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PHYSICIAN'S MANAGED CARE REPORT

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INSIDE

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Existing technology can ease many woes, but practices are slow in using it

Take advantage of today's advances to boost tomorrow's profits

The good news is that the majority of America's physicians agree that technology and the Internet are likely to make tremendous transformations in how medical practices operate in just a few years. Indeed, experts say technology is available to allow physicians to streamline operations and improve efficiency.

The bad news is that many physician practices are slow to adopt technology, and those that don't move soon may be left behind.

"With the exception of a few large hospital groups, we have not seen a lot of technology assessment taking place. I encourage physician practices to complete their assessment quickly to see what they need to do. The real message is to embrace technology for the office just as you would for the clinical side," says **Lee Akay**, managing partner for PricewaterhouseCoopers MCS Healthcare Practice in Pasadena, CA.

Clock resumes ticking for HIPAA privacy rules

Administration moves forward on implementation

The clock is once again ticking for implementation of the patient privacy protection rules in the Health Insurance Portability and Accountability Act (HIPAA). Secretary of Health and Human Services **Tommy G. Thompson** has approved implementation of the new regulations, but some changes can be expected.

Providers and insurers now will have until April 12, 2003, to comply with the regulations. The original HIPAA rules were scheduled

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Akay 's firm co-sponsored a survey on physicians and the Internet conducted by Harris Interactive for the Health Technology Center, a San Francisco-based nonprofit organization that promotes the use of new health care technologies. The survey showed that the potential for using the Internet is growing more rapidly than most industry observers thought possible. **(For tips on how you can make the transition to high technology, see story on p. 67.)**

The study surveyed physician leaders and office-based practicing physicians and found widespread agreement that computers have already had a positive impact on the practice of medicine and quality of care.

More than one-third of those surveyed said Internet-enabled clinical and business services offer a clear advantage, and 96% said these technologies will improve quality of care by 2003. **(See a list of "essential" Internet-enabled applications according to the physician respondents, at right.)**

"The message we heard over and over is that there is a payback for technology, both financially, in terms of time, and in improving quality and tying the patient to the physician," says **Genny Jacks**, senior advisor with the Health Technology Center.

Technology gives physicians the information and control they need to develop strong relationships with their patients, Jacks adds. For instance, with Internet technology, a primary care physician doesn't just turn patient care over to a specialist; he or she can coordinate the data flowing to them and participate in the care.

If patients have questions, they can e-mail their doctors rather than staying on hold or waiting for the telephone. If patients have a chronic disease, the Internet allows the doctor to help them manage it without coming into the office.

"In the early days, when people talked about managed care, they meant coordinated care, being able to anticipate, prevent, and manage problems. This communication technology enables physicians to do just that," Jacks says. **(For more on how managed care companies are using the Internet to streamline administrative tasks, see p. 68.)**

The survey showed that physicians already are getting diagnostic reports and laboratory values and communicating with ancillary providers and hospitals over the Internet, Jacks says.

Technology can help physician practices improve performance and customer service as well as boosting their own satisfaction with how their business is run, points out **Michael J. Alper**, president of Meridian Health Care Management, a managed care consulting firm in Woodland Hills, CA.

"The impact of not taking advantage of today's technology means that it will cost physicians more to run their business and that their patients will become dissatisfied because it takes longer for things to happen," he says.

One typical response from physicians is that they don't want their staff to have access to the Internet because it may take time away from doing their work.

"That is just a temporary response for not changing current operations," Alper says.

In today's health care environment, doctors have got to see more patients every day to bring in more dollars, even in a capitated environment, points out **Henry Golembesky**, MD, FAAP, a pediatrician and principal with CSC Consulting in San Francisco.

The Internet offers practices a way to gain efficiency without significant cost, he adds.

"It's an exciting time. We can no longer say that the technology isn't there. It's available. It's a matter of how we get it in place and make it work so work flow is enhanced rather than slowed down," Golembesky says.

Cost is no longer an excuse for not shifting to technology, he adds. Computers are inexpensive, and application service providers are a quick way

Six 'essential' Internet-enabled services

Physicians responding to the Health Technology Center survey on technology identified the following six services as "essential" for future use and found them valuable because they reduce administrative costs, speed payments, and improve quality of care (figures in parentheses indicate the percentage of physicians now using the services):

- diagnostic reporting (34%);
- claims processing services (35%);
- pharmaceutical information (34%);
- purchase of medical office products (29%);
- e-mail communication with patients (29%);
- electronic medical records (19% are testing or have implemented EMR). ■

12 steps for a successful transition to technology

Experts recommend you follow these 12 steps to ensure your practice makes a successful transition to higher technology:

1. Make sure you have enough computers in your office and they are in the right places.

A computer at the front desk is a must, says **Michael J. Alper**, president of Meridian Health Care Management, a managed care consulting firm in Woodland Hills, CA.

2. Don't use cost as an excuse not to act now.

"You can buy a top-of-the-line computer for $600 and connect to the Internet for $20 a month," Alper points out.

3. Invest in a cable modem or DSL line, rather than relying on dial-up Internet access.

This will save money and time in the long run, says **Genny Jacks**, senior advisor with the Health Technology Center, a San Francisco-based nonprofit organization that promotes the use of new health care technologies.

4. Look to your professional organizations for guidance on how to use the Internet and other technology.

5. Investigate options in your community.

For instance, your hospital affiliates may be able to make information available to you through physician Web portals.

6. Team up with payers who can support you in your use of technology, and take advantage of payer products that can help you run your practice more efficiently.

7. Check out application service providers that can give you access to technology for a reasonable price.

Systems that help with prescription writing, checking for formulary compliance, and drug interactions and dosages may give your practice the greatest return, says **Henry Golembesky**, MD, FAAP, a pediatrician and principal with CSC Consulting in San Francisco.

