Ask a Lawyer

Managed Care Reimbursement: Does It Conflict with Optimum Care?

Nayna Campbell Philipsen, RN, Ph.D., JD, LCCE

Abstract

In response to a reader's question, Dr. Philipsen examines the possibilities of conflict of interest in various methods of physician reimbursement.

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NAYNA PHILIPSEN is a practicing attorney in Baltimore, Maryland, and is associated with the State of Maryland's Department of Health and Mental Hygiene. She is also a health educator at St. Agnes Hospital in Baltimore.

Question: I work with a group of Managed Care Organization (MCO) physicians who are paid through "capitation." That means the physicians are paid the same per patient whether they see that patient often or never. Isn't this "conflict of interest"? Is a conflict of interest legal?

Answer: I will address your first question first. The conflict of interest with a capitation system of reimbursement is obvious. The conflict is between the patient's interest in optimum care and the physician's interest in optimum income.

Whether "capitation" or "fee-for-service," all methods of physician payment present a potential conflict. This is not an area that has been subject to the specific law or regulation that you suggest in your question, however. Limits on reimbursement systems that have been set through law have focused on eliminating "bonuses" to physicians for decreasing patient services. Perhaps that conflict is the most obvious to the lay observer.

Physicians have preferred to make the resolution of this conflict a professional ethics issue. As such, it is largely up to the values and conscience of the individual practitioner. In your group of physicians who are reim-

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bursed through capitation, there may be both dedicated physicians who show an active caring for their patients' interests and others who merely meet the minimum standard of care. Both are "legal."

You might be thinking that the conflict between patient care and physician income in the capitation system of reimbursement is obviously dangerous to patients because the physician is tempted to give minimal—not ideal—care. In fee-for-service reimbursement, the physician is paid for performance. What is the conflict with patient well-being there?

The difference is that in your capitation examples, profits increase when care is withheld. In the traditional fee-for-services method of reimbursement, profits increase when services increase.

First, fee-for-service physicians are tempted to provide unnecessary services to increase their reimbursement. At best, these are inconvenient and expensive, and at worst, they carry actual health risks for patients. This is the most apparent conflict in the fee-for-service reimbursement system. However, there are other potential abuses: patient referrals (Does the referring physician own part of the imaging or rehab center?), kickbacks (Does the referring physician get part of the specialist's fee?), side profits (Is the referring physician also the salesperson for crutches, eye glasses, or drugs?), hospital recruitment (Does the physician get awards from a hospital based on admissions?), and gifts (Is the drug company paying for the physician's vacation in the Bahamas?). The difference is that in your capitation examples, profits increase when care is withheld. In the traditional fee-for-service method of reimbursement, profits increase when services increase.

These methods of reimbursement are present today in both managed care organizations (MCOs) and in traditional independent practices. Most MCOs are a combination of fee-for-service and capitation reimbursement systems and perhaps other systems as well (e.g., physician-employee models). A private practitioner may be participating simultaneously in a health maintenance organization (HMO), a private-pay organization (PPO), and traditional plans.

Since none of these methods of payment is illegal, does that mean there has been no response to conflicts between reimbursement and care? I think the answer is "no," but we could do more. First, I think that these conflicts are proactively minimized by professional, cultural, and personal ethics. Second, medical malpractice cases and state professional licensure regulations enforce a minimum standard of care and of ethical practice, albeit often reactively. Third, parties in direct interest, such as private insurance companies and the Health Care Financing Administration (HCFA), are putting great efforts into developing payment guidelines that balance the interests of the patient (payer) and physician (payee), and in educating professionals about these guidelines. Fourth, some of the specific abuses listed above are themselves illegal (e.g., kickbacks and self-referrals) and even criminal.

Consumers (patients) need to be aware of the nature of this conflict in the practice of their caregivers. Patient consumers are vulnerable to abuse because they are often under the stress of illness, do not pay for these services directly, and may be unaware of the nature of the conflict (i.e., whether they are at risk for under-utilization or for over-utilization of medical services by their caregivers). If the physician is paid through capitation, the patient should take a deliberately active role in requesting care. In a fee-for-service plan, the patient should make special efforts to weigh the relative risks and benefits of proposed procedures, treatments, and office visits. All patients should be cautious in situations when the physician doubles as the salesperson, pharmacist, or treatment center owner.

