

VI

VOLUME VI

Healthcare
Price, Cost
& Utilization
Benchmarks

VI

VOLUME VI

Healthcare Price, Cost & Utilization Benchmarks

+CPro

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Susan Darbyshire, Art Director

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HCPro, Inc.

P.O. Box 1168

Marblehead, MA 01945

Telephone: 800/650-6787 or 781/639-1872

Fax: 781/639-2982

E-mail: *customerservice@hcpro.com*

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Employers raising PPO deductibles to offset costs; CDHPs affecting other plans

The line between PPOs and consumer-driven health plans (CDHP) has become increasingly blurred as employers shift costs to reduce healthcare expenses.

One figure highlighting this shift is PPO deductibles, which nearly doubled between 2007 and 2008, according to Mercer's National Survey of Employer-Sponsored Health Plans, a survey of 2,900 private and public employers. The median PPO deductible doubled in just one year as more employers looked for ways to reduce their costs. (See Figure 1.)

Employers in smaller companies, especially, are raising deductibles. For larger companies (those with 500 or more employees), median deductibles for individual and family coverage were \$300 and \$800 respectively in 2008.

PPO deductibles are a byproduct of the consumerism movement, says **Blaine Bos**, a worldwide partner at Mercer in Minneapolis. "The introduction of the [health savings account (HSA)] may have changed employers' thinking on just how high a deductible can go without causing employees to revolt," Bos says. "Raising the deductible has become the fallback for employers faced with cost increases they can't handle. It's the easiest way to reduce cost without taking more out of every employee's paycheck."

Meredith Baratz, vice president of market solutions at UnitedHealthcare in New York City, says high deductibles are not new to healthcare and were around before health insurers turned to managed care. Earlier designs were low-cost and catastrophic

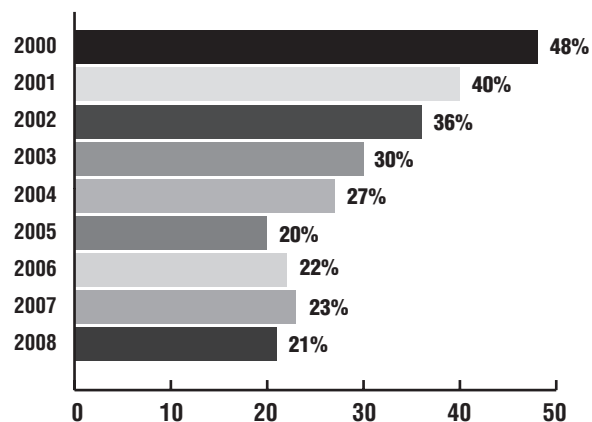
FIGURE 1

Median deductibles for PPO plans

Year	Deductible
2000	\$250
2001	\$500
2002	\$500
2003	\$500
2004	\$500
2005	\$500
2006	\$500
2007	\$500
2008	\$1,000

Source: Mercer's National Survey of Employer-Sponsored Health Plans.

% of PPO sponsors not requiring a deductible



care options, which Baratz says is different from the way CDHPs work now. Consumerism is more than merely shifting costs; it's a way to educate individuals about costs of care. It pairs fiscal accountability with support services to help people make better health decisions, she says.

"Ultimately, at the end of the day, that's what will drive affordability in healthcare. It's people taking the opportunity to own their health, to stay healthy, to manage a chronic illness effectively," Baratz says.

On the other hand, PPOs with high deductibles don't have HSAs, and they lack the member education component.

"Now, you are in a very different model, and one that is pretty revolutionary, as we have seen it take off in the past eight years, which is the idea of creating financial accountability with the net of support information that people need to get really involved in their health decisions," Baratz says.

Health plans and employers have created Web sites that offer price and quality information, which insurers contend have created better-educated consumers and are even helping members not enrolled in CDHPs. "Once that information is made available, it can be used by other employees [in PPOs or HMOs]," says **Garry Ramsey**, chief marketing officer at Bluegrass Family Health, an integrated health plan based in Lexington, KY. "We are seeing that the employee is much more engaged in the process because he is part of the healthcare equation."

However, **Joseph Paduda**, principal at Health Strategy Associates in Madison, CT, believes high-deductible

accounts, camouflaged as consumerism, are simply catastrophic plans that are forcing the poor out of healthcare. Having a \$1,000 deductible is the same as having a million-dollar deductible for people with limited incomes—they can't afford either one, Paduda says.

"I think there is a significant uptick in the number of folks who can't afford their healthcare, whether they have insurance coverage or not," he says.

Paduda predicts more acute episodes and chronic disease, such as asthma, depression, and chronic obstructive pulmonary disease, because members won't be able to afford care.

High-deductible plans show that health plans are no longer managing care, Paduda says. "What's happening is the commercial health insurers, both for-profit and nonprofit, have given up any pretense that they actually manage care. It's managing reimbursements and managing benefits. They don't manage care," he explains.

In previous economic downturns, health plan members have used more medical services because they were concerned that their employer was going to stop coverage. For example, a weekend warrior who wrenched his back would head to the doctor's office when the pain would likely subside over time. Higher utilization meant more costs. That kind of utilization might not happen this time around because deductibles place a greater cost share on employees.

"Higher employee cost-sharing—like a \$1,000 deductible—could prevent that spike in utilization that we've seen in other recessions," Bos says.

FIGURE
2

Percent of employers that offer consumer-directed health plans (CDHP)

Employer size	CDHPs offered in:				Very likely to offer in 2009
	2005	2006	2007	2008	
Small (10–499 employees)	2%	5%	7%	9%	14%
Large (500 or more employees)	5%	11%	14%	20%	25%
Jumbo (20,000 or more employees)	22%	37%	41%	45%	45%

Source: Mercer's National Survey of Employer-Sponsored Health Plans.

Costs stabilized

For the fourth consecutive year, employers held health benefit cost increases to about 6% in 2008 as employers shifted costs to employees. If employers had not transferred more costs onto their employees, Mercer estimated the costs of the largest medical plan would have risen by about 8%.

Bos says health insurers have contained premium costs because of a combination of cost shifting, health management programs, and quality initiatives. “Most of these programs today are bearing a considerable amount of fruit,” he says.

Membership low, interest high

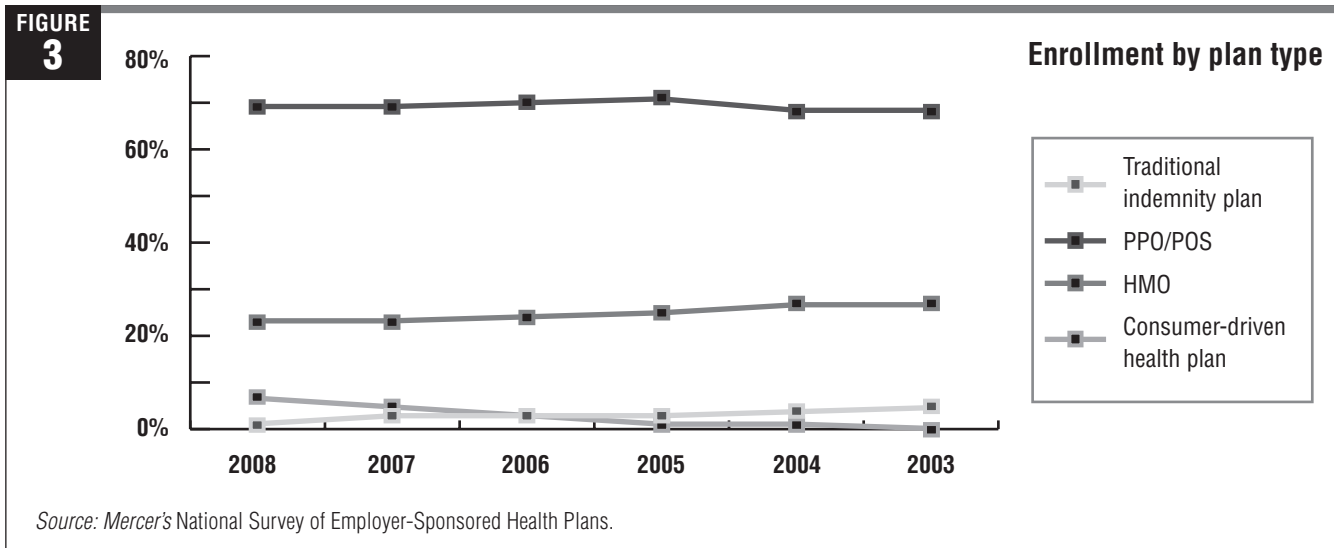
CDHPs have been the flavor of the moment, but membership remains in the single digits, although more employers are creating the plans each year.

In 2008, nearly half of jumbo employers offered CDHPs, whereas one-fifth of large employers had the plans. Small employers have not created CDHPs

as quickly. In 2008, 9% of small employers offered CDHPs, but that number is expected to jump to 14% in 2009. (See Figure 2.)

Ramsey says CDHPs account for 11% of Bluegrass Family Health's business, but that amount grows every month. In fact, the number of members with CDHPs increased by 30% between December 2008 and January 2009. “As the employers raise the costs, meaning the employee contribution to the premium, as well as reducing the benefits, [CDHPs] become a little bit more attractive to the member,” says Ramsey, adding that Bluegrass expects CDHPs will account for 40% of its business within five years.

The number of members who are actually enrolled in CDHPs remains in the single digits. Membership has increased from 1% in 2004 to 7% in 2008, which supporters point to as proof of CDHPs' growing popularity. Not surprisingly, PPO/POS topped plan type enrollment at 69%, with HMO a far-distant second. (See Figure 3.)



Bos suggests that health insurers with a heavy HMO membership be aware of the shift to healthcare consumerism, as that is what employers want. “I would be cognizant that if I am going to continue to be a viable offering, I am going to need to respond to that movement,” he says.

Lower costs in CDHPs

CDHPs are costing employers less money. Costs per plan member in CDHPs increased 4% from 2007 to 2008, whereas HMOs increased by 9.1% and PPOs by 6.3%. PPO plans with deductibles greater than \$1,000 still cost over \$400 more than CDHPs, according to the study. (See Figure 4.)

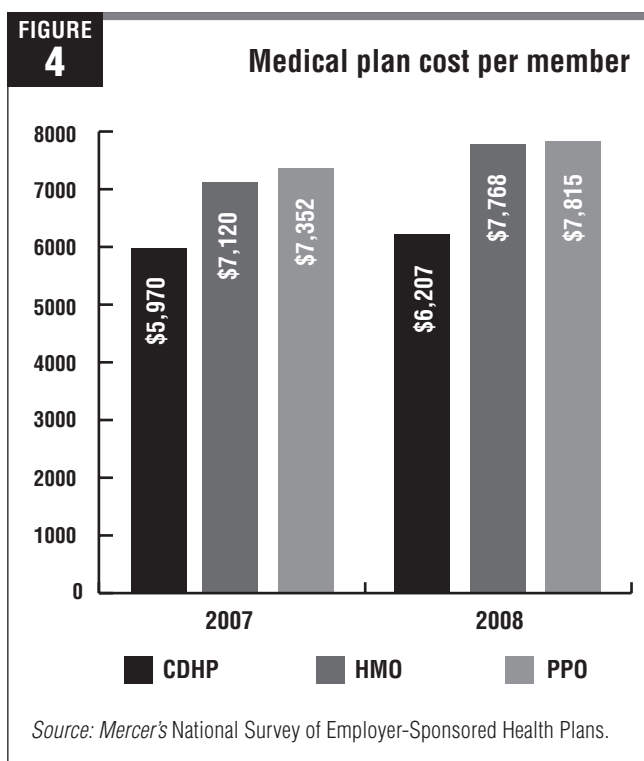
“Difficult economic times may speed both the adoption of CDHPs by employers and higher enrollment rates where employees have a choice of plans,” says Bos. “With so many employers already requiring relatively high deductibles, it’s not a big step for them to put in an HSA with a \$1,150 deductible—the minimum amount for 2009—and use the savings to fund the account, improving overall value to employees.”

Baratz says UnitedHealthcare performed research to compare its traditional PPO plans against CDHPs and found that the consumer-directed plans cost 7%–9% less than traditional PPO plans—mostly because CDHP members were doing the following:

- Using the health system properly, resulting in fewer hospitalizations
- Filling the same number of prescriptions, but opting for more generic rather than name-brand drugs
- Choosing more preventive and evidence-based care

Those in CDHPs were more apt to follow preventive screenings, such as mammograms, cholesterol screenings, and prostate exams, because UnitedHealthcare’s CDHP does not charge members for preventive care.

“What we’re taking from those data points is that people are making informed decisions about their health and their healthcare, but they’re being smart about it.



They are not forgoing care,” says Baratz. “What we’re seeing is people getting the care they need and making decisions about saving money where they can.”

CIGNA says members of its CDHP, CIGNA Choice Fund, do not put off recommended care any more than members of traditional CIGNA plans. **Will Giaconia**, vice president of CIGNA Choice Fund in Bloomfield, CT, says promoting consumerism allows members to compare doctors and hospitals based on quality and costs. “We have fully integrated [the tools] and made them much more powerful and real for the consumer. It’s about engaging the consumer with the information when they need it,” Giaconia says.

Breaking down CDHPs further, HSA-based plans cost \$6,027 per member, compared to \$6,420 for plans with health reimbursement arrangements (HRA). Unlike HSAs, HRAs are only funded by the employer rather

than the employee and/or employer. More than one-quarter of employers do not contribute to HSAs, and the employers that do contribute donate nearly \$700 per CDHP member, according to Mercer.

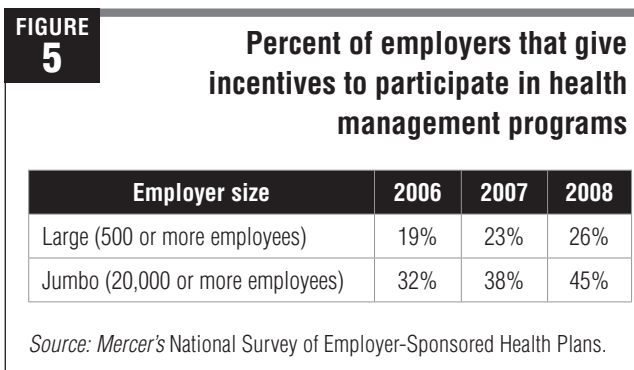
Ramsey says members are better off in CDHPs than PPOs with a high deductible because there are out-of-pocket caps and savings accounts in CDHPs.

Additionally, CDHPs are a more attractive option for employees than traditional PPOs with deductibles, says Bos. “If your employer puts money in the account and you don’t use many services, you can end up ahead. But it all depends on how you use healthcare,” he says.

Incentives on the rise

Mercer also found that many large employers are adding incentives as a way to encourage employees to use health management programs or improve health habits. Twenty-six percent of large employers and nearly half of jumbo employers offer incentives to take part in health management programs. (See Figure 5.)

Jumbo employers are also implementing special plan provisions related to employee smoking status, such as lowering premium contribution for nonsmokers. Although nonsmokers benefit from this approach, most employers are not actively penalizing smokers.



Employers are increasingly turning to incentives, but few have implemented disincentives. Bos says this is because disincentives create a “negative environment.” For disincentives to gain popularity with employers, research is needed to show that they have a positive effect.

“It is really going to be dependent on a lot of solid case studies that that particular methodology saves more money than the carrot methodology,” Bos says. Large employers are also using employee health risk assessments as part of their wellness offerings. Sixty-five percent of large employers offered health risk assessments in 2008, compared to 56% in the previous year.

Retiree insurance drops

Although there has been much consternation about employers dropping health coverage, Mercer found that current employee coverage has remained steady during the past seven years. Sixty-five percent of employers offered health coverage to active employees, which was a slight increase over 2007. (See

Figure 6.) Bos suggests the consistency could be because employers are standing pat and waiting for healthcare reforms.

