RETHINKING CAPITATION REIMBUSEMENT ECONOMICS

[Sub-Capitation, Micro-Capitation and other Emerging Models]

David Edward Marcinko

She didn't know it couldn't be done, so she went ahead and did it.

Mary's Almanac

The accounting numerics that physicians should know regarding capitated medical provider insurance reimbursement contracts may still be underappreciated by some doctors. The mathematic methodology for evaluating the potential impact of these contracts on practice economics may also be vague. Therefore, simple financial stochastic modeling will be demonstrated to illustrate the impact on a proto-typical solo family practice physician's office. The modeling however, is applicable to most any medical specialty or to small and medium group practices.

HISTORICAL REVIEW

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.

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 Historical documents, though muddled, indicate that soon thereafter at least one "physician," John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, Matthew Holt of the Health Care Blog wrote that colleague Jon Stewart the historical archeologist, considered Sidney Garfield MD [1905-1984] 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 "àla carte" eatery. It is based on more modern Health 2.0 market dynamics and the Cost Volume Profit Analysis calculations outlined below.

Market Dynamics

Continuing changes in the Health 2.0 marketplace 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;
- Stop loss.

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 Rate and Contract Terms: 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?

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 services 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 errors."

EVALUATING THE 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:

$$\frac{\text{Total Fixed Expenses}}{\text{(Net Revenue per Visit – Variable Expenses per Visit)}}$$

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 20.1.

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.

[Insert Table 20.1]

Payer Mix Scenarios

We can now develop scenarios to help evaluate the impact of changes in payor mix. Computerized spreadsheets are idea 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 20.2.

[Insert Table 20.2]

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 20.3.

[Insert Table 20.3]

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 20.4.

[Insert Table 20.4]

SUB-CAPITATED CONRACTS

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.

Orthopedic 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.

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.

[Insert Figure 20.1]

EMERGING 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.

In the Health 2.0 era, it can be seen that capitation has some advantages, as our cost accounting information has demonstrated.

For example, capitation can create and align incentives that help patients, providers, and payers by limiting their contingent fiscal liabilities. Capitation is again being viewed by some in a more positive way, going forward.

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 is 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.

Acute Episodes of Care [AEC]

A related packaged medical care concept, called "acute episodes of care," is also being studied.

For example, in June 2008 the Centers for Medicare & Medicaid Services (CMS) outlined a planned demonstration beta project that would combine payments for both hospital and physician services for a select number of acute episodes of care, with the intent of seeing if such an approach will be more efficient and improve the quality of care. The project, called the Acute Care Episode Demonstration [ACED], tested whether a global payment will better align the incentives for both types of providers leading to better quality and greater efficiency.

If enacted, the hospitals and physicians selected to participate in the final ACED project would see their payments combined for certain cardiac and orthopedic inpatient surgical services. CMS selected as many as 15 ACE sites in Colorado, New Mexico, Oklahoma and Texas for the first year of the three-year demonstration that began January 1, 2009. The selected sets of procedures included in the bundled payment demonstration are 28 cardiac and 9 orthopedic inpatient surgical services. According to CMS, these elective procedures were selected because profit margins and volume have historically been high; there is sufficient marketplace competition to ensure interested demonstration applicants; the services are easy to specify, and quality metrics are available for them.

Although still early, some healthcare organizations are voicing early support for the concept, which holds the promise of providing more transparent pricing for healthcare episodes. Currently, patients are often confused by receiving multiple bills from separate provider groups that provided services during a traditional medical or surgical care episode.

Nevertheless, the ACED reflects an ongoing commitment to actively pursuing the best medical care for Medicare beneficiaries through value-based purchasing by testing

whether an approach of bundling payment for both hospital and physician services will work. And, pending positive preliminary results, the private sector is sure to follow.

NURSING CAPITATION

Capitated reimbursement is predominantly, but not exclusively, within the realm of physician providers. For example, a Community Nursing Organization [1994-2001 project examined an innovative approach to community nursing and ambulatory care services for Medicare beneficiaries. The hypothesis was that provision of such services would promote the timely and appropriate use of health care and to reduce the use of costly acute care services.

Organizations participating in the CNO demonstration were paid a fixed per-member-per-month capitated rate for covered services. But the participating CNOs were only at risk under capitation for a subset of Medicare benefits [partial-capitation or carve-out]. The financial incentive was to minimize utilization covered under the capitated payment, but not necessarily to minimize utilization of services not covered because traditional Medicare, not the CNO, would be at risk.

Final results indicated that the CNO model under partial capitation led to increased Medicare costs based on findings consistent across several analytic approaches. The cost differences between treatment and control or reference groups persisted after the application of increasingly complex risk-adjustment methods. Moreover, the differences increased over time and were robust to changes in the way CNO participation was defined. Lastly, there was no statistically significant evidence of increase in physical or social functioning of the treatment group, as compared with the control group. CNOs cost

more without providing any health benefits along dimensions measured [Source: Voluntary Partial Capitation: The CNO Medicare Demonstration Project, Austin Frakt, Steve Pizer, Robert Schmitz, and Soeren Mattke - Health Care Financing Review 2005).

