FULCRUM STRATEGIES
SUPERIOR PROVIDER ADVOCATES
CELEBRATING 15 YEARS

FULCRUM NEWSLETTER

AUGUST 2020

Capitation: The "C" Word

By Ronald Howrigon, President & CEO

For years, if not decades, we have been hearing about healthcare reimbursement transitioning from a fee for service system to a value-based system. Until recently, these predictions were much like the song "tomorrow" from the movie Annie, where tomorrow is "always a day away." Oddly enough, it may be the Covid-19 pandemic that creates the catalyst to make tomorrow, today.

Recently BlueCross BlueShield of North Carolina announced a new program called "Accelerate to Value." This program will provide independent primary care practices with additional funding to replace the revenue lost during the Covid-19 crisis. To receive this money, the group must stay independent, join one of four approved ACOs, and consider a capitation contract next year.

For many physicians, the use of the "C" word causes a great deal of trepidation. They get worried that capitation is just a slick way for payers to trick providers into accepting less money for the services they provide.

Let me begin by saying that being skeptical of anything coming from a payer is always a good thing. That being said, not everything they do is bad, and in this case it isn't.

Capitation is a tool. Nothing more, nothing less. Like any tool its value and effectiveness lie with the skill of the person using the tool rather than the tool itself. A scalpel in the hands of a gifted surgeon can save lives. That same scalpel given to a child will result in someone getting hurt.

Capitation, as well as other forms of value-based reimbursement, is designed to help fix one of the fundamental economic flaws of our health care system; a flaw that contributes to our problem of health care hyperinflation in this country. You see, our current fee for service system pays doctors to treat illness, injury and disease. It does not pay doctors very well to keep people healthy or help them avoid illness and disease. Capitation reverses this and pays doctors to keep people healthy. For example, things like imaging go from being revenue sources to expense centers. Under capitation, the most profitable patient is the patient that is healthy and stays healthy. From a philosophical standpoint, most doctors would love to be paid for keeping people healthy rather than only being paid when treating an illness or disease.

The benefit or harm that a capitation contract can have on a practice is determined by the details of the agreement. These details can be complicated and are the key to determining how these agreements function. How do I know this? Well, I negotiated my first capitation contract almost 30 years ago. I have negotiated single specialty, PCP, hospital and full delivery system cap agreements. Most of these I negotiated while working for insurance companies. Some of these agreements worked very well for both parties, including the providers on the other side of the agreement. Some of them were financially devastating. I negotiated and managed one such agreement that went so poorly that the hospital system actually paid the insurance company for the pleasure of treating its members. I'm not kidding. The cap contract was so bad that after paying for leakage to other hospitals, the cap pool had a negative balance, so the hospital had to send a check to the insurance company to cover the deficit. That's how bad these things can get. On the other side of the spectrum was a single specialty cap contract that performed so well for the physician group that their revenue was actually higher than the full billed charges for the services

they provided. While these are the extremes, it does point out the variability of these agreements. So how does a medical group ensure that the contract they enter into is beneficial? The key lies in three areas.

1. Understand the data. You have to be able to compare the revenue from capitation to the revenue that the old fee for service agreement would have produced. This will allow the group to figure out if they are starting out even, ahead, or behind.
2. Understand the way the cap works. If you have seen one cap agreement, then you have seen one cap agreement. They are all different and they all have different provisions. Understanding how they work is key to being successful under these new payment models.
3. Manage your group's performance. Working under a cap environment is in many ways similar to managing under a fee for service agreement. Groups have developed very good systems and reporting to measure physician production under fee for service agreements. This is because production is king in a fee for service world. In a capitation environment, you need to develop new tools and reporting to manage individual performance under these agreements. If excessive imaging is a cost center under a capitation agreement, you need to be able to measure and manage any over utilization of imaging by the physicians in your group.

Groups that are able to effectively handle these three things, can and are very successful in a cap environment. Those that can't or don't, are likely to fare very poorly.

New payment models, like capitation, have been predicted for years. For many physicians, this was always a future problem that didn't need to be addressed right away. Well, the future is now. It's time to get started. Your ability to transition to these new payment models will either secure your future or eliminate it.

