

# CAPITATION MANAGEMENT REPORT™

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## Lawsuits over capitation

### Physicians win lawsuits over inadequate PMPM rates

Capitated physicians are at risk for more than the financial costs of medical care they provide their patients.

Legal liabilities surround them for malpractice, negligence, poor outcomes and non-referral to specialists. In addition to those medical issues, capitated doctors also take various breach of contract risks when they enter into agreements with health plans.

While the number of lawsuits have diminished over the last several years for various reasons, capitated providers can typically be involved in two types of lawsuits, says **Brian Heller**, PhD, a principal in the Toledo, OH office of Managed Liability Associates, a Washington, DC-based consulting firm.

The lawsuits typically faced by and brought by capitated providers involve charges of:

- **Non-referral to specialists.** Patients file lawsuits against physicians or HMOs alleging that capitation played a causal factor in medical malpractice because the primary care physician failed to refer, or to refer in a timely manner, the patient to a specialist. The reason for the non-referral generally cited in the lawsuit is that the doctor received a financial incentive to withhold care.

- **Inadequate capitation rates.** Physicians file lawsuits against health plans because, they say, the low rates paid are intentionally trying to drive the doctors out of business, or that they breach their contracts in various ways.

In a 2002 case won by six physicians against Blue Cross Blue Shield of Kansas City, a jury awarded the doctors more than \$3 million in unpaid fees and \$3 million in punitive damages. The case currently is pending appeal.

In December 2003, Blue Cross Blue Shield of Rochester (NY) lost its final appeal on a judgment that awarded more than \$18 million in back payments to 2,500-physician Rochester Community IPA. The lawsuit successfully claimed that the health plan

failed to pay the agreed upon PMPM rate for patients in 1997 and 1998.

In two 1999 cases in Dallas involving Medicare+Choice patients, primary care physicians were sued for non-referrals. Both cases were settled out of court. Each of the cases claimed interference with the provision of "appropriate" medical care due to the capitation arrangements. (See "Description of lawsuits that alleged malpractice in which capitation was involved," page 10.)

"These are the type of cases we look at before they are brought to make sure they are structured properly. We also review cases brought against clients to determine whether they have merit," says Heller, who testifies as an expert witness.

#### **Cap-related lawsuits on the wane**

"Our impression is that there is a significant reduction in these types of lawsuits," says Heller. "One reason is the reduction in the prevalence in capitated arrangements.

"Another element in litigation is the lack of communication to the member of the financial arrangement [with physicians]. Most health plans have remedied that and provide details of the contract in marketing materials to patients that tell them it is a cap arrangement," he says.

While contract risks remain, Heller says fewer physicians are filing lawsuits against health plans over inadequate rates because cap rates have been increased the last two years and because reimbursement models have changed.

"The models in place now are less likely to have bonus arrangements that reward primary care physicians for lowering utilization," Heller says.

While some of the non-referral lawsuits charge that capitation provides a disincentive for delivering services, the courts generally have not been willing to

find that capitation is directly to blame, says **Erling Hansen**, an attorney and principal with MLA based in Washington, DC.

"Most of these cases have been settled," Hansen says. "While they do not hinge on capitation, there are sections in the complaints that allege capitation was at fault."

### **Study shows capitation benefits**

"There are many experts willing to testify that the whole managed care system is corrupt, especially capitation, because it led to denial of patient care," says **Robert Chabon**, MD, a physician, attorney and principal with MLA based in Kansas City.

"These experts appear over and over again and say capitation is the devil's creation and that patients suffered unduly," says Chabon, who testifies as an expert witness to refute such claims. "They don't cite evidence. In fact, there is evidence to the contrary. We have been successful in arguing against that position, but it continues to be brought up."

A recent study refutes claims that capitated patients receive less care than fee-for-service patients. A 2002 study by Wake Forest University School of Medicine shows that capitated physicians offer more preventive care and health counseling than fee-for-service physicians.

"Some people argue that capitation turns physicians into money managers and that they should not be at risk to financially manage their patients. But we are in a climate of spiraling health costs that are out of control. Health plans have to keep operations under some cost controls. We found if capitation is done ethically, it promotes cost-effective health care in an era of growing concerns," according to **Rajesh Balkrishnan**, PhD, assistant professor of public health sciences at Wake Forest in Winston-Salem, NC.

In the Wake Forest study, Balkrishnan found the following:

- Patients in capitated plans were 17% more likely to receive health counseling services than patients under fee-for-service arrangements and were 3% more likely to receive preventive services.
- Physicians with a mix of capitated and fee-for-service patients spend approximately equal time with each type of patient. The authors concluded that medical ethics and standards of practice drove the physicians to not differentiate patients by type of payer.<sup>1</sup>

"The evidence shows that capitation eliminates poor quality by providing greater care," Chabon says.

