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PPMC options less alluring to practices given industry's woes

Groups search for other sources of capital

What a difference a year makes. Physician practice management companies (PPMCs), once billed as the answer to managed care contracting woes and a much-needed source of capital infusion for medical groups, now are finding it increasingly hard to generate a positive buzz. It's the difference between being able to get a prime table at any restaurant in town a year ago and having a hard time even catching the restaurant manager's eye today.

The verdict: The dance card for PPMCs is not as full as it was last year, due to such highly publicized failures as the exodus of Birmingham, AL-based Medpartners from the PPMC business and falling earnings among some of the country's largest PPMCs. But consultants and practice leaders say not everyone has written PPMCs off as a passé trend. What's left are two reactions: a mixture of skepticism and caution among practices who are considering affiliating with a PPMC, and an increased willingness to look for other strategic partners who can help a practice gain managed care contracting advantages.

"A lot of physicians I know are rediscovering IPAs [independent practice associations]," says **Elaine Scheye**, president of The Scheye Group Ltd., a Chicago-based strategic advisor to physicians and hospitals. "They've seen their colleagues down the street or across town affiliate with PPMCs . . . and hear all sorts of stories of disenchantment. At last, as a result of recent turmoil within the PPMC sector and the attendant publicity, physicians are sifting through all of the promises that PPMCs have offered, and are meeting them with a healthy skepticism."

Although IPAs traditionally don't offer the kinds of management services that PPMCs boast, they can give physician groups the advantage of strength in numbers when approaching negotiations with payers.

Practices also may be more open to other arrangements after reading comments like the ones made by **Mac Crawford**, MedPartners chairman and chief executive, in the *Chicago Tribune* and *New York Times.* Crawford said he wasn't sure whether the management of doctors should be performed by publicly traded companies.[1]

Scheye says she has encountered no practices that report any value-added benefits from affiliating with a PPMC — especially given the typical 15% of monthly revenue that PPMCs charge medical groups as management fees.

PPMCs that stick to managing one specific medical specialty "are doing a better job and have the potential to satisfy the physicians affiliated with them," she says. Many of these firms are developing outcomes data and treatment protocols, particularly with respect to disease management for specific groups of patient populations during a time when payers are demanding evidence of superior clinical outcomes and utilization management skills.

Three owners in five years

The uncertainty surrounding the PPMC industry is demonstrated by the history of Wheaton Clinic, a 20-physician clinic based in suburban Chicago, and several sister practices owned by MedPartners. During the past five years, the clinic has been through two owners and is about to be owned by a third. Wheaton was originally owned by Aetna (now Aetna US Healthcare), which sold many of the physician practices it owned to MedPartners. The MedPartners announcement in November means Wheaton Clinic is one of several Chicago-area practices (representing a total of 270 physicians) up for sale.

"The one piece of advice I have is, 'Don't think anything is final,'" says **Julie Kuehn-Bailey**, a spokeswoman for the MedPartners Chicago office, who also serves as marketing director for several of the firm's Chicago-area clinics.

Bailey says the clinics did realize some value from the MedPartners affiliation in two ways. First, MedPartners was able to bring together a number of small and medium-sized practices in the Chicago area, and thus provide the strength in numbers that is so important in managed care contracting. Secondly, the firm provided employees to negotiate more favorable managed care contracts for the collective group of practices.

"But now that they're spinning us off, I don't think it's a threat to our managed care contracts or their value," Bailey says. "They [MedPartners] are talking about keeping us together, and our physicians are staying together. That's what gives us a competitive advantage in contracting."

MedPartners has given its group of Chicago-area practices two options: Either buy back the practice (which will not likely happen, given the expense) or MedPartners will sell the practices to a local health system or practice management firm, giving the physicians with the current MedPartners-owned Chicago clinics a say in selecting the new owner.

