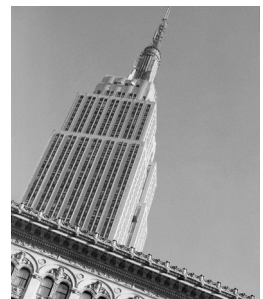
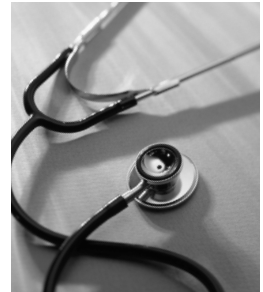
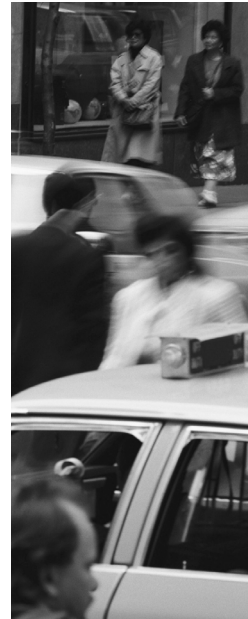
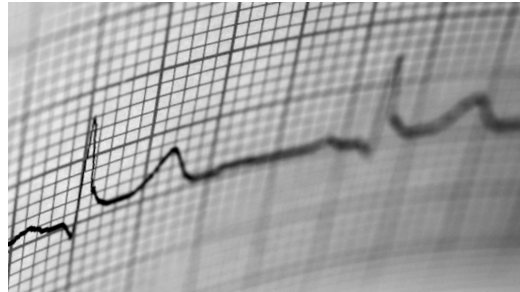


# Capitation and the Evolving Roles of Providers and Payers in New York



# Capitation and the Evolving Roles of Providers and Payers in New York

Gregory C. Burke, MPA

DIRECTOR, INNOVATION STRATEGIES

Suzanne C. Brundage, SM

SENIOR HEALTH POLICY ANALYST, INNOVATION STRATEGIES

Nathan Myers, MPP

SENIOR HEALTH POLICY ANALYST, MEDICAID INSTITUTE

May 2016



Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSEHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, or staff.

Support for the work of the United Hospital Fund's Innovation Strategies initiative is provided by The Peter and Carmen Lucia Buck Foundation and TD Bank.

Copyright 2016 by United Hospital Fund

Free electronic copies of this report are available at the United Hospital Fund's website, [www.uhfny.org](http://www.uhfny.org).

# Contents

- Executive Summary ..... 2**
- Introduction ..... 3**
- Accountable Care Basics ..... 4**
- What Changes Under Full-Risk Capitation?..... 5**
  - Capitation Requires New Skills and Capacities .....7
  - Changing Roles for ACOs and Payers Under Capitation ..... 11
- Challenges Posed by Capitation..... 13**
  - Providers.....13
  - Health Plans ..... 14
  - Consumers..... 15
  - Policymakers..... 16
- Some Open Issues ..... 17**
- Appendix ..... 19**

## Executive Summary

In New York and nationwide, recent steps toward value-based purchasing have involved shared savings and shared risk contracts between payers and providers. Under such contracts, an organized provider group—an accountable care organization, or ACO—is held accountable for the quality and costs of care they provide to a defined population; in return, the payer agrees to share with them some or all of the savings they generate in caring for that population each year. The next major step in this direction is capitation: prepaying provider groups a flat, periodic, per-enrollee fee for all the health care required by its defined population. Capitation increases the providers' financial risk, and their incentives for providing quality, efficient care.

Capitation's advance payments give providers flexibility in their approaches to working within a fixed budget; they also have the effect of shifting to providers many functions traditionally performed by payers. As they embark on capitation, ACOs face a series of decisions about which of these administrative functions they will control, and how they will do so. They can build these new capacities themselves, partner with a health plan, outsource the functions to a third party, or some combination of these. Whichever approach they adopt, ACOs will find themselves taking on new roles, and they may end up duplicating functions that payers still perform under contracts with other providers.

These shifts and potential duplications have different implications for different parties in New York's health care system; this report delves into those different effects, both short-term and long-term. Capitation changes providers' perspectives on how revenues are generated and spent, and their relationships with their network and the sponsoring plans. For payers, capitation challenges their basic business model, changes their cost structures, and—as ACOs assume more of payers' own functions—has the potential to create their own competition. For consumers, capitation could increase engagement with providers, though duplication of efforts could also sow confusion as to which entity is responsible for which functions. For policymakers, capitation is likely to increase overall system costs in the short term, challenge the State's existing regulatory structures, and increase the oversight required of the financial health of ACOs and providers.

## Introduction

Value-based payment (VBP) has emerged as a central theme in federal, state, and commercial insurance strategies for health reform. Citing the need to move away from traditional fee-for-service (FFS) payment, policymakers—and, to some extent, plans and providers—are enthusiastically embracing new value-based approaches to paying for health care services, giving providers financial incentives to increase care quality and reduce unnecessary utilization and cost, actions that are not rewarded under FFS systems.

Accountable care contracts are cited by Medicare, Medicaid, and commercial health plans as important innovations in VBP. Under such contracts, an organized provider group—an accountable care organization, or ACO—is held accountable for the quality and costs of care they provide to a defined population; in return, the payer agrees to share with providers some or all of the savings they generate in caring for that population each year, comparing the total health care expenses generated in caring for that population to a benchmark.

