
GETTING PAID IN THE MANAGED CARE WORKPLACE: THE BASICS OF PHYSICIAN COMPENSATION

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One thing residency programs have in common is that they all end. At some point, clinical training is over and one enters the “real world” of practicing physicians. The clinical practice environment within an academic medical center can be quite different from practice in the health care marketplace, although the differences may diminish over time as teaching hospitals redefine themselves in response to demands of an ever-evolving health care system [1].

Entering the “business” of medicine has always presented challenges to new physicians whose training neglected essential principles of successful practice. For example, in 1981, when one of the authors completed a family practice residency and entered private practice, he found himself well prepared to care for patients but poorly equipped to address business decisions, such as how much to charge for services and whether to participate in insurance company networks.

To an even greater degree today, residents find themselves inadequately prepared to address the complex business decisions awaiting them in the current health care marketplace. In a recent survey, third-year residents rated their level of preparation for communicating with patients and for critically analyzing the medical literature as much higher than their preparation for managed care practice [2]. Even residents training in areas of high managed care penetration have been found to lack critical knowledge needed for successful practice in managed care and, furthermore, stated that they were insecure about this knowledge base [3]. This knowledge gap of residents and new physicians has been cited by many [4–6], including health plans [7],

and has led to a growing demand for residency programs to provide education and training in the business of medicine. Indeed, the program requirements for family practice, internal medicine, and pediatric residency programs set forth by the Accrediting Council for Graduate Medical Education contain guiding statements as to what should be covered under “practice management” curricula [8].

What does it take to be ready for medical practice in today’s managed care environment, and what can one do to improve the chances for success? Although a comprehensive answer to these questions is beyond the scope of any article, a good starting point is to look at one business issue critical to all graduating residents: compensation.

What Compensation Method is Right for You?

New physicians entering the current health care marketplace must be prepared to deal effectively with many compensation-related decisions, some of which may be complex or financially risky. This preparation begins with a basic understanding of the common physician compensation methods currently in use, which are reviewed here. For this article, we define *compensation* as payment received by a physician in return for providing medical services. Other forms of compensation, such as employee benefits (sick time, vacation, pension), stock (provided by some health maintenance organizations [HMOs] to their participating network physicians), recognition (promotions to leadership positions, awards), and reimbursement received for other reasons (payment for teaching or administrative duties) are not discussed.

Before delving into the basic terminology of physician compensation methods, consider the following scenario.

Two residents at the same hospital will complete their training in 6 months and have begun seeking job opportunities. Dr. Kelly, an internal medicine resident, is considering 4 options.

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- Option 1 is to set up a private practice and join a well-established local physician independent practice association (IPA) that has contracts with several HMOs. The local health insurance market is dominated by large HMOs. Without the HMO contracts, Dr. Kelly would be unable to bill the HMO for her services (eg, office and hospital visits for HMO patients). The IPA receives capitation for primary care services, and the average capitation rate for primary care is \$14 per member per month. She is uncertain how to evaluate this opportunity: Some IPA physicians say they are doing well financially, but others say they are losing money.
- Option 2 is to move to a small rural community that is seeking an internist. Dr. Kelly would be 1 of 4 internists in the community and would be setting up her own private practice. Managed care has not yet arrived in force, and community physicians are generally reimbursed at a discounted fee for service rate, with discounts averaging 15% of usual, customary, and reasonable charges. She is uncertain whether this option represents a good deal financially.
- Option 3 is to join a local physician group as a salaried physician. Dr. Kelly would receive a base salary of \$100,000 plus a bonus payment if the group operates profitably for the year. The group receives virtually all income as total physician capitation from various HMOs.
- Option 4 is to join a staff-model HMO as a salaried physician. Dr. Kelly would receive a base salary of \$90,000 plus a bonus payment based on a favorable annual performance review.

Dr. Frank, an orthopedic surgery resident, also is considering 4 options.

