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PHYSICIAN'S MANAGED CARE REPORT

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Sweeping privacy rules will change how you handle patient information

Two years and counting toward compliance

Are the medical charts for patients who have an appointment that day usually sitting out in your reception area? Do you sometimes discuss patients with your colleagues on the telephone in earshot of anyone passing by your office?

When you hire a new billing clerk or receptionist with experience in other medical practices, do you give short shrift to informing her about patient confidentiality?

Is your fax machine out in the open where anyone can see what is being faxed in?

Any of these could get you in hot water with the government when the Health Insurance Portability and Accountability (HIPAA) privacy regulations go into effect in 2003.

The regulations cover health plans, health care clearinghouses, and health care providers who conduct financial and administrative transactions electronically.

Signed into law by President Clinton in December, HIPAA mandates sweeping changes in the way most physician practices handle individually identifiable patient information.

The law is so new (published in the *Federal Register* on Dec. 28) and so lengthy (1,535 pages) that it will be several months before anyone can conduct a detailed analysis of all its provisions and implications. There's also a chance that the Bush administration or Congress will make changes before the final rule goes into effect Feb. 28. Following that is a two-year compliance period.

When it is fully implemented, HIPAA could very well save money for health care providers because it standardizes the way transactions are conducted. In fact, while the Department of Health and Human Services projects that implementation of the privacy rule will cost $17.6 billion nationwide, it also projects savings of $29.9 billion over 10 years from implementation of other HIPAA standards.

The health care industry has a lot of work to do, however, before that happens.

Even though all the minute details of the requirements aren't yet available, physician practices are advised to start their preparation now so they'll be in compliance by the Feb. 28, 2003 deadline.

"What we are telling clients now is that HIPAA is very real and that they should start assessing where they are and trying to determine the amount of work they have to do in the next two years, then work out a strategy to accomplish it, " says **Peter Adler**, a health care attorney with the Washington, DC, office of Foley & Lardner. **(For details on what you must do, see related article on p. 19.)**

In a nutshell, the privacy regulations mean that physicians will have to protect the privacy of patients' medical information, will have to inform patients in writing about how the practice will use their information, and will have to track and manage the information according to the way they told the patients they would.

The regulations cover any individually identifiable information, whether it is disclosed during oral conversations, electronic transmission, or written documentation, whether it is by hand, by typewriter, or in a computer.

"The original rule applied only to information in digital form and it was confusing to determine what was covered. For instance, if a transcriptionist typed the physician's notes on a word processor and printed it out, it would have been covered. But handwritten notes would not. The final rule covers information in any form," says **Janice Cunningham**, an attorney with The Health Care Group, a Plymouth Meeting, PA, consulting firm.

The final rule is the first comprehensive federal protection for the privacy of health information and the first to set out penalties for failing to maintain patient privacy.

The federal regulations pre-empt state privacy protection laws unless the state laws are more stringent.

"Physicians have always been ethical about patient privacy. That is just being formalized. How they do what they say they are going to do to protect their patients' privacy and proving that they did it are the critical elements of the HIPAA privacy regulations," says **Jon Zimmerman**, senior manager for HIPAA and e-business initiatives for Siemens Medical Solutions Health Services Co. (formerly Shared Medical System) in Malvern, PA.

The final rule establishes civil and criminal penalties for noncompliance. They range from $100 per person per incident for unintentional disclosure up to a $250,000 fine and 10 years in prison for selling medical information.

The regulations do not give patients the right to sue providers but President Clinton has called on Congress to pass legislation allowing patients to hold health plans and providers accountable for inappropriate and harmful disclosures, and to extend privacy protections to life insurers, workers compensation programs, and others that routinely handle sensitive medical information.

The reaction of the medical community to the HIPAA privacy regulations has been generally favorable, particularly since the final rule eliminates a number of troublesome provisions of the proposed rule. **(To learn more about the differences between the original and final rules, see below.)**

However, most feel, as the American Medical Association's **Donald J. Palmisano**, MD, JD, put it: "the devil is really in the details this time.

Differences in the Proposed and Final Rules

Type of information: The proposed rule covered only information in electronic form. The final rule extends coverage to include paper records and oral communication.

Requiring consent for routine disclosures: The final rule requires patient consent for routine disclosures of health records. The proposed version allowed routine disclosures for treatment, payment and health care operations, such as internal data gathering.

