CAPG April Symposium

Capitated Risk Contracts: Must-Have Provisions

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The Voice of Accountable Physician Groups

Introduction

- This presentation covers some of the key provisions found in a professional services capitated health plan agreement with a physician organization for
  - Commercial
  - Medicare Advantage
- This presentation follows the general construction of a capitation agreement

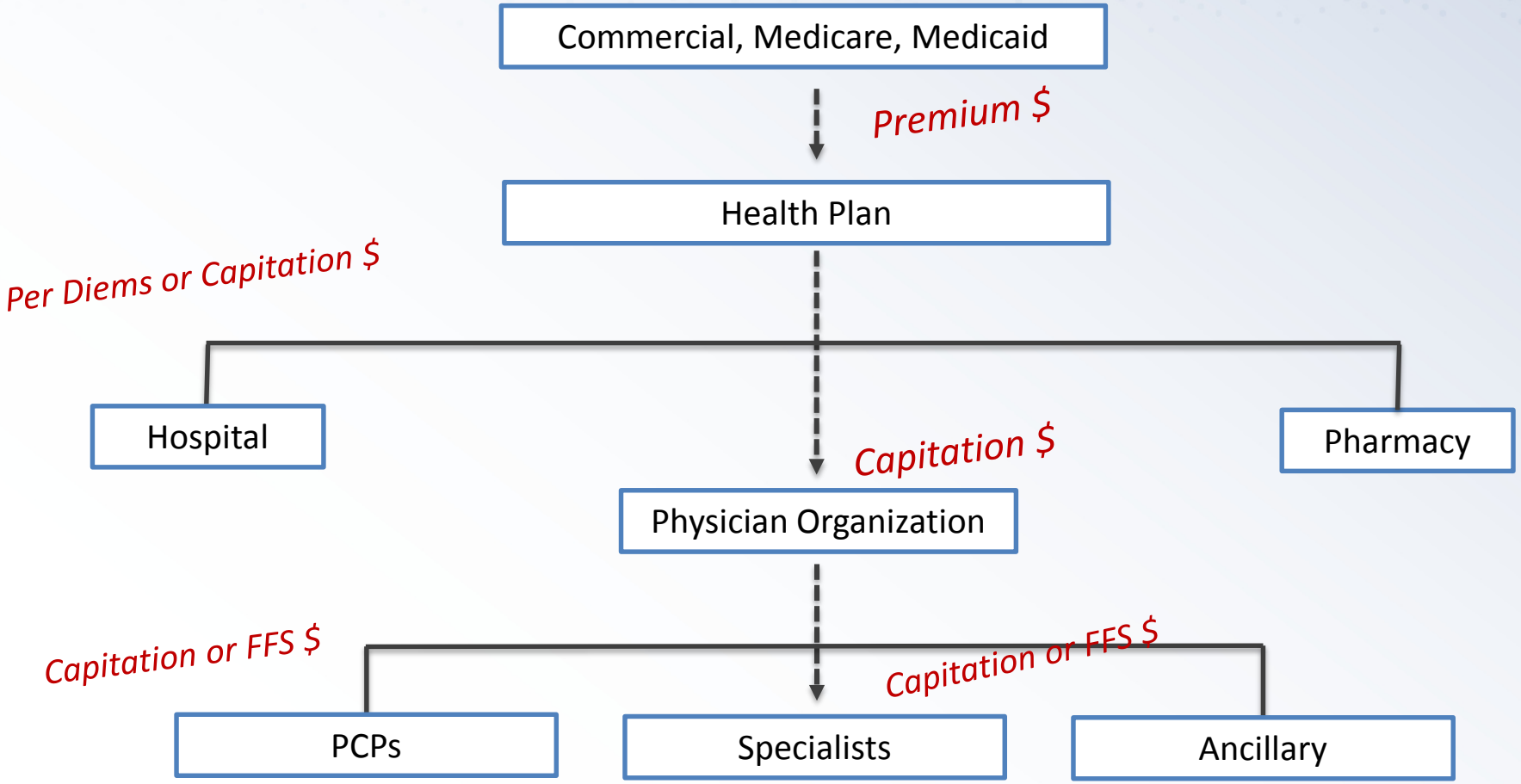
Types of Reimbursement

- Retrospective Reimbursement
  - Reimbursement is made after services are provided
  - Fee-for-service (FFS)
- Cost-Based Reimbursement
  - Reimbursement based on allowed rates
  - FQHC, Critical Access Hospitals
- Prospective Reimbursement
  - Reimbursement in advance of the delivery of services
  - DRG
  - Global Payment / Case Rate
  - Capitation

What is Capitation?