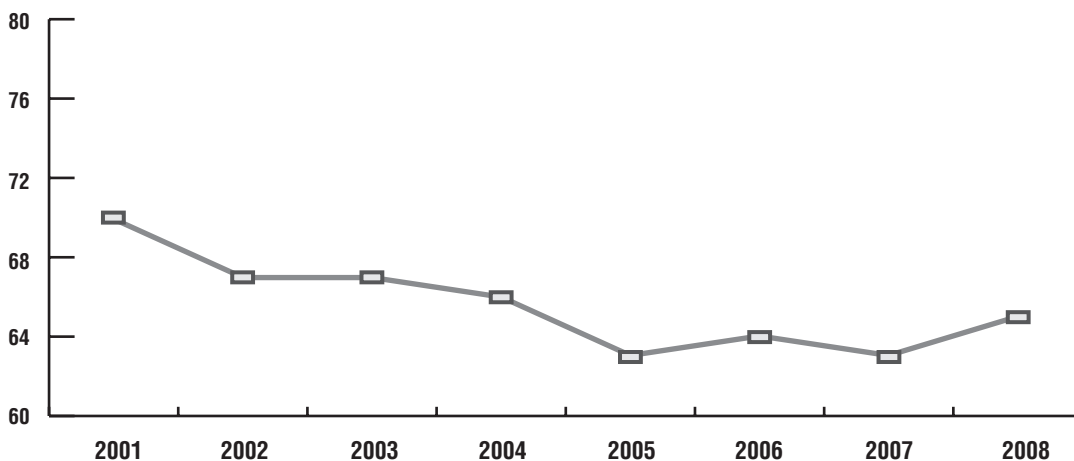
The coverage decrease has come in retiree medical plans. The percentage of large employers that offer coverage to Medicare eligibles and pre-Medicare eligible retirees has dropped sharply in the past 15 years. In fact, the number of large employers that offer coverage to Medicare eligibles has decreased from 40% in 1993 to 19% in 2008.

Bos says that trend is likely to continue and suggests the erosion of retiree coverage could force older employees to delay retirement.

“The slowing economy makes the lack of retiree coverage a bigger issue,” he says. “Companies that hope to reduce their workforce through attrition rather than layoffs may find older workers hanging on longer because they don’t want to lose their health benefits.”

FIGURE 6

Percentage of employers that offer health coverage to employees



Source: Mercer’s National Survey of Employer-Sponsored Health Plans.

MGMA survey: Most providers paid for call coverage

Sixty-two percent of healthcare providers receive some form of additional compensation for on-call coverage, most at a per diem or hourly rate, according to MGMA's inaugural Medical Directorship/On-Call Compensation Survey Report.

MGMA, based in Englewood, CO, reported data on 317 medical practices representing 2,536 providers. This is the first time MGMA has collected survey data for on-call compensation, so trends are hard to identify. But the fact that so many physicians are compensated for on-call services came as a surprise, says **Kristina Ziehler**, MGMA survey analyst.

Ownership affects pay

Whether a physician is paid for call coverage depends on the type of practice. Seventy percent of providers in hospital-owned group practices received additional compensation, compared to 58% of providers in practices not owned by hospitals.

This makes sense, says **Christopher Kashnig**, manager of physician services at Madison, WI-based Dean Health System. Kashnig, who previously worked at the Christie Clinic in Champaign, IL, hasn't come across much demand for call compensation among physician-owned practices.

"It's a cultural thing," Kashnig explains. "Independent groups are, by definition, independent. They, of course,

agree that money is always a good thing. However, they run the risk of losing some of that independence when they are taking call money from a hospital." The exception, he says, is when the call coverage begins to interfere with the practice; that's when those groups begin to seek additional compensation.

Interestingly, although ownership may have been a factor in whether on-call compensation was offered, it didn't seem to have an effect on how much was paid.

Parsing the types of coverage

Note that the data provided refer to all types of call coverage combined, with most of the responses related to unrestricted call. One finding is that unrestricted call seems to be compensated more highly than restricted (i.e., when the physician remains on the premises). For instance, orthopedic specialists averaged \$350 per day for restricted call versus \$800 for unrestricted.

The survey also found, less surprisingly, that trauma call is generally associated with higher compensation than general ED call. For example, median compensation in general surgery for unrestricted and general ED call is \$500. For trauma call, it's \$2,000 (no data were available for general surgery restricted call).

Factors that affect compensation levels

As with overall compensation, the amount a physician is paid for on-call duties is affected by several

factors. In particular, geography, specialty, and group type correlate with payment. Here's a closer look at these factors:

- **Geography.** Physicians in nonsurgical specialties in the western region of the country reported more than double the daily median compensation for on-call coverage (\$1,080) compared to those in the southern region (\$500). General surgeons in the eastern and western regions received half (\$500) the daily rate of those in the Midwest (\$1,000). Orthopedic specialists had a median daily rate of \$825 in the western region, 55% of that in the eastern region (\$1,500).
- **Specialty.** Family practice physicians reported the lowest median daily rate (\$300), whereas neurosurgeons reported the highest (\$2,000). Among those falling in between were pediatricians (\$895) and urologists (\$500). This finding was not unexpected, says **Crystal Taylor**, assistant director of surveys at MGMA. Specialties in the highest demand—and those with the most acute shortages—are likely to have the highest on-call compensation.
- **Group type.** Overall, physicians in multispecialty groups reported higher compensation for on-call coverage than did their peers in single-specialty groups. A dramatic example of this is OB/GYN: Per diem compensation in a single-specialty practice is \$750; in a multispecialty practice, it's \$2,337. Another significant disparity is in invasive/interventional cardiology, with \$465 for single-specialty and \$2,298 for multispecialty. One possible reason, says

Ziehler, is that multispecialty groups have more bargaining power thanks to their numbers and the specialty mix. They are also likely to have deeper pockets. (There was an exception: Neurosurgeons in a single-specialty group averaged \$2,850; those in a multispecialty group averaged \$1,450.)

Pressure to pay

Anecdotally, it appears that more hospitals are compensating physicians for call and are paying more. But given that it's MGMA's first such survey, there aren't enough data to confirm that yet. (That is the trend that was reported in *2008 Physician On-Call Pay Survey Report* from Detroit-based Sullivan, Cotter and Associates, Inc. In that survey, approximately 64% of participants reported that their physician on-call pay costs had increased within the past 12 months: 25% reported a 1%–10% increase, 24% reported an 11%–50% increase, and 15% reported an increase of more than 50%.)

That most hospitals are paying for call coverage corresponds to what **Steven A. Nahm**, vice president of The Camden Group in El Segundo, CA, hears from colleagues. Hospitals that are not paying are still experiencing pressure to pay, Nahm reports.

Then there's the domino effect to consider. "Once a hospital begins to compensate a specialty for on-call coverage, other specialties are soon to follow," says **Peg L. Stone**, a compensation consultant at Atlanta-based PLS Professional Associates, LLC. With each successive survey, there are more participants and higher amounts being paid.

Although there's been some discussion of instituting deferred compensation plans, neither Nahm nor **Debbie Huber, MBA**, vice president of sales and client services at EA Health Corp. in Solana Beach, CA, has encountered it. "We find physicians are already burdened related to the provision of on-call services and, subsequently, prefer timely compensation for services rendered," says Huber.

Hospitals push back

Hospitals may be paying more, but there's increasing pushback. A few are employing physicians directly instead of paying for call. Some that currently pay for call are beginning to take a firm line and refusing to increase compensation—even though some physicians continue to request increases, says Nahm.

"Hospitals are, in fact, reducing both their budgets for physician compensation programs as well as actual physician compensation for on-call services," Huber says. So far, physicians have accepted the changes and continued to provide on-call services. The situation is tenuous, though. "We do believe a risk is present for physicians to not accept reduced compensation and to vacate on-call obligations for voluntary call panels," says Huber.

Accounting for differences

Stone notes that there's considerable variation in the results of several call coverage surveys. Small sample size is one reason; another is the pronounced variation among markets, even among hospitals. "Each situation is somewhat unique," she says.

Stone is seeing several trends emerge, from more per diem arrangements to allowing physicians to bill patients for their services in addition to receiving payment from the hospital.

Looking ahead

Next year's MGMA survey should also provide insights on trends. The survey team has already identified areas to explore. For example, says Ziehler, in follow-up conversations, the survey team learned there's no standard per diem rate for holiday and weekend pay. Look for questions on that topic next time.

The next survey should also demonstrate numerically, rather than just anecdotally, whether more physicians are being compensated for on-call coverage—and whether there's a disparity among specialties that could shift on-call compensation rates, Ziehler says.

Poor risk contract results not common: Survey finds commonalities of successful programs

Skeptical physician groups often say poor risk contract financial performance is the reason they stay away from capitation. As a result, capitation is usually associated with physicians not getting paid enough, although the payment method remains popular in California and other pockets of the country. However, a recent study found that poor results are not as common as has generally been believed.

The 2008 Capitation and Risk Contracting Survey, released by the American Medical Group Association (AMGA) and ECG Management Consultants, found the following:

- Whether risk contracts are financially attractive depends heavily on the dominance of payers or providers in the market
- The ability to participate in risk contracting largely depends upon whether a health plan offers the option in a group market's area
- Effective risk contract management requires significant investment in contract administration and oversight
- Unfavorable contract terms are the single greatest barrier to risk contracting participation

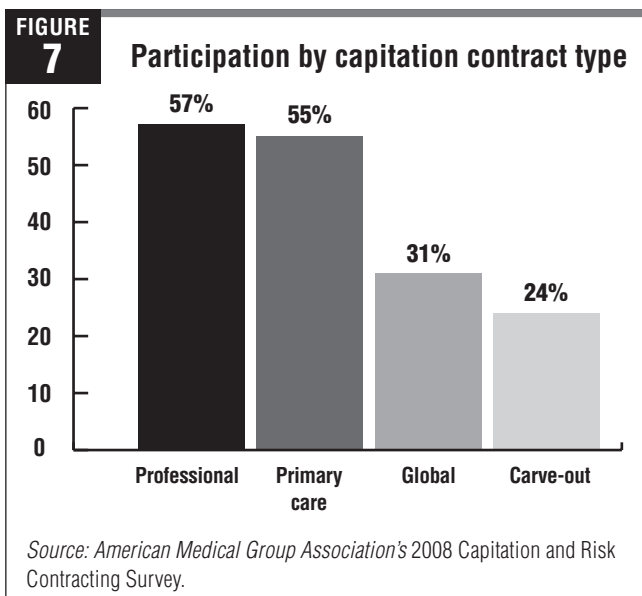
ECG Management Consultants believes the findings are timely because of the anticipated changes in the U.S. healthcare system.

“Regardless of the changes to the healthcare system, organizations who are able to better manage risk and demonstrate true value to purchasers of healthcare services will likely have strategic advantages over other organizations,” says **Josh Halverson**, senior manager at ECG Management Consultants in St. Louis.

The 2008 capitation survey was based on 2007 data and focused on medical group leaders. Seventy-five AMGA member organizations responded to the survey, which was broken down into five topics: prevalence and scope, risk contract management, health plan characteristics and performance, physician acceptance, and barriers and limitations.

Of the 75 organizations that responded to the survey, 64% have participated in risk-bearing contracts in the past three to five years. Not surprisingly, western states had the largest percentage of risk-contracting participation by region (84%), and 67% of respondents have been involved in risk contracts for at least 11 years.

Thirty-six percent of participants reported that the revenue derived from risk contracts is greater than half of their organizations' total revenue, including 62% of respondents in western states. On the other end, 67% of respondents in the Northeast with risk-bearing contracts said risk contracts contribute to less than 10% of their total revenue.



Thirty-three percent of those with risk contracting own a health plan and are most likely to offer commercial HMO-POS and Medicare Advantage plans.

More than half of respondents described their organizations' financial performance in risk contracts as above average or excellent in the past two years. Less than 10% cited poor financial performance.

The survey found that professional and primary care capitation are the most attractive to providers, whereas global risk is the least attractive. (See Figure 7.)

Primary care and professional capitation are the most frequent contract types; global and carve-out contracts lag behind. (See Figure 8.)

“Under professional and primary care capitation, physicians are generally at risk for services they provide. Because they have the greatest degree of control, physicians are most willing to assume professional and primary capitation,” says Halverson. “Global risk includes any inpatient episodes, which expose the group to greater levels of risk to issues beyond their control. However, groups with access to hospitalist and/or intensivist programs often are able to better manage global risk.”

On the topic of how to influence physicians' behavior, the highest percentage of respondents said they have referrals and prior authorizations to control utilization, with physician bonus payments as the second most popular. Pay for performance and group bonus

FIGURE 8
Interest in risk contracting by contract type

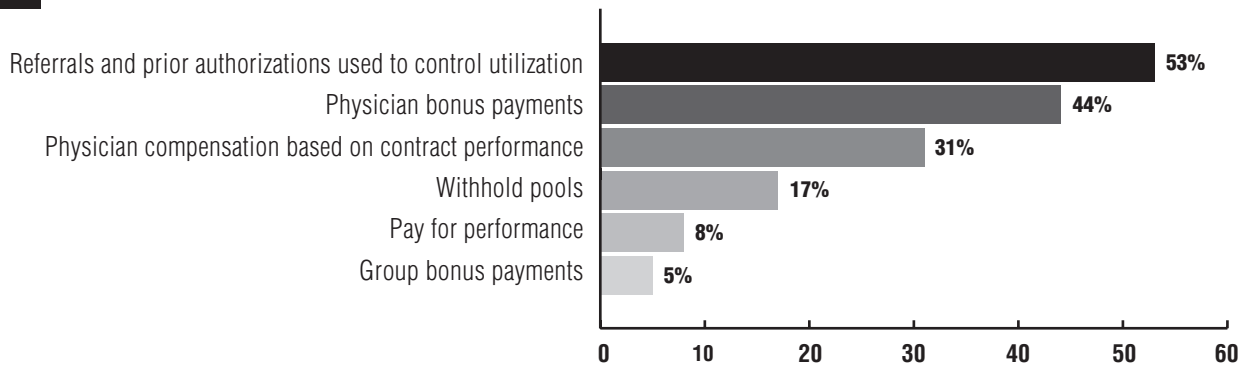
The survey asked respondents to rank each type of risk contract based on order of interest to their organizations using a scale of 1–7, with 1 representing the least interest and 7 representing the most interest.

	Average score	7	6	5	4	3	2	1
Professional capitation	4.8	34.3%	17.1%	8.6%	5.7%	8.6%	17.1%	8.6%
Primary care capitation	4.6	14.7%	32.4%	5.9%	17.6%	11.8%	5.9%	11.8%
Pharmacy risk	4.1	9.1%	6.1%	24.2%	21.2%	27.3%	9.1%	3%
Mental health risk	3.5	9.7%	3.2%	19.4%	9.7%	16.1%	32.3%	9.7%
Vision risk	3.3	6.5%	12.9%	6.5%	25.8%	3.2%	16.1%	29%
Full or global risk	3.3	17.1%	11.4%	2.9%	8.6%	8.6%	11.4%	40%

Source: American Medical Group Association's 2008 Capitation and Risk Contracting Survey.

FIGURE 9

Physician incentives



Source: American Medical Group Association's 2008 Capitation and Risk Contracting Survey.

payments were each used by less than 10% of respondents. (See Figure 9.)

“Managing capitation really requires a culture and a system of incentives that reward physicians for managing health. Many group practices have mixed incentives between traditional fee-for-service and capitation arrangements. To successfully manage risk, there must be an underlying culture and commitment to capitation,” says Halverson.

