitates coordination among integrated care teams across multiple departments and multiple organizations
- Works seamlessly with other point solutions already in use within a healthcare system, or functions as part of a complete, end-to-end solution

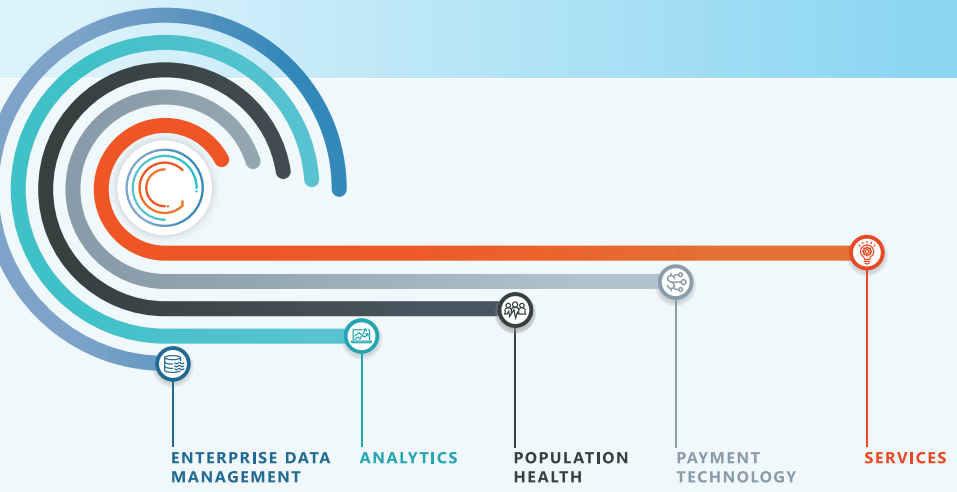
Payment systems in use today are monolithic and costly to modernize. Most were originally built as legacy fee-for-service payment technology and don't work for capitation adjudication because it's such a dramatic shift from FFS payments. These systems require a lot of manual work to process capitation claims. That wastes time and money and frustrates overworked and understaffed revenue cycle teams.

But choosing a capitation payment software that was purpose-built to handle value-based care APMs gives you an advantage over competitors using legacy FFS systems. It automates much of the work, ensuring accurate payments and facilitating efficient distribution to care partners within your network. It's cost-effective and minimizes the strain on teams, which minimizes burnout and improves morale.

THE SOLUTION YOU NEED

Learn more about capitation adjudication payment technology available from Cedar Gate. Our industry-leading solutions were purpose-built for a future focused on value-based care and alternative payment models. Get started on your journey with the right tools.

For more information, email learnmore@cedargate.com.



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