

Chapter 17

ACOs, GLOBAL PAYMENTS AND CAPITATION REIMBURSEMENT

[Eliminating Fee-For-Service Physician Compensation]

David Edward Marcinko

Hope Rachel Hetico

There is increasing recognition that the prevailing model of primary care practice that evolved in the United States under the current fee-for-service (FFS) reimbursement system is dysfunctional. Models of enhanced primary care such as the patient-centered medical home (PCMH), and the models discussed in this chapter, are being introduced nationally and are considered a foundational element of new global payment arrangements. Under these types of arrangements in particular, but in primary care more broadly, primary care practices are expected to reorient toward providing enhanced services designed to both optimize patient experiences and health, which requires a fundamental change in the way primary care practices are reimbursed for their services.

After dismissing fee-for-service payment as antithetical to meaningful payment reform, we must now recognize that global payment that covers all medical, coordinating as well as non-physician services of the PCMH is tantamount to old fashioned "capitation."

Yet, various medical capitation reimbursement systems have been used for centuries. On the other hand, global reimbursements in the form of pay-for-performance [P4P] initiatives have been used for the last 20 years. And, Accountable Care Organizations [ACOs], using modifications of these two reimbursement machinations have been in force for less than a decade.

- So, how are these issues related?
- How do we unit them; can and should we unite them?
- What implications exist for medical malpractice insurance entities?
- How about for professional liability policy premium setting purposes and economic risk management of medical providers?

Most importantly, are some medical providers paying too much for professional liability protection, in the rapidly changing insurance ecosystem, and are others paying too little? So, to contain liability overhead expense costs, the physician-executive should understand the dynamics of the insurance industry and agent selling process, which is generally sold through one of three agency avenues:

- Direct insurance agents,
- Captive insurance agents, and
- Independent insurance agents.

BRIEF HISTORY OF ACCOUNTABLE CARE ORGANIZATIONS [ACOs]

According to the *Health Dictionary Series* of administrative terms; valuation expert and colleague Robert James Cimasi MHA, ASA, AVA CMP™ of www.HealthCapital.com; an ACO is a healthcare organization in which a set of providers, usually large physician groups and hospitals, are held accountable for the cost and quality of care delivered to a specific local population. ACOs aim to affect provider's patient expenditures and outcomes by integrating clinical and administrative departments to coordinate care and share financial risk [personal communication]

Since their four-page introduction in the PP-ACA of 2010, ACOs have been implemented in both the Federal and commercial healthcare markets, with 32 Pioneer ACOs selected (on December 19, 2011), 116 Federal applications accepted (on April 10, 2012 and July 9, 2012), and at least 160 or more Commercial ACOs in existence today.

Federal Contracts

More recently, Donna Marbury writing in *Medical Economics*, revealed that Federal ACO contracts are established between an ACO and CMS, and are regulated under the CMS *Medicare Shared Savings Program (MSSP) Final Rule*, published November 2, 2011. ACOs participating in the MSSP are accountable for the *health outcomes*, represented by 33 quality metrics, and *Medicare beneficiary expenditures* of a prospectively assigned population of Medicare beneficiaries. If a Federal ACO achieves *Medicare beneficiary expenditures* below a *CMS established benchmark* (and meets quality targets), they are eligible to receive a portion of the achieved *Medicare beneficiary expenditure* savings, in the form of a *shared savings payment*.

Commercial Contracts

Commercial ACO contracts are not *limited* by any specific legislation, only by the contract between the ACO and a commercial payer. In addition to *shared savings models* which may not be in effect for another 3-5 years, Commercial ACOs may incentivize *lower costs* and *improved patient outcomes* through reimbursement models that share risk between the payer and the providers, i.e., *pay for performance compensation* arrangements and/or *partial to full capitation*. Although commercial ACOs experience a greater degree of flexibility in their structure and reimbursement, the principals for success for both Federal ACOs and Commercial ACOs are similar. And, nearly any healthcare enterprise can integrate and become an ACO, larger enterprises, may be best suited for ACO status.

Larger organizations are more able to accommodate the *significant capital requirements* of ACO development, implementation, and operation (e.g., *healthcare information technology*), and sustain the sufficient number of beneficiaries to have a significant impact on *quality* and *cost metrics*.

CAPITATION REIMBURSEMENT HISTORY

According to Richard Eskow, CEO of Health Knowledge Systems of Los Angeles, capitated medical reimbursement has been used in one form or another, in every attempt at healthcare reform since the Norman Conquest. Some even say an earlier variant existed in ancient China [personal communication].

Initially, when Henry I assumed the throne of the newly combined kingdoms of England and Normandy, he initiated a sweeping set of healthcare reforms. Historical documents, though muddled, indicate that soon thereafter at least one “physician,” John of Essex, received a flat payment honorarium of one penny per day for his efforts. Historian Edward J. Kealey opined that sum was roughly equal to that paid to a foot-soldier or a blind person. Clearer historical evidence suggests that American doctors in the mid-19th century were receiving capitation-like payments. No less an authoritative figure than Mark Twain, in fact, is on record as saying that during his boyhood in Hannibal, MO his parents paid the local doctor \$25/year for taking care of the entire family regardless of their state of health.

Later, Sidney Garfield MD [1905-1984] is noted as one of the great under-appreciated geniuses of 20th century American medicine stood in the shadow cast by his more celebrated partner, Henry J. Kaiser. Garfield was not the first physician to embrace the notion of prepayment capitation, nor was he the first to understand that physicians working together in multi-specialty groups could, through collaboration and continuity of care, outperform their solo practice colleagues in almost every measure of quality and efficiency. The Mayo brothers, of course, had prior claim to that distinction. What Garfield did, was marry prepayment to group practice, providing aligned financial incentives across every physician and specialty in his medical group, as well as a culture of group accountability for the care of every member of the affiliated health plan. He called it “the new economics of medicine,” and at its heart was a fundamentally new paradigm of care that emphasized - prevention before treatment - and health before sickness. Under his model: the fewer the sick – the greater the remuneration. And: the less serious the illness, the better off the patient and the doctors.

Such ideas were heresy to the reigning fee-for-service, solo practice, ideologues of the mainstream medical establishment of the 1940s and ‘50s, of course. Throughout the period, Garfield and his group physicians were routinely castigated by leaders of the AMA and county medical associations as socialistic and unethical. The local medical associations in Garfield’s expanding service areas – the San Francisco Bay Area, Los Angeles, and Portland, Oregon - blocked group practice physicians from association membership, effectively shutting them out of local hospitals, denying them patient referrals or specialty society accreditation. Twice in the 1940s, formal medical association charges were brought against Garfield personally, at one time temporarily succeeding in suspending his license to practice medicine.

Of course, capitation payments made a comeback in the first cost-cutting managed care era of the 1980-90s because fee-for-service medicine created perverse incentives for

physicians by paying more for treating illnesses and injuries than it does for preventing them — or even for diagnosing them early and reducing the need for intensive treatment later. Nevertheless, the modern managed care industry's experience with capitation wasn't initially a good one. The 1980-90s saw a number of HMOs attempt to put independent physicians, especially primary care doctors, into a capitation reimbursement model. The result was often negative for patients, who found that their doctors were far less willing to see them — and saw them for briefer visits — when they were receiving no additional income for their effort. Attempts were also made to aggregate various types of health providers — including hospitals and physicians in multiple specialties — into “capitation groups” that were collectively responsible for delivering care to a defined patient group. These included healthcare facilities and medical providers of all types: physicians, osteopaths, podiatrists, dentists, optometrists, pharmacies, physical therapists, hospitals and skilled nursing homes, etc.

However, the healthcare industry isn't collective by nature, and these efforts tended to be too complicated to succeed. One lesson that these experiments taught is that provider behavior is difficult to change unless the relationship between that behavior and its consequences is fairly direct and easy to understand. Today, the concept of prepayment and medical capitation is to uncouple compensation from the actual number of patients seen, or treatments and interventions performed. This is akin to a fixed price restaurant menu, as opposed to an *à la carte* eatery.

Global Capitation

As we have seen, an ACO is a provider-led company willing to be accountable for the full continuum of care for its patients. Global capitation will be used. A report by the Dartmouth Institute for Health Policy & Clinical Practice and the Engelberg Center for Health Care Reform at Brookings Institution outlines how providers in an ACO would be paid.

“Spending benchmarks must be projected with sufficient accuracy based on historical data (or other comparison groups) and savings thresholds to provide confidence that overall savings will be achieved. Sufficient measures of quality to provide evidence of improvement are also essential.”

In other words, if the costs for treating the entire population of primary care patients assigned to the physicians in the ACO are expected to increase 5 percent next year in a specific geographical area, and the ACO keeps that hike to 2 percent, the providers get to keep some portion of the extra 3 percent.

Episodes of Care

Treatment in an ACO is a departure from the way things are done today. In an ACO, or a virtual ACO, the entire team will be paid for the episode of care. The care team has

incentives to follow every checklist to prevent infection and error; for example. It is an entirely co-operative approach.

