AMERICAN HEALTH CONSULTANTS

PHYSICIAN'S MANAGED CARE REPORT

physician-hospital alliances • group structures
integration • contract strategies • capitation
cost management • HMO-PPO trends

INSIDE

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New survey paints a pretty picture of how better practices succeed

The lesson: Benchmark, retain staff, monitor satisfaction

David Gans, MSHA, CMPE, knows a successful medical practice when he sees one. As director of survey operations for the Medical Group Management Association (MGMA), in Englewood, CO, Gans spearheads the organization's annual survey of medical groups and produces an annual report describing the characteristics of the top-performing groups.

The MGMA's *Performance and Practices of Successful Medical Groups for 2000* is based on 1999 data. Of about 1,100 organizations responding to the MGMA survey, only 10% to 15% met the MGMA criteria for successful medical groups, Gans says.

"We know that we can identify organizations that are meeting higher standards, and once we've identified those organizations we can find out what they are doing that enables them to achieve their high level of performance," Gans says.

The study examined the performance and practices of eight types of medical groups: multispecialty groups, multispecialty with primary care only, family practice, cardiology, orthopedic surgery, primary care single-specialty aggregate,

21st century techniques for success

The phrase "work smarter, not harder" has been tossed around for several years but in today's health care environment, it just doesn't seem possible. That's why *Physician's Managed Care Report* is devoting this issue to ways that you can increase your efficiency and stay profitable.

In this issue, you'll learn how some of your fellow practitioners maintain their profitability and income in these days of declining reimbursements. We'll show you how to reduce the paperwork hassle for physicians, what kind of technology might help ease your office logjam, and how a business plan can give your practice a road map to success. ■

Key Profitability and Cost Management Indicators
All Multispecialty Groups

	Better performers	All
Total gross charges per FTE physician	$811,238	$672,272
Total medical revenue per FTE physician	$561,361	$479,657
Revenue after operating costs per FTE physician	$259,700	$194,772
Total operating costs as a % of total medical revenue	52.35%	58.20%
Operating cost per medical procedure/service inside the practice	$23.30	$29.67

Source: *Performance and Practices of Successful Medical Groups 2000.* Reprinted with permission from the Medical Group Management Association, 104 Inverness Terrace East, Englewood, Colorado 80112-5306. Telephone: (303) 799-1111. Web site: www.mgma.com. © 2000.

medicine single-specialty aggregate, and surgical single-specialty aggregate.

The report utilizes the MGMA cost survey, an extensive assessment of expenses, revenue, and staff data. The report compares practices against their peers. For instance, multispecialty groups are compared to other multispecialty groups.

The report examines performances in four areas:

- profitability and cost management;
- productivity capacity and staffing;
- accounts receivables and collections;
- managed care operations;

"We also recognize the need for quality of care. Patient satisfaction is one measure that identifies quality," Gans says.

According to Gans, the No. 1 priority for top-performing medical groups is performance measurement and benchmarking. "If you cannot measure your performance, you cannot manage your performance, either," Gans says.

Performance measures allow you to track your results over time and benchmark to known standards, Gans points out.

"If you know what is surrounding you and where your benchmarks are, you can measure them against accepted standards developed in the industry and see what steps you need to take," Gans says.

Benchmarking helps a practice identify its weak areas, strong points, and where its efforts to make improvements should be focused.

"If practices know their own internal data, they can compare themselves to external benchmarks and change the things that should be changed while retaining the elements that should be retained," Gans says.

However, Gans warns, rather than rushing to measure every little aspect of your practice, you should be selective.

"Managerially, a practice can't measure everything but should concentrate its initial efforts where they can obtain the greatest benefit. They can improve one area and then move on," Gans says.

Here are some of the characteristics of best-performing practices that show up over and over in the annual survey:

- **Communication and teamwork.**

"There is respect, cooperation, and good communication among the clinical staff, the administrative staff, and the physicians in the practice," Gans says.

For instance, on a scale of 1 to 5, with 1 being very low, the better performers rated their communication between physicians and staff an average of 3.48 while the others in the survey rated their practice a 3.42. Rating on effectiveness of the physician-administrator team were more dramatic, with better performers achieving a 3.86 rating compared to 3.69 for others.

- **Relative stability of staff.**

"In the better performers, the chief administrative officer and physician president or chief executive officer have been in their positions longer, and the staff has too," Gans says.

For example, in better performers, the chief administrative officer had been on the job for 8.25 years compared for 6.89 years for other practices. The professional staff turnover rate was 2.21% annually for better performers and 4.7% for others.

The best-performing practices took steps to retain their staff. Health insurance and retirement plans are standard for better performers but they also offer educational expenses and percent-of-profit bonuses for administrators in their benefits packages. Although staff costs are a medical practice's biggest expenditure, the cost of personnel for the better performers is above average.

For instance, among all multispecialty groups, the better performers had an average cost of $153,875 for support staff, compared to $148,710 for all respondents to the survey.

- **Written policies and procedures.**

"If you have written policies and procedures, your probability of doing what you need to do is much greater," Gans says. He adds that the better-performing practices also make it a point to educate the staff about written policies. For instance, collecting co-payments at the time of service and

validating insurance coverage are vital for a practice to maintain a good cash flow.

According to the MGMA survey, 93.55% of better performers have written policies for collection co-payment at the time of service, compared to 71% of others. Among better performers, 74.19% have written policies to verify insurance prior to service while only 57% of others have the policies.

• **Electronic claims submission.**

The better performers submit the majority of their claims electronically, Gans says. "If you bill electronically, you get cleaner claims and higher collection rates. You get immediate feedback if there are technical problems with the claim," he says. For instance, if your claim has an invalid CPT code or is missing a key variable, the rejection comes immediately on your computer screen, rather than three weeks later by mail.