The three major models of accountable care are shared savings, shared risk, and capitation. Under most shared savings and shared risk arrangements, providers continue to be paid on a fee-for-service basis, and savings and losses against their benchmark are calculated at the end of the year. Under full-risk capitation arrangements, providers are prepaid for all the care required by their attributed patient populations. Capitation's advance payments give providers flexibility in their approaches to working within a fixed budget; and they also take on many functions traditionally performed by payers. This shift represents a major change for provider groups and payers alike.

The shifting roles of providers and payers under capitation are the main subject of this report. In the sections that follow, we will review the basic features of accountable care contracts between provider groups and payers; describe what changes are expected under capitation; review the new skills and capacities many providers have determined they will need in order to operate under capitation; explore the changing roles of providers and payers under capitation; and identify some challenges the expansion of capitation contracts may pose for providers, payers, consumers, and policymakers in New York State.

We also review some open issues, including the ability of providers to take on those new roles, the ability of payers to craft these new contracts and operate under them, and the capacity of New York's regulatory structure to oversee the performance of providers and plans under these new arrangements.

In preparing this paper, we reviewed the relevant literature and interviewed twelve leaders from groups with experience in providing or purchasing care under shared savings and capitated payment arrangements, including providers, payers, and plans, as well as national experts, all of whom were extraordinarily generous with their time and insights. A full roster of those interviewed is included in the Appendix to this report.

## Accountable Care Basics

The number of accountable care arrangements between provider groups and payers in New York State has been growing. Since 2012, 33 New York organizations have been selected by the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare’s ACO programs,<sup>1</sup> involving over 450,000 Medicare FFS beneficiaries and more than 17,000 physicians. While there is currently no analogous census of ACO arrangements available for the commercial insurance sector, payers report an increasing number of accountable care contracts with provider systems across the state, most of those being shared savings models.

Under most accountable care shared savings programs, providers continue to be paid as they have always been in caring for attributed patients, using FFS payment systems. If the ACO is successful in generating savings in caring for that population (comparing their attributed patients’ total costs of care to a benchmark),<sup>2</sup> they are eligible to share in those savings. The main drawback of the shared savings model is that it gives providers contradictory incentives. If an ACO can reduce utilization and costs in the near term, it may receive shared savings at the end of the year. However, if its providers deliver *more* services and higher costs in the near term, they will continue to bill and collect more under the prevailing FFS system.

Many payers (including CMS and New York State’s Medicaid program) have proposed that it is important for ACO arrangements to migrate from shared savings to shared risk or capitated models. They reason that it is only when providers face the prospect of having to repay or absorb their “excess” expenses (i.e., expenses that exceed their target) that they will have a sufficient incentive to manage their attributed patients’ care, improve quality, and focus on reducing preventable utilization and costs.

Providers in ACOs face challenges in two broad areas: they must improve their performance as an integrated delivery system, and they need to build or buy a number of functions historically performed by payers.<sup>3</sup>

ACOs have had to adopt new and unfamiliar perspectives, focusing on improving the care of defined populations across the continuum, and on reducing their total costs of care. An ACO’s success has often depended on its ability to craft and manage a clinically integrated delivery system with established systems to measure and improve quality. ACOs need an organizational structure (often a new organization itself) that can enter into accountable care

<sup>1</sup> As of January 2016 there were 30 Medicare ACOs based in New York: one in the Pioneer ACO Model program, and 29 in the Medicare Shared Savings Program (MSSP); three participants in the MSSP left the program in January 2016.

<sup>2</sup> Other innovative payment methods—such as medical home care management payments, pay-for-performance (P4P) incentives, and bundling—can coexist with shared savings and shared risk arrangements. Medical home payments, designed to cover the added costs of operating an advanced primary care program, can be retained as direct payments to the involved providers, and are simply counted as expenditures—as are P4P incentive payments—in calculating shared savings. In theory, bundled payment arrangements could also be retained under a shared savings or shared risk arrangement, by excluding both the costs of providing the covered services and the agreed-upon, bundled payment from the calculation of savings or losses.

<sup>3</sup> Burke G and S Brundage. April 2015. *Accountable Care in New York State: Emerging Themes and Issues*. New York: United Hospital Fund. <https://www.uhfnyc.org/publications/881042>

contracts with payers on behalf of their participating providers; that can manage, track, and report on utilization and quality; and that has clear processes for the distribution of shared savings or losses among those providers. These are substantial changes from most providers' traditional roles.

In addition, ACOs have begun, under both shared savings and shared risk arrangements, to take on some of the functions traditionally performed by payers—notably care management for high-risk patients and claims data analytics—that are essential to managing the care of the patients attributed to them. ACOs working under shared savings and shared risk arrangements generally receive regular feeds of claims data from their contracted payer that depict their attributed population's historical and current utilization—and (sometimes) costs. Most providers are unfamiliar with claims data, so they need to build or buy expertise in claims data analytics to track and analyze utilization and costs.

Paying for delivery system changes, claims data analytics, and care management represents new costs for these provider groups, which must invest their own money in these capacities well in advance of any shared savings revenues they may receive. None of the Medicare ACOs in New York have received any up-front funding from CMS to capitalize this new infrastructure. Some of the state's Medicare ACOs have chosen to build that infrastructure themselves, while others have chosen to outsource the new functions to a payer (e.g., Universal American and United/Optum), a consultant (e.g., Aledade), or a third-party administrator.