Half of risk-contracting respondents said they purchase stop-loss insurance to protect individual doctors

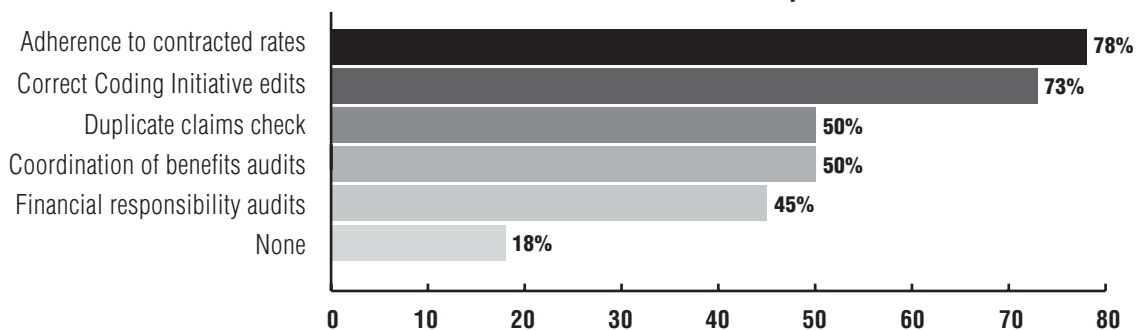
from adverse contract performance, with the most common form of insurance an individual policy purchased from a separate reinsurance carrier.

Most groups perform multiple types of audits and analyses to ensure contract performance and health plan compliance, with adherence to contracted rates and coding audits the most frequently used methods.

Although more than 50% of risk-contracting respondents reconcile patient eligibility with premiums to ensure proper reimbursement, many organizations do not perform any type of premium audit. (See Figure 10.)

FIGURE 10

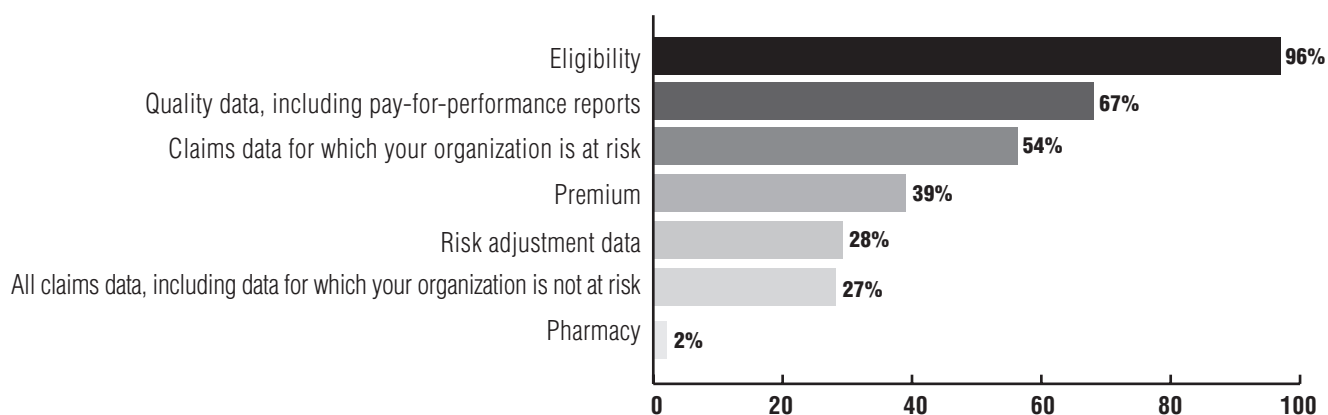
Contract performance audits and analyses



Source: American Medical Group Association's 2008 Capitation and Risk Contracting Survey.

FIGURE
11

Types of data shared by health plans



Source: American Medical Group Association's 2008 Capitation and Risk Contracting Survey.

Relationships with health plans

Respondents were asked to describe their experiences in risk contracting with four major health plans: Blue Cross Blue Shield, Aetna, CIGNA, and United/PacifiCare. Researchers found that although health plans are providing eligibility data, they are not likely to supply claims data or premium data for which a group is at risk. (See Figure 11.) “This is cause for concern, because without this information, groups are unable to perform the necessary audits to ensure adherence to contracted

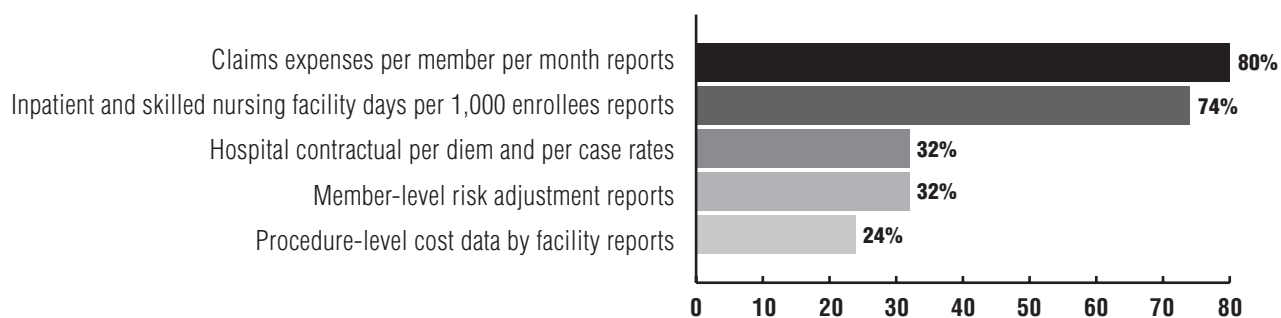
rates for services rendered and proper premium payments for the covered population,” the survey stated.

Regarding primary reports, health plans most commonly provide information that share contract performance information. (See Figure 12.)

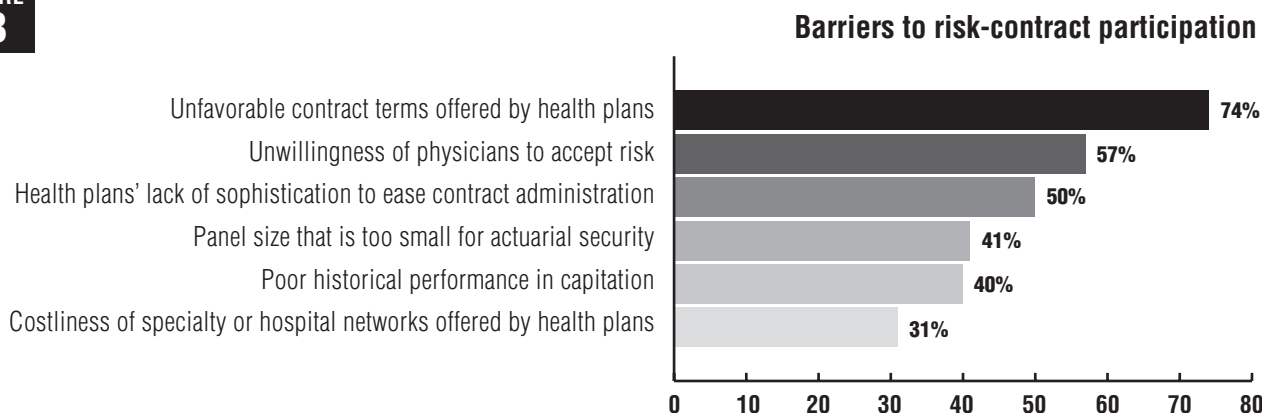
Most survey participants said the quality of data from health plans is within acceptable limits, but almost 30% suggested below average or poor data quality caused

FIGURE
12

Contract performance data shared by health plans



Source: American Medical Group Association's 2008 Capitation and Risk Contracting Survey.

FIGURE
13

Source: American Medical Group Association's 2008 Capitation and Risk Contracting Survey.

reporting delays and significant rework. Seventy-two percent of respondents described the timeliness of the data received from a health plan as average.

A health plan's utilization management staff can help group practices in the areas of patient management and cost-control efforts, but most respondents said the staff was not helpful. That reaction is coupled with more than half of respondents saying their financial performance was good or excellent with a specific health plan, and it was appreciated when health plans provided more data and utilization support.

"Physician organizations indicated through interviews that valid and consistent data regarding utilization was more important than utilization management staff. Sharing of good utilization and medical expense information between health plans and physician organizations appeared to be uneven and represents a significant opportunity for improvement," says Halverson.

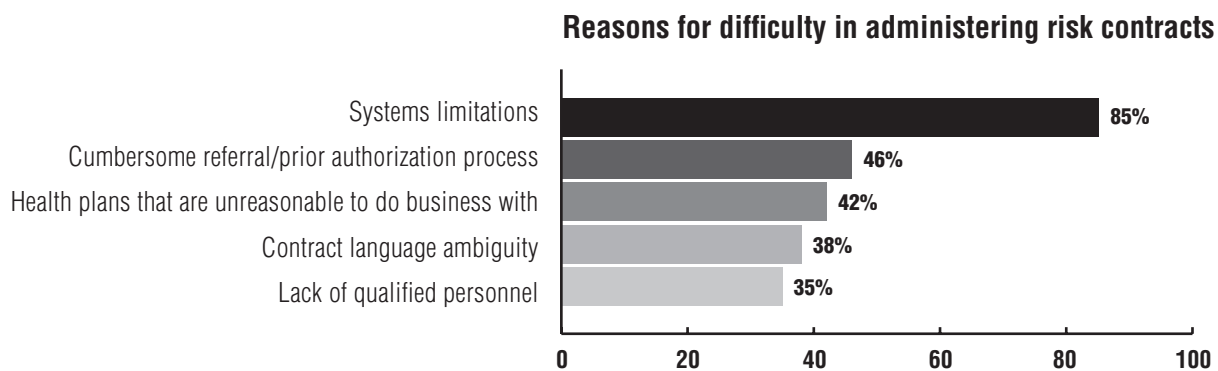
Nearly 50% of survey participants said physicians' interest in capitation within their organizations was mixed, although more than 30% suggested physicians

were enthusiastic about increasing patient volumes under risk-bearing contracts.

More than half of respondents said their organization's financial performance in risk contracts during the past two years was above average or excellent, with fewer than 10% claiming poor financial performance.

On the topic of barriers and limitations, respondents said unfavorable contract terms are the largest barrier to participating in risk contracts, with more than half of the participants pointing to physicians not willing to accept risk. (See Figure 13.)

Halverson says one way to avoid unfavorable contract terms is that "reimbursement must be commensurate with the level of risk assumed by groups. The most successful groups have the ability to prospectively conduct analysis to determine the level of risk and the expected reimbursement associated with contracts. Organizations must have the tools necessary to determine their risk and define an acceptable risk premium. Objective, data-driven analyses are the best tools to inform contract negotiations."

FIGURE
14

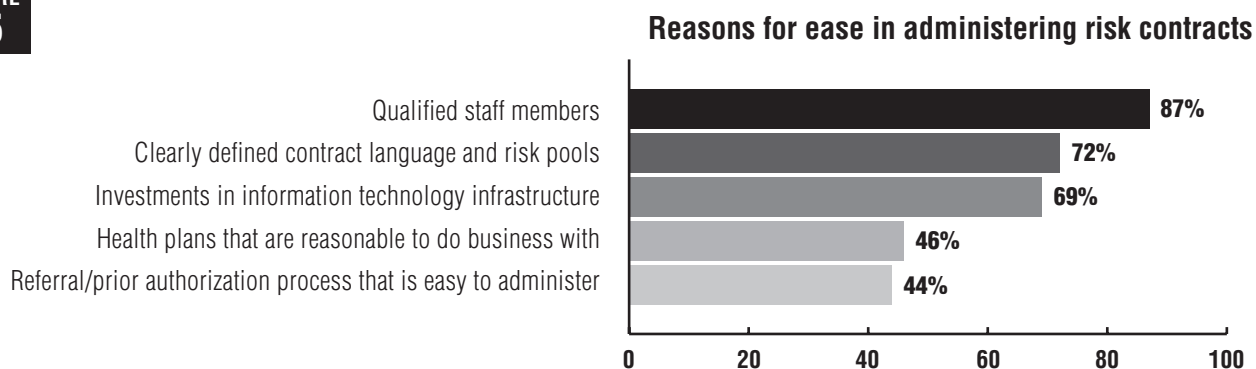
Source: American Medical Group Association's 2008 Capitation and Risk Contracting Survey.

Thirty-six percent of survey respondents said their organizations have difficulty administering risk agreements and pointed to system limitation as the biggest barrier. (See Figure 14.) Those who have not had difficulty administering the contracts say qualified staff members and clearly defined contract language and risk pools helped contract administration. (See Figure 15.)

One reason why some groups experience poor risk-contract financial performance is they are unprepared to effectively manage the risk, Halverson says. Those

groups often don't have the necessary infrastructure, organizational expertise, and culture to do so. "In order to successfully manage risk, organizations must have systems and support to monitor utilization of services and medical expenses. System limitations were frequently cited as barriers. In addition, access to hospitalist and intensivist programs are necessary to effectively manage the expenses of inpatient care; these are often unavailable to groups," says Halverson.

Brian Weible, FSA, MAAA, consulting actuary at Wakely Consulting Group, Inc., in Clearwater, FL,

FIGURE
15

Source: American Medical Group Association's 2008 Capitation and Risk Contracting Survey.

says many payers have discontinued risk contracting because the payer needs the fee-for-service claims data to receive accurate revenue when that revenue is contingent on diagnosis or other patient claim-specific information. These data are difficult to collect under capitation/risk arrangements.

“The exodus from acceptance of risk is really on both ends—many physicians went back to fee-for-service work, but others exited on the other side of

the stage, meaning some of them actually became licensed risk-taking entities,” he says. “Especially with the Medicare product, where CMS may reimburse at \$1,000 per member per month or more, raising \$5 million to start an HMO may be quite feasible for mid-to-large physician groups who were successful under risk arrangements but wanted more control of product design and/or ownership of their patients.”

Renewals: To negotiate better terms, know where you stand

Carefully considered negotiation can lead to more favorable contracts, yielding higher rates and fewer headaches. But before your organization can negotiate from a position of power, it needs to know where it stands.

Several consultants shared their insights about what healthcare organizations can do to best position themselves for contract renegotiations. Although some of the tactics and strategies may sound obvious, many organizations fail to lay the proper groundwork for negotiations.

Find your contracts

For some healthcare organizations, this is basic. But most of the experts consulted pointed out that in many organizations, the administrator can't put his or her hands on the paperwork.

It becomes “an Easter egg hunt,” says **Jeffrey B. Milburn**, Colorado Springs–based independent consultant with MGMA Health Care Consulting Group.

It may not be an issue for hospitals, but it is one for many private practices. In fact, **Reed Tinsley, CPA, CVA, CFP**, principal at Reed Tinsley & Associates in Houston, estimates that 70% of medical practices have this problem. Everything should be in one place (Tinsley suggests a binder) and readily accessible.

Once you know where the contracts are, inventory them and make sure the important dates and deadlines are in your calendar. Be sure to record the:

- Renewal or anniversary date.
- Deadline for notifying the payer of your intent to renegotiate.
- Negotiation period. (Some contracts include a stipulation that the practice can only renegotiate on the anniversary, says **Penny Noyes**, president of Health Business Navigators in Bowling Green, KY.)

The burden to act

Don't wait until the renewal date to look at contracts. By then, it may be too late. It's especially easy to let them renew by default: Today, most managed care contracts include evergreen clauses that allow the contract to renew automatically if neither party takes action by a certain date, says Noyes.

Automatic renewal is not necessarily a bad thing; for example, it helps ensure continuity of care. But you have to manage it, says **Robin J. Fisk, Esq.**, of Fisk Law Office in Ashland, NH.

Tinsley notes that evergreen clauses put the burden on the provider. If you want changes, you have to take action within the time frame allotted by the payer.

Intent to renegotiate: Follow instructions

Courts have ruled that the party wishing to terminate an evergreen contract must give “clear and unequivocal” evidence of its intent, and that applies to renegotiation, says Fisk. Notice must be delivered in the manner outlined in the contract.

Fisk addresses this in her blog, *Managed Care Contracting & Provider Payment* (*managedcarecontracting.typepad.com*): “Therefore, when negotiating renewal terms for a contract containing such a clause, all parties must keep the deadline for notice of nonrenewal foremost in mind, as well as the contractual requirements for method and address for delivering the notice of nonrenewal.”

Assuming there’s a 90-day notice to renegotiate, begin the process at least 150 days out, says Noyes. (Fisk suggests 180.) That’s when you want to meet with decision-makers in your organization and develop a negotiating strategy. For a January 1 renewal, you should be starting now.