8. Whether you sign up for an application service provider or buy the software yourself, make sure that whatever technology you are using will meet Health Insurance Portability and Accountability Act compliance standards.

9. Choose a company that has good support.

Getting your people up and running with technology is a quick way to get a payback, Jacks says.

10. Train your office staff to use the computers and familiarize them with the Internet.

11. Stay current with software and technology support.

12. Plan on a transition period to the new system.

Over time, when you get your patient base into the system, the amount of work is going to decrease, Golembesky says. ■

to link your practice with the outside world without a big capital investment, he adds.

"It's not often that a specialist has all the information he or she needs about a patient's past medical history, laboratory and X-ray information. They are making decisions based on fragmented information or duplicating things they don't have to do. It's not a matter of these being bad doctors or bad hospitals. It happens even in the best of organizations," he says.

The Internet and other technology has the potential to give doctors the information they need to decide what course of treatment a patient needs, Golembesky says.

"Many hospitals are providing linkages to doctors' offices using Internet technology. It allows a doctor to look at progress notes, laboratory and X-ray studies and follow the patient from the office to decide what to do between visits," Golembesky says. ■

Technology can cut medical error rate

7% report using automated prescribing systems

When the Institute of Medicine (IOM) of the National Academy of Sciences issued its shocking report on medical errors and patient safety last year, the committee recommended physicians adopt automated prescribing systems.

But a recent survey of physician leaders and physicians in large- and medium-sized practice groups showed that while many physicians use the Internet to look up information on drugs, only 7% have started using automated systems for prescribing.

"It was really a surprise that the penetration was so small, considering that pharmaceutical

and other companies have made this technology available," says **Genny Jacks**, senior advisor with the San Francisco-based Health Technology Center, one of the sponsors of a recent survey on physicians and the Internet.

Automated systems for prescribing have the potential to greatly reduce medication error rates and can save busy physicians time, says **Henry Golembesky**, MD, FAAP, a pediatrician and principal with CSC Consulting in San Francisco.

"The availability of information at the point of care is going to be critical. When physicians can have access to things like electronic order entry, it has been shown to markedly reduce the chance of medication errors," he says.

For instance, if a physician miscalculates the dose he or she wants to give a patient, the computer can automatically question the dosage and check for allergies and drug interactions. These kinds of applications can eliminate the problems pharmacists often have in reading physicians' handwriting.

"With diagnoses, it can suggest to me laboratory and X-ray studies I haven't ordered that I might want to consider," Golembesky says.

"This is a critical issue because it allows physicians to track whether the patient actually bought the drugs and if they got it refilled regularly, in addition to tracking what drugs the patient is on and if the prescribed drug will interact with any of them," Jacks adds.

Golembesky noted that one practice saves 30 to 45 minutes per day per internist by using hand-held computers for prescription writing and refills. Also, many hospitals across the country have implemented computerized ordering systems in the inpatient setting. Some large clinics have such a system in the outpatient setting, he says.

"The problem has been getting medical staff to start using it and to be comfortable with it," he notes.

Software is available that allows you to write prescriptions and have them checked against the payers' formulary, screened for drug interaction, and sent electronically to the pharmacy.

Some companies offer hand-held computers that allow a doctor to order prescriptions and laboratory and radiology studies, Golembesky says.

"Everyone is looking for a new model. No matter who we talk to — pharmacists, providers, or payers — they recognize that the current system is close to breaking," asserts **Lee Akay**, managing partner for PricewaterhouseCoopers MCS Healthcare Practice in Pasadena, CA, co-sponsor of the Health Technology Center study.

Some physicians have complained that devices provided by pharmaceutical companies may favor that company's products. However, there are ways around this, Akay says.

"If we look at the error rate and the potential that this [automated prescribing systems] would offer, the benefits definitely are bigger than the disadvantages," he says. ■

Solutions are at hand to ease administration woes

Remember when practices fought faxes?

The managed care system is "screaming for improving efficiency," and today's technology is the way to do it, asserts **Michael J. Alper**, president of Meridian Health Care Management, a managed care consulting firm in Woodland Hills, CA. Meridian provides administrative services to provider organizations and HMOs to support managed care activities.

Technology is available for physicians to verify patient eligibility, schedule appointments, conduct referral transactions, and manage co-payments or other insurance functions on-line, Alper says.

"A few years ago, when insurers tried to improve the referral process by allowing faxed documents, the biggest roadblock was that most physician offices didn't have fax machines," he points out.

The same is true with computer programs that will make the managed care process smoother.

Take, for instance, the problem of finding timely and accurate information on a patient's eligibility, probably the biggest complaint physicians have about administering the managed care business.

"We heard a lot of complaints that by the time the hard copy list of eligible patients arrives in the mail, it's often out of date. Physicians need to move the process to electronic commerce," Alper says.

Many insurers offer web-based products that will verify patient eligibility, but the biggest hurdle is that physician offices don't have computers and Internet access in the areas where they need them most — the business office, Alper says.

"Physicians often have a computer in their office, but they are not widely deployed in the business office," he says.

The one problem with verifying eligibility via the Internet is that patients don't always remember the name of their insurer and don't have proof of insurance with them. "There is no universal repository in case the patient doesn't know his or her insurer," Alper says.

The referral process is typically slow when it's done by telephone or fax, but if the provider can log onto a web-based product, the system can check eligibility and the appropriateness of the referral on a clinical or administrative basis and give a response in real time, Alper says.

"Many insurers are not able to handle referral processing on-line today, but it is absolutely coming soon," Alper says.

Electronic claims processing is much more common, Alper says. The Health Insurance Portability and Accountability Act, which mandates standardization, will make electronic claims submission easier, he adds.