- Option 1 is to set up a private practice and join the same local IPA Dr. Kelly is considering. Like Dr. Kelly, Dr. Frank would be paid for providing services to HMO patients; without the HMO contracts, he would be unable to bill the HMO for his services. The IPA receives discounted fee for service payment for specialty services at a rate of 95% of Medicare.
- Option 2 is to move to a medium-size community that is seeking an orthopedist. Dr. Frank would be the only orthopedist in the community and would be setting up his own private practice.

Managed care has not yet arrived in force, and community physicians are reimbursed using discounted fee for service, with discounts averaging 15% of usual, customary, and reasonable charges. Dr. Frank worries about having enough patients and being on call all the time. He wonders if these disadvantages are balanced by what may be a better financial deal.

- Option 3 is to join a local orthopedic group as a salaried physician. Dr. Frank would receive a base salary of \$175,000 plus a bonus payment if the group operates profitably for the year. The group receives virtually all income as inpatient case rates or contact capitation from various HMOs. Dr. Frank understands that the group members earned less income last year than in the previous year.
- Option 4 is to join a staff-model HMO as a salaried physician. Dr. Frank would receive a base salary of \$150,000 plus a bonus payment based on a favorable annual performance review.

Dr. Kelly and Dr. Frank meet for lunch to compare notes about their job prospects. They confess their confusion about what each option offers so far as future compensation and determine they need more information to properly evaluate their options and make informed decisions.

Common Methods of Physician Compensation

Current physician compensation methods are highly variable and constantly changing but, generally speaking, fall into four major categories—fee for service (FFS), capitation, variations or combinations of FFS and capitation, and salary. FFS is used by traditional payers (eg, indemnity insurance companies, most Blue Cross Blue Shield companies, regular Medicare, most state workers' compensation programs) as well as managed care payers (eg, HMOs, preferred provider organizations [PPOs]). Managed care payers use capitation, particularly primary care capitation, with increasing frequency. Financial risk sharing models, often combining elements of more than one category of reimbursement, have gained popularity and are used widely in some parts of the country.

FFS remains a very common, if not the most common, form of individual physician reimbursement in managed care contracts. (The money used for FFS reimbursement to individual physicians may come from an IPA or a physician group that has a capitated arrangement with an HMO.) Prior to the discounted fee schedules introduced by health insurance companies

in the 1960s, reimbursement typically was a fee determined by the physician performing a specific medical service and paid by the patient directly to the physician. This model of physicians setting fees is commonly referred to as *traditional FFS*, to indicate the typical business practices prior to health insurance plans and the government becoming actively involved in determining the fees physicians can charge.

Traditional FFS Reimbursement

Setting a Fee Schedule

Under traditional FFS, a physician establishes a charge for each service he or she provides; a comprehensive list of these specified charges is a *fee schedule*. Today, physicians entering solo private practice still must create a fee schedule if they expect to use FFS for reimbursement. Because federal antitrust regulations prevent physicians from establishing standards for fees, information on existing fees in any specific geographic area is difficult to obtain. Common techniques a new physician might use include calling physician offices and conducting a fee survey or purchasing one of several publications containing ranges for physician fees, such as *Medical Fees in the United States* [9]. A physician who joins an existing group does not need to create a fee schedule because the group will already be using one.

Billing codes. Fee schedules usually are based on a set of billing codes derived from the Physicians' Current Procedural Terminology (CPT), a classification system of the American Medical Association (AMA) that assigns a unique 5-digit code to each medical procedure or service performed by physicians [10]. The CPT coding system contains 7000 codes and is used almost universally by physicians in the United States to bill payers and by payers to pay for physician procedures and services [11]. CPT codes cover both evaluation and management (E&M) and non-E&M codes. The E&M codes include office or other outpatient visits, hospital visits, consultations, emergency department services, critical care services, nursing facility visits, home visits, case management services, and other related physician services. Non-E&M codes consist primarily of procedures, laboratory services, radiology services, and other miscellaneous services.

