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PHYSICIAN'S MANAGED CARE REPORT

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INSIDE

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Are you ready for a future filled with boomers, technology, and more MCOs?

Experts herald the new year with a mixed bag of predictions

Charles Dickens could have been talking about the health care environment in the coming years when he wrote, "It was the best of times, it was the worst of times." When *Physician's Managed Care Report* asked a group of experts what doctors could expect in 2001 and beyond, we got a mixed bag of answers, both positive and negative.

The good news for physicians: As the baby boomer population ages, you're going to have a steady supply of new patients.

The bad news: You're going to have to have to see more patients and work harder to keep them happy.

On a positive note, there's a whole world of new technology out there to help physician practices increase efficiency, improve patient care, and achieve quicker turnaround on accounts receivables. **(For more information on computer technology, see related article on p. 4.)**

With the increase in government and managed care regulations and demands from patients, however, you're going to need it. **(For a look at HIPAA and ICD-10 changes, see p. 5.)**

On the other hand, there is a glimmer of light at the end of the tunnel as payers and government officials begin to recognize that increasingly complex rules and regulations do nothing to improve health care for Americans.

Some people call what's happening in health care the hamster effect — the faster a practitioner runs, the faster the wheel spins. No one is optimistic that the situation is going to change.

"Based on the trends over the last several years, physicians are going to be asked to work harder and be more productive to stay even with inflation," comments **William F. Jessee**, MD, president and chief executive officer the Medical Group Management Association (MGMA), based in Englewood, CO. **(For suggestions on how your practice can survive this trend, see chart on pp. 2-3.)**

One reason is a larger supply of patients as baby boomers age,

Six Tips for Survival in the Coming Years

1. Practice more efficiently.

"In the past, practices have been able to get away with some inefficiency. It was tolerable because the margins were enough to compensate for inefficiencies in practice," says **Bob Elson**, MD, MS, of iMcKesson Provider Solutions Group, an Internet-based technology company with headquarters in Minneapolis.

Now, reimbursement rates have dropped and the hassle factor for physicians has gone up. Not only is reimbursement less but physician practices also have to deal with more overhead and an increasingly complex array of payer rules.

Physicians should move back to the basic mentality of how to increase the efficiency of their practices, adds **Randall Killian**, MS, MBA, executive vice president of the National Association of Managed Care Physicians in Glen Allen, VA. "They have to reduce costs, increase customer service and patient satisfaction, and collect what is owed them," he says.

2. Look for alternative sources of income.

Some physician practices are earning money by dispensing products that are quasi health care-related, such as vitamins, grooming supplies, and other therapeutic aids, says **John Knapp**, JD, an attorney with Cozen and O'Connor in Philadelphia.

"Some doctors' offices are doing this and doing it quite profitably," Knapp says. The trend is particularly strong in women's health care as obstetricians and gynecologist dispense skin care products, vitamins, and other items that are not traditional medicine, he adds.

Knapp recommends that doctors look for revenue sources that are not reimbursed by insurance but that consumers are willing to pay for out of pocket, including cosmetic surgery or laser surgery.

"I am seeing physicians revisiting the concept of having their own products, whether it's direct contracting or filing for an HMO license or setting up independent centers," DeMarco says.

Physician-owned centers have done very well, he adds. For instance, if employers say the cost of imaging in the local hospitals is soaring, consider joining with your fellow physicians and creating an independent imaging center. If you can't get procedures scheduled when you want or have to wait for get lab tests, consider setting up an ambulatory surgery center.

3. Don't be tempted to cut back on staff to save money.

"Doctors often shoot themselves in the foot when they see income going down and respond by reducing staffing. Those with higher staffs are doing better and collecting more of the money that is due them," says **William F. Jessee**, MD, president and chief executive officer the Medical Group Management Association (MGMA), based in Englewood, CO.

The MGMA's annual survey shows that practices that are the most profitable and financially successful have more staff per physician than practices that are not doing as well, Jessee adds.

For instance, the MGMA survey shows that some practices are failing to collect 15% of their accounts receivables, money that is legitimately due them. The solution could be hiring another staff person who is not highly paid but is persistent and can keep trying to collect from the managed care plans.

creating a bigger demand on the health care system.

"Age is the single biggest factor in determining the use of health care. As the population ages, the demand for health care will increase. Physicians are not going to have to worry about having enough patients," says **Randall Killian**, MS, MBA, executive vice president of the National Association of Managed Care Physicians in Glen Allen, VA.

That's good news on one hand, but it means that doctors are going to have to figure out how to see more patients, points out **John Knapp**, JD, a health law attorney with Cozen and O'Connor in Philadelphia. "This may include everything from faster through-put to extending hours or making the hours more convenient for patients," Knapp adds.

A cause for concern is that when people start running too fast, they trip and fall down, Jessee adds. So far, that hasn't happened with America's physicians, Jessee says.

"But at the pace some primary care physicians are running people through the office, patients may say stop, or the doctors may mistakes because they are too rushed," he adds.

Physicians also can expect to see a dramatic shift in the type of patient they see. Today's older generation, for the most part, will listen to what they are told, will wait patiently for an appointment, and tend to be loyal to their long-time physicians.

Not so with the next generation of commercial patients and retirees, who are more demanding, more focused on outcomes, and who insist on good customer service from their doctors, says

The extra money collected could more than offset the cost of an additional employee, Jessee points out.

Jessee suggests you benchmark your practice against other practices to see how you are doing. If your collections are less than average, look at what you may be doing wrong.

4. Prepare a long-term budget.

If your practice is like many, you don't really plan ahead for future expenditures. Maybe you haven't had to in the past because your cost of supplies and personnel remained fairly stable.

However, in today's high-tech climate, things have changed and you'll need to plan ahead to keep your practice financially viable.

In the near future, you'll have to implement the Office of the Inspector General's compliance guidelines, follow regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA), and get ready for the new ICD-10 codes. All of these will require major investment of money and staff time.