## What Changes Under Full-Risk Capitation?

Formally defined, capitation in health care is a flat periodic per-enrollee payment for providing a specific set of health care services to a defined population. Capitation payments are generally expressed as some dollar amount per member per month (PMPM), where “member” means an enrollee in some managed care plan. Under capitation, providers receive a fixed fee for each member enrolled for the range of services covered by their contract, regardless of the amount or intensity of services provided.

There are a variety of different types of capitation arrangements<sup>4</sup> based on the services covered and providers involved, but most fall into one of three broad categories:

- Professional services capitation (for example, primary care capitation), in which physicians and physician groups can receive capitation to cover costs of their services to the plan's enrolled members;

<sup>4</sup> Venable RS. 1998. *Capitation: Tools, Trends, Traps, and Techniques*. Practice Management Information Corp.



- “Carve-out” contracts, in which payers negotiate capitation contracts with providers of specific services (covering, for example, dental services, behavioral health, laboratory testing, and prescription drugs); and
- Full-risk capitation contracts, under which a provider group accepts responsibility for the attributed population’s total costs of care.

There are variations on these models as well. In some cases, a payer may offer a capitation contract to an ACO for services that the ACO participants provide to its members, but continue to pay claims from other types of providers (e.g., hospitals, behavioral health providers, or out-of-network providers with whom they have negotiated payments). In others, the payer will carve out specific services and types of claims (e.g., behavioral health, prescription drugs) from its capitated contract with an ACO, and set up separate subcapitation contracts.

A number of New York State payers are already involved in capitation contracting, but most of these are limited, as in the first two types of capitation described above.<sup>5</sup> Only a few (e.g., HealthFirst’s unique provider-sponsored plan model, and Emblem’s contract with Montefiore) represent full-risk contracts.

In many ways, capitation contracts between provider groups and payers represent an incremental progression from shared savings and shared risk arrangements; but in others, they represent a radical shift.

Capitation is similar to shared savings and shared risk in that all three methods reward high-performing, clinically integrated delivery systems. The three methods require the same basic infrastructure, particularly care management expertise, delivery system-wide programs of quality improvement, and the ability to use claims data to analyze performance and guide management interventions. They all use total costs of care as the basis for financial modeling and incentive payments; and they use similar mechanisms to attribute patients to providers and to measure clinical quality patient satisfaction.

However, capitation differs from shared savings and shared risk in a crucial way: under shared savings and shared risk, health plans continue to pay providers directly (generally using fee-for-service methods) for care they provide, and savings or losses are retrospective, calculated against a benchmark at year-end. Under capitation, providers’ income is no longer generated using fee-for-service payment systems; providers are prepaid for their services, receiving their aggregate projected revenues up front (net, in some cases, of funds and withholds). This difference in payment method has three important implications:

First, under capitation the provider organization agrees to care for the covered population on a **fixed budget**. The provider organization receives a monthly total payment for all care covered by the contract; there are no benchmarks or retrospective calculations of savings or

<sup>5</sup> Newell P, CS Shearer, and N Thaper. November 2015. *Setting the Stage for Payment Reform: Updating New York’s Regulations on Risk Transfers Between Health Plans and Providers*. New York: United Hospital Fund. <http://www.uhfnyc.org/publications/881080>

loss. Receiving a fixed per-member, per month payment gives the provider group a predictable flow of funds based on the predicted total costs of care for the covered population. This improved cash flow gives the provider group the funds to invest in the required infrastructure—particularly claims data analytics, quality improvement, and medical management—and an incentive to do so efficiently.

Having a fixed spending target that is not subject to the vagaries of the benchmarking process means that, if the ACO can manage utilization and costs below that amount, they get to keep all of the savings they generate. Conversely, if they exceed that budget, they are responsible for all of the resulting losses.

Second, capitation **uncouples payment to providers from the fee-for-service system**. This gives the ACO the flexibility to decide what services to pay for (including non-traditional services not usually covered under fee-for-service payment systems) and how much to pay providers for them.

Third, prepayment can bring about a dramatic **change in providers' perspective**. When a provider group is paid in advance, the services it provides to patients are no longer sources of revenue; they become costs. This engenders a change in providers' traditional mindset; they can no longer think of specialty services and hospital admissions as sources of revenue, but rather as costs to be managed and avoided if possible. This shift in perspective is an intended consequence of the move away from fee-for-service payment systems, but it will not necessarily be an easy one for providers.

In these ways, capitation represents a fundamental change in the way a provider does business, not merely taking another step along a path already defined by shared savings and shared risk models.

## Capitation Requires New Skills and Capacities

Under capitation, an ACO accepts a higher degree of accountability for the care and costs of care of its defined population. To succeed, ACOs must put in place all of the basic capacities needed to participate in a shared savings or shared risk program, and—in addition—must consider whether to expand their capacities to include (and potentially replicate) services traditionally provided by payers.

