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INSIDE

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Low payments may stick around unless physicians act aggressively

Providers can be their own worst enemy by putting their fate in the hands of others

If emergency physicians are displeased by the state of their current earnings under managed care, they need look no further than the factors driving pricing decisions in emergency departments (EDs). Emergency physicians are generally being paid between 45% and 55% of what they should be charging under commercial managed care contracts, according to estimates gleaned by *The Managed Care Emergency Department* based on discussions with consultants and emergency physicians.

Earnings here are defined as the amount ED physicians are paid for each patient visit according to each *Current Procedure Terminology,* or CPT, code on their claims compared with what they should be charging. Providers would be making more money if they took an informed, aggressive stance in setting their own contracted fees, say experts who advise medical groups on reimbursements.

Even physicians participating in small, single-hospital medical groups can work with their contracting facilities to design a more equitable fee structure, these sources say. "By all estimates, physician reimbursements in emergency medicine are quite low, says **Wesley J. Burbank,** a former health care actuary with Deloitte & Touche in Richmond, VA.

Marketplace getting inhospitable for providers

The issue is coming to the fore now with announcements by health plans that they are postponing expansion plans and either cutting back or dropping out of Medicare and Medicaid managed care contracts.

While health plans rarely if ever increase reimbursements, in the past they have created opportunities for higher overall revenue by increasing patient enrollments and offering more-generous coverage.

All that may be threatened in the future as health maintenance organizations (HMOs) face higher losses and administrative costs and begin to retrench financially. Meanwhile, "safety-net" providers such as emergency physicians could be saddled with more patients and fewer dollars from payers, experts say. Two factors are cited as being at fault: the payment mechanism and the physicians themselves.

- The prevailing payment mechanism

Part of the problem stems from the financial benchmarks used by commercial carriers to pay physicians, according to Burbank, who now works for a large health plan sponsored by George Washington University in Washington, DC.

The prevailing benchmark comes from the current Medicare physician payment formula and is based on the often-criticized Resource-Based Relative Value Scale (RBRVS). The system has been criticized for resulting in low payments and unrealistic assumptions of the true cost of rendering medical care.

"The RBRVS is the Medicare gold standard for physician payments," says Burbank. MCOs use the RBRVS as the floor for setting their own rates in the belief that the Medicare rates reflect a fair and comprehensive view of costs, which isn't always the case, Burbank says.

- Emergency physicians themselves

If payment levels are low, emergency physicians are also to blame, according to veteran consultant **Michael Williams, MPA,** president of The Abaris Group in Walnut Creek, CA. They are at fault for receiving payments that are low compared with specialists, such as internists and family practitioners, because they have unwittingly left important decisions about their fees up to non-physicians and those outside their own specialty.

A growing number of these outsiders include non-physician administrators of independent practice associations (IPAs) and management services organizations (MSOs) who work for large multi-specialty groups. In a number of cases, these groups are negotiating important contracts with health plans without any input from emergency providers, says Burbank.

"Providers [including ED medical directors] are simply accepting whatever the managed care organization (MCO) offers without question," Williams asserts. *(For a list of suggested ways physicians can become more proactive in setting fees, see the chart on.page 121.)*

Professional fees in emergency medicine would rise if individual physicians took a stronger, more active role in determining their fee structure, Williams says. If they don't, payments for emergency medicine are likely to remain flat or fall further behind charges that should account for actual costs.

Lack of data hampers physicians' clout

Hampering the ability of providers to align fees more realistically with charges is the lack of dependable statistics. No one knows exactly what emergency physicians are or should be making per emergency visit. Income and salary surveys, while helpful, don't get to the core of the problem, Williams says.

In fact, the RBRVS offers the closest data set on payments, Burbank says. "Nobody that I know is tracking this. But even without data, we can say that, at face value, emergency specialists are accepting payments that are quite low," Williams says. *(To obtain the latest RBRVS data, see the Editor's note on page 122.)* The reasons aren't hard to find:

- The nature of market-driven health care delivery

MCOs are well aware of physicians' practice patterns, says Burbank. They know what services providers are rendering and their costs. Driven to keep costs to a minimum, when health plans increase membership they usually require providers to change their practice pattern.

The tactic isn't only designed to accommodate a higher expected patient volume, it's also intended to keep costs-per-patient to a minimum. Therefore, practice patterns are artificially modified to curb the number of lab tests, x-rays, and more expensive diagnostics.

