Although you may have heard that capitation and other forms of risk contracting are “dead” or falling out of favor across the United States, don’t believe it for a moment. Here and there, a health maintenance organization (HMO) may be reassessing its commitment to capitation; however nationally, risk contracting is still a hot issue for payers. As reported by Interstudy in its HMO Industry Report 9.2 (1999), 64% of specialists currently receive capitation for one or more Medicare HMO contracts. Only 15% of Medicare HMOs do not do any capitation with their primary care physicians.
At a minimum, it’s clear that for the population most significant to ophthalmology, risk contracting is not something to be dismissed. Nor should you dismiss risk contracting for those younger than 65 years.

To negotiate risk contracts effectively, you must understand how to play the game. Negotiations combine mind-game blending elements of chess, poker, and voodoo. Research, planning, and timing—combined with a little luck and an occasional bluff—create an interesting and challenging process. It’s also essential to have a qualified managed care business advisor and a health care attorney in your corner.

Before any negotiation, you must prepare a carefully crafted issue list divided into these categories: (1) items on which you can (and should) meet in the middle; (2) items you can afford to let slide; (3) deal breakers that must be resolved in your favor or there’s no deal to be signed. You must be very clear on issues falling into the third category.

In the Summer 1999 issue of Administrative Eyecare (pages 21–25), I discussed many problematic issues applicable across various types of provider agreements. Here, and in the next issue, I’ll discuss several “twists” specific to risk contracting you may encounter when reviewing a deal offered by an HMO, an independent provider association (IPA), or through a third-party administrator. Risk contracting—including but certainly not limited to capitation, percentage of premium (POP), episodes of care, and contact capitation—creates a set of concerns distinct from those encountered in fee-for-service arrangements. You can’t afford to be unaware of these issues.

**Percentage of Premium**

No deal is better than a bad deal, and bad deals typically do not get better with time. Percentage of premium makes that painfully clear.

Percentage of premium is an at-risk reimbursement mechanism full of potential problems. Although it’s most often applied to global capitation payments to medical groups or multispecialty IPAs, some HMOs are trying to use POP for single-service specialty contracts. Percentage of premium carries all the risks of tradi-
tional per member, per month (PMPM) capitation plus some “kickers” that allow a payer to unilaterally reduce your payments at any time without your approval. Unless you can negotiate a contract with protections against these kickers, it’s a methodology you should avoid.

Essentially, you agree to accept a POP collected by the payer—that percentage supposedly representing ophthalmology’s share of the payer’s annual plan expenditures. Thus, to provide medical/surgical services, you might be offered “X%” of a Medicare HMO’s revenue from the Health Care Financing Administration (HCFA) or “Y%” of a commercial plan’s premiums to provide routine vision examinations. Ideally, the payer presents you with historic data to substantiate that the payment it proposes accurately represents vision or eyecare’s percentage share of the total health care premiums. You are then at risk for all specified services.

Problems with POP Contracts
Often, a payer doesn’t or won’t provide appropriate historic data. Even if it does provide good data, that’s only OK until the payer’s marketing department decides it’s time to buy market share by lowering premiums charged to employers.

For example, if you were receiving 2% of a $200 per month premium (i.e., $4 per covered life) and the marketing department drops the premium by 5% to $190, your compensation would automatically drop the same 5% to $3.80. (These numbers are for explanatory purposes only.)

You have done nothing wrong. The practice may have done a superb job managing utilization, controlling costs, and achieving high levels of patient satisfaction. But without protections in your POP contract, you have no say in the matter, and must take your lumps.

In addition, you may not be able to confirm that you’re being paid properly under a POP contract. Health maintenance organizations are required to file their premium rates with the Department of Insurance. Thus, you can determine the rates an HMO has announced. But health plans don’t have to charge that amount, and they’re not always obligated to reveal the rates they’ve negotiated with an individual employer. Thus, unless you have a contractual stipulation stating that the HMO must open its books to substantiate individual premium rates used in POP calculations, the HMO may be able to say “trust us.” And, you may have no recourse.

Let’s say that at the start, your POP contract paid $1 per covered life for a plan’s 65,000 lives. You then get a letter stating that some new companies have been added and certain established accounts have renegotiated their premiums. Your next statement shows you’re receiving $1 per life on 61,500 lives, $.83 per life on 19,000 lives, and $.96 per life on 800 lives.

