Changing Or Eliminating A Poorly Performing Provider Agreement

A recent inquiry from a practice makes the timing right to resurrect here an issue I first discussed in ophthalmology more than 20 years ago. If a practice or facility finds that it's in a poorly performing deal what not-so-obvious issues might come up in efforts to change or eliminate it? And how might apparently desirable changes actually end up with a practice or facility facing unexpected complications?

Look before you leap. Switching from capitation to fee-for-service

A few years back a practice approached me to discuss its capitated arrangement that had been in place for awhile. The physicians seemed to understand the realities of capitation and how to manage an at-risk patient population. Utilization seemed to have been line with what was expected, and satisfaction surveys indicated that the patients were happy with their care. Perhaps most significantly the patient load from this capitated plan didn't displace large numbers of patients from better paying plans.

The problem, and inevitably this problem, was after "going with the flow" the practice finally realized that the capitation rate was just too low, even though it was typical for the area. And it had not been adjusted for some time.

When staff ran some numbers they found that the cap rate now was equating to only a little more than 40% of current year Medicare Allowable. (Yes! 40%) Clearly, the compensation structure of this old contract needed to be changed.

Coming up with a more practice-friendly proposal was essential. New numbers were crunched based on recent utilization, current costs, demographic shifts, newly added Covered Services, adjustments to Medicare Allowables, and other factors different from those when the cap rates were set years ago.

The physicians asked for a compensation arrangement that would pay no less than twice the current cap rate and would exclude (carve-out) a few surgeries that would be paid according to a negotiated fee-for-service schedule. The proposal was a substantial departure from that which had been in place, but the physicians were willing to stand firm and drop the contract if the payor wouldn't make significant adjustments in order to continue with capitation.

Alternatively they proposed that the agreement instead convert to fee-for-service. This fall-back position to convert the deal to fee-for-service seemed at first glance to be an ideal and simple solution to the practice's financial woes. Just dump capitation and all its worries. But it became clear that simply turning off the capitation spigot one day and turning on fee-for-service the next could have unexpected consequences.

How? Why?

Conversion consequences

When a capitation contract converts to fee-for-service there will be a significant and immediate cash flow disruption -- one that could go on for several months. Under capitation one should receive prospective payment(s) each month for each covered population, this without having to wait for claims to be processed. But upon conversion that steady and guaranteed revenue stream ends.

Assume a capitated arrangement is set to convert on January 1st. The cap checks stop with the December payment and you begin sending in claims. Depending on how often claims are submitted and how quickly and accurately a payor processes those claims it could be several weeks (months?) before the dollars once again start flowing **steadily** on that patient population.

Meanwhile the practice has its on-going expenses for the care of those patients and for the office in general. And when contracted on a fee-for-service basis staff has to deal with more paperwork -- referrals, prior authorizations, tracking a new category of receivables, and so forth – administrative “hassle” that staff should not have to deal with, or to a much lesser extent, under capitation. These and other financial and administrative matters could be problematic for as long as it takes things to settle down.

If negotiations seemed headed in the direction of abandoning capitation then to minimize this potential fee-for-service cash flow problem the physicians also asked for an advance equal to one or two months' anticipated claims exposure based on historical utilization numbers. The practice would agree to pay that money back gradually over several months so that the cash flow transition would be disrupted as little as possible. The proposed arrangement was logical and financially sound for both sides.

The devil was in the details, of course.

It took a lot of determination from the practice. And, this was critical, the process required flexibility from the payor and recognition that, in the long term and all things considered, it was better off with **this** practice in-network under a hybrid plan than to say “*No*” and lose the deal entirely.

Indeed, this was a very unusual arrangement that required both sides to think way outside the traditional box. But the lesson here is if you have the opportunity to dump a capitated contract be certain that you've thought it through and are prepared financially and administratively for transitional factors. It's not a simple matter of turning off one spigot and turning on another.