Princeton University economist Uwe Reinhardt, PhD, believes that ACOs are a good idea “as ideas go.” However, “it is not at all a new idea. It’s the Kaiser model, the Ellwood-Enthoven Model.” In fact, Jan Berger MD, president and CEO of Health Intelligence Partners and a member of MANAGED CARE’S editorial advisory board, said, “As much as many say that this is different from old capitation models, I do not clearly see the difference.” Again, it will depend on the details [personal communication].

Capitation Market Dynamics

Continuing changes in the Health 2.0 marketplace today make evaluating capitated contracts both difficult, and vital, to the success of a physician’s practice. Market dynamics have shifted to a less restrictive form of managed care arrangements. This shift has resulted in the prevalence of more PPO products than more restrictive HMO coverage. The shift in insurance coverage initially appears to favor the physician’s ability to remain in “fee-for-service” [albeit it at reduced rates] contract arrangements however, it also makes remaining capitated contracts more critical to evaluate. The fewer patient members under capitated arrangements the more financial risk the physician may incur. And, the emergence of a new machination, known as micro-capitation, illustrates the fluid nature of this concept.

Capitated Reimbursement Contracts

For physicians in solo practice or in small group practices, the common path to capitated contracting comes through membership in an Independent Practice Association (IPA) or similar affiliation which has the legal authority to secure health plan contracts on behalf of its members. Even though the individual members of the IPA may not be involved in negotiations with the health plans, it is important for to understand the terms of each contract. The key areas of concern are:

- Patient mix;
- Capitation rate and contract terms;
- Service responsibility; and,
- Stop loss coverage.

Patient Mix:

Health plan contracts are marketed to specific population groups and the demographic characteristics of the patient populations will vary accordingly. Typically, the target population is identified in terms of the health plan’s “product” – Commercial private plan, Medicare plan, or Medicaid plan. It is important for the physician to know about the population that is covered by the contract, in anticipation of the types of services that those patients will require. Physicians should inquire about the age/sex/health status

characteristics of the population the health plan expects to enroll, and compare those to the current profile of the practice.

Capitation Contract Questions and Responsibilities:

The most important considerations are the actual capitation rate and the factors that can affect that rate, either up or down. It is also important to have a sense of “market comparison” on the capitation rate provided under the contract. Here is a list of specific questions physicians should ask.

- Which Health Plans can access this contractual arrangement? Is the Health Plan limited to just the one negotiating the contract or are there silent or affiliated plans that can access the agreement. This will impact the number of lives covered under this agreement.
- What is the monthly capitation rate paid to the physician? What is the IPA keeping from the health plan’s payments to cover the cost of their services?
- Is the capitation rate a fixed amount per member per month, or will it be age/sex adjusted based on the actual blend of patients who are assigned to the physician?
- What day of the month will the capitation payment be paid? Does the contract stipulate that the IPA must pay interest charges for late payments?
- Are there any “low enrollment guarantees” built into the contract to provide for minimum payment amounts in the early stages of contract enrollments? Some contracts provide for fee-for-service payments until enrollments reach an effective level for capitation, such as 500 members.
- Are there provisions for retroactive changes in the enrollment assigned to the practice, and are there specific time limits on those provisions, such as 30, 60 or 90 days? Failure to include time limits on retroactive enrollment adjustments may result in disruptions to cash flow and increased administrative paperwork.
- How are bonuses, if any, earned and paid? What are the specific measures if bonuses are based on performance?
- What penalties and deductions from the capitation payment can be imposed for actions such as “inappropriate referrals” or for referrals to non-contracted providers?
- How often can the capitation rates be re-negotiated?
- What are the physician’s financial obligations upon termination of the contract? Does the contract convert to a fee-for-service agreement or is continuing care for the patient covered under the existing capitation rate? If so, what is the contract time limit for providing continuing care?

Contract Service Responsibilities:

Physicians should ask for a copy of the list of the services that are included in the capitation payment. All rendered services should be defined by CPT® or similar billing code. Physicians who take primary care contracts and who also practice in specialty fields, such as allergy, cardiology, gastroenterology, or pulmonology, should have a clear

understanding of how these services are managed under the contract – whether they are included or excluded in the capitation payment; whether these services can be billed separately. Other key questions about service responsibilities include:

- What are the restrictions or limitations on billing patients for services that are not covered by the responsibility matrix? If it is permissible to bill for these services, are there restrictions on the billing rates?
- How is the physician reimbursed for non-physician services, such as supplies, lab tests, and injections? This is particularly important if the practice has a high number of pediatric patients or provides allergy shots.
- What are the financial responsibilities of the practice for call coverage? Does the contract require that the physician pay for call coverage out of the capitation payment? If so, how is this payment handled – physician to physician, or as a deduction from the capitation payment?

Stop Loss:

Another critical factor is reinsurance for high cost cases – Stop Loss coverage. Physicians should know if the contract has Stop Loss provisions, what the costs are for coverage and the effect on the capitation rate once the Stop Loss level has been reached. In some cases, the contract may convert to a new capitation rate. In others, payment may be on a predetermined “fee-for-service” arrangement. It is also important to know who is responsible for identifying cases when they reach the Stop Loss limit, and whether there is a time limitation when filing a Stop Loss case.

In addition to these key points in capitation contracts, physicians should also anticipate that there will be “administrative burdens” related to new contracts. In most situations, the IPA or other physician organization will take responsibility for credentialing for the provider network, for Utilization Management and Quality Management programs required by the health plans, and for claims administration. Each physician, however, will be required to submit encounter data and respond to various queries and requests for information. In some cases, health plans or IPAs may stipulate financial penalties for failure to comply, for poor timeliness, or for “administrative

FIXED PAYMENTS RE-EMERGING

Today, the national conversion to a modified form of capitation financing is again re-emerging in the employed physician business model, hospitalist and PP-ACA era as a marketing force, and not merely a temporary healthcare payment trend. More than 40% of all physicians in the country are now employees of a managed care organization that uses, or is re-considering, actuarially-equivalent P\$P, global reimbursement schemes or medical capitation.

The Promise?

Has medical capitation reimbursement finally fulfilled its promise as a quality improving and revenue enhancing machination; or is it just another managed care and PP-ACA cost reduction strategy that financially squeezes doctors and hospitals, and limits patient care and choice? To answer this query, one needs to review the Stark Laws.

Whole Sale Medicine

Curiously, Stark Laws I, II and III were created to eliminate self-referral concerns potential leading to excessive medical care and fee-for-service payments. Ironically, these types of economic enriching paradigms of less-care were perfectly acceptable. Many, also never understood how a commitment to treat an entire patient population cohort could be made with little or no actuarial information. Hence frustration was the initial exposure of many medical providers to capitated reimbursement; also known as “wholesale medicine.”

Aligned Incentives

But, since inception, more modern medical cost accounting endeavors have gradually demonstrated that capitation has some advantages over traditional fee-for-service care. For example, it can create and align incentives that help patients, providers and payers by limiting their contingent fiscal liabilities. So, capitation in the current credit-deprived nationally economy is increasingly being viewed in a more positive way. More importantly, those healthcare organizations and providers that embrace it may thrive going forward; while those opposed may not!

Global Physician “Capitation” Payments Making a Comeback

Since passage of the PP-ACA many insurance carriers are making a major change in the way they pay physicians? It’s moving from [discounted] fee-for-service pay to per-patient per-year capitation rates, adjusted for age and sickness (severity adjustments), plus a bonus for those MDs who improve patient health status. No definition of this term was given; however. Under the new “incentive” plan, these plans hope to transfer risk to primary medical care groups.

Typically, capitation will cover all primary care, specialist, counselor and hospital costs. Interestingly, BCBS has publicly denied that this system is “capitation”, and assured the public that it has safeguards in place to make sure patients won’t be under-treated and doctors won’t be underpaid. Yet, BCBS for the State of Massachusetts hopes to cut the growth in medical costs in half in two to four years among providers who accept this cloaked *global capitation-redux*.



ECONOMICS OF SHIFTING TO-AND-FROM CAPITATION REIMBURSEMENT

Shifts in payor mix can cause dramatic impacts to the financial performance of a medical practice. While it is important to try to evaluate the impact before taking on capitated business, similar principles apply as physician practices shift back to fee for service business from capitation. Before taking capitated contracts, physicians should answer three questions:

1. How much capitation should I accept as a percent of my total business?
2. How will the shift to capitation affect my practice financially?
3. How much will I need to reduce operating expenses in order to break even or profit from capitation?

As physicians' practices shift back to fee for service from capitation, two additional considerations must be addressed:

1. How much capitation is too little?
2. How will another shift in payer mix impact my practice cost structure?

Whether shifting to or from capitation, it is important to understand the factors that contribute to overall practice economics. The following examples can help a physician answer these questions by demonstrating the effect of changes in payor mix on a solo primary care physician practice. The methods described may also apply to other medical specialties or group practices.

The Shift to Capitation

To determine the impact that a capitated contract might have on a practice, it is necessary to analyze the economics of that practice. In traditional fee for service practices, there are three key financial measures:

1. Net revenue and net revenue per patient visit.
2. Office expenses including fixed expenses such as rent, and those that vary with patient volume such as medical supplies.

3. Net income, the amount remaining to be paid as physician compensation or reinvested in the practice.

By adding capitation to the practice, a physician must consider two additional factors:

- The capitation rate per member per month.
- The estimated number of visits for each capitated patient.