Below, Noyes shares some other important timetable highlights:

- Approximately 105 days before the contract renewal date, and at least 15 days before you are required to provide notice, send a letter stating your intent to renegotiate. Deliver the letter in whatever manner is mandated in the contract. If no method of delivery is specified, Noyes recommends certified mail. (See “The letter of intent” later in this chapter for components of this letter.)
- On the notification date, contact the payer to confirm receipt of the letter.

- Approximately 60 days from the contract renewal date, you should receive the new contract. (Negotiations generally occur 30–75 days out.)
- Sign the new contract at least 30 days prior to the renewal date.

Prepare your checklists

Next, create a checklist of items to review or discuss. Just how thorough it is is up to you. For example, **Maria K. Todd, MHA, PhD**, CEO and managing partner of Global Health Sources, LLP, in Pompano Beach, FL, has a 26-page model checklist.

Some items are simple. For example, you want to have a current contact person and information for each plan, the rates, and the total charges. Ideally, you want a payer report card that covers fee schedules, contract renewals, late payments, chargebacks and offsets, dispute resolution, coordination of benefits, and pay for performance, according to several of our experts. Essentially, you want to know how much work was expended to achieve the payment as well as the return for your money, says Todd.

But even without a formal report card, you can come up with a checklist of items to explore prior to negotiations.

Identify problems, ask questions

As you prepare for renegotiation, look at issues with specific payers. What’s happening that’s causing problems or costing money? Are there high-deductible health plan collection, coding, or preauthorization issues?

“When you are going in for negotiations and renewals, you have to do your homework,” says Milburn. “You

should know ahead of time what the account receivables are in relation to other payers, what the denial rate is, what the hassle factor is, what the trends are.”

You can then say to the payer representative, “We are having a lot more trouble collecting your receivables, your reimbursement payments, than anyone else’s. We need a rate increase for that.”

Survey your departments, says Fisk. Are claims being paid? Are payers denying certain line items? Are they giving your organization a hard time about preauthorizations for certain services?

Generate a list of top 10 denials, she says. Are certain codes more likely to be denied than others?

The point is to determine what’s causing problems in your organization with a particular payer and then seek concessions. Fisk suggests coming up with some potential solutions you can propose during the negotiation process. “You are showing you are trying to work with them to resolve the problem,” she says. “After all, it is a relationship.”

Fisk cites the following example: One payer always issued discharge notices immediately before the discharge time, making discharge planning “a fire drill” for the hospital. During negotiations, the hospital proposed a solution that included a reasonable timeline with specific deadlines, and the payer accepted.

But you shouldn’t simply look for problems. Here are some other issues to consider:

- Do any of your contracts involve self-insured plans? Noyes warns that “60%–80% of the

patients accessing nearly any non-government plan agreement you sign will be in plans of self-insured employers or health and welfare funds.” That means they are governed by ERISA, not state insurance regulations. Identify those plans so you can ask to have provisions added that, at a minimum, provide the protections afforded by your state’s insurance department.

- What products does the payer offer? Look at the various insurance products offered and decide which ones you want to participate in, says Todd.
- Can the payer make unilateral, midyear changes to the contract or manual?
- What’s the payer’s financial status? Todd and Milburn advise gathering data on the financial state of each payer with whom you are dealing, including market share in your community. Such information is available from the state insurance department, stock reports, and insurance brokers, says Milburn.
- What does your organization need? Consider specific provisions you want to include in a contract to help you reach your goals and identify payers that stand between your organization and those goals, Milburn says.
- What does the payer need? Milburn also advises clients to consider what the plan wants out of the negotiations. What is its market strength, contracting style, and negotiating style?

It’s all about being strategic. Healthcare organizations generally have marketing strategies, but they

rarely have contracting strategies, says Milburn, but they should.

Use your leverage

Hospitals have greater leverage and are able to negotiate more effectively from a position of strength. However, practices are less willing to do so, says Tinsley.

This is particularly common among small practices, he says. They assume they cannot win and won't try to negotiate the one thing that has the greatest effect on their livelihood—managed care contracts.

Even small practices may be able to win concessions depending on factors such as location and quality.

There's almost always some leverage. You can always use the threat of termination, but you need to have your board or practice leaders behind you before you move forward with such a threat, Fisk says.

It doesn't have to be an ultimatum. Too few organizations realize they have the power to negotiate, say Todd and Tinsley. Focus on your strength, whether it's patient numbers, geography, specialty, or quality.

Invest the time to find this information and bring it to the table, says Tinsley. "If I'm more cost-effective than my peers, I'm making more money for payers," he says. Payers may be willing to adjust rates accordingly. "But you have to go get it."

The letter of intent

In evergreen contracts, payers often include specific contractual requirements for termination or renegotiation, says **Robin J. Fisk, Esq.**, of Fisk Law Office in Ashland, NH. Read those provisions carefully and craft your letter accordingly.

Penny Noyes, president of Health Business Navigators in Bowling Green, KY, offers guidelines for what that letter should include:

- The official notice address in your agreement.
- Tax identification number, practice name(s), and address(es).
- The stated intent to renegotiate the terms of the managed care agreement.
- The anniversary date.
- A request for a new contract (not an addendum).
- Contact information.
- A clause stating intent to terminate if satisfactory terms are not reached 30 days prior to the anniversary date. (This gets the clock ticking. If you are gun-shy, suggest the possibility of terminating, but know the suggestion does not put the pressure on to respond as quickly.)
- A deadline for a response (typically, two to four weeks).

Do your homework before going out of network

Two databases of usual, customary, and reasonable (UCR) rates owned by Ingenix, a wholly owned subsidiary of Minnetonka, MN-based UnitedHealth Group, will soon cease to exist following two settlements in January 2009 between the insurer and New York State Attorney General Andrew Cuomo. The databases have been used for years to determine payment for most out-of-network and other UCR services. But Cuomo's investigation found that the databases understated the market rates of medical care by up to 28%, leading to systematic underpayments for out-of-network care.

“Usual and customary” is defined as the charge for healthcare services that are consistent with the average rate or charge for identical or similar services in a certain geographic area, says **Susan Stone, MBA**, president of Managed Care Analysis, a healthcare consulting firm in Redwood Shores, CA. However, insurers determine their UCRs based on numerous variables.

“Historically, usual and customary fees and other methodologies that health insurers use have been confusing to physicians and patients, and they still are,” Stone says. “Usual and customary payments are almost always reduced. PPOs sometimes pay nonparticipating providers based on participating provider fee schedules and, other times, seemingly random amounts.”

Typically, insurance policies pay 70% or 80% of the UCR after the member's copay, “so the amount that gets paid under these claims can be very low, depending on the physician's billed charges,” Stone says.

However, it's unclear whether or how much doctors will recoup in back payments under this deal. Although UnitedHealth agreed to pay \$350 million to doctors around the country who were underpaid, due to use of the Ingenix database, the exact mechanisms of those repayments have not been fully explained.

In the meantime, the Chicago-based AMA and state medical societies have filed lawsuits against Aetna and Cigna—two plans that used the Ingenix databases—seeking similar repayment based on violations of federal racketeering and antitrust laws that resulted in intentional underpayments to out-of-network physicians.

Although the plans—along with WellPoint and some smaller health plans—have agreed to spend millions to fund a new database, both have indicated they will vigorously fight attempts to impose repayment for past out-of-network underpayments.

Seeking to recoup back payments may not be worth the effort that's required, says **Jeffrey B. Milburn, MBA, CMPE**, a consultant with the Medical Group Management Association Healthcare Consulting

Group in Colorado Springs, CO. Many payer contracts have clauses that prevent providers from jumping on to class action suits, Milburn says.

Additionally, UCR language affects two groups of physicians, he says. On one hand, providers that sign managed care contracts with payers may negotiate UCR payments for certain procedures that are carved out of their contracts or for new procedures that aren't covered under their contract language.

On the other hand, physicians who don't contract with a payer but treat patients at a contracted hospital seek UCR rates as out-of-network providers. Both groups may have been affected by underpayments using the Ingenix databases, but documenting the losses may be more costly than whatever dollars are available from the settlement, Milburn says.

Look to private database as UCR alternative

The creation of an allegedly independent database of UCRs raises another question: Can providers have confidence in this system? Noyes isn't so sure. If payers continue to feed their UCR data, Noyes says she wonders what will prevent the same past abuses from occurring in the future.

"In my view, [the new database] is not even necessary, because you can buy UCR data at a very reasonable price from EMC2 Captiva," Noyes says. The Hopkinton, MA, firm has actually lowered prices on its UCR databases, medical insurance coding, and fee information, she says.

Some of the funding provided by UnitedHealth and the other plans will be used to create a healthcare

consumer Web site featuring market prices that can be accessed by physicians and patients. Although such a move could improve cost transparency, Noyes says she wonders whether the information will be used appropriately. The typical consumer may not understand how to use UCR information, which is complicated by the use of modifiers, multiple procedures, and other claims editing rules.

Know where payers gather their claims data

Nevertheless, the overall effect of the UnitedHealth settlement on contracting could be enormous, "because it's much harder to predict what will happen if you walk from a contract if there's not a good data set out there," Noyes says. "Assuming this new data set becomes available, however, more providers might actually become aware that they can go out of network and recoup 80% of their charges instead of 80% of a negotiated fee."

The new database will affect all contracts "because it will become the standard if providers can get their hands on it," Milburn adds. "Just like many contracts are written as a percent of Medicare, if a payer comes in and says, 'We want to pay you usual and customary,' there's going to be a standard for that pricing on a regional basis."

How that standard is established is the \$64,000 question. "Will it be the charge level or the usual and customary payment in that community?" Milburn says. "Somebody has to define reasonable charges and payments." If the data come from tracking contractually allowable amounts that should be collected by physicians either from the payer or the patient, for example, the numbers could be reasonable, he says.

Before going out of network, Stone advises providers to learn where payers gather their claims data. “How relevant is the data to a specific physician in a specific specialty?” she says. “What is the time period? And is the data relevant to their region? Payments can be drastically different for the same specialty from one region to another.”

“If everyone is willing to accept Medicare, that will become the benchmark,” Stone adds. “But if they don’t accept that standard, they need to compare UCRs to their billed charges or to average payments they receive from other insurance companies.”

Do the math before taking capitation risk for vaccines

Pediatricians have long wrestled with the challenge of deciding whether to accept risk for vaccines in their capitation contracts and, if so, how to structure the cost in their PMPM rates. With increased utilization and newer vaccines for the pediatric population, more PCPs now face this decision, and the choices aren't pretty.

Organizations should establish risk contracts to target services they can control, but neither providers nor carriers have control over immunization schedules, which are set by the American Academy of Pediatrics (AAP) in Elk Grove Village, IL, says **Courtney R. White, FSA, MAAA**, consulting actuary in the Atlanta office of Milliman, an actuarial and consulting firm.

"For the most part, if the American Academy of Pediatrics recommends these vaccinations, parents are going to follow that advice," White says.

Consequently, "we see fewer PCPs taking risk, in general, and in the majority of contracts, vaccines and immunizations are carved out," he adds. "And that would be my general recommendation."

Compared to about five years ago, the number of immunization doses required for children has increased by nearly 50%, White says.

For example, now a second dose of the varicella vaccine is recommended before a child enters school, following an initial dose when the child is aged 12–15 months.

Practices are facing an increase in the types of vaccinations recommended for children. In the past few years, these have included the rotavirus and human papillomavirus. Thus, a \$2 PMPM rate for children's vaccinations that might have been sufficient five years ago could bankrupt a pediatrics or primary care practice today, White says. "Milliman looked at the vaccination trend from 2006–2007 and saw 75% increases in utilization, on average, due to all of these changes," he explains.

Under these conditions, pediatrics practices that accept risk for vaccinations could take a financial loss on every patient. In fact, the risk associated with vaccinations has become so great that White says he likens it to prescription drugs or maternal care—services that typically are carved out of capitation contracts and paid on a case rate or FFS basis.

Under the circumstances, "any physician organization or IPA would be crazy to take full financial risk for vaccines unless there's a built-in cost escalator," says **Michael J. Kinstler, MD**, president and chief medical officer of Quality Care Providers, Inc. (QCPI), a primary care IPA based in Atlanta.

Strike pediatric vaccines from global contracts

QCPI has seen the full range of financial exposure associated with vaccine risk. A decade ago, taking risk for vaccines was a no-brainer, since there were few childhood immunizations and the costs for most were only \$10–\$12, says Kinstler, a practicing internist. Today’s vaccines include new indications and increasingly expensive drugs.

“When you see multiple doses of \$150 vaccines, there’s no good way to predict your costs,” Kinstler says.

QCPI has a pediatric infectious disease specialist who provides input to Georgia on the pediatric immunization requirements for students to enter public schools. “Even with his help, there was no way we could control this risk,” Kinstler says. “When a new indication is introduced for every 13-year-old in your plan and they need three doses, you’ve just spent hundreds of thousands of dollars that you didn’t budget.”

Part of the problem is that many manufacturers are sole sources for particular vaccines, enabling them to hike prices without competitive constraints—sometimes as much as 15%–20% twice per year, Kinstler says.

Despite evidence of frequent price changes, QCPI wasn’t able to convince payers to build in risk corridors for PMPM rates associated with pediatric immunizations.

Thus, the organization has struck vaccines as a line item from all of its capitation contracts, although it retains risk for some other injectables. QCPI accepts

global risk for primary care services, including inpatient and outpatient, office-based, and limited laboratory services.

Kinstler advises capitated provider organizations that still hold risk for vaccines to renegotiate their contracts, insisting that payers take back the risk by invoking a clause that every capitation contract should include to abrogate the contract terms if costs exceed a certain risk threshold. If capitation contracts have renewed annually with little adjustment in the terms, providers should arm themselves with historical cost and actuarial data and expect a fight, Kinstler says, adding that “if you’re at risk for vaccines, you have to monitor them on a rolling monthly basis. Office visits swing seasonally, and vaccine utilization shifts seasonally as well. But the unit costs also keep changing—usually not in your favor.”

Consider risk for administration costs

Although capitated groups should carve out the drug costs associated with children’s vaccines, they might still opt to accept risk for the AMA’s current procedural terminology (CPT) codes associated with administration costs.

“We’ve seen groups go both ways on the administration,” which is a more predictable number, White says. “It’s not that children are coming in for more visits,” he adds. “It’s just that they’re getting more done at those visits.”

A 2006 statement issued by the AAP’s private payer advocacy advisory committee emphasized the need for physicians to be reimbursed for the full direct and indirect costs of pediatric immunizations, including

the purchase price of the vaccine, personnel costs for ordering and inventory, storage costs, insurance against loss of the vaccine, wastage and nonpayment, and lost opportunity costs associated with the up-front investment in vaccines. Combined, the AAP estimated the total costs of providing a vaccine at approximately 17%–28% above the direct vaccine purchase price.

“It’s a big strain on a practice even to stock vaccines,” says **Steven A. Robey, MBA, MBH**, QCPI’s medical economist. He advises provider organizations to negotiate arrangements in which payers supply the vaccine products directly “so there’s no middleman.”

Small practices with lower volume also need to account for vaccine packaging that may require them to spend thousands of dollars up front to purchase multiple units of an expensive vaccine that may not be fully used for four months or more.

In addition, many new vaccines must be stored in special refrigerators, “and if the power goes out, you can lose thousands of dollars’ worth of product,” Kinstler says.

But the administration expense “is separately reportable from the vaccine product,” the AAP statement added. “Some payers mistakenly believe that inadequate vaccine payments can be made up by nominal immunization administration fees. However, these are two separate expenses.” The CPT includes eight

codes for immunization administration, ranging from 90465–90474, depending on the route and age.

“The administrative fee we kept as a flat fee, because we still had control over that,” Kinstler says.

Don’t be lulled by one-year trend

Looking ahead, White says he doesn’t expect to see the same number of changes in children’s immunization schedules as during the past several years, although providers are still likely to see higher trends for this service than the overall medical trend.