"We're looking at almost every health system in the area, entertaining what they have to say at this point," Bailey says. Because the collective group of practices have a patient base representing about 25% of the patients in the community, they are in a fairly enviable position. "We recently sold off one of our [affiliated] practices before the MedPartners announcement, and we had health systems that said, 'We know you're not for sale, but if you ever are, let us know.'"

The clinics have only received two phone calls from patients about the MedPartners situation since the MedPartners announcement, she says.

One area that offers hope for the PPMC industry is an accounting requirement implemented by the federal Securities and Exchange Commission (SEC). Because of inconsistencies in accounting methods used by PPMCs, the SEC now requires publicly-traded PPMCs to amortize goodwill over a period of 10 years or less, Scheye says. By comparison, some PPMCs in their infancy amortized goodwill over a 40-year period.

While restatement of the financials resulted in the reporting of lower earnings at many PPMCs, this enforced standardization ultimately benefits the industry, Scheye says. "These changes in the end probably have done the PPMC industry the greatest service. Now, PPMCs must give truer pictures of their financials. Survival of the fittest will be the practice as PPMCs will have to achieve financial viability and stability by being able to demonstrate results, integrate their acquisitions and grow internally."

Kuehn-Bailey, who has worked for her practice under three different PPMC owners, says PPMCs can work in the right situation. "If you're out there by yourself, I would have to think it adds value," she says. For example, a practice may have an excellent marketing manager, but may need help in getting its management information systems up to date or improving its billing collections. "But if you're already a self-sufficient operation, take a close look at the [PPMC's] management fee and what you would be paying."

One practice manager who did not wish to be identified sums up the feelings of some practices that have chosen to go the PPMC route. "I'm not sure who else is out there," he says. "Insurance

companies tried to own groups and weren't successful. Hospitals tried to own groups and weren't successful. If PPMCs don't work, how will groups get capital? It's still difficult to get physicians to retain earnings, especially with reduced reimbursement. The question is whether [PPMCs] can generate enough of a profit margin to make Wall Street happy."

Thinking of linking with a PPMC?

Read these pointers first

Despite recent skittish activity on Wall Street among the physician practice management company (PPMC) industry and the exodus of industry leader MedPartners of Birmingham, AL **(see related story on p. 1)**, many practices find overtures from PPMCs attractive. Chicago-based consultant **Elaine Scheye** of The Scheye Group Ltd., a strategic advisor to physicians and hospitals, advises her clients to approach a bid from a PPMC very cautiously. Scheye gives practices the following advice:

• **Don't rule out your local bank as a source of capital.**

"Banks have become more sophisticated in their lending packages," she says. "If they have a good business plan, I don't think physicians necessarily need several million dollars [of capital] immediately to grow and compete effectively. Whenever you talk about access to capital, in the end you're going to dance to someone else's tune. He or she who has the gold rules, and PPMCs want a majority role in governance. With banks, you've got different criteria. Yes, physicians assume personal liability . . . but [they] are also essentially left alone unless or until they can't make a loan payment."

• **Do a cost-effectiveness analysis of your practice and for individual physicians in the group.**

Have this in place before discussions with a potential PPMC partner begin. Determine how healthy the practice's financials have been for the past few years and what the projections are for the next five years. How good are the current managed care contracts in place for the medical group (and for the individual physicians, if appropriate)? Are the physicians considered providers of choice for the leading managed care organizations in the immediate geographic area?

• **Determine what services the practice needs.**

As part of the cost-effectiveness analysis of the practice, determine what sorts of services the practice needs. Services can be purchased through a contract with local vendors for a specific need. For example, if your practice needs help updating management information systems and generating better financial data, a contract with a local management information services firm is far more reasonable from a cost standpoint than spending 15% of monthly revenues on a PPMC. Develop a request for proposal based upon a list of specifications, and obtain bids from firms that may be able to meet your needs. An added bonus is the service you get from a local vendor, whose best interest is in keeping you satisfied to continue the relationship.