- A method of payment for medical services for which a physician organization is paid a fixed amount, normally a per member per month (PMPM) amount, regardless of the quantity or type of medical services provided to the member.
- Capitation is
  - Prospective reimbursement
  - A method of spreading risk over a population
  - A budgeting tool
  - A management tool
  - A belief system

Flow of Funds



Risk Contracting Considerations

- The Pros and Cons
  - Budget
  - Cash Flow
  - Triple Aim
- Risk Readiness Assessment
  - Financial
  - Operational

Risk Contracting Considerations (con't)

- Assessing Health Plans for Risk Contracting
- Business Risk
- Insurance Risk

Articles of Agreement

- Definitions
- Physician Organization Obligations
- Health Plan Obligations
- Delegated Responsibilities
- Compensation
- Term and Termination
- General Provisions
- Governing Law and Regulatory Requirement

Definitions

- Allowed Rates
  - The valuation of Covered Services provided or arranged by Physician Organization.
- Authorization
  - Is the procedure for obtaining the prior approval of the Health Plan, or the Physician Organization if delegated for medical management, for the provision or referral of Covered Services.
- Corrective Action Plan
- Covered Services
- Division of Financial Responsibility (DOFR)

Definitions (con't)

- Emergency Services
- Fee for Service Agreement
- Members
- Service Area
  - "is that aggregate geographic area determined by and located within a thirty (30) mile radius from the Physician Organization's designated participating hospital(s) and including all zip codes containing a participating PCP facility. A PCP facility refers to the Physician Organization's principal and satellite offices, if a medical group, and to the offices of each of its contracted or employed PCPs, if an IPA or medical foundation."
  - Specific zip codes are listed in an exhibit
- Medically Necessary

Definitions (con’t)

- Participating Provider
- Premium
- Primary Care Physician (PCP)
  - Primary Care Physician is any of Physician Organization's Participating Providers who meet Health Plan's criteria for providing initial and primary care Covered Services to Physician Organization Members, for maintaining the continuity of patient care, and for initiating and coordinating referrals for Covered Services to Physician Organization Members.
- Provider Manual

Definitions (con't)

- Reciprocity Rate, payments made by
  - Health Plan to Physician Organization
  - Other Capitated Providers to Physician Organization
  - Physician Organization to Other Providers
  - Normally, at the Allowed Rates
- Referral Services
- Employer Group Agreement and Evidence of Coverage
  - Employer Group Agreement and Evidence of Coverage are the Health Plan documents that describe the costs, benefits or services, procedures, conditions, limitations, exclusions, and other obligations to which Members are entitled to under a managed care plan. A copy of a current Employer Group Agreement and Evidence of Coverage for each managed care plan shall be provided upon request to Physician Organization.
- Member
- Urgently Needed Services

Medicare Advantage Definitions

- CMS Agreement
- Medicare Advantage Plan
- Medicare Advantage Members
- Monthly CMS Payment to the Health Plan
- Medicare Advantage Revenue to the Physician Organization
  - Net Medicare Revenue

Physician Organization Obligations

- Provide or Arrange Covered Services
  - Physician Organization, through its Participating Providers, shall provide or arrange Covered Services in the Physician Organization Service Area to Physician Organization Members, in coordination with Health Plan and Health Plan's Participating Providers and in accordance with the terms and conditions set forth in this Agreement. Physician Organization shall be financially responsible for Physician Organization Services.
- Professional Standards
  - Professional Standards. All Covered Services provided or arranged by Physician Organization shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in a culturally competent manner and at physical facilities in accordance with (i) the generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment, (ii) the provisions of Health Plan's Quality Improvement Program and Medical Management Program, (iii) the requirements of State and Federal Law and (iv) the standards of Accreditation Organizations.

Physician Organization Obligations (con't)

- Physician Organization Licensure/Registration (if any)
  - Physician Organization is legally organized and incorporated under the laws of the State of (indicate state). Physician Organization shall maintain in good standing at all times during the term of this Agreement any and all licenses, certificates and/or approvals required under State and Federal Law for the performance by Physician Organization of the duties required by this Agreement. Physician Organization shall notify Health Plan upon receiving any notice from any entity with the regulatory or contractual authority to audit Physician Organization relating to compliance with applicable law, including, without limitation, notices of medical surveys or financial audits.
- Physician Organization's Participating Providers Licensure
  - Each of Physician Organization's Participating Providers shall maintain in good standing at all times during the term of this Agreement the necessary licenses or certifications required by State and Federal Law to provide or arrange Covered Services to Physician Organization Members.