It is often difficult to isolate the financial performance related to one specific payor contract because the same resources are used to care for all the practice's patients. One way to evaluate the impact of a new contract is to determine what the practice's breakeven volume level is before and after the shift to capitation. Breakeven can be described as the level of patient volume required to cover all practice expenses. It is an important measure because once a practice achieves breakeven volume each additional visit contributes to practice net income. Two variables that impact breakeven are revenue per visit and variable cost per visit. Breakeven volume equals:

Total Fixed Expenses

(Net Revenue per Visit – Variable Expenses per Visit)

In some cases, the impact of a shift in payer mix on breakeven volume can be dramatic. This is illustrated in the following examples.

Baseline Example

The baseline example is an internal medicine physician in solo practice. Currently, payment for services is from traditional fee-for-service sources including indemnity insurance, some discounted rate plans, self-pay patients and Medicare. To analyze the potential financial impact of a shift in payor mix to or from capitation, it is necessary to establish a few key statistics from the practice's most recent twelve-month period. Total net patient revenue and total operating expenses can be easily identified. Next, identify fixed operating expenses, which are those costs that generally do not change with volume within a defined range of capacity, such as space, most staffing and utilities. Subtracting fixed expenses from total operating expenses provides total variable expenses, or those costs that are directly related to patient volume, such as medical supplies. Average variable expense per visit is calculated by dividing total variable expenses by the number of patient visits. The baseline practice profile is shown in Table 1.

In the Baseline example, the practice needs 2,028 annual visits to break even. Any additional visits contribute \$81.38, or the difference between net revenue and variable expenses, to net income.

Table 1 Baseline Practice Profile

	Total Annual	Average per Visit
Patient visits FFS	4,800	
Total net revenue	\$480,000	\$100.00
Fixed expenses	\$165,000	\$34.38
Variable expenses	\$89,400	\$18.62
Total practice expenses	\$254,400	\$53.00
Net income	\$225,600	\$47.00
Breakeven visits	2,028	
Contribution to net income after breakeven		\$81.38

Payer Mix Scenarios

We can now develop scenarios to help evaluate the impact of changes in payor mix. Computerized spreadsheets are ideal for analyzing these “what-if” scenarios. In each scenario, assume that the practice is at capacity with 4,800 visits, so new capitated patients represent a shift from fee for service business, and are not incremental business to the practice.

Scenario 1:

Let’s assume that 333 of the practice’s patients shift to a capitated plan, and that on average, a capitated patient has three visits per year, for 1,000 total visits. The physician receives a capitation payment of \$12 per member per month. The average revenue per visit under the capitated agreement is \$48 (\$12 per month times twelve months, divided by three visits), a substantial reduction from the fee for service average of \$100. Therefore - the breakeven number of visits for the practice increases to 2,339 as the overall average net revenue per visit decreases to \$89.17. In order to maintain the fee for service breakeven level of 2,028, the practice would need to reduce total costs significantly. However, even modest reductions in operating expenses can help to compensate for the downward pressure of capitated contract rates on net revenue. In Scenario 1, total expenses are reduced by 10% through a combination of fixed and variable cost reductions. Scenario 1 is shown in Table 2.

Table 2 Payer Mix Scenario 1: Shift to Capitation

	Total Annual w/ No Expense Reductions	Avg per Visit w/ No Expense Reductions	Total Annual w/ Expense Reductions	Avg per Visit w/ Expense Reductions
Patient visits - FFS	3,800		3,800	
Patient visits - capitation	1,000		1,000	

Total net revenue	\$428,000	\$89.17	\$428,000	\$89.17
Fixed expenses	\$165,000	\$34.38	\$148,500	\$30.94
Variable expenses	\$89,400	\$18.62	\$80,440	\$16.76
Total practice expenses	\$254,400	\$53.00	\$228,940	\$47.70
Net income	\$173,600	\$36.17	\$199,060	\$41.47
Breakeven visits	2,339		2,051	
Contribution to net income after breakeven		\$70.55		\$72.41

As a medical practice shifts back from capitation to better paying fee for service business, it is important to remember two things:

1. Increasing revenue per visit does not mean costs should increase.
2. Be careful to maintain enough capitated business to average out the effect of a few high utilizers, or get out of capitation entirely.

Maintain Practice Cost Savings

Let's assume that the practice was able to decrease operating expenses by 10%. With the shift to capitated business, the practice's net income is \$199,060. What happens if the practice's business shifts back to fee for service? If the costs revert back to the levels before cost savings were implemented, the practice's net income and breakeven volume are the same as they were originally under the Baseline Scenario. But if the practice is able to maintain the cost savings it experienced, net income increases by \$25,460, breakeven volume decreases by 244 visits, and each visit above breakeven contributes \$83.24 to the bottom line. This is shown in Table 3.

Table 3 Shift from Capitation to Fee for Service

	With Old Cost Structure	With New Cost Structure
Total visits	4,800	4,800
Net revenue	\$480,000	\$480,000
Total expenses	\$254,400	\$228,940
Net income	\$225,600	\$251,060
Breakeven visits	2,028	1,784
Contribution to net income after breakeven	\$81.38	\$83.24

Manage the Level of Capitated Business

Physicians are paid a fixed amount per member per month to care for capitated patients. Capitation rates paid to the practice are determined actuarially based on demographics of

the patient population covered, including their anticipated utilization of resources. When a practice has a significant number of capitated patients, the effects of a few high utilizers are usually offset by the utilization patterns of the rest of the population.

For example, if the average number of visits per year for a capitated patient is three, it is likely that a few patients will have more visits, but that most patients will visit the physician less frequently. In a practice with a large capitated population, those patients offset the additional use of resources (cost) required to care for the higher utilizers.

Assume the practice's capitated enrollment shifts mostly back to fee for service, so that only fifty capitated patients remain. Ten of those fifty are high utilizers, requiring 10 visits per year. The contribution to net income drops by nearly half, from \$31.24 to \$15.97. As an extreme example, assume that only fifteen capitated patients remain and that ten of them are high utilizers. The contribution drops to only \$2.02 per visit, barely enough to cover variable costs. The impact of this is shown in Table 4.

Table 4 Shift from Capitation to Fee for Service

	333 Capitated Patients	Fifty Capitated Patients	Fifteen Capitated Patients
Capitated patient visits	1,000	220	115
Average visits per capitated patient	3.00	4.40	7.67
Annual capitation revenue	\$48,000	\$7,200	\$2,160
Capitation revenue per visit	\$48.00	\$32.73	\$18.78
Variable expense per visit	\$16.76	\$16.76	\$16.76
Contribution to net income after breakeven	\$31.24	\$15.97	\$2.02

SUB-CAPITATED CONTRACTS

The often-contentious dilemma of “carve-outs” from capitated managed care contracts is abating in some parts of the country, just as it is accelerating in others. Under this scenario, medical services or products such as surgery, trauma, physical therapy, eye-care, immunizations, certain tests, wound care, or prosthetic devices may be excluded from a managed care contract in favor of another, often sub-capitated, provider [Diagram 1]. However, if you or your healthcare organization is contemplating a sub-capitated contract, consider the following example.

Primary Care Example

In another example, a primary care group notes that allergy testing, and related services, are included in their contract proposal. Since these services are not in their area of expertise, they negotiate to have them deleted, reducing the capitation rate accordingly.

Thus, the following are conditions considered important for carved or sub-capitated risk contracts:

- equivalent risk for the provider and sub-capitated specialist;
- fixed expenses for the sub-capitated specialist;
- predictable and low cost of care, per specialty episode;
- high episodes of specialty care (not unusual or unpredictable events);
- definable and understood responsibilities of the specialist;
- profit and cost savings potential for both the referring and specialty provider; and
- existence of re-insurance.

Orthopedic Specialty Example:

An orthopedic group notes that foot surgery is listed in a new capitation contract that it is considering. The group is not comfortable with such surgery and they ask that these services be excluded. Since the contract provider will not exclude the surgery, the orthopedist group either has to accept it and perform unfamiliar surgery, or reject it.

MICRO-CAPITATION

More than a few medical providers and healthcare facilities have developed natural aversion to capitated reimbursement. Almost since inception, it has always been associated with the worst components of managed care; hurried office visits and soul-less physicians.

A decade ago, astute physician executives and healthcare administrators were averse to the idea that they should accept pre-payment for unknown commitments to provide an unknown amount of services. It seemed to create an unnatural and difficult set of incentives where fewer patients were seen and less care rendered for more compensation. Curiously, Stark Laws I, II and III were created to eliminate concerns that self-referral could lead to excessive care and fee-for-service payments, though this system had long been perfectly acceptable. Many also never understood how a commitment could be made with little or no actuarial information. Hence frustration was the initial reaction of many medical providers to capitated reimbursement.

Medical Care Packages

When capitation is focused on discrete medical conditions, or subsets of clinical conditions rather than through CPT® or MS-DRG activities, it is delivered in more discrete “medical care packages.” This creates a true healthcare marketplace where price, quality, and medical outcomes can be compared side-by-side, or provider-by-provider, or facility-by-facility.