Minimum necessary disclosure: The final rule relaxes the "minimum necessary" requirements for the purposes of "treatment" which includes referral or consultation to other health care providers. For other disclosures, such as payment or general administrative operations, providers must disclose only the minimal necessary information needed to fulfill the purpose of the disclosure.

Protection against unauthorized use of records: The final rule prohibits companies that sponsor health plans from accessing personal health information from the sponsored plan for employment purposes without authorization from the patient.

"We will be closely examining the new rules to make sure there are no dangerous loopholes or unexpected problems," says Palmisano, a member of the AMA's board of trustees and a national expert on patient privacy and confidentiality issues.

Still to come are security regulations that will set out how you should secure your data, particularly when it is being transmitted electronically.

Most experts expected that the security rules would be issued in conjunction with the privacy rules. Now they are anticipating that HHS will issue the final security rules by the end of February.

Some people in the health care field speculate that the Clinton administration rushed to announce the privacy standards before the new administration took office.

There are spots in the privacy regulations where the final security rules will be plugged in.

"From reading the proposed regulations, it appears that the security regulations are not blazing new trails. They are the best practices when it comes to keeping data secure," Adler says.

The Office of Civil Rights of the U.S. Department of Justice has been given the authority to investigate violations of the final privacy regulations.

There is a whistleblower provision, which allows anyone who feels they have been hurt by violation of the privacy regulations to file a complaint. The regulations also allow the Office of Civil Rights to conduct general compliance reviews without a whistleblower. ■

How to prepare for HIPAA: Some dos and don'ts

Don't wait until the last minute

Compliance may be two years away, but you're well advised to start now making sure your practice will comply with the new Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

"The last thing physicians want to do is to wait until the last minute, then make an all-out effort to comply," says **Peter Adler**, JD, a health care attorney with the Washington, DC, office of Foley & Lardner.

Information on the specific requirements for compliance is sketchy now because the regulations are so new. But within three months, there is likely to be a plethora of information available, including some package plans for compliance, predicts **Janice Cunningham**, JD, an attorney with The Health Care Group, a Plymouth Meeting, MA, consulting firm.

However, there are some steps that you can take now to make sure you will be in compliance when the Feb. 29, 2003, deadline rolls around.

Start by examining your current policies and procedures for protecting patient information and comparing them to the HIPAA regulations, suggests **Jon Zimmerman**, senior manager for HIPAA and e-business initiatives for Siemens Medical Solutions Health Services Co. (formerly Shared Medical System) in Malvern, PA.

"Once physician practices understand their policies, procedures, and practices, they can determine where the gaps are and what they need to do vs. what they are actually doing now," Zimmerman says.

Look at where the gaps in patient privacy occur in your office and take steps to close them up, he adds. In some instances, it may be as simple as moving your files to a locked room.

"The rule is that identifiable patient information is supposed to be inaccessible. If that means building a wall or moving the documents to a secure location, that's what the practice will have to do."

A small practice can probably make a good start toward establishing HIPAA compliance in a short time. It will take a large physician group a lot more time, Zimmerman says.

"The requirements of HIPAA are scalable. Other than the privacy rights notices and the consent, small practices don't have to do the same level of things as large organizations do," Adler says.

Here are some other do's and don'ts for HIPAA compliance:

• **Understand whom you communicate patient information to.**

Determine which entities you do business with qualify as a covered entity or a business associate under HIPAA regulations.

Review all your forms, policies, procedures, and contracts with your business partners to make sure they are HIPAA compliant.

Understand what steps your covered-entity partners are going to make and what steps your business associates are going to make to become compliant, and coordinate with them.

If you do business with a hospital on a regular basis, you should define your policies and make sure they coincide with the policies of the hospital.

• **Start developing a HIPAA compliance plan.** Your policies and procedures to protect patient privacy should reflect how all communications will be handled, even conversations in the hall. Set up a checklist of issues that have to be resolved for your practice to be in compliance.

• **Appoint a designated privacy officer.** This staff member will be in charge of formulating and compiling your privacy policies and procedures and keeping up with documentation.

The privacy officer will also deal with patient questions or complaints about your privacy policies and procedures.

• **Develop a plan for training your staff on privacy regulations and come up with a way to document the training.**

Training should cover topics such as who has the right to identifiable patient information, what consent form is required for distributing the information, patient rights to access their information, and other privacy and confidentiality issues.