"Physicians look at their long-term needs and plan for them. If items such as replacing the computer system, upgrading their technology and training new staff on coding, compliance, and other issues are in the budget, it's a lot easier to manage," says **William J. DeMarco**, president of DeMarco & Associates, a Rockford, IL, health care consulting firm.

5. Retain some money at the end of the year.

DeMarco recommends saving some of your end-of-the-year cash to re-invest in your practice.

"I advise my physician clients not to take all the money out at the end of the year. The accountants will invariably disagree and say the tax man will get some but if you reinvest in your practice, you can minimize the tax impact," DeMarco says.

Keep enough cash on hand at all times to handle emergencies so you can keep borrowing to a minimum," DeMarco suggests. "Businesses can get under water quickly if they borrow for this equipment, then turn around and borrow for that equipment, thinking it will be paid off at some point," he adds.

6. Take advantage of economies of scale by joining other practices for some services.

If you're not interested in merging with other practices, you can still benefit by joining with other groups to create a central company to provide strategic services such as billing, administrative services, and compliance activities, DeMarco says.

Under a "confederation" arrangement, individual practices keep their autonomy but share administrative staff and services, and their costs, he adds.

A physician-owned company can buy practice software, hire a compliance officer, handle billing functions, and take over managed care negotiating and purchasing for its member practices.

"There are rules. All the practices have to bill the same way, and develop business policies the same way. We're not talking about merging assets. They will each remain separate corporations but they will join together for billing, managed care negotiations, purchasing, and other functions," De Marco says.

For instance, having a compliance office as suggested under the OIG compliance guidelines may be prohibitive for a small practice. But if you join together with nine other practices, you can hire someone to handle compliance activities for all 10 groups, he adds. ■

William J. DeMarco, president of DeMarco & Associates, Inc., Rockford, IL. **(For information on dealing with baby boomers, see p. 12.)**

"Physicians can't see every patient for as long as they like. They're going to have to get a certain number of people through the office. They can't triple-schedule patients any more. People aren't going to put up with long waits. Even the retirees realize that their time is valuable, too," he says.

Physicians who want to prosper in the future will become focused on customer service and making their practices user-friendly, Killian adds. Health care financing is going to get more complex and in the coming years, physicians will continue to have to deal with more plans with different rules and different procedures.

This will add to the cost of overhead for the practice without any real return.

"It's getting harder and harder for physicians to collect the money they earn in office-based practices," Jessee says. He cites studies that show that Medicare rejects 26% of physician office claims because they are incomplete or for some other reason. About 40% of those claims are never resubmitted.

"If you assume they are legitimate claims, physicians are leaving a huge amount of money on the table because it's such a big hassle and so expensive to resubmit the claims," he adds. It costs about $6 to submit a claim. If you're going to get only $10 and you have to submit it twice, you are going to lose money, Jessee says.

But one bright spot is a willingness among providers and government agencies to at least talk about reducing the administrative burdens on physicians.

The MGMA has talked with health plans about the possibility of using standardized paperwork and rules, such as the same credentialing form or a single set of rules for prior authorization.

"These kinds of things alone could strip out a lot of unnecessary duplication for physicians. Nothing has happened yet but a year ago there wasn't even any dialogue," Jessee says. But now, the Medicare Payment Advisory Commission has launched an initiative to simplify its administrative structure. Also, the Senate budget committee has requested that the General Accounting Office study administrative structures of government programs and their impact on medical practice.

"At least we are getting some people to pay attention," Jessee says. ■

The future is now for technology in the office

Stop playing computer catch-up

It may not be too long before patients will come into a physician's reception area and insert their "smart card" into a slot that verifies their health information and tells them when there's an empty examination room, says **Randall Killian**, MS, MBA, executive vice president of the National Association of Managed Care Physicians in Glen Allen, VA.

The physician will walk in with a wireless computer device on which he or she accesses the patient's medical record. At the end of the visit, the information will be automatically relayed to the health plan for payment and entered into the electronic medical record.

If the patient has a chronic illness, the computer will prompt the physician to institute the disease management protocol and will flash an error message if the plan of care isn't within the approved guidelines. The computer also will automatically alert physician if the patient needs a mammogram, a flu shot, or a retinal eye examination.

"That's the future. The technology is available for it right now," Killian comments.

Technology still has a way to go before a physician office can be fully automated, adds Killian who describes some technology offered by vendors today as "trying to build airplanes in the air." Practitioners who want to flourish in the future should nevertheless be looking at adapting technology for their practice.

In the meantime, there are other ways that technology, combined with the Internet, can help improve your practice. Here are two:

• **Claims-related transactions.**

Physician practices are learning that the amount of time spent on hold with the insurance companies and faxing and mailing documents can be sliced to a fraction by doing it over the Internet, says **Sandy Lutz**, health care analyst with PricewaterhouseCoopers in Dallas, and author of the firm's *HealthCast 2010 E-Health Quarterly*, a newsletter covering future trends in health care.

"We found that physicians are seeing real productivity gains from handling claims-related transaction on the Internet. We're seeing real examples of that happening." Lutz says.

There are up to 10 claims-related tasks that can be done on the Internet in a matter of seconds, Lutz points out. Among them are checking patient eligibility, finding out co-pay requirements, checking claim status, finding out referral information, and in some cases making referrals, she says.

According to Lutz, research by Pricewaterhouse Coopers shows that conducting claims-related functions on the Internet increases staff productivity, reduces claims errors, increases the percentage of clean claims, and reduces accounts receivables.

"Physicians are going to start to realize that the Internet is something real they can use. There has been a lot of hype and promises that weren't realized in the past but the benefits are starting to become more concrete," Lutz says.