The discrete services provided by vertically or virtually integrated medical teams would enable a new level and degree of expertise. High-volume providers would develop

additional experience, which would enable them to introduce innovations and efficiencies in a classic economies-of-scale cycle. With the additional delivery and outcomes experience, providers would be much more willing to put out a set fee for a set grouping of clinical services, because they would have some confidence in their ability to deliver care for that price. Philosophically, this is still capitation, but it is a finer “micro-capitation” at the medical condition level (*lowest common unit of care delivery that can be measured*); not the gross CPT® code or MS-DRG level.

To emphasize the concept, the term “*micro-capitation*” was coined by Dr. Scott L. Shreve in 2008 [personal communication]. It makes some sense because it is for a definable, controllable, and limited set of clinical activities in which providers can, with confidence, provide services for a set fee. Micro-capitation delivered in smaller “care packages” will be a critical new clinical-service-product as we transition toward a futuristic competitive marketplace.

Micro-capitation around specific medical conditions, or acute episodes of care, also provides a manageable unit of healthcare delivery in which we can develop the appropriate care linkages across all provider lines, and form a team to deliver a full episode of care. It represents a properly sized clinical bite in which the appropriate healthcare infrastructure allows for better outcomes measurement, monitoring, comparison, and ultimately consumption in a competitive healthcare marketplace. The marketplace today is taking a fresh look at capitation exposure, and attempting to control economic risk by moving to discrete micro-capitated “care packages” or bundles that can be understood, measured, and marketed.

Table 5

SAMPLE ALLOCATION FORMULA FOR COMPREHENSIVE PAYMENT SYSTEM	
25%	Primary Care Physician Re-imbursement: \$250,000 before Bonus/Fringe Benefits
60%	Staff, fringe, rent, office expense (assumes hiring of multidisciplinary office team charged with timely delivery of personalized comprehensive care): \$600,000
	<ul style="list-style-type: none"> nurse practitioner \$100,000 nurse \$90,000 .5 FTE nutritionist \$35,000 .5 FTE social worker \$35,000 receptionist \$60,000 medical assistant \$50,000 rent \$40,000 office expenses \$50,000 insurance \$50,000 physician FBs \$75,000–\$90,000
10%	Information technology/patient safety/quality monitoring: \$100,000 purchase/lease/setup of electronic health record and quality monitoring system \$35,000, data manager \$35,000

5% Performance bonus, annual meeting mutually established goals: \$50,000

Note: Example assumes an average comprehensive payment of \$800/year/patient, an average panel size of 1,250 patients/full time primary care physician and team, 30 percent fringe benefit unless otherwise specified, and gross revenue of \$1 million/full time equivalent primary care physician and team.

Source: A. H. Goroll, R. A. Berenson, S. C. Schoenbaum et al., "Fundamental Reform of Payment of Adult Primary Care: Comprehensive Payment for Comprehensive Care," *Journal of General Internal Medicine*, March 2007 22 (3) 410–15.

INSURANCE AGENTS AND THE LIABILITY INSURANCE INDUSTRY

To contain liability overhead expense costs, the physician-executive should understand the dynamics of the insurance industry selling process, which is generally sold through one of three agency avenues:

- Direct insurance agents serving as employees of a single insurance company;
- Captive insurance agents representing only one insurance company; or
- Independent insurance agents representing multiple insurance companies.

An agency relationship is defined as the ability to solicit, create, modify or terminate a property and casualty malpractice insurance policy. Under this *Law of Agency*, the agent and insurer are one and the same, and the acts and knowledge of the agent are deemed to be acts and knowledge of the insurer, regardless of whether the insurer has actually authorized the agent to do business. The insurer is bound by acts of its agent, if a relationship has been established through express, implied or apparent authority.

The first two agents have little incentive to promote any company other than the one they represent. The later agent type brings a different set of complexities to the choice arena.

For example, they often receive bonuses, incentives or are held to production quotas as a requirement of employment. Commission structures are the most important incentives at work on the selling side of the process since different companies pay varying percentages of total premium dollars sold. This can work against the doctor because the agent has an incentive to sell the highest priced product in order to earn the greatest commission. Upon request, however, a reputable insurance brokerage house will provide in writing a detailed market comparison that demonstrates the major options available to the practitioner. This is because, in contrast to agents, an insurance broker is an independent contractor who examines the malpractice needs of the client and then shops for coverage to best fill those needs. Moreover, group insurance purchasing usually nets a better deal than a practitioner could negotiate individually. Thus, if capitated medicine as demonstrated by many managed care organizations (MCOs) continue, the potential for reduced operational costs through lower medical malpractice premiums could be significant.

The Capitation Liability Theory

The major thrust of the Capitation Liability Theory (CLT) suggests that a fixed rate reimbursement system [global reimbursement, ACOs, P4P, and/or full, partial or micro-capitation] reduces the incidents of malpractice because of a reduction in the total number of patient-physician encounters and the acuity of those encounters, particularly for invasive procedures such as surgery and for procedural specialists. Consequently, some providers may be paying too much for professional liability protection in the presently changing healthcare industrial complex, and others too little.

The Liability Premium Setting Process

Most liability insurance companies and their associated underwriters and actuarial advisors have limited interest in the nuisances of patient care and tend to focus economic factors such as income/loss ratios, market forces, and trend analysis as a basis for a continuing line of insurance coverage. Their bottom line concern is financial and typically considers only those factors that can be altered to realize projected growth, profitability, and return on capital projections. Carriers have considerable latitude in how they function as a business, whom they insure, how they align their members, in what manner they allocate reserves, and how they manage cost/income factors and determine market variations for the purpose of setting premium levels. If their cost trend is downward and their profit trend is upward, efficiency is confirmed. To this end, underwriters and actuaries strive to make the premium pricing process a scientific discipline, but ultimately the process is still a decidedly heuristic one.

As the liability premium pricing process arrives at the bottom line of corporate fiscal responsibility, the stability of the individual company and national market forces determine premium structure on a comprehensive basis. Managed care entities may be national in scope, but the delivery of healthcare services is a local business. The potential negative effect of national pooling on individual premium pricing is significant as the CLT is confirmed. Unfortunately, liability underwriters are reluctant and even secretive about sharing confidential experience data. These professionals are skilled at data collection, information management, manipulation and trend analysis to justify and defend their own charges. Challenging such cost projects and making a case for premium reductions is not easy but can be addressed with adequate knowledge, information and constant persistence, as described below.

CLT Areas of Interest [Litigation Equation]

The Capitation Liability Theory (CLT) considers four primary areas of potential significance in malpractice liability management and premium costs. This is known as the litigation equation, and includes (1) patient communication factors, (2) provider healthcare delivery systems and reimbursement factors, (3) payer factors and, (4) revised liability legislation and patient encounter data factors.

Patient communication factors include reduced economic and financial fear, consideration of cultural barriers, improved medical awareness through continuing education, concern for geographic access, focused primary and specialty care availability, management information systems, and the frequency and duration of utilization.

Provider reimbursement factors and healthcare deliver systems include both soft and hard varieties. Soft provider factors include increased patient availability to services, accessibility to timely appointments, office and quality care satisfaction surveys, communication assessments, known fixed costs and technical information interchanges. Hard factors include managed operational procedures, reduced illness severity's, defined treatment options, reduced clinical variations, outcomes measurements and quality monitoring, performance quotas, aligned financial incentives, and predictable reimbursements.

Payer factors include practitioner screening and shifting, quality assessment, behavioral modification and team care, provider discipline, complaint management, cost and call economic considerations, and adequate capitalization rates. Liability factors include allegation frequency and severity, standards of care, defensibility, risk management, premium pricing, loss adjustment, settlement losses, and administrative costs.

To fully understand the CLT, all four parts of the litigation equation must be recognized. These factors, when integrated with underwriter data and experience, determine the level of liability risk and the ultimate cost of malpractice coverage. If capitated medical care is deemed to involve less risk than seen in the indemnity environment, the cost of liability coverage should gradually decrease as the percent of capitated manager care increases, in a particular office setting. In actual terms, the CLT suggests that capitated insurance and patient care risk are inversely, but not necessarily proportionally related, since experiential data will determine the percentages.

Premium Structures and Models

Collectively, liability claim managers suggest that financial issues are a secondary, albeit precipitating factor, in 15-25 percent of all malpractice allegations. Adjudicators further state that aggressive attempts to collect account balances, deductibles, co-payments, and non-covered services are a significant causative factor in litigious individuals. The liability factor is compounded if the medical outcome is less than desirable. The theory also does not discount the significance of contingency legal arrangements prevalent in the litigation process. Correspondingly, the following four reimbursement structures and models can be reviewed in light of this information.

The fee-for-service reimbursement model was the bedrock of healthcare financing until recently and was the dominant model of paying for medical services. This insurance driven and technology motivated approach was powered by utilization and consumption with limited concern for the total cost of care or economic consequences. While indemnity providers continue to be forgiving in the management of patient indebtedness,

the incidence of financial hardship and subsequent litigation is believed to be the most frequent in this system. A recent review of provider owned insurance carriers generally supports this conclusion.

