CAPITATION AND RISK MANAGEMENT

January 5, 1996

John Ashbaugh
Human Services Research Institute
2336 Massachusetts Avenue
Cambridge, MA 02140
(617) 876-0426

Gary Smith
The National Association of State Directors of Developmental Disabilities Services, Inc.
113 Oronoco Street
Alexandria, VA 22314
(703) 683-4202

CAPITATION AND RISK MANAGEMENT

John Ashbaugh, HSRI **Gary Smith, NASDDDS**

February 5, 1996

The compelling feature of managed care to entitlement-weary policy-makers and budget makers is the ability to capitate their funding obligation, shifting some or all of the risk for expenditures over and above the cap to managed care organizations. The risk may be shared by providers and consumers. There are a number of different schemes designed 1)to share the risk and 2) and to keep it at a reasonable (productive) level.

Assigning Risk

Managed care organizations are often differentiated in terms of the amount of risk that they assume. There are three models: full risk, partial risk, and no risk.

MCO (full risk). An entity (usually a private for profit organization) assumes a full-risk, capitated contract for plan eligibles. The organization is responsible for any costs above the agreed upon capitation amount. When an MCO is placed at full risk, almost by definition it must have relatively wide-ranging authority over nearly all dimensions of system operation. The narrower the MCO's range of authority, the higher the risk that itwill not be able to manage the system within the capitated amount.

MCO **(partial/shared risk).** Unlike the full-risk model, the MCO's liability is limited by excluding some expenditures from the cap, or by limiting the MCO's liability for expenditures above a pre-determined cap with the payor (state) usually covering,. The risk may be shared in a number of ways:

Stop loss or reinsurance provisions typically hold the contractor (MCO or provider) liable for the full cost of services to an individual up to a set dollar amount, commonly termed the *attachment amount.* The contractor is then liable for a percentage of any expenses above the cap up to a ceiling beyond which the contractor has no liability. The stop loss provisions may cover the entire managed care plan, or may cover some subpopulations and not others; some services and not others.

For example, if :
an MCO opted to participate in the stop-loss program with an attachment amount of $50,000;

the risk was divided 80% state, 20% MCO; and the MCO incurred a cost of $80,000 serving an individual enrollee.

Then:
the MCO would receive $24,000 in addition to the $50,000 capitation payment (80% of the difference between the total cost and attachment amount)

Source: Kaye, Horvath and Sherman, 1995,p.48)

As stop loss provisions apply on a consumer by consumer basis, it is conceivable that the aggregate cost of serving all consumers could exceed the payments made by the state through capitation without any individual case exceeding the attachment amount (Kaye, Horvath and Sherman, 1995) if the costs for most consumers ended up above the average cost figure used in setting the cap. This would more likely be the case with MCOs operating in a system with voluntary consumer enrollment where lower-cost consumers gravitate to one MCO and leave the higher-cost consumers to another.

Risk Corridors have been used by states primarily to guard against such selection bias (Kaye, Horvath and Sherman, 1995). They operate on an aggregate as opposed to an individual basis with the state (payor) and MCO (contractor) sharing responsibility for any surpluses or losses for the entire consumer population or specific subpopulations. The state's share of the surplus or deficit in the formula depends on the exact amount of the plan's surplus or deficit and usually changes as the surplus/deficit amount increases.

For example, a plan might provide that:

If the MCO generates an annual surplus or deficit of less than 5% of the of revenue in **(**first risk corridor), the plan retains 90% of the surplus or deficit and 10% accrues to the state

If the MCO generates an annual surplus or deficit of between 5 and 15% of revenue (second risk corridor), the plan retains 50% of the surplus or deficit and 50% accrues to the state

If the MCO generates an annual surplus or deficit greater than 15% of revenue, the MCO retains 10% of the surplus or deficit and 90% accrues to the state.

Source: (Kaye, Horvath and Sherman, 1995), p5l-2].

Depending on the situation, the state may increase or decrease the number of risk corridors, increase the size of the risk corridors or change the percentage shares of the surpluses or deficits. It is important that the state clearly delineate the allowable and non-allowable costs to be used in calculating the surplus/loss amounts. An audit procedure must be established to determine these costs.

MCO (no risk) Managed care organizations (MCOs) that assume no risk to their base funding may also be known as third party administrators (TPAs) and administrative service organizations (ASOs). These organizations typically assume some. not all, of the responsibilities of a managed care organization and are not fully accountable for the performance of the service delivery system. MCO's may be offered limited incentives marking the achievement of specific performance objectives.

State agencies designated as MCOs may be full or partial risk MCOs to the federal government (HCFA), but by definition can only be no-risk MCOs to the state and state taxpayers. County agencies designated as MCOs by a state might be full or partialrisk MCOs to the state, but can only be no-risk MCOs as far as county taxpayers are concerned. The Arizona Division of Developmental Disabilities is a full-risk MCO from the perspective of the Health Care Financing Administration under the provisions of the I *1* 15 Waiver. However, from the state's perspective, it is a no-risk MCO since the State is responsible for covering all expenditures beyond the federal cap set for Arizona's Long, Term Care System for people with developmental disabilities.

Co-capitation. Managed care organizations (MCOs) might share the risk with other MCOs. For instance, a managed long term care organization responsible for the long term support of persons with disabilities might arrange for their medical care through a managed health care organization. Rather than work under two separate caps where the counter-productive tendency is for the MCOs to shift responsibilities and costs one to the other, they agree to work under a single cap with a pre-arranged method for sharing any surplus or loss. Similarly, a managed care organization might contract with managed services organizations) to provide long term supports to disabled enrollees through the MSO network(s) of services and supports. Again, there is a prearranged method for splitting any surpluses or losses.