THE HEALTH 2.0 VIEW GOING FORWARD

Yet another new look at capitation reimbursement involves an emerging theoretical construct where incentives are created for physicians to provide effective and efficient primary care.

Comprehensive Payment Reform [An Emerging Theoretical Construct]

In "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," a team of physicians led by Alan H. Goroll, MD, of Massachusetts General Hospital, reported on how their proposed system avoids the problems of previous capitation systems, which merely bundled together inadequate fee-for-service payments, substantially increasing payments for primary care in return for greater accessibility, quality, safety, and efficiency.

Under their model, medical practices would receive monthly payments for each patient under their care, with adjustments made according to the patient's needs and risks. Over two-thirds of the payments would be designated to pay for multidisciplinary healthcare teams (e.g., nurse practitioners, nutritionists, and social workers) and for information systems to monitor safety and quality, including interoperable electronic health records. Fifteen to 25% of payments would be linked to performance in meeting benchmarks of cost-effectiveness, efficiency, health outcomes, and patient-centered care.

Payments for hospital and specialist services, laboratory tests, imaging studies, and other ancillary services would remain unchanged and continue to be paid under a resource-based relative-value scale system. Appropriate use of such services would be promoted through reliance on evidence-based guidelines and performance incentives linked to efficiency.

Advantages of Comprehensive Payments

This proposed comprehensive payment system moves away from payments based solely on discrete face-to-face patient encounters. Instead, primary care medical practices would be paid comprehensively for providing coordinated, well-organized primary care—which in turn would lead to a healthier, more productive population and reduced need for hospitalizations and other costly services. These comprehensive payments differ from capitation systems of the past decade in three important ways:

- payments would be adjusted according to patient levels of risk and need;
- outcomes and patient satisfaction measures ensure that health services would not be underused; and
- funds would be provided to support healthcare teams and infrastructure.

It is thought that these features would avoid the pitfalls of earlier capitation systems, which had the effect of erecting barriers to necessary care and encouraging providers to avoid complex patients.

Economic Assessment

Under one possible projected scenario, medical practices might receive an average of $800 per patient per year rather than the usual fixed payment system of per member/per month compensation. This would increase total health care spending for a given population by 2% to 3%. While in the short run such a comprehensive payment system would represent a net investment in primary care, in the long term it is projected that reductions in waste and improvements in care would ensure the system would pay for itself.

In addition, the comprehensive payment system would free up time that primary care practices now devote to claims billing, coding, and other administrative tasks embedded in the current system. By separating income from volume of patient visits, the new system would enable practices to tailor care to the particular needs of patients—from customized office visits with members of the healthcare team to e-mail and Web-based communications, group visits, and even visits in patients' homes.

[Insert Table 20.5]

ASSESSMENT

Abuse is possible in this system necessitating certain safeguards. For example, disbursement guidelines would ensure the appropriate use of funds targeted for health care team salaries and systems. Objective, validated measures of risk and need as well as independent audits might prevent "gaming" of the risk-adjustment process. And, to prevent practices from "dumping" patients onto specialists, the per-capita payments could follow patients when specialists assume most of the responsibility for their care.

Moreover, skeptics that Capitation Version 2.0 will succeed abound. Noted hospital CEO and blogger Paul Levy feels that doctors and hospitals will be at risk of being caught in the middle.

"You also need to let the public know what the new environment will be for their care so doctors and hospitals are not caught in the middle, the way it happened during the last experiment with managed care. If the Commission does half the job in its recommendations and leaves the rest to be fixed in the future, it will leave us will a lot of unintended consequences and will undermine the good that might otherwise come from a new payment scheme."

Source: http://runningahospital.blogspot.com/2009/05/provider-payment-considerations.html

And, health insurer CEO Charlie Baker echoes wonders whether patients will accept the implications of the model. In addition to the fear that doctors will be incentivized to withhold care, patients might also worry about a possible "restrictions on their ability to see any physician they wanted to see."

Source: http://www.letstalkhealthcare.org/health-care-costs/an-old-idea-is-new-again/

CONCLUSION

Changes in payer mix, to and from capitation and micro-capitation reimbursement, may have significant impacts on medical practice economics and ought to be considered. It is important that physicians understand the financial, service responsibility, and administrative terms of payer contracts. It is also important to test the potential financial impact of a shift in payor mix. By applying the accounting

fundamentals described in this chapter and book, physicians can anticipate and prepare for the emerging changes that are likely to occur in the future.

COLLABORATE NOW: Continue discussing this chapter online with the author(s), editor(s) and other readers at: www.BusinessofMedicalPractice.com

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Table 20.1 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

Table 20.2 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

Table 20.3 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

Table 20.4 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

Table 20.5

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

- 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.