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INSIDE

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Are you spotting 'flags' that indicate a potential medical error problem?

A well-educated patient is your best line of defense

There's no doubt that one of the biggest medical issues in the news lately has been patient safety and the Institute of Medicine of the National Academy of Sciences report late last year spotlighting patient deaths and injuries as a result of medical errors.

Although the vast majority of fatal errors occur in a hospital setting and hospitals have received most of the attention so far, physician practices should start to look at patient safety in their offices, the experts advise.

"In general, medicine is very safe, but medicine also is very complex and not without risk," notes **Nancy Dickey**, MD. She is past chairwoman of the board of directors of the National Patient Safety Foundation (NPSF) in Chicago, one of several organizations joining to look for ways to reduce medical errors. "Any error that harms a patient is one error too many. While we may never achieve perfection, we must continue to strive for it."

"Most of the problems are not problems of individual performance. They are system failures. What practice administrators should focus on is how to make the systems work better," asserts **William Jessee**, MD, president and CEO of the Medical Group Management Association (MGMA) in Englewood, CO.

Watch for the signals

One way to begin your quest to improve patient safety is to think about the clinical-practice and patient-risk issues that keep you up at night, advises **Sandra Berkowitz**, RN, JD. She is senior vice president and managed care practice leader with Marsh Inc., a Philadelphia firm specializing in insurance and risk advisory services.

There are flags you can look for that can signal that your office systems need improvement. These include:

• missed appointments by patients who need important follow-up diagnostics;

• patients with a rapid increase in the number of office visits with more complaints;

• patients who call more than three times on the same issue;

• patients with bad test results who don't follow up.

For instance, if a 15-year-old asthma patient has been in the office three times recently with peak flows that are less than marginal and ends up in the emergency room, that should be a red flag.

"If we have some measure to steer the practice to doing quality care, we'll sleep better at night, be more satisfied that we have done a good job, and at the same time avert medical errors," says **Fay Rozovsky**, JD, MPH, senior vice president of Marsh Inc. and practice leader for Project MindShare in Richmond, VA.

Reduce errors by educating patients

Teaching patients how to be good patients goes a long way toward reducing medical errors, she points out.

One approach is to develop a brochure that introduces patients to your practice and explains how they can work to ensure they get the care they need. But you should supplement your written materials with personal communication, she adds. For instance, encourage your patients to be totally honest with the doctor or the nurse practitioner and not hide or emphasize symptoms. "It's very hard to diagnose when you don't know what the problem is."

If there is someone in the room with the patient, Rozovsky suggests asking that person to leave so everything said between patient and doctor is confidential.

Rozovsky suggests approaching any problems a patient may have with compliance upfront. Find out if the patient might have problems taking medication or can't afford it, and deal with it deftly. If you think a patient needs a drug that can't be taken with alcohol and the patient loves fine wines, you need to know it and make sure the patient is comfortable with taking the drug.

"The only way doctors can know is if they start questioning. They should be sure they understand how the patient feels and that the patient is comfortable with the treatment," Rozovsky says.

If you believe a patient needs a certain antibiotic but her plan won't cover it, be upfront with that patient. Tell her how much it is likely to cost out of pocket and ask if she still wants that prescription. If she doesn't, suggest alternatives but point out that it may take longer to treat the problem.

"You aren't questioning the patients' pocketbook, but you are telling them they have two tracks to take," Rozovsky says.

"For both plans and physicians, it is a matter of grappling with the idea of customers being empowered. Patients have choices to make. Do they want to spend $80 on medicine or go to a concert? Physicians have presumed they knew the answer to that," Berkowitz says.

What makes the patient satisfied is to feel better, to have a chronic illness managed well, to have someone they can talk to when they call, Rozovsky points out.

"If patients are unhappy, they feel dissatisfied and have bad outcomes, then you have all the right balls in line for a lawsuit," she adds. ■

Reminder to self: Use more office reminders

Don't let tests, procedures fall through the cracks

If you're a pet owner, your veterinarian probably sends you a reminder card when it's time for your pet's shots and checkup. Don't your patients deserve the same kind of reminders and follow-ups that your dog or cat receives?

"Patients greatly appreciate the fact that somebody cares enough to follow up and see if they have a test. It increases confidence and reduces liability. It's a no-lose situation. It's easy to set up. We have to wonder why we aren't doing that," says **William F. Jessee**, MD, president and CEO of the Medical Group Management Association (MGMA) in Englewood, CO.

The MGMA conducted an informal poll of members last year, asking them to identify what they perceived to be the risks in an office-based practice. Of the 200 people who responded, 57% said that the greatest risk was lost diagnostic or lab testing.

"A lot of times, things fall through the cracks. We weren't surprised that was perceived as a common risk, but we were surprised that it was the biggest risk," Jessee says.

Their perceptions are backed up by the MGMA's Center for Research project to improve

the effectiveness of early diagnosis and treatment of breast cancer in office-based practices. The study was originally funded by a grant from a Denver malpractice insurance carrier.

When researchers analyzed the last 10 years of claims, they found that delays in the diagnosis of breast cancer was the second biggest cause of liability claims, Jessee says.

"We have worked with oncologists to do a closed claim analysis to see if common system breakdowns lead to delay. It's not a matter of a knowledge gap. We know that early diagnosis is important, and when that doesn't happen, something broke," he says.

Researchers found that in the vast majority of cases, the system broke down. For instance, the patient may have been referred for a routine mammogram and there was no evidence that the patient had a mammogram or no evidence that the report came back to the doctor, or if it did come back, no evidence that it was reviewed.

"These kind of issues are fairly well solved by putting protocols in place," Jessee says.