• **Patient satisfaction focus.**

"During our site visits and telephone encounters with our better performers, every time we talked about what the practice did financially, they also brought up quality of care and what they are doing to get feedback on patient satisfaction," Gans says. More than 70% of better performers routinely measure patient satisfaction, compared with 57.78% of others.

"In almost every case, we see that the better performers use the data they get from patient satisfaction surveys to evaluate their internal operations and make changes," he says.

• **A compensation plan that rewards physician productivity.**

Well over half of the better-performing practices have a compensation methodology for physicians that bases at least half of compensation on physician productivity. ■

How working smarter can boost your bottom line

Why the Hedges Clinic excels

A series of initiatives that help doctors work smarter and an emphasis on physician productivity has helped the Hedges Clinic in Frankfort, IL, maintain profitability and manage costs at a time some physician practices are floundering.

"In order to run our practice like a business, we work to streamline the process and to help the physicians to be able to see more patients," says **Frank Schibli**, administrator for the multispecialty, primary care-based practice in suburban Chicago. "The more patients we see, the more profitable it can become."

The group is independent and is owned by the physicians. There are nine full-time equivalent (FTE) physicians and a support staff of 34 FTEs.

The group offers pediatrics, internal medicine, OB/GYN, and general surgery, as well as a variety of ancillary services including laboratory, radiology, mammography, ultrasounds, and allergy testing.

• **The practice is independent and is owned by the physicians.**

It is featured in a video education series based on the Medical Group Management Association's *Performances and Practices for Successful Medical Groups* survey report. The Hedges Clinic is spotlighted in the video *Improving Profitability*.

"When you look at the numbers in the Medical Group Management Association reports, it looks like we have too many support staff based on the number of physicians we have. But when you look at patient encounters, our staff is a lot busier than the staff in other practices. Our staff tends to do more work and to work harder," Schibli says. **(For information on physician compensation, see p. 36.)**

RNs to the rescue

Among the practices that help improve the clinic's profitability are hiring RNs to assist physicians, creating a "runner" position to assist nurses, and having ancillary services in-house so test results are available before patients leave.

Schibli credits the RNs with helping increase physician productivity. Each physician has the same RN working with him or her all the time. The practice works better for Hedges than having a pod of nurses because the nurses are familiar with the physicians' practice styles, and creates continuity, particularly for tasks that carry over into the next day.

For instance, if a physician sends a patient to the hospital for tests and the results aren't available that day, the nurse knows is familiar with the situation the next morning and doesn't have to be re-educated. Some RNs have been with the practice more than 20 years.

To optimize the nurses' time, the practice has positions called "patient care coordinators," better

known as "runners," who work with the nurses. Their job includes cleaning up the rooms, stocking the rooms, getting patient charts, and taking patients to ancillary services.

"Their purpose is to allow the nurses more time to prep the patients and make phone calls. This in turn gives the doctors more time to see more patients," Schibli says.

Even though ancillary services aren't as profitable as they were a few years ago, they save money in the long run by saving staff and doctor time, Schibli points out. In most cases, physician can get test results while patients are still in the office, enabling them to make a care decisions without having to play telephone tag with patient after the test results come in.

"It also allows the physician to get the patient's chart done and out of the suite instead of having to go back to it in the future," Schibli says.

Schibli anticipates that Hedges will always have a laboratory.

"It's good for the bottom line in time savings. We still make some money but it's not like it used to be," Schibli says.

Like most administrators, Schibli struggles with keeping good employees.

"Medicine is one of the few industries where everyone else tells you what you are going to get paid. Some employees don't understand it," he says.

One key to employee retention is Hedge's profit-sharing plan for employees who have been with the practice two years. **(For details on the profit-sharing plan, see p. 37.)**

Here are some other keys to the Hedges Clinic's success:

• **Careful selection of insurance contracts.**

The practice looks carefully at the insurance contracts it accepts and tracks the percentage of each type of payer, such as capitated, fee-for-service, Medicare, and Medicaid. The practice is fortunate because no one company controls more than about 20% of the market.

"We have every contract that we want. We have terminated some based on other issues. We got to the point when we decided that the hassle factor wasn't worth the additional income," he says.

Only 10% of the practice currently is capitated. The practice has set a limit of 20% capitation.

Taking the steps to terminate the first contact was difficult because of the uncertainty of how it would affect the practice, Schibli says.

Some patients the group lost had the opportunity to change plans, however, and Hedges was able to get them back.

Work ethic contributes to clinic's profitability

Compensation based partly on productivity

The Hedges Clinic in Frankfort, IL, encourages its physicians to work as hard as they can and as smart as they can, says **Frank Schibli**, practice administrator.

"Our physicians have a strong work ethic. They enjoy practicing medicine and are willing to go that extra mile," Schibli adds.

Doctors are paid a salary and a quarterly bonus based on a formula that results in more pay for more productivity. Here's how the formula works:

• 45% split evenly;

• 45% based on production, or the dollar volume the physician generates;

• 10% based on patient count, to encourage them to see more patients.

The patient count part of the formula is designed to compensate physicians such as pediatricians, who have to see more patients to produce the same dollar volume a surgeon produces with one procedure.

"The compensation is equally unfair because there is never anything that is fair. We try to keep it as equally unfair as possible," Schibli says.

Each physician receives a monthly report that includes data on how many patients every doctor saw, how much money each produced, what the ancillaries were, how many capitated patients the practice saw, and a comparison of the year-to-date patient count with previous years.

"Since the information is shared among all physicians, there may be some peer pressure for physicians who see fewer patients than the norm. If it's a partner who notices that a physician isn't as productive as his peers, it carries more weight than if an administrator points it out," Schibli says. ■

"Quality of care and patient satisfaction are very important to us. When we terminated a contract with one insurer, some of our patients were willing to change plans to keep coming to us," he says.

Good will building

Because the practice is in an affluent area, 2% or fewer of its patients are on Medicaid.