If you practice just has a blurb covering privacy and confidentiality in your policies and procedures manual, that won't be sufficient. You must document that every employee has received the training in your office, even if they previously worked for another medical practice. All employees must be re-certified every three years.

• **Determine whether your state's privacy regulations will pre-empt the federal regulations.** If your state already has privacy laws that are more stringent than HIPAA, the state laws will take precedence.

If you are practicing across state lines or involved in telemedicine, look at the laws in all the states in which you practice.

• **Before buying a packaged compliance plan, make sure it can be tailored to meet the needs of your individual practice.**

The problem with canned plans is that one plan can't possibly cover medical practices ranging from solo practitioners to 100 or more physicians, Cunningham says.

• **Don't go it alone.** Consult with your health care attorney to make sure you are doing what you need to do within your particular practice. Professional organizations and the large payers in your community may be able to provide sample consent forms or checklists to aid in compliance, Adler suggests.

• **Include money in your budget over the next two years to cover the cost of HIPAA compliance.** ■

Nine key components of the HIPAA privacy rule

Here are some bread-and-butter issues

Here is a synopsis of what the new HIPAA privacy rules mandate:

1. Physician practices must maintain physical security of all health care information. This includes limiting access to computer terminals and physical access to other documents. Records should be kept under lock and key, with limited access.

For instance, your reception staff no longer will be able to keep patient files sitting out unless they are in a closed and locked area. Sign-in sheets should ask for minimal information.

"What HIPAA requires is that a physician practice be extremely careful as to where files are located. For instance, patients should not be able to look over the shoulder of a nurse or physician and see someone else's patient record on the screen," says **Peter Adler**, JD, a health care attorney with Foley & Lardner's Washington, DC office.

2. Access to individually identifiable health information is restricted to a "need to know basis."

You must develop criteria setting out which of your employees needs to see identifiable health information and identify the people or groups of people who will review the requests of disclosure.

For instance, the billing people shouldn't have access to the clinical notes and the clinical people don't need to know the patient's financial information, according to **Janice Cunningham**, JD, an attorney with The Health Care Group, a Plymouth Meeting, PA, health care consulting firm.

If the front desk is doing just scheduling and registration, they don't need access to either the financial or the clinical information, she adds.

3.You can disclose only the "minimum information necessary."

For most disclosures, the regulations require you to disclose the minimum information needed for the purpose of the disclosure. For instance, if

you are asked to release information to process a workers' compensation claim, you must restrict the information disclosed to the minimum necessary amount.

However, the final rule does not apply to the transfer of medical records for treatment. The new regulations give providers full discretion to determine what information to include when you send patients to other providers for treatment.

4. Patients have significant new rights of control over their health information.

The new law gives patients access to their individual health information that is in your files. This means that you will have to make the records open to a patient any time he or she wants to see them.

They will be able to request a correction or amendment to any information which is incorrect or with which they disagree.

The regulations give patients the right to a "disclosure history," which lists entities that receive the information.

5. You have to provide your patients a written notification of their rights.

You will be required to give patients a clear, written, detailed explanation of how you use, keep, and disclose their health information. Patients also have the right to request restriction on the use and disclosure of their health care information. Your consent forms must state these rights.

The law states that the individual has the right to review your privacy notice before signing the consent. This will make it difficult if you decide to change your privacy practices. Adler suggests that you state in your consent form that you have the right to change your privacy practices

6. Patients must give written consent before you share their information.

The final provisions require physicians to obtain written consent from patients whenever payment, treatment, or operations result in disclosure of health information.

You must obtain a patient's written authorization to use or disclose health information for treatment, payment, or health care operations, including use within your own organization.

The consent form needs to be written clearly and should clearly identify what kind of consent is being given.

You must get the authorization at the onset of care, with the exception of emergency care and legal requirements, such as treatment in an emergency room. Consent documentation must be kept for six years.

If you have been using a blanket consent form for release of records, it probably will no longer be adequate. Under the new HIPAA regulations, physicians will have to obtain very specific patient consent any time they release identifiable health information. The consent form must state exactly to whom the information is going and for what purpose.

For instance, if you are referring a patient to a specialist, you can't give the specialist any diagnostics, background notes, or written or oral information about the patient unless you get specific written consent from the patient.

"There has to be a new consent form every time a physician releases patient information. If there is a patient with multiple problems who is referred to several specialists, there will have to be a separate form for each specialist," Cunningham says.

Patients also must sign a consent form if you are sending their health information to a third-party billing company or payer. A one-time consent form is okay in this case.