As a result of their study on breast cancer, the MGMA's Center for Research has developed a CD/ROM-based training program for office staff and protocol for management of women at risk and women with a self-diagnosed lump. The center is in the second phase of testing the protocol among patients in 30 medical groups in Colorado. "If it works, we plan to shift into high gear," Jessee says.

Follow up with patients

An integral part of every physician's practice should be a plan to follow up when patients have a procedure, or when they should come in for routine tests, says **Fay Rozovsky**, JD, MPH, senior vice president of Marsh Inc., a Philadelphia firm specializing in insurance and risk advisory services, and practice leader for the company's Project MindShare in Richmond, VA.

She advises practices to develop a tickler file to remind patients of routine tests such as mammograms. Practices should have a system in place to ensure that when a physician prescribes a laboratory test or procedure, these actions take place:

- The patient has it done.
- The physician sees the results.
- The information is noted in the chart.

"These [systems] enhance patient safety but they also enhance patient satisfaction," Jessee says. ■

Communication is key to reduce drug interactions

Determine exactly what the patient is taking

Since medication errors and drug interactions are a leading cause of patient harm, how do you make sure it never happens to your practice? When the Medical Group Management Association (MGMA) conducted an informal survey of its members, respondents cited drug interactions as the second biggest risk in office-based practices.

The issue is complicated by the fact that patients often see more than one specialist, explains **Fay Rozovsky**, JD, MPH, senior vice president at Marsh Inc., a Philadelphia firm specializing in insurance and risk advisory services, and practice leader for the company's Project MindShare in Richmond, VA.

"The doctor who prescribes one drug may not be in communication with another doctor seeing the patient, and the patient ends up getting drugs that counteract each other," she says.

But there are other scenarios that could also result in adverse reactions to medications. For instance, a patient may be taking an antibiotic prescribed by a dentist following a root canal. Or they may be taking herbal remedies from a naturopath that interacts with the medication a physician prescribes. Special health food diets, over-the-counter remedies, and medicine given to them by a friend could also cause problems if you aren't aware of them, Rozovsky points out.

"Just asking a patient, 'What did your doctor prescribe to you?' is a loaded question," she says. Instead, talk to the patient frequently about what he is taking. Make it clear what you mean by medication. Point out the dangers of sharing prescription drugs. "Ask the right questions and give illustrations to the patients about what you mean," she advises

Rozovsky suggests developing a survey with specific questions on what patients are taking. The questionnaire could be given to patients as part of the introduction to your medical practice and repeated each time a patient visits.

Consider having a brown-bag day. Encourage your patients to bring in all the drugs and over-the-counter remedies they are taking. Go through them, and make sure they are taking the right things in the right sequence, she says. ■

9 ways to improve patient safety in your office

1. **Conduct an inventory of risk areas.**
One risk assessment tool is available to members on the Medical Group Management Association (MGMA) Web site. "We encourage people who are in an office-based practice to go through the self assessment program. Some people have told me that the program alone is worth the cost of membership," says **William Jessee**, MD, MGMA president and CEO.

2. **Develop a flowchart of processes that occur in your office from the time a patient calls for an appointment until they walk out the door.**
Go through the flowchart of office processes and look at all the areas where something could go wrong. Include how patients are triaged, how long it takes for them to get an appointment, what happens when they walk through your parking lot. Review the flowchart of a patient who comes in contact of your practice and determine what could lead to a breakdown in the system that would injure patients.

3. **Examine your office for patient safety problems.**
Include access to drugs or sharps, the type of seating in your waiting room, and what hazards patients may encounter walking through your office. Check the parking lot to make sure it is safe. For instance, when the weather is cold, make sure the parking lot and walkways are clear of ice and snow.

4. **Discuss patient safety issues at staff meetings and keep staff aware of the issue.**
Keep the lines of communication open among all the staff, and make them aware of patient safety concerns.

5. **Urge your patients to come in with a list written questions.**
See that they check off the list when the questions are answered. The questions and answers should also become part of the patient record, Rozovsky suggests.

6. **Encourage your patients to call if they think there is a problem.**
Make sure patients with chronic conditions don't wait to call until the problem is exacerbated. Make sure patients know there is no such thing as a dumb question.

7. **Give your patients times when they can call and get a reply.**
Make sure your practice has the right person taking calls. The patients may prefer talking to the nurse practitioner or physician assistant. If it's a complex problem, that person could refer the patient's call to the doctor.

8. **Keep your internal communications flowing well so everything can be documented.**
For instance, if a patient calls after hours, the patient's questions or problem and your response must be documented in the records. If you have evening clinics, the staff should have access to the patient records.

9. **Investigate the latest technology to see if it will work for you.**
Technology has the potential to cut down on medical errors, particularly when it's a case of poor physician handwriting, dosage errors, or lost records.
"There is no question that many of the most glaring safety issues relate to the lack of computerized systems for capturing information," Jessee says. For instance, it's harder to lose test results in an electronic file than in a paper file.
"The new emphasis on safety issues has given visibility to the importance of information management," Jessee says. However, he points out that right now most of the medical information systems are fragmented. ■

Take a proactive approach to patients' Internet use

Make sure they go to Web sites you find credible

It's a scenario you've either already experienced or soon will: A patient comes to you with a problem. You examine him, make a recommendation, and suggest a follow-up visit. The patient goes home, logs onto the Internet in search of more information about his condition, and comes across www.quackMD.com, a Web site that espouses the latest off-the-wall therapy.

The patient stalks into your office for the follow-up visit, carrying reams of material he downloaded from the site, and furiously accuses you of not telling him the truth.

Patients getting the wrong information over the Internet is a major risk to the patient-physician relationship, asserts **Fay Rozovsky**, JD, MPH, senior vice president at Marsh Inc., a Philadelphia firm specializing in insurance and risk advisory services, and practice leader for the company's Project MindShare in Richmond, VA.