"Some of our Medicaid patients are those who came into a difficult situation that forced them to go on public aid. When they are employed again, they remember that we were willing to see them when they were down and out," Schibli says.

• **Convenient appointments.**

The practice reserves 25% to 30% of each physician's time slots for same-day appointments. "It makes it more stressful for the staff but it's good for the patient. If a child wakes up with a fever, the parents can bring him in that day, instead of having to wait for an appointment," Schibli says.

Overall, the same-day appointments improve patient satisfaction, which is part of the entire chain of operations, Schibli points out.

In addition, the clinic offers "urgent care hours" until 9 p.m. four days a week and from 2 p.m. to 6 p.m. on Saturdays. The practice contracts with a part-time physician who treats patients with minor problems such as injuries and sore throats.

"Many in our client base are not interested in taking the day off work because they have a sore throat," Schibli says.

The practice charges slightly more for urgent care visits than for regular office visits but the fees in no way approach what a patient would pay in an emergency room.

• **Re-educating the staff.**

The practice makes sure the staff understand why things have to be done a certain way and how everything they do affects the rest of the practice.

For instance, Schibli emphasizes to the reception staff why they need to verify insurance coverage when the patient checks in and what happens when they don't. Now, the receptionist gets the appropriate insurance information to determine what doctor the patient can see and whether the ancillary services can be done in-house or if the patient must be referred to someone else with whom his or her insurance has a contract, Schibli points out. ■

Profit-sharing plan helps boost staff retention

In-house plan similar to a 401k

Some non-physician employees of the Hedges Clinic in Frankfort, IL, have amassed a retirement fund that totals as much as $500,000 through the practice's profit-sharing trust. That helps explain why turnover at the clinic is so low.

The trust is similar to a 401k plan except that employees do not have to make a contribution. The employee share is based on a formula. Over the past 10 years, the employee share has come out to about 12.5% of gross wages. Some employees have between $250,000 and $500,000 in their retirement plans.

"The amount of money they can produce for their retirement can be quite sizeable," says **Frank Schibli**, administrator of the practice. However, he emphasizes that the plan "is not a get-rich-quick stock option type of plan."

Employees become eligible for the profit-sharing plan on their two-year anniversary date. They have to be 21or older and have to work 1,000 hours or more a year. They take their money with them when they leave the practice.

The fund is self-directed, which gives the employees the opportunity to learn about investments. Employees can invest in whatever they choose, with approval of the plan's trustees.

"We leave it up to the individual employee. It forces them to learn about investing and everybody needs to understand about money to prepare for the future," he says.

The profit-sharing plan is in-house, so its administration costs the practice nothing. Schibli is the plan administrator and trustee and handles all the paperwork.

The profit-sharing plan helps retain good employees but Schibli has an additional goal in mind.

"I read a lot of financial journals and I am concerned at how low the median asset values of families are. It's really scary. I made it my goal to make sure the people who leave here are beyond those numbers." ■

Hard work, smart staffing keys to higher incomes

Texas practice is a top earner

When Collom and Carney Clinic Association, a multispecialty practice, interviews new physicians, it always shows the prospective employees the level of productivity the practice's doctors achieve.

"There's usually one of two responses — either euphoria or fear," says **Tom Simmons**, CMPE, chief executive officer of the Texarkana, TX, physician practice.

Some physicians say that the practice demands more work than they are willing to do. Others comment that the patient volume must mean good income and that's the kind of practice they want to join.

"We are looking for physicians who want to perform at a high level. The process probably begins and ends at the recruitment stage. We believe that people with indications of high productivity are probably not made, but are born," Simmons says.

The process works. Physicians at Collom and Carney achieve far in excess of their peers.

For instance, the salaries of physicians in the internal medicine department are 180% of the median salary for similar physicians included in the Medical Group Management Association (MGMA) annual survey.

In 2000, 95% of the physicians in the practice had their highest income ever.

"A lot of them have worked harder to accomplish that but we've had that trend for the past few years," Simmons says.

A whopping 90% of physician pay is based on productivity. "You can't drive the work ethic if you don't have the compensation," Simmons says.

Collom and Carney is a 68-physician multispecialty practice with 450 employees, including physicians. The practice owns a chain of dialysis facilities and 25% of an ambulatory surgery center. It has always been in the 90th percentile for income and productivity in the MGMA survey.

When members of the practice interview prospective physicians, they discuss professional and personal goals and show them the level of productivity the Collom and Carney doctors are expected to achieve.

For instance, in internal medicine, the average physician admits 10 patients when he or she is on call and does 10 histories and physicals.

The practice also looks for the highest achievers among physician applicants. For instance, 30% to 35% of its physicians were members of the Alpha Omega Alpha medical society.

"We have found generally that those in the top of their medical class have a strong work ethic," Simmons says.

The practice is located in Northeast rural Texas where there is only a small infiltration of managed care, but the practice still uses many insurance rules and pre-certification practices.

Doctors at Collom and Carney spend less than 5% of their time on tasks that involve anything but treating the patients.

"When we recruit doctors, we tell them we want to minimize the paperwork hassles they have in practice. Anything we can accomplish for them — anything that does not need to be written and signed by a physician — we handle that for them," he says.

'You don't want to have a doctor who is compensated at $200 an hour doing a $10 an hour job.'

Collom and Carney keeps a close eye on the administrative structure and moves administrative tasks to non-physician employees so doctors can concentrate on seeing patients.

When doctors arrive at the clinic from the hospital they already have three to four patients in rooms, with the charts on the doors or pulled up on the computer screen. The nurse has already taken the initial information.

Collom and Carney's aggregate support cost is 15% to 20% higher than its peer groups in the MGMA survey but the group's productivity is 70% to 80% higher.

"You don't want to have a doctor who is compensated at $200 an hour doing a $10 an hour job," Simmons says.

If there's an opportunity to use a signature stamp, rather than a doctor's signature, the practice takes it.

