

Move to capitation can bring rewards, risks to specialists

By Jeremy N. Miller
AMNEWS CONTRIBUTOR

Even in markets heavily penetrated by managed care, most specialists until recently still have been paid on a fee-for-service basis. Increasingly, however, specialists are being “carved out” or “sub-capitated,” where they are paid a flat amount per member per month.

Capitation can produce rewards as well as risks for specialists. And there are steps you can take to reduce the dangers and maximize the benefits.

Specialist capitation gains steam

HMOs, as well as such physician organizations such as independent practice associations and medical groups, often turn to specialist capitation for their own protection. Once they've agreed to accept a fixed premium or capitation fee to assume the risk to provide all primary care and specialist medical services, they're wary of paying contracting specialists at production-based, fee-for-service rates. They want to capitate specialists to fix these costs, leaving many specialists feeling forced to accept capitation.

But some specialists are seeking out capitated contracts, viewing them as an opportunity to maintain or gain market share, stabilize income, and profit, if they can control utilization while maintaining quality and patient satisfaction.

Virtually every specialty is being capitated today, including radiology, orthopedics, ophthalmology, oncology, surgery, obstetrics, cardiology, dermatology and neurology. Such ancillary services as lab and durable medical equipment also are being capitated.

Pre-contracting considerations

Specialists and payers, particularly those with little or no prior experience with capitation, need to appreciate the risks of these contracts. The “sub-capitation” rate to be paid for specialty services is only one of the many important contract terms.

First: Who will be the payer? Will it be an IPA or medical group or an HMO or insurance company with whom the specialists have a “direct” contract? Direct contracting appears to be more common in the eastern United States than on the West Coast. A recent Inter-Study report indicated

that the overall rate of capitation among West Coast specialists is more than twice the national average.

Payers should be evaluated on such factors as how long they've been in business, their experience with specialist capitation, market share, financial strength, track record in paying specialists, and medical information systems.

It's equally important to determine who the provider of the specialty services will be. Frequently, a single physician specialist will not have the capacity to provide all of the agreed-upon services. Multiple office locations and sub-specialists may be required.

To meet these demands, many specialists are forming fully integrated, single-specialty groups or specialty IPAs. But these arrangements can raise antitrust concerns if they're not carefully structured. For example, if too many of the specialists in a geographic area form an IPA or group, the organization could be viewed as a monopoly. And even with a capitated contract, price-fixing is still a risk if the IPA or group is improperly structured.

Specialists also need to evaluate themselves and be prepared for capitated contracting. Does the specialty IPA or group have enough specialists to care for a large volume of enrollees and provide all required subspecialty services? Are the offices conveniently located to cover the designated service area? If the specialists don't have prior capitation experience, can they evaluate the payer's prior specialist utilization information and their own practice costs to determine a fair capitation rate?

Finally, the specialists need to carefully select a team to analyze the capitated contract and negotiate with the payer. The team should include one or two physicians, the practice administrator, an actuary or other managed care consultant, and a health care law attorney experienced in managed care contracting.

Understanding key contract terms

Through careful preparation and negotiation, specialists can significantly reduce their risks, even under a capitated contract. Here are some of the key terms you'll find in a typical contract:

! **Definitions:** Many contracts will contain a section that defines its key terms. The definition of "covered services" those that will have to be provided in exchange for the fixed, capitation payment is the single most important. Obviously, the fewer services for which the specialists are responsible, the lower the risk. Contracts that simply state they're for "orthopedic" or "neurological" services are clearly inadequate because the precise scope of practice of most specialties is not fixed. The contract, therefore, should include a detailed service matrix, with the covered services defined by CPT code or other precise classification system.

! **The payer's obligations:** Payer's obligations should include, but not be limited to, paying the capitation amount each month, verifying eligibility, assisting and supporting the specialists' offices, collecting and distributing utilization and other key information, credentialing and handling grievances.

! **The specialists' obligations:** In addition to providing the covered services for the agreed-upon rate, the specialists likely will have to submit certain encounter data, meet quality standards, agree not to discriminate against capitated patients or "balance bill", collect co-payments, follow approval procedures for cross-specialist referrals and hospital admission, participate in peer review, assist in credentialing, meet insurance requirements and comply with the payer's administrative procedures.

! **Compensation:** Because there is less experience in capitating specialists, calculating the capitation rate can be tricky. As noted above, the capitation rate cannot be considered in a vacuum. Its adequacy is inextricably tied to the definition of covered services. There are also vast differences in capitation rates depending upon the population covered, age and sex, and the particular specialty. Contracts for such specialties as orthopedics and obstetrics-gynecology might pay \$3 to \$4 per member per month or more, whereas those for hematology-oncology might pay 20 cents or less. Sometimes an actuary should be consulted to determine an adequate capitation rate.