Relative value scales. Several tools can help physicians determine how much to charge for a specific service. The most common tools, called *relative value scales* (RVs), assign a relative value or weight to each service or procedure. By selecting the dollar value for one RVS unit, an entire fee schedule can be established using a dollar-per-unit value, or conversion factor, to convert RVS units into charges. For example, CPT code 99201

(office visit for a new patient with limited presenting problems, typically requiring 10 minutes of face-to-face time) may have an RVS unit value of 3, whereas CPT code 99205 (office visit for a new patient with severe presenting problems, typically requiring 60 minutes of face-to-face time) may have a value of 9. If the RVS conversion factor is set at \$10, the charge for code 99201 would be 3 (the RVS units) times \$10 (the RVS conversion factor) or \$30, and the charge for code 99205 would be 9 times \$10 or \$90.

The first RVS was developed in 1956 by the California Medical Association and was updated until 1974, when the Federal Trade Commission became concerned that the California RVS might violate antitrust regulations [12]. Although numerous scales may be used, a particularly important RVS is the Medicare resource based relative value scale (RBRVS). The Medicare RBRVS is used by most HMOs and indemnity health plans as well as by Medicare to determine physician reimbursement [11]. A 1997 survey of public and private payers conducted by the AMA showed that 61% used the Medicare RBRVS in some way [11]. The Medicare RBRVS system was developed for the Health Care Financing Administration and was implemented in January 1992 [12]. The unit values in the Medicare RBRVS result from combining three factors: the time and intensity of physician work, the practice expense directly related to the service or procedure, and the malpractice cost associated with the service or procedure. In addition, the Medicare RBRVS has a geographic practice cost index for each of the 210 Medicare payment localities. The conversion factors used with the Medicare RBRVS were last updated in 1998 and are approximately \$37 per unit for all physicians.

Table 1 demonstrates how a physician would charge for providing 100 patient visits and associated services under traditional FFS during a typical month. All numbers are illustrative only and assume 100% collection of fees. In this example, the physician would bill for a total of \$12,000 and would expect to receive payment of \$12,000. The total number of services is greater than the total number of patient visits, because it is assumed that some patient visits included office-based services such as laboratory testing, minor procedures, radiography, and vaccinations.

Adjustments to Fee Schedules

Insurance companies and other payers (eg, Medicare) do not always pay the full amount charged by a physician. The insurer may compare the physician's charge to a benchmark and pay whichever is the lower

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Table 1. Traditional FFS Reimbursement for a Physician for 1 Month of Services

Service	Fee per Code*	No. of Services Provided	Total Amount Charged	Total Amount Received [†]
Office or hospital visit	\$100	100	\$10,000	\$10,000
Laboratory service	\$25	20	\$500	\$500
Minor procedure	\$150	10	\$1500	\$1500
Total		130	\$12,000	\$12,000

FFS = fee for service.

*Fee per code is intended to represent the "typical fee," not the highest or lowest fee.

[†]Assumes 100% collection rate.

amount. Benchmarks include Medicare's allowable charges (ie, the fees contained in the Medicare RBRVS) and the usual, customary, and reasonable charges (UCR) that an insurer may set for a geographic area.

How UCR fee schedules are used. Physicians who charge less than the local UCR amount typically receive payment in full from a health plan, whereas physicians who charge more than the UCR are paid only the UCR fee. A patient may be liable for the difference between what the payer will pay and what the physician has billed. The situation in which a physician bills an insurance company, receives partial payment, and then bills a patient for the remaining balance is called *balance billing*. In a case in which a contract between a physician and payer prevents the physician from balance billing, the physician cannot bill for charges above what the payer's fee schedule will reimburse and in effect agrees to a fee discount. UCR fee schedules help a payer keep physicians' charges for specific services relatively uniform. **Table 2** demonstrates how a UCR reimbursement model affects physician compensation for services.

How UCR fee schedules are created. Most UCR fee schedules in use today developed in basically the same way, as illustrated by the following hypothetical example. In 1980, an indemnity insurance plan conducts a survey of fees charged by physicians serving the plan's members, based on which it develops and publishes its "1981 UCR fee schedule." The fee schedule lists a range of expected fees for each service (eg, \$35 to \$50 for an intermediate office visit to an internal medicine physician). In 1982, the plan decides to modify the 1981 UCR fee schedule to contain only a single fee for each service. This fee is used to establish an upper limit for

paying physician charges (eg, \$45 for an intermediate office visit to an internal medicine physician). The new fee schedule is referred to as the "modified 1981 UCR fee schedule." The fees in the modified 1981 schedule are anchored to the fees contained in the 1980 survey, with no adjustment for inflation and no repeat survey to look for changes in physician charges.

