PEARLS OF CAPITATION CONTRACTING

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In this chapter, our attention will turn to some key provisions in capitation contracts on which the physician leader should focus his or her attention. In earlier sections, the nature of risk taking, the meaning of capitation, and various approaches to capitation have been discussed. Now we will look at converting these concepts into a workable contract.

A contract that compensates providers through some form of capitation is in most respects identical to the typical fee-for-service managed care provider agreement with which most physician leaders have become familiar. The contract provisions that are required by statute, regulations, or accreditation standards are found in capitation contracts as well as in more traditional provider agreements. These include clauses holding patients harmless for any charges, nondiscrimination provisions, requirements for the maintenance of records, cooperation with quality and utilization review programs, definitions of medical necessity and emergency services, and other contract boilerplate. Not surprisingly, capitation contracts begin to differ as issues of payment and the scope of services for which the providers are financially responsible are addressed.

Because taking risk is best managed when shared, capitation contracting is usually accomplished through provider networks. These might be PHOs, multispecialty practices, or single specialty/primary care groups. Whatever the form, the capitated network will in turn contract with individual physicians, as employees or independent contractors, each of whom will participate in the risk sharing. For the purposes of this chapter, we will address capitation contract issues from the standpoint of the physician network and the medical leader, rather than of the PHO or the hospital member/partner. We will focus on several key areas of concern in the contract and will discuss different drafting approaches for contract provisions.

Defining Scope of Services for Which Physicians Are at Financial Risk

Description of Capitated Services

Capitation is a means for transferring financial risk for the cost of providing certain services to the providers of those services. It is therefore crucial to the physician leader that the scope of the medical services for which risk is being assumed is clearly specified in the capitation contract. The amount of the monthly capitation payment cannot reasonably be determined unless the scope of services is fully understood. The negotiation process for a capitation contract should start with defining those services, even before a capitation rate is determined.

All managed care provider contracts define “Covered Services.” In fee-for-service contracts, where the physician will be paid solely for the medical
services he or she performs, the physician is only concerned with whether a particular service that the physician intends to provide is covered by the health plan as a benefit or whether the patient is personally responsible for the entire cost of the service. Because the physician bears no financial risk if he or she refers a patient to another provider, the full scope of services for which a health plan will pay benefits is not a significant concern. The fee-for-service provider contract will usually define covered services very broadly, as meaning any covered benefit under a health plan contract, without regard to the physician’s actual scope of practice and without affecting his or her compensation.

A sample of a broad provision on covered services would be: “Covered Services shall mean all medical services for which a subscriber is entitled to a benefit under the terms of the applicable health plan.”

When physicians begin to share risk, however, it is necessary to limit the scope of the services to which that risk applies. The physician group must define the services covered by the capitation payment in as much detail as possible to ensure that services are limited to those the physician group personally provides or for which it has contracted with other providers to provide. An assumption of risk by a physician group for the cost of services it neither provides nor controls takes on the characteristics of the business of insurance, an issue discussed elsewhere in this book, potentially subjecting the group to state insurance regulations.

The capitation contract may define the services for which risk is taken by incorporating, as an exhibit to the contract, a detailed description of such services. The contract should refer to that exhibit as it defines the covered services to which it applies: “Covered Services shall mean those services for which a benefit is provided by the Health Plan that are set forth on Schedule A, attached hereto and incorporated herein by reference.” The attached exhibit should expressly cover several issues: the medical services for which the physicians are financially at risk; any special services specifically carved out from the at-risk services; and ancillary or related services specifically included within the capitation payment.

The description of included services can be very specific, such as a list of certain CPT codes for all capitated services for which the physician is responsible, or it can be more general, incorporating a reference to a certain specialty (see table on page 105 for examples of the two approaches).

Example of Detailed Schedule A
Physician Covered Services, by CPT-4 code, for which the Primary Care Physician is capitated include:

1. New Patient
   90000 - Brief Service
   90010 - Limited Service
Example of Less Detailed Schedule A

Physician Group is capitated for the following Covered Services: Services performed by Physician Group or other Contracting Physicians with Health Plan in the specialty area of general surgery.