• **Negotiate an exit strategy as part of the affiliation agreement and include specifics in any contract you sign with a PPMC.**

Many practices have signed contracts with PPMCs that have included non-compete clauses or costly buy-back provisions. Remember that a non-compete clause could force physicians in your practice to leave the community, set up shop again, and start from scratch — an onerous task for professionals who have invested time and money in developing a professional reputation and patient base.

Given the flurry of PPMCs that have filed for bankruptcy protection, physicians need to work closely with their legal counsel to draft contracts that take this worst-case scenario into consideration. Proper contract language, drafted with the help of an attorney, can ensure that legal safeguards are incorporated into all affiliation agreements that physicians and the practice may sign in their consideration of affiliating with an intermediary. Physicians need to be mindful that if the PPMC they affiliate with winds up seeking bankruptcy protection, it is presently unclear whether the physicians would be able to collect on monies owed them because the intermediary contracts with the HMOs on behalf of its affiliated physicians, Scheye says. ■

Reference

1. Japsen B. Another painful lesson in medical economics. *Chicago Tribune,* Nov. 12, 1998:1 / News. ■

OB/GYN practice exports its management talent

Ohio practice helps manage cap contracts

Practices tired of the so-called hassle factors in managed care — from making sure precertification requirements for managed care patients are met to following up on payments owed the practice — have sought out physician practice management companies as a way to spend less time on administrative functions and more time taking care of patients **(see related story, p. 1)**. One Ohio OB/GYN practice has developed this kind of expertise on its own and is now using this experience to help other OB/GYN practices interested in better managing their managed care contracts.

OB/GYN Management in Dayton, OH, has parlayed its four years of managing risk contracts for OB/GYN practices that contract with United HealthCare Corp. in the Dayton area into providing similar services for OB/GYN practices in other markets.

> "If incentives are aligned correctly, you don't need to do the kinds of preauthorization and care denials that traditionally are associated with managed care."

"We're not a practice management firm, and our doctors still practice medicine," says **David Astles**, executive vice president for the company. What the group does provide is utilization management, outcomes reporting, and other services necessary to manage capitated contracts for groups of OB/GYN physician practices that contract with the same payer.

OB/GYN Management was formed when two-physician practice Huey & Weprin OB/GYN responded to United's request for proposal to manage all OB/GYN contracts under United's specialty network manager program. The practice now manages the capitation dollars for a 113-physician OB/GYN network in the 15-county Dayton region.

"Our vision of the world is that OB/GYNs need to organize and deal with integrated health care systems and deliver quality, efficient care. If incentives are aligned correctly, you don't need to do the kinds of preauthorization and care denials that traditionally are associated with managed care," says **Stuart Weprin**, MD, CEO of OB/GYN Management. "We're offering stability to physicians — not only financial stability, but a way for physicians to regain control of their lives and speak with one voice."

The firm's experience with United was so positive that Weprin began speaking to groups in other markets about the experience. The exposure lead to him being approached by payers and physicians in several markets outside Dayton. Within the past year, OB/GYN Management has signed deals with groups in Florida representing a 275-physician network contracting with BlueCross BlueShield Health Options and approximately 100 physicians in Kansas City, MO, who contract with Prudential HealthCare.

The deals the company strikes with physicians and payers vary by market, but the OB/GYNs essentially are paid a per member per month capitation rate for physician services by the payer (facility fees for hospital care are not included). Unlike traditional subspecialty management network setups, OB/GYN Management pays the physicians in each network based on the number of patients seen. Weprin says incentives for physicians who are efficient utilizers are built into the system.

Weprin admits it's hard to set up systems for tracking outcomes data, but the advantage of doing so is that the group can demonstrate cost-effective care with good outcomes. The firm uses its own proprietary software system, which has been developed over the last four years and is still being modified.

The 80% of physicians in the Dayton market who have demonstrated good utilization capability retain day-to-day utilization management responsibility for D&Cs, laparoscopies, and hysterectomies. For other cases that require an immediate decision, Weprin is consulted in his capacity as medical director. In addition, cases are discussed at monthly governing board meetings that consist of eight physician representatives in each market.