Some UCR fee schedules in use today may base their fees on surveys performed many years ago. From the health plan's perspective, this practice helps to manage cost and prevents fees from increasing in response to physicians arbitrarily increasing their charges. However, the UCR fee schedule also prevents fees from increasing in response to legitimate increases in physician charges due to increases in practice overhead expenses. As a result, some physicians may feel that UCR fee schedules are unfair.

It is not common practice among health plans to adjust UCR fee schedules annually to account for inflation, and most UCR fee schedules are adjusted at irregular intervals. Typically this occurs when fees have significantly failed to keep up with charges and when physician complaints to the health plan increase. A commonly held belief among health care actuaries and economists is that FFS reimbursement models actually (if inadvertently) provide an incentive to physicians who desire a higher total income to deliver an increased number of services; if true, this would lead to increased total costs and overall health care cost inflation. This belief is the primary factor leading health plans and the government to search for alternatives to FFS. Health care payers interested in avoiding health care cost inflation will attempt to substitute an alternative compensation method for traditional FFS reimbursement.

Table 2. How UCR and Discounted FFS Reimbursement Models Affect Compensation

Service	No. of Services Provided	UCR Fee	Discounted Fee	Total Amount Received	
				UCR Fee	Discounted Fee
Office or hospital visit	100	\$80	\$50	\$8000	\$5000
Laboratory service	20	\$25	\$16	\$500	\$320
Minor procedure	10	\$120	\$67	\$1200	\$670
Total	130	—	—	\$9700	\$5990
Difference between traditional fee schedule (\$12,000) and modified fee schedule (%)				-\$2300 (-19%)	-\$6010 (-50%)

FFS = fee for service; UCR = usual, customary, and reasonable.

Discounted FFS

Discounted FFS arrangements are based on standard fee schedules, the most common being the Medicare RBRVS. Milliman & Robertson, Inc., the largest actuarial consulting firm in the United States, advises its health plan and provider clients that discounted FFS fee schedules typically contain discounts of at least 30% of UCR. Agreeing to a discounted fee schedule means that on the average, a physician will receive 70% of their UCR charges [13; unpublished Milliman & Robertson, Inc., proprietary databases, 1999]. Although it is not unusual for payers to develop their own unique fee schedules, most develop fee schedules based on the Medicare RBRVS.

Health plans using Medicare RBRVS-based fee schedules use the Medicare RBRVS service units but substitute their own dollar-per-unit conversion factors. As a result, physicians practicing in different locations may receive different payment amounts for the same service. In addition to the geographic variation index built into the Medicare RBRVS, health plans may vary the conversion factors paid for different CPT codes. For example, a health plan may use the actual Medicare RBRVS conversion factor to reimburse CPT code 99212 (office visit for an established patient); this is referred to as *100% of Medicare* because the health plan is using the full Medicare conversion factor. However, to reimburse CPT code 93000 (routine electrocardiogram [ECG]) the same health plan may use a factor that is half the corresponding Medicare conversion factor; this is referred to as *50% of Medicare*. The result of this

mixing of conversion factors is a composite fee schedule that is very difficult for physicians to evaluate.

The percentage of Medicare actually paid generally is determined by market conditions, such as competition (ie, what other payers in the same geographic area are paying) and demand for a specific physician or group. The latter factor may lead to a specific physician or group receiving higher reimbursement rates than other similar physicians or groups. Table 2 demonstrates how a discounted FFS reimbursement model affects compensation.

FFS as Applied in Managed Care

When FFS is used in a managed care setting, some financial risk almost always is transferred to the physician. Risk transfer may be achieved through denial of payment by the managed care payer or through a reimbursement withhold. Payment denials and withholds applied to payment amounts are calculated using the discounted FFS reimbursement model adopted by a managed care payer.