Some insurers give providers a bonus if they communicate electronically, Alper says. "It's because everybody says they need to improve their customer satisfaction," he adds. ■

Now's the time for docs to take the lead

Don't wait for payers, government to act

Physicians have a good opportunity to have a major influence as the health care industry moves toward higher technology and the Internet, **Lee Akay** maintains.

"Physicians now have a chance to take a leadership role, where in the past they have had inherent risks but not rewards," says Akay, managing partner for the Pricewaterhouse Coopers MCS Healthcare Practice in Pasadena, CA, which co-sponsored a recent survey on physicians and the use of the Internet.

Physicians who replied to the survey say they believe it will take action by the Health Care Financing Administration or other payers to require providers to use the Internet for claims processing and other administrative services.

But Akay disagrees.

"It's important for physicians to participate in the leadership for a change rather than waiting for someone else to decide," he says.

Because of the consumer backlash against some insurance policies, payers are re-examining their network strategies, and many are moving from capitation to some preferred provider organization-type product.

At the same time, payers are moving to standardize their electronic systems to comply with the Health Insurance Portability and Accountability Act (HIPAA). As HIPAA is implemented and payers develop network strategies, physicians have a good opportunity to come together and assume a leadership role, he says.

"On the provider side, leadership has been fragmented, and it's been easy for payers to develop strategies to keep passing the risk to providers," Akay says. That's why physicians have to take more of a role in the changes so they, too, can reap some of the rewards and avoid some of the risks.

"As we use these Internet-enabled processes and technology, we need to decide how to fairly share the efficiencies and savings across the board so it all doesn't go to one stakeholder," Akay says.

At the individual practice level, Akay suggests that physicians make sure any associations they belong to have representation equal to the payer side. "Physicians should encourage their leadership to unite around a common cause so they can be represented equally at the table," he says.

It will take a concerted effort and a large organization to make a difference, he says. "For instance, in California, some payers own 18% of the market. A single individual practice can't go against that. That is where an association can play a role," he says. ■

Digital guide offers fingertip antibiotic info

Information is free on the Internet

A new digital guide developed by Johns Hopkins University gives physicians a point-of-care decision-making support system for antibiotics and infectious diseases.

The information is free and is available on the Internet. It can be used with Microsoft-based personal digital assistants.

The Antibiotic Guide (ABX Guide) offers information on more than 160 drugs and more than 140 diseases treated by specialists and primary care physicians. The guide was developed by experts who continually make updates to reflect changes in the field, according to **John G. Bartlett**, MD, chief of the division of infectious diseases at the Baltimore-based medical center.

"We believe this guide and the technology on which it is based will rapidly advance evidence-based and outcomes-based medical care and enrich medical education while addressing key concerns such as medication errors, delays in the incorporation of new developments into practice, and antibiotic resistance," Bartlett says.

With the guide, instead of using outdated and voluminous paper versions of drug references, physicians can carry an electronic version that puts the essential information at their fingertips.

Physicians have to cope with more than 1,500 treatment guidelines issued by government agencies and medical organizations in an effort to standardize best practices, Bartlett points out.

"The guide isn't designed to take the place of the physician's own experience or judgment. The goal is to help physicians plan treatments by making the most current information available at the point of care in the doctor's office or hospital," adds **Walter Atha**, MD, director of the project.

Antibiotic information changes constantly

One of the biggest problems doctors face is trying to keep up with all the information on antibiotic use that is published in weekly and monthly medical journals, Atha adds. "New research may find that some drugs aren't effective any more against certain bacteria or that certain combinations of drugs shouldn't be used. That's why antibiotic guides are one of the most important types of reference a doctor uses," he says.

The infectious disease experts who use the ABX guide can update the information in the guide at any time by accessing the Internet.

The guide will include emergency alerts, such as FDA recalls, giving physicians up-to-the minute access as soon as they update their database. The ABX Guide is the first in a series of easily navigated, regularly updated digital medical specialty handbooks from Hopkins experts.

The next guide will cover treatment of HIV/AIDS.

For more information and a copy of the guide, log onto: http://hopkins-abxguide.org. ■

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to go into effect Feb. 28, with full implementation due by Feb. 29. 2003. But because of a technicality, the Bush administration halted implementation until further review.

Although Thompson is allowing HIPAA implementation to move forward without substantial changes, some of the original rules may be modified as the administration issues guidelines on how the rule should be implemented.

The privacy regulations require physicians to protect the privacy of patients' medical information, inform patients in writing about how the practice will use their information, and handle the information in the way they told patients they would.

Thompson gave examples of three areas the modifications will cover:

- Doctors and hospitals will have access to necessary medical information about patients they are treating and will be able to consult with other physicians and specialists regarding patients' care.
- Patient care will not be hampered by confusing requirements surrounding consent forms.
- Parents will have access to health information about their children, including information about mental health, substance abuse, and abortion.

The privacy regulations require physicians to protect the privacy of patients' medical information, inform patients in writing about how the practice will use their information, and handle the information in the way they told patients they would.

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

Beginning early in 2001, the Department of Health and Human Services met with lawmakers, special interest groups, health care leaders, and individual citizens to solicit their comments. In addition, HHS received more than 24,000 written comments on the matter, Thompson says.

"My staff . . . found that most of the submissions broke down into similar concerns. Thousands of the comments were clearly part of mass-mailing efforts in support of a particular view," he adds. ■

Physician's Capitation Trends™

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Fee for service resurges, but capitation outlook brightens

Changes in economy could keep payment in flux

Capitation, once the "golden child" of managed care, is starting to take a licking — and many experts wonder if it will keep on ticking as payers' primary pay vehicle.

