Capitation Issues

UNDERSTANDING CAPITATION

By example, a typical HMO enrollee pays a premium of $150 per month for a comprehensive policy. Of that, about $18 is used for the plan administration-claims payment, dispute resolution, contract negotiation, marketing and physician credentialing. Another 7% to 10% covers carve-outs and stop-loss. Carve-outs are separate contracts for prescription drugs, mental health services or other items. Stop-loss coverage funds the care of patients whose cost of care is unusually high.

The remaining $117 covers the provision of medical services. About $145 to $155 is for professional services of primary care physicians and specialists and $55 to $60 goes to hospitals and other healthcare facilities.

Many physicians are still paid on a fee-for-service basis, with some portion of the payments withheld and then distributed at the end of the year if a surplus remains. Withholds are a stepping stone to full capitation.

The HMO will typically group its primary care physicians into four- to 15-member primary provider groups. Each group is essentially a risk pool. Group members get withholds back if the group stays within budget. Primary care physicians are generally capitated.

Capitating specialists are more difficult and are relatively rare. Most medical groups involved in capitation prefer to pay specialists on a fee-for-service basis while carefully managing utilization and costs.

Hospital capitation methods include a flat per patient rate, a rate adjusted for age and sex, or a set percentage of the capitation dollar. Hospitals can use several types of risk pool arrangements with their physicians and HMO partners to control utilization and ensure high quality service. These include splitting any dollars left at the end of the year between physicians and the hospital, establishing a target base-use rate for the covered population and then paying an agreed upon per diem payment for each day under the target, or using a combination of these methods.

RISK MANAGEMENT ISSUES

Utilization Patterns. Several forces will cause capitation utilization patterns to differ significantly from fee-for-service experience. First, many capitation programs have historically attracted younger, healthier individuals less likely to enter the health care delivery system. Conversely, a population consisting of primarily older and less healthy individuals would tend to raise utilization expectations. Second, capitated

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programs tend to reverse the underlying risk structure, placing providers at risk for excess utilization.

Malpractice Litigation. Malpractice risk is present regardless of how the provider compensation program is structured. However, certain compensation structures can convey the presence of incentives to deny appropriate care. Courts have recently awarded sums based on the presumption that compensation structures were incentives for someone to inappropriately deny care.

Total Treatment Costs. Capitated providers are generally held accountable for the cost of referrals to other providers and fees associated with medical lab and other facilities used in the delivery of care.

Capitation as Managed Care. Provider capitation is often part of a managed care program, but provider capitation is not managed care on its own merit. True, capitation does place providers at risk and may induce providers to change practice patterns. In reality, most providers are too focused on delivering care to adequately assess the implication of assuming risk.

Fee for-Service Experience Applies. Utilization patterns tend to differ under capitated and fee for-service compensation models. Further, cost structures vary due to provider discounts and other program provisions.

Physicians As Business Experts. Most physicians receive very little practical business training. Complex health care financing programs layer physicians with additional administrative burdens and often represent barriers to cost-effective delivery of appropriate care. In many instances, physicians don't know if the patient they are seeing is or is not capitated.

CAPITATED PAYMENTS ON THE WAY IN?

In the past, the person who paid the bill (an insurance company, the government or the patient) was charged a separate fee for each service. In the future, managed care companies and the government will be paying many of these bills on a *capitated* basis. Rather than paying a fee for each service the hospital and doctors provide, they'll pay the hospital a fixed amount, (negotiated ahead of time) per month, per patient. The hospital and its doctors take on the risk of caring for that patient in the most cost-effective way – avoiding the expense of either overtreatment or undertreatment. Let’s examine an automobile accident.

Past – Fee for Service

- Ambulance company sends a bill.
- Orthopedist sends a bill for setting the arm.
- Surgeon sends bill for operation.

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- Anesthesiologist sends a separate bill.
- Hospital bill for room, drugs and services arrives.
- Neurologist sends in his bill.
- Orthopedist sends a second bill for removing the cast.

The insurance company pays about 80% of these bills. The patient pays the remainder. The employer pays premiums to the insurance companies.

Future – Capitated

The hospital's health care network consolidates the bills for the ambulance service, the room, drugs, services of doctors and the specialists. They all belong to one network.

The managed care company pays the hospital's network a fixed amount per month to care for the patient. The amount was negotiated when the hospital and its physician network signed a contract with the managed care company at the beginning of the year. The employer and the patient pay a fixed premium of say, $200 a month to the managed care company. All of the patient's care is covered as long as he used the company's network of doctors and hospitals, ambulance service, etc.

CAPITATION FROM PHYSICIAN'S VIEWPOINT

Case A

One physician innocently entered an IPA HMO arrangement and took a real *financial bath* almost from the beginning.

A fairly high percent of the new patients had serious medical problems whose care quickly exhausted the physician's capitation earnings, and specialists and hospital costs depleted the money the plan withheld against referrals. By the end of the year, what had looked like a good financial arrangement on paper cost the physician more in uncompensated care than it had paid him.