If a more general scope of services covered by capitation is used, the physician leader must be sure that the contract spells out any specific services within that general scope that are not to be included in the capitation payment. For example, a capitation payment for primary care services might specifically exclude services for allergy and asthma treatment, or a general surgery capitation payment might exclude organ transplants or certain CPT codes for thoracic procedures. The physician leader should focus on ensuring that capitation covers only services that the physician group actually provides or that it can successfully subcontract to other physicians to provide at favorable rates. Some examples of carve-out provisions are:

Physician Group shall not be financially responsible for the following services:
- Transplants
- Surgery performed by primary care physicians or other physicians whose primary specialty is not general surgery
- Obesity surgery
- General surgery on an emergency basis by any physician who is not a member of Physician Group

Physician Group shall be responsible for all Covered Services except:
- Mental health services
- Allergy and asthma services
- Hospital emergency services
- Pharmacy services
- Laboratory services

Most medical services include more than just the physician’s personal
services. Clinical laboratory tests or radiological procedures are often necessary in order for the physician to properly diagnose or treat patients. Pharmaceuticals may also be needed. The capitation contract needs to address which of these ancillary services are to be included in the capitation payment, thus placing the physician at risk for the cost of the services. For example, a primary care group may have pharmacy costs included within its capitation in order to encourage management of this service. An orthopedic surgeon may have in-office x-ray costs included in the capitation, but not radiological procedures performed at a hospital or at a freestanding imaging facility. Clearly, the costs of these ancillary services will greatly affect determination of the capitation rate, and covered ancillaries must clearly be defined in the contract.

Another situation to be clarified would be services by other providers who would otherwise have the right to bill for or be paid for their own services. Assistance in a surgical procedure might be provided by a surgical assistant, a primary care physician, or a surgeon. If the surgeon performing the procedure is a member of a capitated surgical group, who is responsible for paying the person assisting? Similarly, if a specialty service is capitated to a specialty group and a primary care physician elects to provide the specialty service to the patient, who pays for the service? These areas need to be articulated in the capitation contract.

**Description of Health Plans**

A physician may accept capitation directly from a licensed HMO or through a larger provider network. It would not be uncommon for the capitation to apply to only one product line offered by a health plan or to less than all the health plans with which the network contracts. The capitation contract needs to be clear as to which products or plans the capitation applies:

“This Agreement shall cover Physician Group’s services to enrollees in the HMO’s Medicare Choice Plan only. Without limiting the generality of the foregoing, this Agreement shall not apply to the HMO’s commercial plan, Medicaid HMO plan, PPO indemnity plan, or ERISA products for which the HMO performs a function other than as an HMO insurer. Participation by Physician Group in all plans other than HMO’s Medicare Choice Plan shall be negotiated separately by the parties.”

“This Agreement shall apply to the following health plans with which the Network contracts:

- Blue Cross Blue Shield Commercial
- Blue Cross Blue Shield Medicare Choice
- United Commercial”

Similarly, an HMO that offers a standard prepaid plan to subscribers, with a panel of participating providers, may also offer a point-of-service option in conjunction with that plan. Under a point-of-service plan, the
subscriber is able to choose the physician by whom he or she will be treated, regardless of whether the physician is included in the health plan’s participating provider network. Neither the plan nor the network providers have any control over the patient’s choice of physician, and the only restricting factor is the amount of additional copayment the patient will have to pay out of his or her own pocket as a result of seeing a nonpanel physician. If the additional copayment is relatively small, the patient is effectively free to choose whomever he or she wants to see. If participating providers have been capitated for all physician services under the HMO’s standard plan, including the point-of-service option, they bear the financial risk every time the patient goes outside the network panel. The capitation contract must clearly state whether the capitation payment includes point-of-service options and who will be responsible for out-of-network services. If the health plan expects network physicians to be responsible for all out-of-network services within the capitation rate, it is important that the level of additional copayments the patient has to pay when going out of network be sufficient to discourage a patient from going out of network. This should be reviewed by the physician leader as part of negotiation of the capitation rate.

**Service Area of Responsibility**

Every HMO is licensed to provide its prepaid health plans within certain geographical areas (i.e., certain counties within a state). State insurance regulators want to know that the HMO has adequate provider coverage in the allowed service area to ensure that covered services will be readily accessible to subscribers. The plan may capitate providers for any necessary services for subscribers within the authorized service area, thus sharing those risks with providers, but who is then responsible for services performed outside the authorized geographical service area? Generally, an HMO plan will limit benefit coverage to services that are rendered within the plan’s authorized service area, except for out-of-area emergency services, which must be covered and are always the health plan’s financial responsibility.