The plan usually achieves this change through increased pre-authorization and clearance policies with payers but also with revised practice guidelines that they attempt to impose on medical groups. The net effect is that physicians are working harder, seeing more patients, and spending less time with them. At the same time, the reimbursement level doesn't change or changes slightly, says Burbank.

The problem is exacerbated under capitation contracts, unless providers can carve out certain complex procedures or negotiate firm risk thresholds that guarantee a higher

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Eight ways the physicians can increase their pay

- **Get educated:** Find out the basis for your MCO's physician payment policies. Speak to the plan administrator with prepared questions regarding the contract, its provisions for ensuring an equitable fee schedule, and how the group can forge better rates.
- **Network:** Identify the physician leaders within the organization and work with them to evaluate existing payment levels and to set more equitable terms.
- **Take a global or case rate:** But also try to operate more efficiently as a clinician without sacrificing your high standards of patient-care quality and effectiveness. Be prepared to balance standards of cost and caring.
- **Be flexible and creative:** When negotiating case rates or global fees, develop bundled fees that include routine services but that won't put you in the poor house. For example, bundle your lab work in one fixed fee but leave yourself enough room for some profit. That may take flexible, creative accounting.
- **Anticipate profiling:** It's how payers will set rates. Do your own profiling and negotiate from an informed position of strength.
- **Insist on extra dollars:** Carveouts and risk corridors that set volume thresholds on expensive procedures have been touted for years. But they work. Check with your accounting department and determine where to draw the line before you ask the payer or medical group for more money.
- **Know your case mix:** About 15% of emergency department revenues come for full-pay sources such as automobile casualty and homeowners' insurance claims. Medicare fee-for-services cases also pay better than managed care. Be aware of these patient volumes when calculating your optimum payments. They'll help offset the effects of heavy discounts and shortfalls from outliers when renegotiating your other contracts.
- **Understand your vulnerabilities:** Determine your hospital's level of uncompensated care, including shortfall from Medicaid and charity cases. They'll help you to determine how bad your hit is from low commercial payers. You'll also know whether you're wasting your time working at that hospital or medical group.

Source: These suggestions were offered by the sources quoted in this issue's cover story.

payment at a pre-determined patient volume or number of procedures, says Williams.

- The prevalence of large medical groups and systems

IPAs and other managed care vehicles such as physician hospital organizations (PHO) are intent on designing contracts with low payment rates for one reason: To hold down their costs, says Burbank. Therefore, they are likely to negotiate low rates, especially to cover high-volume users of health care services. Emergency medicine is one such area.

Small medical groups are feeling intense pressures to align with large systems and practice management to survive. But the price they pay in gaining access to hospital contracts is by making large concessions on reimbursements, says **Bruce Gipe, MD,** an emergency physician and president of Southwest Critical Care Associates, a Los Angeles, CA, group that staffs hospitals with intensivists.

When viewed from the physicians' talent and skill perspective, "nothing in the payment rate reflects the reality of saving a 19-year-old car accident victim compared with a simple sore throat case,"

- Over-reliance on the Medicare RBRVS

Similarly, the current system of determining physician payment rates based on the RBRVS has enabled MCOs to keep payments artificially low by using the RBRVS as the basis on which to negotiate discounts, Gipe says. This is especially so in markets with high managed care penetration.

In a less HMO-driven market, payers usually apply other methods of keeping down costs and payments to the ED. One prominent method has been to curb utilization for non-emergencies by applying heavy co-payments and coverage restriction (e.g., as high as $25 for an ED visit compared with $10 for a physician office visit).

But, in markets such as California, the RBRVS has resulted in payment rates that are relatively fair and closer to rates for office visits and inpatient stays. It isn't easy to generalize, Gipe says. Furthermore, physicians of all stripes have taken issue with the RBRVS, particularly with the practice expense component of the formula, as being unreflective of actual physician working conditions.

(The RBRVS is composed of three unevenly weighted factors: the physician's work value [54%], a physician's malpractice costs [5%], and practice expenses [41%])

Hospitals fast becoming uneasy allies in the payment mix

- The prevailing view of hospitals as cost centers

In addition to the above-cited factors, hospitals are under keen pressure to minimize use. At the same time, they depend on physicians to generate patient business and make appropriate, cost-effective clinical decisions.

MCOs are resorting to imposing shared-risk arrangements with hospitals and physicians that result in situations that require the hospital dividing one global fee with the physicians. In many cases, hospitals are leading the way in developing global fees and case rates, which have the effect of ratcheting down physician reimbursements.