A recent rise in popularity of fee-for-service payments has slowed capitation's momentum, but some experts say the softening economy will force employers to become more stingy with health benefits, bringing a resurgence of capitated payments. Meanwhile, studies show that capitation rates are on the rise, making the payment methodology more attractive to many providers. **(See story, p. 72.)**

The revival of fee for service can be traced to a combination of recent events: the concern of HMOs about losing doctors who are fed up with capitation's restraints; a growing rash of lawsuits claiming that financial incentives resulted in bad care; and the fact that employers have been willing to pay for more expensive benefit packages to keep workers happy.

In past months, for instance, major health plans like Aetna, UnitedHealthcare, Cigna HealthCare, PacifiCare Health Systems, and Coventry Health Care have each announced they are converting some of their previous capitation agreements to fee-for-service (FFS) contracts. Also giving FFS a boost is the boom in popularity being enjoyed by preferred provider organizations (PPO).

Multispecialty practices with capitated contracts dropped from 68% in 1996 to 58% in 2000, reports the Medical Group Management Association (MGMA) in Englewood, CO. Based on this trend, MGMA's survey guru, **Dave Gans**, predicts the overall cap rate among multispecialty groups could fall to 40% in the next two years.

Rather than going straight to fee for service, some plans are modifying their cap arrangements. In Colorado, for instance, Anthem Blue Cross and Blue Shield has changed its money-losing capitated global risk contracts by converting to less risky payment pools for hospital and pharmacy charges. Physicians in the pools share savings with Anthem but are not responsible for losses.

Experts also note that California doctors are dropping their pharmacy and hospital risk provisions, but not professional risk. At PacifiCare, for instance, members under global risk contracts dropped from 91% in 1998 to 66% in 2001. Meanwhile, members under professional risk only fell from 99% to 98% during the same time frame.

Because the costs of one sick patient can exceed the capitation income from several healthy patients, a primary care physician needs at least 100 to 150 capitated patients to make the payments worthwhile. This is a major reason larger groups have traditionally done better under capitation. However, this is also changing.

According to MGMA, groups generating from half to all their income from capitation had a median revenue of $533,211 per physician in 1999 — less than the median revenue of $562,673 per physician earned by groups that accepted no capitation at all. Groups earning 11% to 50% of their income from capitation only generated a median of $507,043 per physician.

Flush from double-digit premium rate hikes, many insurers say they plan to raise both their capitation and fee for service rates more than usual this year. Because of the fundamental differences in the two payment systems, however, it is difficult to determine how any increase in reimbursement compares between them.

Because PPOs cannot guarantee patient volume, for example, the fee-for-service fees they

Taps for capitation? Not just yet, study says

Researchers find healthy rate hikes

Despite a recent resurgence of fee-for-service contracts, capitation rates in nearly all categories and specialties are on the rise, finds a study by the Manasquan, NJ-based Managed Care Information Center.

"Rates are up to the point that physicians and other providers are finally seeing recent premium increases passed along in their cap contracts," notes **David Schwartz**, who conducted the survey.

"As poorly performing medical groups have dropped out of this market, better performers with the higher rates are pushing the overall average up," says Schwartz.

Overall, the center found that nearly 70% of respondents report that their rates have increased this year, with increases in double digits for many specialties.

As to reports that there is a mass exodus of groups from capitation, the study found 78% of respondents are either seeking more capitation or maintaining their current level of risk agreements.

"Risk contracting is as much a part of most providers' lives as it ever was, and capitation appears to be poised for at least moderate growth in the coming two to three years," Schwartz says.

In fact, "if employers continue to see the kind of premium increases they've seen this year, capitation may make a very big comeback as cost control becomes top priority again." ■

have to pay primary care physicians are 10% to 15% higher than what an HMO pays for the same capitated services, estimates the Chicago-based Milliman and Robertson consulting company.

But don't get your hopes too high. With the economy cooling, many observers predict employers will start to tighten their purse strings by restricting their more generous PPO and fee-for-service arrangements. That argument is backed up by studies from the Washington, DC-based Center for Studying Health System Change showing that fee-for-service-related health costs have grown at two and a half times the average rate in recent years. ■

Capitation boosts new, noninvasive technology

Devices can trim length of stay

Capitation is having its impact not only on practice management but also on many areas of medical technology. One of the most responsive areas of clinical technology is cardiac care.

"Managed care and capitation payment systems that increase cost pressure on health care providers are reducing the average time a cardiac patient spends in intensive care," notes *Health Industry Today*, a technology specialty publication. "As a result, providers are relying to an ever-increasing degree on cardiac monitoring devices that can detect and prevent potential cardiac complications sooner, and with greater accuracy."

Many hospitals and physician practices are changing to noninvasive devices whenever possible and retiring their invasive counterparts. Noninvasive devices typically are safer, easier, and more efficient to operate.

Scientific advances, miniaturization in equipment, and increased computer capabilities have combined with the widely documented spread of cardiac disease to intensify research focus on these devices as well, says **Manoj Kenkare**, a financial analyst with Frost & Sullivan, a New York City-based technology investment firm. Kenkare describes the convergence of clinical, financial, and market trends in a report titled, "World Cardiac Output Monitoring Equipment Markets."

Heart failure is associated with one million hospitalizations and 250,000 deaths in the United States annually. Historically, heart attacks were treated in a single facility — the hospital. But as the health care market has become more complex, more web-like, and more built upon a string of systems, alliances, and networks, the provision of care has moved toward multiprovider systems, Kenkare notes.

Payment systems are following suit. Physicians and hospitals often link their insurance

commitments through global capitation, making lengthy hospital stays a concern of both hospitals and physicians.