Capitation arrangements are designed to move utilization risk from payers to providers, on the theory that providers are best able to control services to patients. The problem, of course, is that physicians and hospitals don't control who gets sick or how sick they get.

For the physician, a large number of catastrophic cases, too few patients, unusual illnesses, services or treatment patterns, or simply a miscalculation about who would join the plan can make the difference between a capitation rate the physician can live with or financial disaster.

Case B

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In another instance the physician innocently entered an IPA HMO and got hit with the young married crowd. The physician found himself providing far more obstetrical services than expected. The physician's capitation rate was based on an average utilization that didn't account for nearly so much prenatal care.

The physician would have done better to ask for capitation rates that varied according to the age and sex of enrollees. Then, even if all the plan members who chose him as primary physician were women of childbearing age, the physician's capitation income would reflect the higher-than-average need for medical services of the patients.

Lowering the Capitation Risk

To reduce a physician's risks from losing on capitation, there are several possible steps to be taken:

- Don't move to capitation until the plan sends the physician a reasonable number of patients.
- Get stop-loss protection to cover individual large cases.
- Know the demographic characteristics of the HMO's members.
- Get capitation rates based on patient age and sex.
- Renegotiate contracts after the first year.
- Don't accept risk for service that the physician cannot control, such as out-of-area services.

PHYSICIAN'S CAPITATION AGREEMENT CHECKLIST

A checklist of what a physician might wish to consider before going to capitation, should be of interest to all involved with health care.

Overview – Review of Payment Methods

- *Fee-for-Service.* The practice of charging a specific amount per service rendered is becoming extinct in the managed care environment.
- *Discounted Charges.* Usually differentiated by service category based on volume level, discounts will normally be off *physician's charges* rather than *usual, customary and reasonable fees.*
- *Fee Schedule. A* fee schedule should be attached as an exhibit to the contract; such contract should also contain a reimbursement mechanism.
- *Capitation.* Fixed monthly reimbursements should be designed so the physician can earn just as much for practice time while using that time more efficiently.
- *Withhold/Incentive Arrangements.* Monies withheld to create cost-saving incentives should be placed in an interest-bearing escrow account.

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Procedures for Payment

- Establish a specific time for payment to the physician measured from the date of submission, not the date of approval.
- Avoid attempts to include a waiver provision if a claim is not filed by a certain date.
- Include a provision for penalties for late payment by the managed care organization.
- Stipulate that forms and information to be submitted will be a *complete claim*.
- Define protocol for claim denial.

Length of Contract Terms

- One year is ideal; open is not good.

Termination of Agreement

- *Without cause* clauses are preferred where possible.
- If *with cause* these are the causes:
  (a) Failure of the managed care organization to make timely payment
  (b) Any change by the organization in its subscriber agreement, operational protocols or administrative requirements affecting physician duties
  (c) Failure of the organization to meet certain volume targets
  (d) Material breach of the contract by the organization.

Obligation of Physicians

- Agree to provide the same services to members that are provided customarily to other patients.
- Have the right to bill and collect for co-payment and noncovered services at full charges.
- Do not agree to the so-called *hold harmless* provision, which states the physician will not bill any enrollee for nonpayment of services.
- Be able to refer patients to the physician best able to treat them.
- Agree to accept some minimum number of patients selected at the provider's discretion. There should be no limit on non-HMO patients.
- Reserve the right to refuse to treat patients for any of these reasons: failure to comply with directions regarding care, threats or abusive behavior, refusal to make co-payments, fraudulent or unlawful behavior, refusal to comply with office procedure and policies, or inability to establish a satisfactory doctor-patient relationship.

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- The physician should not agree to indemnify the HMO for patient disputes.

Managing the Arrangement

- The physician should be entitled to payment for services if proper procedures for identification and verification of members were followed, but they were unable to obtain preauthorization prior to treatment, or if verification of eligibility or authorization was erroneously provided.
- The physician, not the organization, should retain the right to determine *medically necessary* and *emergency* conditions.
- No payment may be retrospectively denied; if so, the physician should be able to seek payment from the patient.
- The physician should be able to appeal any precertification or concurrent review denial by phone to the person who made the decision. The organization should be responsible for informing the patient and explaining the denial.
- On any concurrent-review denial, the physician should be paid for services rendered pending deposition of the issue.
- The utilization review of the organization should be included with the contract.

Miscellaneous

- The organization should have access to copies of patients' records only as permitted by law and then should pay for the copying of this information.
- Ensure that the professional liability coverage required is reasonable and that the organization has liability insurance.
- Include a statement in the contract that the physician is an independent contractor and will render all medical judgments and services without interference or control.
- Appropriate state law should govern the contract in any litigation.
- Neither the physician nor organization should be able to assign the agreement without written consent of the other.

CAPITATION IS GROWING IN POPULARITY AND ACCEPTANCE

Recently, many plan sponsors and providers have concluded that capitation offers better sharing of risk and reward than discounting.