Instead of setting yourself up for a confrontation with a patient who is angry about conflicting information he found on a Web site, Rozovsky suggests teaching your patients how to use the Internet to find good information.

This will involve searching the Internet yourself to find credible Web sites with information you know is accurate. Explain to patients how they can use the Internet to increase their understanding of their disease and help them manage it, she adds.

Check out the sites set up by the health plans you contract with, and see what they are telling your patients, adds **Sandra Berkowitz**, RN, JD, senior vice president and managed care practice leader with Marsh Inc. in Philadelphia.

Many health plans are creating hyperlinks to Web sites they believe contain useful and credible information, she adds. "They are sort of a double-edged sword. The information a plan may be feeding into its home page to attract patients may not be information the doctor is familiar with."

Before you pass judgment on the insurer's site, look at its Internet strategy, Berkowitz suggests. "The plans feel that an Internet strategy is a survival issue. They view it as adding value to their services in an effort to get customers to stick to them," she says. Companies anticipate that in the not-too-distance future, instead of sponsoring insurance coverage themselves, employers will give employees a defined contribution and allow them to pick their own plans, she says.

"If the plans don't create a way to attract the individual customer, they believe they will have missed the boat when the shift comes from the employer picking the plan to the individual choosing," Berkowitz adds. ■

Work with health plans to boost patient outcomes

Good guy/bad guy scenario is never helpful

If a health plan won't cover a treatment you think a patient should have, speak up, advises **Sandra Berkowitz**, RN, JD, senior vice president and managed care practice leader with Marsh Inc., a Philadelphia firm specializing in insurance and risk advisory services.

"It is the patient's interest that physicians must advocate and document," she says. Sometimes this may mean telling a patient that you recommend a treatment that the plan has not approved, and that he or she has the option of paying for it. "Sometimes you have to disclose it and document it. The record should show that you don't stop when the benefit isn't covered and you feel the patient should seriously consider this option."

When Berkowitz works with health plans to develop a risk management program, she asks them to think about what things they would flag, and what situations would create risk for the plan, the member, or the physician.

One red flag that plans often identify is when a primary care provider becomes very vocal in advocating on behalf of the patient, she says.

This could be because the plan has overlooked something the physician feels doesn't put the patient first, she adds. "It is becoming clear that the physician must advocate on behalf of a member when they believe that the plan has made a necessity determination in error. The courts have become quite a bit more sympathetic to providers who stick their neck out. A fair amount of legislation has developed that forbids plans from deselecting providers because of member advocacy."

Complaining about the health plan and creating an adversarial relationship won't help your patients, Berkowitz point out.

But working with providers to reduce the variance in outcomes in medical treatment will, she says. She cites disease management and oncology as two areas where providers and plans have been successful in developing protocols.

Berkowitz urges physicians to get involved in development treatment protocols with the health plans, pointing out that plans usually want the doctors involved to increase overall physician buy-in. "There is a whole lot of cost associated with variability whether it's bad outcomes or a lot of treatment going nowhere. Care management is the area that has the greatest hope that both the physician and the plan are on the same page."

Rather than ranting and raving about what the plan won't cover, it's more productive for providers to work with the plan to create evidence-based medical standards, particularly in the case of chronic illnesses, Berkowitz says. ■

Share, don't hide, your adverse outcomes

Create a formal format and get ahead of the game

When **Sandy Berkowitz**, RN, JD, talks to physicians about what kind of adverse outcomes screenings they do, she rarely gets many answers.

"Among most physician practices, monitoring patient safety incidents is a pretty minimal activity. They obviously assume that they don't make mistakes, but there is pressure on the managed care plans, and they are going to be forced to ask questions of their physicians," says Berkowitz, senior vice president and practice leader with Marsh Inc. in Philadelphia.

Health plans don't want to know about adverse screenings, and providers don't want to tell, and both parties are assuming that no one will really push them into sharing information. But with the new emphasis on patient safety and possible legislature, that's likely to change, she adds.

Physician practices are going to be in a position of having to share some kind of patient safety information with their insurers, and they would be well advised to start now to look at ways to do it, she says. "Practices should create a format that demonstrates they tracked these events on an ongoing basis and get the jump on it."

Create a report you will be comfortable with that covers adverse outcomes. Indicators might include these scenarios:

❒ one patient being seen by more than one provider in the same office;

❒ a patient calling more than three times for the same issue during a 24-hour period;

❒ an asthma patient who shows up in the emergency room after three office visits with marginal peak flows.

Look at that data knowing that at some point in the future, you may have to share it, Berkowitz says. "Whatever these indicators are, the practice could be challenged to come up with a [formal] format," she says. ■

Safety initiative targets ambulatory settings

Plan includes research, education, communication

When the Medical Group Management Association (MGMA) in Englewood, CO, launched its patient safety initiative last fall, it was in October, one month before the well-known Institute of Medicine report on medical errors and patient safety issues.

"We felt that patient safety was going to be an emerging issue in health care and that we needed to be out-front, says **William Jessee**, MD, president and CEO. "We felt that we had something unique to contribute because our competence is in how an office runs in an ambulatory setting."

The MGMA initiative takes a four-pronged approach to patient safety: research, education, communication, and advocacy. The association is working with other organizations to develop a base of information about what the risks are and how physician practices can control them.

The education program aims to raise awareness of safety for medical groups by teaching practice administrators about safety and encouraging them to share information about good practices and where the risks might lie.

"The communication aspect is related to the educational objective but is more a matter of communication within and among practices about safety issues," Jessee says. In the advocacy arena, MGMA's Washington, DC, office is working "to make sure the cure isn't worse than the disease," he adds.

"Once the report came out, it shifted from being a health care professionals' issue to being a public and political issue." The MGMA is working to make sure that whatever legislation is passed helps the safety issue instead of harming it, Jesse says.