"The point is to alleviate the paperwork nightmare that today's doctors experience," Simmons says. The nurses call in all prescriptions, return all patient phone calls, and call patients with lab

(Continued on page 43)

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

Capitation skills undergird practice, insurer operations

10 reasons to stay up to date

Like Dr. Jekyll and Mr. Hyde, capitation has a changing image that tends to morph from savior to pariah and back again. Once called a modern-day version of the California Gold Rush, capitation rocketed to the spotlight in the mid-1990s as a smart new way to contain costs and improve health. But in time, its reputation tarnished as many physicians and patients found it to be too cost-conscious and simply too chintzy.

Amid capitation's checkered past, news accounts have featured stories of its demise, as well as accounts of its return to the spotlight. "Everyone is going back to fee for service," some headlines report. Yet a few days later, reverse predictions surface, asserting that "Capitation is here to stay." So what's reality?

Reality is that the best strategy for practice administrators is to stay on top of capitation and its methodologies, whether the practice is currently swamped in risk, or is shifting back toward more fee-for-service contracts, say consultants with Expert System Applications Inc. (ESAI). ESAI is a practice management software company based in Solon, OH.

ESAI officials offer these 10 reasons to stay up to date on capitation:

1. The principles for calculating capitation rates can and should be used for projecting medical revenue and costs — regardless of the method of reimbursement. If you think about it, revenue and cost levels are not so much a function of your contracting methodology but rather how you run your practice overall. Capitation is one way to predict what you need to provide services, cover costs, and make a profit.

2. Capitation offers useful benchmarks for evaluating both discounted and traditional fee-for-service contracts. It is common business practice to compare the profitability of one contract against another. Typically, you compare how one fee-for-service contract stands against another, or how a discounted fee-for-service contract is doing relative to other contracts. It is just as sensible to compare performance with capitation contracts, or with "shadow capitation" numbers, i.e., developing some "what if" scenarios as if the contract had been capitated. For example, evaluate how the practice would have fared had a particular fee-for-service contract actually been capitated with X,Y, Z rates and coverage requirements. **(For a basic example of this kind of computation, see related story on p. 40.)**

What drives managed care?

3. Discerning the drivers of capitation enables you to understand what drives managed care overall. "To understand the core of the capitation concept, the focus should not be on the rates but rather on the driver of a capitation rate," ESAI officials say. The key drivers are (1) utilization rates (and what affects utilization rates), (2) medical services covered under the plan and the fee-for-service equivalent fees per unit of service, and (3) required co-payments.

4. If you understand the drivers of a capitation contract, you are equipped to analyze a health plan's cost components. Cost can be the toughest part of your analysis, and capitation expertise really hones in on cost analysis that you can apply across your practice.

5. Capitation places a significant emphasis on monitoring quality performance. This is an ever-evolving skill that can do nothing but improve your bottom line and your patient care across the board.

How to apply capitation to discounted FFS proposals

Just because you're not in a capitation contract right now doesn't mean you can't use its principles with savvy to arrive at some very useful information about your other contracts, say consultants with Expert Systems Applications Inc. (ESAI), a Solon, OH-based medical software company.

Here is ESAI's example: A primary care physician opts to enter into a contract with an HMO that has agreed to reimburse on a contracted fee-for-service basis. The physician estimates that he or she will immediately obtain 50 to 100 patients from the HMO contract, and your task is to project both the range of additional revenue and the operational impact upon the practice.

Your practice data indicate that among your active patients, the average annual number of visits is three times a year. The new HMO contract agrees to pay 70% of your office visit fee of $70. This means the doctors average discounted payment under the new contract would be $49 (70% X $70 = $49). You then multiply $49 times the average of three visits a year, which amounts to an average of $147 per patient. This would equate to a per member per month rate of $12.25 (by dividing $147 by 12 months).

Monthly revenue will then range from $12.25 X 50 = $612.50 for 50 patients, to $12.25 X 100 = $1,225 for 100 patients.

The impact on operations can be similarly calculated by projecting the total visits for the patient population.

From these calculations, the cost factor is not apparent, so the questions become (1) whether the additional patients will noticeably drive up costs, and (2) whether opting instead for an actual capitation approach, in which all enrollees provide a PMPM fee, would pay off better. Also, utilization rates and costs per unit can often stray from the average. Thus, more refined estimations based on gender, age, and disease status, can be important if you want a more precise picture. **(For an example of a more detailed analysis of costs and capitation payment scenarios, see story on p. 41 on how a women's specialty health system is dealing with global capitation by developing variations on the standard per-member per-month capitation methodology described here.)**

Regardless of your next steps, however, you're well on your way to applying basic capitation methodologies toward assessing a wide range of contract arrangements. ■

6. Capitation's focus on efficiency also can benefit every patient and physician who walks in your doors each day. You can measure efficiency in all your contract arrangements on a per-case or alternative basis.

7. Many fee-for-service arrangements still have additional partial risk sharing arrangements that require capitation analysis. For example, many contracts have payment thresholds which, if they are exceeded, provide additional payments on a capitated basis.

8. "If a competitor is capitated, you might want to monitor their performance," ESAI officials note. For example, you may know that Practice X in your city entered a major capitation contract with a large insurer. In your professional networking circles, this competitor may be willing to share some of its experiences with you and others in the network. Or, the insurer may be willing to share some parts of the experience to entice your practice. Either way, you can't grasp the merits or demerits without up-to-date expertise in capitation itself.

9. "If a future [capitation] proposal is made to you, you might want to be able to adequately evaluate it," officials point out. If capitation is out of fashion in your market, that doesn't mean it always will be, or that insurers won't take steps to make their proposals more palatable. Also, some practices have had huge success with capitation. Don't get too rigid in viewing your possibilities, ESAI consultants recommend.