The regulations allow disclosure without patient consent for some activities including quality assurance, public health, judicial or administrative procedures, limited law enforcement activities, emergency circumstances, identification of a deceased person or cause of death, and activities related to national defense and security.

The physician can refuse treatment if the patient refuses to sign the consent form.

If there is an emergency or it's a case where the law requires you to give treatment, you may treat the patient without the consent form

The new regulations also require providers to obtain specific consent for non-routine uses of information and most non-health care purposes such as releasing the information to financial institutions determining mortgages or selling mailing lists to interested parties.

Providers and health plans cannot condition treatment on patient's agreement to disclose health information for non-routine uses.

7. All entities covered by the rule must have a privacy officer.

This is someone who is basically in charge of ensuring that the records in your office are handled in accordance with the privacy regulations. If a patient has a complaint about how his or her records are handled, the privacy officer would handle it.

8. Staff must receive training on your privacy

policies and procedures every three years.

"The organization will have to provide documentation that training has been given," Adler says.

The training should cover all aspects of how and why you are protecting health information and should be in conjunction with security training, which will be mandated in the yet-to-be-released security regulations. Your staff must be re-trained and re-certified every three years.

9. You must make sure that anyone with whom you share confidential patient information follows the HIPAA privacy regulations.

The Department of Health and Human Services puts the onus on providers to make sure that anyone with whom they share individually identifiable patient information follows the HIPAA privacy regulations.

"If physicians share confidential patient information with other entities, they must bind their business associates to adhere to the same regulations as the practice," Cunningham says.

"Business associates," referred to as "business partners" in the regulation, are people who perform or assist in the performance of a function or activity or perform legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services.

The new regulations have softened the burden of requiring physician practices to police their business partners. However, if you know there has been a violation of the HIPAA privacy regulations, you have to push for immediate corrective action. ■

Original HIPAA law tied to universal health insurance

More provisions to be released

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has its roots in President Clinton's plan to provide universal health insurance for all Americans.

When those efforts failed, Congress passed HIPAA, also known as the Kennedy-Kassebaum Act. It originally was legislation intended to make it easier for people to move their health insurance from one employer to another.

"Instead of just making sure that health insurance was portable and that people couldn't be denied coverage for existing conditions when they changed jobs, Congress took it as an opportunity to look at the health care market as a whole," says **Janice Cunningham**, a health care attorney with The Health Care Group, a Plymouth Meeting, PA, consulting firm.

A major issue was the fact that there were no rules about privacy, security, and confidentiality measures, or who had access to information, how it could be shared, and what patient consent was needed.

Congressional action

Congress decided that the health insurance portability issue needed to be addressed immediately and passed the law with a provision giving Congress until August 1999 to pass comprehensive legislation on protecting privacy and ensuring confidentiality of electronically stored medical information.

The act stipulated that if Congress failed to act by the deadline, the Secretary of Health and Human Services (HHS) would create regulations that standardize all electronic data interchange of health information and protect the security of electronic medical records.

Since then, HHS has released proposed regulations in increments.

The rule "Transactions and Code Sets" was published in final form by HHS on Aug. 16. The rule provides standards for electronic transactions and code sets that health care providers and payers use to identify diagnoses, drugs, and procedures.

When the rule goes into effect, all providers will use and all health plans must accept the same electronic transaction standards. Providers will have until Oct. 16, 2002 to comply with the regulations.

The privacy and security standards were first released in late October 1999 with a 60-day comment period. The final regulations were originally scheduled to be published by Feb. 21, 2000. However, HHS received so many comments from the public — more than 52,000 — that the final regulation.

"We were expecting the final rule to be issues in the spring of 2000 but there were so many comments, it took the entire year," Cunningham says. ■

(Continued on page 27)

Medical staff salaries are on the rise

Expect to pay more to keep valued employees

If you want to stay up with your fellow practices and retain your valued employees, plan on giving your staff a raise this year.

"The job market is tight right now and in some areas of the country it's almost impossible to get well-trained workers. Practices are going to have to be a bit more generous in regard to salaries and fringe benefits, especially health insurance," says **Dorothy Sweeney**, vice president of The Health Care Group, a Plymouth Meeting, PA, consulting firm.

Medical practices anticipate raising their staff salaries between 2.64% and 5.28% in 2001, according to The Health Care Group's *2001 Staff Salary Survey*. The survey includes information on salary and benefits from about 1,100 medical practices across the country, Sweeney says.