Heller says other research has shown capi-

tated primary care physicians do not limit referrals.

"There is research that shows when you capitate a primary care doctor, there is no effect on specialist utilization; they refer just as much," Heller says. "When you capitate specialists, there is an impact on specialist utilization; they tend to reduce their services."

Heller cited a 1999 report, "Rewarding Cost Effective Medicine," by the Advisory Board Company, a Washington, DC-based consulting firm. (For more information, visit [www.advisoryboardcompany.com](http://www.advisoryboardcompany.com).)

### **Lawsuits directed at physician organizations**

**Michael Alper**, president of Meridian Health Care Management, Woodland Hills, CA, says the lawsuits charging capitation provides perverse incentives for doctors to withhold referrals usually are directed more at physician organizations.

"I have come across some of these lawsuits, but I am not aware of anyone prevailing," Alper says.

#### **Figure 1: Description of lawsuits that alleged malpractice in which capitation was involved**

- HMO was sued by Independent Physician Association who argued that IPA had been driven out of business through HMO's breach of contract and global capitation contracting model, and was assigned to arbitration. (Heritage Southwest Medical Group vs. PacifiCare of Texas. Currently in arbitration).
- HMO was sued for delay of treatment and wrongful death of member. Plaintiffs argued that the HMO's surplus-sharing capitated model led to non-referral to specialists, which resulted in delay in treatment and death. (Hutton, et. al. v. Hendrickson, et. al. Involved Harris Methodist HMO. Settled in 2000).
- Health plan was sued for damages resulting from denial of access to physician of member's choice. Plaintiff argued that the policy of referral to participating specialists restricted access to member's specialist of choice, who was providing necessary continuing care. (Hammer v. Hardwick, et. al. Involved Harris Methodist HMO. Settled in 2000).
- HMO was sued for wrongful death resulting from delay in receiving needed care during emergency. Plaintiffs argued that HMO's Medicare+Choice risk program did not clearly communicate that member could self-refer to an emergency department for urgent care, thereby causing delay in needed care resulting in death. (Gordon et. al., v. Jack Hardwick, M.D. and Harris Methodist Health Plan. Settled in 2000).
- HMO was sued for damages when member underwent bilateral leg amputations below the knees due to delay in referral to specialists. Plaintiff argued that delay in referral resulted from HMO's capitated disincentives to physicians.
- In Ching v. Gaines, et al., a jury in Ventura County, CA, awarded \$3 million in damages in November 1995 to the family of Joyce Ching, who died of colon cancer that went undiagnosed for months. The patient's capitated primary care physicians allegedly ignored her repeated requests for a referral to a medical specialist. Although the providers finally referred the patient, her condition worsened and she died. Her husband sued her PCPs and their medical group for malpractice. The lawsuit also alleged breach of fiduciary duty, arguing that the physicians, who were being paid a fully capitated fee of \$27.94 a month to treat the patient and would have been directly responsible for costs exceeding that amount, had a financial incentive not to send the patient to a specialist. The trial judge dismissed that allegation before trial.

Source: Managed Liability Associates, Washington, D.C. Visit [www.managedliability.com](http://www.managedliability.com). For more information, visit <http://www.zurichna.com/zus/aboutus.nsf/0/a38cca428f3f720085256c67006ec458?OpenDocument>.

"Groups have concerns about these kinds of lawsuits, but referral decisions are not driven by dollars or incentives."

As a protection against improper referrals or inadequate referrals, Alper says groups monitor referral patterns of physicians. "We are trying to determine if a physician has higher or lower referrals [than others]. There are many reasons for that to happen, and we use our peer review procedures to address these issues."

### **Lawsuits allege non-referral**

"My experience tells me that I really can't identify a situation where a physician failed to make a referral because he or she was operating under a cap contract," Chabon says. "Certainly the physicians in the groups I work with are concerned about low payments made to them under capitation. But the doctors put patients first."

In a case frequently cited that involves capitation, a jury in Ventura County, CA, awarded \$3 million in 1995 to the family of Joyce Ching, who died of colon cancer that went undiagnosed for months. The jury decided in *Ching v. Gaines* that the PCPs failed to refer Ching to a specialist in a timely manner.

The lawsuit also charged that capitated payments of \$27.94 a month made to Ching's primary care physicians contributed to the non-referral decision, a charge that typically is cited in these type of lawsuits. However, the trial judge dismissed that charge before trial.

"It is very difficult to prove that capitation was part of a physician's decision-making process," says **Alan Bloom**, general counsel for Maxicare in Los Angeles. "HMOs are not being sued anymore for non-referral because there are elaborate procedures now to get a referral.... HMOs have grievance processes now."

### **Who's accountable for referral decisions?**

With capitation, some health plans delegate management and financial responsibilities (including quality assurance and credentialing) to capitated provider organizations. In referral decisions, legal questions sometimes arise as to which entity has legal accountability for what area of responsibility, the health plan or the provider group.