Conversely, a capitated model reimbursement system views the patient and the services they require as a cost driver to be debited against a fixed rate or constant reimbursement scheme. Utilization is controlled, referrals managed and technology limited as well as creating a new set of behavioral problems, stress, frustration and liability. However, patient indebtedness and personal financial hardship is substantially, reduced, and so is a precipitating liability factor.

The quasi socialistic model is powered by entrepreneurs who believe that health care is immune to market forces, such as competition or accountability. Reformer-change agents suggest consumer needs and social welfare in general will prosper through structured business systems with quantifiable and measurable processes. This top-down management structure embraces the general public opinion that affordable healthcare is a right, and that managed markets are the best model for this philosophy. Although results remain uncertain, the market trend is irreversible.

A mixed model or transitional reimbursement system represents the best, or perhaps the worst, of both payment options and is a major administrative challenge for the healthcare provider. Services may be classified as a profit or debit depending on the payer arrangement and all care must be performed with equal concern for quality, medical necessity and appropriateness. Gatekeepers manage the capitated care, control referrals and provide care for at-risk for reimbursement, with the ultimate payer intent of a 50/50 provider mix of primary care and specialists. Frustration is significant for all participants, but the number of malpractice allegations, are believed reduced.

A preliminary evaluation of these four reimbursement methodologies suggest the level of malpractice risk, and associated litigation, is decreasing as the volume of capitated managed care increases.

[A] Insurance Legislation Implications

The current malpractice insurance market has evolved as a result of legislative action, in response to the liability crisis of the early 1980's, with the introduction of the Liability Risk Retention Act (LRRRA). This Act, of 1986, turned a hard market for malpractice insurance soft, as legislative action expanded the definition of liability and preempted state regulations which restricted small groups from underwriting for commercial insurance buyers engaged in similar or related business activities.

The LRRRA permitted the formation of Risk Retention Groups (RRGs) and Purchasing Groups (PGs) to qualify as insurance companies and retain certain layers of risk while transferring higher layers to reinsurers. In essence, the LRRRA flipped the insurance

industry upside down and returned the decision-making process and control back to the consumer.

The fundamental difference between RRGs and PGs is that RRGs retain risks, and PGs do not. In enacting the LRRRA, Congress provided two ways for insurance buyers to obtain liability coverage. These included becoming owners of their own liability insurance company (RRG) or becoming members of a PG that purchased insurance from a commercial carrier, usually at a substantial discount. The homogeneity requirement states that both RRGs and PGs must be engaged in a similar or related business, but there are no group size requirements, representing a significant marketing factor. PGs can evolve into RRGs if growth, profitability and actuarial data are favorable. The advantages can be summarized by the following benefits:

- Tailor made coverage and Favorite premium rates
- Better policy terms and Ownership of the loss experience
- Segregation of loss data and Reward for good experiences
- Risk management and loss prevention programs
- Long term commitments from insurers

As the healthcare delivery system is transformed by consolidations, mergers and acquisition, so goes the liability need of the individual, group or institutional provider. Traditional insurance solutions are no longer suitable for the medicine of the new millennium as hospitals are combined into larger systems, and large systems are merged into even larger organizations with ownership of, or in partnership with, physicians and alternative treatment centers. Risk factors and pricing models of the past become inappropriate for contemporary providers who function within a corporatized structure.

As these larger organizations develop, their malpractice insurance needs change and so must the companies that supply those needs. Larger groups can afford to take on attrition or frequency risks, internal to their own capital base and organization structure. As systems grow, groups become increasingly interested in risk layering, reinsurance and loss sensitive pricing options.

Larger systems can institute and provide their own internal risk prevention, quality monitoring and incident management processes. Medical malpractice premium pricing ceases to be a one-dimensional market, even in the same geographic community or specialty provider class. Regulatory management and capitated reimbursement price controls are thus redefining the industry at all levels and liability pricing and pricing flexibility are no exception.

Moreover, frequency, severity and average indemnity payments are not necessarily reflective of the entire medical liability industry or specialty underwriters. The significance of risk based, capitated reimbursement systems in the stability of the current professional liability market is not identifiable from current data, but believed to be a factor. Additionally, liability data from the several closed panel capitated reimbursement systems

suggests support for the stability trend. As interesting as this may be, staff model HMOs, which are a shrinking type of delivery option, are not necessarily reflective of other vertically integrated and at-risk delivery systems more prevalent in the emerging healthcare marketplace.

Therefore, the following six processes can be used to support reduced professional liability costs in an ever-evolving reimbursement system:

- Knowledge of the local medical malpractice market environment and provider position in it.
- Clarity on how and by whom medical service payment is provided, as well as payment mix, percentages and trends.
- Reticence to accept quoted liability rates as the only possible option since further inquiries, comparisons, evaluations and alternatives may be available.
- Implementation of a data tracking system with risk management and risk education.
- Features, technology driven proprietary information, and specific data for each medical specialty.
- Familiarity with the concept of clash coverage or multiple coverage for a given exposure incident. A single policy covering all entities is always less expensive than multiple policies covering multiple entities.
- Dissemination of risk and the transfer professional liability to corporate medicine (i.e., PPMCs, IPAs) enterprise systems and managed care structures, thereby layering risk and coverage.

Consequently, doing nothing to reduce professional liability costs in an increasingly integrated delivery system environment with capitated reimbursement is a guarantee financial drain on medical office net income after expenses.

[B] Indemnification Concerns

An indemnification or hold harmless clause in a managed care contract is quite specific about the legal relationship between the medical provider (agent, servant or employee) and the managed care entity, should a medical malpractice issue occur. In the strongest possible language, most MCOs will attempt to shield or indemnify themselves from the actions of their providers, according to the vicarious liability concept of respondent superior under the normal laws of agency.¹ Furthermore, according to attorney Richard W. Boone, JD, of Vienna, Virginia, “What we are really recognizing is that although there may be two entities being sued, there is really a single event”. It then makes legal and economic sense to know in advance which entity will be providing the defense and indemnification and price the capitated contract accordingly. Applying this advice may necessitate additional negotiations, but it does suggest that another reason to rethink risk-based reimbursement and liability protection in a managed care environment.

¹ See www.law.cornell for further information on the law of agency.

Liability Coverage Forms

Over the past decade, medical liability was one of the most profitable and exciting segments of the insurance industry, producing returns averaging 30 percent over the five years from 1989 to 1993 and well above the financial sector industry average. Specialists, underwriters, provider owned mutual companies or healthcare associations now underwrite about 70 percent of the U.S. medical malpractice market, with 73 percent being claims-made policies.

Under traditional insurance policies, there was an occurrence form which was maintained even if a negligence claim was made several years later, and a claims-made form developed to prevent the stacking of claims. By definition, occurrence is the repeated stacking of risk exposures and a loss that occurs during two or more policy periods meant that two or more sets of policy limits apply on top of each other. By contrast, a claims-made policy covers claims that are first made during the policy period. Other features of the claim-made form are that it reduces the time medical records must be kept for future claims, and that it is more inflation proof than occurrence coverage. Most other provisions of the two forms are identical, and the only real difference is what triggers the coverage. Occurrence coverage applies to the injury that occurs during the policy period, while the claims-made form states that insurance applies only if a claim is made during the policy period. Another departure from the occurrence form is that the claims-made agreement states that insurance does not apply if the claim occurred before the retroactive date or after the policy period. Usually, when an occurrence policy is renewed by a claims-made policy, the retroactive date is the effective date of the claims-made policy, thus eliminating overlapping coverage. Once established, the retroactive date may be advanced only with the written consent of the insured doctor, and after being informed of the right to buy a supplemental extended reporting (SERP), or tail coverage, policy. Otherwise, a gap would result if the coverage were to be renewed on an occurrence form, or if the coverage was permanently terminated. Once in effect, SERPS of unlimited duration cannot be canceled and can be purchased for an endorsement charge of about 200 percent of the annual coverage premium. SERPs effectively then become the transitional opposite of the retroactive date, as it excludes coverage for earlier occurrences because other insurance applied. It is also import to note that claims-made policies are initially less costly since the SERP is purchased later, while tail coverage is initially included with an occurrence policy making it more costly.

More recently, however, healthcare has become a claims-made market of change with intensified financial challenges and consolidation driven primarily by the evolving managed care industry and risk-shifting capitated reimbursement environment. The Capitation-Liability Theory can be considered one result of this paradigm shift.

The Contrarian Viewpoint

The paradigm shift in healthcare reimbursement models may signal a decrease in medical liability risk; or it may actually increase the risk. Errors of commission, which may be

more likely in a fee-based system, are easier to prove than errors of limited treatment and omission. Nevertheless, the changes in health care reimbursement may actually be setting the stage for increased medical liability costs, going forward in the new millennium, as described in the three models below.

[A] Pure At-Risk Capitation Model

Under the Pure At-risk Capitated Model, the healthcare provider receives a sum-certain each period in return for treating a certain pool of patients. The provider must provide care to all patients that request it during the specified time period. The fewer patients that the provider treats, and the fewer treatments rendered per patient, the lower the cost per patient and the greater profit during that time period. Obviously, this model creates a powerful incentive for the provider to treat fewer patients and to provide fewer services to each patient. The incentive is to under treat. Under this scenario, the number of liability claims made is likely to decrease because fewer patients are treated, and fewer at-risk procedures are performed. However, the likelihood is great that claims that are presented will result in a larger payout. This is because by under treating a patient, the adverse condition may have significant time to worsen until definitive treatment is undertaken, and damages will be much greater.