One result is a growth in subacute products. These products enable patients to move from costly intensive-care beds to intermediate-care beds. Other products are aimed at promoting faster recoveries that lead to cost savings. Cardiac output monitoring devices are becoming vital for acute and non-acute care settings. These devices also are useful in pain clinics, which triage patients presenting with chest pain in the emergency room. Monitoring devices also help with decisions being made during observation periods.

Health care refocuses on core operations

The health community is recoiling from a period of major emphasis on "the whole continuum of care," says **Stuart Friedman**, vice president of the Tiber Group, a health care management consulting firm in Chicago. The buzz now is for health systems to back off this distribution-channel or population-based mentality and focus on improving core operations.

But be wary of retreating too much to basics, Friedman says. "Health systems need to grow," he asserts. "As margins contract due to increasing costs and decreasing reimbursement, health systems must grow to ensure reinvestment in their communities."

Innovation for your hospital, health system, or group practice will be tough, but employers and consumers will continue to insist upon it, especially as the Internet drives information further into public view. Friedman predicts these additional technology trends based on cost pressures connected with information expansion:

- a large array of new genetic-based tests and treatments;
- an explosion of non-surgical devices;
- patients seeking to interact with their physicians electronically;
- physicians being required to order pharmaceuticals electronically;
- technology, automation, and standardization easing the nursing shortage.

To make the best use of technology and market pressures, Friedman recommends assessing your group's product portfolio, defining new roles for your group practice, using partnerships strategically, operating to some degree as a venture capitalist, and balancing full service with focused "best of breed" services as well. ■

MedPAC recommends revamping fee formula

Sustainable growth rate factor in disfavor

The Medicare Payment Advisory Commission has recommended Congress eliminate the sustainable growth rate (SGR) factor from the equation used to set annual updates in Medicare's physician fee schedule.

The SGR sets a target spending level for physicians. Payments for services then rise or fall depending on whether actual physician spending exceeds, meets, or falls below the target.

"After reviewing the design of the SGR system, MedPAC concludes that it cannot maintain payment rates at the right level," says a MedPAC report. "The system does not adequately account for all relevant factors that affect the cost of providing physician services."

Providers have filed a series of complaints in recent years about how the SGR is determined and used.

Medicare Economic Index could be used

In its place, MedPAC is recommending Congress create a new system to account for physicians' costs of providing Medicare services. While not advocating a specific approach, the commission's report did point out that the existing Medicare Economic Index could be used to calculate an annual increase in physician payments. The index already measures inflationary changes in doctors' costs, such as office expenses, medical materials and supplies, and liability insurance.

MedPAC also noted that additional changes to the update may be necessary even if the index is used as a base to calculate physician payment increases. For example, annual increases may need to reflect whether scientific and technological advances have upped costs of providing patient care.

Under the initial estimates released by the Health Care Financing Administration on March 1, the 2002 SGR would increase 6% — the highest preliminary estimated hike ever.

While groups such as the American Medical Association have criticized the SGR, they are also worried that the system created to replace it will be worse. ■

Many practices paid twice for same service: OIG

Changes in pay practices recommended

The same Medicare claims are often paid twice because carriers' processing procedures are not set up to catch duplicative payments, according to a study by the Office of Inspector General (OIG). What's more, these double payments frequently go unnoticed by auditors.

Based on its research, the OIG concludes that up to 25% of the providers studied had a "significant number of" (meaning at least 20) potential duplicate billing overpayments.

The OIG says confusion among carriers and providers about whom to submit bills to for specific services is the main cause of most double payments. Other reasons for duplicate billing include confusion resulting from carrier transitions, having offices or performing services across state lines, and inadvertent errors by billing services.

Some providers, for instance, told the OIG they submitted duplicate bills to Medicare because they just did not know which carrier to bill for a certain claim. One New York City physician told investigators that he learned that services he provided in Queens should be processed by a different carrier from the one that processed claims for services he provided in other locations.

He resubmitted his claim for the services delivered in Queens to the appropriate carrier, assuming he would not receive reimbursement from the incorrect carrier. However, he was reimbursed by both carriers for the same services rendered in Queens.

To prevent such multiple reimbursements, the OIG is recommending that the Health Care Financing Administration (HCFA) revise its Common Working Files edits to detect and deny duplicate billings to more than one carrier. These files were established in 1991 to improve the accuracy of Medicare claims processing.

However, if HCFA determines this change is too costly, the OIG wants it to increase its post-payment reviews, especially in regions where providers commonly perform services in multiple carrier jurisdictions.

To access the report, "Medicare Payments for the Same Service by More Than One Carrier" (OEI-03-00-00090), check the OIG web site at www.hhs.gov/oig/oei/whatsnew.html. ■

HCFA to pilot-test new peer review process

System will test using physician reviewers

The Health Care Financing Administration has decided to launch a pilot study testing an innovative physician peer review of denied Medicare claims proposed by the California Medical Association (CMA).

"There's a sense of injustice and abuse that has become fairly common in the physician community, and the development of a pilot study to address some of our concerns will help to deal with that," comments **Melvyn Sterling**, MD, chairman of the CMA's Medicare Evaluation and Management Technical Advisory Committee. "Physicians are just really angry and upset, and that's not helpful in resolving our issues with HCFA."

According to a HCFA letter to the CMA, ". . . we are designing a pilot program intended to determine whether the outcomes of medical review determinations are substantially different when performed by specialty physician reviewers as compared to the current system of employing nurse reviewers." Present plans are to have the pilot ready for testing before next fall.

This peer review concept, known as the California plan, was an outgrowth of physician dissatisfaction with HCFA's 1997 proposed evaluation and management documentation guidelines.

Under the CMA plan, physicians from the same specialty as the practitioner whose claim was denied would perform a peer review focusing on "outliers," or those physicians whose claims don't fit a normal billing profile, notes an analysis by the American Medical Association. This would then be backed up by education efforts to help physicians understand why a carrier denied their claims, where appropriate.

