Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

Do's & Don'ts of Capitation Contracting

John B. Benear II

To cite this article: John B. Benear II (1995) Do's & Don'ts of Capitation Contracting, Oncology Issues, 10:6, 20-22, DOI: 10.1080/10463356.1995.11904576

To link to this article: https://doi.org/10.1080/10463356.1995.11904576

Published online: 28 Sep 2017.

Do's & Don'ts of Capitation Contracting

by John B. Benear II, M.D.

Although specialty capitation is not yet widespread, this approach may become more common as market forces place pressure on managed care organizations to focus increased attention on the bottom line. Capitation can reduce costs, engineer greater value, and at the same time streamline patient care.

Negotiating a contract for capitation is a complicated process, requiring business acumen that physicians are not likely to acquire on their own. They must instead work with their legal and management consultants to evaluate such contracts, especially since these arrangements entail greater risks than traditional fee-for-service contracts.

Key concerns that determine success in a capitation agreement can be grouped into three categories: general contract terms, payment and report card issues, and practice issues. Physicians must deal with each during the critical contract negotiations.

GENERAL CONTRACT TERMS

Entry and exit. The contractual document must clearly spell out a patient's entry and exit into the oncology practice. It should define whether the patient becomes the responsibility of the oncologist at the time of diagnosis, at the time the pathology report returns, or at the time all the staging studies have been completed. The practice is best served when physicians see the patient after he or she has been completely assessed, so appropriate expenses can be computed.

Termination of a patient relationship must be described because physicians' rights to deal with a problem patient are not as free as they are in the situation of general fee-for-service practice. An abusive or noncompliant patient can be "fired" from a fee-for-service practice, but in an HMO contract with a sole source subspecialty provider, the payer must mediate.

Annual rollovers. The duration of the contract affects the practice's financial viability over the long term. If, for example, a practice negotiates a short-term contract of one year, the health care payer may want to negotiate the capitated rate downward at the end of that period. Because practices want to keep profits on their side of the equation, clear contract terms must be established to avoid a withering price spiral after just one year. Specified terms for annual rollovers with floors for capitated rates are important, if they can be negotiated. A general rule is to allow no more than a 10 percent annual reduction. If an insurer is paying $1.50 per member per month, next year it should not be allowed to cut the payment by a large percentage, for example, to $0.54 per member per month. The payment should be reduced to no less than $1.35 per member per month.

Withholds. Withholds are a common feature of capitation contracts and are sometimes used by payers as incentives to control physician behavior. Withholds usually relate to practice efficiencies and defined bonuses related to quality or utilization review. Physicians sometimes react negatively when they do not receive what they interpret as their full payment up front. However, a 10 to 15 percent withhold—paid back at the end of the quarter or the year—is reasonable. Furthermore, withholds are considered risk sharing. As such, they can help to insulate a physician from antitrust concerns in a network-type contracting arrangement.

Sharing in risks for provision of services can be a major source of enhanced revenue for oncology practices. Creating formulas related to optimal hospital utilization or outpatient care are areas where enhancing practice efficiency can generate additional revenue for the practice. Because these formulas are quite complex, it is best to work with an expert in capitation contracting to create parameters for incentives.

Clear definitions of coverage. A capitation contract must clearly define which oncology services and diagnoses are covered and which are excluded. A contract may be as explicit as to include ICD-9 or CPT codes in the contract. One must be certain that patients are not undertreated and that the language used in the contract does not reflect or imply a different standard of care for patients under the contract in relation to the providers' usual fee-for-service population.

Exclusions for new technology. Oncology is especially vulnerable to technology changes, so contracts must specify how newly approved drugs, drug indications, or new procedures will be handled from a payment standpoint. Spell out what items are to be included in capitation

John B. Benear II, M.D., is an oncologist with Cancer Care Associates in Tulsa, Okla.

rates. Excluded items may include the cost of some drugs, for example, certain growth factors or new antiemetics. Flat fees can be negotiated for specific procedures, such as ultrasound-guided biopsies.

