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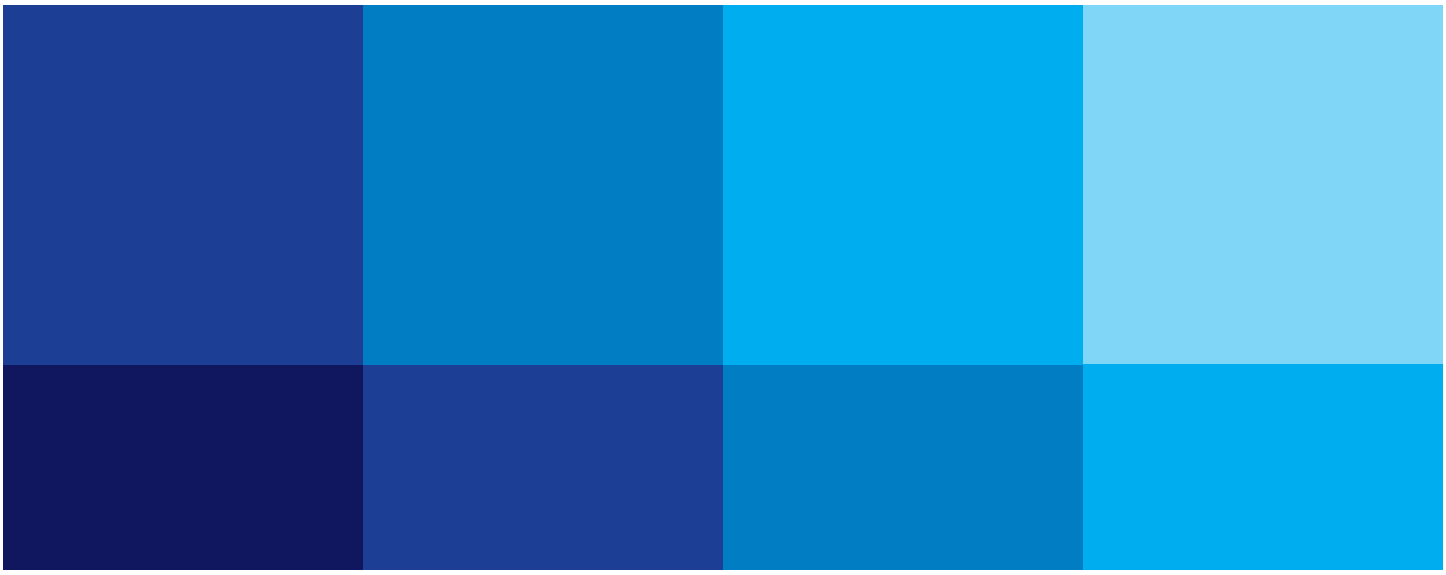

Providers Want Capitation, But What Are Health Plans Thinking?

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Health plans recognize that a successful future requires strategic ties to their provider partners to ensure patient access and high quality care. Payers and providers alike have saluted the Affordable Care Act (ACA) precept that such partnerships involving advanced payment methodologies are beneficial for patients, providing financial incentive to providers and resulting in lower costs of care for payers.

However, will a Biden Administration continue to back the move to more value-based payment (VBP) agreements? Covid-19 has now upended local, state and federal economies, with corresponding declines in commercial health coverage and a forecasted upsurge in public coverage.[1] Looming budget constraints will jolt all sectors, including health care. Will advanced payment, including capitation, grow in a post-crisis health industry with many payers lacking the necessary internal systems and capabilities to appropriately support capitation and other robust risk arrangements?

In a series of interviews with experts composed of payers and providers with successful experience in capitation and other risk arrangements, we explored whether there is a continuing imperative for VBP. Their conclusion? The trajectory to capitation remains directionally solid amidst new challenges and a new presidency. One caveat is that provider readiness, payer capabilities and local market conditions will continue to slow uptake in some regions. Experts further caution against

inertia, which has a strong magnetism to return to the "normal" fee-for-service (FFS) payment structure despite the longer-term likelihood of lowered reimbursement.