The salary survey describes the hourly rate paid to medical personnel and what kind of fringe benefits practices offer their employees. According to the survey, 95% of physician practices provide health insurance in some form to their full-time employees and 36% provide insurance benefits for part-time workers.

"This is going to increase, especially for part-time workers, because competition is pretty keen for good, part-time health care workers," Sweeney says.

Sweeney advises her physician clients to carefully examine their compensation packages on a regular basis with an eye to retaining good employees who are popular with patients.

"There is a lot to be said about how much the staff is a factor in helping a doctor retain patients. Patients don't really know what makes a good doctor but they do know if it's easy to get an appointment and if the staff is nice," she adds.

Medical practices have a harder time finding and keeping good personnel in their reception area, Sweeney says. "There's always more than a 50% turnover ratio. It's a tough job, it's not highly paid, and people will leave for 10 cents or 25 cents an hour," she adds.

Personnel costs are the highest expense for the majority of medical practices. That's why staff salaries present such a balancing act — you need to contain costs but at the same time, you need to hire and retain quality staff.

Once a year, physician practices should take a careful look at each position in the practice, the work that is involved, and salaries.

Sweeney recommends analyzing the salaries and benefits you are providing and comparing them to industry standards. Look at health insurance, paid vacation, and holidays, not just the salaries.

Here are some tips for hiring and retaining top-notch personnel:

• Don't make lack of experience a factor in deciding not to hire an applicant you like if the person is intelligent and has a sense of customer service.

"You can teach people what they need to know but you can't always find someone with the kind of personality needed to work with patients. This is especially important at the front desk and in the clinical area," she says.

• Conduct an employee evaluation once a year in conjunction with raising salaries.

• Make sure your work environment is pleasant and that employees will find it comfortable to work in your office.

• Make sure your staff know that the physicians and management team appreciate their efforts. For instance, you might say to your staff, "We've had a really tough flu season and we made it through. Thank you for your hard work."

"Make them feel like all of you are in it together," Sweeney says.

• Keep the lines of communication open. Discuss any requests for raises with your employee but keep in mind that sometimes you have to say no.

The Health Care Group's Staff Salary Survey includes regional information organized by ZIP code. Among the medical practice positions it tracks are office manager, billing coordinator, bookkeeper, clerical / insurance, data entry, file clerk, lab technician, medical assistant, nurse

Nationwide Hourly Averages for Physician Practice Staff

Position	Less than 2 yrs experience	2-5 yrs experience	5 yrs +. experience
Billing Coordinator	$12.39	$13.65	$14.65
File clerk	$7.43	$8.01	$9.53
Lab Technician	$11.18	$13.20	$14.31
RN	$15.08	$16.12	$17.76

Source: Staff Salary Survey, 2000 The Health Care Group.

practitioner, receptionist, registered nurse, and X-ray technician.

"Practices can get information on salaries for administrators, managers, and nursing positions but our clients kept asking us, 'What should I pay my front desk person?' That's why we got involved in tracking the staff salaries," Sweeney says.

The survey for 2001, which includes salary and fringe benefit information for 24 job categories organized by ZIP Code, is available for $195. A summary showing the national averages of some positions is available on-line at www.healthcare-group.com. ■