• **Communication with patients.**

"Physicians have got to start understanding that they can make use of the Internet in their practice by providing information for patients, for office functions such as medical record keeping, and for prescription writing. Otherwise, they are going to be left in the dust," says **William F. Jessee**, MD, president and chief executive officer the Medical Group Management Association, in Englewood, CO.

Patients are interested in scheduling appointments, finding out laboratory results, and having prescriptions refilled over the Internet, says **John Knapp**, JD, a health law attorney with Cozen and O'Connor in Philadelphia.

"We are well into the age of computer access. This means that doctors will have to think more

and more about doing as other businesses do and making it convenient for patients to access electronically," Knapp says.

"Savvy physicians are going to start setting up Web sites and maintaining them to create a value-added environment for their medical practice," adds.

Physicians are going to be under pressure to provide Internet links so patients can learn more about their medical conditions or drugs that are prescribed for them.

"We're already starting to see physicians setting up mechanisms for e-mail interchanges that allow patients to ask questions and get answers by e-mail. Really savvy doctors offices are going to use processes like broadcast e-mail to keep up the relationship with patients," Knapp adds.

For instance, you can e-mail your patients reminders for appointments, bulletins and medical alerts, or a reminder to schedule an appointment for a checkup.

"Some physicians used to send out post cards. Now they can communicate electronically," Knapp adds.

If you want to move in that direction, here are some tips:

- Take the time to acquaint yourself with today's technology and how it can benefit your practice.
- Prepare a budget for upgrading your computer software and hardware to take advantage of the technology boom.
- Make sure someone in your office is up to speed on Internet access.
- Consider investing in high-speed Internet access, such as a DSL line or cable modem for your office.

"This is the kind of investment that will really pay off for physicians," Lutz says. ■

'Physicians [are] setting up mechanisms for e-mail interchanges that allow patients to ask questions and get answers by e-mail. Really savvy doctors offices are going to use processes like broadcast e-mail to keep up the relationship with patients.'

Record and coding system changes are coming fast

HIPAA, ICD-10 changes critical

Two or three years may seem like a long time but physician practices need to be aware and plan ahead for changes that are on way, experts say. The clock has already begun ticking toward the deadline for complying with Health Insurance Portability and Accountability Act (HIPAA) regulations.

Practices must comply with electronic data interchange requirements by Oct. 16, 2002. Privacy and security regulations expected to be released soon will also have a two-year compliance deadline.

If that's not enough to set your teeth on edge, the proposed 10th version of the International Classification of Disease (ICD-10) is moving through government channels, with some experts predicting that implementation will occur in 2003, just a little more than two years down the road.

Revisions for the ICD-10 are expected to be complete by early January and testing will begin later this year. The new classification system will replace the ICD-9, which has been in use for more than 20 years.

"In the next two years, physicians are going to have to trash the system they have been using and reload a bunch of new codes. This is going to be a process that is more difficult than the Resource-Based Relative Value Scale [RBRVS]," says **William J. DeMarco**, president of DeMarco & Associates, a Rockford, IL, health care consulting firm.

Don't be deceived by the fact that HIPAA regulations give you a long compliance period. You need to start preparing now.

"HIPAA compliance is going to be expensive and time-consuming. People who wait until the last minute to comply will find themselves saddled with a significant administrative burden and significant cost of overhauling their computer system and training the staff," says **John Knapp**, JD, a health law attorney with Cozen and O'Connor in Philadelphia.

The "Transactions and Code Sets" rule provides standards for electronic transactions and code sets that health care providers and payers use to identify diagnoses, drugs, and procedures.

But what will probably be the most onerous for physician practices is the privacy and security rules

that apply to any kind of identifiable health information and deal with everything from consent forms doctors to how doctors should limit access to personally identifiable health care.

Although the final rules are yet to be announced, physicians are advised to start now working on HIPAA compliance.

"HIPAA is going to happen and those who are waiting for the final rules are going to be way behind," comments **William F. Jessee**, MD, president and chief executive officer the Medical Group Management Association, (MGMA) based in Englewood, CO.

Here are some tips for getting ready for HIPAA:

• Include provisions for HIPAA compliance in your long-term budget. This should include money for computer hardware and software as well as training for your staff, DeMarco advises.

• Adopt measures to protect personally identifiable health care information in your office, Knapp suggests. These may include physical security measures, such as locks and pass cards, and training for staff who are going to have to keep logs of who has access to what information and when it is released.

• Start to look at electronic security measures, such as passwords and levels of access so that not all personnel within an office will necessarily be able to get access to the same information.

(Editor's note: For detailed information on HIPAA requirements, see Physician's Managed Care Report, *December 1999 and October 2000. For more information on ICD-10, visit the American Health Information Management Association Web site at www.ahima.org.)* ■

Managed care is staying; make the best of it

It won't change, but you can

You've heard it before and you'll hear it again. Despite the fervent hopes of the health care community, managed care is here to stay.

"Managed care is not going away, despite the horrible press it gets," says **William J. DeMarco**, president of DeMarco & Associates, a Rockford, IL, health care consulting firm. "The truth of the matter is that few insurance companies are surviving unless they take some kind of managed benefit approach."

In fact, DeMarco predicts that managed care will loom even larger on the horizon as the economy slows.

"There will be more workers who are looking for guaranteed benefits with predictable costs. Employers are going to look for more HMO options. The people who want more benefits are usually not the healthy people," DeMarco points out.

With some projecting that the Medicare Trust Fund will go bankrupt sooner than most people thought, there is going to be more focus on managed Medicare, DeMarco says.

"We'll see a resurgence of managing care, more than just managing claims. The focus is going to be on quality as well as cost," he says.

Higher premiums won't trickle down

Although many HMOs are reporting significant premium increases, don't count on any of that money coming to you, warns **John Knapp**, JD, a health law attorney with Cozen and O'Connor in Philadelphia

"The early evidence is that the HMOs are going to retain most of their premium increases to offset internal costs and improve their profit margin. Doctors should not expect to see significant fee increases, even though managed care organizations are receiving increased premium dollars," he adds.