For example, if a MCO limits the provider's ability to provide mammogram screenings, far fewer women will be diagnosed with the earlier stages of breast cancer. By the time a woman falls within the age parameters of the MCO to be eligible for the mammogram, a small surgical lesion may have progressed to a large metastized lesion. The eventual liability would become much greater. This model is more common with primary care provider (PCP) medical groups. In the current trend, PCPs are seeing more patients while the specialists are seeing fewer patients. The gatekeeper concept, and the plans that require the PCP group to pay specialists, all seek to encourage treatment by PCPs and limit referrals. The incentive for this outcome is the real or perceived increased cost of specialist treatment. Not only are PCPs seeing more patients, they are also treating more conditions and performing more procedures which, a decade ago, was more often under the purview of a specialist. The result is that PCPs may end up treating conditions, and performing procedures, for which they are not suited by training or experience. As PCPs venture into these areas, the likelihood of incompetence, patient injury and liability claims, increase.

In this model, specialists also see more patients that are likely to increase the specialist's risks. The patient may have had previous treatment by the PCP and the specialist's treatment may be more advanced. In the past, the chances were that a specialist may have initiated conservative treatment, but now gives more advanced treatment and increases his/her risk. The prior treatment by the PCP may not only have been ineffective, but the patient may actually be worse. Consequently, a sicker patient increases the risk for the specialist. Finally, the pure-at-risk capitated model may increase risks for greater injuries and greater awards/settlements.

[B] Reduced Fee-for-Service Model

Under the Reduced Fee-for-Service Model, the provider receives a fee for every patient treated and a fee for every procedure performed. The provider can increase revenue by increasing the number of patients treated and the amount of procedures performed. Under this scenario, there is no decreased liability risk, or it may actually increase for several reasons.

First, more patients are treated and more procedures are performed. Each individual patient encounter carries with it a degree of risk. By increasing the number of encounters, the risk is increased. It would appear that the risk would increase arithmetically, but in fact it has the potential to increase exponentially. The reason is that the provider only has a certain amount of time in which to provide the service. In the current environment, the provider must squeeze more encounters into the same time period, than a decade ago. The increased workload may increase stress and fatigue on the provider. With increased stress and fatigue, mistakes are more likely. Therefore, the increased liability risk is not only due to the increased number of patients, but also the increased fatigue levels that may result in medical error. Under the Reduced Fee-for Service Model, there is also the possibility of under treatment. The reimbursement for certain procedures may be determined by the provider to be unreasonably low and avoid such procedures. To the extent that the provider performs a lesser procedure, the possibility of increased liability exists.

[C] Hybrid Capitation / Reduced-Fee-for Service Model

This Hybrid Capitated/ Reduced Fee-for-Service Model is commonly employed with a group of specialists, as opposed to primary care physicians. An entire group of specialists will be capitated with a fixed dollar amount (risk-pool). The allocation to the individual specialist will be based on a function of the allowed rate of all procedures performed by the individual, compared with the allowed rate of all procedures by the group. Although the entire group of specialists is capitated such that the MCO's liability is limited, each individual provider still acts on a (reduced) fee-for-service basis. Unless there are disincentives, this forces each provider to compete for a smaller share of the monetary disbursement. By performing more services/procedures, the individual provider can increase the share of the total allocated capitation. However, by increasing the number of services performed, in aggregate, the total reimbursement per service/procedure is reduced.

Unlike the Pure At-risk Capitation Model, which gives incentive to reduce the number of services/procedure, this hybrid capitated/fee-for-service model actually creates incentives, up to the point of diminishing marginal (marginal cost > margin benefit) returns, for the individual to increase the number of services. The increase in services will continue until the individual perceives that the per-procedure reimbursement has fallen to levels that make the addition or continuation of certain services/procedures unprofitable.

This model has several advantages for the MCO. First and foremost, the MCO's liability is limited and definite. Second, specialists will individually seek to increase the number of patients treated. Consequently, MCO patients have access to needed specialist care. Finally, this model also has the potential to incite the drawbacks of both the at-risk capitated model and the reduced fee-for-service model. There is incentive both for under treatment in certain instances, and for increased patient encounters, in other instances.

Miscellaneous Liability Factors

The current managed care environment also poses several other threats that may work to increase the number and severity of claims. These factors relate mostly to the depersonalization of modern medicine and create forces that can increase the likelihood of a lawsuit.

Unlike prior decades, there is a significant decrease in the patient loyalty factor. Patients are driven by MCO and PP-ACA plans, and providers are driven by costs and revenues. Patients perceive physician services to be interchangeable and medically equivalent. Currently, most have no loyalty to any one individual provider. Patients select PCPs based on the list in an insurance book. When they change plans (either by employer substitution or by change of employer), they often are required to select a new PCP from a new list of options. Patients consider the PCP to be the "insurance company's doctor", and the idea of "my personal doctor", departs with bygone days. Loyalty to medical specialists is especially strained since, in the past, patients often chose specialists based on reputation. Now, it is just as likely that the patient will be referred to an unknown specialist and have no input into the selection process. This factor, combined with less time for the specialist to develop patient rapport, leads to the patient viewing the specialist more impersonally, when considering whether to file a malpractice claim.

Additionally, with patients changing MCO and ACA plans and being subjected to narrow ["skinny"], less comprehensive and different medical provider, treatment facility and hospital panels [out-patient and ambulatory clinics, etc], there is the increased likelihood that one provider may start a treatment plan and may not finish it. With patients switching providers, the provider will lose control of the patient. Subsequent treating physicians may find fault with the prior treatment and cause the patient to seek redress. This also may increase the likelihood of claims.

THE MEDICAL AND HEALTHCARE ACTUARY

Health actuaries analyze potential risks, profits and trends that will affect their employers, which are often in the health insurance, government health services and medical provider industries. They advise companies on issuing policies to consumers based on risks, calculated premiums and upcoming changes in health-care costs. It's common for an actuary to have a bachelor's degree or higher in actuary studies, mathematics or statistics.

Coursework on medical terminology and hierarchy of the medical field is also beneficial. In addition to academic education, certification is also necessary to reach "professional status," which is required by most employers. The professional organization, Society of Actuaries, certifies actuaries in the health and medical field. Their statistical work is commonly done with predictive tables, probability tables and life tables that are created on customized statistical analysis software such as Stata or XLSTAT. The actuary field as a whole is growing faster than other fields, according to the Bureau of Labor Statistics. By 2020, it is expected to expand by 27 percent. The average annual salary for an actuary in 2010 was \$87,650. Specifically in the health insurance field, the salary was slightly higher at \$91,000.

ASSESSMENT

Given emerging new payment mechanisms of the modern era [global reimbursement thru ACS, medical homes, P4P, and capitation] are some medical providers paying too much for professional liability protection in the presently changing healthcare industrial complex, and are others paying too little? More time, data and research is needed for a definitive answer. But, the time for provoking the question has arrived.

CONCLUSION

Liability underwriters and actuarial advisors are risk-adverse by education and training. They react slowly, cautiously and incrementally to shifting risk factors; especially toward trends that suggest reduced underwriter income and liability premiums. Physicians and medical group administrators must therefore develop their own strategies for evaluating liability risk factors, and lead the trend to reduced operational expenses through managed liability costs. This is accomplished by exploring new medical payment models and the advantages/disadvantages of LLRAs, as presented in the Capitation Liability Theory of this chapter.

COLLABORATE

Discuss this chapter online with others at: www.MedicalExecutivePost.com

REFERENCES

- Cimasi, Robert, James: Accountable Care Organizations: Value Metrics and Capital Formation. Productivity Press, Boca Raton, FL, 2013.
- Eskow, R: A Brief History of Capitation; From Medieval Days to the 21st Century. Sentinel Effect, 2007 <http://sentineleffect.wordpress.com/2007/04/16/a-brief-history-of-capitation/>

- Landon, Bruce: Structuring Payments to Patient-Centered Medical Homes JAMA 2014; 312(16):1633-1634. doi:10.1001/jama.2014.9529
- Marbury, D: ACOs have three more years before sharing risks with CMS. Medical Economics, New York, NY, December 3, 2014,
- Marcinko, DE and Hetico, HR: Analyzing and Negotiating Cost-Volume Profit Medical Contracts; in, Healthcare Organizations [Journal of Financial Management Strategies]. In, Marcinko, DE [Editor]: iMBA Inc Publishing, Atlanta, GA 2010.
- Marcinko, DE and Hetico, HR: The Business of Medical Practice [third edition] Springer Publishing, NY 2011.
- Marcinko, DE and Hetico, HR: Dictionary of Health Insurance and Managed Care. Springer Publishing, NY 2006.
- Marcinko, DE and Hetico, HR “*Financial Management Strategies for Hospitals and Healthcare Organizations*” [Tools, Techniques, Checklists and Case Studies]. Productivity Press, Boca Raton, FL 2014.
- Marcinko, DE and Hetico, HR: Dictionary of Health Economics and Finance. Springer Publishing, NY 2007.
- Marcinko, DE and Hetico, HR “*Hospitals and Healthcare Organizations*” [Management Strategies, Operational Techniques, Tools, Templates and Case Studies]. Productivity Press, Boca Raton, FL 2013.
- Marcinko, DE and Hetico, HR *Comprehensive Financial Planning Strategies for Doctors and Advisors* [Best Practices from Leading Consultants and Certified Medical Planners™]. Productivity Press, Boca Raton, FL 2015.
- Stewart, Jon: The Story of Dr. Sidney R. Garfield: The Visionary Who Turned Sick Care into Health Care: The Permanente Press, San Francisco, CA, 2009.