From the CFO Desk:
A Gentle Reminder...Dust off your Disaster Plan!

By: Cindy Nyberg, CFO & Strategic Planning Consultant

Many of us have attended meetings concerning disaster planning. We've all spoken to our staff about documenting workflows, tasks, and key strokes. As a manager, you train your staff in many areas, but do you have a disaster plan? Do you have your department's workflow and task (to the key stroke) documented and up to date? Is your staff cross trained? If you don't, let's not judge or shame, because we all fall short sometimes. I've walked in your shoes so I know that in the course of staff turnover, navigating through each day, and changes in requirements, a disaster plan is something that easily falls to the bottom of the "to do" list.

As we begin to reengage in life, the risk of our staff or ourselves contacting COVID-19 increases and makes a disaster plan more important now than ever before. Many of you may have already experienced this. Although, I hope not.

Example: What would you do if 60% of your billing staff contracted the virus and were out of the office for 14 days at the same time? We are talking about the staff that navigates the maze of payer and coding requirements every day. The staff who makes sure your charges are entered correctly and filed every day and your payments are posted every day. The staff that follows up on denials and patient balances to make sure the practice is paid. The staff that answers provider, staff, and patient questions. In my experience, billing departments can easily get behind in two weeks and it may take six months to catch up. This scenario is one of my worst CFO nightmares.

My recommendation is to function under Plan A, B & C. Plan A would be to have a disaster plan with the tasks, workflows, and key strokes documented. Staff members would be regularly cross trained. As this disaster plan is implemented, the staff would prioritize work and fill in the gaps without a disruption, so critical work would be completed. In Plan B, prepared to have as many of the infected staff work from home as possible, even at a reduced capacity. Being prepared means having the workflows, laptops and technology available. Plan C is a mix of A & B, and I would be rolling up my sleeves to help.

Since March, we've learned to expect the unexpected. The pandemic has reminded us of the importance of being prepared and dusting off your disaster plan. Hopefully it will never be needed. Good Luck!

Is This CAP Deal Really Good for Me? How Can You Tell?

By: Dustin Clark, Vice President, COO

During my career I've seen capitation rise and fall.

And rise.

And fall again.

In the near future, it looks like we're going to see a new wave here in North Carolina. BlueCross/BlueShield has introduced a new program that helps make independent, primary care practices financially "whole" after suffering through the enforced closures and restrictions during the early phase of the pandemic. One of the catches to receiving the funding they've offered is you must commit to at least consider signing a capitation contract effective in 2022. Not such a terrible ask; you just have to consider it, but, how will you know if what they offer is a good deal for you? How would you even begin to figure it out?

To know if any capitation deal is at least equivalent to your current fee-for-service agreement, you're going to need to analyze your current contract. That'll take a working knowledge of how your current rates are built and applied, and utilization data to determine what you're doing and how often. Most practices can get their hands on that kind of information, but it's surprising how many can't or aren't sure how. With those two pieces, you can put together the financial value of your contract; we do it every day for our clients here at Fulcrum. The cap side, though, is a little different. Instead of being offered a percentage of Medicare or some payer-specific schedule of fees, you're going to be presented with something like "how about $9.25 per member per month?" Is that good? Is it the same as what you're getting paid now? Less? To know, you're going to need a totally different set of data with which to compare your existing analysis. First, you'll have to know how many members are assigned to you in the payer's system. A "member month" is just what it sounds like, so to get a year's worth of "utilization" to multiply by your cap rate, you need to multiply the number of members assigned to your practice by 12. This isn't just the number of patients you've seen in a year, since there will be some members who are officially assigned to you, but who don't come in very often. Those could be missed if you're trying to pull the data from your system. The payer will have to tell you how many members are assigned to your panel. After that, multiply by 12 to get total member-months, then by your "per member per month" rate, and you get a basic calculation of your annual revenue.

