



Capitated & Risk Sharing Models FAQ

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1. Why do public and private sector payers (i.e., Medicare, Medicaid, etc.) want to change from Fee-for-Service (FFS) healthcare payment models?

A: In a FFS payment model, the provider or facility get reimbursed for **each** service provided. This can create an incentive for providers to increase the volume and cost of services provided versus focusing on value of care provided. This model can also lead to uncoordinated and fragmented care through inefficiencies within the healthcare system, which can also drive up overall healthcare costs.

Source:

<http://www.fastercures.org/assets/Uploads/PDF/VC-Brief-AlternativePaymentModels.pdf>

2. What other types of alternative payment models (APMs) currently exist?

A: Current APMs include, but are not limited to, accountable care organizations (ACOs), Medicare Shared Savings Program (MSSP), pay for coordination, pay-for-performance (P4P), bundled payments, upside- and downside-shared savings programs, partial- or full-capitation, and global payments. To get a brief overview of these types of payments, please visit the sources below.

Sources:

<http://www.ashp.org/menu/PracticePolicy/ResourceCenters/Pharmacy-Practice-Managers/Patient-Centered-Medical-Homes.aspx>

<http://www.mckesson.com/population-health-management/resources/what-payment-models-exist/>

<http://www.beckershospitalreview.com/hospital-physician-relationships/5-payment-models-for-aco-providers.html>

3. What is a capitated risk-sharing model of care?

A: In this model of care, payment is not dependent on the number or intensity of the services provided, but rather risk is shared between provider, patient, and insurance. Payers can establish risk pools which offer incentives for each provider to act in the overall best interest of the patient. These “risk pools” can range from relatively modest “per member per month” (PMPM) payments for primary care providers involved in patient centered medical homes

(PCMHs) to payments covering the total risk for all services (i.e., professional, facility, pharmaceutical, etc.). There are a variety of risk-sharing models based on how providers determine which payments are paid to them based on FFS or via risk-sharing. Newer capitation models also include a quality element to ensure balance between provision of appropriate care and reduction of costs.

Source: American College of Healthcare Executives (Chapter 20: Capitation, Rate Setting, and Risk Sharing)

4. How does a value-based cost of care model differ from a traditional FFS model?

A: Value-based care models are often structured according to a shared-savings/shared-risk model, which incentivize providers to reduce spending for a defined patient population by offering them a percentage of any net savings they realize (upside risk), or having them take a loss on excessive costs (downside risk). Many of the value-based incentives and penalties rely on measuring and reporting clinical quality measures, which can include many aspects of patient care including health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagement, population and public health, and adherence to clinical guidelines. In some models this is built into PMPM rates, while in others it is still separate as a P4P bonus or penalty.

A few ways capitation differs from FFS:

	Capitation	Fee-for-service
Relation of charges to profit	Decreasing volume (of high-cost populations) or lowering costs will result in more profit	Increasing volume and charges will result in more profit
Collection of revenue	Payer payments are collected upfront before services are provided (make profit until breakeven point is met)	Revenues are collected after services are provided (at a loss until breakeven point is met)
Variability of payments	Risk-based payments that may vary based on health of the population (i.e., payments usually higher in higher-cost populations)	Payments do not vary based on the health of the population, just level of complexity of visit
Risk to providers, insurance, purchaser/patient	<u>Providers</u> bear short-term risk because cost may exceed revenues (hard to predict high-cost outliers: atypical patient that requires numerous intensive services that are expensive); <u>Insurance</u> bears long-term risk because providers can increase their contract at renewal; <u>Purchaser/patient</u> still bears ultimate risk because insurance can increase premium	<u>Providers</u> bear little risk because they get paid based on each service they will provide; <u>Insurance</u> bears short-term risk, but can increase premiums next year to offset losses; <u>Purchaser/patient</u> still bears the long-term risk because insurance can increase premium

Source: American College of Healthcare Executives (Chapter 20: Capitation, Rate Setting, and Risk Sharing)

5. What providers are involved in capitated-risk models and are pharmacists recognized providers?

A: In a capitation model, set payments are received and the system decides where to invest those dollars. Provider status does not play as much of a role because it is an outcomes-based system not a “per service” based system. In a risk-sharing model, it comes more into play as there are still FFS payments which systems would potentially like pharmacists to be able to capture, depending on the priorities of the system (patient population, mission, clinic model, etc.). It should be noted that in some cases, pharmacists charging FFS could potentially increase overall healthcare costs (albeit with potential for a good return on investment (ROI)) which could decrease shared-savings or even lead to penalties. Pharmacists can focus on demonstrating savings to the system and/or quality improvement in both capitated and risk-sharing models to ensure resource allocation from the capitated payments. It may also vary depending on the negotiated contract with the network. Typically, capitated payments are used most often with primary care; however, it can be applied to any provider.