READINGS

- Diamond, F.: Accountable Care Organizations Give Capitation Surprise Encore. Managed Care, Washington, DC, September 2009.
- Irving, F: Top 10 ACS cashing on shared savings. Medical Practice Insider, December 02, 2014.
- “Fostering Accountable Health Care: Moving Forward In Medicare,” January 2009. Health Affairs. Available at:
<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.2.w219>
- “Reforming Provider Payment: Moving Toward Accountability for Quality and Value,” March 2009. Dartmouth Institute for Health Policy & Clinical Practice, and the Engelberg Center for Health Care Reform at Brookings. Issue Brief. Available at: http://www.brookings.edu/events/2009/0311_aco.aspx
- “Recommendations of the Special Commission on the Health Care Payment System,” July 16, 2009. Special Commission on the Health Care Payment System. Available at:
http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf

- “Reforming the Delivery System,” June 2008. Report to Congress by the Medicare Payment Advisory Commission. Available at: http://www.medpac.gov/documents/Jun08_EntireReport.pdf.
- Hackbarth G, Reischauer R, Mutti A. Collective accountability for medical care — toward bundled Medicare payments. 2008. N Engl J Med. 359(1):3–5.
- “Budget Options Volume 1: Health Care,” December 2008. Congressional Budget Office. Available at: <http://www.cbo.gov/doc.cfm?index=9925>

CASE MODEL 1

TO JOIN OR NOT TO JOIN AN ACO [EVALUATING A MODERN PP-ACA CONTRACT PROPOSAL]

A new Accountable Care Organization network wanted a multi-specialty medical group to contract with them to provide medical services to all subscribers. Compensation would be in the form of a fixed-rate capitated payment system, a.k.a. per member / per month (PM/PM).

The medical group practice administrator reviewed their request for proposal (RFP) very carefully, but is still not sure what to do.

KEY ISSUES:

Facts to know for an informed PM/PM capitated reimbursement decision:

- annual frequency [office visits] or service-rate per 1,000 patients
- unit cost of medical services per unit-patient
- co-payment dollar amount per patient
- co-payment frequency rate per 1,000 patients
- variable cost per patient
- under-capacity medical group office utilization rates, and
- fixed overhead office-cost coverage [+/-].

SOLUTION:

There are several issues to resolve:

- 1) Be sure that all office fixed costs are paid, since revenues are fixed, and costs vary with patient volume.
- 2) Be sure there is sufficient unused office capacity for the additional patients. Additionally, one must determine the maximum amount of services provided under the PMPM rate that will make it possible to still break even.
- 3) Expected costs per patient must be estimated. If total PMPM cost is less than the PMPM compensation premium, the capitated contract might make economic sense for the medical group. If not, it should be rejected or re-negotiated.

CASE MODEL 2

MICRO-CAPITATION: A CHRONIC DIABETIC CARE PACKAGE IN DUBUQUE, IOWA

A family practice doctor in rural Dubuque Iowa (population ~5,000) cared for a fairly sizable population of diabetic patients. Dubuque is the county seat nestled at an elevation of 6,200 feet in an incorporated area of more than 500 acres.

In reviewing several paper charts, and EHRs, the doctor recognized that many patients were not getting the care they needed. In questioning these patients, he learned it was difficult for them to receive proper care because busy schedules created seasonal encounter difficulties. The physician determined to bolster his sparsely attended diabetic clinic by creating a new micro-capitated Diabetic Care Package [DCP].

CO-ORDINATION OF CARE

In order to deliver this Diabetic Care Package, the family practice physician entered into conversations with other medical providers to determine a pricing schedule, how care was to be coordinated, and how the virtual team would work together to deliver care. They agreed to revenue splits, performance metrics, and a mechanism to market the micro-capitated service. Contingencies were even made for patient needs that extended beyond the initial DCP provider agreement.

MEDICAL CARE VALUE-ADDED

Because an entire year of routine care was included for a single discounted fee, given the efficiencies gained through care coordination, patients saw the clinical and financial value-added. The physician signed-up 50% of his current patient population immediately (250 people). An additional 100+ patients signed-up within the first 90 days, as word-of-mouth marketing and positive local press reports made the program more widely known.

KEY ISSUES:

- 1) Coordination: A single program coordinator would help schedule appointments and provide outcomes measurements.
- 2) Staffing: All participating medical providers were staffed and organized to deliver their component services and, because they were all working at under-capacity, no new equipment or staffing would be required.

SOLUTION:

The DCP included the following medical services:

- four routine medical office visits,
- a bi-annual podiatric visit for foot care,

- an annual optometric eye examination, and
- four additional in-home nutritional / medication consultations.

Multiple side effects emerged from initiation of the DCP, including a spontaneous patient support group that met bi-monthly to discuss nutrition, insulin regimens, and related diabetic healthcare issues. The program coordinator participated actively with the group and recognized the opportunity for the various component providers to present the latest treatment options on a monthly basis. These meetings built additional rapport, patient confidence, and served as a recruiting mechanism for other diabetics in the community.

Within two years, three other physicians began selling modified versions of the Diabetic Care Package with new features, functions, and capabilities. The average community A1C metric, which was assembled by the patient support group, dropped from 9.5 to less than 7.0, for the known 472 community diabetic patients.

[Source: Modified courtesy of Scott I. Shreve MD; personal communication]

THE END

THE NEGOTIATION PROCESS

Once the numbers are crunched, the formal negotiation process with the MCO consists of a five-step sequence, according to Professors Bruce Patton and William Ury, of the Harvard Business School.

1. Don't bargain over positions. Taking them only makes matters worse since egos often become identified with positions. Is it harder to rob a friend or a stranger?
2. Separate the people from the process before considering the substantive problem. Figuratively, if not literally, both parties should come to see each other as working side by side, attacking the problem, not each other.
3. Invent options for mutual gain since having a lot at stake narrows your vision and inhibits creativity. Brainstorm possible solution options that advance shared interests and creatively reconcile differences.
4. Insist on using objective criteria rather than discussing what the parties are willing, or not willing, to accept. These standards can be a matter of custom, law, informed opinion, or market value.
5. Know your bottom line limit, and recognize that you do not have to come to an agreement in each and every situation. Therefore, you must know your best alternative to a negotiated agreement (BANTA) and be prepared to say "No," and walk away.

Furthermore, financial steps to successfully negotiating capitated medical contracts will involve the following key elements: developing a pricing model; using effective negotiation skills; incorporating protective contract clauses; and monitoring, implementing, and renegotiating the contract as needed.

Use Effective Negotiation Skills

The general negotiation skills advocated by the Harvard Business School (above) are very effective when beginning to negotiate an MCO contract. The following skills are also excellent tips for how to effectively negotiate payment agreements.

- **Do not get emotional, upset, or angry ... stay cool!** — Although financial negotiations are a vitally important matter to you, it is probably just another job to your MCO opponent. He or she will likely negotiate with many doctors, and you are not important enough for him or her to get upset about. Do the same with him or her, and stay cool.
- **Do not get personal or lose your dignity** — No one will respect an angry, loud, or abusive doctor. This type of behavior will not only NOT get you an increase, but you may be delisted from the plan because one can reasonably infer that your patients might get treated in the same impolite manner as your MCO opponent.
- **Do not share your information** — If you have good results or outcomes with a particular treatment protocol, do not share them with the plan unless they sign a non-disclosure, non-compete, or no sale agreement with you. Get information before you give information that might later be used against you.
- **The first offer should not be the last offer** — Even if you “split the price difference,” you might not receive a better financial deal. On the other hand, the initial offer was likely so low that even a “split” would benefit the MCO; so be careful. Splitting the difference is not negotiation.
- **Stand firm and await counter offers** — Once you have performed the calculations to determine your bottom line, don’t settle for less. You will only be offered less next time. Be aware of your best alternatives.
- **Leave something on the table** — If you give something, in return for getting something, you will foster a continuing relationship with your MCO plan. For example, you might accept a slightly lower pm/pm rate in exchange for a “diabetic carve-out.” In an older geographic neighborhood, this might be a better deal for you since wound or ulcer care is expensive. Your opponent can then go back his or her supervisor and brag about “putting one over on you,” by getting a lower capitation rate! In other words, you both get bragging rights.
- **Do not be afraid of calculated risks** — Partial or full risk, fixed based medical capitation is the wave of the future. So is the corporate practice of medicine seen in professional practice management corporations

(PPMCs). Do not be foolhardy, but those who take calculated and informed risks will prosper, while conservative types will not.