**Table 1. Migrating ACO Administrative Functions from Payers**

*Blue shaded areas indicate functions for which ACOs might assume responsibility.*

<b>Product Design, Sales, and Regulatory Compliance</b>		
<b>Product Design</b>	<b>Marketing</b>	<b>Compliance &amp; Risk Management</b>
Actuarial soundness	Specify population covered	Insurance rules, regulations
Network design	Purchaser relations	Policies and procedures
Co-insurance and deductibles	Advertising and sales	Risk management
Premium rate-setting		

<b>Provider-Facing Functions</b>		<b>Member-Facing Functions</b>
<b>Provider Relations</b>	<b>Medical Management</b>	<b>Customer Service</b>
Network management	Quality reporting and improvement	Member communications
Credentialing	Utilization management	Call center and member services
Provider contracting	Disease management	Health education
Provider communications	Care management	Track and report on member experience
	Care coordination	Appeals and grievances

<b>Finance, Planning, and Analysis</b>	
<b>Finance</b>	<b>Planning and Analytics</b>
Pricing services	Planning
Receive, adjudicate, pay claims	Claims data and analytics
Tracking expenditures	Monitor, report on quality
Monthly, regular reports to providers	Monitor utilization, expenses, costs
Monitor and report to plan / purchaser	Track provider and network performance
Reinsurance and stop-loss	

Through our interviews with the outside experts, we developed a framework that identifies some of functions provided by payers under traditional payment schemes. In Table 1, we grouped those functions into four broad categories. The experts whom we interviewed suggested that an ACO operating under a capitation contract would likely want to control or strongly influence those functions that have the greatest impact on the measures of the ACO's success: whether it improves quality, provider experience, and member experience, and whether it controls costs. They suggested that ACOs themselves might want to assume responsibility for these functions, indicated by the shaded areas in the table.

The reasons that ACOs accepting capitation contracts would want to take on these functions vary by category, as spelled out below.

**Provider-Facing Functions.** ACOs accepting full-risk capitation are responsible for the performance of an entire provider network in caring for their attributed population. To do so effectively, they must be prepared to assume or oversee a series of new functions that affect their relationships with participating providers, including credentialing, contracting, communications, and network management. Most important, they will need to control processes for medical management, including care management, quality improvement (identifying and spreading best practices and reducing variation), and sensitive functions like pre-authorization and utilization management, which can greatly influence both costs of care and provider satisfaction.

**Member-Facing Functions.** ACOs will also want to control (or strongly influence) functions that affect their relationships with members. They will need to develop or enhance member services, supported by 24-hour call centers to handle patient questions and complaints, and to organize and deliver programs of health education to engage and support patients and their caregivers. Their performance in these areas can influence patient engagement (which contributes to improved outcomes), member satisfaction (a measure on which ACOs are generally graded), and member retention (which is key to attribution).

**Finance, Planning, and Analytics.** Perhaps the greatest challenge facing ACOs under capitation is in the broad category of finance, planning, and analytics. Under shared savings and shared risk arrangements, ACOs need to develop basic capabilities in some of these areas; but since most of their provider payments are still tied to fee-for-service billing (and only a small portion to the year-end bonuses based on the shared savings they may generate), their performance in these areas may not be perceived as critical.

Under capitation, however, ACOs need robust health information and planning capacities, including the ability to assess and adjust for risk, to promptly produce clinical and claims data analytics needed to support quality improvement, to track performance against budget, and to mitigate the potential impact of the increased risk they are assuming. ACOs will also need to develop or acquire new financial, actuarial, and accounting systems, including the capacity to negotiate payment rates, and pay bills received from providers.

Assuming these functions will bring up many challenges for providers:

*1. A Different Financial Model.* Providers accepting capitation payments must learn a new financial vocabulary, and build or acquire a new set of financial planning and management skills. They will need<sup>6</sup> to master concepts like actuarial soundness, risk adjustment, and risk mitigation; to manage co-insurance and deductibles; to shift from cash accounting to accrual accounting; to reserve funds to cover out-of-network care and expenses incurred but not

<sup>6</sup> Evaluating and Negotiating New Payment Models, AMA Practice Management Center, 2012  
<http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/state-based-payment-reform/evaluating-payment-options.page>

reported; and to consider the need for stop-loss and other reinsurance coverage to protect them against unforeseen, extraordinary expenses.

*2. Changing Payments.* A major advantage capitation confers on ACOs is the flexibility to change what services are paid for, how much to pay for them, and how to make those payments. Under capitation, an ACO gets its payment up-front each month; the question is, how best to spend it? Capitation enables provider groups to move away from compensation methods based on traditional FFS payments. Simply adopting historical FFS payment methods would leave unused one of the most powerful levers of change that capitation provides.

The ability to alter payment methods and amounts enables an ACO to pay for high-value but historically undervalued or under-reimbursed services (e.g., advanced primary care, home telemonitoring, care management, and telemedicine). It also offers the ACO an opportunity to better align provider incentives through the use of techniques like sub-capitation and case-based payment; and to reward improvements in productivity, quality, and patient experience, along with utilization and cost management. In fact, having the ability to pay differently for services—to rationalize the way health care dollars are spent—is one of the key reasons cited by ACO providers and providers sponsoring health plans for pursuing capitation and provider-based insurance plans.<sup>7</sup>

Taking responsibility for setting provider payments is a complex and particularly sensitive undertaking for provider-based systems, since its decisions—potentially increasing or reducing payments compared to prevailing FFS fee schedules—have the potential to directly affect their participating providers' incomes. Some provider groups (like group practices and faculty practices) have experience in designing compensation schemes for their physicians and other professionals, incorporating productivity, quality, patient satisfaction, and utilization factors. For many ACOs, however, the ability to alter and realign provider payments represents a new and potentially divisive undertaking. It requires an organization that providers trust; sophistication in the use of electronic health records and claims data; and—perhaps most important—a legitimate, transparent, and accountable decision-making process that involves the participating providers, particularly around issues of resource allocation.