Denial of payment. Managed care payers may not pay for selected services when participating physicians do not adhere to contractual or medical necessity criteria. For example, most health plans require that the plan be notified in advance of an elective surgery. Failure to notify the plan may result in the plan refusing to pay for the surgery. Or, payment for services such as potentially avoidable hospitalizations (eg, admitting a patient for procedures that could have been performed without risk to the patient on an outpatient basis) may be

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Table 3. How a Managed Care Discounted FFS Model Affects Compensation

Service	Fee	No. of Services			Total Charges [†]	Payment [‡]	Withhold (15%)		Total Received
		Provided	Budgeted	Reimbursed*			Withheld	Returned	
Office or hospital visit	\$50	100	85	98	\$5000	\$4900	\$735	\$85	\$4250
Laboratory service	\$16	20	15	20	\$320	\$314	\$47	\$0	\$267
Minor procedure	\$67	10	9	10	\$670	\$657	\$98	\$45	\$604
Totals		130	109	128	\$5990	\$5871	\$880	\$130	\$5121
Difference between charges and total payments received (%)									-\$870 (-15%)

FFS = fee for service.

*Based on a 2% denial rate.

[†]Includes charges for denied payments.

[‡]Includes withholds.

denied. In the authors' experience, denial of payment to hospitals is more common than denial of payment to individual physicians [14]. According to the Greater New York Hospital Association, a hospital trade organization, payment denials to hospitals appear to be increasing in frequency [unpublished survey by the Greater New York Hospital Association, May 1999].

Withholds. Managed care plans may withhold a percentage of each participating physician's payment to establish a reserve fund for use when total charges exceed budget allowances. In these cases, the withhold reserve is not returned to the physician and is used to pay for the budget overruns; the net effect is an increased fee discount for the health plan. However, if the total physician charges are equal to or less than the budget allowances, 100% of the withhold is returned to the physician. To avoid losing their withholds, physicians must understand the utilization assumptions used to establish the budget (ie, how many services are budgeted for by the health plan?) and try not to exceed those assumptions. **Table 3** demonstrates how a managed care discounted FFS reimbursement model with a 15% withhold and a 2% denial rate for physician services can affect compensation, given certain budget assumptions and no change in the physician's utilization of services. **Table 4** uses the same budget assumptions but assumes lower utilization of services. (Although the actual percentage of reimbursements withheld by managed care plans varies widely, withholds of 10% to 15% are most common.)

Capitation

Capitation is prepayment to a provider for each health plan member assigned to that provider. In return for the capitation payment, the provider agrees to provide a specified health service or set of services. Capitation is used to reimburse individual physicians, medical groups, IPAs, hospitals, or integrated delivery systems, which may include participating physicians, hospitals, and ancillary providers.

Because capitation prepays for services, a capitated physician receives a predetermined amount—typically expressed as a per member per month (PMPM) dollar value—whether the health plan member receives services or not. This contrasts with FFS, in which the physician is paid only if he or she renders a service to the member. Capitation allows the physician to capture revenue for all health plan members—those who will actually receive services as well as those who will not. Under capitation, a physician must manage the utilization of services and the costs for those services within the income set by the capitation amount. A major reason for a managed care plan to capitate providers is to predict health care costs more accurately and to hold providers partly accountable for health care expenses and utilization. However, capitation also places the provider "at risk" for the costs of providing services; the more services covered by the capitation payment, the more risk shouldered by the provider.

How Capitation Rates are Determined

The first step a managed care plan takes in determining a capitation rate is to define the service to be capitated.

Table 4. How Reducing Utilization Affects Reimbursement

Service	Fee	No. of Services			Total Charges [†]	Payment [‡]	Withhold (15%)		Total Received
		Provided	Budgeted	Reimbursed*			Withheld	Returned	
Office or hospital visit	\$50	90	85	88	\$4500	\$4410	\$662	\$502	\$4250
Laboratory service	\$16	15	15	15	\$240	\$235	\$35	\$35	\$235
Minor procedure	\$67	10	9	10	\$670	\$657	\$98	\$45	\$604
Totals		115	109	113	\$5410	\$5302	\$795	\$582	\$5089
							Difference between charges and total payments received (%)		-321 (-6%)

*Based on a 2% denial rate.