Even after a rate has been agreed upon, there are other ways to reduce risk. For example, the contract could provide for extra payment if actual utilization exceeds a target rate used to determine the original capitation amount. The contract might also provide for certain "carve-outs that will be paid on a discounted fee-for-service basis. These might include multiple-trauma cases, physical therapy and durable medical equipment for an orthopedic contract, bone marrow transplants for an oncology contract and open heart surgery for a cardiology contract. Expensive drugs, such as those used for chemotherapy and infertility, often are covered on a fee-for-service basis.

Specialists should be aware that, from an actuarial standpoint, they likely will need to have many more assigned patient lives than would be required by a primary care physician who is capitated. To achieve adequate "actuarial spreading" of the risk, the minimum number of lives may range from as low as 1,000 for radiology to more than 50,000 for neurosurgery. The contract could provide that, until the minimum acceptable number of lives is reached, the specialists will be paid on a discounted, fee-for-service basis. This is known as a "low-enrollment" guarantee.

Will the specialists be eligible to participate in any risk-sharing pools? If so, the contract should state in detail the formula for risk-sharing and when payment will be made. The contract should also specify whether specialists will be able to participate in coordination of benefits payments, exactly when the capitation payment will be paid each month (with a penalty for late payment) and whether co-payments are to be collected.

Finally, does the payer offer or require stop-loss insurance for catastrophic cases? If so, what is the cost, and what are the terms of coverage?

! **“Dumping”**: Specialists need to be aware that if they accept capitation, their relationship with primary care physician “gatekeepers” may change dramatically.

Specifically, in situations where the primary care physicians have accepted “full risk” for all primary care and specialist medical services - but the specialists are charging the primary care physicians on a discounted, fee-for-service basis - the primary care physicians will have a financial incentive not to “over-refer” to the specialists. Once the specialists are capitated, however, the primary care physicians may be too willing to refer cases to the specialists who can no longer separately bill the primary care physicians for their services.

This potential problem can be addressed, in part, by carefully defining “covered services.” For example, primary care physicians might be required to attempt to treat routine, lower-back pain, rather than immediately referring the patient to an orthopedic surgeon.

Specialists also should discuss with the payer and be familiar with the procedures for authorizing referrals to specialists in order to decrease the likelihood of excessive referrals. And they should be aware that the payer might withhold authorization for expensive procedures until the specialist capitation contract is signed, only to approve a flood of expensive cases just in time to dump them on the unsuspecting specialists.

! **Utilization review and quality assurance**: The contract should specify what plans, procedures and protocols a specialist will be expected to follow in handling cases. Hospital admission and specialist referral procedures as well as mechanisms to resolve referral disputes should be included.

! **Exclusivity**: Typically, specialists are not asked to become exclusive providers because the payer cannot offer enough covered lives to make an exclusive arrangement economically viable. Specialists, therefore, should be very careful about agreeing to a contract that attempts to limit their ability to enter into contracts with other payers.

! **Term and termination**: Unless the specialists have prior experience with capitation, they probably should not enter into a contract for more than a one-year term. This reduces the risk of being stuck with what could turn out to be a bad contract. In addition, specialists may want the contract to provide for early termination, with or without cause, if it proves disastrous, financially or otherwise.

Of course, a “without cause” provision also means the payer can cancel the contract on short notice. A typical contract will provide that it can be terminated on little or no notice if there is “good cause.” But the contract should state that if the payer alleges a cause for termination, the specialist will have a reasonable period to attempt to “cure” the alleged breach. On the other hand, if the payer is delinquent in making the regular monthly capitation payment, the payer should have no more than, perhaps, 10 days to make the payment or risk having the contract terminated by the specialists.

The contract also should discuss post-termination responsibilities. Many contracts will attempt to require specialists to continue to treat patients who are under their care at the time of termination until the treatment is completed or until the payer decides to transfer the care to another specialist. Specialists should try to limit their post-termination obligations to no more than 30 days, and during that time, they should be paid at a previously agreed upon fee-for-service rate.

! Amendment: The contract should state that it can be amended only with the written approval of both parties. Specialists should be on the lookout for hidden amendment provisions that allow the payer to unilaterally change the contract by adopting “administrative” policies and procedures.

By carefully approaching and handling the contracting process, specialists can significantly reduce the risks of capitation agreements, and increase the likelihood of a successful and rewarding experience.

Health care attorney Jeremy Miller is a principal in the Los Angeles law firm Miller Health Law Group. He can be reached at (310) 277-9003.