Most doctors have realized that managed care isn't going away, comments **Randall Killian**, MS, MBA, executive vice president of the National Association of Managed Care Physicians in Glen Allen, VA.

"What I've seen this last year, as opposed to previous years, is a greater acceptance of managed care. Most doctors have realized they have to deal with it," Killian says.

The only way a physician can survive is to get serious about managed care and create a partnership with the MCOs, DeMarco asserts. Being able to resolve issues without acrimony is an important part of it, he adds.

DeMarco warns physicians not to let their negative attitudes about managed care affect the staff, who may in turn treat managed care patients like second-class citizens.

"Physicians should remember that if they tell

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Physician's Capitation Trends™
• Capitation Data and Trend Analysis •

HCFA's 4.5% pay hike may boost PMPM payments

Increase applauded by the AMA

The Nov. 1, 2000, *Federal Register* announced a 4.5% overall increase in Medicare payments for physicians starting Jan. 1 — an increase that typically is folded into the way the Health Care Financing Administration (HCFA) and private-sector payers calculate their new year's capitation payments.

Typically, when negotiating per-member-per-month (PMPM) payments — even for non-Medicare patients — insurers rely on Medicare's Resource Based Relative Value Scale (RBRVS) to set payment levels. This year, in fact, is the first year that Medicare's payments are fully based on RBRVS, rather than being phased in at varying levels with a separate practice cost component.

The 4.5% across-the-board increase will hike the physician payment schedule's conversion factor from $36.61 to $38.26. The conversion factor is the dollar value that is multiplied by the weighted value of each service a physician performs to derive payment amount. All physician services are reflected by a CPT code, which is weighted based on cost and intensity of the service.

News of the increase was met with appreciation from American Medical Association (AMA) Chairman **Ted Lewers**, MD. "This is good news for America's seniors and the physicians who care for them," Lewer said in a prepared statement.

While 4.5% is the overall increase, payments will vary widely across specialties because of the full phase-in to RBRVS. Specialty CPT codes, which historically have reflected relatively higher practice expenses than other CPT codes, will likely see overall payment declines as the system attempts to level out those disparities.

For example, office-based physicians will see higher increases than surgeons, whose charges tended to be higher than RBRVS-based rates. Optometrists are expected to see a 12% increase, while dermatologists and rheumatologists will see 9% rate increases. Thoracic and cardiac surgeons will see an average 1% reduction, according to the *Federal Register*. In negotiating capitation payments, practice officials should be certain that their new payment rates from HMOs reflect HCFA's newest assessment of adequate payment levels.

The AMA had even more interest than usual in HCFA's announcement this year because of the "sustainable growth rate" (SGR) issue. In 1999, the AMA stated in a lawsuit that HCFA was underestimating the SGR in 1998, making 1999 reflect $3 billion in underpayments to physicians. AMA- backed legislation required HCFA to correct the omission of the SGR, Lewers explained.

"Today's announcement [about HCFA's physician payment hike] also indicates that the spending target for 2000 . . . has been increased to 8%," Lewers said. "This is an enormous improvement, almost four times the original year 2000 SGR, or the 2.1% that HCFA estimated in the fall of 1999." ■

A way to ease drug costs: Put the writing on the wall

Post prices for MDs to see

While physicians are well aware of the general issue of high drug costs, they don't often know the actual costs of drugs they prescribe to their patients. That's a key finding of a recent survey of 189 physicians at Mount Sinai Medical Center in New York City.[1]

To help with cost awareness, practice officials

at Mount Sinai are posting actual costs of 100 commonly prescribed drugs on the medical center's intranet, say Steven Reichert, MD, Todd Simon, MD, and Ethan Halm, MD, all on staff at Sinai, and researchers for the survey project.

Sinai leadership is hoping this simple information resource is one way to make at least a dent in physician awareness of what patients are paying for specific drugs so that both patients and institutional costs can be better monitored. The Web site is available from any physician work station.

Drug cost reporting is just one outcome of the study aimed at measuring attitudes about prescribing and knowledge of medication costs among both attending physicians and residents. In the study of physician knowledge and attitudes, researchers found the overwhelming majority (82%) of physicians feel that cost of medicines is an important consideration in prescribing, and 71% were willing to sacrifice some efficacy to make drugs more affordable.

While physicians have access to hospital- and office-based drug costs, they often lack knowledge of what patients pay for drugs in retail settings. Only 33% had easy access to what drugs cost consumers.

"Two factors likely contribute to continued inadequate knowledge of medication costs," Reichert and colleagues report. "First, medical schools and residency training programs provide little or no formal education about medication costs and insurance coverage of pharmaceuticals. Second, there are few ways to obtain reliable drug price information in a timely fashion. Cost information is rarely if ever included in medical journals, textbooks, or drug-prescribing guides [including the *Physicians Desk Reference*]."

The variation in practice- and hospital-based drug purchases is widely reported. **(See *Physician's Managed Care*, October 1999, p. 151; July 1999, p. 104; and March 1998, p. 40.)** Drug companies sometimes offer discounts and rebates to providers in conjunction with certain managed care companies, and even finding agreement on average wholesale prices offered to larger groups is not easy. What individual patients or customers pay may not resemble what providers or insurers have access to.

A little bit of accurate information may go a long way, Reichert and team say, given the survey's finding that physicians are open to learning about true drug costs for patients. "Physicians were predisposed to being cost-conscious in their prescribing habits, but lacked accurate knowledge about actual costs and insurance coverage of drugs," the study says. "Interventions are needed to educate physicians about drug costs and provide them with reliable, easily accessible cost information in real-world practice."