The $.04 reduction on just 800 lives is really no big deal—the total dollars are few. But there has been a huge population increase overall (approximately 15,000 lives), and a large part of that increase is coming to you at a drastically reduced rate (~17%). Over a year’s time, that adds up to quite a few dollars.

Along with that revenue (premium) decrease, you should not be surprised to see a utilization increase because these patients now have access to less-expensive care. Assume in this case it’s access to a routine vision examination (i.e., the patient does not have to be sick to obtain the service). The adverse effects of the increased utilization played against premiums lower than initially negotiated are obvious.

But there’s another particularly nasty surprise for many who sign POP agreements. You may negotiate a rate thinking you’ll receive a percentage of the actual premium only to find that the amount you are paid is a percentage of the money left after the plan has deducted certain expenses. That is, you’re expecting a percentage of the gross premium.

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but the plan pays you a percentage of the net. And who likely decides what expenses are applied to determine the net? The payer, of course.

Can a payer do this? Without a contractual provision prohibiting it, probably yes. And how does that play out? Let’s see.

Assume that you negotiate for 5.5% of an HMO’s premium, but the plan deducts 15% from the gross premium to cover its expenses—marketing, commissions, funds for risk reserve pools, and whatever else it wants. You end up with 5.5% of 85%—not quite the deal you thought.

So, if you are to get involved in any POP contract, make sure the document specifies you’ll be paid a percentage of the gross premium. If the payer won’t agree to that, the agreement must be negotiated to state in great specificity which expenses can be applied against the gross before your percentage is calculated. You would also need some limits on those specified expenses to prevent unreasonable withering of the net.

**Suggestion: Proceed with Caution**

I encourage you to avoid POP contracts. They are driven by factors outside your control and are too risky, particularly in highly competitive times when health plan marketing departments are in fierce battles for new members. Although premiums are increasing for the first time in many years, that’s not a reason to think that reimbursements are ramping-up. Nobody should be surprised to learn that double-digit premium increases charged to employers this year are not being passed down to providers.

However, if a POP contract is offered, if that contract has significant potential value to your practice, and if you can get protections written into the document covering problematic issues, including those mentioned, it might be worth considering.

Note that commercial POP agreements have more built-in risk than those with Medicare HMOs. The commercial HMO can lower its rates essentially at will, while HCFA sets Medicare HMO rates annually.

**Subrogation**

“Subro what?” If you asked 20 ophthalmologists or administrators what subrogation means and to explain how it might affect an at-risk practice, group, or network’s financial performance, I suspect you’d find most would not know. That’s a shame, for in certain circumstances, having the right contractual language could mean thousands of dollars to ophthalmologists in an at-risk arrangement.

Subrogation is a little-understood provision in most managed care provider agreements and in those between payers and patients. It is a means by which health plans can recover some or all of their costs for a member’s care from money paid to that person by a third party.

For example, assume HMO member and golfer Ed Jones is hurt when struck by a golf cart. An HMO pays a physician for Ed’s care. Subsequently, Ed receives a financial settlement in a lawsuit against the golf course. The HMO can then collect from Ed’s settlement to cover its outlay for his care.

That’s subrogation. It’s standard fare in the contract each subscriber signs when enrolling in a managed care plan. The member agrees that the health plan can take its recovery off the top of any award or payment to the member.

**How Health Plans Involve You in Subrogation**

Health plans write subrogation language into provider agreements to obligate providers to assist payers in their recovery efforts against members. Typically, physician involvement means little more than supplying records. If you look at your managed care provider agreements, you’ll probably find “subrogation” in a section by itself or included under “coordination of benefits,” although subrogation is quite distinct from the latter.

If you’re a fee-for-service provider and an HMO has paid you for a patient’s care, you’re covered. Subrogation means nothing financially to your practice, and your cooperation in supplying records simply helps the plan recover what it’s legally entitled to. After all, the plan was at risk for the patient’s care, and it took the financial “hit.”
The “Twist”: When the Physician, Group, or Network Is at Risk

However, if you’re working under a risk agreement (e.g., paid only a nominal PMPM capitation fee or, perhaps, a case rate), you—not the plan—take any “hit.” And you, not the plan, should be entitled to subrogation recovery rights, which could amount to hundreds or thousands of dollars. Subrogation is not a financial recovery mechanism reserved exclusively for health plans. It may also be available to providers, but only if they know to ask.

You should not miss any legal opportunity to collect revenues in addition to at-risk payments. Therefore, it’s essential to secure subrogation recovery rights in your provider agreement. If you don’t and the plan retains the rights, it can collect and keep all the money recovered from third parties, pocketing a handsome, undeserved bonus. Let’s look at an example of how subrogation can affect a practice in an at-risk arrangement.