But what about out-of-network services within the allowed geographic service area of the plan? For example, an HMO may be licensed to provide its products throughout a state, a very broad service area. It may then enter into capitated contracts with networks of physicians in several different regions of the state. Each network has its own area of responsibility and a panel of patients assigned to the network. In its own area, the network provides routine and emergency services. What happens when a person assigned to one network seeks emergency care at a facility outside the network’s area of responsibility?

If the capitation contract does not exclude financial responsibility for emergency care provided by networks within the broader service area of the health plan, it is probable that the physician group will bear responsibility for any
emergency services for its assigned patients of the type for which it is capitated. If the health plan has contracts with physicians at all area hospitals, there may be reciprocity arrangements for emergency services pursuant to which all contracted physicians agree to a discounted fee for service for emergency care. Nevertheless, the risk of emergency care provided by other networks may be a large risk for a group of physicians to undertake, and the physician leader needs to understand the scope of this risk.

Nonemergency care sought outside the network is more complicated. If the patient must go through a network primary care “gatekeeper” and may then only utilize network specialists, financial responsibility issues will only arise when a capitated network does not include a certain type of specialist on its physician panel. The capitated panel will then be responsible for payment unless the service not provided by the network physicians was a carve-out (as discussed above). If patients are free to utilize any specialists, not just those who are participating in the capitation contract, participating specialists need to protect against risk when a primary care doctor sends a patient to an out-of-network specialist. This can be accomplished by working with the health plan to establish protocols for primary care physicians, such as requiring them to refer to a network specialist as a first option and to an outside physician only if the patient insists. The health plan must agree to enforce such protocols appropriately, and the specialist group should seek the right to adjust the capitation rate if primary care physicians maintain a pattern of out-of-network referrals.

“Health Plan shall establish protocol for referrals by Contracting Primary Care Physicians for Capitated Specialty Services that will require that before a referral may be made to a physician who is not a member of Physician Group, the patient shall have first been referred to a member of Physician Group and the patient must then have requested a different referral.”

**Defining Payer Services to Be Rendered to Capitated Physicians**

Whenever physicians accept a risk-sharing arrangement with a payer, it is crucial that they be able to monitor their performance and appropriately manage care to their patients. This requires access to detailed information about utilization and costs. One of the most frequent complaints from physicians about capitated managed care is their inability to obtain such information from payers on a timely basis. It is therefore vital to specify in the capitation contract the nature of the information the payer will furnish on an ongoing basis.

The specific information needed will vary, depending on the services being capitated, but will generally include the following:

- Information on patients covered by the capitation.
- Utilization data.
• Capitation payments made, withholds retained for noncapitated provider services, claims paid out of withholds, estimated claims incurred but not reported for noncapitated providers.
• Claims reports.

Provisions for required reporting by the payor can be stated in a general manner or may detail the periodic reports to be furnished:

“Health Plan shall provide Physician Group with periodic reports, not less frequently than monthly, concerning Physician Group claims, out-of-network claims, hospital utilization, and emergency department visits.”

“Health Plan shall provide the following written reports to Physician Group on a monthly basis within 15 days following the end of the previous month:

• Physician Group Claims Report, broken out on a per provider basis.
• Out-of-network paid claims report.
• Out-of-network pended claims report.
• Emergency department visit report.
• Pharmacy utilization report.
• Monthly and year-to-date hospital utilization report and comparison to budget.
• List of members for whom capitation payment is paid.
• List of retroactive additions and deletions from capitation payments.
• Amount of monthly withhold from capitation payment and status of withhold account balances.”

Utilization and medical management are usually functions performed by the health plan, for which it retains part of the premium dollar. Increasingly, physician groups that are accepting risk for medical services are seeking to take on responsibility for these tasks through a delegation of medical management from the health plan and are seeking greater capitation rates for their increased role. A primary care group that is assuming risk for all medical services should at least have a medical management system of its own in place to control referral costs.

“Physician Group shall be responsible for the performance of the initial level of utilization management of Covered Services provided by the Physician Group for Health Plan Enrollees. Physician Group’s policies and procedures for utilization management must meet or exceed the requirements of the National Committee for Quality Assurance and any applicable state or federal laws or regulations.