6. How is performance measured in the various types of capitated-risk models and what are the components of care that determine performance?

A: The following are defined “Domains of Performance” for a P4P system. These measures are usually reported publicly. Performance may include the following measures:

- Clinical outcomes
- Clinical process quality
- Patient safety
- Access and availability of care
- Service quality
- Patient experience or satisfaction
- Cost efficiency or cost of care
- Cost-effectiveness
- Productivity
- Administrative efficiency and compliance
- Adoption of information technology
- Reporting of performance indicators
- Participation in performance-enhancing activities

Source: <https://www.rti.org/pubs/bk-0002-1103-mitchell.pdf>

7. What role(s) do pharmacists play in capitated-risk models and how do pharmacists break down silos and integrate into an organization’s team-based care?

A: Pharmacists may be recognized as providers based on the contract between the facility/office and the payer. The role of the pharmacist in a capitated-payment model is to work as part of an inter-professional team to ensure patients receive the highest quality care while managing total costs to the patient. The average health care spend for all patients noted in the population of the contract needs to be kept lower than the total amount of capitated payments

for all covered members in the group for the services to be profitable. Specific ways in which pharmacists can play a role in capitated risk models include:

- Decrease medication spending
- Improve chronic disease management
- Assist with Transitions of Care
- Provide Annual Wellness Visits
- Enhance patient access to care and facilitate caring for larger patient panels

8. How do you determine the clinical need for a pharmacist in a capitated-risk model? What data do pharmacists need in order to successfully design services that will align with organizational goals?

A: You can determine the clinical need for a pharmacist by evaluating the organization's current patient outcomes and identifying areas for improvement. Pharmacists will need data regarding target outcome measures for the organization as well as current patient outcomes. It would also be useful to obtain data regarding the utilization of current resources, preventative care, and what is offered by the organization. When looking at outcome measures to evaluate overall care, if for example, patients were not meeting their A1C goals, pharmacists could focus on targeting that patient population and provide ways that we could improve outcomes. Examples could include providing additional diabetes education and adherence monitoring and as well as medication management to adjust doses and make recommendations that are appropriate for the patient in terms of cost, availability, and utility. The most important factor is identifying the area of need within the organization and determining what services pharmacists can provide within the interprofessional team to improve patient care.

9. What data is important to collect to show pharmacist worth and how do you attribute direct and indirect cost savings to pharmacy services?

A: Important metrics to collect to show pharmacist worth could include any of the following, depending on your focus area within the organization: medication costs, specific disease state goals (A1C, BP, etc.), number of hospitalizations, and/or cost-effectiveness of therapeutic or preventative interventions. Direct cost savings could relate to decreases in medication cost and overall cost of patient care. Indirect cost savings would relate to decreases in hospitalizations, ER visits, and prevention of illness and worsening outcomes. By providing services such as comprehensive medication management, disease state management, immunizations, etc., pharmacists play an integral role in decreasing overall costs by optimizing drug utilization, recommending cost-effective therapy options, and providing preventative care. Additionally, pharmacists can provide disease state and medication education to further emphasize the importance of controlling chronic disease states and meeting goals to prevent future hospitalizations and negative outcomes. With available data, retrospective reviews could be performed to compare services with and without pharmacy involvement in team-based care.

10. Who are the key stakeholders in an organization that pharmacists need to engage with in order to establish a pharmacist's presence and encourage the organization to invest any shared-savings on expanding pharmacy services? Who does one contact to get a pharmacist involved in a capitated-risk model?

A: The key stakeholders that the pharmacist needs to engage are the physicians and providers within the organization, leadership of the organization, billing and IT departments, and the patients themselves. Providers and health insurers share responsibility for capitation success and should be contacted regarding pharmacist involvement in the organization and overall patient care. Pharmacists can evaluate the area of need within the organization or setting and determine where we can provide the most support to improve patient outcomes (e.g., MTM, immunizations, specific chronic disease state management, transitions of care, etc.).

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