Health maintenance organization member John Wilson presents with an eye injury. He fell at an amusement park and struck his face against a hot-dog cart. The examination shows corneal and scleral abrasions, and you suspect a possible orbital fracture. You treat what you can and send Mr. Wilson for a radiology consultation, which confirms the fracture. Over the next several weeks, the patient sees you several more times and also receives care from two providers at another facility. His care costs amount to several thousand dollars.

Assume that payments to all physicians and to the diagnostic imaging center come from your monthly capitation. Your group’s risk budget takes a significant financial “hit.” That’s not fun, but it’s understood. You accepted that as a risk when you signed the capitation contract. You assume that’s the end of Mr. Wilson’s saga.

Later, you learn that Mr. Wilson was working when injured; he was the vendor pushing the hot-dog cart. This changes the situation because Wilson’s injury was probably covered, at least in part, by workers’ compensation. Recoveries from the state workers’ compensation fund may be available to the party holding subrogation rights.

You learn about this possibility and check the provider agreement. You discover that you did not secure subrogation rights against patient recoveries. The HMO still retains those rights, and so it will pocket any cash recovered from the state fund. In fact, the HMO makes money twice—first from the margin it carved off the top of the premium before passing the capitated risk to you and second, in the windfall recovery from the state. In that windfall is the rudest surprise of all.

Too often, practices learn after the fact how potentially valuable subrogation rights can be. What can you do to avoid being left out?

Suggestion: Investigate and Ask

Ask your attorney to draft contractual language that you’ll present to the plan that transfers comprehensive subrogation rights against the member from the plan to you. Any transfer of subrogation rights is subject to limitations or considerations imposed by individual state law. For example, “hold harmless” provisions or other state-specific matters may preclude your right to pursue compensation in addition to at-risk payments.

Ideally, you want exclusive recovery rights for any services you provide or fund. You also want to include carefully drafted language that protects you in an action initiated by an irate patient who doesn’t understand why you’re seeking financial recovery against him or her. After all, as far as the patient knows, you’ve already been paid by the health plan.

Co-payments: Part 1

When most providers and administrators discuss co-payments, they’re thinking in terms of revenue in addition to payments received from a health plan. So, for example, a practice might contract to receive $45 for a certain service. When combined with a $10 co-payment from the patient, that makes total reimbursement $55. If the front office
staff forgets to collect the co-payment, the practice gets only $45. That is simple enough in fee-for-service agreements.

But it’s not always so simple with capitated agreements. If not careful, you could find your practice or group locked into an agreement that, in effect, assesses you a “penalty” each time a patient presents for service! This financial surprise begins with an innocently worded paragraph in the provider agreement:

**Capitation Payments**
On or before the 20th of each month, Physician shall receive an amount equal to the applicable monthly capitation rate adjusted for Co-payments and/or Co-insurance as shown below for each Participant in Physician’s Patient Panel.

The second half of the financial trap is contained in another paragraph, probably on another page, usually worded something along these lines:

**Encounter Data**
Physician shall provide the health plan with encounter data on a timely basis showing all services provided to each Participant for whom Physician receives Capitation Payments. Such encounter data shall be submitted in a format acceptable to the health plan within forty-five (45) days after the date services were rendered.

**The Financial Trap and Deadly “Penalty”**
The key words in the first paragraph are “adjusted for Co-payments.” The key words in the second paragraph are—the entire paragraph!

In signing an agreement with these provisions included, you’re agreeing to provide an on-going detailed list of each patient encounter every month. And you’re agreeing that the plan can deduct an amount (“adjusted”) equal to the patient co-payment multiplied by the number of patient encounters each month.

For example, if the co-payment is $10 and plan members accessed your network 350 times during the month, your next capitation check will be reduced by $3,500. To make the situation worse, let’s assume that your front-office staff forgot to collect (or unwisely waived) co-payments for 25 of those patient visits. Not only did your network lose that $250, but you’re also hit for $10 on each of those 25 encounters based on a health plan’s assumption that your staff did collect the money. It’s a double whammy, but one easily avoided.

**Suggestion: Specificity Is Key**
Before submitting any bid or considering any payer’s offer, be certain to clarify whether the health plan defines risk reimbursement in addition to or net of co-payments. Then, you’ll have the proper reference from which to analyze the financial sense of any deal.