“Physician Group shall report to Health Plan in writing on a monthly basis regarding its performance of utilization management. Any initial decision by Physician Group which would have the effect of denying a benefit or medical care to an Enrollee shall be reported to Health Plan within 24 hours.”
A specialty group under capitation is not in a position to take responsibility for medical management, but it has as much concern about it as does a primary care group. If the health plan is not properly managing care, primary care physicians in the plan’s panel may find it economically attractive to over-refer to the specialist network that is capitated—it means less work for the primary care physician and no reduction in revenues. To accomplish this, the capitation contract should obligate the health plan to establish, in conjunction with specialists, referral protocol for the specialty. If historical referral patterns of primary care physicians in the panel to capitated specialists show any material variance, the capitation rate should be adjusted, due to the health plan’s failure to properly medically manage.

“Health Plan, in consultation with Physician Group, shall establish protocol for when referrals by Contracted Primary Care Physicians for Capitated Services are appropriate. Health Plan shall monitor compliance with such protocol and provide a quarterly report to Physician Group on compliance with said protocol. If Contracting Primary Care Physicians fail to follow such protocol for more than 10 percent of the referrals to Physician Group during any quarter, the capitation payment to Physician Group shall be increased by 10 percent during the following quarter.”

While some medical and utilization management may be delegated to the physician group, it is important that the capitation contract state that the health plan has sole final responsibility for decisions of benefit coverage and medical necessity for coverage purposes and that the contract is not intended to give any third party (e.g., a patient) a right of action against the physician group. This will help limit the physician group’s litigation risks for decisions that are ultimately the managed care organization’s responsibility.

“Notwithstanding the foregoing delegation of initial level utilization management of Covered Services to Physician Group, Health Plan shall be solely responsible for all final utilization management decisions, including all decisions on benefit coverage and medical necessity. Health Plan and Physician Group intend that nothing in this Agreement is intended to confer any rights or remedies on any entity or person other than Physician Group or Health Plan and that no third party shall have any rights, benefits, or claims under or as result of this agreement.”

**Payments to Providers**
Calculation of capitation payment rates is a topic covered in other chapters, so we will not be discussing the subject here. There are numerous other points relating to the capitation rate and to payment to the capitated physicians that should be addressed in the capitation contract.

As an initial point, a physician group may elect to accept capitation from a health plan for certain, but not all, services the group provides for plan members. The capitation contract should state that any services not
included in the scope of capitated services that are provided by the physician group should be reimbursed on a fee-for-service basis.

Often times when a capitation rate is being negotiated, physicians can not get adequate information about the demographics and the medical histories of patients that will be assigned to the group. The plan might have a new product line with no subscriber history, or there may be insufficient numbers of subscribers in the plan for any reasonable actuarial data to apply. In such cases, there needs to be a provision in the plan that allows for renegotiation of the capitation rate if actual demographics or medical conditions of the ultimate patient group vary materially from actuarial or historic norms. This protects capitated physicians from unknown risk due to a lack of adequate information.

“If, following the first two quarters’ experience, actual utilization under this Agreement exceeds projected utilization as budgeted and furnished to Physician Group by Health Plan by more than 10 percent, the monthly capitation payment for the last two quarters shall be increased proportionately to said increase in utilization.”

Capitation arrangements will include withholds from the capitation payment to provide a reserve for the health plan to pay for services provided by physicians not included in the capitated group or network. A reserve is needed because the plan will not receive bills from out-of-network providers until after the monthly cap payment has already been made to the capitated group. These incurred but not reported claims from out-of-network physicians constitute a significant risk for the health plan in the event of termination of the capitation contract or insolvency of the capitated group. The contract should clearly state the amount of the withhold and the specific uses for the withheld funds. There should be periodic reconciliation of the withhold fund and an accounting of the fund to the group from the plan. If possible, all withheld funds should be placed in an interest-bearing account so the capitated group does not lose the time value of the money.

“Ten percent of each month’s Capitation Payment will be withheld in a Withhold Fund. Claims for out-of-network Capitated Covered Services will be deducted from the Withhold Fund. Health Plan will provide a monthly accounting of all withholds and deductions from the Withhold Fund.

“Surplus funds in the Withhold Fund will be distributed to Physician Group at the end of each contract year. An accounting of all withheld amounts and deductions from the Withhold Fund shall be prepared on an annual basis by Health Plan and furnished to Physician Group within 90 days following the end of each contract year. In accounting for use of the Withhold Fund, Health Plan may deduct from the Fund all out-of-network claims for services rendered during the year of the accounting that were paid by Health Plan during the 60 days following the end of the contract
year. Payment of the surplus funds shall be made by Health Plan at the time of the annual accounting.