10. "Health plans continue to use capitation principles to actuarially project medical costs so that a premium rate for those services can be determined, even when their reimbursement is on a fee-for-service basis," ESAI consultants say. Your practice may be disillusioned with capitation, but that does not mean it's going away entirely. Throughout the indemnity profession, it is alive and well in the practice of health insurance methods. ■

Brigham and Women's tackles global cap pitfalls

Capitation that doesn't kill; what you should know

Just when women's health centers were hitting their stride and focusing on the value of comprehensive health care — POW! — capitation came along.

In women's health care, and other areas of high medical specialization, capitation is bringing huge issues of balancing quality of care with cost containment. Specialists, however, aren't giving up. Overall, three concrete adjustments to capitation payment methodologies can go a long way to mending some of the financial disrepair among these highly specialized centers, according to some experts who are fighting these issues every day. Their strategies can be useful not only to women's medicine; they can also be applied to other areas of specialized medicine, as well.

Brigham and Women's Hospital in Boston is one example of a health care system that committed itself wholeheartedly to women's health starting 20 years ago. Now, it is absorbing some significant blows financially to survive capitation's grip on the Boston market. Brigham also is in a highly competitive market where capitation isn't likely to go away anytime soon.

Brigham's experience — and recommendations for capitation payment changes — are described in a recent study by **Andrew J. Sussman**, MD, MBA, **Robert Barbieri**, MD, and **Troyen A. Brennan**, MD, JD, MPH, Each of these authors is a clinician in the Brigham system and an official in the physician-hospital organization (PHO) that oversees managed care contracts.[1]

Brigham has more than 50,000 patients enrolled in these contracts, with 20,000 of them in global capitation (hospital services are capitated as well as physician services). About 100 primary care physicians and 900 specialists in the system participate in risk contracts. Brigham's is the largest birthing center in the state and it averages 400 premature infant deliveries each year.

Global cap contracts need modifications

"Tertiary women's health centers are excellent resources for patients to receive coordinated care from obstetricians, gynecologists, medical and surgical specialists, and primary care physicians," Sussman and team point out. The drawback is that, "Many global risk capitation payment systems are not adapted appropriately to pay for the care." As a result, hospital costs often exceed PMPM payments. The key is to better adjust the hospital side of the payment picture, these officials suggest. Here are their recommendations on how to do that, thus maintaining the superior care offered in highly specialized health systems and at the same time making global capitation work:

• **Develop case-mix adjusted length-of-stay (LOS) benchmarks.** A PHO's global capitation performance can still be measured in part by how well the hospital meets LOS targets, but these targets need to be adjusted for case mix given that in specialty centers, LOS is bound to be higher than for other non-specialty hospitals. The reason women choose Brigham's primary care physicians, for example, is to get access to the prestigious specialist care that would be available in the same health system if they become pregnant, if they seek fertility services, or if they seek other specialized services unique to women.

Once the specialist hospital meets or comes below case-mix adjusted LOS, then services that increase LOS based on clinical need should not be charged against the agreed upon capitation payment, Sussman and team suggest.

• **Carve out infertility and neonatal expenses, and then spread those costs across the entire health plan.** For example, with infertility care, the carveout should include pharmaceutical and procedural expenses. With neonatal care, carveouts should extend to high-risk pregnancy patients and neonatal unit expenses. Development of clinical guidelines also would cultivate more cost-effective infertility and neonatal care, as well as the use of generic pharmaceuticals, to control costs.

• **Adjust capitation based on patient health status.** Relying on sex and age as indicators for payment adjustments is far too limited, particularly in a specialty setting as diverse as a large women's centers like Brigham, Sussman says. The most promising health status adjuster may lie in Ambulatory Care Groups (APGs), which assign each patient in a plan a score based upon one of 52 diagnosis groups. This is a system Medicare is phasing in and which may well work better in private sector contracting as well, these officials suggest.

Here is how APG scoring or coding works: Each diagnostic group is ranked according to the

intensity of resources need for medical problems. Upon assigning that score to each patient in the capitation plan, payments for the patient mix are adjusted accordingly.

"Then capitation budgets can be adjusted within an integrated delivery network and between integrated delivery networks," Sussman and team explain. "For example, a primary care physician group with less healthy patients can be paid appropriately a higher capitation budget than a group with relatively healthier patients."

Specialist care such as that in this case example — and those in other specialties and in other urban areas — provide a significant contribution to patient care, but they suffer selection biases which are threatening their financial solvency under capitation, Sussman says. These three payment adjustments to global capitation agreements would advance these centers so that they could thrive even under the restraints of a fixed-payment environment.

Reference

1. Sussman A, Barbieri R, Brennan T. Global capitation at a women's health referral center: The challenge of patient selection. *Obstetrics & Gynecology* 2000; 96:1018-1022. ■

Medicare HMO insurers lower rates to seniors

Several major health plans recently announced they would reduce premium costs to beneficiaries in their Medicare HMO plans. Their announcement came on the heels of HCFA announcing increases in payments to Medicare HMO insurers for the year 2001. Here are three recent examples:

• Independence Blue Cross, based in Philadelphia, announced that it would reduce its premiums by 9% to $59 a month for some 60,000 senior HMO enrollees; and by 5% for enrollees in its alternative HMO plan, in which beneficiaries pay $114 a month.

• The Bloomington, MN-based HealthPartners, announced that it will reduce premiums by more than 23%. Its Medicare HMO, Partners for Seniors, will offer a reduction from $99.50 to $76 per month. The plan also announced it will extend its travel benefit at no cost from the current coverage of $5,000 to $100,000 for beneficiaries who receive care out of state.

• Atlanta-based Blue Cross and Blue Shield of Georgia announced an 11% reduction in its senior HMO offerings, which brought the monthly premium to $35.50.

• The cuts to consumers may have stemmed from the Medicare, Medicaid and CHIP Benefits Improvement and Protection Act of 2000, passed in December, which allocated Medicare+Choice plans $9 million over 5 years as part of an $11 billion package. Some Congressional critics complained that the increases would have been better used to improve benefits — such as hotly debated pharmaceutical benefits.

