READER'S RESOURCE 1.4
Interview with Bruce Cappo, PhD, Clinical Associates, P.A.

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Bruce Cappo, PhD, is the founder and owner of Clinical Associates, P.A., a major behavioral multispecialty satellite practice in the Kansas City area. Dr. Cappo has been innovative in branching out to underserved areas and growing his practice. But, as he details, competitive pressures are increasing. He kindly gave of his time to talk with Brett Steenbarger about the growth of his group, the collaborative strategies he has employed to this point, and the challenges of a consolidating market. Note how the issues of scope and integration have played a major role in the planning of the group practice.

STEENBARGER: Maybe you could give me a little background on yourself, how you became involved in group practice originally, and how your group has evolved.

CAPPO: When I was in the second year at Kansas University and had completed my master's degree, I had started working at the mental health center in Leavenworth. . . . A psychiatrist was there. I became very interested in his private practice. He had a large practice. He was doing a lot of rural stuff as well as work based out of Shawnee Mission near Kansas City. Then I went away, finished up my internship, came back, and ended up being the clinic administrator at that mental health center. He asked me if I was interested in joining his group. He had himself, another psychiatrist, a PhD psychologist, and a woman who was a nurse and a psychologist. The other psychiatrist died and it was the four of us. Then we started expanding a little more, adding people, some of them who had worked at the mental health center previously and had gone on to get their advanced degrees and were interested in the private practice world. . . .

STEENBARGER: This was back when? What year?

CAPPO: 1987, 1988. Then we started branching out a little more into the community there in Leavenworth as well as some of the outlying communities. As we grew bigger and people knew us because of the mental health center—it was because of the small towns where everybody knows you—then they would just call us. As people we had contact with spread out to further and further places, they would call us to further and further places. We started going to a lot of nursing

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homes—I think we were covering nine nursing homes at one point—and in a lot of those we were the only nonphysicians to come in and offer services. . . .

[This is a great example of using a niche strategy to secure a base from which subsequent expansion can occur. See Chapter 2 for a discussion of core strategies.]

STEENBARGER: As you were expanding, how was that expansion taking place? Was everyone in the same physical locale or were you expanding in a network?

CAPPO: We were all based out of an outpatient office in Shawnee Mission. It really started as more of a billing office because the psychiatrist was more inpatient-based initially and would just see outpatients at the hospital. We also had another hospital in Leavenworth where they gave us offices. So we didn't have a huge need for an outpatient office. As the practice started growing more, we did move across the street into nicer, larger offices. Then in the smaller communities we would just find the local physician for the hospital and say, "Hey, we want to rent space a half day a week," and that worked out very well. The physicians loved to have us in there, because they could funnel their patients to us. . . .

[Note how Dr. Cappo's group kept start-up costs down by renting space cheaply and using independent contractors, even as it positioned itself nicely with hospitals, nursing homes, and medical practices.]

STEENBARGER: So you were really going after the medical practitioners, renting some space near them, facilitating referrals. Were you working from a staff model for your group at that point? . . . Were people added to the group employed on a salaried basis?

CAPPO: No, this was all on a percentage. . . . I think it was 30% would go back to the practice and that would include all overhead. You'd cover your own testing expenses, travel, and that sort of thing.

STEENBARGER: So the folks joining the practice were independent contractors.

CAPPO: Yes . . . and then when that started getting so big that it was difficult to manage, the psychologists were handling all the paperwork and the reports and had more demands for office staff in the outpatient area. The psychiatrists weren't experiencing that and didn't want to pay for it . . . so I ended up splitting off down the hall, let's see, 3 or 4 years ago, and I took some of the folks with me, including unlicensed assistants. It changed a bit in the last few years, but you could have comparable physician extenders in unlicensed assistants with a psychologist.

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So I could have PhDs [who weren't] finished with their supervision or hadn't completed all their requirements.

STEENBARGER: And they could bill under your name?

CAPPO: Right. Managed health care has pretty much put a stop to that!

STEENBARGER: Yes. In most areas, they're not too happy when people do that!

CAPPO: But you used to be able to do that. So I had those people as employees, because I was obviously supervising them. And now they've gone on to get their degrees and we have them as independent contractors.