Reference

1. Reichert S, Simon T, Halm E. Physicians' attitudes about prescribing and knowledge of the costs of common medications. *Arch Intern Med* 2000; 160:2799-2803. ■

Key skills identified for surviving managed care

Researchers offer protocol of competencies

Have you got what it takes to survive managed care? Maybe it's hard to know if you were never really trained in managed care in general, or capitation in particular. With that in mind, three researchers have developed a protocol of specific clinical competencies for effective managed care practice.[1]

In addition to developing a useful protocol, researchers surveyed four groups of physicians to determine what would be important in training physicians for capitation and its related hybrids. They surveyed 790 physicians — residency program directors, residents, managed care directors, and primary care residency program directors in areas of high managed care penetration. Response rates in each group ranged from 67% to 94%.

Ultimately, they learned that all four groups place a high priority on the emerging new skills of risk-based practice management and patient care, and that what counts most is making it all work. The most successful approach, researchers found, requires a balancing act of four main areas — patient care, performance monitoring, teamwork and coordination of care, and organizational issues.

These findings bode well for the future of capitation and other managed care systems approaches, say Michael J. Yedidia, PhD, and Colleen C. Gillespie, PhD, both professors of health and public service at New York University in New York City, and Gordon T. Moore, MD, a

(Continued on page 10)

Core Competency Checklist

Below is a checklist extracted from Yedidia and team's accounting of core competencies of managed care, as identified by their surveys:

Organizational issues

☐ Economics — Evaluate managed care organization contracts and compensation plans on the basis of their incentives for particular practice behaviors.
☐ Ethics — (1) Act on ethical principles in resolving conflicts that may arise if it is decided that a patient needs procedures or services that are not covered by a managed care organization. (2) Explain the reasons for a decision to allocate resources to serve the needs of populations at the potential expense of individual needs.
☐ Managed care and health care delivery — (1) Predict the impact of different payment arrangements on consumer and practitioner behaviors within a specific health care environment. (2) Act as a resource on aspects of managed care practice for colleagues who have not had training in this area. Managing multiple managed care organizations — (1) Reconcile your own treatment approaches with the potentially contradictory guidelines of multiple managed care organizations. (2) Adhere to the regulations of several managed care organizations in implementing referrals and ordering procedures.
☐ Practitioner morale and satisfaction — Develop a program updating the knowledge and skills of your colleagues and addressing practitioner morale and satisfaction.

Patient care

☐ Clinical epidemiology — Determine the effect of a positive or negative test result on the probability that a patient has a particular medical condition.
☐ Cost-effective clinical decision-making — Weigh the costs vs. the probable yield of a particular diagnostic procedure in managing a patient with a specific medical condition.
☐ Evidence-based medicine — Locate and critically evaluate research evidence and apply one's own conclusions to the care of an individual or patient group.
☐ Patient satisfaction — Interpret patient satisfaction data to make appropriate changes in practice operation.
☐ Population-based medicine — Use data on patients' communities and environments to design tailored strategies to reduce the incidence of undiagnosed conditions.
☐ Practice guidelines — Adapt clinical guidelines based on evaluation of evidence from relevant research.
☐ Prevention — Use data on patient population to design and evaluate a disease-specific prevention programs.
☐ Time management — Use time efficiently in the clinical encounter to maintain quality of care while sustaining an adequate flow of patients.

Teamwork and coordination of care

☐ Case management — For patients with complex disease processes, ensure access to necessary clinical services, coordination of care, and efficient use of resources.
☐ Collaboration — (1) Assess the roles of all practice personnel in regard to patient education and institute a plan for making better use of their expertise in this area. (2) Delegate responsibility and share authority with nurse practitioners and/or [physician assistants] to ensure productive teamwork.
☐ Gatekeeping — Perform the "gatekeeping" role for a panel of patients, maintaining quality and cost-effectiveness of care.
☐ Referral management — Evaluate referrals to specialists for appropriateness and quality and initiate strategies for improving their effectiveness.

Performance monitoring

☐ Clinical efficiency — Conduct time and work flow analysis to enhance productivity.
☐ Continuous quality improvement — Identify clinical conditions appropriate for quality improvement projects and participate in implementation.
☐ Practice profiling — Compare one's own practice profile to those of peers and make appropriate changes in one's practice behavior.
☐ Utilization management — Weigh the benefits of case-by-case concurrent review vs. practice profiling in addressing a particular clinical issue.

Based on their surveys, the researchers found that a majority of medical training program directors favor teaching mastery of these "essential tasks." Currently, the study's surveys show that about 40% of the programs surveyed are addressing two-thirds or more of the tasks.

Source: Yedidia M, Gillespie C, Moore G. Specific clinical competencies for managing care: Views of residency directors and managed care directors. *JAMA* 2000; 284.

physician at Harvard Pilgrim Health Care in Boston, who conducted the surveys.

"While recent surveys have documented considerable disaffection toward managed care among academic physicians, this negativism does not appear to have carried over to their views on the importance of teaching specific managed care tasks related to population health," the researchers write. "In spite of fundamental differences on other health care issues, our findings indicate that residency directors and MCO medical directors place high importance on specific clinical behaviors and that they share a similar vision of priorities for applications to future medical practice." ■

Insurers budge on some rigid capitation issues

Is a kinder, gentler era coming?

The ice between capitated physicians and insurers may be thawing a bit. Just recently physicians in two states scored some policy changes they've been pursuing for quite some time.

In Georgia, the Atlanta-based office of Aetna announced these changes, effective Jan. 1, 2001:

• Independently contracted primary care physician practices with 200 or fewer Aetna U.S. Healthcare HMO members will receive fee-for-service payments.

• Physicians will receive 90 days advance notice of significant payment or administrative changes to provider contracts that will have a material adverse financial impact.

• Regular meetings with the Medical Association of Georgia will be scheduled to discuss ongoing issues.

• Computer discounts and free Internet access will be available to all physicians, dentists, nurses, and medical students across the country via an agreement with Hewlett-Packard Co. and NetZero.