*3. Paying Bills.* Beyond negotiating and setting rates of provider payment, capitated ACOs must actually pay provider claims. Receiving and paying bills from providers for their services will be a new and unfamiliar undertaking for most ACOs.

Historically, providers have been on the receiving end of payments; under capitation, the ACO also becomes the payer. The ACO must build (or contract with a plan or a third party to provide) a claims payment infrastructure, able to accept and adjudicate claims, manage co-insurance and deductibles, work with other payers to resolve issues like coordination of benefits, and promptly pay bills from providers both within and outside its network.

<sup>7</sup> Interviews with leaders of Montefiore and Crystal Run ACOs.

## Changing Roles for ACOs and Payers Under Capitation

An ACO can provide these new functions in a number of ways: some (like credentialing and care management) may be formally delegated to them by the plans, as part of their capitation contract; an ACO may elect to have the plan continue to provide specific services (like bill payment) for a fee; or they may outsource certain functions (like claims data analytics and reporting) to a third party. Whether an ACO chooses to develop specific capacities will depend on whether the ACO plans to manage those functions directly or expects to achieve equivalent results by using the payer's existing infrastructure or working with a third party. When an ACO chooses to develop or acquire specific capacities itself, it may duplicate services the plan continues to provide to its members.

ACOs accepting full-risk capitation can acquire the needed infrastructure using one of three broad approaches or some combination of them, depending on their own current and developing capabilities:

- They can build their own capacities, such as medical management, claims analytics, rate negotiation, and bill-paying. Generally, a provider group's instinct is to control as many of these functions as possible, but this can be a costly proposition. Many of these new skills come with steep learning curves or require new sets of experienced employees who may be hard to find and expensive to hire.
- Provider groups that also operate insurance companies (e.g., Northwell or Crystal Run) can share the needed infrastructure with their own "captive" insurance company, purchasing those services internally and taking advantage of scale and the expertise in their own health plan.
- They can partner with health plans or third-party administrators, purchasing services that enable them to establish and manage provider networks, or to handle claims payment, financial reporting, and analytics. Some payers (e.g., Optum/United, Universal American, and Aetna) and other third parties (e.g., Aledade) have positioned themselves to provide these functions to developing ACOs, either for a set fee or in exchange for a proportion of the premium or capitation.

The first two of these approaches requires that an ACO make substantial investments in new functions. Of the three alternatives, purchasing key functions with health plan partners (or sharing functions with them) would be the most readily accessible to most provider groups.

Although the experts we interviewed indicated that successful ACOs are most likely to prioritize controlling certain functions, many combinations are possible. ACOs and payers can handle these capacities in a variety of ways (see Table 2), ranging from no delegation to full delegation of these functions. In any scenario, certain functions will always remain with the payer.

**Table 2. Models for Delegating Administrative Functions from Plans to Providers Under Capitation**

Key: ✓ marks plan responsibility; ✓ marks ACO responsibility; ✓✓ marks shared responsibility.

Administrative Functions	No Delegation		Maximum Delegation		Maximum Sharing		Example 1		Example 2	
	Plan	ACO	Plan	ACO	Plan	ACO	Plan	ACO	Plan	ACO
<b>Product Design, Sales, and Regulatory Compliance</b>										
Member Enrollment/Advertising	✓			✓	✓	✓	✓		✓	✓
Fraud, Waste, and Abuse	✓		✓		✓		✓		✓	
Legal	✓		✓		✓		✓		✓	
Compliance	✓		✓		✓		✓		✓	
<b>Provider-Facing Functions</b>										
Utilization Review	✓			✓	✓	✓		✓		✓
Utilization and Care Management (UM)	✓			✓	✓	✓		✓		✓
Drug Utilization Reviews	✓			✓	✓	✓	✓	✓		✓
Quality	✓			✓	✓	✓	✓	✓		✓
Network Management	✓			✓	✓	✓	✓	✓		✓
Disease Management	✓			✓	✓	✓		✓	✓	
Provider Relations	✓			✓	✓	✓	✓	✓	✓	
Credentialing	✓			✓	✓	✓		✓	✓	
<b>Member-Facing Functions</b>										
Appeals and Grievances	✓			✓	✓	✓	✓	✓	✓	✓
Member/Customer Service	✓			✓	✓	✓	✓	✓	✓	✓
Member/Provider Services Help Desk	✓			✓	✓	✓	✓	✓	✓	
<b>Finance, Planning, and Analysis</b>										
Claims Administration	✓			✓	✓	✓		✓	✓	✓
Risk Adjustment & Reinsurance	✓			✓	✓	✓	✓	✓		✓
Medicaid Management & UM Metrics	✓			✓	✓	✓		✓	✓	

Source: Adapted from New York State Department Health, Medicaid Redesign Team. October 22, 2015. Presentation from Technical Design II Subcommittee meeting (Slide 17). The functions listed in that table are here regrouped to match the categories in Figure 1. [http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/technical\\_design/docs/2015-10-22\\_td2\\_subcommittee.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/technical_design/docs/2015-10-22_td2_subcommittee.pdf)

Whenever and however an ACO takes on delegated responsibility for any of the payers' traditional functions, it is accountable to the plan with which it contracts for its performance as a provider and payer; and it must absorb the costs of that new infrastructure using its capitation payments.