[†]Includes charges for denied payments.

[‡]Includes withholds.

This can be an individual service (eg, a chest radiograph) or a group of services (eg, all radiology services). Next, the health plan estimates the number of services used by a defined population over a specified time period (eg, 1000 plan members during 1 month). The defined population is typically divided into subgroups based on gender and age. Actuarial convention is to divide the population into 5-year age-groups that are further divided into male and female subgroups (called *5-year age sex bands*). The outcome is an estimated utilization rate for each 5-year age sex band. Next, the health plan attempts to determine whether utilization can be safely reduced. Several reports have documented significant geographic variation in medical service utilization without any significant difference in outcomes [15-17]. To calculate the capitation rate for a defined service, the average charge for the service must be determined. The capitation rate is calculated by converting the average charge (eg, for 1000 members over 1 month or 1 year) to a PMPM rate. Most health plans use actuaries to develop capitation rates. A simple illustration follows.

ACME HMO wants to capitate cardiology office visits and ECG services. In the past year, 1000 ACME members had 250 cardiology office visits and underwent 1200 ECGs. An actuarial consulting company retained by ACME HMO estimates that 15% of these cardiology office visits and 10% of the ECGs were redundant and therefore unnecessary. The consultants use physician and nurse reviewers to examine a set of actual patient charts to determine whether the cardiology visits and ECGs were necessary. ACME HMO's

average payment for a cardiology office visit is \$150 and for an ECG is \$50. Based on target utilization rates for 1 month, ACME HMO determines that the total estimated charges for both services for 1000 members for 1 year should be \$69,000. This converts to a PMPM capitation rate of \$5.75 (Table 5). Table 6 presents the results of capitation on compensation if the actual number of cardiology visits varied from the targeted number of visits.

Primary Care Capitation

The goal of primary care capitation is to create a financial incentive for primary care physicians (PCPs) to control the total cost and quality of primary care services for a given population, commonly referred to as a *panel of patients*. When a patient is assigned to a PCP's panel, the process is called *paneling*. Typical primary care capitation programs require patients to see their paneled PCP for all primary care services and do not allow the physician to submit charges for services covered by the capitation payment. This allows the HMO to control its costs by limiting total primary care costs to the capitation amount. It is customary for primary care capitation to contain reimbursement for patient management. This refers to the time a PCP is expected to spend reviewing reports from the HMO and helping to achieve specific quality goals (eg, target rates for immunization, mammography, and serum cholesterol screening). To minimize variation due to small numbers, most managed care plans use capitation for PCPs only if the physician has a panel with a minimum number of members (eg, 50). PCPs who practice in a

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Table 5. Calculation of PMPM Capitation Rates

Service	Avg. Charge per Service	Target Utilization per Month	Total Estimated Charges for 1000 Members for 1 Year	Total Estimated Payment PMPM
Cardiology office visit	\$150	30	\$54,000	\$4.50
Office ECG	\$50	25	\$15,000	\$1.25
Combined	—	—	\$69,000	\$5.75

ECG = electrocardiogram; PMPM = per member per month.

group may consolidate their panels and quickly meet this membership threshold.

Primary care capitation includes payment for all services that would normally be provided by a PCP. Because specialty costs traditionally have exceeded primary care costs, critics of individual primary care capitation argue that it actually creates an incentive for PCPs to increase specialist referrals. To manage this outcome, some health plans pay PCPs an enhanced capitation that covers additional services (eg, rounding on patients in the hospital) and routine services that might be referred to specialists. Or, physicians may be paid through a hybrid model of capitation and FFS that incorporates a fee schedule for necessary routine services (eg, immunizations) and additional services (eg, hospital rounding, some office procedures). By combining capitation and FFS, health plans attempt to create an incentive for PCPs to manage as much care as possible and to limit specialty referrals, while acknowledging differences in practices.