Aetna HMO enrollees will also see some new flexibility, given these changes:

• simplification of the precertification process, including the areas of outpatient surgery, most durable medical equipment, and many types of injectable drugs;

• the option to use specialists as a principal physician for members with serious illnesses.

Georgia physicians called upon Insurance Commissioner John Oxendine to achieve these changes. "These policy changes are just the beginning of our overall efforts to strengthen relationships with Georgia physicians and, indeed, with all our constituents," says Aetna's Georgia-based General Manager **Mary Louise Osborne**.

Oxendine describes the changes as a move in the right direction. "We have been working for some time to improve the relationship between doctors and HMOs for the ultimate benefit of consumers," Oxendine says. "I'm glad our work is paying off. Aetna's announcement represents a significant first step."

Two weeks earlier, Aetna made a peace offering to California physicians who have vociferously protested high drugs costs amid what they decry as rigid, underpaid capitated agreements. Aetna announced that it will immediately pay doctors the cost of any new vaccines recommended by the American Academy of Pediatrics (AAP) in Chicago and the Centers for Disease Control and Prevention in Atlanta. This includes payment for the newly released vaccine, Prevnar, which protects infants and children from pneumococcal infections that can cause ear infections and meningitis.

Once the appropriate capitation increases are determined and Aetna and the physician medical groups sign the new contracts, the medical groups will regain financial responsibility.

"Through our conversations with the [California Medical Association] and the AAP, we were made aware of the financial challenges physicians are facing to provide the new vaccines to their patients prior to the change in their contracts," says **Howard Arkans**, MD, regional medical director for Aetna in San Ramon, CA. "This policy will ensure that our [policy holders] in California receive the appropriate immunizations for their children and that physicians are compensated accordingly for the cost of providing the vaccine to our members."

Aetna officials are touting these changes as significant shifts in corporate attitude. "This commitment by Aetna shows that health plans and physicians can sit down together to find solutions that are in patients' best interests. Our discussion and Aetna's decision could mark the beginning of a new kind of managed care — one in which physicians, patients, and health plans can work together toward the best care within a financially sound, quality health care system." ■

(Continued from page 6)

patients their insurance company won't cover a certain procedures because they're cheap, the insurer may come back and say they won't cover it because the doctor overcharges. It's hard to get the trust back when insurers call you a heavy biller," DeMarco says.

The best way to deal with managed care is to be a careful negotiator and make sure the contracts you sign are to your benefit to begin with, DeMarco says. "Physicians have been forced by managed care to accept the managed care payer's fee schedule rather than staying with their own." DeMarco says.

Physicians should negotiate a little harder to come up with a good deal from managed care payers, DeMarco says. He tells of clients who have one fee schedule and they negotiate up to 10% off when contracting with managed care plans.

"They can actually predict whether they make money or not. And they get rid of the managed care contracts that are not producing for them," he says.

After you sign the contract, you should keep a close eye on your billing and your receivables, he warns

"Some physicians complain that managed care is awful because they don't get paid enough when, in fact, I've seen practice after practice where they are billing less than the amount they originally agreed on," DeMarco says.

DeMarco worked with one physician group that had agreed to take 10% off its regular fees and loaded the information into the computer so that 10% off the customary fees was automatically deducted.

The insurance company also automatically subtracted 10%, which meant that for almost three years the physician group gave the MCO a 20% discount without anyone noticing.

Here are some other tips for dealing with managed care companies:

• **Make sure you can get out of the contract.**

The agreement you have with a managed care company is sure to have several paragraphs describing how they can fire you but you should also make sure there's a clause that describes how you can sever your relationship with an HMO.

DeMarco tells of one 50-member independent practice association that had been paid under a capitation contract with no escape clause. When they wanted to renegotiate, the insurance company paid all the claims during the negotiation period and then told the doctors that they would have to pay $400,000 to get out of the deal.

'Physicians are not always willing to say no and create conflicts but physicians who have gotten out of some of their managed care agreements have been able to increase their revenue because they eliminated bad payers.'

• **Make sure the contract will be to your benefit.**

"It gets to be a real headache for a lot of people. To make the decision to unwind a managed care relationship, you have to look at how it will affect your patients and how to deal with the loss of income and patient market share temporarily," DeMarco says.

Be especially wary of contracts that base reimbursement on the Resource Based Relative Value Scale (RBRVS), DeMarco says.

For instance, if your contract is based on RBRVS fee schedules, make sure it is a standard Medicare fee system for your area. Insurers may base their fee schedules on the RBRVS for a totally different state.

• **Learn to say "no" to managed care.**

You have to know what the fee schedule is and what kinds of conversion factors the HMOs will use. If you can't make money with a contract, you should not go into negotiations.

If a company has not delivered on its promises or if it asks you to discount with the hope that you'll get more patients, you should say no to the contract, DeMarco says.

"Physicians are not always willing to say no and create conflicts but physicians who have gotten out of some of their managed care agreements have been able to increase their revenue because they eliminated bad payers," he adds.

• **Don't count on your attorney to tell you if the contract is in your best interest.**

Your lawyer can tell you if it's a legal contract but if you are asking the lawyer if your practice will make any money on the contract, you're asking the wrong person, DeMarco says. "Lawyers practice law and focus in on that. They can't tell a physician if a contract is a good business decision. That's why physicians need to have their practice parameters in place before they walk into negotiations," DeMarco says. ■

Physicians need new skills for boomer demand

DM, outcomes tracking add value to practices

They're demanding, they're outspoken, they want hard, cold facts — and there are a lot of them. They're the baby boomers and as they age and need more medical care, they will likely create headaches for your practice.

The baby boom population represents an opportunity as well as a challenge for physician practices. They will be receptive to cutting edge technology and new treatment methods but they're going to want to know upfront what the outcome will be.

There are so many of them that practitioners are going to have to scramble to take care of their health care needs. At they same time they will be unwilling to wait weeks for an appointment or cool their heels in your waiting room.