“There’s probably going to be some catch-up from the 2008 schedule or because there are regional shortages in certain vaccines, such as hepatitis A or varicella,” Kinstler says.

However, even a more predictable one-year trend doesn’t make childhood immunizations a safe bet for capitation. “There continue to be new vaccines in the pipeline, as well as new indications for existing vaccines,” Kinstler says.

“Even if there’s not a material change over the next five years, you’re still going to have shortages that pop up from year to year, so you’ll have gains and losses within your capitation rate,” White says, adding that carriers may still try to put healthcare providers at risk for this service, “but vaccines are truly out of a provider’s control.”

E-visits improve efficiency for capitated physicians

Payers are recognizing the power of the Internet, and capitated provider organizations stand to benefit.

According to the New York City-based Manhattan Research's 2008 *Taking the Pulse v8.0* telephone and online survey of 1,832 practicing U.S. physicians conducted during the first quarter of 2008, 36% of physicians communicate with patients online, up from 31% in 2007 and nearly double the 19% who used secure messaging five years ago. Twenty-five percent of physicians reported communicating with patients via the Internet.

Among physicians who have not yet used a secure online messaging service, 24% indicated they intend to start using one in the next 12 months. Among physicians who communicate with patients online, the most popular activities include answering clinical questions, discussing symptoms and treatment options, and determining whether an office visit is necessary.

Lack of reimbursement for these virtual visits is one of the biggest stumbling blocks cited by physicians who continue to shun online communication. Some doctors also worry that, by e-mailing with patients, revenue from traditional visits may decline.

But GreenField Health, a primary care practice in Portland, OR, relies on e-mail and telephone

communication for approximately 80% of patient contacts, freeing up staff to see patients who need in-person care on a timely basis. Patients can contact their provider at any time by e-mail, telephone, or through an online system, and lab results are reported to patients via e-mail or telephone. The strategy allows the clinic's nine physicians at two sites to provide walk-in and same-day appointments to any patient who needs them.

"The challenge in the traditional fee-for-service environment is that most plans pay for visits, and they pay for volume," says **David Shute, MD**, a partner at GreenField Health. "Consequently, all kinds of things get pushed into visits so that they're reimbursable. That's actually inefficient, in terms of utilization." For example, e-mail is more efficient than an office visit, without any reduction in the effectiveness of clinical care, for medication adjustments, diagnostic test results, arrangement of consultations with specialists, and many follow-ups for recent clinical services.

"The other problem is that a doctor's day tends to be very, very busy with visits, and that doesn't leave time to provide care in other ways that may make more sense in the big picture," Shute says. For example, practices with greater scheduling flexibility can provide patients with better ongoing care management, including preventive and screening services and education on self-management.

Use e-mail exchanges in capitated systems

To make the system work, GreenField Health matches each patient with a health coordinator, who interacts with consulting physicians, hospitals, laboratories, and other ancillary services on behalf of the patient. Health coordinators are trained as medical assistants and serve as the point of contact for referrals, ordering tests, and other services. The program requires one health coordinator for every 500 patients.

Some regional payers in Oregon reimburse for the e-mail and telephone consultations, but payment is not yet universal, Shute says.

To support its electronic communication and research and development, the practice charges an annual patient fee ranging from \$170 for children under 10 to \$350 for those 60 and older, with discounts available for multiple members of the same family and employees at certain local companies. Such reliance on e-mail to enhance care could have an even greater effect on medical groups that accept capitation.

“If anything, we make this system work in a fee-for-service world, but it’s an ideal way to provide care in a capitated environment,” Shute says. “When you’ve got a fixed pot of money to provide someone a set of services, it frees the providers—in this case, primary care doctors—to do what is most efficient and what makes sense.”

For example, when Shute treats a patient for high blood pressure who is capable of generating reliable blood pressure readings and e-mailing the data to him, he reviews the information and simply replies

electronically with instructions to maintain or adjust medication dosages.

“That’s a concrete example of something that most people would agree is clinically safe and appropriate, yet in a more traditional setting, it winds up being a visit,” Shute says. “In a capitated setting, it’s a more efficient system for the practice and a much more efficient system for the patient.”

Document e-visits in patient charts

For noncapitated providers and those operating in a mixed reimbursement environment, a payer’s decision to reimburse Web or telemedicine consultations should automatically be recognized in managed care contracts with in-network providers unless a health-care organization has negotiated an exclusion that requires prior review and approval of payer policy changes, says **Susanne Madden**, president and CEO of The Verden Group, a healthcare consulting and research firm based in Nyack, NY. In any event, “the actual medical policy decision-making is going to override some of those clauses,” she says.

Practices that provide critical care or chronic disease management (e.g., endocrinologists and internal medicine physicians that care for individuals with complications from diabetes) should seek to negotiate more aggressively with payers to include electronic consultations in their capitation rates, especially in new contracts, Madden adds. When a severely ill diabetes patient doesn’t need to travel to a physician’s office for a visit, “it can only benefit the insurance company because it does substantially reduce costs,” she says, adding that “just because you have the

technology doesn't mean you're capturing the right information." The patient's chart must be updated following an electronic encounter, she notes. Practices that don't document e-visits appropriately will be on dangerous ground if they bill for them, she says.

Finally, providers can't bill for an electronic consultation using the AMA's new CPT 99444 if it's related to an office visit that occurred within the previous seven days. Many patients have questions following office visits, and e-mail is an efficient and convenient way to respond to these queries. "But if you're going

to bill for them, you've got to follow the rules," says **Elizabeth Woodcock, MBA, FACMPE, CPC**, a healthcare consultant, author, and principal of Atlanta-based Woodcock & Associates.

Physician organizations also need to use an established Web portal that offers the requisite security and communication infrastructure, as well as the abilities to retrieve e-mails on a timely basis and to capture billing data. Organizations should work closely with vendors before choosing a communication platform to ensure that it meets their goals, Woodcock says.

Take a business approach to your managed care contracting strategy

Whether negotiated payment arrangements represent a small or large portion of your net patient revenues, contracting changes that are occurring on a macro scale may significantly affect your healthcare organization this year and next, says **Christopher J. Kalkhof, FACHE**, director of the Healthcare Industry Group, LLC, at Alvarez & Marsal in New York City.

With federal and state governments partnering with MCOs in programs such as Medicare Advantage, managed Medicaid, and Child Health Plus, and more than a dozen states considering universal healthcare coverage initiatives, many healthcare organizations will see their payer mixes evolve to where 80% or more of net patient revenues will be based on negotiated payments.

Stand-alone organizations—especially independent physician practices—have the greatest exposure to reduced reimbursement. In 2008, Kalkhof oversaw an AMA study that indicated that 40% of physician practices still sign managed care agreements “without having any idea what they’re going to be paid,” he says. Although large medical groups, hospitals, and integrated organizations take a more businesslike approach to managed care contracting, the current economic environment is creating a difficult climate for all healthcare providers. Health plans have taken big hits in their investment income, and many are losing members to layoffs and diminishing healthcare

benefits. This year, UnitedHealthcare expects to lose at least 350,000 members—and perhaps as many as 925,000—nationally, says Kalkhof.

All of this means health plans won’t be eager to give away the store during contract negotiations. “Payers are going to draw a line in the sand and stand behind it more aggressively than they have in the past, when they were enjoying greater profitability and more flexibility in contracting,” Kalkhof says.

By identifying the critical elements of your contracts and developing a contracting strategy aligned with your business plan, your organization can manage the effect of managed care contracts on your bottom line, provided you ask the right questions, Kalkhof says.

“Managed care plans don’t volunteer that they’re willing to pay you more,” he says. “You have to extract that information and provide a certain business rationale.” Improving managed care contracting requires strategic financial planning, pre-negotiation due diligence analysis, and market data analysis. Bottom line, organizations need to understand the products covered under their contracts and how much they will be paid for which services.

Make a business case for participation

Although many consultants advise healthcare organizations to opt out of managed care contracts, that

strategy isn't practical—or even prudent—for most providers. In Kalkhof's view, the decision to participate with a given MCO should be driven exclusively from a business perspective, after weighing potential benefits and drawbacks. "Some practices can do fine on a cash-only basis, but that's increasingly limited," he says.

Some of the pros of participation—given a favorably negotiated contract—include:

- Increased patient volume through a physician referral management program and ongoing retention of existing patients
- Opportunity to negotiate better-than-average reimbursement and pay-for-performance (P4P) bonuses for hospitals and practices
- Inclusion on the MCO's participating provider lists and Web sites
- Electronic claims payment options, automated eligibility, disease management programs, and accelerated cash flow
- MCO group and Medicare benefit plan designs that provide members with financial incentives to use in-network physicians and hospitals

Participation can also have downsides, including:

- Reduced control over pricing strategy and patient care treatment
- Increases in contract compliance and administrative costs

- Changes in referral patterns with physicians and hospitals
- Increased economic risk exposure through models such as capitation and P4P or value-based purchasing programs
- Potential exclusion from specific MCO product networks
- Pressure to participate in all payer products with the MCO

"If your practice is not viewed as friendly or vital to a payer in their network—especially as they start getting into tiered networks with efficiency ratings—you can find yourself losing a lot of patients as opposed to retaining them and maybe attracting a few more," Kalkhof says.

If you consider going non-par, recognize that you may lose patients to competitors, encounter disruptions in traditional physician referral patterns, and experience a raft of business issues ranging from increased patient dissatisfaction to heightened collection challenges. Moreover, most national for-profit health plans have contracts with PPO networks for out-of-network coverage. Consequently, providers often need to weigh a difficult contract negotiation using a market-based fee schedule against the prospect of seeing patients out-of-network while facing certain disruptions in care and uncertain reimbursement.

"Practices that choose to become nonparticipating with a specific MCO must develop and execute strategies to maintain patient volume, service mix, and net patient

revenues,” Kalkhof says. “Step back and look at this from a strategic financial planning perspective. If you understand the payers in the market and the mix of patients that you attract in your service area, and you build your strategy around that, you can create an economic model that makes sense for your practice.”

Adopt a strategic financial planning approach

Developing a strategic financial planning approach to managed care contracting involves three distinct phases, says **Max L. Ludeke, MHA, FACHE**, a Houston-based healthcare consultant and former CEO of Doctors Hospital Parkway + Tidwell in Houston. The first phase, developing a contract development strategy, begins with an internal assessment, which includes the following core components:

- Review your multiyear strategic goals and objectives
- Assess patient satisfaction with your organization and with each MCO
- Inventory managed care contracts, comparing each for content and balance
- Model, analyze, and rank contracts by payer, product type (e.g., HMO vs. PPO), and profit or loss on each; by market share and market segment in each service area; and by dollars generated, denied, or in aging accounts receivable
- Assess contract payment approaches (e.g., fee schedule, percent of charges, capitation, or other)
- Analyze each MCO’s patient CPT mix and payment relative to service costs

Before confronting payers in contract negotiations, “you need to know who you are, and you need to have a standardized process for looking at each contract,” Ludeke says.

For example, hospitals with hundreds of managed care contracts need a mechanism to manage that information.

Employees in the business office should know what each plan is contractually obligated to pay so they can ensure that payments are accurate.

The next step is to conduct an external review, which includes the following core components:

- Identify trends in managed contracting strategies and reimbursement in your marketplace
- Identify threats to your payer reimbursements and establish a pricing strategy for each MCO tier
- Examine payer medical claim loss ratios and trends
- Understand the role of your organization’s physicians, mid-levels, and staff members
- Understand the business needs of referring physicians
- Identify opportunities for collaboration

The goal of this exercise is to understand the issues and opportunities in your market.

“What are the reimbursement trends?” Ludeke says. “What are the business threats? What pricing

strategies are being used? How successful are the managed care plans in your market? How much money are they making?”

Treat managed care contracts as a portfolio

With these analyses under your belt, Ludeke says to take a strategic approach to contracting that treats each contract as a component of your managed care portfolio:

- Use the data to review key procedure codes by service-area draw and estimate the effect on your practice
- Analyze the data from your internal assessment to determine your key contracting points and establish minimum thresholds for payments
- Develop contract exit and patient retention strategies
- Develop managed care contracting strategies and goals by segment, by MCO, and by product within each segment
- Develop a coordinated approach with physicians, independent practice associations, and physician hospital organizations, as applicable

Before initiating negotiations, healthcare organizations should develop an internal contract management process improvement effort, Ludeke says. Create an organizational chart defining the structure of the managed care contracting function or department. Develop a formal managed care contracting review process (see “Use these checklists before, during payer negotiations” later in this chapter).

Determine contracting metrics and create proposal templates. Develop measurable contracting payment rule definitions and key contract terms—including pre-authorizations—for practice. “You need all of the policies and procedures in place before you go to negotiations,” Ludeke says.

Determine denials or underpayment recovery dollars as negotiating tools, and use appropriate analytical tools to monitor the performance of payers. “No matter how good the rates that you negotiate, it’s not uncommon for managed care companies to pay you less than the negotiated rate,” Ludeke says. “When you file a claim, you should know what you expect to be paid based on the contract terms so you can validate that the payment is correct.”

Emphasize the value of your services

Focusing on specific aspects of the managed care contracting cycle will generate different levels of net revenue improvement, Ludeke says. For example, organizations that focus on improving reimbursement rates and payment rules (e.g., strengthening contract terms, P4P terms, risk-based payments, strategic pricing by MCO tier, and administrative costs) may increase their net patient revenue by 5%–50%. Those that focus on clarifying physician referral management and MCO service mix may increase net patient revenue by 10%–20%, while those that focus on end-to-end revenue cycle optimization—denial avoidance and payment compliance—may increase their net patient revenue by 5%–30%.

Organizations that focus on clinical quality improvement—integrating financial performance and cost reduction initiatives—also may improve net patient revenues by 5%–30%.

“This last area is a major opportunity for improvement as we become more sophisticated in coordinating between the office practice and the hospital,” Ludeke says. Focusing on business intelligence and resource consumption is especially important when negotiating global payments, which figure prominently in contracts with teaching hospitals and academic medical centers.

An integrated business model is the most effective way to deal with managed care plans on even footing in the current environment, Kalkhof says.

“The most innovative providers will look to operate business models that configure the services they sell to better fit what the buyer is actually looking to buy,” he says.

Providers that don’t attempt credible managed care negotiations are lumped into the lowest “street rate,” while large group practices, hospital networks, and integrated delivery systems start negotiations from a higher threshold. Thus, healthcare providers seeking

higher reimbursement from their managed care contracts must articulate a clear value proposition for their services and create a competitive position that gives them greater leverage during negotiations.

“This kind of business model, assuming quality and efficiency, will also be important with respect to payer tiered-product networks,” Kalkhof says.

For most healthcare providers, especially independent physician practices, managed care agreements represent the only significant opportunity to improve net patient revenues. When negotiating with health plans, the key argument to make is “that you should be paid adequately for the services and value that you provide,” Kalkhof says.

Because healthcare organizations rarely turn a profit on Medicare and Medicaid contracts, “when you go to commercial payers, you need to create a business case for why you need 20% or 30% above cost from them,” he says. “They won’t listen to you if you don’t have the data to back up your request.”

Use these checklists before, during payer negotiations

Christopher J. Kalkhof, FACHE, director of the Healthcare Industry Group, LLC, at Alvarez & Marsal in New York City, says following these seven key guidelines can help you evaluate managed care contracts in terms of your business needs and improve your leverage with payers:

- Do plan and prepare methodically for contract negotiations with payers, keeping in mind the effect on your practice. Making your legitimate business case with payers will improve your outcomes.
- Do ask relevant questions about the effect of the payer's agreement on your practice's operations and revenues. You may not like the payer's answers, but you should ask the questions before signing an agreement.
- Do consider whether you need to participate with a particular payer or payer product. What are the compelling business reasons to stay or walk away?
- Don't expect payers to actively steer patient volume. Your physicians' referral relationships and your organization's business and marketing strategies will allow you to attract and retain patients.
- Don't sign payer agreements unless they include specifics with respect to the rules that govern your reimbursement and payments.
- Do understand how quality and evidence-based medicine outcomes will affect your organization's reimbursement and how payers will use your quality and efficiency performance information in regard to their product offerings, practitioner reimbursement, and participating provider network configurations.
- Don't feel compelled to conduct business as usual with payers. Doing more of the same will not necessarily benefit your organization. Are you operating in the right business model for a marketplace dominated by managed care organizations? If not, consider the alternatives and opportunities for collaborating with other providers.