Physician Organization Obligations (con't)

- Physician Organization's Participating Providers Information
  - Physician Organization shall provide Health Plan with a complete list of its Participating Providers, together with the provider specific information required by Health Plan for credentialing and for administration.
- Physician Organization's Participating Providers Additions
  - Physician Organization shall use its best efforts to provide at least sixty (60) calendar days prior written notice to Health Plan of the addition of any Participating Providers. Such notice shall include the provider-specific information required by Health Plan.

Physician Organization Obligations (con't)

- Physician Organization's Participating Providers Terminations
  - Physician Organization shall provide ninety (90) calendar days prior written notice to Health Plan of the termination of any of its Participating Providers; provided, however, that if any Participating Providers are terminated with less than ninety (90) calendar days notice, then Physician Organization shall provide written notice to Health Plan within five (5) business days of Physician Organization becoming aware of such termination.

Physician Organization Obligations (con't)

- Physician Organization's Subcontracts with Participating Providers
  - Physician Organization shall demonstrate and certify to Health Plan prior to the Commencement Date and upon Health Plan's written request at any time during the term of this Agreement (in the format specified by Health Plan) that its subcontracts with Participating providers comply with requirements of this Agreement.
- Acceptance and Transfer of Members
  - Physician Organization shall accept all Members who select or who are assigned to Physician Organization and who live or work within the Physician Organization Service Area.

Physician Organization Obligations (con't)

- Encounter Data
  - Physician Organization shall maintain and provide to Health Plan, no later than the fifteenth (15th) day of each month, (i) the utilization data pertaining to Covered Services which are provided directly by Physician Organization and its Participating Providers and (ii) the utilization data pertaining to Covered Services which are paid for by Physician Organization during the preceding month, including data not provided in the most recent submission.

Physician Organization Obligations (con't)

- Right to Re-Assign Members
  - Health Plan reserves the right to re-assign Members from Physician Organization to another physician organization, or to limit or deny the assignment or selection of new Members to Physician Organization or Physician Organization Participating Provider: (i) during any termination notice period; or (ii) if the Health Plan determines that Covered Services are not being properly provided to, or arranged for, such Members as required by this Agreement and that such failure poses an immediate threat to the Members health and safety.

Physician Organization Obligations (con't)

- Termination of the Physician/Patient Relationship
  - Provider Organization or Participating Provider may terminate the professional relationship with a member with Health Plan's consent and in accordance with the procedures set forth in the Provider Manual.

Health Plan Obligations

- Marketing
- Enrollment and Assignment of Members
- Eligibility
  - Verification of Eligibility
  - Print Identification Cards
  - Maintain Eligibility Lists

Health Plan Obligations (con't)

- Administration and Provision of Data
- Provider Manual
- Benefit Design and Interpretation: Coverage Decisions

Health Plan Obligation (con't)

- Case Management
- Carve-Out Program Management
- Out-of-Area Medical Services Management
  - Health Plan shall manage and coordinate Out-of-Area Medical Services. Health Plan, in conjunction with Physician Organization, shall make all decisions regarding the duration of a Members care at the Out-of-Area provider and transfer of the Member to a Physician Organization Service Area provider.

Delegated Responsibility

- Medical Management
- Credentialing
- Claims Processing
- Delegated services detailed in exhibits
- Payment for delegated activities

Compensation

- Capitated Professional Services
- Capitation Payments
- Carve out (Non-Capitated) Compensation
- Co-Payments
- Retroactive adjustments
- Eligibility Guarantee
- Low Enrollment Protection

Compensation (con't)

- Incentive Programs
  - Withholds
  - Hospital Incentive Program
  - Pharmacy Incentive Program
- Individual Stop Loss
  - Professional Services

Compensation (con’t)

- Collections of Copayments
- Collection of Charges from Third Parties (TPL)
- Coordination of Benefits (COB)
- Eligibility Verification and Protection

Term and Termination

- Term
- Termination of Agreement with Cause
- Termination of Agreement without Cause
- Notice of Cure Period
- Term with Intent to Renew

General Provisions

- Independent Contractor Relationship
- Member Appeals and Grievances
- Disputes Between Physician Organization or Its Participating Providers and Members
- Disputes Between Heath Plan and Physician Organization
- Assignment

General Provisions (con't)