This means that physicians are going to have to increase their efficiency and deal with the new patient loads effectively. They're going to have to keep track of their disease management and treatment outcomes to provide the information this new health care population wants.

Lean on nurse practitioners, PAs

"Physician assistants and nurse practitioners are probably the physician's first line of defense against the future patient — the angry and demanding baby boomer with Internet access," says **William J. DeMarco**, president of DeMarco & Associates, a Rockford, IL, health care consulting firm

Nurse practitioners and physician assistants give physicians an opportunity to see the severely ill, most challenging patients but still accommodate patients with routine problems.

"To be successful in the future, physicians need to ask if every patient that walks through their office needs to be seen by a physician," adds **Randall Killian**, MS, MBA, executive vice president of the National Association of Managed Care Physicians in Glen Allen, VA.

Physicians are adding physician assistants, nurse practitioners, and even social workers to their practices to deal with patients who have psycho-social, in addition to medical needs.

"There are a lot of issues, particularly with the medically underserved and the elderly, that are not medical but social issues and should involve a patient education effort rather than a physician visit," Killian says. Among these are nutrition, preventive measures, and education on chronic disease, he says.

In addition to excellent customer service, the next generation of patients is going to want performance statistics, DeMarco says. That's why it's essential for physicians to look at performance measures, being able to track how many people with a particular problem had a good outcome with no recurrence, and with no extra costs.

"They are looking for a guaranteed outcome but they can accept performance statistics to assure them they'll have a good outcome," DeMarco says.

You also may need to show the patient of tomorrow how you stack up against your peers in managing chronic diseases, says DeMarco.

In fact, from a business standpoint, disease management may be the best way to deal with the increasing health care needs of the next generation, Killian adds.

Efficiency from a business perspective is the ratio of input to output, Killian points out. In medicine, efficiency means the best outcomes at the lowest cost, he adds.

"Whether you call it disease management or health management, it is in essence combining the business and clinical piece of the practice to get the best outcome at the least cost," he adds.

With disease management, or more correctly, health management, physicians are focusing more on preventive care and maintaining wellness. Until recently, disease management has been a pie-in-the-sky approach to patient care, Killian adds.

"Health plans and pharmaceutical companies partnered together and developed great disease management models," Killian says. However, practicing physicians often didn't have the time to implement the models, he adds.

Killian tells of a panel discussion during which a family practitioner was asked what he thought of a particular disease management plan. "I don't have time to look at disease management models. I spend all my time treating patients," was the reply.

The National Association of Managed Care Physicians is concentrating on helping physicians implement disease management programs. "We have great models that have been approved by the medical directors of health plans but

getting the physicians to implement them is where the rubber meets the road," he says.

The association has held seminars in 2000 on the subject and has others planned for 2001. ■

Physicians get hospital records over the Internet

System created with off-the-shelf software

Physicians who practice at Overlake Hospital Medical Center in Bellevue, WA, can access patient medical records, review laboratory tests and pharmacy records over the Internet.

Before the WebChart system was instituted in August, if a patient came into the emergency room and was sent to her doctor for a follow-up, the doctor had to call the hospital to get the history and treatment records.

If a family physician referred a patient to a specialist who hospitalized him, the physician had to either drive to the hospital and look at the charts or call the specialist.

Physicians who referred patients to the hospital for laboratory tests or X-rays had to wait for the results or call the hospital.

With the new system, physicians merely have to log onto the hospital's secure Internet site and enter their security code to see lab results, patient record transcription, and other data. The only equipment needed is a computer with Internet access and a Web browser.

The hospital developed WebChart for about $250,000 using off-the-shelf software in association with vendors. More than 100 doctors are using the service. The chart on the computer screen looks like a paper chart with tabs that access radiology, lab results, and other data.

"It helps us tremendously in the transfer of patient information from the hospital back to the physician. There is a ton of pressures on our physicians. They need to be efficient and they don't need to be driving over here or being on hold for a long time just to find out something," says **Bruce Elkington**, chief information officer for the 257-bed nonprofit hospital

The hospital system's WebChart is available to all medical staff of the hospital and requires only Internet Explorer and a security card.

If doctors are called at home, they can access the chart from their home computers.

"We do this dance between the physician offices and the hospital getting information about what happened to the patient here back to the family physician. As a technology-oriented guy, it's frustrating to me that the guy who changes my oil and has my car's history on a wireless device is more technologically up to date than the physicians I work with," Elkington says.

Since the system was started in August, Elkington has received rave reviews from the physicians, who like being able to get the information quickly and easily, no matter where they are.

"It's made a difference in patient care. I can get the information very quickly and it saves personnel time when I can look it up, rather than getting the staff to call," read one physician's e-mail.

If physicians have automated medical records in their office, they can copy and paste the hospital data.

If you'd like your hospital to develop such a system, Elkington has some words of advice: "Don't let 'perfect' be the enemy of the 'very good'."

The doctors who helped develop WebChart told Elkington that if they could get the lab results, the transcriptions, and the pharmacy information on their patients, they would have 90% of what they needed.

"The problem with creating complete comprehensive cross-provider medical records is that it's like boiling the ocean. It's a project so big and complex that attempts haven't been too successful, Elkington says. ■

The Internet is changing the path to CME credits

Courses are available anytime, anywhere

If you've ever scrambled at the last minute to find a nearby conference to fulfill your continuing medical education (CME) requirements or sat through lengthy seminars while patient demands piled up in your office, you can appreciate the value of getting at least part of your continuing medical education over the Internet.

The Internet is providing physicians with more options for fulfilling their CME requirements.

The courses you need are readily available any time and anywhere you choose.

"Prior to the advent of Internet CME, physicians had to get their education at conferences. This took them out of the office and away from their personal and professional lives," says **Scott Beck**, chief sales and marketing officer of Medimorphus.com, a Salt Lake City firm offering career development services, health care recruiting and CME over the Internet through a partnership with Healthstream.