Total Physician Capitation

In total physician capitation (also called *global capitation*), a medical group, IPA, or other provider organization is paid a capitation or budgeted amount for all professional services (both primary and specialty) that are paid benefits of a health plan. This creates an incentive for the provider group to manage both primary care and specialty costs and for PCPs to work closely with their specialist counterparts. HMOs and other organizations (most often regulatory organizations such as Medicare and state insurance departments) may scrutinize professional service capitation models for attempts to provide incentives to PCPs to inappropriately avoid referrals to specialists, particularly if the capitation is paid to PCP groups. This practice is called *underutilization*. However, an attempt to underutilize specialists for appropriate care will backfire if patients ultimately become sicker or require hospitalization

because they did not receive timely specialty care. To avoid this possibility, physician groups—as opposed to individual PCPs—may be capitated for all professional services. PCPs who are part of a group are less likely to gain personally by underutilizing specialists because group managers often scrutinize the group's total costs to identify physicians who underutilize specialty services. Other checks in this model include quality review and provider profiling performed by the HMO for both under- and overutilization.

Specialty Capitation

A recent development is for HMOs to capitate specialty services (eg, cardiology, orthopedics) separately. Sometimes referred to as *specialty carve outs*, these specialty IPAs are paid a PMPM capitation amount intended to cover all of the specialty services. Within the specialty IPA network, the participating specialists may be compensated on an FFS basis. However, because the specialty IPA as a whole is held to a total dollar amount, it must manage the utilization of those services to ensure that costs do not exceed the capitation amount. Specialty capitation creates an incentive for specialists to manage the cost and care of their patients and to share in the savings or deficits.

Hybrid FFS and Capitation Models

Inpatient Case Rates and Contact Capitation

Inpatient case rates are fixed fees paid to individual physicians—commonly surgical specialists—to cover costs associated with specific procedures. (Services provided by other physicians usually are not included in the case rate.) For example, a general surgeon may receive an inpatient case rate payment for exploratory laparotomies to cover all preoperative hospital visits, surgical fees, and, frequently, some postoperative outpatient care.

Contact capitation is a modification of the case rate model to include services not related to hospital admission. Under contact capitation, physicians—most

Table 6. How Changes in Utilization of Office Visits Affect Compensation

Target Utilization per Month	Actual Utilization per Month	Annual Reimbursement	Income per Service	Percentage of Traditional FFS
30	35	\$54,000	\$129	86%
30	30	\$54,000	\$150	100%
30	25	\$54,000	\$180	120%

FFS = fee for service.

commonly specialists—receive lump sum payments when patients are referred for their services. For example, a cardiologist who contracts with an HMO that uses contact capitation for cardiology services sees a patient with congestive heart failure who has been referred for consultation and ongoing care. That cardiologist then receives a single payment for all services rendered under that referral (ie, for a single, defined episode of congestive heart failure).

Inpatient case rates and contact capitation can reduce physician income significantly. However, because physicians who can reduce their utilization rates can benefit financially, these reimbursement methods remain popular. For example, physicians who can reduce overall utilization by 20% recoup some of the losses that result from fee discounts, payment denials, and withholds.

Budget Reconciliation and Flexible Fee Schedules

In budget reconciliation and flexible fee schedule models, the performance and resource utilization of a capitated provider group are compared to medical and institutional expense targets to determine appropriate adjustments to reimbursement payments. (Individual physicians may be reimbursed through capitation or FFS arrangements.) Payments in these models are not prepaid but are reconciled to a predetermined budget. At regular intervals (ie, monthly, quarterly, semi-annually, annually), the group's health care expenses are totaled and compared to the budget. When budget deficits occur, the capitated provider must make up some or all of the losses. How the deficits are made up varies for each contract. It can be as simple as having each physician pay an equal share of the deficit, or it can be complex, involving fee withholds and other financial mechanisms. Stop loss insurance (ie, a form of reinsurance that limits the financial losses for which a provider is responsible) can minimize financial risk, but most forms of stop loss insurance will not completely protect against budget deficits. Similarly, when budget surpluses occur, savings may be shared with the providers as bonus payments.