Currently, carriers usually use nurses to perform claim review, only calling in a physician for especially difficult cases.

While many physicians feel they will end up winning more questioned claims with fellow practitioners conducting the review, some experts predict there will be no major change in audit results. In fact, physicians may even end up losing more appeals because doctors tend to be stricter reviewers than nurses, says **Gerald Rogan**, MD, medical director for National Heritage Insurance Co., California's Medicare carrier. ■

Extended hours can bring a win-win solution

It can be a win-win situation for your practice

Are you looking for a way to keep your patients happy and improve your bottom line? If so, you might consider expanding the hours that you see patients.

"Many practices could benefit from having hours that are convenient to patients," says **Elizabeth Woodcock**, FACMPE, an Atlanta-based health care consultant and director of knowledge management for Physicians Practice Inc.

In fact, Woodcock reports that during her work on the Medical Group Management Association's annual performance and practices survey, she found that many of the better-performing practices offer extended hours for the convenience of their patients.

> 'If a parent knows their child can come in at 7 a.m., they're less likely to call at 3 a.m.'

Most practices focus on adding evening hours, but morning and weekend hours work very well for some practices, Woodcock says. For instance, pediatrician offices and primary care practices find that their patients like coming in before work.

Catawba Pediatric Associates, PA, located in Hickory, NC, is typically open 78 hours a week for normal business hours and more than 80 hours a week when patient demand is high.

Patients are scheduled from 8 a.m. to 8 p.m. Monday through Friday and 8 a.m. to 5 p.m. Saturdays and Sunday. The staff may see patients as late as 10 p.m. in the winter, says **Deborah Cashion**, practice administrator.

The practice normally sees only emergencies after 5 p.m. and charges extra for other visits. The exception is summer, when well-child visits are scheduled after hours at no extra charge. **(For a look at how other practices arrange their hours and schedule their staff, see p. 76.)** Typical patients are those with ear infections, sore throats, and infants with fever — patients who would normally go to the emergency room.

The pediatric practice's extended hours are popular with parents as well as payers, Cashion points out. "A lot of managed care companies don't like for their patients to go to the emergency room. The parents pay a higher co-pay and sit there longer than if they came here," Cashion says.

The Hedges Clinic in Frankfort, IL, finds that many patients are willing to pay extra to see a doctor during "urgent care" hours, says **Frank Schibli**, practice administrator.

"We find the area we are in is fairly affluent, with a lot of dual-income households. Many in our client base are not interested in taking the day off work because they have a sore throat," Schibli says.

The urgent care fees are slightly higher than the fees the practice charges during regular office hours but in no way approach what a patient would pay in an emergency room.

Extended hours allow practices to increase their customer satisfaction with little increase in cost, Woodcock says. And there may be other benefits as well.

For instance, one pediatric practice found that if it had early morning appointments, after-hours calls were minimized, Woodcock says. "If a parent knows their child can come in at 7 a.m., they're less likely to call at 3 a.m.," she adds.

The practice found that after-hours telephone calls were reduced by 25% when they expanded their hours to include early morning "Kids' Express" hours.

"Expanded morning hours are a very popular concept for pediatric practices," she says.

Other patients, particularly those who work full time, also find that it's much more convenient to be able to see the doctor early in the morning, early in the evening, or on weekends.

Extended hours also give you an opportunity to maximize the return on your overhead. "One of the most common mistakes physicians make is not to leverage their facility," Woodcock adds.

Maximizing your hours of operation gives your practice an opportunity to leverage its overhead costs, she says. The typical physician practice spends 5% to 10% of every dollar it takes in on the facility, she points out. You're paying for your facility 24 hours a day, seven days a week, no matter how many hours you use it.

For instance, if you see patients from 9:30 a.m. to 11:30 a.m. and then again from 1:30 p.m. to 4:30 p.m., you're using your facility to make money for five hours a day even though you're paying for it 24 hours a day.

Extended hours factors to keep in mind

Here's how to decide

Whether or not extended hours will improve your practice depends on the types of patients you have, their ages, and their situations, says **Elizabeth Woodcock**, FACMPE.

For instance, if most of your patients are retired, there may be no need to schedule them to come in at 7 a.m. or 7 p.m. because they aren't pressed for time during the day.

But if your have a pediatric or orthopedic practice or if you treat a lot of people who have full-time jobs, staying open for a few extra hours each week could make a big difference to your patients.

"It's really very much customer-dependent in terms of how popular it will be with patients," says Woodcock, an Atlanta-based health care consultant. She suggests considering the following before expanding your hours:

- What will expanded hours do for your patients?
- What will they do for the practice financially?
- What will they do for the physicians?

Take the feelings of your staff into consideration as well, she says. "You don't want to make it a situation where it is making everybody in the practice miserable, or it will backfire," Woodcock says. ■

"The landlord isn't giving them a break for the extra 19 hours a day when they aren't seeing patients. If a practice extends its office hours just by one hour a day, it's essentially getting the use of your office for free for five hours a week," Woodcock says.

Many practices run out of space and have to move to another facility because they don't have enough exam rooms, Woodcock says, adding that many of these practices actually see patients only a few hours a day.

Woodcock tells of working with a busy OB/GYN practice that opened another office and started seeing patients from 9 a.m. to 4 p.m. at both offices instead of being open from 7 a.m. to 7 p.m. every day.

An overhead shock

"They were shocked that their overhead was so much higher. But now, they are actually paying for what they were getting free in the early morning and evening," she says.

When the practice was open from 7 a.m. to 7 p.m., they were seeing patients for 12 hours a day. Now, they've increased their office hours by two hours a day, but they doubled the facility cost, she points out.