Medical errors top consumers' concerns

Patients more afraid of doctor error than flying

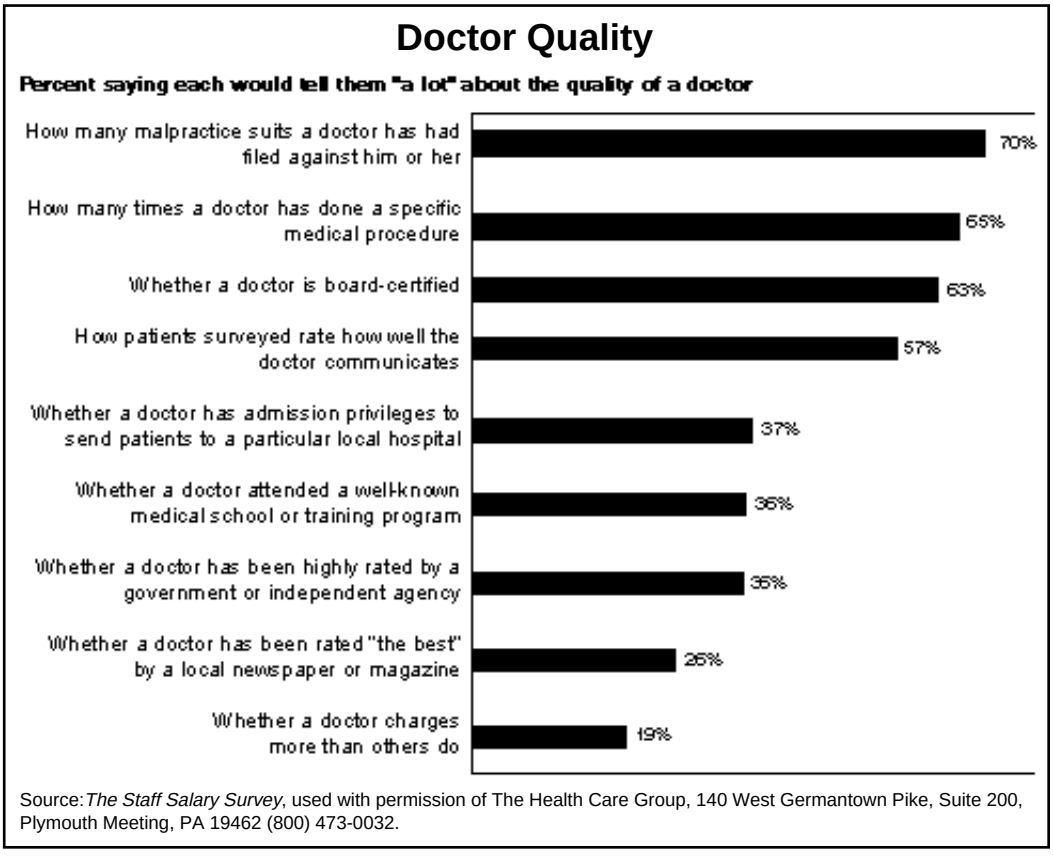
Americans are more concerned about medical errors than they are about flying on an airplane, according to a survey by the Kaiser Family Foundation and the Agency for Health Care Research and Quality (AHRQ).

In fact, 47% of the more than 2,000 Americans surveyed reported that they were "very concerned" about an error resulting in injury happening to them when receiving health care in general, and 40% expressed the same concern about going to a doctor's office for care. Only 32% reported being concerned about an error causing an injury when flying on commercial airplanes.

In addition, the majority believes the government should promote, monitor, and provide information about the quality of health care and that providers should be required to publicize information about medical errors.

The vast majority of those surveyed said that information about medical errors (71%) made by a health plan's doctors and hospitals was tops in determining the quality of health plans, and that malpractice suits (70%) would be the biggest factor they would use in determining the quality of doctors.

Other factors respondents said would tell them "a lot" about the quality of a doctor includes how many times a doctor has done a specific medical procedure (65%), whether the doctor is board certified (63%), and how patients surveyed rate how well the doctor communicates (57%). Only 19% said that cost of treatment would be a factor in determining the quality of a doctor. **(For more information, see chart below.)**



Source: *The Staff Salary Survey*, used with permission of The Health Care Group, 140 West Germantown Pike, Suite 200, Plymouth Meeting, PA 19462 (800) 473-0032.

At the same time, respondents to the survey of more than 2,000 adults showed that people are more likely to rely on the recommendations of family, friends, and health professionals they know than on standardized quality indicators. They also said that they are more likely to choose familiar hospitals and doctors, rather than highly rated ones.

In fact, half of the respondents said they would choose a surgeon they had seen before and who was well-rated, compared to 38% who said they would choose

a surgeon who was rated higher.

Less than 20% of respondents cited consumer groups, government agencies, or newspapers or magazines as a source that would have "a lot" of influence their choice of a physician. **(See chart below.)**

Only 7% of the public have seen information about quality on the Internet, although 28% said they would be likely to go on-line for such information in the public.

About one in 10 respondents say they have used information that compares quality among doctors, hospitals, or health plans to help them make their health care choices.

The survey showed that while most Americans get their health coverage through the workplace, 60% do not believe that employers are a trusted source of information on the quality of health plans because they believe the employers are more concerned with saving money on the benefits they provide.

Provider experience plays an important role in determining the quality of a doctor or a hospital, according to the study. For instance, 65% say the number of times a doctor has conducted a specific medical procedure is an important measure of quality.