Sometimes the fee is negotiated before a medical group's arrival on the scene, Williams says, and to land the business, the group isn't likely to demand renegotiating the contract. For this reason, some emergency physicians advocate for separately capitating emergency physicians as a means of bringing more equity to physician reimbursements.[1]

- Competition among physician groups

Contracting with medical groups, especially in emergency medicine, remains extremely brisk and highly competitive, says Gipe. It's the primary reason a group or practice management firm isn't likely to balk at the existing rates.

However, in some cases a medical group will have to draw the line, says Burbank. A physician group known to Burbank recently terminated its contract with a PHO after the PHO recorded losses of $5.6 million in its first year. The HMO had originally offered the PHO 80% of the premiums collected from enrollees, which is a common practice in many PHO contracts.

At first the offer seemed attractive, Burbank recalls. But soon the PHO realized that its own costs of maintaining the contract drove down rates to below 65 cents on the dollar, which the PHO in turn had to divide between the hospital and the physicians.

- The HMO business cycle

Hospitals will sometimes try to persuade physician groups to go along with low rates. The carrot held out to them is that the contract in question will lead to related business for both the hospital and the medical group, Gipe observes. "In those cases, physicians don't have a lot of leverage. They either walk away from the ED or swallow the terms and move on," Gipe adds.

The problem is that HMOs are extremely business-cycle driven. When business is good, they tend to be more flexible and less stringent with their underwriting standards, including their willingness to negotiate flexible fees. When business takes a downturn, they're likely lower payments and get quite inflexible with providers, Gipe says. Yet, physicians don't have the same luxury in either case.

"If the MCO lowers its premium dollars to attract more enrollment business, your percentage of each dollar may remain at 80%, but the portion in real dollars is a different story," Burbank says, "That's why physicians face an uphill battle on payments." ■

Reference

1. Stapczynski JS. Capitation for emergency physicians. *Ann Emerg Med* 1998;27:501-505.

Editor's note: *To look up the latest Medicare RBRVS data, log on to the Federal Register's Web site at: http:\\www. access.gpo.gov\su_docs. Click on the Oct. 31, 1997 link under the health care physician fee heading, or contact the National Archives and Records Administration. Telephone: (888) 293-6498. Fax: (202) 512-1262. E-mail: www.gpoaccess@gpo.gov. According to the Health Care Financing Administration in Baltimore, the new RBRVS figures were due out in late October or November.*

Learn a little risk management

Expert explains why good doctors get sued

Physicians need to make increasingly difficult decisions about patient care these days. They are being asked to care for large populations of patients under managed care and risk contracts. Meanwhile, they must stay continually abreast of new technological advances, new drug regimens, and other changes in acceptable medical practice.

And all of this is occurring within an atmosphere that places patients at odds with their insurers and sometimes, even with their physicians.

So how can physician groups reduce the risk of being sued for malpractice in this evolving health care world?

The biggest answer boils down to improving patient communication, says **Ross M. Miller, MD, MPH,** a Los Angeles medical director of quality management and risk management for a large Southern California managed care organization (MCO). The MCO asked not to be identified.

Miller's responsibility as medical director of quality includes reviewing all member complaints from HMO members about alleged quality-of-care deficiencies, known as member perception reports.

One of the largest categories of complaints is in the area of communication, Miller says.

Most of the time, physicians could alleviate this type of complaint, Miller says, by asking a patient a simple question at the end of the visit: "Have I answered all of your questions?" or "Is there anything else you need today?"

Communication skills are important

Physicians who have good communication skills are less likely to be sued, Miller says.

"Studies show that patients with good doctor-patient relationships, even with the same adverse outcomes occurring, have less chance of being sued," he explains.

Miller lists these three explanations as possibilities for

why good physicians get sued:

- They forget or fail to recognize how patients perceive quality.
- They do not employ personal risk management strategies in daily practice.
- They get caught in system failures.

With these points in mind, Miller offers these guidelines to preventing lawsuits and other patient problems:

1. Understand what patients want.

Patients perceive quality medical care based on a variety of criteria, including how well they feel and function after visiting the provider, Miller says. *(See strategies for preventing adverse outcomes, on pages 124-125.)*

Does the patient feel or function better after the doctor visit? If not, then the patient may not be satisfied with the care.

For example, suppose a patient goes to the emergency department for coughing and cold-like symptoms, and the doctor diagnoses bronchitis and prescribes an antibiotic. The infection gets better, so the physician believes the patient has received the correct diagnosis and treatment.

However, the patient may still feel miserable, and unhappy with the care.