Expanding office hours can be beneficial to physicians as well because it gives them a chance for more flexible hours, Woodcock points out.

Most of the time, each doctor still works the same number of hours per week, but they are just working at different times, she says. ■

Creative staffing cuts cost of extended hours

Solution should be geared to individual needs

There's no single solution to staffing your office if you decide to extend your hours. Staff plans and hours of operation vary widely.

But **Elizabeth Woodcock**, FACMPE, does have one admonition: "Don't be overstaffed. It defeats the whole purpose of having expanded hours unless you're doing it simply to serve the patients," says Woodcock, an Atlanta-based health care consultant and director of knowledge management for Physicians Practice Inc.

In general, practices that have early morning or evening hours do not have a nurse on duty during their expanded hours, Woodcock says. Instead, most practices support one staff person in front and one in back.

The easiest way to extend your hours is to find someone in your practice who wants to work outside of typical office hours and is willing to work at night, she says.

The next best solution is to rotate the responsibilities among existing staff. Or, you might consider making the position a multi-tasking position.

For instance, some practices have used the night receptionist, whose job does not entail the same full workload as the day receptionist, to make patient collection telephone calls that can't be made in the middle of a busy waiting room.

The receptionist can check the patients in and spend the rest of the time calling on accounts. This means you aren't paying staff to sit around, and it can improve patient collections, as well.

Practices that offer extended hours for their patients have come up with a variety of workable solutions. For instance, Bristol Street Pediatrics in Elkhart, IN, books appointments from 7 a.m. until 7 p.m. Monday through Friday and from 8 a.m. to 12 p.m. on Saturday.

All employees work a four-day work week (35 to 37 hours a week) and have one full day off during the week, says **Anne Cutler**, administrator. The staff alternate Saturday morning work.

The doctor on call stays for the evening hours and sees whatever patients come in. On Saturday, one nurse practitioner and two doctors see patients.

The six physicians in the practice rotate the weekend hours. One doctor who works the Saturday hours is the on-call doctor for the weekend. The other is the one who is on call Friday and Sunday nights.

Clinic uses skeleton staff after hours

The Hedges Clinic in Frankfort, IL, has a contract with a physician who has an independent practice and is willing to work its urgent care hours for a salary. The clinic operates after hours with a skeleton staff — a receptionist, laboratory technician, X-ray technician, and nurse.

Urgent care hours at Hedges are Monday, Thursday, and Friday from 5 p.m. to 9 p.m., Wednesdays 2 p.m. to 9 p.m., and Saturdays 2 p.m. to 6 p.m.

Catawba Pediatric Associates in Hickory, NC, has six physicians, two nurse practitioners, and a staff of 56 who see patients for up to 80 hours a week. There are typically four providers at the Hickory office Monday through Friday. At 5 p.m., there is one physician and one nurse practitioner. The practice has a separate support staff for evening and weekend work.

Physicians rotate working nights and weekends. The on-call physician is responsible for working in the office. For instance, in winter, they have split weekends off. If a physician is on call on Friday, he or she is also on call on Sunday.

In the summers, they rotate being on call and staff the office on Friday, Saturday, and Sunday.

One auxiliary staff member stays at the front desk and has back-up until she can handle the patient load by herself, usually around 6 p.m. to 6:30 p.m. ■

Do-it-all doctors often waste valuable time

It shouldn't cost $200/hour to do a $10/hour job

Who is the one person in your practice who can do it all — check in patients, verify eligibility, file for insurance, clean the treatment room, and treat patients?

It's the physician, of course.

But the fact that a doctor can take on many tasks in a practice doesn't mean he or she should do so, says **Richard C. Haines, Jr.**, president of Atlanta-based Medical Design International.

Access to physician must be controlled

If the physicians in your practice don't concentrate on the job they were trained to do, it's a huge waste of time and a roadblock to efficiency, he adds.

"A classic problem is that doctors typically do all kinds of things they don't have to do. You don't have to go to medical school to get patients out of the waiting room," he says. The only way to gain efficiency in an ambulatory care setting is to control access to the physician and the physician's time, Haines says.

Haines has developed what he calls the "four S's" that affect doctor potential: style of practice, staffing, systems, and space.

One of the first steps in creating efficiency is to keep the doctor on task and on time and to eliminate as much wasted time and effort as possible. That's where manipulating the four S's can help.

Here's an explanation of how the four S's affect physician practices:

• **Style of practice.** This element is the hardest of the four S's to change because it depends on the individual personality of each physician, and it's hard to change someone's style, Haines says.

"A doctor is entitled to practice in the style he prefers, but you can influence the impact of the style," he says.

For instance, Haines worked with one physician who had a difficult time leaving the exam room. He'd often stay and chat with the patient while other patients cooled their heels in other exam rooms. Haines' solution was to design examination rooms with the sink by the door so the doctor could talk to the patient, wash his hands, and exit.

Another physician client insisted on walking patients to the check-out counter. The physician felt it was part of his practice style and that he was communicating with the patient at the time.

After watching the doctor in action, Haines pointed out that the doctor typically was three steps ahead of the patient and waited to talk to the patient until he got to the checkout counter where the staff could hear what was going on. Changing his habit increased his efficiency, Haines says.

The optimal practice environment is different for every doctor, and, furthermore, is likely to change through the years, Haines adds. For instance, Haines has observed over time that internists tend to see patients at a slower rate as they get older. "It's not because they're slowing down. It's because their patients are getting older and they end up seeing patients with more problems," he says.

Eliminate waste, increase efficiency

Expect a variation in the time each doctor spends with patients, and work to maximize each individual doctor's potential. "You don't want to tell one doctor he has to speed up when it's unnatural for the doctor to do that," he says.

It's not an issue of pure speed, Haines notes.