In December, the MGMA teamed up with the American Hospital Association (AHA) and the Institute for Safe Medication Practices (ISMP) to improve patient safety. They are developing a suite of assessment tools and protocols for office-based practices that will be consistent with what is being used in inpatient settings.

The tools for office-base practices will be similar to the tool developed by the ISMP and AHA to identify, understand, and reduce medication errors

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Physician's Capitation Trends™

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HCFA issues new rule on Medicare capitation

Agency stirs up capitation changes

Amid the stormy public debate over patient rights and managed care in general, the Health Care Financing Administration (HCFA) recently released an extensive regulation updating Medicare capitation requirements for insurers and physicians.

The Medicare+Choice (M+C) regulation is broad in scope. Below are key questions and answers excerpted from the 150-page new rule published in the June 29, 2000, *Federal Register*, which relate specifically to capitation payment and physician participation in Medicare capitation:

Question: In the past six months, what impact has HCFA's new capitation risk adjustment system actually had? This new capitation methodology is geared to make capitation easier to deal with — especially when patient costs go up unexpectedly. How did payment levels actually respond?

Answer: Actual results are not yet fully clear to HCFA, but analysts are projecting impacts based on mathematical simulations in selected regions. Here are key findings, based on those projections:

• "None of our regions will experience increased [total] payments under the proposed system."

• "The variation between regions is not considerable." For example, organizations in the Atlanta region will see an average 0.7% reduction, and organizations in the Seattle region will see less than a 0.4% reduction.

• Payment levels do not vary based on size of the plan's enrollment. "The variation in impact between the small organizations and the large M+C organizations does not appear to be systematic," the regulation states. "M+C organizations of all sizes are very close to the national average, although smaller organizations will experience a slightly higher reduction."

The risk-adjustment methodology, in which Phase one was begun last January, seeks to adjust capitation payments more sensibly so that more resources can be provided for more costly illnesses and lower payments to less costly treatments. **(For highlights of how this methodology works, see *Physician's Managed Care*, March 2000, pp. 39-42.)** Some physician groups and payers have complained that it really boils down to less money, making them eager to get out of the program. HCFA officials, however, are unconvinced; they attribute it more to overall market uncertainty.

Question: If a Medicare+Select insurer plans to drop me out of their contract, or if they plan to leave Medicare+Select in my area, how many days notice is that insurer required by regulation to give me? Are they required to give me notice?

Answer: Insurers are required to give you adequate notice, although sometimes that doesn't happen, leaving physicians feeling like their patients are being abandoned. The new regulation extends the required notice from 15 days to 30 days notice. Here is how the regulation states this requirement: The insurer must "make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days (revised from 15 days) before the termination effective date." [This notice applies to] "all enrollees who are patients seen on a regular basis by the provider whose contract is terminating. The burden associated with this requirement has not changed."

Also, the regulation includes a provider

anti-discrimination provision that requires the insurer to explain in writing the reason the provider is being dropped.

Question: Insurers complain that the new risk adjustment methodology reduces their payments, but HCFA officials say that's not necessarily true. What influence does HCFA believe the new adjusted capitation payment strategy will have on insurer participation in Medicare capitation contracts?

Answer: Current projections showing lowered payment totals in many areas will change as insurers are more comfortable bringing in less healthy patients, HCFA officials say. The incentive of the risk adjustment scheme is to offer insurers and physicians more of a safety net so that the capitation approach is fluid enough to cover higher-cost patients. Once insurers begin to enroll more at-risk patients, their capitation allocations will increase, rather than decrease.

Here is how the regulation expresses their logic: "Projections on reduced payments assume a stable mix of enrollees. However, we assume that organizations will respond appropriately to the incentives to attract more seriously ill beneficiaries. As a result, organizations can do better under risk adjustment than they would if case mix stayed the same." **(For more coverage of insurer response to renewing their Medicare capitation contracts, see story, p. 122.)**

Question: While physicians and insurers question payment issues, what's happening to premium payments that patients have to provide?

Answer: In a nutshell, here is the patient experience with Medicare HMOs: Higher premiums (therefore higher out-of-pocket costs to them) and reduced benefits. That's not a happy combination for patients, HCFA officials recognize. "While benefits, premiums, and cost sharing remained relatively stable in 1999, year 2000 has been different," the *Federal Register* notice points out.

Premiums have especially increased for rural residents. In 1999, a basic plan averaged $5.35 per month, while it tripled in cost to $15.84 in FY 2000.

Across the country, competition is driving a Wild West atmosphere of a wide array of offers that come, go, decrease, increase — seemingly overnight to some beneficiaries. The variation is incredible, HCFA points out. The biggest wild card appears to be the presence or absence of prescription drug coverage.

Here is how the regulation addresses the roller coaster cost issues for patients: "In Oregon, for example, premiums range from $35 to $83 for benefit packages that do not include outpatient drug coverage, and between $81 and $123 for packages including drug coverage. In Florida, the enrollment-weighted average monthly premium is $84 per month, and all enrollees in Florida M+C plans have drug coverage in their basic package." ■

How competitive is your market? Try these tools

InterStudy offers 'index of competition'

Often at professional meetings, the first thing networking practice managers want to know is not only if a particular colleague or practice is doing well financially, but also what competition that person or practice has to deal with.

Depending on a manager's personality, some thrive in a hotbed of competition and some prefer a less-stressful work environment.

Here's something that can help: InterStudy has devised a quantitative measure for market competition, called the index of competition (IOC), says **Tammy Lauer**, lead researcher for the Minneapolis-based managed care research firm. InterStudy's IOC is based on another index called the Herfindahl index, which is the squared sum of the HMO market shares of all HMOs operating in a given metropolitan market. The IOC equals one minus the Herfindahl Index. IOC values can range from zero (which would be a monopoly, or the least competitive) to one (which is the highest possible level of competition among many HMOs with similar market shares). As more HMOs enter a particular market, the IOC increases.