Log on, take a test

Now, you can simply log on to a site, take a course during your lunch hour or when you have a little extra time because a patient didn't show up for an appointment.

There are a growing number of sites that offer thousands of hours of CME credit and that allow you to scan and identify areas of interest before you sign up for the course.

If you are interested in taking a CME course, you enter your credit card number if there is a charge, read the course material, digest the information and take an exam at the end. If you pass, an electronic certification may be available on the spot or e-mailed to you at a later date.

It's considerably cheaper than going to a conference, particularly when you factor in travel costs and other expenses.

"Internet CME is a concept whose time has come," asserts **Jean Lalonde**, co-founder and president of I.C. Axon, a Montreal firm that created the MyPatient.com, an interactive case-based physician educational site.

"The convenience of the Internet is really important. It provides a huge opportunity for learning, not just three times a year when you fly away to attend a convention, but anywhere and

Here are some sites for Internet CME

CMEWeb.com offers CME courses in 20 medical specialties ranging from alternative medicine to emergency medicine to travel medicine.

The course material, eligible for American Medical Association Category 1 credits, comes from newsletters published by American Health Consultants and includes text and some charts. Most of the information is in 1.5-hour segments. The same material is available for physicians who are not yet computer proficient, in the company's CME Select program.

MedCases.com offers Web-based CME courses using simulated patients who present specific complaints. To earn credits, the physicians resolve the case.

Medimorphus.com already offered online healthcare recruiting and career management when it joined with HealthStream to offer more than 1,400 hours of CME credits to its users. The site offers CME credits from institutions such as the Cleveland Clinic Foundation, Duke University Medical Center, Vanderbilt University Medical Center, and GE Medical Systems.

MedLecture.com offers video-streamed Grand Rounds lectures by experts from top medical schools. The site has relegated all commercial advertising to a separate "Exhibit Hall" site that users may choose to access.

Medscape.com has continuously updated CME courses in 20 medical specialties that satisfy the requirements for the American Medical Association's Category 1 credits. The site also offers continuing education for pharmacists and nurses.

Mypatient.com presents case-based CME courses for primary care physicians in a format that simulates clinical practice and the physician-patient relationship. The site allows physicians to present their own cases, which are reviewed by the University of Virginia School of Medicine's office of CME to ensure case quality. ■

COMING IN FUTURE MONTHS

- What the new HIPAA privacy and security regulations will mean to you
- How to put patient satisfaction data to work in your practice
- Why mid-level practitioners are essential in today's physician offices
- The latest technology and how it can improve your practice
- The hows and whys of financial management

any time," he adds.

There generally are three types of organizations that offer CME online:

• content producers who produce the content for the online courses;

• aggregators that compile content from a number sources and make it accessible through links at their site;

• university organizations that offer limited courses on certain subjects from their own sites.

Sponsored CME usually is financed by unrestricted grants from a pharmaceutical company that puts its advertisement on the sites and is usually free, while non-sponsored content has no advertising and is available for a nominal fee.

American Health Consultants, publisher of *Physician's Managed Care Report*, developed its CMEWeb.com site four years ago after noting a large number of calls in November and December from physicians facing end-of-the year deadlines for earning CME, says **Marcus Underwood**, director of new media and content licensing

"We talked to some of the physicians and discovered it was a common problem," he adds. The company put some of its information online and the physicians asked for more. "They can take it day and night and take as little or as much as they need," Underwood says.

While CME on the Internet offers a lot of opportunities for physicians, it does have its downside, Lalonde points out.

"The information available is extremely broad and diverse and this gives physicians a lot of

Make sure your Internet experience is positive

Check out CME developer's reputation first

Not all Internet CME content is created equal. That's why you need to do some research before you jump onto the Internet for Web-based continuing medical education,

Here are some suggestions for making your experience a good one:

• Check out the developer of the course material to make sure it is from a reputable source.

• Preview the material to make sure it is what you are interested in and that passing the course will give you the CME credit you need.

• Make sure the material is in a format that you are comfortable with and that it is easy to use.

• Make sure your technology will support the material. For instance, if the material includes audio and video, you need at least a Pentium II computer and high-speed Internet access, such as a cable modem in order to access the material quickly.

• Check with your colleagues for suggestions on Web sites they have found useful.

• Find out if you can download the information for future reference. ■

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opportunities. On the other hand, because it is broad with a lot of diversity, there is a challenge to weed out what you need," he adds.

One of the problems of online CME sites is that there is no standard navigational tool and no standard expectations have been developed, Lalonde points out. This means you have to learn to navigate your way through each site.

You may also need to look at several sites before finding one that meets you needs.

"No online service has been able to identify the exact needs of an individual physician. I don't think any one site provides a comprehensive solution right now," Lalonde says.

When I.C. Axon was planning its online CME courses, it began by working with nearly 300 physicians, asking them to name their most memorable moment in medical education. "By and large they tended to say that the cases they studied during rounds formed their most memorable undergraduate experiences. There was an overwhelming consensus that case-based learning was important," he says. The company concluded that case studies delivered online would be a familiar way for physicians to learn.

Professional rapport missing

With Internet CME, you miss the personal interactions that you get at conferences. You don't have a chance for group discussions or to question the expert directly, points out **Randall Killian**, MS, MBA, executive vice president and director of CME for the National Association of Managed Care Physicians, in Glen Allen, VA. His organization offers both conference-based and online CME courses.

The questions that are asked after you complete an online CME course may not be the questions that you need answered, he adds.

"Internet training is great for physicians who want some just-in-time training on various disease states, treatment protocols, and new pharmaceutical products," he says.

Technology is another problem. If you don't have the latest computer and high-speed Internet access, you may find yourself spending more time waiting for a site to load than it takes to read the course materials. "In health care, one of the challenges is the level of technology within the institutions. If you don't have the most up-to-date technology available, it takes some of the value out of the Internet," Beck says. ■

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