"If their ability to function in daily life isn't better by the next day, and that's their expectation, then they will perceive it as a poor-quality intervention," Miller says.

It's important to make sure the patient understands how long it will take for the medication to work and alleviate the symptoms.

"The bottom line is that when you have poor physician patient communication, that can lead to complaints," Miller says.

2. Enhance communication skills.

These days, there are more opportunities for communication problems because patients no longer are treated solely by one physician or provider.

"We work in systems; the days of the solo practitioner hanging out a shingle are pretty much over," Miller says.

Now physicians work in provider groups and integrated delivery systems, so a failure can be within the system, he adds.

Physicians often feel rushed when they're seeing their patients and this can lead to giving their patients an inadequate evaluation.

The HMO has included articles on effective communication in its provider newsletters, and the company has referred physicians to communication skills courses.

"If we notice a trend of providers having issues related to poor communication or poor quality then we may put those doctors on some type of action plan," Miller says.

An action plan might include attending a communication skills course, receiving counseling, or something as simple as having the physician change lengths of appointment times in the schedule, to allow a little more time with each patient.

The HMO places data regarding member perception reports about providers in a credentialing file. All providers are recredentialed at least every two years.

Also, Miller's organization tracks and trends all quality-of-service issues that members have identified as problems.

Communication skills include the physician's:

- "bedside manner," and verbal or nonverbal behavior;
- attitude about patients, such as rushing, ignoring, or being curt with patients.

3. Obtain informed consent.

Usually this should be obtained in writing. Its purpose is to inform the patient of the information that a reasonable person would want to know about a procedure before making a decision, Miller says.

Each state has its own rules about what is required as far as consent documentation, but this also is important for the physician's own protection.

"One of the skills of risk management is to have documentation of informed patient consent," Miller says. "If patients know what might happen then they're not surprised, and then if an adverse event occurs they're not as angry."

Informed consents do not protect physicians from allegations of negligence, although they could reduce the chances of malpractice suit.

Physicians also should practice informed consent communication in their daily patient encounters as a good risk management practice, Miller says.

For example, when prescribing a medication, a physician might inform the patient that not all of the patients who take this medication get better.

Physicians are having a tough time right now, and that's making them focus a lot on what they're doing and changes in health care systems.

Although these changes have made many physicians anxious, they still need to pay close attention to basic risk management, Miller says.

4. Keep thorough documentation of patient encounters.

Documentation can be a physician's best friend or worst enemy when it gets into the hands of lawyers, Miller says.

"Attorneys get ahold of the medical records, and a lot of times that determines whether they have a case," he explains.

To document effectively, Miller says, physicians should do the following:

- Communicate information about the care in order to give credit for what was done in the event of an adverse outcome.

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Strategies for Prevention & Management of Adverse Outcomes

Why Good Doctors Get Sued:
- they forget or fail to recognize how patients perceive quality
- they do not employ personal risk management strategies in daily practice
- they get caught in system failures

How Patients Perceive Quality:
- function as well or better after interaction
- low cost
- don't want to be injured in process of Rx
- want to understand about their condition and treatment options
- humane, kind, respectful interaction with provider, nursing, and office staff
- short phone wait, prompt appointments, short office visits, and prompt follow-up
- short waits for test completion and prompt communication of results
- referral to specialist if not responding
- availability after hours for emergencies
- satisfaction with health plan and relationship of plan with provider

Traditional Risk Management Loss Prevention and Reduction:
- Establishing provider-patient relationship
- Once begun, prevention of injury to patient
- If yes, prevention of negligence claim
- If filed, prevention of malpractice suit
- If yes, winning the lawsuit
- Extends to issues of quality of care, prevention of injury, and helping injured deal with it most effectively

How Providers Perceive Quality:
- being able to make the diagnosis
- using a state-of-the-art approach to treatment
- having a low complication rate
- relying on top-quality consultants
- having the patient get well

Why Do Patients Seek Legal Advice?
- bad result or perception of bad result
- unhappy or dissatisfied patient
- social system that supports lawsuits

Communication Strategies:
- ability to listen effectively and allow patients to express their concerns
- ability to provide information in a way that ensures patient understanding
- conveyance of a feeling of respect for the patient
- feeling that the provider is willingly accessible and available

Functions of Effective Communication:
- data collection skills to understand the nature of the patient's problem
- relationship skills to build and maintain maximum provider-patient rapport
- educational skills to ensure patient understanding, informed consent, and maximum adherence