Interestingly, the 10 most competitive large markets aren't all in California, as one might guess. The most competitive large market is Kansas City, MO, with Charlotte, NC, coming in second and Tampa, FL, coming in third. InterStudy says that Denver reflects the most competitive of medium-sized markets, with an IOC of 0.828.

Or perhaps you have an interst in high-growth HMO areas — either as ones where you want to

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Benchmarks for HMO Inpatient Days per 1,000 Population: Commercial, Medicare, and Medicaid

	25th Percentile	50th Percentile	75th Percentile	Mean
HMO Comm. Inpatient Days per 1,000 Pop.				
Large Markets	211	228	242	224
Medium Markets	219	235	245	228
Small Markets	213	233	250	219
HMO Medicare Inpatient Days per 1,000 Pop.				
Large Markets	1,262	1,455	1,817	1,544
Medium Markets	1,245	1,532	1,895	1,608
Small Markets	1,265	1,693	2,049	1,639
HMO Medicaid Inpatient Days per 1,000 Pop.				
Large Markets	233	416	515	393
Medium Markets	239	392	471	377
Small Markets	232	388	499	395

MSAs with the Largest Net Enrollment Growth from July 1998 to July 1999

Rank	Metropolitan Area	Net Enrollment Growth July-98 to July-99	Plans with Largest Enrollment Contribution
1	Los Angeles-Long Beach, CA	428,485	California Care, Care 1st Health Plan, PacifiCare of CA, Tower Health, Universal Care
2	Fort Lauderdale, FL	220,630	Aetna U.S. Healthcare Inc. — a Florida Corporation, Health Options Connect, Health Options Inc., HIP HealthPlan of FL, United HealthCare of FL Inc. (South Florida)
3	Riverside-San Bernardino, CA	211,296	Inland Empire Health Plan, Kaiser Foundation Health Plan Inc. — Southern CA Region, PacifiCare of CA, Tower Health
4	Pittsburgh	197,731	Advantage Health/QualMed Plans for Health (Western Pennsylvania), Gateway Health Plan, Keystone Health Plan West, Three Rivers Health Plans, UPMC Health Plans
5	West Palm Beach-Boca Raton, FL	183,524	Aetna U.S. Healthcare Inc. — a Florida Corporation, Health Options Inc. Humana Medical Plan Inc., United HealthCare of FL Inc. (South Florida)

The table includes plans new to a metropolitan statistical area (MSA), as well as plans that grew through mergers or acquisitions.

Source for both charts: Interstudy, Minneapolis.

jump into the action, or as areas you want to avoid. **The table on the bottom of page 121** shows cities where the largest HMO enrollment growth is taking place — two in California, two in Florida, and one in Pittsburgh. These five MSAs account for 73% of the net enrollment in HMO growth in the past year.

Another subtle measure of market competition and/or intensity is reflected in the inpatient per 1,000 population benchmarks established in a particular market. **The table on the top of page 121** shows InterStudy's benchmarks for large, medium, and small markets across commercial, Medicare, and Medicaid payers. Unexpectedly, the smaller commercial markets have a tighter mean ratio (219) than the large markets in that category (224). As you would expect, Medicare's ratios are much larger. ■

Payer bailout continues from Medicare+Choice

The grim news of desertion of Medicare-HMO contracting by payers continues to plague the Health Care Finance Administration (HCFA). In preparing their business strategies for the year 2001, some of the nation's largest insurers announced recently their intention to drop out of Medicare+Choice (M+C), the government capitation-driven plan for seniors.

In response, HCFA officials say it's a natural reflection of sweeping changes aimed at improving the program overall, as well as to the national trend of stagnant HMO growth.

Recently, Foundation Health Systems (FHS) of Los Angeles; Aetna US Healthcare of Blue Bell, PA, and Oxford Health Plan in Trumbell, CT, announced their departure from Medicare capitation — blaming their pull-out on inadequate reimbursement from the federal government.

Apparently none of the payers making the announcement, however, are pulling their Medicare+Choice contracts completely, but rather in certain localities where they feel reimbursements aren't adequate. FHS pulled out of some areas, said **Jay M.Gellert**, president and CEO, in a prepared press statement, so that the company could afford to stay in Medicare markets in other areas. And, other payers are expected to announce their plans to ditch Medicare+Select throughout the summer.

The companies' departures were expected, since the Medicare+Choice program has been a key complaint among members of the managed care biggest lobby, the American Association of Health Plans (AAHP), based in Washington, DC.

Medicare officials respond in two ways:

- saying there is no reason to believe the program is dying when in fact it is still growing overall;
- maintaining that many of the localities where insurers are dropping out actually are receiving higher capitation payments, which casts suspicion on whether cost is the driving factor.

Medicare says payment levels are not the only reason for the departure of the plans because in some these same areas payments have either gone up or will be going up. "Payment is rising in all counties this coming year [FY 2001] by an average of 5%, and will rise by as much as 18% in some areas," HCFA officials wrote in the June 29, 2000, *Federal Register* notice on new Medicare capitation rules.

"BBA [Balanced Budget Act] payment reforms were designed to increase payment in counties that had the lowest rates, and therefore the fewest number of plans," the regulation points out. "Yet counties receiving the largest increases under the BBA payment system are experiencing the most disruption. Plan withdrawals are affecting 11.1% of enrollees in counties where rates are rising by 10%, but affecting only 2.3% of enrollees where rates are rising by just 2%."

Overall, HCFA officials seem to view highly touted payer departure from Medicare+Select not as a knock against the risk-adjustment system, but rather the natural turmoil associated with such sweeping changes. "While several states have experienced a significant loss of access to M+C plans, other states have seen access to M+C organizations increase," HCFA officials wrote in the regulatory notice. "In addition, the M+C program continues to grow despite challenges that parallel those in the large managed care market in the United States.