Healthcare organizations should always approach payer negotiations from a position of authority, not acquiescence, say Kalkhof and **Max L. Ludeke, MHA, FACHE**, a Houston-based healthcare consultant and former CEO of Doctors Hospital Parkway + Tidwell in Houston. By initiating negotiations, setting the agenda, analyzing rate proposals, and preparing counterproposals, providers demonstrate that they take managed care contracting seriously.

Ludeke advises that provider organizations use this checklist prior to negotiations to consider the strategic value and importance of each payer to your business plan and financial goals:

- How does your relationship with each key MCO relate to your overall business goals and objectives?
- Do your business goals and objectives with key MCOs drive your pricing and negotiating strategy?
- Is the organization making or losing money on key MCO contracts? Do you follow a standard process to assess these gains or losses? Can net revenues under existing contracts be improved?
- Does your relationship with MCOs help your organization to be more competitive in the marketplace?
- Are your patients loyal to the physicians in your organization or to the MCO?
- What will happen to MCO reimbursements if the state or federal government reduces MCO plan payments? Are the fee schedules linked?

Use these checklists before, during payer negotiations (cont.)

- How are your top line services affected by MCO contracts?
- How are your competitors using MCO plans to their competitive advantage or disadvantage?
- What is your patient services market share by MCO product? How important is your contract to that MCO, and how important is that MCO to your business operation?
- How do your MCO contracts affect operational and capital planning—especially if you're signing three- to five-year contracts?
- How will the organization's decisions on key MCO contracts affect patient referrals to and from the practice?
- What staffing and technology capabilities does the organization need to optimize its MCO revenues?
- What is your compelling value proposition for MCO plans?

In the second checklist, Kalkhof suggests critical questions about the business effect of managed care contracts to consider during negotiations. Know the answers to all of these questions to make informed decisions before signing a managed care contract:

- How does the proposed reimbursement compare to practice charges, cost, and Medicare for the same service?
- What are the administrative requirements under the payer's contract? What pre-authorizations are required for which services, and how will these affect current referral patterns?
- Who determines medical necessity, and how is it defined?
- What are the specific eligibility determination requirements, and how are retroactive terminations handled?
- What are your appeal rights? How many levels of internal and external appeals are allowed, and how are disputes resolved?
- How are underpayments and overpayments handled?
- Is the practice required to accept the contract under an "all payer" contract with the MCO?
- Is the agreement evergreen? What are the termination provisions?
- What is the annual inflation factor?
- How and where has the MCO modified the reimbursement fee schedule from traditional Medicare?
- Is the fee schedule provided?
- How are nonparticipating referrals and coverage handled?
- What pay-for-performance incentives are involved, and what are the specific mechanisms to obtain incentive payments? Are they realistic and meaningful?
- If capitation payments are involved, what is allowed as a billable service outside the cap rate? Are payments risk-adjusted?
- How are new services and technology added and reimbursed?
- What are the payment timelines?

Medicare study: Risk-adjusted model underpays, ignores functional status

Medicare's capitation model does not take into account a beneficiary's functional status and underpays for multiple comorbidities. This lowers reimbursements paid to physicians and health insurers involved in Medicare managed care plans who treat frail patients with multiple chronic conditions, according to a study that appeared in the October 2008 *American Journal of Managed Care*.

"Medicare Capitation Model, Functional Status, and Multiple Comorbidities: Model Accuracy" found that the Centers for Medicare & Medicaid Services Hierarchical Condition Categories (CMS-HCC) risk-adjusted model for Medicare payments under-predicted payments for patients with hypertension, lung disease, chronic heart failure (CHF), and dementia. (See Figures 16–17.)

**FIGURE
16**

Cost ratios for target chronic conditions included in HCCs

Chronic condition	Number of activities of daily living deficiencies						
	0	1	2	3	4	5	6
Arthritis	23,507	1,739	866	547	506	501	264
Actual cost	0.93	1.71	2.19	2.57	2.54	2.69	3.54
Predicted cost	0.96	1.47	1.63	1.8	1.93	2.26	2.61
Cancer	12,099	801	406	236	222	197	128
Actual cost	1	2.18	2.15	2.52	2.94	3.42	3.64
Predicted cost	1.05	1.69	1.78	1.92	2.09	2.43	2.62
Lung disease	5,759	492	275	144	133	108	75
Actual cost	1.23	2.48	2.56	3.17	3.4	2.79	3.81
Predicted cost	1.19	1.7	1.89	2.01	2.22	2.63	2.88
Stroke	3,663	459	294	202	232	251	206
Actual cost	1.24	1.83	2.15	2.47	2.45	2.61	3.91
Predicted cost	1.2	1.7	1.85	1.99	1.96	2.38	2.67
Chronic heart failure	3,601	520	285	192	207	221	149
Actual cost	2.56	3.23	3.5	4.21	3.39	3.37	5.44
Predicted cost	2.16	2.55	2.73	2.94	3.17	3.38	3.62
Diabetes	5,991	571	287	210	176	174	88
Actual cost	1.29	2.5	2.92	3.65	2.79	3.8	5.04
Predicted cost	1.28	1.96	2.21	2.21	2.52	2.99	3.2
Coronary artery disease	8,486	759	404	251	202	246	155
Actual cost	1.24	2.02	2.56	2.75	2.45	2.88	3.51
Predicted cost	1.18	1.7	1.87	2	2.25	2.47	2.69

Source: "Medicare Capitation Model, Functional Status, and Multiple Comorbidities: Model Accuracy."

FIGURE
17

Actual, predicted cost ratios for target chronic conditions not included in HCCs

Chronic condition	Number of activities of daily living deficiencies						
	0	1	2	3	4	5	6
Hypertension	21,238	1,493	726	484	467	393	247
Actual cost ratio	0.97	1.85	2.13	2.67	2.94	2.92	4.07
Predicted cost ratio	0.98	1.52	1.72	1.85	1.99	2.36	2.69
Heart disease	16,170	1,306	677	412	393	430	251
Actual cost ratio	1.16	2.15	2.44	2.66	2.65	2.69	3.96
Predicted cost ratio	1.13	1.69	1.85	1.99	2.13	2.37	2.82
Osteoporosis	4,136	427	222	158	160	184	109
Actual cost ratio	0.95	2.04	2.23	2.81	2.24	2.18	3
Predicted cost ratio	1.01	1.64	1.57	1.81	1.94	2.05	2.27
Dementia	1,421	218	165	118	143	177	158
Actual cost ratio	1.79	2.43	3.18	3.33	3.03	3.03	4.13
Predicted cost ratio	1.61	2.09	2.19	2.4	2.48	2.6	3.08

Source: "Medicare Capitation Model, Functional Status, and Multiple Comorbidities: Model Accuracy."

"The difference between the actual costs and predicted payments was partially explained by beneficiary functional status and less-than-optimal adjustment for these chronic conditions," the researchers state.

CMS-HCC is a risk-adjustment model that "relies on demographic and diagnostic information available from administrative data to predict resource use," according to the study. **Rong Yi, PhD**, senior scientist and principal of analytic services at Verisk HealthCare, Inc., in Boston, says CMS tried to discourage vague coding and gaming of the system when it created HCC, which uses a subset of ICD-9-CM codes that focuses on chronic conditions or acute complications of chronic conditions.

"While this is a very good policy decision, we have found that nonchronic conditions often have cost implications for future years," says Yi.

Although HCC includes lung disease/cancer, stroke/arthritis, and diabetes/coronary artery disease (CAD), there is still a discrepancy between the actual and predicted cost ratios, according to the study. (See Figure 18.)

The underpredicting suggested in the study could play a large role in reimbursements to physicians and insurers because two-thirds of noninstitutionalized Medicare beneficiaries over the age of 65 have two or more chronic conditions, according to the study.

Katia Noyes, PhD, MPH, associate professor in the department of community and preventive medicine at the University of Rochester (NY) and the lead author of the study, says plans and practices with a large proportion of frail elderly could lose money because of the model.

The HCC model does not take into account functional impairment. This could affect Medicare's Special Needs

**FIGURE
18****Actual, predicted cost ratios for pairs of target chronic conditions included in HCCs**

Chronic conditions	Number of activities of daily living deficiencies						
	0	1	2	3	4	5	6
Lung disease and cancer	1,983	205	102	60	48	39	18
Actual cost ratio	1.35	2.15	2.69	2.84	3.64	3.61	4.44
Predicted cost ratio	1.29	1.86	1.95	2.26	2.69	2.87	3.28
Stroke and arthritis	2,357	330	219	153	163	159	127
Actual cost ratio	1.25	1.93	2.52	2.67	2.43	2.46	4.31
Predicted cost ratio	1.26	1.78	1.89	2.04	2.11	2.39	2.8
Diabetes and coronary artery disease	1,869	234	132	83	70	74	37
Actual cost ratio	1.67	2.64	3.85	4.21	3.57	4.59	5.78
Predicted cost ratio	1.54	2.14	2.37	2.29	3.06	3.23	3.86

Source: "Medicare Capitation Model, Functional Status, and Multiple Comorbidities: Model Accuracy."

Plans (SNP), which provide coordinated care to dual eligibles with certain chronic illnesses who reside in institutions such as nursing homes.

Yi says non-claims based information such as functional status, socioeconomic, culture, linguistics, and geography affect how patients interact with the healthcare system. "Including non-claims based data has been discussed for quite a number of years in the risk-adjustment and predictive modeling field, functional status being one of them. Clinically, functional status significantly affects how a patient seeks care and follows the doctor's treatment requirements," she says.

Yi says collecting these kinds of data elements will take a large effort. "Unless there is a systemwide effort to start enforcing the collection of such data elements, we can debate the underpayment relating to not having functional status or other factors like this forever. I personally don't think one can do much about it at all," she says.

The model also doesn't take into account dementia, osteoporosis, and other chronic conditions that could affect a patient's health status and care.

Researchers looked at how 11 target comorbidities may affect functional impairment, including arthritis, osteoporosis, diabetes, CAD, CHF, and dementia.

Certain combinations of those ailments could affect patient performance in activities of daily living (ADL), which would affect medical costs. ADLs include bathing, dressing, and eating. The researchers say the more ADL deficiencies a patient has, the greater the difference between the HCC model's predicted cost and the actual expenses.

In the study, researchers looked at 46,790 community-dwelling Medicare beneficiaries between 1992 and 2000. Nearly three-quarters of beneficiaries in the study had two or more target comorbidities.

"Patients with CHF and dementia reported the highest level of deficiency across all ADL categories: 14.38% relied on others' help with eating (feeding), and more than 50% used help or assisted devices for bathing. Other groups with a high ADL deficiency level included patients with stroke combined with hypertension or arthritis, CHF

and osteoporosis, and CAD and diabetes,” according to the study.

The findings mean that the CMS-HCC model “significantly underpredicts expenses for patients with hypertension, lung disease, CHF, and dementia after adjusting for patients’ disability level,” wrote the researchers. (See Figure 19.)

Ross Winkelman, managing director at Wakely Consulting Group in Denver, who helps managed care organizations develop Medicare Advantage filings and bids, says his company has seen a similar understatement of the HCC risk-adjustment models for subgroups. Another issue is the limited number of

comorbidities recognized in the HCC model and delays that increase risk scores. Managed care organizations or provider groups that accept a percentage of risk-adjusted benchmarks and serve a disproportionate number of sicker, more frail individuals will likely be underpaid, and those with healthy populations will be overpaid.

“Risk adjustment dampens these effects but does not completely eliminate them,” says Winkelman.

Kirk L. Shanks, MAS, actuarial analyst at Wakely Consulting Group in Clearwater, FL, points to another concern: The Medicare HCC model is based on the previous year’s claims data. For example, if an

FIGURE 19

Actual, predicted cost ratios for pairs of target chronic conditions, with one of the conditions not included in HCCs

Chronic conditions	Number of activities of daily living deficiencies						
	0	1	2	3	4	5	6
Arthritis and hypertension	13,885	1,178	556	388	353	299	185
Actual cost ratio	1.02	1.73	2.31	2.74	2.85	2.91	4.11
Predicted cost ratio	1.02	1.53	1.69	1.82	2.01	2.37	2.76
Heart disease and cancer	5,657	528	252	150	137	128	84
Actual cost ratio	1.27	2.42	2.66	2.81	3.03	3.46	4.28
Predicted cost ratio	1.24	1.82	1.87	2.08	2.3	2.64	2.94
Stroke and hypertension	2,590	342	210	146	164	171	137
Actual cost ratio	1.31	1.78	2.29	2.4	2.97	2.82	4.53
Predicted cost ratio	1.24	1.74	1.92	1.97	2.17	2.51	2.87
Chronic heart failure and osteoporosis	441	114	53	46	46	63	32
Actual cost ratio	2.96	3.12	4.35	5.86	3.07	2.48	3.27
Predicted cost ratio	2.24	2.64	2.58	2.84	3	2.86	3.25
Chronic heart failure and dementia	259	65	60	33	57	59	65
Actual cost ratio	4.06	3.96	4.66	4.4	3.53	3.66	6.14
Predicted cost ratio	3.04	3.03	3.2	3.46	3.61	3.66	4.24

Source: “Medicare Capitation Model, Functional Status, and Multiple Comorbidities: Model Accuracy.”

individual is healthy in 2007 and becomes ill in 2008, the provider group or managed care organization would receive lower payments because of the patient's low-risk score based on 2007 data.

If the patient leaves the plan in 2008, the group or organization would not receive increased payments. However, if the patient is in the same plan in 2009, and the HCC increases the individual's risk score, the group or organization would recoup the previous year's costs with 2009's higher payments.

Shanks says another example is a new 65-year-old Medicare beneficiary who is ill but has no encounter data with CMS. "The plan would be paid a default rate, which is relatively low, in the first year. The plan would not get the benefit of the increased risk score and associated plan payment until the next year," he says.

Effect on health plans

These discrepancies affect not only physicians, but also health plans involved in Medicare managed care programs.

"Our results demonstrate that unless a special disability adjustment is introduced for patients with comorbidities, entering into risk arrangements with Medicare for services provided to people with multiple comorbid conditions may be more risky for health plans serving this population than anticipated," wrote the researchers.

SNPs that are not qualified for the frailty adjustment are "financially at a disadvantage in providing care to the very frail and disabled," the researchers wrote. These kinds of disincentives could push managed care plans to not enroll those individuals.

"[Private insurers] probably should start looking at collecting more information on functional status just as Medicare should," says Noyes, adding that the payment model's deficiencies could be a catalyst for primary care doctors leaving for specialty care.

In specialty care, doctors are responsible for only one condition rather than the multiple comorbidities in primary care.

The payment model could potentially benefit specialty care, which is more costly than primary care. "I think that's one reason why there is an outflow of providers from primary care," says Noyes. "[Primary care is] where most of the elderly get their care."

Noyes says she is hopeful that Medicare will review its payment system and adjust for comorbidities and functional status. However, she does not expect changes, because tweaking the system is unlikely to save money, although it could improve quality and outcomes. "My experience tells me that very few things in this current system of healthcare saves money. You may improve quality of care, but everything comes at a cost," she says.

Accurate comp calculations crucial to fair market value

Increasingly, health systems are acquiring private practices. Accordingly, it's more important than ever for physicians to understand what their practice is worth. That means they must understand the concept of fair market value (FMV).

Valuations are crucial to crafting buy-sell agreements, mergers, and regulatory compliance. But given how widespread the trend is, this article will focus on FMV as it relates to practice acquisitions, with emphasis on compensation and retention and recruitment-related issues.