Rapport-building skills: acknowledge and address emotions:
- reflection: acknowledge an observed response
- legitimation: validate patient's emotions
- support: explicit statements of support
- partnership: statements confirming collegial approach to problem solving
- respect: acknowledge positive coping behaviors or coping mechanisms of patient

Data Gathering Skills:
- appropriate and effective questioning: "open-to-closed" cone of questioning
- facilitation: verbal ("tell me more . . ." "go on") and non-verbal (nodding) techniques
- surveying: e.g., what else? priorities?
- summarization: correct misunderstandings and provide additional information; confirms hearing and understanding to patient; builds rapport

Educational Skills:
- establish baseline of concerns and current knowledge
- correct any misinformation
- short and simple informative statements
- opportunity to ask questions

Goal: "accomplish complex education in situations of high emotional intensity!"

Informed Consent:
- what a reasonable provider would say about a procedure = what any reasonable patient would want to know about a procedure = what the individual patient would want to know to make a reasonable decision about the procedure
- state defines process in detail including documentation required in record

"Uncertainty":
- we as physicians are not certain of all outcomes
- in most instances, we are able to deal with these outcomes effectively, even if unexpected
- patients need to know this so they are not surprised and dismayed if an unexpected event occurs
- does not protect a provider from allegation of negligence

Provider Management:

- understand the dynamics and stress associated with behavior:
  — disorganized thinking
  — guilt and defensiveness
  — fear of lawsuit and tendency to blame
  — increase vulnerability to error
- maintain impeccable records; don't change them; dictate promptly; document care personally

System Failures, Human Error, and Adverse Outcomes:

- adverse outcomes occur in context of excellent medical care
- adverse event: complication or negligence?
- system which establishes how care is given may contribute to adverse outcomes
- prevention of error through elimination of system failure

Taking Action: Premises:

- error rates in medicine are relatively high.
- blaming and search for culprits won't work.
- achieving error reduction requires system changes.
- job for organization leaders; instill value.
- improvements will require measurement: to gain knowledge (not only carrots and sticks).

Pharmacy Techniques:

- familiarity and follow state and federal laws
- multiple drugs or drugs with narrow therapeutic index (e.g. dispense one at a time)
- contact the prescriber if any questions
- periodic written requests/file of phone orders
- don't make substitutions without permission
- discuss therapy with patients; written instructions
- document actions taken and concerns

Medical Director Checklist:

- job description: informed oversight; uniform handling of decisions; legal/regulatory comply
- documentation: info and logic used for decision
- review: benefits, UR procedures, med records
- speak up: interview providers
- consult experts: standard of care applied
- time: be aware of required turnaround times; communicate delays, reason, and expected close
- appeal right: no inform = violate good faith

Follow-up Documentation: Defensible Office Systems:

- date test/referral ordered
- test/referral ordered
- reason for test/referral
- consequences explained for not undergoing test/referral
- date test/referral received
- date results read and initialed by MD
- additional tests, follow-up appointments, other recommendations
- date and manner patient notified of results and any further recommendation
- whether patient followed through on further testing/recommendation

Patient Abandonment: Minimizing accusations:

- check with health plan re: regulations
- notify patient in writing
- state reason for discharge from practice (e.g. non-medical compliance)
- indicate availability to provide care for period of time until new provider obtained
- send letters certified with return receipt

Attorney-Client Privilege:

- oldest protection of confidential communication
- encourages clients to be completely truthful
- promotes communication and eliminates fear of disclosure to third parties
- fosters voluntary compliance with the law by promoting freedom of consultation with attorney
- state and federal law generally the same
- establish: communication between privileged persons in confidence for legal assistance

Quality Assurance Privilege:

- available in some states, defined under law
- QA process: developed by health care entity and follows written standards and criteria
- includes activities and investigations related to: quality of care; practice review; training, experience, and conduct of licensed professionals; analysis of use of health services and facilities
- immunity for QA participants
- information and record of actions confidential/ protected

Peer-Review Privilege:

-
-
-
-

tion of complications and death

-
-

not subject to discovery

Source: Ross M. Miller, MD, MPH, Medical Director, Quality Management and Risk Management for major MCO, Los Angeles. (Information was included in a presentation on "Why Good Doctors Get Sued" at the National Managed Health Care Congress held in Atlanta in April.)

Continued from page 123

- Be accurate, comprehensive, timely, legible, and objective.
- Reflect the provider's thinking and develop an action plan.
- Be careful with subjective judgments, such as criticisms of other care and disagreements with staff.
- Avoid certain language, such as the words "accidentally" and "erroneously."
- Never use an inadequate report.
- Do not ever change the record.

