Managed Care Organizations (MCOs) were established to provide comprehensive healthcare services to their enrollees through efficient utilization management and using cost-effective ways without compromising the quality of care. The traditional insurance plans (Indemnity Plans) used Fee-for-service payment model. This model had no control or regulation on utilization management as well as prices and payment. The focus was more on illness rather than wellness. There was a growing need to control the rapidly rising healthcare cost. Hence managed care plans came into the forefront with their ideas of payment mechanisms which would not only contain the cost but also allow risk sharing between the insurers and the providers. The three key payment mechanisms used by MCOs are Capitation, Discounted Fees, and Salaries.

Capitation

Capitation is a fixed periodic payment per patient to a healthcare provider. The provider is prepaid a flat rate for each member of the managed care plan, irrespective of amount and intensity of services utilized by the member during the contract period. In return, providers are under contractual agreement to provide specific health service or set of services laid out in the agreement. The prepayment is expressed as per member per month (PMPM) dollar amount. This amount is calculated using local costs and average utilization of services, along with adjustments made for age and gender. The patient mix and resource utilization are not the same everywhere, hence the capitation rate varies from one region to another. The first step in determining capitation rate is to define services to be capitated. Then these services are quantified in terms of usage per specific population over a specific period (e.g.,1000 members over a month). Next, an average charge for the service is determined. Finally, the capitation rate is calculated by converting the average charge (e.g., for 1000 members over 1 month) to a per member per month (PMPM) rate.

Under the traditional fee-for-service payment method, the physicians get paid when they provide service. The providers bear negligible risk in this model of payment because they are paid based on services provided. In contrast, capitation allows fixed payments to providers regardless of the volume of services rendered. This shifts the risk from insurer to providers. The providers bear the risk that the costs of providing service may exceed capitation amount. The providers are contractually obligated to provide services even if the capitated amount does not cover the cost of those services. As a result, to generate profit providers must manage the utilization of services such that their costs for those services are under the capitation limits set by MCO. Capitation makes providers assume the full financial responsibility for their patients' service use which gives them an incentive to reduce utilization. Evidence also shows that the same physicians, when paid on a capitation rather than a fee-for-service basis, used significantly fewer hospital admissions in treating patients (Stearns, Wolfe, and Kindig, 1992). The physicians have more incentives to shift focus on wellness rather than illness under this plan. The physicians are encouraged to use preventive and primary care services to keep their patients healthy so that they can also minimize the number of tests, procedures, and services in their future visits. There is also a concern that some physicians might intentionally under-utilize resources withholding required care to the patients. MCOs keep a check on such practices through periodic utilization reviews and peer review panels.

There are several types of capitation plans such as Primary Care Capitation, Specialty Capitation, Total Physician Capitation (Global Capitation), etc. Primary care capitation covers all primary care services while Specialty Capitation is intended to cover all the specialty services. Total Physician capitation includes both primary and specialty services, allowing physicians to provide integrated care and achieve necessary coordination between primary care physician and specialist. A provider group is contracted with a capitated rate for both primary and specialty services rendered to the member. This allows the provider group to share risk between both primary care and specialty, preventing the chances of under- or over-referrals.

Discounted Fees

Discounted fee plan is a modified form of fee for service. Under this reimbursement system providers agree to provide health services at prearranged discounts of their regular fee-for-service fees. Providers generally accept such contracts because of the volume of business that MCO can bring them. The fees are discounted by a certain percentage from the physician's usual and customary charges. Similar to FFS model, Providers can bill the MCO for each service rendered to the patient. The reimbursement is through a pre-negotiated schedule known as the fee schedule. Fee schedules are derived from standard schedules, the most common being Medicare Resource-based relative value scale (RBRVS). However, some payers may choose to develop their own unique fee schedules as well. There are other alternative methods as well to present discount to the providers, such as bulk rate or package rate (services bundling), DRG rate, Per Diem method, etc. Per Diem method is a flat fee per day irrespective of number or intensity of services provided.

The insurer bears the risk in FFS type of payment mechanism since payment is based on amount and intensity of services being provided. However, some risk is transferred to the provider in discounted fees plan. Since the payments are discounted, there is some risk, although very less compared to capitation, that payments are lower than the cost incurred. This provides a slight incentive for providers to balance treatment plans keeping cost-effectiveness in mind. MCOs can achieve additional risk-transfer through payment denials and withholds when providers do not follow contractual or medical necessity criteria. For example, failure to get pre-authorization for elective surgery or hospitalization for surgery which could have been done in an out-patient setting may lead to denial by MCOs.

Salaries

Under this payment model, physicians are employees of MCOs and are paid fixed salaries. This method of payment is similar to the original HMO model known as staff-model HMO, where physicians are employed and salaried, and members receive all their services through HMO-run medical centers. Some examples of staff-model HMOs are Kaiser Permanente (Oakland, CA), Harvard Pilgrim (Quincy, MA), and Group Health Cooperative of Puget Sound (Seattle, WA).

Salaried physicians receive their compensation as per their employment agreement irrespective of the number of patient visits or services provided to patients. However, MCOs are able to transfer some financial risk to their employed physicians through contractual agreement of payment adjustments such as bonuses, withholds and retrospective-utilization targets. Retrospective utilization target compares baseline prediction of pre-determined number or level of services utilization over a one-year period with an actual utilization by patients over the year to determine a bonus payment. Physicians meeting utilization target expectations become eligible for the bonus. Some organizations also use patient satisfaction scores, measures of outcomes of care, etc to determine physicians' bonuses. Another payment adjustment that MCOs use is 'withhold'- some portion of compensation is withheld and paid later provided that the physician meet certain performance standards. Unlike other payment mechanisms, salaried physicians also entail risks related to the employment agreement and it is not uncommon to see noncompete or termination of employment clauses in their contract.

Conclusion

The types of payment mechanisms in healthcare are important deciding factors for hospitals' operations and finances. Managed care uses forms of payment methods which allow sharing of financial risk between insurer and provider. This provides incentives for physicians to take part in utilization management and contribute to containing the rising costs of healthcare. At the same time, pay-for-performance models along with various quality measures imposed by Managed care payment models ensure continuing improvement in the quality of care and health outcomes.

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