"As of January 2000, there were 6.2 million M+C enrollees, representing over 16% of the more than 39 million seniors and disabled Americans in Medicare." Total Medicare managed care enrollment has doubled in the past four years — from 3.1 million in 1995 to 6.9 million in FY 2000."

However, the rate of growth indeed has stagnated, officials noted, and is now registering at a 1% growth rate in recent months, HCFA officials report. ■

(Continued from page 118)

by medical staff and hospital-based pharmacists.

"We want to piggyback on what they are doing in the hospital so that there will be consistency," Jessee says. "We'll get a bigger bang from everybody's buck from that." ■

Tight control of finances brings capitation success

Monitoring contracts, claims is the key

By carefully monitoring its contracts and its expenditures, Alton (IL) MultiSpecialists has flourished in a heavily managed care environment. The 20-physician practice realizes nearly half of its revenue from capitated payer sources and treats about 10,000 patients under fully capitated arrangements.

"We actually do a very good financially. We make a profit every month on our capitated contracts," says **Virginia L. Drone**, CEO for Alton Multispecialists.

The practice has three commercial contracts and two Medicare contracts with three payers. It has 100% responsibility for all professional services, and because of that, it maintains a mini-insurance function through which it pays claims through a network of about 60 to 70 specialists in the greater metropolitan area, Drone says.

The practice maintains contracts with specialists to provide services that physicians in the practice do not cover. Specialties within the practice include obstetrics and gynecology, general and vascular surgery, orthopedic surgery, neurology, gastroenterology, pulmonology and otolaryngology.

"We insist that if we have a capitated arrangement, we have full control over claims payments. Most physician practices with full risk do not pay their own claims. In those cases, if there are differences between the payer and the practice it comes after the fact," Drone says.

In most of these cases, the payer has paid for services that the capitated group has not approved. "We feel we can do it better than the payers," she adds.

The practice computes an income and expenses statement each month for each of its managed care products. "We convert all our payments to per member per month by specialty so we can compare our expenditures and benchmark them with national data," Drone says.

If the analysis shows that the practice is spending more than what is spent nationally by other commercial or Medicare products, Drone conducts a review. "I evaluate our products on a monthly basis to make sure we are not inconsistent with national benchmarks," she says.

Part of the group's success is in negotiating contracts that will pay off, she says. A committee that includes Drone, the organizations chief financial officer, and managed care coordinator conducts negotiations.

The practice has been treating patients under capitation arrangements since 1985 and has 15 years of data analysis the committee uses in negotiating with managed care contracts.

"In the negotiation phase, I use the data on what our costs are and fold in the overhead. I believe you have to go in armed with the reality of what your experience is and argue that you need to have sufficient coverage, plus your expenses and a decent profit," she says.

Staying in the black

Keeping a handle on claims and making sure they are accurate and the treatment is appropriate helps keep the practice in the black, Drone says. The practice has invested in hardware and software that allows it to automatically evaluate the claims. The software itself processes the claims for accuracy and appropriateness and for bundling and unbundling.

"It gives us a response to the adjudication of that claim. Then we can ask for office notes or operating room notes to evaluate whether the process has been billed as documented in the records," Drone says.

All claims for which the practice has total financial responsibility go through the software, whether they are from members of the practice or outside specialists. If the claims do not meet the practice's standards, they are denied and must be appealed.

"We will deny the claims from both internal and external physicians. It is up to the practice to appeal it," Drone says. This sometimes puts the practice in the position of appealing denied claims from its own physician to its own organization.

"But, in this marketplace, we have to treat ourselves the same way we do the outside providers. We don't discriminate or give our physicians any better break than any others," she adds.

The appeals are reviewed by the medical director and by Drone. If the appeal is denied, the compensation is withheld. "It gives the physicians an incentive to be very accurate." When the practice is audited by its payers, its claims accuracy always exceeds 95%, she points out.

Proper coding is the key to accurate claims, Drone asserts. "We stress that both the accuracy and the appropriateness of how a physician codes is important." Physicians can play a key role in preventing coding errors or correcting them when they occur, and not days or weeks later, she adds.

The practice requires new physicians to go through significant training in ICD-9 and CPT coding. The organization's corporate compliance committee regularly reviews the provider billing and coding techniques. ■

Protocols, referral control are key cost measures

New physicians are 'shadows' for a week

A new doctor joining Alton (IL) MultiSpecialists can expect to spend a week shadowing another physician to learn about how the practice operates. The training program helps the new group member understand the practice's procedures, philosophies, and methods of reducing costs, says **Virginia L. Drone**, CEO.

Here are some of the other programs that Alton MultiSpecialists has instituted to increase efficiency, provide better patient care, and keep costs under control:

Disease management

The practice makes extensive use of protocols as part of its disease management program. In addition, the disease management coordinator, a registered nurse, works with patients with chronic conditions such as low back pain, congestive heart failure, and diabetes. As a result of the patient education programs, for example, the practice has seen a great deal of reduction in emergency room visits for congestive heart failure patients, she says.

Referral guidelines

The practice has worked with its primary care physicians to develop referral guidelines for various subspecialties. The referral guidelines establish what primary care physicians should do to work up a patient or what specifications should be met before the patient is referred to a specialist.

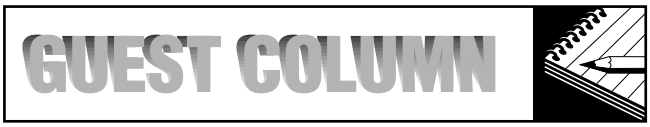
"We have found that from this activity, we have significantly altered referral patterns so specialists are truly getting patients who are ready for care, rather than premature referrals," Drone says.