## Challenges Posed by Capitation

The shift to full-risk capitation brings with it different challenges—strategic, administrative, and financial. Below, we review some of the difficulties likely to be faced by the different stakeholders involved: providers, health plans, consumers, and policymakers.

### Providers

**The Performance Imperative.** To succeed in accountable care, an organized provider group must ensure that, on the whole, its network is providing high-quality, cost-effective care to populations of attributed or enrolled plan members. To succeed, ACOs need to be able to operate effectively as a delivery system, establishing and enforcing a common culture of quality focused on managing the care its members need across the continuum of care; and putting in place the infrastructure and systems needed to manage the care of diverse populations, with particular competence in caring for potentially high-risk, high-cost patients.

ACOs accepting capitation require an organization with a solid infrastructure, and legitimate, trusted leadership and governance, and transparent decision-making processes around provider payment. This can be difficult to accomplish in a multi-specialty group or integrated delivery system, where all providers work under a unified governance and management structure. It will likely be a particular challenge for new, hybrid organizations, such as the Performing Provider Systems created under the State’s Delivery System Reform Incentive Payment (DSRIP) program, which are composed of providers who may not have worked together closely before.

**The Investment Challenge.** Providers pursuing capitation will need to manage competing investment demands: they will need to invest in improving the performance of the delivery system itself, while at the same time creating the new infrastructure and processes necessary to take on functions traditionally performed by the payer. Investments in building new roles are arguably long-term investments in delivery system transformation; however, in the near term they are dedicated to comparatively small populations of patients and compete with other needs—such as investing in equipment, facilities, and staff—directed toward all patients cared for by the ACO and its participating providers. Accepting and investing in the capacities to manage under capitation—making it one of the organization’s investment priorities—may not be the right strategy for all delivery systems.

**Changing Provider Payments.** Unlike shared savings contracts, in which participating providers continue to generate their own FFS revenues and work toward shared savings bonuses at year-end, capitation contracts give the sponsoring ACO the ability to change what it pays for, to decide what new services to pay for, and to decide how providers are paid for their core services—thus affecting their income. This is a potential source of conflict, which is best resolved through a legitimate decision-making process.



**A Radical Shift in Frame of Reference.** Under capitation, an ACO will need to consider specialty services and hospital admissions as costs rather than sources of revenue, which is a new mindset. New skills and protections will need to accompany this new outlook as well: financial systems to track and manage capitation payments against a fixed budget; reinsurance and stop-loss protections, which will enable the ACO to handle extraordinary costs without threatening the financial viability of the enterprise or its providers.

**Changing Relationships With Patients.** Capitation has the potential to engender a closer and more supportive relationship between providers and patients. However, capitation contracts also give providers a direct economic interest in closely managing the costs of care for their patients, which could change the relationship in a different way. Providers should be transparent with patients about these changed incentives. In addition, under capitation providers may be working with tools to help them control costs—utilization management systems and processes, including prior approval and denials—that have historically been a major point of friction between consumers and health plans. Unless capitated provider groups handle these “customer-disappointing” functions thoughtfully, they will run the risk of damaging their relationships with the patients they serve.

**Redefining “Us” and “Them.”** Providers operating under capitation are essentially limited networks, with sharp distinctions among three different cohorts of providers: those participating in the ACO, those outside the payer’s established network, and those participating in the payer’s network, but not in the ACO. In any network, providers have an incentive to keep as much patient care as possible within their network; this will be particularly true for networks operating under capitation, so payments will support those participating in the ACO.

**What Happens If We Succeed?** A final challenge that ACOs will face under capitation is how they will handle the hoped-for reductions in utilization and cost if all goes according to plan. Successfully reducing referrals for specialty care and hospital admissions may yield cost savings overall, but could also reduce income to participating providers. Some ACOs may be able to offset lost volume and revenue through market share growth, but many will face an uncomfortable issue: how to handle lost revenue and excess capacity among participating providers.

## Health Plans

**What Business Are We in?** The first challenge facing health plans is capitation’s threat to their business model. Under capitation they are moving away from their traditional role as insurers offering purchasers actuarially sound coverage for health services for their members, and then negotiating contracts with health care providers to purchase those services. Historically, plan profits have been largely the result of achieving a spread between the premium they receive and the actual costs of providing the covered services to the populations they cover. Under a capitated contract, plans’ opportunities for achieving that profit are reduced and transferred to the contracting ACO. More of the payers’ margins will come from their broker role developing health insurance products and marketing them to

purchasers, and perhaps from commoditizing their information technologies and selling their data analytics capacities to delivery systems.

**Spreading Infrastructure Costs over a Shrinking Base.** Under capitation, payers are delegating some of their risk and a range of important functions—care management, claims payment, quality improvement, utilization management—to provider groups. Although capitated ACOs can take responsibility for many functions historically in the payers’ purview, the payer must maintain its own infrastructure to serve the remainder of its traditional contracts, amortizing the cost of maintaining those capacities over a smaller base.