"We don't want to rush the doctor through his office visits. What we want to do is eliminate all the waste that impairs efficiency," he says.

• **Staffing.** Doctors must have adequate staff and be able to delegate efficiently.

"We hear a lot of about holding staff down to save money, but what usually happens is that tasks that could be handled by the nurse or the support staff are done by the doctor. You don't need a $200-an-hour person doing a $10-an-hour job," Haines says.

Haines tells of doctors who clean the paper off the examining table and set up the room in the interest of holding down staffing costs. "It's simply false economy," he says.

One rule of thumb in physician office staffing is that the staff should be able to manage more patients than the doctor. For instance, if you expect a doctor to see six patients an hour, you need a staff that can manage at least seven patients per hour, Haines says.

That way, if staff have to deal with extra problems or someone is absent, the physician still sees six patients an hour.

"If the staff can manage fewer patients, it means the doctor sees less. If they can manage the same number as the doctors and there is a glitch, the practice's productivity falls behind," he adds.

• **Systems.** There must be a good system in place to maximize the doctors' time, allowing them to go from patient to patient in the least amount of time and with the least dependency on other people.

The two most common reasons doctors come out of the examination room and look for a nurse is to give the nurse verbal instructions or to ask which room they go into next, Haines says.

"Both can be done in other ways so the doctor can keep working and the staff can do their job without having to worry about being around for the doctor," he says.

Order slips, pagers can save time

To optimize the doctor's time, you need systems that allow the doctor to transmit the information to the nurse without having to find her and tell her directly, he adds. Some practices have set up order slips and check-off lists that the doctor leaves on the door. Others use inter-office pagers to let the nurse know what needs to be done.

"These simple things can take a tremendous burden off the staff," he says.

• **Space.** If the space isn't adequate and well-designed, productivity goes out the window.

Doctors with a higher volume need more examination rooms. For instance, a doctor who sees two patients an hour doesn't need as many rooms as one who sees eight patients an hour.

When you plan space, look at how it is arranged as well as how much space you have. For instance,

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Haines says he worked with one doctor who had three examining rooms and typically saw about 40 patients a day but was exhausted at the end of the day.

Haines found that two examining rooms were together, while the third was down the hall. To get to the third room, the doctor had to pass the check-out counter and often stopped to chat with the patients who were paying their bills.

Haines redesigned the space to make all the exam rooms adjacent. Subsequently, the doctor's productivity reached 50 to 70 patients a day and he wasn't as tired. "When we kept all three exam rooms together, he stayed on task," Haines says.

As a general rule of thumb, plan for 15 minutes to elapse in the period of time in which the doctor leaves the room, the patient gets dressed, the staff re-does the room, a new patient is brought in, and vital signs are done. When the patient doesn't undress, it usually takes eight minutes for the room to turn around.

If you have a surgical practice, plan on having an extra room for each surgeon to take care of the stream of patients coming in for postoperative rechecks. "To have one extra room sitting there is going to cost about $20 a day. If you have to err, err on the side of having too many," Haines says.

Ways to maximize physician time

If you want to maximize the efficiency of the doctors in your practice, Haines recommends you consider implementing the following steps:

• **Come up with external strategies to help the doctors stay on task.**

For instance, Some doctors have difficulty bringing the patient encounter to an end. If this is the case with a doctor in your practice, the medical assistant could pop into the room near the end of the visit to go over the prescription or put on a bandage.

"Find a way to turn over the last minutes of the visit to the assistant," Haines suggests.

• **Manipulate the schedule to give every doctor the time he or she needs to practice.**

The number of patients a doctor schedules each day will depend on the severity of the patient and on the doctor's practice style.

• **Make sure not every doctor is scheduled at the same hours every day.**

"You don't want to have everybody working on Tuesday but nobody on Monday, " he says.

• **Recognize that the doctor and nurse have different jobs that probably require them to work at different paces.**

• **Maximize the number of hours a clinic is used.**

If there are a number of physicians in your practice, you need fewer examining rooms if all of them aren't seeing patients at the same time.

"The space is an expensive part of the cost of running a practice and it's normally used just six or seven hours a day. Any time you can use it longer, you get more results out of the same investment," Haines says. ■

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Editorial Questions

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Reform needed urgently, IOM report says

Care 'tangled, highly fragmented,' panel says

On the heels of last year's blockbuster report on medical errors and patient safety, the Institute of Medicine (IOM) has issued a new report calling for reorganization and reform to fix the nation's "disjointed and inefficient" health care system.

"America's health system is a tangled, highly fragmented web that often wastes resources by providing unnecessary services and duplicating efforts, leaving unaccountable gaps in care and failing to build on the strengths of all health professionals," the report says.

The report calls on Congress to create an "innovation" fund of $1 million to subsidize promising projects and publicize the need for significant changes, just as public funds supported the mapping of the human genome.

Clinicians, health care organizations, and purchasers should focus on improving care for common, chronic conditions that are the leading causes of illness and that use a substantial amount of health care resources, the report says.

But physicians, hospitals, and health care organizations often work independently of each other, rather than coordinating patient care across a variety of settings.

Information technology is the key to health care reorganization, the report concludes, calling for a nationwide effort to build a technology-based information infrastructure.

"Health care organizations are only beginning to apply technological advances. For example, patient information typically is dispersed in a collection of paper records, which often are poorly organized, illegible, and not easy to retrieve," the report states.

The report calls for the elimination of most handwritten clinical data within the next 10 years through technology-based systems such as electronic records, patient-provider e-mail, automated medication order entry systems, and computerized reminder systems.

The Report, "Crossing the Quality Chasm: A New Health System for the 21st Century" is available on-line at www.iom.edu. Click on "What's New" and look under "New Reports." ■

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