Subcapitation. Managed care organizations might pass risk on to their service providers with some providers paid on a capitated basis rather than a traditional fee-for-service basis. Payers or managed care organizations might authorize these payments directly or arrange for the consumers themselves to authorize payment.

Under all risk sharing arrangements, each organization or individual sharing in the risk must have reserves. The reserves should be sufficient to meet their service obligations under the worst case scenario.

Limiting Risk

The agency imposing, a cap--state (payer) or MCO-- may also limit the risk to the organizations) agreeing to work under the cap--MCO(s) or provider(s)--in various ways. it may adopt consumer-centered capitation rates, "carve out" risky populations or services, allow for the retroactive settlement of some MCO claims, or limit the number of enrollees an MCO, MSO or provider is obligated to serve.

Multiple Consumer-centered Capitation Rates. In capitation, the state as payor can limit the risk to the MCO by paying the MCO different capitation amounts for individuals based on expected differences in their utilization patterns (costs). While single rate systems are relatively simple to construct (divide current service dollars for services included in the scope of benefits) by the expected/allowed number of enrollees discounted by how many individuals those dollars are expected to accommodate. Single rates represent capitation at its most "global" level. A single rate approach pays the MCO the same fixed amount per enrollee without regard to the enrollee's characteristics or expected service utilization patterns.

The multiple rate systems can be more sensitive to variations in demand; they enable an MCO to be paid commensurate with the needs of the consumers served thereby decreasing the risk of payments being too high or too low. However, they can be difficult to develop. They hinge in part on the availability of data that can serve as a valid basis for constructing what are termed "rate cells".

Rate Carve-outs The state may carve out or exclude some subpopulations, services and supports from the capitation scheme where the associated costs are relatively unpredictable or unmanageable. There is no advantage to the state as payor to increase the risk to MCOs unless there are potential efficiencies to be gained by the MCO's managing the risk. Furthermore, where figures on the current costs of serving particular consumer subpopulations or of providing particular services and supports are uncertain (unpredictable), it makes little sense to include these wild cards under the cap. Capitation rates that prove too low hurt consumers, the MCOs and providers. Capitation rates that are too high, stand to cheat the taxpayer and those consumers awaiting the shortened supply of services and supports. This is not to say that carved-out subpopulations, services and supports should remain perennially apart from the cap. Every effort should be made to understand and learn how to manage the costs of these subpopulations, services and supports to the point where they can reasonably be managed within a cap. Still there may always be some subpopulations, services and supports where that is simply not possible in the foreseeable future.

Retroactive Settlement. It may make sense for the state to allow the MCO to claim some or all of any expenses incurred for the utilization of some services and supports that prove to be beyond the level upon which the capitation rate is predicated. This would make sense only in the case of those services and supports, the actual provision of which can be cost-managed but which must be available on demand (e.g. crises support). , This arrangement would eliminate or decrease any financial advantage to denying such services to individuals while still allowing the MCO to manage the actual service delivery under a cap. This approach should be constructed carefully so that it doesn't create incentives for cost shifting--for using these services more than necessary.

Solvency Requirements. The state may further limit the risk to the state, MCO and consumer by assuring that the MCO and providers have the working capital ands assets needed to underwrite contract performance under the worse-case scenario. This is done by imposing solvency requirements on the MCO and optionally on providers within the MCO network that are working under capitated rates.

The continuing ability of MCOs to deliver and pay network providers to deliver services and supports is obviously of critical importance to consumers. There are no federal solvency standards for risk-based managed care plans even in the health care field; though, the Health Care Financing Administration recently issued a guide on the subject. A number of state developmental disability authorities have procedures to cover for providers who for programmatic or fiscal reasons cannot continue to operate. However, to our knowledge, few have established standards by which to identify providers let alone networks of providers (MCOs) that haven't the fiscal strength to maintain quality services and supports. The greater the risk being assigned to the MCO(S) or providers, the more important it is for the state to set MCO solvency standards and protections.

Fixing Enrollment. The demand for publicly-sponsored long term services and supports among people with developmental disabilities, let alone the millions of others disabled as adults, far exceeds the resources available to provide them. Even now, residential services in most states are available only to those persons in near-crises situations. Several years ago, the Center on Residential Services and Community Living (1993) estimated that there were roughly 200,000 persons with mental retardation on formal wait-lists for residential, day and vocational services. This doesn't include the many more who don't bother applying given the remote chance of success. While in some states, it may be possible to obligate MCOs to cover unmet demand, in most states this would be unrealistic as states and counties, the end payers, can't afford it.

The risk associated with the unmet demand can and should be kept to a negligible level by confining the managed care or organization's obligation to those currently served plus a reasonable number of others awaiting, services and supports .

Incentives can be included to convert cost savings into waiting list reductions. This fixed obligation with incentives will be no less effective than an open-ended obligation in addressing unmet demand, and will reduce the chances that the MCO will be required to hold reserves well in excess of those required. There is no advantage to broadening (managed care) plan coverage well beyond the ability of the payer and managed care savings to cover.

Close

Capitation is a defining feature of managed care. The use of capitated payments introduces risk to the managed care organizations, providers and consumers that must operate within. It is important that some risk accrue to all parties sharing responsibility for the delivery of supports. It is in the interest of all concerned that the risk is no more and no less than that needed to bring about the more cost effective delivery of long term supports.

Horvath, Jane & Kaye, N. (Eds.). (August 1995). Medicaid managed care: A guide for states, 2nd edition: Volume III. Getting you money's worth: Purchasing and financing Medicaid managed care. Portland: National Academy for State Health Policy.