**Duplication and Its Costs.** Duplication of functions creates economic inefficiency for the payer, and it increases total system costs, as providers and payers operate duplicate infrastructures. It also has the potential to create confusion for members, who may not know which care manager they should be working with.

This raises the question of the optimal place from which to mount and operate such services, and whether this is an issue that would be appropriate for a more unified approach and perhaps regulation: How and where should such services be organized, and what standards should be used to measure their performance?

**Partnering—With Whom?** Conventional wisdom suggests that payers will ultimately develop capitated contracts with large, hospital-led systems; but some payers (e.g., United/Optum and Universal American) are partnering instead with organized physician groups, investing in the physician groups’ infrastructure and care management capabilities, and counting on them to reduce hospital costs without the explicit partnership of the hospitals. It is not yet clear whether other payers will pursue this strategy too.

**Enabling Your Own Competition.** As provider groups (physician groups and systems) accepting capitation gain more experience with the insurance business, more providers may follow that path, developing and offering branded insurance products of their own. In the long term, plans offering capitation contracts to provider groups may, in fact, be enabling their own competition.

## Consumers

**A Closer Relationship With Their Provider Organization.** Consumers served by capitated ACOs are likely to have a different experience with their providers and health plans and a different set of relationships with them. When the ACO takes on functions like care management, patient education, and customer service, consumers are likely to have closer and more effective relationships with the delivery system. This may help increase patient engagement.

**Services Covered.** A capitated ACO has the flexibility to modify what services are covered, and in what settings. This could mean that members could receive expanded access to high-value services (e.g., telephone communications, e-visits, or home visits) that historically have not been covered under FFS payment systems.

**Deductibles and Copayments.** ACOs accepting capitation may choose—with the assent of the sponsoring plan—to modify the way they implement a health plan’s policies for co-insurance and deductibles, lowering barriers to high-value care (especially prevention and primary care), in order to ensure that the patients have access to those services, which are likely to improve quality and reduce avoidable utilization.

**Anticipating Conflict.** Capitation gives provider groups incentives to more closely manage care, utilization, and costs of care, and it can give them new tools to do so: utilization management systems and processes, including prior approval and denials. Consumers need to better understand the nature of these contracts and required disclosures; how capitation can affect relationships with their provider group; what their rights are and how they can appeal decisions with which they do not agree; and what pathways exist for resolving conflicts with the provider group over utilization management decisions.

**Defining and Marketing the Product to Consumers.** Capitation contracts to provider groups are new and unfamiliar to many consumers, and providers and plans will need to consider how best to offer and explain those new products to purchasers and members. Today, many shared savings contracts are largely invisible to consumers and purchasers, operating “below” an existing health plan offering. In those cases, there is a question as to whether such arrangements need to be more clearly identified as a different offering, with full disclosure to the members regarding the narrow network with which it has contracted and the incentives under which the group is operating. In capitated contracts there is much tighter alignment between the plan and the provider group. This may lead to more consideration of co-branded managed care offerings, in which the terms of the agreement, incentives, and expanded role of the provider group are made more explicit.

## **Policymakers**

**Aggregation.** As providers consolidate into multispecialty groups and tightly organized systems in order to perform effectively under accountable care contracts with specific payers, they are creating larger and more unified care systems. These systems can command higher prices from their remaining payers. Policymakers today are of two minds on this phenomenon. On one hand, it furthers a stated public policy objective: creating higher-performing, clinically integrated health systems that can offer more patient-centered, less fragmented care. On the other, the creation of partnerships in place of competition among groups increases market leverage and may raise antitrust concerns in some cases.

**Protecting the Public Good.** As the formulation “full-risk capitation” indicates, a provider entering into such a contract faces some financial risk—it may lose money, perhaps enough to destabilize the ACO or its major provider partners. Though insurance risk remains with the health plan under a payer-offered full-risk capitation program, there is real potential that an ACO participating in a capitated contract could be financially destabilized. This issue

was recognized and addressed in the drafting of New York State's ACO regulations,<sup>8</sup> under which provider groups licensed as ACOs accepting shared risk and full-risk capitation contracts must provide evidence to the State that they have adequate resources and reserves to cover excess expenditures, and reinsurance and stop-loss coverage to protect the organization from unforeseen, extraordinary expenses. As more providers (particularly safety-net institutions) move into risk-transfer arrangements, such protection will require ongoing attention by State regulators.

**New Hybrid Structures in a World of Silos.** Finally, as providers move further into the insurance business, and as payers develop increasingly close relationships with providers and provider groups, the historically bright line marking off insurance from the delivery of health care services has begun to blur. As discussed in a recent UHF issue brief,<sup>9</sup> there are questions as to whether the regulatory system currently in place in New York State is equipped to manage this transition effectively and in the public's interest.

The aggregation of providers into ACOs and their evolution into provider-payer hybrids raises concerns about how and to whom these new mega-systems will be accountable. The current regulatory structure has not yet adjusted to effectively oversee integrated risk-bearing provider groups with many clinical specialties, but instead uses licensing and zone-specific regulations to focus on separate silos of activities by providers and plans.

