One question I am frequently asked is "how much should I expect to be paid on a capitated contract", or "is 42 cents a good deal", etc.... People often expect a quick answer. Unfortunately the quick answer is... it depends. Every situation is different because no two contracts are the same. In a national poll, Urology capitation ranged from 29 to 65 cents per patient per month (PMPM). In fact, 65 cents may not be better than 29. Each potential contract deserves careful attention and analysis. Consideration should be given to the multiple features that decide a fair capitation. Time should be spent analyzing and contemplating because this is a contractual commitment. A hurried decision can be costly, as it may take months to eject from a contract. There have already been casualties, as some physicians hastily committed to capitated arrangements they were not able to service at the agreed upon rate.

If properly planned out and carefully implemented capitation can work to the provider's advantage. It can be advantageous to the provider for the same reasons it is advantageous to the medical group because it provides consistency and predictability. It offers the advantage of knowing exactly how much money will be received from each account every month. It may consolidate work that has previously been sent to multiple groups and allows an opportunity for exclusivity and growth. It enforces and encourages efficient use of resources.

Medical groups who contract with specialists capitate for several reasons. Firstly, they themselves are capitated by the HMO. They receive payment per patient per month regardless of services performed. They in turn prefer to capitate their providers because it offers them consistency and predictability. They know in advance what their expenses will be. This makes them a more valuable business entity. They capitate to reverse the incentive of the provider. While on fee for service the provider incentive is to do more, on capitation the incentive is to do less. Not only does this limit expenses in provider services but also in hospitalization costs, pharmaceuticals, home health services, etc. They capitate to shift risk from themselves to the providers.

From the provider point of view the key concepts at play are risk and work. Taking on a capitated contract is a commitment to take on risk. The risk is a willingness to perform work of an unknown volume. In order to be fairly compensated for this, the risk must be calculated and quantified. One of the major variables that go into judging risk includes population and demographics (age, gender). Certainly a population of senior citizens will require more work than a younger population. It is essential to obtain information on the age mix; how many patients under 35, 35-50, 50-65 and over 65. Presently most contracts will break population into commercial (under 65) and senior. A basic rule of thumb in urology is that seniors require 7 to 10 times the work of a commercial group. Capitation rates should reflect this difference. It is advantageous to "carve out" senior and commercial patients instead of blending them together to a single rate. This is because medical groups generally deal in bulk populations and a sudden large increase in senior patients at one time could be very costly if not separately carved out.

Consider the services for which the contract holds the provider liable. Consider radiology, and whether, for example transrectal ultrasound and IVP are expected to be performed by the provider or subtracted from the capitation. Consider if medications such as Lupron and BCG are to be supplied by the provider or subtracted from the capitation. Consider complex surgical cases, or surgical services not performed by the provider. Should the need arise, clarify who pays for it. Consider uncommonly occurring events such as services that arise outside the geographic area you cover. If a patient presents to an ER at a hospital the provider does not have privileges at, who pays the expense? What if the patient is out of town when services are required? These are just some of the variables that need to be considered when calculating a fair capitation.
Capitation can be calculated if you already have exclusive coverage of these patients and have had it for at least 6 months. Then, capitation figures can be based on prior experience. For example, you have had an exclusive agreement to service 15,000 patients at a fee for service arrangement for the last 12 months. You have been paid $88,000 for these services. You are now being asked to switch to capitation. Covered services and patient population are to remain unchanged. This comes out to 48.9 cents PMPM. However, it is important to factor in a behavioral adjustment factor. Previously primary care physicians were discouraged from referring work to specialists. The utilization review committee now has financial incentive to refer the work out to see more patients. One can see a significant increase in volume and should add 10-20% to the predicted level—to 58.4 cents PMPM in the current example. However, depending on the group’s hospital and ancillary arrangements, incentive may vary.

An ideal system would allow one to determine risk based on years of demographic and utilization information nationally collected and regionally adjusted. This information is currently held by the insurance companies who do not freely disclose it. However, it would be valuable for us as providers and business owners to know how many units of work are required to service a particular contract with particular demographics. We need statistics on work units per thousand people for each age range. This could then be applied to the demographic particulars of a contract being entertained. This would need to then be adjusted for community standards, overhead and target profit.

This is a workable goal and should be the aim of the urologic community nationally. An effort should be undertaken by our national organizations to collect data on work units per age group and other vital information. This is essential to enable urologists across the country to deal with capitation—which is certain to be the predominant method of payment in the future.