5. Manage bad results.

Once an adverse outcome has occurred, there are certain strategies a physician may use to manage the situation. The provider should meet with the patient and family to answer their questions thoughtfully, Miller says.

The provider should summarize the entire situation and provide full disclosure, without accepting responsibility. This is a good opportunity to allow the patient and family to vent emotions and to provide him or her with empathy.

Finally, the provider should make sure the patient knows what will be done about the situation and how progress will be communicated.

It's important for physicians to understand the dynamics of what a patient goes through and how to minimize the patient's anger after something bad has occurred, Miller says.

"The bottom line is to not hide anything, but to realize that your initial reaction is to be defensive," he adds.

When physicians or other providers become defensive they may take unwise actions, such as changing a medical record or refusing to return the patient's phone calls.

Instead, they should try to understand the whole dynamic behind a patient's behavior and be careful not to do or say anything that might sabotage the chance of preventing a lawsuit, Miller says.

"Make sure you receive some guidance and advice either from your insurance company or a risk manager or legal contact about what to say and whom to say it to," Miller says. ■

Avoiding LOS quick-fix mentality is crucial

It's not the solution, but how you get there

It's one of the thorniest and most emotional issues in health care: How long should patients be allowed to stay in the hospital following an illness or surgical procedure? With hospitals and managed care companies battling in Maryland and elsewhere over the interpretation of length of stay (LOS) guidelines, and Congress once again threatening to crack down on HMOs, some experts worry that we could soon face another push to legislate the medical management of patients. Others, however, worry that without such legislation, hospitals will be forced to cut LOS so close to the bone that patient care could be threatened while costs are merely shifted to elsewhere in the continuum.

Karen Zander, RN, MS, CS, FAAN, principal and coowner of the Center for Case Management in South Natick, MA, says she's concerned by the fact that some quality professionals think cutting LOS is synonymous with cutting costs and increasing efficiency. She says the emphasis on solutions and improving quantifiable outcomes has obscured the need to improve the processes that create positive outcomes.

"If your process is in place and correct for a given patient, your length of stay isn't going to be an issue," says **Paula S. Swain, RN, MSN, CPHQ,** president of Paula Swain Seminars and Quality Consulting in St. Petersburg, FL. "I mean, if the patient needs a certain level of service and you have been very efficient in getting the testing done, getting the antibiotic in place, and that sort of thing, then that's how long it takes for that patient."

Swain adds that simply lowering LOS is a "quick fix," and focusing too much on LOS numbers can give physician leaders misleading ideas about the success of a pathway. For example, if patients have a "path pause" or go off the pathway, average LOS for the procedure is likely to increase, leading some to conclude that the pathway isn't working. In fact, the problem may be that "the people who are integrated in the path aren't cueing off each other," Swain says.

"We've been slow at emphasizing the variances in the pathways that point us to becoming more efficient," Swain says. "If you and everyone else who works in the process understands how the process works, then you're going to save money, save energy, and be more efficient and effective."

When a team thoroughly understands the plan of care for a population of patients, team members are taken by surprise less often and are better able to manage patients, whether or not those patients are on a pathway, Swain says. "They've got a heads-up that, gee, after the third day, we're always going to have a high propensity for a certain problem to happen," she says. "And in that situation, if everyone is knowledgeable about that, they're much more efficient at doing their assessment and putting the patient on the right track in the first place."

Swain also notes that for many procedures, the bulk of the cost is incurred in the first few days, with additional

days not necessarily adding much expense. In those situations, a lower LOS may look good on paper but adds little to the hospital's bottom line.

And if you're part of an integrated delivery system, cutting LOS irresponsibly could have a negative impact on the bottom line, not to mention resulting in patient outcomes that are less than stellar. In some cases, for instance, fewer days in the hospital simply means more days in outpatient rehabilitation, or home care, or even return visits to the hospital.

Such cost shifting, however, isn't always a bad thing – at least according to Milliman & Robertson (M&R), the Seattle-based actuarial firm that has ignited controversy with its stringent LOS guidelines. "The goal of medical management really is to align the person's medical acuity with the proper level of care," says **Gary Brace, FSA,** a consulting actuary with M&R in Atlanta. "If a person is medically stable enough to be transferred from, say, an inpatient to a subacute setting or to some type of postacute setting, then presumably there's less intense nursing equipment needed, so the costs are going to be slightly reduced. So, yes, there's a shifting to different levels of care, but it's not like [the patients] are being discharged back into the home without any kind of follow-up. There's a transitioning or a stepping down as the acuity starts to stabilize."