Under capitation, a plan sponsor buys a menu of health services for set price. The providers retain the surplus if the cost of caring for the covered population is less than

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the agreed level, or bear the loss if the cost is greater. Employers prefer capitation because it is a guaranteed budget for the plan and makes providers accountable for the cost of the services they render. Providers prefer capitation because the advance payments improve their cash flow and financial position, compared to discounted fee-for service arrangements.

However, employers are concerned about the ability of caregivers to deliver quality services is an at-risk environment.

Will patient services, and ultimately quality of care, suffer if providers under price? Employers should consider and install controls to prevent deficiencies in care whenever capitation is under consideration. This will raise employer diligence to a level acceptable to the employer.

EMPLOYER AND THE HMO

What Employer Looks for in an HMO

- Significant experience in, and an understanding of, the employer's
- marketplace.
- A solid reputation, documented steady growth and financial strength and maturity.
- Local service accessibility to meet employer and employee needs, including field account representatives and trained customer service personnel.
- A large, geographically dispersed provider network that is accessible and convenient to members.
- A formal provider selection process and appropriate provider reimbursement methods.
- A strong primary care physician gatekeeper function and referral process.
- Effective administrative medical resources such as utilization review and a quality management program.
- A commitment to pursue accreditation from the National Committee on Quality Assurance.
- An emphasis on preventive care benefits and value-added health education and wellness programs.
- A willingness to be flexible with plan design and the ability to establish a solid, long-term partnership.

What Employer is Attracted to an HMO

- Curbing rapidly rising costs
- Providing comprehensive benefits – including preventive care

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- Adopting a full managed care approach, based on the primary care physician gatekeeper function
- Maintaining strong employee relations
- Developing a plan that is easy to communicate and easy for members to understand and use
- Simplifying plan administration
- Improving the type of information provided in utilization and experience reports.

CAPITATION AND THE SPECIALIST

In General

Capitation with the IPA-HMO; originally had capitation only for primary care. Increasingly, capitation is being used for the specialists. The result is the specialists are putting together specialty-related networks to help bear the risks of capitation. The end result is the ranks of the specialists will be thinned, with few remaining carrying too great a load because the primary care HMO physicians do *dumping* on the specialists. A specialist, under capitation, can go broke if such specialist is dumped on. Already, networked or pooled specialists are changing their clinical practices by trimming back. Example: cardiologists agree, as a group, to eliminate expensive nuclear treadmill tests and use the cheaper EKGs.

Power of Economic Forces

Managed care is forcing capitation on the specialists; as HMOs are burdened and squeezed, the passing of the buck to the specialists by means of capitation makes good sense. With their economic power, the HMOs proceed to trim down the list of specialists with whom they capitate. Those selected are dumped on; the others lose market share. Result is that health care costs will come down.

Impact on Specialist

When capitation brings down specialists' income, it's usually for the same reasons primary-care physicians have found: the rate is too low, the number of referrals has surpassed expectations, or the contract requires too many services. If specialist and primary-care services aren't clearly defined, primary-care physicians will tend to refer excessively.

Capitated specialists stand to benefit if the HMO-IPA gains new members, raising monthly capitation income. In order to prevent risk from swamping them, they can maintain group reserve funds, obtain excess loss coverage or get contractual

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provisions allowing them to renegotiate their rates. With specialty networks, however, it's common to pay each physician on a fee-for-service basis. The network decides which claims from its physician members to pay and how to adjust the fee schedule on a month-to-month basis.

In managing the pool, disciplines are put in place to deal with these issues.

- Peer review
- Fraud and inappropriate billing
- Financial incentives
- Use of RBRVS (Resource Based Relative Value Schedule)
- Control statistics.

MANAGED CARE AND RISK SHARING

With managed care risk-taking various risk assumers may be involved

- Employers
- Providers
- Joint (e.g., insurers and HMOs).

Employer Risk Sharing

These often come about as a result of a PPO or point-of-service (POS) or consolidation of risk pool. Generally, only the large employers are involved in such risk sharing programs.

The employer may *go on the risk* in these ways:

- *Rate Guarantees*: This is for the fully insured plan only. A simple example is a three year rate guarantee of $100 first year, $105 the second and $110 the third. It could also be for the self-funded plan and the administrative fees.
- *Rate Trend Ceiling*: Both insurers and HMOs are offering these guarantee. Not commonly seen.
- *Trend Guarantees:* This arrangement is generally used for self-funded plans. The trend factor will almost always vary by PPO-POS-HMO etc. There are many variations of this guarantee, e.g., PPO vs. POS; flat v. formula-driven; in-network *v.* out-of-network. Also, the guarantee is revoked if employer downsizes, benefit design changes, family mix changes, HMO penetration changes, e.g.
- *Claim Cost Risk-Sharing:* Mechanically, this is done, using incurred claims, on a retrospective basis with settlement completed 4-6 months after plan year end. This arrangement is almost exclusively for self-funded plans.
- *Performance Guarantees:* The areas of performance rating are usually these:

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Customer satisfaction
Customer service
Claims service (accuracy-timeliness)
Data reporting
Network management
Overall performance.

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