For instance, the referral guidelines for ear tubes for young children specify that a child with ear infections isn't referred to a specialist until there is a clear demonstration of chronic disease. These guidelines follow the recommendations of the American Academy of Otolaryngology, she adds.

Referral tracking

All physicians in the practice get together for lunch on Fridays to discuss the appropriateness of referrals to specialists outside and inside the medical group. The group generally looks at 50 to 75 pending referrals at each weekly meeting.

"It is a type of prospective peer review. It helps ensure that referrals from the primary care doctors to specialists are necessary," Drone says. The weekly meetings have cut down on the number of referrals to specialists and have helped the physicians learn from each other, she adds. ■



Road to electronic records filled with many potholes

By **David Main**
Partner, Shaw Pittman
Washington, DC

(Laws and procedures regarding medical records are evolving quickly, thanks to technology and new regulations. This question-and-answer format by consultant David Main addresses some of those trends.)

Question: What is the biggest challenge facing health care providers with regard to medical records?

Answer: The biggest problem that health care professionals face is the transition from paper to electronic records. Medical records have been in

paper form for so long, it will be a huge challenge for providers, hospitals, and insurance companies to convert records into electronic forms in a way that will maintain integrity.

Technology is the future of the industry. Patients want it for convenience and accuracy. For example, I went to a doctor the other day for a checkup. His practice has two locations, and I had been to his other office previously. When I arrived for my appointment, he didn't have my file, even though I had told the office to transfer the records. Electronic records could have solved this problem. Soon patients may want to make appointments on-line like they buy airline tickets.

Moving to an electronic model will have its advantages and disadvantages for providers. On the one hand, electronic medical records are portable, they are easier to code for billing and business purposes and more convenient. Generally, the main challenges when dealing with electronic records are privacy, integration (i.e. having systems that communicate effectively with each other), human errors, and duplication. It is important for providers to keep up with the technology, stay informed, and also remember that electronic medical records are not infallible.

Question: How can medical record mix-ups occur?

Answer: Many hospitals have five or six computer systems that don't talk to each other. Under such circumstances, when accessing data you may not end up with a complete file. There could be pieces of information on different computers. Integration of computer systems is key.

There can be instances of duplicate medical records. For example, a patient's last name might change, or there could be two people with the same last name who end up with each other's medical files — a very dangerous situation.

There is also the human error element; data may be recorded incorrectly, and there can be a false sense of security engendered by electronic records. A provider may look at a computer screen and assume that a record is complete or correct, when in fact, it is not.

Question: How can medical record errors be avoided?

Answer: Health care professionals need to stay abreast of the technological developments in the industry. There are usually many local resources, associations, and trade publications that provide information about new technology. For example, here in Washington, DC, we recently formed the HealthTech Network, made up of providers and health care professionals from the Greater Washington area who meet once a month to discuss these issues.

There are many Web sites and companies offering low-cost technology and services such as on-line claims processing for providers; Healtheon / WebMD is an example. For hospitals with complicated records systems, the problem of medical records mix-ups may be tougher and more expensive to resolve. Physicians as well as other providers have to realize they are in a very rapidly changing environment. The new platform is a technological one. For example, I recently heard that medical students at Duke receive a laptop with all their books, lectures, and work for the next four years upon arrival. They plug in their laptops at the library to study. It is a different world!

Question: What legislation has been put in place to prevent medical record mix-ups?

Answer: There has been very little. There have been hearings on Capital Hill about medical records, and there are some proposals on the books that would require medical record errors to be reported and resolved by a specific agency. The only solid legislation, the Health Insurance Portability and Accountability Act (HIPAA), has been enacted to protect the privacy of electronic medical records.

Question: Will HIPAA help prevent medical record mix-ups, and how will this legislation affect health professionals?

Answer: HIPAA will probably help prevent medical record errors because it will impose strict technology requirements to maintain security. Providers using electronic records will be required to have the sophisticated technology necessary to ensure the privacy of records.

HIPAA will be the standard, and the balance is in favor of the patient, in favor of privacy. Electronic records will have to be secure. Of course, HIPAA does not apply to paper records, so a provider will have two choices: Either keep paper records, or comply fully with all the HIPAA standards. Under the regulations, it is an absolute requirement that electronic records remain secure and private.

Question: What impact will new technology have on individual providers?

Answer: We are in the process of upgrading an entire industry. Many providers won't be able to afford the new technology that will be required to maintain electronic medical records.

There is a shortage of capital and reimbursement at the federal level for the hospital industry, and many individual providers may react the way my doctor did — simply hope to retire before having to convert to an electronic practice. But technology is the future of the business. Providers, in cooperation with hospitals and insurance companies, should strive to learn more and embrace technology.

[David Main is based in Washington, DC, and is a partner with the health care practice of Shaw Pittman. You can contact him at (202) 663-8443. E-mail: david.main@shawpittman.com. Web site: http://www.shawpittman.com.] ■

Report says e-care will reduce medical errors

Internet-based technology at the point of care has the potential to greatly reduce medical errors and save money, according to a new report from Friedman, Billings, Ramsey & Co., an Arlington, VA, holding company for a venture capital, investment bankers, and Internet holdings company.

"The introduction of technology at the point of care should reduce medication errors by eliminating illegible manual prescription errors and the possibly fatal adverse drug interactions that can occur when the wrong drug is prescribed," says **James Ackerman**, the company's senior healthcare and technology analyst and author of the report "e-Care: Internet Solutions Changing the Paradigms of Health."

The growth of spiraling health care costs, "health care consumerism," and the use of wireless technology will drive the penetration of the Internet into health care, allowing patients to better monitor their own health, empowering physicians with more resources, and providing payers with a better mechanism for managing care, Ackerman says.