M&R remains sensitive about its image and what it considers an unfair portrayal of it as a company that values cost containment more than effective patient care. That image has arisen largely because of the way some managed care organizations have interpreted the company's guidelines. The Baltimore-based Maryland Hospital Association, for example, has charged that several insurers in the state, including the local Blues, have regarded the guidelines as absolute standards, denying days beyond what M&R recommends for a given procedure.

Brace says that's an "incorrect interpretation" of the guidelines. "The guidelines are just that," he says. "They're guidelines that are applied to an average uncomplicated diagnosis. If there are comorbidities, then there needs to be a clinical judgement applied, not necessarily hard-and-fast adherence to the guidelines."

Brace adds that M&R actuaries themselves don't blindly apply the LOS recommendations contained in the guidelines when conducting chart reviews. "When we assess network efficiency, we'll use the guidelines as benchmarks, but we'll take them with a grain of salt if we recognize through the chart review process that there are comorbidities. If the length of stay says they should be discharged in three days but we recognize that there were certain additional diagnoses that necessitated a longer length of stay, then we're not going to say an extra day or two was inappropriate." ■

Physician survey: Not all managed care is bad

Yet paperwork, denial appeals still bother doctors

Does managed care impede physicians in their ability to provide high-quality care? Not necessarily, according to a recent survey of physicians in six major metropolitan areas.

While physicians bashed some health plans and lambasted "major hassles," they scored other managed care plans as high or higher than fee-for-service ones in the Quality Catalyst program of The MEDSTAT Group, a health care information firm based in Ann Arbor, MI. This is the only national health plan rating program that incorporates the physician perspective, says Dennis Becker, MEDSTAT senior vice president.

Paperwork and reimbursement hassles

Some health plans do interfere with care, but the fault lies with plan management rather than the managed care model itself, says Becker. Based on ratings from physicians and consumers, those poorly implemented plans aren't likely to survive, he asserts.

For example, one-third of physicians called "getting help with appeals for denied claims" a "major hassle," and one-fourth similarly criticized the paperwork burden and claims reimbursement process. *(For more information on physician ratings of hassles in managed care, see chart.)*

"Those plans that look at their physicians as a strategic group to deliver on the mission of the health plan are going to be very successful," says Becker. "Those plans that ignore the voice of the physician as a key stakeholder probably will not be successful and [will not] survive long-term."

Physicians gave health plans widely varying ratings, with an overall average of 43-58 out of 100, which represents a neutral opinion. That was about 20 points lower than enrollees, who gave average scores of 68 to 79.

Results were adjusted for receptivity toward managed care, so scores represent actual differences among plans and weren't skewed by physicians with overall negative feelings toward managed care, says Becker.

Some 9,000 physicians in six major metropolitan areas received surveys in 1997, asking their opinions about health plans, with a response rate of about 30%.

Results of a second survey of 40,000 physicians in 20 markets will be released this fall. The survey, conducted in conjunction with J.D. Power and Associates and the New England Medical Center, is also conducted among enrollees and corporate benefits managers.

The MEDSTAT Group Quality Catalyst

Excerpt: Physician opinions of plan administration

How much of a hassle is each of the following administrative aspects of the health plan? (major hassle/a hassle/minor hassle/no hassle at all/don't know)

% indicating major hassle

✔ Paperwork burden	26%
✔ Getting authorizations for inpatient admissions	19%
✔ Getting authorization for lengths of stay	18%
✔ Getting authorizations for tests and procedures	19%
✔ Getting authorizations for referrals	19%
✔ Getting reimbursement for claims	26%
✔ Providing up-to-date information about benefits and coverage	17%
✔ Getting help with appeals for denied claims	32%
✔ Exercising independent clinical judgment	13%

Source: The MEDSTAT Group, Ann Arbor, MI.

Physicians and enrollees generally agreed on which were the best and worst health plans in the markets. That may reflect the influence physicians have on enrollee opinions about their health plans, says Becker. ■

Briefs
in Managed Care

HMO medical appeals often overturned

Patients of your practice who are leery of appealing a denial of coverage from their HMO can take heart at a new study released by Georgetown University researchers for the Kaiser Family Foundation.

The study found that when people have sought independent reviews of HMO medical decisions, one-third to one-half of the decisions are overturned.