Pharmacy costs are spiraling upward while HMOs are dropping out of Medicare, often citing drug costs as the reason. **(For an update on the protracted issue of drugs and Medicare HMOs, see *Physician's Managed Care Report*, February 2001, pp. 23-24.)**

Growing fears of a recession make saving money on expensive necessities like prescription drugs even more important, according to **Celinda Lake**, president of Lake Research, a public opinion polling firm based in Washington, DC. For Gore supporters, this issue ranked No. 2, and for Bush supporters, it came in at No. 5, she reports.

If economic woes persist, the difference in the two camps of voter opinion could shift dramatically, she says. Also, economic pressures coupled with an evenly split Congress suggest that the debate is likely to soar in early 2001. ■

M+C increases expected

Federal payments to Medicare+Choice managed care organizations are expected to rise in 2002, with hikes in the floor rates for poorer counties increasing as much as 5%, according to the Health Care Financing Administration (HCFA). The official rates for 2002 will be announced in March.

Every Medicare managed care plan will see an increase in its year 2002 rates, says HCFA Acting Deputy Administrator **Robert A. Berenson**. Under current rules, M+C organizations that enter a county where no M+C plan has operated since 1997 — or where all of the plans left the program as of Jan. 1, 2001 — qualify for a new additional bonus of 5% for the first year and 3% the second year. ■

(Continued from page 38)

results. "The doctors do call patients back in some circumstances, but we are selective," Simmons says.

The practice employs clerks who handle pre-certification, set up patient examinations, and call the hospital to arrange admissions. "The doctors' involvement in all those things is just in writing the orders," Simmons says.

The clinic is in a community of 56,000 with about 350,000 in the trade area. The physicians see more than 200,000 active patients, about 60% of the local market.

The practice works hard to stay on schedule, although emergencies do crop up from time to time. "If you don't stay with the schedule, you can't accomplish any of these goals," Simmons says.

On average, patients can get an appointment in one day to one week.

The practice hires part-time physicians only when it needs help complementing the work schedule. For instance, in a few locations, the practice may contract with someone to work only one or two days a week.

At present, only one physician is part-time. "We are looking for people with a full-time commitment to the practice of medicine," Simmons says.

The practice employees mid-level providers who are used selectively in some departments.

"Our use of mid-level providers is uniquely adapted to the needs of each department. They aren't just thrown into every department," he says.

For instance, in the internal medicine department, a nurse practitioner sees patients who can't get a regular appointment that day, as well as patients of a doctor who is on call and has to be at the hospital the entire day.

"In internal medicine, the mid-level providers are a release valve to take care of the overflow of patients. The family practice department doesn't have the same problem," Simmons says.

Each of the departments at Collom and Carney has its unique approach to management.

"You can't buy a book. There is no cookie-cutter approach to increasing productivity. Every situation has its own set of problems you have to analyze. We can't draw a lot of parallels between the departments, other than going through the productivity analysis for each one," Simmons says. ■

What makes a practice hum in the 21st century?

How providers cope with additional workloads

Physicians practicing in the 21st century face a myriad of problems and challenges that were unheard of just a few years ago.

They must maximize their reimbursement but at the same time make sure they don't get accused of fraud.

They must see more patients to make up for declining margins, but at the same time they are drowning in paperwork.

Instead of just sending out a bill and getting a check back in the mail, physicians have to fill out endless paperwork and jump through multiple hoops just to get paid.

At the same time, patients expect more. They don't want to wait for an appointment and they refuse to spend a lot of time in the waiting room. They're a demanding bunch and they'll switch doctors in a heartbeat if they aren't happy.

Many insurers now expect physicians to offer disease management programs for their chronically ill patients.

Insurers are paying less and at the same time physician practices have to deal with more overhead and an increasingly complex array of payer rules.

Practices can no longer get away with the inefficiencies of the past because the margins are no longer enough to compensate for them, points out **Bob Elson**, MD, MS, of iMcKesson Provider Solutions Group, an Internet-based technology company based in Minneapolis.

It all adds up to greater costs, limited reimbursement, and shakier financial grounds for today's physicians.

Stories of bankrupt practices and declining incomes for physicians are often in the news. But despite it all, some practices are flourishing, even in these difficult times.

For instance, at Collom and Carney Clinic Association in Texarkana, TX, 95% of the group's 68 physicians made the most money they've ever made in 2000.

The salaries of physicians in Collom and Carney's internal medicine department are 180% of the median salary for similar physicians included in the Medical Group Management Association (MGMA, with headquarters in Engelwood, CO)

annual survey. **(For details on how this group thrives, see related article on p. 38.)**

"If costs are going up and reimbursement is limited, medical groups must be more efficient," says **David N. Gans**, MSHA, CMPE, director of survey operations for the MGMA.

The organization's report, *Performance and Practices of Successful Medical Groups 2000* surveyed more than 1,100 physicians practices nationwide. About 1% to 15% of the groups surveyed met the MGMA's criteria for better performers. **(For details on what makes a better performer, see the cover story)**.

According to the MGMA report, better performers have:

- lower operating costs per procedure;
- higher revenue per physician;
- higher physician cost (compensation and benefits);
- enhanced productivity;
- better and quicker collections;
- less bad debt.

Better practices focus on efficiency and effectiveness and take proactive steps to avoid mistakes.

"In the old days, the profit margins were so big that if you made mistakes, it didn't matter. Times are tight now and margins of management error are smaller. Practices can no longer absorb their mistakes like in the past," says **Peter Lucash**, president and chief executive officer of Lucash & Co., a Charleston, SC, consulting firm..

A well-prepared business plan is a critical management tool for running a successful practice in today's health care market, Lucash says. **(For details on creating a business plan, see the story below.)**

"Physicians are being pulled in every direction. They are being forced to see more patients than they can reasonably handle. Practices are become more like a bank and carrying large receivables," Lucash says.