As a result, patients will get better treatment less expensively, he adds.

"Today about 3% of hospitalizations are due to adverse drug reactions, and 25% of medication errors result from drug name confusions. Yet studies have shown that more than half of all prescribing errors can be prevented through computerizing the prescription order entry process," he says.

(The report is available at the firm's Web site: http://www.fbr.com.) ■

Federal court dismisses Medicare lawsuit

A U.S. district court judge has dismissed a lawsuit alleging discriminatory Medicare rates.

In dismissing the suit filed in November against the federal government and Secretary of Health and Human Services Donna E. Shalala, Judge Donald D. Alsop called for congressional action to correct Medicare injustice.

The lawsuit, filed by the Minnesota Senior Federation, Metro Region, and Minnesota Attorney General Mike Hatch, claimed that the current Medicare program has created an unfair two-tier health care system for older Americans, based simply on where they live.

The suit charged that the Health Care Financing Administration allows more than a 200% variance in Medicare reimbursement to counties around the country, making the practice biased and discriminatory.

COMING IN FUTURE MONTHS

- Tips from other providers on keeping your accounts receivables low
- Why flexible hours can enhance patient care
- How to improve your staff satisfaction
- Choosing the right compensation model for your staff
- How technology can help boost your practice's efficiency

The suit cited the case of a 72-year old Florida resident who wanted to move to Minnesota to be near her daughter but is prohibited from doing so because Medicare Part C health coverage in Minnesota is insufficient to meet her health care expenses, as compared to her Medicare managed care plan in Florida.

The court's dismissal of the lawsuit "is not to be considered a judicial endorsement of a reimbursement system, which even the defendants concede results in gross unequal treatment of senior citizens," Alsop wrote in his decision. He called for federal officials to "promptly recognize the injustice they have created and enact legislation to correct it." ■

AMA calls on HCFA to enforce oversight on advanced practice nurses

The American Medical Association (AMA) and 49 of the country's leading medical organizations have charged that the Health Care Financing Administration (HCFA) encourages advance practice nurses to practice beyond legally authorized safeguards.

A petition from the alliance was delivered in July to Medicare officials calling for implementation of a process in which nurse practitioners (NP) and clinical nurse specialists (CNS) would have to work in collaboration with a physician in accordance with each state's legally authorized practice requirements.

The organizations charge that HCFA has made no attempt to reinforce the requirements and has no system in place to ensure that patients are protected from the possible consequences of those who overstep their professional expertise.

"Proper oversight of the practice requirements placed on advance practice nurses is crucial to ensure access to comprehensive health care services, patient safety, and confidence in the health care system. HCFA must be accountable to the law and should not encourage NPs and CNSs to practice without these important safeguards in place," says AMA president **Randolph D. Smoak, Jr.**

The organizations called for four actions:

1. Implement a system that ensures Medicare payments are made only for services that are provided in collaboration with a physician and within the state law's scope of practice requirements.

2. Limit distribution and renewal of Medicare billing numbers only to those advanced practice nurses who comply with the laws.

3. Issue detailed instructions to Medicare carriers on implementation on a system to ensure compliance.

4. Conduct an immediate audit, followed by future periodic audits, to ensure that Medicare payments are made only to NPs and CNSs for services furnished in collaboration with a physician and within the law. ■

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Editor: **Mary Booth Thomas**, (770) 394-1440, (marybootht@aol.com).
Editor of **Physician's Capitation Trends: Reba Griffith**, MPH, (rocky.top@worldnet.att.net.)
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@ahcpub.com).
Production Editor: **Ann Duncan**.

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Editorial Questions
For questions or comments, call **Glen Harris** at (404) 262-5461.

NEWS BRIEFS

Poll finds doctors dislike the health care system

The number of physicians who report being discontented with the national health care system is at an all time high, a recent poll reports. In a survey by Strategic Health Perspective, 83% of respondents reported that they detest the health care system, compared to 51% in 1984 and 67% in 1997.

The poll also found that 72% of physicians said fundamental changes are needed in the health care system and 11% said the system needs a complete overhaul.

Only 10% of physicians said they believe managed care has been successful in improving the quality of care, compared with 43% of the public and 86% of health plan respondents. ▼

Physician leaders use Internet to enhance communications

A third of physician leaders attending the American Medical Association's (AMA) House of Delegates Annual Meeting in June signed up for "Your Practice On-line," a service that helps doctors create customized Web sites and improve communication with patients through electronic mail.

The service is offered through Medem, an e-health network founded by the AMA and a group of medical specialty societies.

Medem's customized Web site service is free for doctors who are members of the AMA or one of the six other founding medical societies.

The AMA says its studies show tremendous growth in physicians' use of e-mail with patients and that the number of physician creating practice Web sites has doubled in the past nine months.

Another survey showed that more than 75% of physicians view Web sites as a valuable resource for patient education. ■

SourceKit

The following sources were quoted in this month's issue:

- **Sandra Berkowitz**, RN, JD, Senior Vice President, Managed Care Practice Leader, Marsh Inc., Philadelphia. Telephone: (215) 246-1051.
- **Fay Rozovsky**, JD, MPH, Senior Vice President, Marsh Inc., Practice Leader for Project MindShare, Richmond, VA. Telephone: (804) 364-3071.
- **Medical Group Management Association**, Englewood, CO 80112. Telephone: (888) 608-5601. Fax: (303) 397-1824. Web site: http://www.mgma.com.
- **American Medical Association**, Chicago. Telephone: (312) 464-4837. Web site: http://www.ama-assn.org.
- **National Patient Safety Foundation,** Chicago. Telephone: (312) 464-4848. Web site: http://www.npsf.org/.
- **Partnership for Patient Safety**, Chicago. Telephone: (312) 274-9695. Web site: http://www.p4ps.com. ■