The bottom-line outcome, Weprin says, is a win-win situation for the physicians and the managed care organizations with whom they contract. "It gives the physicians a way to get their care in order, reduces the excesses in care," he says. "And it allows the HMOs to be competitive." ■

A Physician's Perspective on Managed Care

by Elizabeth Gallup, MD, JD, MBA

Making accountability work key to cap contracts

Good data, fair systems essential

Risk is a word with many connotations. To insurers, risk often means the downside, but to physicians practicing in managed care, risk represents the opportunity to benefit from the upside.

The fact is, risk is required for any upside in today's managed care environment, as in any industry. The act of taking a risk, of putting your performance on the line, is required for any reward — be it a simple bonus for a primary care capitation contract or a substantial reward for managing a global capitation contract.

Once it is acknowledged that risk is always a factor of compensation under capitation contracts, the focus can turn to managing that risk in a way that reduces exposure to loss and enhances physicians' ability to earn greater compensation. As providers of care, physicians also are charged with earning compensation in a way that brings value to the delivery of care. Ultimately, that stewardship must translate into outcomes of continually improved efficiencies in the care of patients, which are commonly referred to as quality of care and are rarely defined beyond anecdotal references and discussions in medical staff lounges.

As HMO enrollments grow and carriers pass on more capitation contracts to provider groups or independent practice associations (IPAs), providers will need to grow more sophisticated in their ability to incentivize themselves to "do the right thing." It bears repeating that the "right thing" must be right for both patients and doctors.

The ability to manage risks lies in building incentives and accountabilities into the system. Let's use a physician organization of 100 primary care physicians and 100 specialists as an arbitrary example. Determining how to allocate accountability among physicians is the key to success for all stakeholders in the risk contract — individual physicians, each group practice, and the organization that oversees the contract (for example, an IPA).

The first consideration is who shares in the risk. Contract terms will dictate whether the risk is shared with hospitals or the HMO, or whether it will rest on the shoulders of the physician group only. Of course, if the physicians are ready to manage the full risk, they also will enjoy all of the upside. Younger physician organizations or those that have reason to co-venture with hospitals or HMOs may be better served by sharing the risk with these organizations.

Looking at risk management on a finer level, it makes sense to allocate the responsibility for treatment at the geographic level to physicians. This unit of allocation commonly is a subunit of physicians within the IPA who admit to the same hospital or who share on-call responsibilities.

The unit is likely to consist of seven to 15 physicians who also serve a common geographic area and may practice within one or more clinics. It is not uncommon for a subunit to consist of one large clinic. The size of the group needs to allow for strong peer-to-peer interaction and yet be large enough to see a significant number of enrollees flowing through the subunit to produce a meaningful volume for performance profile reports.

Primary care physicians in the subunit select the specialists for all specialist and subspecialist referrals. It is with these selected providers that risk is shared. This selection process is of the utmost importance, and much heated discussion often is generated in the process. To care for a growing number of enrollees who flow through risk contracts, many subunits decide to include more than one physician or clinic in each area of medicine.

Giving physicians performance incentives

As the process of subunit development continues and more enrollees participate in the capitation contracts, more specialists may become members of subunits. In the beginning stages of subunit development, the enrollee numbers are not likely to be large enough to incentivize physicians to practice the utilization management and patient management skills that are essential to managing risk contracts successfully. However, specialist subcapitation is likely to occur with even 1,000 enrollees. At this level of volume, specialist attention to subunit guideline development

and interaction with primary care physicians is likely to intensify.

As in any business, peer-to-peer interaction is the optimal medium for building a culture of strong performers. Within the context of managed care, stronger performance refers to guideline adherence and a deepening relationship and communication between primary care physicians and specialists to which they refer.

Although this relationship building has been ongoing since long before managed care contracting came about, capitation contracts provide unparalleled incentives among providers for reciprocal support and adoption of physician-directed guidelines.