The basics

If physicians are regularly buying and selling interests in a practice, FMV should be assessed every two to three years, says **Martin D. Brown, CPA**, a shareholder at Pershing Yoakley & Associates in Knoxville, TN.

At its most basic, FMV is the amount at which property would change hands between a willing seller and a willing buyer when neither is under compulsion and both have reasonable knowledge of the relevant facts. Especially for OIG and Stark purposes, it must be an arm's-length transaction consistent with the general market value.

It's obvious, but bears repeating: Hospitals often seek to purchase physician practices as a means to retain existing referrals or to attract new referrals of patients

to the hospital. But that potential referral stream cannot be factored into FMV. Neither can any factor that would appeal to one buyer and not to another—for instance, proximity to the acquiring hospital (or even proximity to a competing hospital).

There are three basic approaches for arriving at value: asset-based, income-based, and market-based. The first two are the most commonly used for physician practices; there usually aren't enough comparable sales in a given area for the market-based approach to be practical.

Getting started

The most important thing to have before embarking on a valuation is a good set of statements and balance sheets, supplemented with good statistical information, says Brown.

For example, if the charges are \$400,000 per physician, identify how many office visits that represents. "It helps you get your arms around what's driving the numbers," he says, adding that although one or two years' worth of data is required, three is ideal. Brown offers the following checklist of data requirements as a starting point:

- Practice financial statements
- Charges, collections, and adjustments
- Accounts receivable and payable

- Fixed asset schedule
- Notes payable and lease obligations
- Payer mix
- Patient volume and number of active charts
- Physician compensation and any discretionary expenses
- Employee list, job description, tenure, and pay rate

FMV is driven by future earnings and the risk associated with those earnings, so forecasts and trends are important. “For example, there is a severe shortage of general surgeons,” Brown explains. “That’s a driver that would likely increase the value of that practice.”

The situation might be reversed for cardiac surgery, where the demand for open-heart surgery is declining because of the availability of other therapies.

For the purpose of financial projections, it makes sense to project an increase in the patient bad-debt expense, given the current economy. It also makes sense to factor in an increase in certain supply costs. Given the current trends, a practice will probably want to project flat reimbursement rates into its calculation.

Numerous other elements go into developing an FMV for a medical practice. Brown offered a good overview in a December 2008 HealthLeaders Media audio conference. (Visit www.hcmarketplace.com/prod-7238.html to order.)

Figuring out compensation

Compensation may be one of the most important aspects of FMV, but what constitutes compensation for such a valuation is very specific. It’s crucial to figure out what to assign to the value of the practice and what to assign to compensation.

Only cash compensation should be included in the calculation. Physicians in private practice generally get all earnings that are left after all expenses. But when calculating FMV, any “ownership dividend”—in effect, an ROI and not compensation for services rendered—must be stripped out of the compensation-expense calculation and allocated to the value of the practice. That means going through the compensation, line by line, to remove everything unrelated to pay for services rendered. For example, comp plans are often loaded with excess fringe benefits, Brown says. Those could include a family cell phone plan, vehicle costs, travel, or entertainment. Such items also need to be excluded from future operations expenses.

You want to look at all the elements of compensation separately and together.

“Once fair market value has been established for the practice, the next step typically involves the development of a compensation plan that will be used for the physicians once they are acquired,” says **Kim Mobley**, principal at Sullivan, Cotter and Associates, Inc. (SullivanCotter) in Detroit. “It is important to look at the entire compensation arrangement once all of the elements are in place.”

“In these situations, you are often chasing a moving target,” Mobley explains. Although one element of

the proposed compensation plan may be reasonable and within FMV, when you add in other components (e.g., sign-on bonus, retention bonus, productivity incentives, and quality incentives), the total compensation may exceed FMV, even though the individual compensation elements appear reasonable.

Salary surveys can help normalize compensation, but given all the variables involved, they are only a guideline.

The role of compensation surveys

Physician compensation surveys conducted by independent organizations should be used to compare the specialty-specific actual compensation levels earned relative to market benchmark norms, Mobley says.

Ideally, such comparisons should also include productivity levels and productivity reflecting actual collections or wRVUs should be used. “In most instances, the compensation approach for the acquired physician practice will be different than what the physicians were used to in their private practice,” Mobley says. “To ensure that the compensation plan is working as intended, as well as to ensure the compensation levels produced represent FMV, the projected compensation levels should also be analyzed.”

If the proposed total cash compensation for the physician falls between the 25th and 75th percentiles of the market, it is generally considered to “fall within a competitive range” and therefore, FMV. If an organization is proposing to compensate the physician(s) above the 75th percentile, there should be strong productivity data supporting such compensation, as well as the business judgment factors, says Mobley.

Another factor to consider is the cost of benefits the acquiring hospital is going to incur, Mobley says. There are physician compensation surveys, including SullivanCotter’s, that report on the benefits-cost benchmark norms.

Compensation errors

Carelessness with compensation may be the biggest mistake made in determining the FMV of a practice, says Brown. It’s not only crucial to coming up with an accurate value, but to establish a realistic figure as a basis for future compensation.

The acquiring entity often feels pressure to pay doctors at least the same amount they earned the previous year. What acquiring entities often don’t fully grasp is that they have taken away the risk of running the practice, Brown says. It makes sense, then, to remove the reward for that risk from the calculations. It’s a matter of striking a balance between the right amount of compensation going forward and the right amount to pay for the practice. Some of what initially shows up as physician compensation needs to be reallocated to net income.

He offers the following example: A physician made \$300,000 in income. But based on the benchmark surveys and the calculations noted above, it could be that the compensation for actual services rendered by the physician should be \$250,000. The remaining \$50,000 is related to the running of the business—“an ownership dividend.”

“So from a value standpoint, you would reflect compensation at \$250,000, and \$50,000 would drop to the bottom line,” says Brown. The hospital would

have to explain to the physician that they will be paid \$250,000 going forward, not \$300,000. However, the physician would then receive a higher value for the practice up front, he says.

The organization also wants to make sure the compensation plan is designed so the productivity targets support the level of compensation that can be earned, says Mobley.

This can be done by looking at actual productivity targets relative to market benchmark norms as well as the ratio of total cash compensation to projected collections or wRVUs. A common mistake acquiring entities make is to pay for the practice and keep the compensation at \$300,000. “When they do that, they’ve usually double-dipped. They will experience losses and never recoup their up-front investment,” says Brown.

A less common—but costly—mistake is failure to normalize taxes. Usually, the practice doesn’t pay corporate income taxes because there’s no net income; it’s all distributed. But in FMV calculations, there is net income projected forward. Therefore, it’s essential to calculate the income tax expense, since that would likely reduce the value. This needs to be done even if the acquiring entity is tax-exempt. If that comes down to the “any willing buyer, any willing seller” concept, you could have a for-profit entity buying the practice.

Recruiting and workforce issues

Valuations aren’t just about tangibles. Intangibles, such as goodwill, can contribute to the value of a practice but can be difficult to quantify. Most recent

transactions that Brown has seen don’t include goodwill, but that can vary by market.

It’s important to distinguish between personal goodwill and practice goodwill—both to arrive at the proper value and to avoid triggering an OIG investigation.

Brown gives an example of personal goodwill in a neurosurgery practice. “The actual skill set of the named individual is so incredibly important that if he or she were not involved in the practice going forward, it could take away its value,” he says. “You can’t sell personal goodwill, because it always stays with you.”

Practice (or professional) goodwill includes intangible practice assets—such as workforce-in-place or locations—that contribute to the revenue stream.

Intangibles related to retention and recruiting can include the following:

- **Recruiting success.** The ability to recruit can enhance a practice’s value. A practice with a good record of recruiting residents and transitioning them into private practice has enhanced value. Such ability—be it based on location, recruiting skills, or anything else—contributes to the bottom line, Brown says.
- **Duration of relationship.** A related question is how long the physicians will stay on board after the acquisition. Is the sale an exit strategy or are the doctors planning to remain with the practice? If the employment agreement is for one or two years, that raises concerns about the long-term viability of the practice. (Likewise, it

makes a difference whether the sale is part of an exit strategy for a retiring physician.)

- **Untapped competency.** Although a minor factor, it's often overlooked by practices. The unused expertise of a physician in the practice, especially if that competency can be put to use by the acquiring hospital or health system, may have bottom-line value. The doctor who is very

good at speaking, teaching, and clinical research, but doesn't have the opportunity to use those skills in the practice, could be a valuable asset.

Developing an FMV that's accurate and avoids the risk of Stark or OIG action can be tricky, Brown says. That's why he offers a final word on the issue: "Be diligent—and careful."

SullivanCotter survey: Higher compensation, lower pay per wRVU

A new compensation survey suggests that physicians are weathering the economic downturn, but it does little to suggest that medicine is recession-proof. Moreover, it highlights the disparity between the highest-paid and lowest-paid specialties.

Sullivan, Cotter and Associates' *2008 Physician Compensation and Productivity Survey Report* reported an average salary increase of 4.4% for specialists and 4% for PCPs. That's roughly on par with the 2007 survey, which reported a 4.5% increase for specialists and 4.3% for primary care.

Seventy-two percent of survey participants reported increases, as compared to 73% in 2007.

Only 10% of organizations reported decreasing physician compensation levels; this was the survey's biggest surprise, especially since that figure has generally ranged from 18%–20% for the past few years, says **Kim Mobley**, principal at SullivanCotter and the survey director. However, the data were collected before the full effect of the economic downturn was realized, Mobley says.

Overall, base salaries constitute 92.7% of total cash compensation, slightly lower than the 93.5% reported in the 2007 survey. The percentage varies by specialty.

The survey includes compensation data for more than 41,000 physicians in more than 150 specialties; 257 healthcare organizations nationwide participated.

It's important to remember that there's a time lag; the data in this report are effective for March 1, 2008, before the worst of the recession hit.

Adjusting wRVUs

Although total cash compensation increased, the average pay rate per wRVU for 10 major specialties declined by 6.3%, which has less to do with market trends and more to do with the modifications made by CMS in 2007 to the value of a wRVU, says Mobley. For many specialties, the wRVU value increased; therefore, physicians could have an increase to their wRVU productivity with no significant change in practice patterns, she notes.

To ensure that their doctors did not receive windfall payments for these modifications, "physician groups and employers revised their compensation programs tied to wRVUs to ensure that compensation levels paid are appropriate for the level of services provided and within the bounds of fair market value," says Mobley.

The result was a decline in the pay per wRVU in many specialties, even though total cash compensation increased. (See Figure 20.)

FIGURE
20

Median total cash compensation per wRVU

Specialty	2007	2008	% Change
Emergency medicine	\$39.3	\$35.45	-9.8%
Family practice	\$42.85	\$39.53	-7.75%
Internal medicine	\$46.49	\$42.5	-8.58%
General surgery	\$49.78	\$45.26	-9.08%
OB/GYN	\$45.28	\$42.69	-5.72%
Anesthesiology	\$36.18	\$37.35	3.23%
Radiology	\$54.46	\$52.74	-3.16%
Pediatrics	\$40.28	\$37.84	-6.06%
Psychiatry	\$54.14	\$55.59	2.68%

Source: Sullivan, Cotter and Associates, Inc., 2008 Physician Compensation and Productivity Survey. Used with permission.

Disparities

The survey helps underscore the disparity between PCPs and specialists. The three highest-paid specialties based on average total cash compensation are:

- Orthopedic surgery—sports medicine: \$638,891
- Orthopedic surgery—spine: \$612,557
- Pediatric cardiothoracic surgery: \$585,963

The three lowest-paid specialties are:

- Pediatric hospitalists: \$152,736
- Pediatric developmental medicine: \$156,538
- Neurology-EEG lab: \$157,063

For a comparison of compensation levels paid in nine major specialties, see Figure 21.

Other trends

The survey revealed several interesting trends, including:

- More organizations are offering hiring bonuses. In the 2008 survey, 57% of the participants used hiring bonuses, compared to only 49% in the 2007 survey. Bonus amounts remained stable, averaging \$10,000 for PCPs and \$17,500 for specialists.
- Use of incentives is growing. The 2008 survey found that 70% of organizations reported using incentive compensation programs for their physicians, up from 60% in 2005. Actual incentives for specialists and PCPs as a percentage of base salary are comparable to those reported in the 2007 survey.
- Use of quality metrics is increasing. The survey found an increase in the use of quality measures

as part of incentive payments; however, the relative amount of compensation tied to quality is small, typically no more than 2%–3% of total cash compensation.

Looking ahead

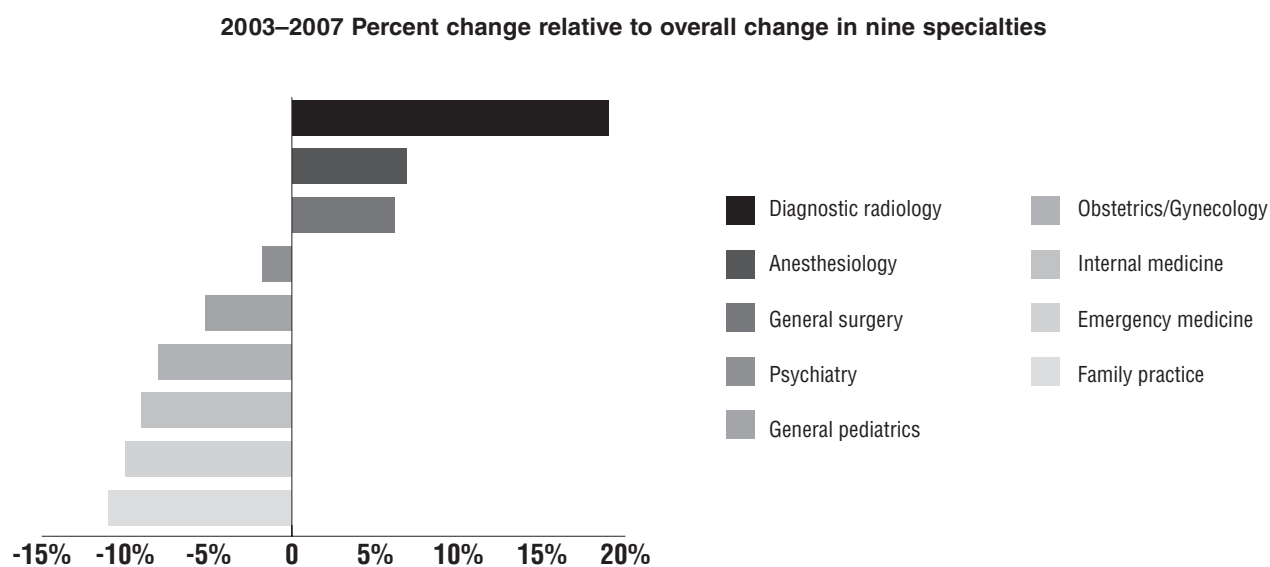
Although the current trend is to compensate physicians based on wRVUs, this approach does not require physicians to manage expenses and neutralizes the effect of a poor payer mix, notes Mobley. Eventually, compensation models must address issues such as revenue and expense management and be economi-

cally sustainable in the long run, she says, adding that SullivanCotter is starting to see organizations have these discussions with their physicians.

Organizations are also beginning to address their physician on-call pay expenditures by reviewing their on-call pay approaches on a global basis, as opposed to engaging in negotiations with single physicians and physician groups, Mobley says. “Thus, we expect to see more formalized and structured approaches to physician on-call pay in the coming year,” she says.

FIGURE
21

Total cash compensation comparison for nine major specialty areas



Note: Overall total cash compensation for the nine major specialty areas increased by 26.7% between 2003 and 2007.

Source: Sullivan, Cotter and Associates, Inc., 2008 Physician Compensation and Productivity Survey. Used with permission.

Use lessons learned from capitation to improve managed care performance

Contrary to popular opinion, capitation isn't such a disagreeable form of contracting—especially during a recession. The *2008 Capitation Survey*, conducted by the AMGA in Alexandria, VA, and Seattle-based ECG Management Consultants, Inc., found that more than half of the respondents characterized their organizations' financial performance in risk contracts during the past two years as above average or excellent, and fewer than 10% cited poor financial performance.