Productivity, cost efficiencies, and collections contribute to a practice's bottom line, Gans points out.

The MGMA has found examples of practices that are more than 50% more productive than their peers.

Extended hours, marketing efforts, a physical plant that enables them to see more patients, and physician compensation tied to productivity are among the techniques the more productive practices utilize.

The report found that savvy medical practices are taking advantage of e-business technology to streamline their practices.

Only 32.85% of all the groups surveyed reported having no Web page. The vast majority used their Web page for general information and marketing but a sizeable percentage of practices, 16.67% use the Internet for patient questions.

"Communication between physician and patient is a new electronic market sector," Elson says, adding that use of technology can dramatically reduce the amount of time physicians and staff spend filling patient requests.

For instance, he worked with a 15-physician clinic that was getting 370 calls each day for reasons other than setting appointments.

The clinic calculated that the whole process was taking 28 hours a day of telephone nurse time and six hours a day of physician time — 3.5 FTEs for nurses and three-fourths FTE for physicians just to support the requests of patients of 15 primary care physicians.

Within nine months of using iMcKesson's Practice Point Clinical Solutions, the practice had reduced its telephone nurse services by one-half FTE, avoided a planned hire for an additional full-time phone nurse, and reduced chart room outsourcing by three FTEs. ■

A business plan helps you get control of your practice

Decide what you want to do, how you'll do it

If you're like many physicians, you may feel as if your practice is controlling you, instead of vice versa.

Today's practices must deal with everything from excessive paperwork to long billing delays and collecting co-pays but these seemingly little things can add up.

That's why **Peter Lucash**, president and chief executive officer of Lucash & Co., a Charleston, SC, consulting and advisory firm, is a fervent believer that physicians need a business plan to survive in today's health care environment.

"A business plan helps physicians get control of their practices and know what is going on," Lucash says.

In a nutshell, creating a business plan requires taking a series of steps that let you know what is going on in your practice. It helps you make

How to determine treatment costs

You don't need an elaborate cost-accounting method to determine how much it costs you to treat your patients, **Peter Lucash** asserts.

"Most practices use 20 to 40 CPT codes. It's not worth it to spend a lot of money on cost accounting. It will probably cost you more than you could possibly gain," says Lucash, president and chief executive officer of Lucash & Co., a Charleston, SC, consulting firm.

Here are two ways to determine your costs:

1. To find your average cost per patient per year, calculate the total expenses for the practice, not including owner-physician compensation.

Calculate the total number of unique patients your practice sees in a 12-month period. (This is a compilation of individual patients regardless of the number of times they are seen. If a patient comes in 12 times in a year, she still is counted as one unique patient.)

Divide the total expenses by the number of unique patients to determine the average cost per patient per year. Divide by 12 to find out the per-patient, per-month cost of treatment.

If a health plan offers you compensation on a per-member per-month basis, you can compare what it costs you per patient per month to what is offered.

"The assumption is that all patients are fundamentally the same. The managed care patient may be healthier but you should assume they are sick," he says.

2. To calculate your costs based on RVUs, calculate the utilization for each CPT code you delivered in a 12-month period.

Multiply the utilization of each CPT code by the RVUs for each and you get the number of RVUs per CPT code.

Add these up and you have the total number of RVUs that you delivered for the year. Divide the total expenses by the total number of RVUs to see your cost per RVU, also known as the Practice Expense Conversion Factor (PECF).

To determine your cost for providing a service, multiple the RVU for each CPT code by the PECF.

"This is what you do to calculate your revenue per CPT code under Medicare. You're doing the same thing for expenses. Your revenue should exceed this revenue calculation," Lucash says. ■

intelligent decisions about what you want to do in the future, Lucash says.

"The analysis has multiple purposes and multiple uses," he adds.

Although the plan should be outlined in some sort of written form, a big, elaborate document isn't necessary, Lucash points out.

"The essence of a plan is not the written document. The essence is what you are going to do with it. The whole purpose of a business plan is the actions you will take," he adds.

You aren't developing a business plan for the exercise, you're doing it to gain control of your practice and your life, he emphasizes.

A business plan has to be an individual decision, made by the physicians in the practice, Lucash says.

"I can produce a plan for a practice, but there is only so much an outsider can do. Only physicians can sit down and decide what they want to do. It's a real individual decision. There's no cookbook method for planning," he says.

The first step in creating a business plan is to get a handle on the nuts and bolts of your practice to see what changes you can afford to make. Look at your financial analyses to see where the money is coming in, where it is going out, and what is sitting there and not being collected.

Look at your patients. Where are they coming from? What is the most common age group? What kinds of problems do they present with?

"Invariably, there will be a surprise or two when a practice analyzes its patients," Lucash says.

You should be able to get information on your patients from your practice system. It should report the number of patients by age, sex, and ZIP code. Lucash suggests using ZIP codes, rather than cities or towns because they help you better pinpoint where your patients live.

For instance, your practice may be getting a number of patients who are on the other side of town. In this case, you should look at why they are coming, and who is referring them.

"If you have a lot of patients who are being referred by one physician, it might be time that you talked to him," he says.

You may have to reformat the data to give you the information you need but it's not a difficult

Set out a plan for attaining your long-term goals

Here are some tips from an expert

You know all the ins and outs of your practice and what you want to do. How do you decide how to accomplish those goals?

Here are some answers from **Peter Lucash**, president and chief executive officer of Lucash & Co., a Charleston, SC, consulting firm, and author of the *Medical Practices Business Plan Workbook.*

If the physicians in your office feel they are working too hard, you might consider hiring a new physician or limiting new patients. Or if you want to market your practice, you might consider low-key advertising or public speaking engagements by a member of your practice.

One practice Lucash worked with decided to advertise with an emphasis on education. Among the advertisements were signs and symptoms to watch out for, reminders of immunizations, what to do when you have chest pain, and when you need to see a physician.