In some cases, budget deficits or surpluses may be rectified by prospectively changing a provider's fee schedule. That is, the fee schedule is decreased or increased according to the degree of cost overruns or surpluses on a go-forward basis (ie, using past performance to calculate future fees). For example, if during the first quarter of a contract year fees exceeded budget by 50%, fees would be reduced by 50% for the second quarter. A flexible fee schedule can also be applied monthly: all participating physicians' costs are pooled each month, and each is then paid a percentage of his or her actual billings based on the total dollars available. In this case, the group will never have a surplus or deficit.

Shared Risk Capitation

A shared risk model establishes a budget for a specified set of services. As more services are included in capitation payments, greater risk is transferred to the providers, who agree to accept more responsibility for managing the total costs (ie, professional, facility, and ancillary costs) of providing care to their members. Shared risk models are commonly used by providers of high cost (eg, hospital) services because they allow the risk of incurring deficits and making profits to be shouldered by two or more entities. If the participants experience costs overruns, they are each responsible for a share of the deficit, and vice versa.

Risk sharing is also useful for dealing with costs that are managed by more than one entity or are outside the total control of a physician group. Commonly, physician groups receive capitation payments for all professional costs (ie, charges for services delivered by a health care professional such as a physician, physical therapist, nurse midwife, etc), and surpluses and deficits for hospital and other ancillary costs are shared between the physicians and the payer or among the physicians, the hospital, and the payer. For example, a network of physicians whose patients are admitted to many hospitals will rely on the HMO's hospital contracts to ensure

competitive rates and on the HMO's medical management to help control utilization. Therefore, the HMO and the group may share the risk for the institutional costs that are jointly managed.

Salaried Positions

In the original HMO model, called a *staff-model HMO*, physicians are employed and earn a salary, and members receive all services at HMO-run medical centers. Kaiser Permanente, Harvard Pilgrim, and Group Health Cooperative of Puget Sound are examples of staff-model HMOs. These HMOs use employment contracts that define physician compensation rates as well as expected performance levels. Similar salaried positions are available within university hospitals and physician groups. Unlike all other compensation methods previously described, salaried positions entail risks that are related to the actual employment agreement and warrant consulting a compensation attorney. It is common for these contracts to contain noncompete and/or termination of employment clauses that are potentially problematic for an employed physician.

Beyond the Basics of Compensation

The type of payment arrangement a physician chooses when entering the modern health care workplace is an important factor in determining how—and to some degree, how much—that physician will be paid for the services he or she provides. However, one's overall financial success in managed care depends on more than simply the method by which one is paid. To be successful requires learning and effectively applying new skills. Physicians must be able to evaluate managed care contracts, understand the principles of quality and utilization management, and operate effectively in a medical group environment. Although beyond the scope of this article, the underlying importance of these additional financial success factors is suggested in the following epilogue to the story of Dr. Kelly and Dr. Frank.

At the conclusion of residency training, Dr. Kelly joins the local physician group as a salaried physician, and Dr. Frank sets up a private practice and joins the local IPA. A year later, they have lunch and discuss how their jobs are working out. Dr. Kelly tells Dr. Frank that her group lost money in the first year she was with them. She is not sure how this will affect her, but she is worried she may be forced to accept a lower salary. She tells him that she is upset because she never received the incentive bonus the group discussed with her when she joined. Dr. Frank asks why

the group lost money, and Dr. Kelly tells him that she was told that utilization was too high.

Dr. Frank tells Dr. Kelly that he also had a rough first year but did "OK" financially. He had to take out a large bank loan to purchase office equipment and to pay office expenses until he was able to build a practice base. Dr. Frank is 1 of 10 orthopedists belonging to the IPA. About 80% of his patient referrals come through the IPA. Over the past 3 months, he has experienced fewer referrals and some payment denials from the HMOs, which together have resulted in a decrease in his income. He is worried that this trend may continue.

Dr. Kelly and Dr. Frank ponder why her group lost money and what can be done to improve the group's financial performance. They also speculate on why Dr. Frank is experiencing fewer referrals and payment denials and what he can do to reverse these factors. Dr. Kelly and Dr. Frank realize they have much to learn about factors that impact how much they are paid. They promise to meet again in 2 months to share what information each has discovered.

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