- Amendments
  - Amendments or Modifications to Agreement
  - Amendments to Provider Manual
- Solicitation of Health Plan Members or Subscriber Groups

Governing Law and Regulatory Requirements

- Governing Law
- No Billing of Members (Member Hold Harmless Provision)

Attachments/Exhibits

- One for Each Product, with Specific
  - Definitions
  - Responsibilities
  - Compensation
- Delegated Responsibilities
- Division of Financial Responsibility (DOFR)

Attachments/Exhibits (con't)

- Commercial Capitation
  - Base capitation
    - Per Member Per Month (PMPM)
  - Adjusted by
    - Age
    - Gender
    - Benefit plan

	Age/Sex
	Adjustment
Member	Factor
Female 18-19	0.5591
Male 30-34	0.3977
	Office Visit
Office Visit	Copay
Copay	Factor
$10	1.012
$15	0.961

Attachments/Exhibits (con't)

- Medicare Advantage Capitation
  - Percent of premium received by the health plan
  - Gross CMS Revenue, Parts A and B (Part D is separate)
  - Net CMS Revenue, defined by the Health Plan

Attachments/Exhibits (con't)

- Delegation Grids (con't)
  - Medical Management

Function	Delegated PO Responsibility/Performance Measure	Reporting Frequency	Health Plan Oversight
Case Management	Develop and document program to perform Case Management function meeting all regulatory and Health Plan standards	No less than quarterly	-Initial onsite assessment -Annual oversight assessment

Attachment/Exhibits (con't)

- Delegation Grids
  - Credentialing

Function	Delegated PO Responsibility/Performance Measure	Reporting Frequency	Health Plan Oversight
Primary source verification of credentialing information	Full compliance with NCQA Standards regarding verification of information within 180 days prior to committee approval date.	Quarterly	-Initial onsite assessment -Annual oversight assessment

Attachments/Exhibit (con't)

- Delegation Grids (con't)
  - Claims Processing

Function	Delegated PO Responsibility/Performance Measure	Reporting Frequency	Health Plan Oversight
Staffing	Staffing sufficient to support claims volume and processing timeliness requirements including: - Staffing levels - Customer Service capabilities - Past experience for claims resolution -Staff available to answer / claims questions during normal hours of operation	N/A	-Initial onsite assessment utilizing approved oversight tool. - Annual oversight assessment utilizing approved oversight tool. - Additional onsite reviews as warranted by the plan utilizing approved oversight tool. - Implementation of Corrective Action Plan(s) for elements of non-compliance.

Attachments/Exhibits (con't)

- Health Plan Allowed Rates for non-capitated services
  - Commercial
    - Percent of Medicare, or
    - Percent of Health Plan Fee Schedule
  - Medicare Advantage
    - Percent of Medicare

Attachments/Exhibits (con't)

- Division of Financial Responsibility (DOFR)
  - Service categories (rows) are services provided to the health plan members assigned to the physician organization
  - Financial responsibility (columns) identifies which party pays for each service category
  - Webinar
    - The Division of Financial Responsibility: Protecting a Physician Organizations' Economic Interests
    - http://capg.org/index.aspx?page=20&recordid=1081

Attachments/Exhibits (con't)

- Division of Financial Responsibility (DOFR)
  - Service categories and financial responsibility are specific to place-of-service, one example is emergency professional services
    - In-area is the financial responsibility of the physician organization
    - Out-of-area is the financial responsibility of the health plan
  - Financially responsible party; who pays the claim
    - Physician organization; pays the claim
    - Hospital Incentive Program or Shared Risk, physician organization and health plan share financial responsibility; health plan pays the claim
    - Health plan; pays the claim

Attachments/Exhibits (con't)

- Division of Financial Responsibility

		Hospital	
Service	Physician	Incentive	Health
Category	Organization	Program	Plan
Emergency Room, OP Facility		X	
Hospital Services, IP Facility			X
Physician Services, IP&OP Professional	X		

Risk Contracting Considerations

- The Pros and Cons
  - Budget
  - Cash Flow
  - Triple Aim
- Risk Readiness Assessment
  - Financial
  - Operational
- Business Risk
- Insurance Risk

Questions and Answers

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End

Summary

- Articles of Agreement
  - Definitions
  - Physician Organization Obligations
  - Health Plan Obligations
  - Delegated Responsibilities
  - Compensation
  - Term and Termination
  - General Provisions
  - Governing Law and Regulatory Requirement
- Attachments/Exhibits
  - Lines-of-business with compensation
  - Delegation Grids
  - Division of Financial Responsibility (DOFR)