So I split off down the hall . . . and started growing a little bit more there. I set up my own P.A. and I'm the only owner of it still. I brought in the unlicensed assistants who were employees at that time and the other people were independent contractors. We started growing with people who wanted to start a private practice and were doing something else part-time and were moving to the full-time aspect of things. Then there were a couple of people who just wanted part-time work to supplement. . . .

STEENBARGER: What market were you going after at that point? Were you sticking with the old strategy of going after the medical groups or were you expanding into managed care? How were you marketing yourself?

CAPPO: We were marketing toward managed health care. We had gotten on early. The psychiatrist's pull was very much an early force in managed care locally. . . . We joined everything in the beginning and then dropped most of them after a year, because they didn't pay, or weren't run right, or whatever. We were doing a lot of things for HealthNet, which is one of the bigger managed care organizations in town, and we're very open to any of the out-of-town folks. . . . So we started getting into those early on.

The second thing we were doing was contract work. We got into the federal prison system. They have a drug and alcohol prevention services program that was run by the federal government. But I actually started back in Leavenworth. Leavenworth has six prisons now, five back then, and they were looking for people to provide outpatient services to folks who were leaving the penitentiary and were staying in that area, who had gone in for drug problems. Well, the mental health center didn't really want to do it and I thought it would be a great idea. . . . So we started getting in there on a sort of fee-for-service basis. Every 3 years it comes up for cycles and so it started to come up for an actual contract award. We bid on that and also bid on some

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surrounding areas . . . and eventually we were able to retain the Kansas City area.

[The work with nursing homes and prisons is an excellent example of collaborative practice. Dr. Cappo's practice has been fueled by forming effective partnerships with solid referral sources.]

STEENBARGER: And how much volume was that accounting for?

CAPPO: That was probably at its highest about $8,000 a month. And now it's fallen off, to only a few thousand a month because of the mandated minimum sentences coming into place. All the people who were getting out after one-third of their sentence are no longer getting out! Eventually down the line, there's going to be this huge bump in the snake, so to speak, when the minimum sentences come due.

The other thing we did was get into the Medicaid arena. There were not many private practice folks doing Medicaid, especially not in Johnson County and higher-income areas. So we had that area, where, if you were doing the volume, you could handle the lower fees. We were basically seeing everybody's patients, because we were the only ones doing it.

STEENBARGER: In doing Medicaid, were you doing it through managed care organizations or were you just working straight with the Medicaid system?

CAPPO: Straight with the Medicaid system. It's now coming out . . . there's going to be an RFP [request for proposal] to turn [Medicaid] mental health into managed health care.

STEENBARGER: And with the Medicaid folks, were you doing this through a clinic entity or through the private practice?

CAPPO: Through the private practice group. . . . It eventually became 20 to 25% of our business. Then we started saying, "Gee, this is getting too big. We need to back off on it." But then there started downward pressure on the rates. . . . By going out to the nursing homes—a lot of the people in the nursing homes had Medicaid—we could be on site and have a lot of people available to us. We knew people were not going to not show up. So it turned out to be economically feasible.

STEENBARGER: Did you find many differences between the public-sector clientele and the ones in the commercial insurance pool?

CAPPO: In the rural areas, not a lot. In the suburban areas . . . there were some difference there, obviously. Although we've had much better luck collecting patient payments from people in the lower-to-middle-income groups than we have from the millionaires!

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STEENBARGER: What kind of growth were you experiencing then?

CAPPO: We were doing about $4,000 a month in billings early on and got up to about $50,000 a month.

STEENBARGER: And in terms of practitioner numbers?

CAPPO: We have 13 now and . . . probably 6 of those are part-time.

STEENBARGER: How many total locations do you have?

CAPPO: Right now we just have this office and the Lawrence office, and we have three other places where we can see people.

STEENBARGER: How have you found the managed care business evolving for your group over the last few years? Is it accounting for more of your volume?

CAPPO: Much more of the volume. And we were in the negotiations more, early on. We were much more partners in bringing these changes about: "What can you do to help?" and so on. Now . . . they're setting more of the rules. "Are you willing to come on?" If they don't get enough people to come on with those rules, they modify the rules only slightly and see what they can get. And it's become much more adversarial. I think they're feeling the squeeze as well.

STEENBARGER: Are those mostly HMOs or the big carveouts also?