However, the imperatives on the Medicare and Medicaid programs, as well as employers, to lower total costs of care amid higher enrollment indicate that the most successful plan and provider entities will build the core capabilities for value-based care. Even in regions with no history of capitation or significant risk arrangements, leading providers will bring new payers into the market with capitation capabilities and take advantage of new programs, such as CMS Medicare Direct Contracting, to access and win in capitation.

Five insights became clear in our conversations:

1. ALTERNATIVE CARE MODELS, INCLUDING TELEMEDICINE, ARE HERE TO STAY AND WILL CAUSE IMMENSE DISRUPTION IN CARE AND PAYMENT MODELS.

The experts we interviewed describe the delivery of services through e-visits, mobile care services, hospital at home, remote monitoring and retail clinics as unstoppable, and that the model has met its moment. Ideally suited to addressing fundamental challenges posed by the coronavirus, telemedicine enabled clinicians to safely triage and treat patients with Covid-19 or concerned patients.[2] Telemedicine has helped manage chronic illnesses or other non-virus-related problems without putting patients at risk.

Telehealth in various iterations has lowered utilization, cut the cost of delivering a significant portion of care and will remake office and inpatient care and patient flow models.[3] As these benefits have been widely recognized, Medicare, states and private insurers have made numerous changes to encourage use of telemedicine. For example, providing follow-up visits via telemedicine, as medically appropriate, may well continue to be the standard of care, emphasizing patient convenience.

Accordingly, this new health care "ecosystem" of disruptive care models unsettles traditional "per click" FFS revenue models, with which most health plans and providers are comfortable. For providers who are paid FFS and who operated under the relaxed emergency rules, the likely reintroduction of requirement of Health Insurance Portability and Accountability Act (HIPAA) compliant platforms will likely result in declined utilization. FFS payers will also wish to implement checks and balances to mitigate excess utilization and to lower telehealth reimbursement.

The regulatory environment, including Medicare policies allowing accountable care organizations more freedom using telemedicine, cost pressures, and both provider and patient demands for convenience, will require providers and payers to collaborate to create innovative payment arrangements that support the use of telehealth solutions.

Thus, as the pandemic lingers, providers, health plans and policymakers face a difficult challenge in designing an optimal payment schedule and regulating compliance policies to govern telemedicine visits in the long-term. Payment policies will require a balancing of interests. On one hand, practices must buy the right technology, invest in staff training, change clinical schedules and help their patients obtain and navigate the necessary technology. On the other hand, telemedicine's ability to make care convenient and more accessible may also encourage excessive use of care and high billing of telemedicine visits.

Our experts advise that both the regulatory environment, including Medicare policies allowing accountable care organizations more freedom using telemedicine, cost pressures, and both provider and patient demands for convenience, will require providers and payers to collaborate to create innovative payment arrangements that support the use of telehealth solutions. A more enduring model than fee cuts will be to incentivize patients to use remote care venues as medically appropriate, while reward providers for reducing FFS care models, something supported by capitation or other risk agreements that reward high quality and a reduced total cost of care.

2. THE FUTURE FINANCIAL SQUEEZE FROM FEDERAL, STATE AND LOCAL GOVERNMENTS WILL REJIGGER PAYER AND PROVIDER STRATEGIES.

The ACA remains at some risk, with declines in commercial coverage from job losses, increasing Medicaid enrollment. Medicare is projected to be insolvent by 2026, if not sooner.[4] The squeeze of future dollars as federal and state money faucets slowly close amid alarming deficits will demand further delivery system economies.

Because of the combined health and economic crises, states have been forecasting severe declines in tax revenue, with projections indicating between 5 and 15 percent reductions in revenue for fiscal year (FY) 2020 and reductions of 10 to 25 percent for FY 2021 (albeit with some recent moderation of these numbers as some states such as California encountered unexpected windfalls in tax revenues even amidst the Covid-19 impact). These declines in revenue come at the same time states are facing significant expenditures related to the public health crisis.[5] Since the main tool in the government's toolkit is to cut reimbursement, all parties will need to do more with less. Implications for state health care programs will vary, with some states implementing across the board cuts, while other states opting to hold health care harmless.