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Childbirth educators (CBEs) are in a position to play a significant role in protecting consumers from abuses related to methods of reimbursement. We can educate consumers to recognize, question, and react to conflicts of interest between reimbursement and medical care. CBEs can easily include resources related to reimbursement in class information packets, including contacts

such as the Patient Care Representative, Special Investigation Unit, or other offices of their insurance plans and hospitals, as well as how to find readable and reliable materials related to their payment and medical inquiries in the library or on the Internet. Patients can maximize their quality of care in any reimbursement system when they identify what that system is and have basic knowledge of how that system functions. With all methods of payment, from capitation to fee-for-service, the aware, informed consumer is the patient who is most likely to get the care that is in his or her best interest.

Finally, we professionals have a special duty, beyond being supportive, to protect patients by enabling them to protect themselves. If you think that a particular

reimbursement-related conflict is abusive and is such a threat to the patient's welfare and safety that it must be eliminated, get informed, get involved, and get it changed. Education, advocacy, and reform are all roles of the certified childbirth educator!

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Kay's Perinatal Crossword Puzzle - JPE 8,2

ACROSS

- 1 Polomeno's article includes the planned content and objectives of a ___ perinatal education program. (Polomeno-JPE8,2)
- 4 Hispanic society gives ___ importance to the position of the mother than the father in nurturing the child.*
- 7 Perinatal education programs need to present ___ expectations of pain during recovery. (Stainton-JPE8,2)
- 10 In this study, pain was reported by all postnatal women in at least ___ location(s). (Stainton-JPE8,2)
- 12 This study sampled 75 women during their first ___ postnatal days. (Stainton-JPE8,2)
- 14 The concept of ___ care is replacing the traditional "fee for service" model. (Geshe-JPE8,2)
- 15 It is important for Hispanic couples to see other ___ couples in the slides presented.*
- 18 Conflict between advice of grandparents and health-care providers is a source of ___ to the expectant couples. (Polomeno-JPE8,2)
- 19 Perceived social support was not correlated with lactation ___. (Boettcher-JPE8,2)
- 22 Grandparents are placed in a no-win situation because of ___ between what children say they want and what they actually want. (Polomeno-JPE8,2)
- 26 More attention is needed in assessment of postnatal pain and provision of ___. (Stainton-JPE8,2)
- 27 Identified grandparenting styles are a) detached, b) passive, c) ___. (Polomeno-JPE8,2)
- 29 Early in childhood, the accumulation of learned impressions is called ___ grandparent identity. (Polomeno-JPE8,2)
- 31 This study found that mothers combining breastfeeding and artificial baby milk had ___ self-confidence than mothers who breastfed exclusively. (Boettcher-JPE8,2)
- 32 The majority of women experienced afterpains especially when ___. (Stainton-JPE8,2)
- 33 Members of the Hispanic community perform much better when allowed opportunities for ___ learning.*

DOWN

- 2 Activities consuming cost are called the cost ___. (Geshe-JPE8,2)
- 3 Stainton's study identifies the location and intensity of ___ after childbirth. (Stainton-JPE8,2)
- 5 Activities necessary for the delivery of services are called ___. (Geshe-JPE8,2)
- 6 Breasts and ___ became more dominant as major locations of pain by Day 2. (Stainton-JPE8,2)
- 8 Hispanic couples are accustomed to ___ style learning which is very different from Lamaze.*

- 9 Women indicated that their pain increased when they were ___ and breastfeeding. (Stainton-JPE8,2)
- 11 Some women find it difficult to request help because they don't want to seem ___. (Boettcher-JPE8,2)
- 12 Grandparenting drive and successful coping is called ___ grandparent identity. (Polomeno-JPE8,2)
- 13 ABC stands for ___ -based costing. (Geshe-JPE8,2)
- 16 Education is one of the ___ factors that influences breastfeeding duration. (Boettcher-JPE8,2)
- 17 When hospital staff distributes samples of human milk substitute, it creates a ___ factor that influences breastfeeding duration. (Boettcher-JPE8,2)
- 20 Many Spanish-speaking countries establish the teacher as the ___ figure.*
- 21 To encourage participation, Hispanic fathers need to see other Hispanic ___ interacting with their babies.*

- 22 The key to a successful program that educates Hispanic couples is to offer a ___ relevant presentation.*
- 23 Effective teaching methods for well-educated Anglo clients may ___ Hispanic couples.*
- 24 Periods between each family life stage are called ___. (Polomeno-JPE8,2)
- 25 The grandparent ___ is ambiguous since expectations are not often clear. (Polomeno-JPE8,2)
- 28 Women rated location, intensity, frequency, and ___ of pain each day. (Stainton-JPE8,2)
- 30 Painful urination and pain in the epidural site were rated as the number ___ site for pain on Day 1. (Stainton-JPE8,2)

Created by Kay Raheja, RN, FACCE

*Clues with an asterisk refer to an upcoming article in a future edition of JPE. Be sure to check your next issue of the journal!

(See solution on page 48)