After that, you're also going to need to know what, if any, exceptions there are to the cap program, how they're paid, and what kind of "leakage" you could be responsible for. If there are exceptions, services that you may perform that are paid outside the capitation rate, they'll be paid on the familiar fee-for-service model. You'll need to know what the fees are, how your rates are constructed, and then add them into your capitation revenue based on your utilization. If you're having to refer patients out to other physicians and specialists, are you on the hook for that medical expense? Some capitation deals make you responsible for the expense incurred by the insurance company when they pay those claims to specialists to whom you've referred patients. According to the contract, you'd be expected to handle those services under the capitation payments, so referring out means the insurance company has "double paid" for that "leakage." They'll reduce your capitation revenue by that amount, so you'll have to be able to at least identify those services and how often you're sending them out. You won't be able to determine the

exact amount to subtract from your capitation revenue, though, because those amounts are based on the other physician's contract with that payer. Easy, right?

Capitation can be beneficial or harmful to a medical practice depending on how it's structured; it's neither always bad for doctors nor always good. To even know on which end of the spectrum any given deal is, you'll need some specific data from both your own systems and from the payer. You'll also need to know what to do with it and how to compare your current contract with the proposed one. Even if you're having someone like Fulcrum do it for you, can you produce the necessary utilization reports from your current system? Do you have copies of your existing contracts? Do you get panel reports on members assigned to your practice? It's much easier to start asking yourself these questions now, and getting your answers figured out, than when the decision is actually upon you. Find out what information you have available, how easy or difficult it is to obtain, and who would be responsible for putting it all together. That way, if you end up with a cap deal on your desk, you'll be ready to dive in and determine "is this even good for me?"

Hindsight is Always 20/20

By: Ashley Elmore and Trista Nelson, Directors, Healthcare Consulting

Many times, when a new client hires Fulcrum Strategies, they explain to us that they haven't looked at their contracts in years. This is a common occurrence, because most practices don't have the time for the tedious and overwhelming process of reviewing several contracts. It is very important, however, that your practice prioritizes a yearly contract and fee schedule review. One of the most common questions our clients have is what they can do as providers to make sure they are being paid according to their contracts. Here are some tips on how you can be sure that you are getting paid according to contract.

Make sure you are familiar with your contracts; know your effective dates and how long it has been since you negotiated your contracts. Understand policies and procedures, and make sure everything is up to date. For example, you should make sure your contract allows for services such as telehealth and that your contracts have the most current state guidelines for billing and appeals.

Another important part of your contract is your fee schedule. Every year, as a participating provider with a payor, you should request a full fee schedule and review that schedule against your contract terms to make sure it's correct. You should also be looking at your chargemaster to make sure you are getting every dollar available to you. For example, you could be missing out on the amount you negotiated if your billed charge is less than the negotiated rate. We have had several clients realize, through this review, that they were leaving money on the table because they hadn't increased their billed charge amounts in several years. This annual review also helps you determine if your contracted rates are acceptable or if they need to be re-negotiated. In many cases a fee schedule review can help your practice decide if there are services you want to add or services that are no longer financially viable.

In many cases, when Fulcrum negotiates the contract terms, we have built in escalators that give the group an increase in rates each year. It is very important that your practice reviews the current rates to ensure that the payors are updating their systems to show the negotiated increases. We have many clients who have built in escalators, but the payor doesn't make the update in their system, causing our client to miss out on the annual increase they should have received. Typically, you only have a certain amount of time to alert the payor to the underpayment error, so you must be diligent in making sure these increases have been made by the payor.

For our clients who have an ASC paid at grouper rates, it also is important to stay informed of the most current CPT code mapping. There have been instances when a CPT code mapping was changed from a higher grouper to a lower grouper, therefore reducing the payment to the ASC. This exemplifies the need to be familiar with your contract language with the payors, because in some cases the payor can change the mapping unilaterally.

We know practices are very busy and only getting busier, but it is extremely important for your group to remain familiar with contract terms and fee schedules with each payor. This will help to ensure that your contact language is not outdated and that you are being properly reimbursed.

Follow us on Social Media!

Healthcare Observances to Remember in August

- Children's Eye Health and Safety Month
- Gastroparesis Awareness Month
- National Breastfeeding Month
- National Immunization Awareness Month
- Psoriasis Awareness Month
- World Breastfeeding Week (Aug. 1–7)
- National Health Center Week (Aug. 9–15)

2664 Timber Drive, Suite 406, Garner, NC 27529 | P) 919.436.3377 | F) 919.436.3378