- **Do not give your MCO opponent too much credit** — Your opponent may know nothing about your area of medical specialty, so do not give him or her information about your practice or profession to use against other colleagues. You might just know more about managed care than he or she does.
- **Take your time — it's usually on your side** — Unless you have no practice accounts receivable reserve, are a new practitioner, cannot get a line of credit, or are really destitute, you probably have time on your side to negotiate a deal in your favor. Often, simple procrastination will increase your capitation or fee rates.
- **Use a professional negotiator or Certified Medical Planner™ if you are uncomfortable** — Although professional negotiators and business specialists may be expensive in the short run, you may gain much more by using them in the long run, especially if they are knowledgeable. If you have been unhappy with your own results to date, by all means get professional assistance.

Incorporate Protective Contract Clauses

Protective or “safe harbor” contract clauses are designed to help clarify the appropriateness of percentage-based MCO contract arrangements, and include: termination, re-negotiation, catastrophic, solicitation, non-disclosure, non-compete, “gag-order,” and solicitation clauses. The [Stark I, II and III] anti-kickback or “safe harbor” clauses make it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce the referral of business covered by a federal healthcare program (Medicare and Medicaid).

According to the Office of Inspector General (OIG), in Opinion 98-4, a percentage-based MCO contract would only qualify for the personal services and management contracts “safe harbor,” and would be suspect if it did not meet ALL six of the following “safe harbor” regulations:

1. The agreement is set out in writing and signed by the parties involved.
2. The agreement specifies the services to be performed.
3. If the services are performed on a part-time basis, the schedule for performance is specified in the contract.
4. The agreement is for not less than one year.
5. The aggregate amount of compensation is fixed in advance, based on fair market value in an arms-length transaction, and not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made by Medicare or a state healthcare program.

6. The services performed under the agreement do not involve the promotion of business that violates any federal or state law.

Other important clauses to consider include: indemnification clauses, procedural “carve-outs,” low enrollment guarantees, utilization rate “kick-outs,” drug or formulary clauses, risk pool limitation clauses, MD/member ratio requirements, “all or none” group clauses, “stop-loss” re-insurance, as well as arbitration and mediation clauses in your home state.

Note: Opinion 98-4 was generated by a request from a single physician. All medical practitioners are entitled to seek an OIG opinion on individual contract arrangements.

Monitor, Implement, and Renegotiate the Deal

Ongoing Total Quality Improvement and Management (TQIM) evaluation, payment schedules, medical and economic credentialing, as well as financial ratio analysis should be done quarterly with MCO administrators to ensure that the contract you originally signed is meeting the expectations of all concerned. For example, the following scheme may be used to assess your contract(s) utilization and net revenue(s).

As HMOs are themselves increasingly coming under their own cost pressures, many are willing to negotiate complementary or alternative healthcare modalities as part of a benefits program (i.e., weight and stress management, nutritional services, biofeedback, herbal medicines, meditation, and yoga).

NEGOTIATING A BETTER PHYSICIAN FEE SCHEDULE

It is known that most health plans operate with fixed fee schedules. While these fee schedules have little or nothing to do with RBRVS, and most are based on a percentage of what Medicare pays, the question is: “are they tied to levels that are more than 3 or 4 years old?” Physicians who have no negotiating tools or a plan in place, and who question the methodology that the payers are using, are (too casual-left) with a ‘take it or leave it’ response from the health insurance provider. Accordingly, a good solid foundation of data, and the above information, is necessary to negotiate better reimbursement rates successfully. The practice administrator or accountant (not 1 in 100 accountants can actually do this) should have this information readily available, especially if the office has an automated billing system.

STEPS TO PREPARING A FEE ANALYSIS

First and foremost, the medical management team in charge of this project will need to determine the most commonly used CPT® codes for the practice. The bulk of primary care or family practice physician fees should be derived from the revenue of the office visit, hospital and preventive medicine codes. This in turn may limit the number of codes

for the study. The frequency of each CPT code should be listed over a 12 month period. If applicable, laboratory fees should also be included to see if there are fluctuating reimbursement schemes for these services. The codes on the list should account for at least 75% of the total practice charges.

DETERMINING TOP PAYERS AND REIMBURSEMENT BY PAYER

It is known that Medicare and Medicaid use established fee schedules and do not negotiate, therefore the focus should be on the other major payers that make up the bulk of the reimbursement. In this process, make sure that the payers in the report are the practice's top payers. The practice administrator will also need to determine the reimbursement for each code that is sent to the various payers' list in the report. The administrator or team leader (the average GP has 3-4 employees, so I don't think there would be a team leader, here). For this project we can use the Explanation of Benefits EOB that is received from each payer that has been selected for the report. When including this data, make sure the allowed amount, not the paid amount, is referenced. After this information has been gathered, each payer's reimbursement rate will need to be calculated as a percentage of Medicare's reimbursement rate. Medicare's current rates for any geographical area can be found at the "Medicare Physician Fee Schedule Look-up" tool on the CMS website. The site also provides a reference to Relative Value Unit, (RVU) that Medicare assigns to each code.

RVU Conversion Factors

It is important for the practice administrator, physician or manager to understand the RVU conversion factors and how they work, simply because most payers are in the beginning stages of using this method. To calculate a payment for service you multiply a particular CPT Code by the Medicare conversion factor for that code. For an example we will use the code 99214 – office visit. The Relative Value Unit for that Code is 2.2. The Medicare conversion factor for the same code is \$37.34. The calculation would result in a rate of \$82.15. Geographical adjustments must be taken into account when performing these calculations. The next step in this process would be to review the fees for each code listed in the report. Calculate each fee as a percentage of Medicare's rates. You will find different statistics for each payer.

Apply the Rules

Follow these basic rules when applying this new process:

- If the charges are being reimbursed at 100%, the fee may be too low. At this point, raising the fee for that code would be acceptable (Usually not the case)
- If several fees are in this category, the practice should just set all its fees to a percentage of Medicare reimbursement across the board, such as 125 percent (many managed care plans pay at less than MC, i.e., 80% MC).

- A tiered fee schedule would be applicable if the payers seem to pay more for certain procedures or diagnostic studies. That would set evaluation and management codes at 125 percent of Medicare reimbursement while charging 150 of Medicare reimbursement for other procedures and diagnostic tests.

The doctor or medical practice administrator should make sure that, no matter which fee schedule is best suited for the practice, it is updated annually to prevent loss of any increases that may occur per payer.

Physician Fee Schedule Augmentation

After all medical practice management data has been gathered, organize it onto a spreadsheet or chart. This analysis report will help to determine the codes and/or health plans that should be targeted for process improvement.

Focus Like a Laser Beam

The focus should be on the highest volume and dollar value codes. Does this mean patients with unusual conditions or low dollar value codes are not treated? Hopefully it will not; but it will push this process forward and the practice will see the greatest benefit from these categories. When you review the report and find that a fee is being paid at a much lower rate, this would be indicative of a necessary negotiation with the payer for an increase for that procedure. Most health plans are committed to preventing disease. Maybe, but they are still actually aimed at treating diseases; not preventing them. If this is true of many payers then they should be willing to provide the incentives for those services to be carried out. You will find that some payers' fee schedules are very much out of line with a percentage of Medicare payments, therefore the practice administrator should focus on those payers and bring evidence of the inadequacies to their attention.

Specialists versus General Practitioners

Specialists are, for the most part, paid at a higher rate than primary care physicians for a similar service! But, with GPs as gatekeepers in the early managed care era, specialty doctor income was actually poised to decrease in some instances, while GP income increased briefly. Unfortunately, this may longer be true today, according to blogger Scott Shreeve MD, whose criticism of the specialty laden AMA coding CPT® commission is legendary. There was a time when Medicare had two conversion factors, and this was the result. This inequity could also be used as a tool for better reimbursement rates [personal communication].

FINALIZING THE FEE AND REVENUE ANALYSIS

When the final preparations of the fee analysis have been completed, it is time to react to the results of the findings. There are several options to choose from when it has been determined that a health plans fee schedule is not in tune with the practice's financial

growth. The practice should act on these results as soon as they are discovered, to avoid the loss of any more revenue.

WHEN NO LONGER ACCEPTING HEALTH PLANS

During the analysis phase, you may determine that a health plan's payment levels are extremely low. You will have to determine whether the plan is worth negotiating or the practice administrator should consider dropping out of the plan altogether at the end of the contract period. It will have to be carefully determined by the local market. If the practice is in a highly competitive market, this process should not be considered as first choice. However, if the market is very slim, the health care purchaser will be responsible for complaining to the health insurance plan provider that there is simply not enough physician coverage for their employees for the area. This could be a very effective way to force a negotiation with the health care company. If this were the case, the area would have less managed care and more MC/MD.

WHEN NOT ACCEPTING NEW PATIENTS FROM LOW PAYING HEALTH PLANS

One option would be to not accept any more patients from the health plan that is reimbursing the practice with low rates. Although this may initially lower your patient count, over time the practice will benefit from new patients with health plans that have a better reimbursement policy. Include snapshot of what the final analysis or report should look like and the details of what it should include. This can be used in any specialty to assist in putting together the individual practice analysis to achieve the same results. But is noble or ethical? What about any willing provider laws?

THE END