But if your practice specializes in elective surgery, such as cosmetic or ophthalmologic surgery, you might consider a different kind of advertising with a different marketing purpose.

"There are multiple purposes in this kind of advertising. You identify yourself with people who will remember you when they are looking for a physician and you educate patients about when it's valuable to come to you," Lucash says.

If someone in your practice enjoys public speaking, you might consider making him or her available to civic organizations or other groups in town.

If problems are occurring in collections, emphasize the importance of good cash flow to your staff.

"The staff needs the tools and guidance and direction to make your practice successful. People respond very quickly to wherever management puts the emphasis," Lucash says.

For instance, if you emphasize to the staff that they should collect past-due bills, they will do it, he says.

Take a tip from other professionals and consider investing in tools that enable you to improve your practice, Lucash says. For instance, a dentist rarely lets a patient walk out the door without scheduling a check-up six months later.

"Physicians don't think that way, nor do they set up their computer systems to handle that," Lucash adds.

[Editor's note: Lucash's book Medical Practices Business Plan Workbook *may be ordered from Lucash & Company, 4 Carriage Lane, Suite 406-C, Charleston, SC 29407. Telephone: (843) 401-0900. E-mail: plucash@awod.com. The cost is $55 plus $2.50 shipping and handling. Master Card and Visa are accepted.]* ■

process, Lucash says.

Most software will allow you to set up a report format so you have to reformat the data only once. Look at your monthly spreadsheet to give you an intuitive feel for what is going on financially with the practice.

"When I was a practice manager, I spent 10 minutes once a month looking at the spreadsheet. You can feel it in your bones after a while," Lucash says.

Know what it costs to see your patients. **(For details on how to calculate your costs, see p. 45.)**

"A classic example of how a business plan can help is that it gives physicians the knowledge they need to know whether or not to sign a managed care contract," Lucash says. If you know your patient costs, you can compare it to the per-member-per-month reimbursement offered by a health care plan.

"Many physicians sign managed care contracts

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without knowing whether they are good or bad, or even if they don't like the contract, they don't realize what the impact is on their practice, he says.

For instance, one physician client of Lucash's was considering a contract with an insurer that was notorious for low payments. However, when he crunched the numbers the contract didn't seem so bad. The HMO had a strong push for preventive medicine and gave physicians cash bonuses for immunizations and mammograms.

Based on patient history and cost of treatment, the practice concluded that the combination of the preventive medicine bonuses and reimbursement was enough to make the contract worthwhile.

Once you have your financial and patient information in hand, you can look at what you want to do in the future. Ask yourself if you're busy enough. Do you want to grow? Should you add another physician?

All physicians in the group should figure out what they want to do personally and professionally.

"There are always other patients who can come in the doors. Doctors need to decide if they are taking on too much. Or, if they want to retire at age 55, they may be willing to work even harder to do so," he says. ■

Tired of phone tag? Internet solution may help

E-mail can do the leg work

What's the biggest source of inefficiency in your office? Playing telephone tag with patients who have questions? Refilling prescriptions? Making sure your patients comply with treatment?

If you have a typical medical practice it's likely that a lot of time and energy goes into dealing with inefficient communication.

Take for instance, the way hard-copy messages get passed back and forth. Perhaps a nurse scribbles something on a sticky note and puts it in a file she places on the doctor's desk. The doctor scribbles something on the note and puts it in another file.

"Things get lost, they get dropped, and no one follows up," says **Bob Elson**, MD, MS, of iMcKesson Provider Solutions Group, an Internet-based technology company in Minneapolis.

Almost any kind of message, including lab results, involves pulling the chart and refiling the chart. "That doesn't even take into account the inefficiencies relating to messages between physicians and patients," Elson notes.

The Internet offers a opportunity for communication through e-mail, says **Matthew Weingarten**, MD, director of clinical programs for Mediconsult, a Tarrytown, NY, health care consulting firm.

For instance, with structured e-mail, patients can go to a physician Web site, click on an e-mail box, and send an e-mail that allows them to cancel an appointment s, receive lab results, or ask

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for a medication refill.

The system does not give patients the ability to add text, so there is no way that an emergency message would sit in a message box unnoticed.

The clinic Web site could be set up so that the patient has a user name and password for security purposes. The patient is notified by e-mail when the response is back and can go to the Web site and log in to get the answer. This system avoids one of the biggest worries of Internet communication — that confidential information will fall into the wrong hands, Weingarten says.

Internet-based compliance programs can offer supportive messages that are sent patients by e-mail at intervals specified by the doctor, Weingarten says. For instance, patients who are taking medicine for ulcers have a natural tendency to stop taking it as soon as they start feeling better. The system can automatically send e-mail message to patients at regular intervals, reminding them of treatment compliance.

An example: Day 5: You should be feeling (describe it). Day 10: If you have X side effects, contact your physician. Day 20: You may be feeling better and tempted to stop your medicine but here are the reasons you should not.

"Our project has been well-received. It offers a real opportunity to extend a physician's reach in an area where both the payers and recipients of health care are expecting it to be extended," Weingarten says. Electronic patient provider interaction software offers a range of services for physicians and patients, Elson says. "It allows the clinic to tackle customer service issues and create a significant Web presence early on," Elson says.

His company offers software that allows the physician to create a personalized Web page for every patient who registers for it. Patients can automatically receive healthcare information from their doctor, request appointments, renew medications, and ask questions on-line.

"One clinic with a busy practice found that 1% of patients per month register for the service. This means that after a couple of years, 25% to 30% of patients will be active users. Physician practices can't expect to get 100% but if they get 30% or more patients using the system, it takes a significant burden off the telephone lines," Elson says.

Among his company's products are tools that manage laboratory test orders and results, allow on-line prescribing, access patient records, provide access to on-line patient data, and integrate clinical tasks. ■

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