Review of documents. If any quality attainment or utilization review documents are referenced as appendices or referred to as issues of contractual obligation, these documents should be available for the physician and his or her counsel to review in full.

Hold harmless clauses. Hold harmless clauses ask the physician to hold the insurer or managed care organization harmless for utilization review and quality attainment issues. In other words, the physician becomes absolutely responsible for any care issues that arise from the contract. It is traditional to warn physicians to avoid "hold harmless" clauses if possible, due to their legal liability. This should be discussed with counsel.

Referral ceilings. This is a common issue that is often overlooked in capitation contracting. When a subspecialist is capped, the disincentives for primary care physicians to refer are eliminated and the subspecialist is vulnerable to a deluge of referrals if not contractually protected. There must be a cap that specifies how many patients will be seen under the umbrella of the capitation rate. A numerical ceiling, above which fee-for-service kicks in, can protect a practice.

PAYMENT ISSUES AND REPORT CARDS

Some payment concerns are peculiar to capitation. One problem that may occur is related to copayments. Physicians sometimes see capitation arrangements as a way of decreasing their costs of billing and do not want to be troubled with copayments. However, if a physician's practice is capitated without a copayment, then a patient would be inappropriately incentivized to see an oncologist for a sprained ankle rather than pay the copayment to see his or her primary care physician. With certain patient populations a copayment of as little as five or ten dollars may control their self-referral behavior. This issue must be dealt with in terms of the payment policy.

The level of risk in the contract is related to the size of the population. There is no hard-written evidence to examine on the issue of population size for oncology capitation contracts. Consultants usually relate that drugs cannot be put under the umbrella of the capitation arrangement unless the population is at least 50,000 beneficiaries or even as high as 100,000 in a healthy commercial population.

With certain patient populations a copayment of as little as five or ten dollars may control their self-referral behavior.

The issue of hospital risk entails a tremendous financial exposure and requires stop-loss insurance, which specifies dollar thresholds beyond which all or part of the patient care costs are borne by the stop-loss insurer. Since stop-loss insurers hold down costs by case management, providers must notify them as costs of care approach the threshold. Practices usually do not have the financial reserves nor the level of sophistication to deal with the financial risks entailed in contracting for hospital care.

If a "report card" is part of the reimbursement formula for a capitation contract, ask for a sample and be privy to the method of compilation. Many report cards are used, some related to the Health Employer Data Information Set. Others are created by large employers. These relate to specific data sets and often incorporate indices of patient satisfaction, such as waiting time and physician attention.

PRACTICE ISSUES AND SEAMLESS ONCOLOGY CARE

Day-to-day practice is a physician's concern. Physicians sometimes function as primary care oncologists, gradually taking over the global care of patients during the time of their active treatment for cancer and then maintaining a fundamental role in patient care, even after the completion of adjuvant treatment for cancer. How to structure this relationship in a capitation contract is problematic in that the provider group is at risk for the expenses of the patient's long-term care. When examining the terms of the contract for patient care, physicians should consider the number of visits they believe are necessary, how they want to structure those visits, and how active they want to be in the long-term care of the patient.

In an era when carve-outs and subcarve-outs are becoming more common, practices may have to deal with patients who are sent to other practices or other sites for transplantation or intensive treatment, and who then come back to the provider group early or only partially recovered from the effects of the procedure. Dealing with these patients and specifying issues of coverage, follow-up, and exclusions from the umbrella of the capitation are important as these situations become more common.

Capitation offers some potential benefits for seamless oncology care. Once patients come under the umbrella of a capitation agreement, the cost of care is borne by the provider. Thus, insurers are less likely to intrude into patient care. Off-label use of drugs and frequency and style of visits are no longer issues of concern, and clinical trial participation is no longer a source of contention with the insurer, although it may be a source of increased practice expense. Physicians and nurses have more time to devote to the tasks for which they are trained—namely the thoughtful and compassionate care of patients with malignant and hematologic illnesses. By accepting risk in a capitation contract, physicians and nurses can become free of third-party denials and second-guessing utilization review. This freedom, however, is accompanied by the responsibility to treat the patient optimally regardless of the payment method. ■