Health plan quality measures cited by respondents include whether the plan has a program to help people with chronic illnesses (67%), how easy it is for plan members to see specialists (66%), and how quickly patients can see a doctor when they need an appointment (64%).

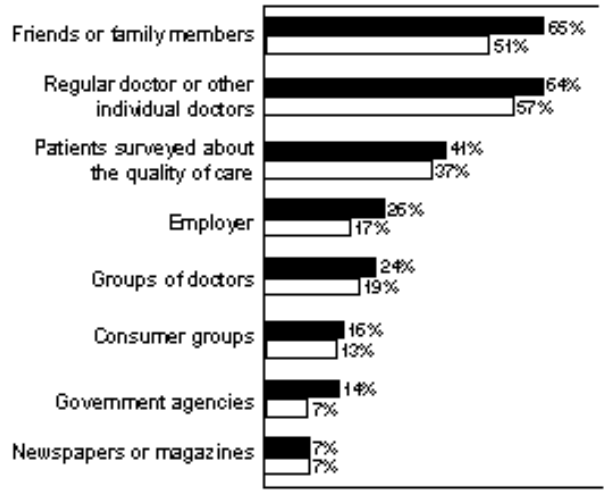
Despite the increased use of the Internet, only 9% of respondents say they have "a lot" of trust in health Web sites for accurate information about prescription drugs, while 70% say they trust doctors and pharmacists to provide the information.

Nearly three-quarters (73%) favor the government requiring health care providers to report all serious medical errors and to make sure the information is publicly available

More than half (60%) believe the government should be involved in promoting, monitoring, and providing information about the quality of doctors, hospitals, and health plans. ■

Influences on Doctor Choice

If they had to choose a new doctor, the percent saying that ratings or recommendations from each would have "a lot" of influence on their choice



Source: *The Staff Salary Survey*, used with permission of The Health Care Group, 140 West Germantown Pike, Suite 200, Plymouth Meeting, PA 19462 (800) 473-0032.

Aetna announces end of 'all products' clauses

Insurer seeks to 'improve relationships'

The nation's largest health insurer, Aetna U.S. Healthcare, has eliminated its "all products" clause, which required physicians to enroll in every Aetna program in order to contract with the health plan.

In making the announcement in December, **John W. Rowe**, MD, Aetna's president and chief executive officer, also said that the insurer was working on other physician policy changes on a market-by-market basis to reflect the specific local needs.

Rowe's news was followed by announcements in several states of specific changes that Aetna has made to improve relationship with doctors in those states.

D. Ted Lewers, MD, chairman of the American Medical Association's board of trustees, called Aetna's elimination of the all-products clause "a good first step toward restoring confidence in Aetna's ability to foster collaborative and cooperative relationships with physicians that benefit patients."

The AMA has been speaking out against that provision of physician contracts for more than two years, he adds, and Aetna eliminated its all-products clause effective Jan. 1.

The new policy applies to all non-hospital-based physicians. In the case of existing contracts, the physicians will have the opportunity to opt out of a product line by giving Aetna 90 days notice when the contract comes up for renewal.

"One of my highest priorities is improving physician relationships with the goal of improve health care quality. Many of our physicians have told us that our all-products policy has been a concern. Creating a more flexible contracting policy is just one example of changes we are making to reduce the 'hassle factor,'" Rowe says.

The company is working on other physician policy changes on a market-by-market basis to reflect local needs that should be addressed, he adds.

In California, Aetna and the California Medical Association announced an agreement on how the provider would give California physicians more flexibility.

The agreement came "after 10 years of strife between doctors and Aetna" according to CMA Chief Executive Officer **Jack Lewin**, MD.

"The AMA is encouraged that the California Medical Association and Aetna have agreed to initiate ever more far-reaching improvements in Aetna's business practices in California," Lewers says.

Under the agreement with the CMA, Aetna agreed to:

• Eliminate the all-products clause.

• Pay actuarially sound capitation rates and begin paying them from the time the patient joins the health plan, rather than waiting for the patient to choose a primary care provider. New patients who do not pick a physician will be assigned to a primary care physician near their home with the option of changing doctors at a later date.

• Pay the cost and administration of vaccines recommended for children.

• Pay for new technology when Aetna and the CMA agree that it is the recognized and appropriate standard of care.

• Stop forcing doctors to take on insurance risks for the cost of the patient's prescriptions.

The organizations also agreed to create a liaison team with representatives from Aetna and the CMA to identify and resolve issues that occur in the future.