The survey results offer some valuable benchmarks and suggest that lessons learned from capitation can be applied to other types of managed care contracting and management.

Capitation isn't exactly the hottest trend in health-care. In fact, the prevalence of risk contracting has been shrinking steadily for more than a decade.

Consider Dreyer Medical Clinic in Aurora, IL, a multispecialty group practice with 143 physicians that serves the suburban communities southwest of Chicago. Approximately 38% of the organization's patients are currently enrolled in capitated plans.

"We used to have much more," says **Charles Derus, MD**, medical director at the clinic. "Capitation is declining in this market, and all of the growth appears to be in the fee-for-service area."

Derus says capitation is a "beautiful thing in a recession" because the contracts continue to pay steady PMPM payments, but he isn't confident that reimbursement will remain as stable on the FFS side of the books. "I anticipate that we're going to see decreases in some of the more discretionary spending for healthcare—and, as people lose insurance, maybe some of the vital areas," he says.

Risk contracting also forces providers to develop a healthy business discipline, which hasn't occurred across all healthcare organizations, says **James W. Lord**, principal at ECG Management Consultants in St. Louis, who supervised the *2008 Capitation Survey*. "When groups understand their costs and negotiate rates for which they know they can deliver the right kind of care, that knowledge translates all the way through fee-for-service medicine to models that could emerge in the future," Lord says.

"Groups that have figured out capitation and made investments in their infrastructure are potentially at a strategic advantage," explains **Joshua Halverson**, senior manager at ECG. "They can go to their payers and demonstrate that they can deliver high-quality care for less."

Seventy-five AMGA member organizations participated in the survey, which was based on 2007 data. Half of the respondents were affiliated with

physician-owned multispecialty groups, and another 28% with hospital-affiliated multispecialty groups.

The remaining participants came from physician-owned or hospital-affiliated primary care groups or academic medical groups. One-third of the respondents were contracting directors or practice administrators. Other respondents included CFOs, chief operating officers, medical directors, physician administrators, finance directors, and managed care directors.

Overall, 64% of survey respondents participated in risk contracting during the past three to five years, although 84% of groups in the western United States accepted cap contracts, compared to 50% of groups in the Northeast and South. Of all risk-contracting participants, 36% derived greater than half of their organizations' total revenue from capitation, whereas 33% generated less than 10% of revenue from risk contracts.

Those numbers also varied by region. Sixty-two percent of the respondents with risk contracts in the western United States generated greater than 50% of revenues from risk, compared to 8% in the Midwest, 17% in the Northeast, and 25% in the South.

Sixty-seven percent of Northeast respondents with risk-contracting revenue reported that less than 10% of their revenues came from capitation.

Use incentives to influence physicians

More than half of the survey respondents indicated they participate in primary care (55%) and professional (57%) capitation, followed by global (31%) and

carve-out (24%) cap. The AMGA organizations were more likely to participate in primary care capitation with commercial HMO or POS plans than with Medicare Advantage (MA) plans, whereas the opposite was true for professional and global cap.

Most respondents with primary care (61%) and professional (67%) cap structured their agreements on age- and sex-adjusted PMPM rates, whereas most global capitation agreements (82%) were structured on a percent-of-premium basis. Surprisingly, 67% of respondents with carve-out contracts used flat PMPM rates.

Overall, respondents with risk-bearing contracts were most interested in professional capitation, followed by primary care cap. Although 40% of participants reported no interest in global risk contracts, another 17.1% indicated they were most interested in such arrangements.

Of organizations that participate in risk contracts, 73% had a department or team dedicated to monitoring and improving performance under capitation, according to the survey. Sixty-four percent had a department dedicated to reconciling and administering risk pools and settlements.

The AMGA groups also used the following incentives to influence physician behavior:

- Referrals and prior authorization to control utilization (53%)
- Physician bonuses tied to contract performance (44%)

- Physician compensation structures linked to contract performance (31%)
- Withhold pools (17%)
- P4P (8%)
- Group bonus payments (5%)

Half of the groups participating in risk contracting also purchased stop-loss insurance—usually from an outside reinsurer—to protect physicians from adverse contract performance.

Use data to demonstrate value to plans

Most survey participants use the delegated model of risk contracting, with 64% performing claims adjudication for their member populations. Seven in 10 respondents with capitation subcontracted with hospitals and other healthcare providers to offer services to covered members.

Seven in 10 performed multiple types of audits to ensure contract performance and payer accountability, including:

- Adherence to contracted rates (78%)
- Correct Coding Initiative edits (73%)
- Duplicate claims checks (50%)
- Coordination of benefits audits (50%)
- Financial responsibility audits (45%)

To ensure contract performance and payer compliance, 55% of groups with cap contracts used Healthcare

Consultation Center audits for MA patients, and 58% used chart reviews for chronically ill and high-risk patients. One in five groups also ensured that patients enrolled in capitated plans were seen at least once per year.

Fifty-five percent of groups with capitation reconciled patient eligibility with premiums to ensure proper reimbursement, and 25% conducted a total premium analysis. However, 45% of organizations didn't perform any type of premium audit.

Respondents reported a mixed experience working under capitation with four major payers: Aetna, Blue Cross and Blue Shield, CIGNA, and UnitedHealthcare/PacifiCare. Although 96% of respondents reported the plans provided adequate eligibility data, only 67% indicated the plans provided quality data, including P4P reports, and just 54% reported the plans provided claims data for which the organization is at risk.

Fewer than half reported the plans shared data about premiums (39%), risk-adjustment (28%), and all claims regardless of reimbursement type (27%). Only 2% reported the plans shared pharmacy data.

“This is cause for concern,” Lord says. “Without this information, groups are unable to perform the necessary audits to ensure adherence to contracted rates for services rendered and proper premium payments for the covered population.”

“The challenge under capitation is finding better ways to manage a population—delivering better outcomes at a lower cost,” Derus says. Although it's always

important to manage acute episodes efficiently, the growing impetus is on managing chronic disease in the outpatient setting. For example, his clinic operates an extensive diabetes disease management program that employs PharmDs and provides intensive outpatient management.

“Because of our clinical integration program, we know how many of our 4,500 diabetics have an A1c level,” Derus says. He uses data to demonstrate the group’s improvements in diabetes care, asthma action plans, and utilization measures such as hospitalizations and ED revisit rates.

“We can talk about efficiency measures that [payers] care about, like length of stay, generic prescribing rates, and switch programs,” Derus says. “We know everybody in our managed care population, and we get reasonably good data from our HMO payers, so we can demonstrate value. We also have an [electronic medical record], so we can make some pretty good estimates on the fee-for-service side, but nothing’s quite as solid as the evidence you get from a capitated population.”

Evaluate outcomes across capitated population

To monitor contract performance, 80% of respondents received reports from payers on their PMPM claims expense and 74% on their inpatient and skilled nursing facility days per 1,000 enrollees. Only 32% received member-level risk-adjustment reports, 32% received reports on hospital contracts on per diem and per case rates, and 24% received reports on procedure-level cost data by facility. Despite some shortcomings in data reporting and contract

management, 54% of respondents with capitation reported excellent or good financial performance with a specific health plan.

Payers that provided more data and utilization management assistance received higher performance ratings from the AMGA groups than those that did not.

Overall, 22% of respondents reported excellent financial performance for their risk contracts throughout the past two years, and 41% said they had above average performance. Only 6% reported poor financial performance.

Provider groups that pursue risk contracting still face some pushback internally. On a scale of 1–5, respondents reported that physician understanding of their risk contracts averaged 3.26, and 48% of survey respondents indicated that some of their physicians were interested in risk contracting and others were not. Nevertheless, 31% reported their physicians were enthusiastic about increasing the member populations in their risk contracts.

Sixty-one percent of the AMGA survey respondents with cap contracts met with physicians at least quarterly to discuss patient management strategies, and 39% provided physicians with at least quarterly detailing of their member populations.

Physicians at Dreyer enjoy the opportunity to apply clinical programs and evaluate outcomes across a managed care population. “It’s not just piecemeal,” Derus says. “It’s not just another 99213 in and out the door or one more arthroscopy on the schedule.

“The nice part about capitation is that, if physicians are engaged, you can look at the population of people you’ve been privileged to care for and try to figure out ways to do it better,” Derus says. “Sometimes it costs more money, and sometimes it costs less. On the whole, we’ve been able to find the sweet spot—become more efficient and improve the care that we deliver.”

Use capitation to diversify reimbursement

Going forward, the opportunity to participate in risk contracting will depend on the availability of health plans that offer these products in local markets, according to the survey respondents. In fact, 43% indicated that payers in their markets didn’t offer risk contracts.

Respondents also cited other barriers to capitation contracting, including:

- Unfavorable contract terms (74%)
- Unwillingness of physicians to accept risk (57%)
- Lack of health plan sophistication in easing contract administration (50%)
- Inadequate panel size for actuarial security (41%)
- Poor historical performance under capitation (40%)

Of organizations with risk arrangements, 37% reported their organizations had difficulty administering risk contracts, citing the following issues:

- Systems limitations (85%)

- Cumbersome referral or prior authorization process (46%)
- Ambiguous contract language (38%)
- Lack of qualified personnel (35%)

In addition, 42% indicated that health plans were unreasonable business partners. The 63% of groups that had no difficulty managing cap contracts cited the use of qualified staff (87%), clearly defined contract language and risk pools (72%), and investments in information technology infrastructure (69%) as their greatest asset and were also more likely to report greater ease in working with payers.

“I wasn’t surprised by the winners, because they’re the ones who have built the infrastructure around [capitation],” Lord says. He cites the relative ambiguity in relationships with payers as an unexpected survey finding.

“We didn’t hear people bash the insurance companies,” Lord says. “Most of our respondents looked at capitation as a solid alternative source of business—one they had learned they could manage pretty well.” The level of infrastructure that groups had built around their cap contracts made the biggest difference in their receptiveness to risk, he says.

In the future, Lord expects groups with experience under capitation to seek MA contracts that allow them to provide care to more severely and chronically ill populations. Follow-up interviews with survey participants suggested a surprisingly high level of interest in capitated MA contracts even among provider groups that don’t participate in risk contracting.

“People are looking ahead five, 10, and 15 years and seeing that the model in healthcare has got to change—essentially, they have to do more with less,” Halverson says.

Although some groups have been less than satisfied with their capitation experience, the prospect of steady PMPM payments is more palatable in an environment in which reimbursement pressures are pummeling providers. “Capitation may be a way to better control their destiny,” Halverson says.

Derus likens having risk contracts in his reimbursement mix to the principle of investment diversification. “If you lock into one payment source, it’s like having your 401(k) in one investment option,” he says.

“I’d rather have some capitation so that, in a down economy, we see some stable reimbursement. We’re protecting our downside, and the revenue’s not bad in an up year either.”

Insurance hassles cost more than \$68,000 per year, but efficient organizations may end up paying less

On average, physicians spend 43 minutes each work-day dealing with insurance-related issues, according to a *Health Affairs* study published in May 2009. That could involve haggling over claims and dealing with insurance-related concerns such as credentialing, authorizations, and formularies.

The byzantine nature of reimbursement may be the primary antagonist, but healthcare organizations are not powerless. Implementing certain practices can save time and money. But first, let's look at the findings.

The Costs to Physician Practices of Interactions with Health Insurance Plans,¹ a study conducted by MGMA, Weil Cornell Medical College, the University of Toronto, and the University of Chicago, found that total staff interaction time systemwide, converted to dollars, equaled \$21–\$31 billion annually—an average of more than \$68,000 per physician per year.

And, perhaps most disturbing, more than 75% of respondents said the costs of interacting with health plans have increased during the past two years. (The full text is available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.28.4.w533/DC1>.)

Physicians—especially primary care physicians—in solo or two-person practices spent significantly more hours interacting with health plans than those in practices with 10 or more doctors.

The study classified interactions with health plans as authorization, formulary, claims and billing, credentialing, contracting, and quality data.

Across practices, physicians and their staffs spent substantially more time on authorization, formularies, claims and billing, and credentialing than they did on submitting or reviewing quality data provided by health plans.

Physicians spend 1.3 hours per week and nursing staffs spend 3.6 hours per physician per week on formulary issues. Primary care physicians spend the most time (1.7 hours weekly) on formulary issues. Physicians and their staffs spend the least amount of time on submitting or reviewing quality data.

Among the other findings:

- On average, physicians spend nearly three hours per week interacting with health plans. PCPs spend significantly more time (3.5 hours per week) than medical specialists (2.6) or surgical specialists (2.1).
- Solo practitioners and their staffs spend up to 50% more time interacting with health plans than did those in larger practices.
- Nursing staff members spend an additional 23 weeks per year per physician interacting with

health plans, whereas clerical staff members spend 44 weeks.

MGMA's position

“Nothing really surprised me; this more or less substantiated what we knew all along,” says **Anders M. Gilberg**, vice president for public and private economic affairs at Englewood, CO-based MGMA.

According to MGMA, the findings are another indicator of the dire need to streamline healthcare administration for physician practices. MGMA offered three suggestions of its own:

- Promulgation of a national health plan identifier regulation by HHS
- Promulgation of national electronic claim attachment regulation
- Standardized machine-readable patient ID cards

(For details, see www.mgma.com/WorkArea/showcontent.aspx?id=28620.)

MGMA says those steps alone could save physician offices nearly \$40 billion over the next 10 years. And they are merely the low-hanging fruit, says Gilberg.

Look inward

Although such systemic changes may increase efficiency and reduce costs, there are still things that can be done at the provider level. The study may generate more ire for insurers, but it should also lead to a little introspection, says **Maria K. Todd, MHA, PhD**,

CEO and managing partner of Global Health Sources, LLC, in Pompano Beach, FL.

The findings should also raise questions about how your organization handles these issues. “What do they get out of the time they spend?” says Todd. The same hours spent by one organization may yield significantly more reimbursements than those spent by another. It’s about spending the time efficiently.

Think strategically and collaboratively

You need a written contracting strategy, says Todd.

“You’ve got to have a managed care strategy,” agrees **Reed Tinsley, CPA, CVA, CFP**, principal at Reed Tinsley & Associates in Houston. Ask, “How do I partner with a payer to manage costs and get rewarded for it?”

Cooperation can pay off, as evidenced by one of Tinsley’s clients, a large otolaryngology practice in North Carolina. The payer was reimbursing \$68 for a nosebleed, whether it was one that could be treated in six minutes or six hours. As a result, many of the more serious cases ended up being referred to the ED.

Tinsley and his client met with the payer and explained that every time a serious nosebleed was referred to the ED, it cost the payer more. They proposed the payer reimburse \$350 for each nosebleed. The provider agreed to meet with the utilization staff quarterly, and if overall costs didn’t go down, payment would revert to the \$68 rate. Costs did go down, Tinsley reports. “It was a win-win-win” for patients, providers, and payers, he says.

Here are a few more tips from our experts to make your dealings with payers less costly and more efficient:

- **Practice prevention.** Try to eliminate unfavorable terms from your managed care contracts, says Todd. You want to have the details spelled out so you aren't disputing the minutiae every day, says Penny Noyes.
- **Identify your cost centers.** Look at the cost drivers for your specialty and then put yourself in the shoes of the payer, Tinsley says.
- **Target items such as procedures and codes that generate problems.** If you find the same things being appealed repeatedly, schedule a meeting with the payer's provider representative and try to resolve those specific issues, Tinsley says. He also offers a second option: "If you know something is going to get

routinely denied, bypass the land of the cubicles and send it directly to utilization review the first time—and include a detailed letter."

- **Develop a payer report card.** Identify which payer cost your organization the most time and money.
- **Get smart, not desperate.** One unintended consequence of the report is that it may send some organizations scrambling for a consultant, regardless of whether he or she is qualified, says Todd. She advises caution before calling in a consultant.

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1. L.P. Casalino, S. Nicholson, D.N. Gans et al. "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive, May 14, 2009.

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