## Some Open Issues

Full-risk capitation—under which providers accept a fixed budget for the total care of defined populations—is an appealing concept. It has the potential to improve the overall performance of our health care delivery system by giving providers clear incentives to improve quality and contain cost increases, and the flexibility to do so. When ACOs accept full-risk capitated payments, capitation has the potential to greatly increase the alignment between providers and payers around the goals of health reform: to improve quality, to improve the patient experience, and to restrain growth in the total costs of care, which is the primary driver of health insurance premiums.

The spread of capitation will be accompanied by great changes in the roles of providers and payers. In the foreseeable future, providers and payers will be inhabiting two different worlds, each with a mixed portfolio of fee-for-service and accountable care contracts, some of which may involve full-risk capitation. In that context, both providers and payers will need similar infrastructures to manage populations and finances—but that duplication has

<sup>8</sup> These regulations require detailed financial filings to the Commissioner of Health and Superintendent of Insurance, and actuarial certification that the terms and conditions of the financial risk-transfer contracts and given proposed stop-loss and reinsurance arrangements put in place are not expected to threaten the financial solvency of the ACO. [https://www.health.ny.gov/regulations/recently\\_adopted/docs/2014-12-31\\_accountable\\_care\\_organizations.pdf](https://www.health.ny.gov/regulations/recently_adopted/docs/2014-12-31_accountable_care_organizations.pdf)

<sup>9</sup> Newell P, CS Shearer, and N Thaper. November 2015. *Setting the Stage for Payment Reform: Updating New York's Regulations on Risk Transfers Between Health Plans and Providers*. New York: United Hospital Fund. <http://www.uhfnyc.org/publications/881080>

considerable costs. It seems clear that that duplication will increase total system costs as providers and payers develop and maintain overlapping or duplicate programs; and that it also has the potential to create confusion for purchasers, members, and patients, who may not be certain with whom they are contracting for their care. The duplication of care management platforms by providers and payers is a particular concern, since care management is generally focused on patients with complex care needs—who tend to be vulnerable and in need of consistent support.

Capitation also sharpens the question of whether such arrangements represent providers moving into the business of insurance; and if so, how and by whom they should be regulated. This shifting role argues for a regulatory system capable of overseeing hybrid insurance-delivery system arrangements.<sup>10</sup>

The growth of accountable care contracts, particularly capitation, signals changes in payers' roles and business models that are already underway, as they continue to develop new relationships with providers and ACOs. Some payers are building new business models, in which they would provide a range of financial, data analytics, and customer-facing services to provider groups pursuing accountable care, in addition to traditional insurance products.

A major unanswered question is whether enough provider groups will pursue capitation and be sufficiently successful at it to make a real difference in the health care and health insurance marketplace. As the experience of ACOs across New York and the nation shows, performing under shared savings and shared risk contracts is a challenge for providers accustomed to the fee-for-service world.<sup>11</sup> Succeeding as an ACO requires resources, time, leadership, and focus. It remains unclear whether any but a few highly evolved delivery systems will be able to succeed under the far more demanding capitation model.

Not every organization will be able to make the investments required to operate under full-risk capitation, and fewer still are likely to succeed. Because they are responsible for any expenditures beyond their fixed budget, there are real costs to generating losses—the threat of destabilizing providers and provider systems. This issue is clearly a concern for the State as it considers how to oversee and regulate these new risk-transfer arrangements.

As New York State and Medicare continue to move aggressively toward value-based payment, making risk-sharing arrangements between payers and providers the new normal, some caution may be warranted about how far and how fast providers and payers may actually be able to move toward capitation. This caution is particularly salient when one considers the potential acceptance of capitation contracts by DSRIP's Performing Provider Systems, many of which lack the history, trust, and integration among participating providers, and the infrastructure required to succeed under such contracts.

<sup>10</sup> Newell P, CS Shearer, and N Thaper. November 2015. *Setting the Stage for Payment Reform: Updating New York's Regulations on Risk Transfers Between Health Plans and Providers*. New York: United Hospital Fund. <http://www.uhfnyc.org/publications/881080>

<sup>11</sup> Burke G and S Brundage. April 2016. *Performance of New York's Accountable Care Organizations in Year 2 of the Medicare Shared Savings Program*. New York: United Hospital Fund. <http://www.uhfnyc.org/publications/881114>

## Appendix

In preparing this report, we interviewed these leaders about their experience in providing or purchasing care under shared savings and capitated payment arrangements; they were all extraordinarily generous with their time and insights.

### Our Expert Panel: Individuals Interviewed

Thomas Auer, MD	President and CEO, Bon Secours Medical Group
Lawrence Casalino, MD	Weill-Cornell Medical Center
Henry Chung, MD	Medical Director, Montefiore CMO
Dennis Horrigan	CEO, Catholic Medical Partners, Buffalo (retired)
Farzad Mostashari, MD	CEO, Aledade
Barbara Radin	Ex-CEO, Bronx RHIO; Ex-Executive Director, MetroPlus (retired)
Stephen Rosenthal	CEO, Montefiore CMO
John Rugge, MD	CEO, Hudson Headwaters Health Network
Stephen Shortell, MD	Univ. of California, Berkeley
Hal Teitelbaum, MD	CEO, Crystal Run HealthCare
Mark Wagar	President, Heritage Medical Systems
Paul Zurlo and colleagues	EmblemHealth