CAPPO: We have not worked with the big carveouts yet. We've had negotiations, all of which have fallen through.

STEENBARGER: Why did they fall through?

CAPPO: Well, in the two cases we've had, there have been simultaneous negotiations going on with different people that we were unaware of at the time. The negotiating entity stated that they were unaware that people in their organization were negotiating with different groups as well. But it's been a "whoever can cut the best deal fastest" kind of thing and I think that we were probably not willing to give in as much.

STEENBARGER: And where were they trying to cut deals? What kinds of conditions were they imposing?

CAPPO: Wanting to share the risk, some capitation. Also just super-discounted fees in terms of their holdbacks, where you didn't have control over whether the company would make a profit. If they take a 15% holdback, you're really counting on them to run their organization lean enough . . . and that just seemed like giving up too much control over things.

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STEENBARGER: Let me get it straight. The withhold is based on *their* performance, not yours?

CAPPO: Well, it's based on the performance of the whole thing overall. They're saying, "We'll sell these contracts and we want a 15% holdback. And if there's a profit at the end, then you guys share in that profit to the extent that you paid into that pool."

STEENBARGER: I see. So it's not just based on your performance as a practice group. . . .

CAPPO: The whole organization. Right. . . .

STEENBARGER: So you're the exclusive provider under that contract?

CAPPO: No, we're in the exclusive provider group, which is less than 10% of their network. Our group is not the only psychologists, but we're probably one of three groups in the entire county. It's pretty limited but not totally exclusive.

STEENBARGER: So if they're doing a withhold, it's not only based on the managed care organization's performance and your performance but on the performance of the other groups as well.

[This is not an ideal arrangement. If a contract requires that a percentage of clinical revenues be withheld and placed at risk based upon cost-effective performance, one wants to be as much in control over the return of the withheld dollars as possible. Under the arrangement described, Dr. Cappo's group could practice very efficiently and still lose the withheld funds.]

CAPPO: Yes.

STEENBARGER: So you're taking multiple levels of risk, it seems.

CAPPO: Yes.

STEENBARGER: Maybe you could talk a little bit about the dilemmas you faced in deciding whether to go with a contract, not go with a contract . . . were those tough decisions for you?

CAPPO: We have, for the most part, been willing to give people a try for about 1 year. It wasn't until the last 1½ to 2 years that things really seemed to take a turn. As of now, we're not as willing to go in for 1 year on things. The one group, through a series of purchase buyouts and mergers, has over 300,000 lives just as a start. They were not willing to cover any psych testing, wanting to pay very low rates, wanting a holdback on the rates they were paying. And they had a ton of lives. And they had a ton of work. So it was a real tough decision in terms of, "Gee, you know they're not going to make money" [as a result of un-

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derbidding to get the contracts]. So you know you're not going to get that 15% back, if they're cutting deals like that.

STEENBARGER: I see. And what sort of rates were you looking at without the 15%?

CAPPO: In the $63–70 range. Seventy was the highest.

STEENBARGER: And they'd take the 15% out of that.

CAPPO: Correct.

[Note: This would create an approximately $42 reimbursement to an independent contractor, after the 30% overhead deduction.]

STEENBARGER: Wow! They really cut down on the reimbursement. It would almost be worth it to move toward a capitation basis with them.

CAPPO: It would, except that . . . the demand for services in the area we're in is pretty high. . . . We're dealing with a lot of kids, we see a lot of ADD [attention-deficit disorder], behavioral problems in adolescence. The parents are real interested. They're open to psychological services. That's an area they search out. A second group we deal with is the Medicaid types of population, even though they may not have Medicaid. There's just a lot of problem families that would be high utilizers of services. And that's what scared us a little.

STEENBARGER: That would be a tough one. They had 300,000 lives and you decided to pass that up. . . . Who decided to take on that business?

CAPPO: Older people who had not been in the managed health care arena and it was kind of a way to get in the door. Their practices had gone way down.

STEENBARGER: Were these groups or individuals in a network?

CAPPO: Individuals. The other were new people coming up. It was all they could get and they were willing to sell their soul to do it. The other thing that they have said to people is that they want an exclusive group. So they would be willing to let in a large group, but then they want to take over a majority of your business and would somewhat own you. A great deal for no one but them! Especially when next year comes around and it's like, "Gee, things are tighter. We need to increase that 15% to 20%" or whatever it is. So eventually I think what they're moving toward is owned practices without the risk of owning the practice.