Physician report cards needed

The curbside consultants and water cooler discussions become peppered with specific quantitative information about comparative patient outcomes reflected in the physician/subunit profiling reports distributed on a quarterly or monthly basis.

These reports, simple in format for user-friendly readability, allow each physician to drill down data to his or her own practice. The data allow physicians to compare performance to a multitude of benchmarks established on at least four levels:

- intra-subunit;
- inter-subunit;
- at an IPA or physician-hospital organization (PHO) level;
- at the regional or national level.

One predictable and understandable objection faced by IPA and PHO leaders is the ability of data reports to factor in the case mix and severity adjustment of patients. Physicians will want to know they are not being penalized for taking on the most chronic patients.

It is common to hear physicians vent their fears about facing possible "train wrecks," as medical catastrophes are referred to in managed care. These wrecks range from cancer patients needing long-term care and technologically intensive treatments to natural catastrophes affecting the health and well-being of a large population.

The data must be carefully weighted to factor in the ebb and flow of the sickest of patients seen by physicians, often internists with excellent reputations for their care of the most chronically ill patients. This factor alone can cause physician groups to seek data information systems and management support of the highest quality. The capital investment and skill level required to manage this data system may even drive physician groups to seek a partnership with established IPA management firms of the caliber of Nashville, TN-based PhyCor's NAMM or the management services organization system of Brown & Toland in San Francisco.

Under any circumstance, the search for the perfect data and support system is labor-intensive. The final selection usually calls for compromising clinical information in favor of financial claims information, or favoring the integrity of claims information and adding on a clinical module that is less sophisticated.

Deal with few hospitals

As mentioned, a factor that usually shapes the makeup of a subunit is the common usage within subunit membership of one or perhaps two hospitals. While hospitalist programs are enlarging the number of hospitals to which physicians admit patients, physicians are almost always more familiar with and favor one hospital. Building a subunit around physicians widely inclined to use no more than two hospitals sets the stage for the greatest accountability among that physician group.

The key to managing risk is the nature of the system of accountability established for physicians. Leaders must ask themselves these questions:

- **Is the system fair?**
- **Are the data reliable and user-friendly?**
- **Are specialists being brought in to the subunits at the appropriate time to respond to the need to adhere to guidelines and improve communications?**
- **Have physicians been educated on an ongoing basis about the meaning of their numbers?**

Underlying all the numbers and reports must be a belief among physicians that the culture is focused on the education process, not on punitive actions. While actions eventually may need to be taken to discourage behavior that is harmful to the group, it is tantamount that accountability be understood as an agreeable and fair way of building a health delivery system that benefits both physicians and patients. A culture of fair play backed up with reliable data and strong managers who understand how to break down the data is the best way to manage the risk all doctors are now facing in the managed care world. ■

Referrals pay off in MCO contracts

Failure to track outcomes, fees could bring you grief

Primary care practices with managed care contracts could compare specialist referrals to writing a blank check from your practice to another physician.

While this may sound dramatic, the reality is that managed care organizations judge primary care practices on the medical outcomes, costs, and frequency of referrals of capitated (and sometimes noncapitated) patients.

"If a plan pays an internist [or primary care physician] by capitation, the internist is financially accountable for referrals," writes Greenville, SC-based practice management consultant **Paul W. Smith**, CPBC, in *Today's Internist*.[1] Smith is a former consultant with The Health Care Group's Greenville office. "If the physician [making the referral] is not under capitation but periodically renegotiates payment rates and other aspects of the MCO relationship, adverse referral utilization data is important. Moreover, referrals for needed services that could be provided in-house represent foregone income."

Tracking referrals painlessly

Few practices are actually capturing these data, and as a result are putting themselves at the mercy of referral data tracked by managed care organizations, says **Robert Connelly**, consultant for The Health Care Group, a consulting firm based in Plymouth Meeting, PA. But referrals can be tracked fairly painlessly once the upfront work is conducted to put a system in place.