"Too often in the past, our relationship with health plans has been characterized by rancor and we have tried to resolve disputes through the courts and the legislature. We hope the future will be built on cooperation, recognizing a mutual desire to serve the needs of patients," Lewin says.

Meanwhile, Aetna's Southeast Region Medical Director, **Catherine Palmier**, MD, outlined new programs and options for members and physicians in Florida.

These include:

• simplifying the pre-certification process for HMO-based products, including outpatient surgery, most durable medical equipment, and many types of injectable drugs;

• eliminating the need for referrals for laboratory services;

• allowing patients to use specialists as their principal physicians with certain appropriate medical conditions;

• agreeing to fee-for-service payments for independently contracted primary care physicians with 100 or fewer Aetna U.S. Healthcare HMO members;

• agreeing to give providers 90 days notice of significant payment or administrative changes to contracts.

In New Jersey, AETNA has agreed to:

• Expand external review to cover pharmacy claims, standing referrals, and emergency care as well as medical necessity and experimental treatment coverage decisions.

• Eliminate pre-certification or referral for magnetic resonance imaging / magnetic resonance angiogram services for members of HMO-based plans.

• Allowing direct access to specialists for members of some HMO products.

• Reduce the number of formulary drugs requiring pre-certification and step-therapy to 33 from 92.

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Final Stark II rules ease some restrictions

Ancillary services exemption expanded

The final Stark II regulations, issued in January by the U.S. Department of Health and Human Services, ease some restrictions on physician self-referrals contained in the original law.

The final rule will be effective Jan. 4, 2002, one year after its publication in the *Federal Register*.

The final rule prohibits physicians from making referrals to most entities which physicians own in whole or in part. However, it permits physicians to refer to entities that compensate them, as long as the compensation paid to the physician is no more than would be paid to someone else who provides the same services but was not in a position to generate business for the entity.

The final rule expands the law's exceptions for ancillary services provided in a physician's office and allows exemptions to permit indirect compensation arrangements, and small, nonmonetary gifts.

Phase I of the Stark rule, which was released Jan. 4, addresses definitions and exceptions that permit referrals within a medical practice. Phase II will not be issued until after the 90-day comment period on Phase I. Phase II of the regulations will address employment arrangements, personal services contracts, leases, and physician ownership interests in hospitals.

"We are pleased that [the Health Care Financing Administration] has included several important changes in the long-awaited final Stark II physician self-referral regulations. Few, if any, federal regulations affect the structure and operation of physician group practices to the extent of this regulation," says **William F. Jessee**, MD, CMPE, president and chief executive director of the Englewood, CO-based Medical Group Management Association.

The self-referral law prohibits physicians from referring Medicare patients to entities in which the doctors or their immediate family members have a financial relationship.

The original law, enacted in 1989, prohibited doctors from referring a patient to a clinical laboratory with which he or she or an immediate family member had a financial relationship.

In 1995, Congress expanded the law to include physical therapy services, occupational therapy services, radiology services and supplies, radiation therapy services and supplies, durable medical equipment and supplies, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics, and prosthetic devices and supplies; home health services, outpatient prescription drugs, and inpatient and outpatient hospital services. ■

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News BRIEFS

Medical societies launch e-cooperative

Ten medical organizations have joined forces to create the Medical Society eCooperative to make Internet-based information and services available to their members.

Each society will build, manage, and control its own Internet services separately and will provide its members with an individualized Internet portal.

The project will allow the societies to benefit from advanced technology and enhanced services while keeping their unique identities.

Physicians will be able to create customized web sites, participate in on-line continuing medical education, and have access to polls, surveys, and other information affecting physicians and their practices. ▼

Medicare MCOs less likely to approve angiography

Medicare patients enrolled in managed care plans are less likely to receive needed coronary angiography following a heart attack than those with traditional Medicare fee-for-service coverage, a new study has shown.

The study, by Harvard Medical School and funded by the Agency for Healthcare Research and Quality, also showed that a significant percentage of elderly heart attack patients did not receive the recommended standard of care for Class I patients, as defined by the American College of Cardiology and the American Heart Association.

According to the study, 46% of Class I patients received the diagnostic procedure if they had fee-for-service coverage, while only 34% of managed care patients received the procedure.

Increasing age and the availability of angiography facilities at the hospitals to which they were admitted were also factors in under-use of the procedure, the study showed. ■

SourceKit

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