Despite the obstacles, providers increasingly believe they must move to risk-based relationships, especially having recently experienced volume reductions under Covid-19.

This "cash crunch," amid increased demand, will require payers and providers to move beyond crisis mode to rethink core strategies, benefit design and provider relationships. Traditional provider coping strategies of provider cost shifting - from low public rates to higher commercial rates - will likely be constrained in part by lower commercial enrollment.

Experts are clear that these skinny wallets will pressure payers and providers to further transition to VBP. As "prudent payers," state Medicaid programs will apply more and more pressure on health plans and providers to show them what they are buying for each dollar.[6]

CMS has methodically moved towards VBP with greater downside risk accompanied by greater access to medical loss ratio (MLR) savings. Despite widespread support for VBP programs and CMS' increasing promotion of downside risk, adoption by providers has been slow and challenged by lack of supporting infrastructure, issues related to changes in business models and a continued ability to make money within existing FFS arrangements. Managing financial risk effectively requires additional staff and resources, including capital reserves and data systems to manage financial benchmarks.[7]

Many providers struggle to overcome the investment hurdle needed to leap beyond current FFS, usually with some upside savings opportunities accessing half of the available savings generated on MLR, to the ability to access 70 to 100% of the savings generated on MLR in a capitated or other full risk model.

However, under FFS payments, providers – physicians, hospitals and facilities – have experienced painful financial vulnerability to severe reductions in volume initially resulting from Covid-19 and from payer efforts to move procedures to outpatient settings, including MRIs and CT scans.[8] Therefore, despite the obstacles cited above, our experts concur with those providers that increasingly believe they must move to risk-based relationships, especially having recently experienced volume reductions under Covid-19.

3. IRONICALLY, WHILE SOME PROVIDERS NOW VIEW "RISK-BASED CONTRACTS" AS LESS RISKY THAN VOLUME-BASED FFS, PAYERS ARE NOT EQUALLY ON BOARD WITH OR READIED THEMSELVES WITH THE CAPABILITIES REQUIRED TO INCREASE SUCCESSFUL AT-RISK REVENUE PARTNERSHIPS.

As the pandemic scared patients away from elective procedures and routine care, awareness and interest among providers about the value of a predictable income stream has accelerated.[9]

However, our experts noted that payers do not appear to be "voting with their feet" in entering into capitation arrangements. Little global capitation is shifting from health plans to first-tier provider health systems or large organized physician groups such as IPAs, if viewed as a percentage of the total cost of care.[10]

Why may health plans be reluctant to enter into risk-based relationships? While few experts noted current health plan significant profits and a lack of pressure to move from discounted FFS with back-end utilization review, many more cited a lack of confidence in the hospital and physician communities.

Among the obstacles:

- Hard-set provider FFS mentality
- Lack of leaders with a track record of success
- Limited physician and ancillary staff networks
- Inadequate value-based care infrastructure
- Lack of informatics to successfully manage care and capitation

Conversely, health plans may lack the supportive infrastructure and necessary systems in most states to manage risk transfer. Even health plans that capitate providers in other areas of the country may not have the systems in other locales to support capitation. It is even more challenging if there is further delegation of responsibilities such as maintaining networks, paying claims or managing utilizationthat take significant time and capital to develop.[11] Health plans that delegate core activities, such as utilization management, network maintenance and claims adjudication and payment, face the significant additional challenges of providing oversight and ensuring compliance.[11]

Our experts agree that despite the challenges, putting more dollars in the hands of providers affords caregivers the "ability to improve outcomes and reduces costs in a way that is financially feasible for both

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parties."[12] They stress that it is not about "risk" or "incentives," it is about giving health care providers the ability/flexibility to sustainably improve quality and enhance efficiency of care delivery.

What our experts are also seeing is a greater willingness and urgency from providers to identify "portable" health plans with capitation capabilities that can move into a new region and grow capitated business with willing and ready providers, particularly for Medicare Advantage and with the advent of the new Medicare Direct Contracting program.