"One example is where a globally capitated provider group runs out of money and is unable to pay their contracted providers. The health plan has been held liable for these obligations in a number of instances," Heller says.

Amidst this dynamic, patients have sued health plans and physicians, alleging a range of claims from medical malpractice, negligent credentialing, and breach of fiduciary duty related to the

capitated contract.

"Any doctor entering into a risk arrangement needs to fully understand the risk, what he is at risk for -- that is best advice to give," says Hansen. "If you are at risk for referrals, understand there is potential for liability for delaying referral."

### **Suing for higher capitation rates**

Under certain circumstances, physicians also file breach of contract type lawsuits against HMOs, alleging low capitation rates.

In the 2002 case won by six physicians against Blue Cross Blue Shield of Kansas City, a jury awarded the doctors more than \$3 million in unpaid fees and \$3 million in punitive damages.

On Nov. 6, 2000, the doctors filed a lawsuit against Blue Cross in the Circuit Court of Jackson County, MO, at Kansas City alleging that Blue Cross breached their contract in the following ways:

- Failing to increase the capitation rates and referral funds.
- Failing to operate the program in accordance with the terms of the contracts, including the community risk sharing principle and the concept of gain in the program.
- Diverting funds from the program.
- Failing to pay monies to the doctors and failing to allow them to participate in gain.
- Failing to provide information to the doctors and concealing the performance of the program from them.

As an example of the tactics used by the company to hide profits, the doctors showed the jury how Blue Cross steadily increased "administrative fees." The fees increased from 8% in the first few years of the contract to 24% and 45%, respectively, during the last two contract years.

The doctors also claimed that in 1995 and 1996, Blue Cross diverted more than \$4.9 million from the capitated program (Prevention Plus) to start up a new HMO called Blue-Advantage Plus that competed directly with the physicians for patients.

In its ruling, the jury said Blue Cross failed to increase the physicians' capitation rates and share profits as required under the contract. Blue Cross also had a fiduciary duty to provide the physicians with financial information as provided for in the contract, the jury said. Blue Cross appealed the verdict.

"The result of some of these suits should make it evident in the HMO industry that it pays to share information with physicians. Most HMOs were not doing that," says Chabon.

In one case related to inadequate payments in Texas involving the state's prompt-pay law, Attorney General John Cornyn filed suit in 2002 against PacifiCare of Texas and PacifiCare Health Systems, Los Angeles.

The lawsuit was filed on behalf of Heritage Southwest Medical Group, Dallas, and other capitated IPAs, as well as their patients, for millions of dollars in allegedly unpaid claims, disrupted patient care, and unresolved complaints. The case currently is in arbitration.

Texas contends PacifiCare failed to properly monitor its "delegated networks," including IPAs. When several IPAs filed for bankruptcy, PacifiCare refused to pay physicians and hospitals in those delegated networks for covered services already rendered.

### **Advice to physicians**

Before physicians get to the position of filing a lawsuit, Alper suggests they have experts carefully review all contract details.

"Physicians should just walk away from contracts that offer too low a cap rate," Alper says. "If an HMO unilaterally changed the cap rate, then there would be a dispute. But most contracts allow HMOs to change rates with a 60- to 90-day notification."

In those cases, Alper says the contracts should provide physicians with the ability to drop the contract within that same time period. "It hasn't happened recently," he adds. "[In fact], we have noticed an uptick in reimbursement rates [although not during a contract period]."

Hansen advises capitated groups to request and closely review quarterly and annual financial reports from health plans. They also need to request utilization data and related information used to determine capitation rates. "Ideally," he says, "the provider contract should include a right-to-audit provision for items that have a bearing on the capitation rate -- for example, to audit premium payments if the capitation is a percentage of premium arrangement."

Chabon says his best advice is to establish clear communication with patients and document. "Defensive medicine is a very bad idea that doesn't

protect doctors against malpractice at all," he says. "I always stress documentation and communication. Doctors don't do enough of it. If they did there would be fewer malpractice lawsuits."

Heller says capitation requires a knowledge set for which most doctors are not trained. "They need expertise to deal with contract analysis and a broader understanding of the health care industry. They also need to fully understand both the liability exposure and protections that they should build into their contracting model," he says. "Capitation is not ordinary contracting."

### **Doing capitation right**

While Chabon says some doctors have rejected capitation because of inadequate rates and the fear of lawsuits for non-referral, he says some health plans and physicians are learning that setting aside differences and working together benefits their mutual customers -- patients.

"There are pockets [around the country] of significant capitation. I believe those are primarily the groups that learned to do it correctly, found it is a decent way of functioning, and learned to do it well," he says.

Capitation can succeed when all participants are focusing on the needs of patients, he says. "I support capitation if it is done correctly."

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