STEENBARGER: It seems as though it puts pressure on you if there's a relative glut of practitioners who have to take fees in the $50 range.

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CAPPO: Yes.

STEENBARGER: Because if you don't take the business, someone else will. As a result, it ratchets everything down. Have you noticed that in the Kansas City market?

[This is what happens when cost, independent of quality, becomes the central priority. It will be interesting to see how this market is affected by the continuing push for quality, including the need for accreditation among managed behavioral health care organizations and the drive for parity between mental health and medical coverage.]

CAPPO: It has. In fact, I was talking with the psychiatrists. Income is down about $20,000 this year each. Our billables have increased [i.e., hours billed], our collection rate has increased, and our receivables [i.e., cash received] have decreased. So we're getting less per unit served. Mostly because of managed health care. The rates have just snaked down, as you're saying.

STEENBARGER: Looking out into the future, the next five years, how are you as a group practice thinking about dealing with this trend?

CAPPO: The thing that we're talking about, that we haven't taken action on yet is that we would get bigger and add more specialties and try to be big enough where we could handle everything in house. We all know each other, we can provide savings by doing that, and then they [managed care organizations] would be more inclined to deal with us directly and more willing perhaps to not pressure us as much on price, because we have internal controls in house.

[Note how the managed care trend is pushing Bruce's group toward even greater levels of integration and collaboration. Note below also that greater collaboration allows the group to maximize its operations apart from the major managed insurers in the region.]

STEENBARGER: When you say "add specialties," what specialties do you currently have and what would you think about adding?

CAPPO: We have just psychiatry, psychology, and social work. Somebody should be into gerontology, perhaps to cover a lot of the nursing home and older dementia kinds of things that we have. We have an adult psychiatrist and a child psychiatrist, but just expanding that, adding more people, and possibly even down the road further a child-based model, going into pediatrics, something like that.

STEENBARGER: What do you foresee with the 1115 waiver [i.e., statewide waiver from Medicaid regulations allowing for demonstration projects re-

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garding cost-savings] going through and the Medicaid recipients being enrolled in the managed plans?

CAPPO: We could come out fine on that. The way the state has done it so far—they've done it with the medical end here last year—they've allowed three or four HMOs to cover the various areas. So if they do that same thing with mental health, there are enough players that we are probably going to be in on one of them that gets the contract.

In terms of being able to manage that, the costs are so escalated now because of the mental health centers that it would probably be quite easy to cut some fat and come out looking pretty good, at least the first few years.

STEENBARGER: Would you be partnering with the mental health centers? Would you be taking business from them?

CAPPO: The latter. . . . They've asked to talk with us. . . . I doubt that marriage is going to work. There's such different philosophies.

STEENBARGER: So all of this is creating tremendous competition for the community mental health centers.

CAPPO: The mental health centers in Kansas have formed their own private organization called the Consortium that can then go out and bid against the private practitioners for private business—you have to be a mental health center to join it—while maintaining the advantage of being able to have master's-level people call themselves psychologists and offer services without licenses.

STEENBARGER: Whoa!

CAPPO: That's been the big thing with the mental health centers that we've fought for years. They go out and they say, "Gee, we'll take that state contract from Blue Cross/Blue Shield. We can offer psychologist services for $30 an hour." Well, they can because they get to call their master's-level people psychologists.

STEENBARGER: So it's not a level playing field, from your vantage point. . . . That's a significant development. Sounds like it could be a significant volume.

CAPPO: Especially in certain areas. The way Kansas is set up, as you know, there are areas where there's just nobody out there. They have only the mental health center to deal with. That's their big advantage and that's what they can sell: "We can blanket the state."

[Note here the opportunities for collaborative practices that can cover wide ge-

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ographic regions and offer high-quality, cost-effective services to the public sector.]

STEENBARGER: Sounds like you do have some capacity in the rural areas. Is that something you're looking to grow?

CAPPO: We do and we are looking to grow it, but we're also very hindered. The only way you can get psychologists out to some areas is by plane, unless you're living out there. . . . It's very expensive.