“If, over the course of any three-month period during the contract year, the Withhold Fund is insufficient to pay all out-of-network claims, the Health Plan and the Physician Group agree to negotiate a new withhold amount estimated to provide sufficient funds to pay all out-of-network claims.”

Because capitation is based on the number of health plan members assigned to the capitated group, information from which to calculate those numbers must be furnished monthly to the group. It should be clear how a person is deemed to be assigned to the group for any given month. Is a plan member who selects the group on the 18th day of the month deemed to be in the capitated membership for the entire month? How about the 10th or the 25th? Any capitation payment made for a given month should be reconciled periodically with actual patient numbers, after enrollments and terminations are taken into account.

“If a Member is added to a Primary Care Physician’s roster of assigned Members on or before the 15th day of any month, the Primary Care Physician shall receive a full month’s capitation payment for that Member for the month, payment of which shall be made retroactively at the time of the next month’s regular PMPM payment. No retroactive payment shall be due if the Member was added to the roster after the 15th day of the month.”

Some health plans are willing to guarantee a minimum number of members who will be assigned to the capitated group for any given month. If that minimum is not met, the risks to the group increase because of an insufficient number of patients to meet a statistical norm. The contract should provide that the capitation rate will either be increased for those months or will revert to some form of fee for service until appropriate numbers are reached.

Capitation contracts will provide for one or more incentive risk pools, whereby providers can receive supplemental payments for better utilization performance than had been targeted by the plan. One of the most common pools is the specialist referral pool, consisting of all the funds set aside to pay potential specialist claims, the unused balance of which is allocated between specialists and primary care doctors. Also common is the hospital bed-day pool, generally reserved from funds anticipated to be needed for hospital inpatient charges, which is divided among physicians, hospitals, and the health plan if actual bed-days per thousand members fall below targeted amounts. It is important to understand exactly how these pools will work in order to understand the upside potential of the contract. The capitation contract needs to define these risk pool funds in detail—their source, their allowed use, how deficits will be funded, and final distribution arrangements.
Finally, the contract needs to discuss how capitation dollars are to be paid. The physician group may want all payments to go to the group for allocation among group members pursuant to a distribution plan agreed upon by the physicians. However, the capitated group may not have the staff or an information system capable of readily administering such payments. It therefore may want the health plan to distribute payments to group members on the basis of a system provided by the physicians. This should be determined prior to the contract’s going into effect.

**Protection from Unexpected Utilization: Stop-Loss**
Stop-loss refers to reinsurance for the provider to protect against statistically unusual utilization, both in numbers and severity. It is calculated both for services to any individual and to the entire covered population. A health plan will generally provide stop-loss protection for its contracted physicians, at a price. Such reinsurance is also available directly from some carriers. A physician group that is capitated only for its own professional fees may not feel that stop-loss is necessary, choosing instead to self-reinsure by collecting the full capitation payment. A group that is financially at risk for others’ services, for ancillary charges, or for facility fees will likely find stop-loss protection a necessity. The cost of such protection from the health plan should be negotiated separately from the capitation payment in order to allow comparison shopping if desired.

**Obligations upon Contract Termination**
Obligations of the parties to each other do not immediately end upon termination of the term of the capitation contract. First, there will probably be a requirement for the physician to continue any treatment in progress until a transition can be arranged, if necessary, to a new capitated physician group. Also, if any plan members are inpatients at the time of termination, the physicians will have an obligation to continue caring for the patient until discharge.

The contract should provide that physicians will receive payment on some fee for service basis for all care after the date of contract termination.

“In the event this Agreement is terminated, Physician Group agrees to serve Plan Members through the last day the Agreement is in effect (the “Termination Date”) and thereafter until the transition of the Member to a new provider can be arranged or until the Plan benefit for the Member ends, whichever occurs first. Compensation for services rendered by Physician Group after the Termination Date shall be on the same fee-for-service basis as Health Plan compensates physicians through its PPO Plan.”