If the plan tells you that co-payments will be deducted from reimbursements, your capitation rate (or other form of fixed payment) must be adjusted upward by an amount exactly offsetting the patient’s co-payment. It ends up a financial “wash” for payer and provider if done properly; if not, you’re short-changed that amount on every patient seen.

Try to avoid a co-payment “adjustment” provision in provider agreements. It compounds the negative financial impact of any co-payments not collected by front-office staff (a double loss). It also imposes an extra administrative burden on your staff; that is, reconciling your monthly utilization report against the plan’s co-payment deduction report. Your staff’s time is too valuable to allocate to this, yet it’s necessary if co-payment adjustments are part of the contract.

Ideally, you want exclusive recovery rights for any services you provide or fund.
Contracts written with co-payment adjustments typically are not round-about means for health plans to take back money from providers. Rather, the health plan is working on the mistaken assumption that the capitation rate agreed to or bid on by a provider accounts for the co-payment adjustment. Unfortunately, the provider probably did not make that same assumption. As a result of the miscommunication, everybody has problems once the contract takes effect.

Co-payments, Benefits, and Populations: Part 2

Co-payments are first-dollar contributions from a patient toward the cost of his or her care. In theory, the co-payment is supposed to reduce utilization by putting a financial cost factor (a barrier) in the patient’s mind. I think the theory often falls flat with medical/surgical eyecare, and it certainly doesn’t hold with routine vision care in which the patient has no psychological or physiological predisposition against seeing the eye doctor (especially if there’s the tangible “carrot” of eyeglasses or contact lenses at the end of the visit). So adding a $5 or $10 co-payment is not going to keep a meaningful number of patients from coming to you for that highly valued eye examination.

But a health plan can turn a capitated deal on its head, increasing your utilization and costs, if it lowers the co-payment but doesn’t increase your capitation rate at the same time. For example, assume you’ve been seeing a plan’s patients and collecting $10 co-payments. Then the HMO signs on a new, large employer, attracting it by offering $0 co-payment vision care and promoting the benefit to new members as “free eye exams.”

You’re certain to see a utilization spike brought about by the effects of a new population and a new benefit combined with the plan’s high-profile promotion of “free.” Your existing capitation rate, based on expected (historical) utilization and a $10 co-payment, may not cover your costs, and these patients will certainly exert a negative impact on your bottom line.

If your practice is added to a new product line introduced by a payer, the same problems can occur. For example, you’re contracted to provide an HMO benefit for medical/surgical care at a $10 co-payment. The plan creates a new point-of-service (POS) option and adds your practice to that panel; for example, as Aetna can and does do in many states with its “all-or-nothing” contacting policy. If the plan does not raise the co-payment to account for the increased utilization sure to occur when patients get more provider choice in the POS option, the financial picture may no longer make sense.

Suggestion: Multiple Rates for Multiple Co-payments, Benefits, and Products

This is a no-brainer. Accept no blended capitation rates! Every co-payment should create a unique reimbursement rate. Every insurance product (e.g., HMO, PPO, POS) should have its own rate. Medicare, commercial, and Medicaid products should all have their own rates. Don’t allow any plan to dump diverse benefits or patient populations into a collective (blended) capitation reimbursement pool; the utilization and cost factors are too disparate.

You must also negotiate a provision in your agreement that if a plan changes benefits or co-payments or if it adds new products, your services to the patients affected are subject to rate renegotiation retroactive to the implementation of the new benefit, co-payment, or product. If you do not demand separate rates for each co-payment, benefit, or insurance product, you’re looking for trouble.

Final Thoughts

Will health plans agree to the suggestions I’ve made? As with everything else in managed care, the answer is that it depends. Some plans are reasonable and willing to make the negotiation process a cooperative, win–win arrangement. Others just don’t care and would happily drop you in exchange for another provider who will take the deal, no matter how flawed.

You must be on guard and ask for what you want. Health plans will not volunteer anything, especially in a risk agreement. Never forget that the payer’s intent in risk contracting is to transfer the risk and hassle from the plan to the provider.

And remember: No deal is better than a bad deal. And bad deals typically do not get better with time.

In the next issue of Administrative Eyecare, I’ll cover more special issues for at-risk provider agreements. Until then, carpe diem. AE

Gil Weber, MBA, is an ophthalmic practice management, managed vision, and eyecare consultant based in Davie, Florida. Telephone: 954-915-6771; e-mail: gil@gilweber.com; web site: www.gilweber.com.

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