4. PAYERS ARE INCREASINGLY SEEKING END-TO-END CONTROL OF HEALTH CARE SERVICES THAT MAY OR MAY NOT INCORPORATE CAPITATION AND ARE LOOKING TO FIND WAYS TO WORK WITH PHYSICIANS TO IMPROVE PERFORMANCE AND MOVE THEM "UP THE LADDER" ON COST AND QUALITY.

While our experts view health plans as currently flush with cash, these plans face current and future imperatives to lower per capita costs of care, competition from new market entrants, including vigorous private equity ventures, an era of consumerism and demand for whole-person care and health equity.[13] Health plans, venture capital, hospitals, health systems and physicians are eyeing innovative "partner" relationships. In so doing, the traditional boundaries of payers versus providers blur. For example, a growing number of payers are consolidating health care services and providers under a variety of contractual and revenue relationships.[14] OptumCare (owned by UnitedHealth Group) has led the way in many parts of the country; however many other health plans are now exploring provider group purchases in order to protect and grow market share and reduce hospitalization.

All of these models lower expenses by shifting care out of the hospital to less costly settings and by managing care and eliminating waste. However, while health plans work to shift utilization outside of the hospital, they also recognize that multiple care "venues" increase the risk of disastrous care delivery fragmentation.[15] Moving patients away from their traditionally valued primary care providers may only be an effective short-term strategy. Thus, payers view streamlining operations with key partnerships and patient-centric solutions that easily integrate with existing data systems as increasingly fundamental to their role in organizing access to care.

The experts we interviewed advise calibrating "spending" on value-based care infrastructure more incrementally and tying to reimbursement, in contrast to seeking full capitation too early.

Recognizing the need in some parts of the country to stabilize the provider networks hammered by Covid-19, many health plans are supporting providers through advanced payments, loans, grants, etc. and are looking for a more innovative collaboration model.[16] These longer-term partnerships can provide the impetus for joint investment that justify infrastructure and expansion, such as telemedicine and remote monitoring. Additionally, collaboration with select providers may allow the health plan to penetrate a new market that previously did not make sense without an anchor provider partner.

5. CAPABILITIES TO MANAGE ALTERNATIVE REVENUE MODELS CAN PROGRESSIVELY BUILD IN SUSTAINED PAYER-PROVIDER PARTNERSHIPS.

Providers' magical thinking and "hope as a strategy" has primarily dominated the move to value and capitation. Even though capitation's penetration and at-risk revenue has stagnated, many health systems and providers seeking to move into value-based care have believed that "if we build the infrastructure and capabilities, they, the payers, will come."[17] This may result in building systems that reduce utilization and reduce compensation, without sustainable financial incentives.

The experts we interviewed advise calibrating "spending" on value-based care infrastructure more incrementally and tying to reimbursement, in contrast to seeking full capitation too early. For example, under one model, primary care providers receive a case management capitation, but the care provided is reimbursed using traditional FFS reimbursement.

In these "partial cap" models, the provider supplies the network and care management, while the health plans continue to pay claims and provide other transactional services, such as utilization management and credentialing. Health plans and providers collaborate to reduce administrative overhead. The health plan shares utilization and quality data with the provider organizations, and together, they work to increase quality, create efficiencies and reduce the total cost of care. Different structures of partnerships that bring unusual players to the table in non-traditional configurations will continue to evolve.

CONCLUSION

Despite the challenges, experts agree that the slow pace of the spread of capitation should not minimize that it is a vital survival strategy for both payers and providers. With CMS now offering capitation for the first time directly to providers through Medicare Direct Contracting it is making it clear that capitation is going to play a key role in provider alignment through VBP arrangements. Our experts conclude that the trajectory to value remains a sound strategy in light of Medicare and Medicaid program fiscal realities, amid higher enrollment, as well as pressure from employers to cut costs. Notwithstanding the strong pull of FFS inertia, the most successful plan and provider entities will succeed in building or buying the core capabilities for success in risk arrangements.

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FOOTNOTES

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