Georgetown researchers said in a recent Dallas Morning News interview that it is hard to compare external appeals processes around the nation because of various state laws. One trend, however, is that most consumers stop fighting after they have been turned down the first time. ■

Federal court upholds malpractice law

A federal judge has upheld an unprecendented Texas law that allows patients to sue their health plans for malpractice. The law means that consumers in Texas can sue to collect damages in state court against health insurers and employer health plans that deny them medical treatment.

A state law called the Health Care Liability Act holds that HMOs could be liable for damages caused by their "failure to exercise ordinary care when making a health-care treatment decision."

Aetna US Healthcare immediately filed suit last September challenging the law after it was enacted, arguing that it improperly sought to circumvent the Employee Retirement Income Security Act (ERISA), which prevents nearly 125 million Americans from collecting damages for denial of medical treatment that results in death, injury, or economic loss.

The Fort Worth Start-Telegram reported that Aetna is working with state officials about how to alter the independent medical review process (which asks an outside party to review a carrier's decision regarding coverage) required by law to avoid conflict with federal law. One suggestion has been to make the review process nonbinding.

As part of the federal court ruling, the judge ruled that ERISA pre-empts the review process for most members of health insurance companies in Texas. However, the judge did not order the state to stop its independent review process.

Since the process began last November, 253 cases have been reviewed. Of the 244 reviews that have been completed, 114 rulings were in favor of the HMO in question and 110 in favor of the patient. ■

Physician CME Questions

34. The reason that pricing is getting greater attention in emergency medicine is due to which of the following factors affecting managed care:
    a. Prudent layperson standards are increasing the number of non-emergency procedures being treated by hospitals.
    b. Cost-shifting to cover uncompensated care is becoming worse.
    c. Medical groups have no idea what they should be charging for their services.
    d. Managed care organizations are retrenching and cutting back coverage to enrollees.

35. At present the only benchmark for physician pricing available to emergency practitioners is the Medicare Resource-based Relative Value Scale.
    a. True
    b. False

36. According to Ross M. Miller, MD, MPH, one of the largest categories of member complaints from HMO members aobut alleged quality-of-care issues is:
    a. doctor-patient relationships.
    b. in the area of communication.
    c. early release from the emergency department.
    d. the price of care.

37. According to Miller, once an adverse outcome has occurred, the provider should:
    a. meet with the patient and family to answer their questions.
    b. summarize the entire situation.
    c. provide full disclosure without accepting responsibility.
    d. let the patient know what will be done about the situation and how progress will be communicated.
    e. All of the above

38. In the story about length-of-stay, Paula S. Swain, RN, MSN, CPHQ, says the bulk of cost from many procedures in incurred in:
    a. the first week.
    b. on the first day.
    c. over the first few days.
    d. over a long period of time.

38. According to the physician survey, what portion of physicians called "getting help with appeals for denied claims: a major hassle?
    a. One-third
    b. Two-thirds
    c. One-fourth
    d. One-half

39. What percentage said that getting reimbursements for claims was a major hassle?
    a. 90%
    b. 58%
    c. 75%
    d. 40%
    e. 26%

40. the study by Georgetown University researchers found that what percent of HMO medical decisions are overturned when people sought independent reviews?
    a. 10-20%
    b. One-third to one-half
    c. Two-thirds
    d. 90%
    e. 75%

Correction:

In the August issue of *The Managed Care Emergency Department*, the source for the chart on page 85 should have been listed as:

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PS Form **3526**, July 1995

Upcoming Conferences

Here is a partial list of upcoming conferences that address issues of interest to ED leaders:

Expanding health care value for a more productive corporate America, Nov. 6-7, Crystal Gateway Marriott Hotel, Arlington, VA. Contact: National Association of Managed Care Physicians, 4435 Waterfront Dr., Suite 101, Glen Allen, VA 23060. Telephone: (804) 527-1905. E-mail: www.namcp.com

Fifth annual scientific assembly of the American Academy of Emergency Medicine (AAEM), Feb. 12-14, 1999, The Westin Horton Plaza Hotel, San Diego, CA. Contact: AAEM, 611 E. Wells St., Milwaukee, WI 53202. Telephone: (800) 884-2236. Fax: (414) 276-3349. E-mail: www.aaem.org

Medicare Billing for the Prospective Payment System: A Practical Guide for Hospitals to Implement the Balanced Budget Act, Nov. 16-17 in Arlington, VA. Contact: AiC Worldwide, Telephone: (800) 409-4242. Fax: (212) 714-9815. Web site: http//www.aic-usa.com.

In Future Issues:

Managed Care is Turning your Hospital into your Worst Enemy: What to do about Contract Termination