There are also likely to be unreported out-of-network claims that can be anticipated will be filed after the date of termination. These claims will need to be reconciled and a continuing accounting provided of all withhold funds. Physicians should anticipate that the health plan will seek reimbursement for out-of-network claims in excess of the withhold.
“Following termination of the Agreement, Health Plan shall continue to pay all out-of-network Claims out of the Withhold Fund for a period of 60 days. Health Plan shall provide an accounting of the Withhold Fund and all disbursements from the Fund within 90 days following the termination date. Any balance remaining in the Withhold Fund as of the date of the accounting shall be paid to Physician Group.”

In order for the physician group to maintain its own utilization and medical management system, the health plan needs to continue to provide data to the group relating to the capitation period on the same basis as during the course of the agreement.

“Health Plan shall continue to provide all regular reports relating to Physician Group’s performance, including information on claims, payments, pended claims, out-of-network claims, and payments, for a period of three months following the termination date.”

Amendments to Contract and Protocols
In a standard fee-for-service provider agreement, a health plan will generally reserve the right to amend the contract and its policies and procedures at any time with advance notice to providers. The plan may also modify its contract with enrollees for terms relating to copayments and deductibles that don’t affect the fee-for-service payment to the provider. A provider will usually have a right to terminate his or her provider contract if the amendments are not acceptable.

In a capitation contract, rights to terminate a contract prior to the end of the term other than for breach are not typical, because each party could find itself facing a different financial risk than had been anticipated if the other party suddenly terminated the contract. Because an early termination right is not something to which a plan will readily agree, the capitation contract should not allow unilateral amendment to the capitation contract terms, to the member benefit plan, or to referral protocol without physician agreement. If the health plan insists on having the ability to make such modifications, there should be provision for modification of the capitation rate if such changes materially affect physicians’ risks and costs.

“Health Plan may modify or amend the terms of the Plan Coverage and Health Plan’s policies, procedures, and protocol by giving not less than 60 days’ prior written notice to Physician Group of the changes; provided that, if there is a material change in Plan benefit structure, copayments, or deductibles or in the services or duties to be performed by Physician Group, Health Plan and Physician Group shall negotiate a revised capitation payment to reflect those changes.

The Negotiation Process
It is not uncommon for a health plan to begin negotiation with a physician group for a capitation agreement by proposing a capitation rate for the monthly
per member per month payment based on limited data presented by the plan. Unfortunately, once a rate gets established by an early tentative agreement, it tends to become etched in stone from the plan’s prospective. Often, it becomes more difficult for the physician leader to obtain the information necessary to fully determine the risk involved once a tentative rate is set. Until the physician leader has obtained as much information as possible and has resolved all questions, such as the scope of services to be included, the payment rate must remain open for discussion. Because the payment rate should not be determined until other contract provisions are negotiated, the physician leader should consider bringing advisors and/or attorneys into the negotiations early on, not just for a later review of material terms already agreed upon.

While a physician group may feel that assistance is not really necessary in negotiating a capitation agreement that only covers its professional fees, it only takes a slight adjustment in a per member per month rate to make a large difference in the total monthly payment to the group. Consultant fees may be dollars well spent if they result in a contract that limits financial risk for the covered services.

Finally, most capitation arrangements are described as risk sharing, which implies that the health plan and providers are in some manner partners in dealing with such risks. There is greater likelihood of a true sharing of information and a balanced resolution of issues if the health plan sees that the physician leader has knowledgeable advice on the issues to be negotiated.

What advisors are available to assist the physician leader? Obviously, there are attorneys who practice in the area of health care and can help with contracting. Actuarial firms, historically more likely to be serving the insurance industry, have expanded their services in response to providers’ needs in this area. Numerous consultants with managed care experience are also available and knowledgeable in capitation issues.

How do you locate such consultants? There are several sources, other than traditional word of mouth and telephone directories:

- State bar association and American Bar Association health law sections membership lists for attorneys practicing in the health care field.
- Various medical professional societies (e.g., American Academy of Family Physicians) maintain referral lists for attorneys and consultants.
- Major national actuarial consulting firms, such as Milliman & Robertson, Towers Perrin, and William Mercer, have offices around the country, and many cities have locally based actuarial firms that provide such consulting.
• Medical Group Management Association has many support services available, has associate members in all consulting fields, and maintains a large library of research materials—888/608-5601; http://www.mgma.org.

Summary
In negotiating a capitation contract, the physician leader should obtain knowledgeable advice early in the negotiation process. Throughout the discussions with the health plan, the key goals should be:

• Defining and limiting the scope of the services for which the group will bear financial risk.

• Establishing what the health plan will do for you to help you manage your financial risk.