Connelly recommends groups take the following steps to get a referral tracking system rolling:

1. Develop consensus among the physicians in your practice regarding referral guidelines.

The physicians in your practice need to determine, as a group, referral guidelines that state the preferred physicians for referrals and criteria for when to refer patients to specialists. Points to consider include:

• Is there one (or more) preferred specialists for each of the major specialties you refer to? This could also be broken down further within a specialty. For example, some orthopedists within your community may be known for total knee replacements, while others may be good for patients with back problems.

• Do these preferred specialists participate in the managed care organizations that represent the bulk of your patient base? If not, it's worth a phone call from a senior physician in your practice to the physician in question, especially if you have numbers that show them the number of patients you refer to them annually that could be at risk if your practice needs to switch to a group participating with your key managed care organizations. The purpose of the call is to let the specialist know you have a number of patients who participate with this plan, and you would like to continue to send those patients to the specialist. Ideally, the physician will respond by making an effort to join the plan's provider panel.

• For each major kind of case your practice sees, at what point does it make sense to refer a patient to an outside specialist? It is necessary to put these criteria in writing, although some providers decry this practice as "cookbook medicine." You can alleviate physician concerns regarding established referral patterns by allowing physicians to play a role in developing these standards.

Once preferred physicians are identified, files for these physicians can be set up in your practice management software system. In addition, the physician staff should communicate this information to your group's administrative staff charged with coordinating referrals.

2. Set up an internal referral tracking system as part of your practice's database. Many practice management software packages have this ability, Connelly says. Although he would not name specific software programs, he did suggest that practices ask the vendor that provided their software program if the system has this capability. If it doesn't, you may want to look for one that does.

Systems that can track referrals probably have additional capabilities of tracking diagnosis codes and the cost of these services. Staff members who make referrals can track each referral by listing which physician a patient was referred to, the eventual diagnosis made, and the cost of treatment.

Specialists communicate their patient care and results of any tests to the primary care physician via a letter. The letter will contain the diagnosis and plan of treatment. Although such a letter usually doesn't contain information on what services were rendered, a primary care physician who refers patient care to specialists controls what the specialist can and cannot do based on the terms of the contract.

Referral Tracking Form

Month of _____

To Doctor:

Specialty:

	Diagnosis	Description	Plan Name	Count	Charges	Avg. Charge
1						
2						
3						
4						
5						
6						

Totals for Diagnosis _____

Totals for Specialty _____

Totals for Doctor _____

Source: The Health Care Group, Plymouth Meeting, PA.

Another option for practices that lack this internal system capability is to use dummy CPT codes, Smith says. This is done by assigning a different referral specialty to each of several CPT codes you never use. Have each physician fill out a referral encounter form whenever a patient is referred to another practice and whenever your physician receives information about a patient he or she referred to another practice. The downside of this option is that information must be entered manually, and you have to rely on your physicians to be diligent about filling out encounter forms.

3. Generate monthly reports to look at costs and utilization data for each physician you refer to, each physician in your practice, and your group as a whole. Practices can set up a module in their computer software system that tracks referral costs and diagnoses in this manner. **(See sample setup, above.)** The practice manager should review these reports with physicians in the practice as a group and discuss the following points:

- Is there a physician in your group who refers more or fewer patients than the group norm?
- If so, are there specifics related to this physician's patient population that justify this volume?
- Are some outside specialists more efficient utilizers in terms of costs, hospital bed days, and treatment outcomes when compared to treatments of patients with the same diagnosis code?
- Are there services your practice is referring out-of-house now that could be potential revenue generators? Connelly says this is rarely the case, but the issue is worth exploring.

4. Deal with physician outliers through one-on-one discussions. Connelly recommends having a senior physician in the practice approach the physician in your practice whose outcomes data fall outside the norm. Not only does the information have more credibility coming from a physician, but the senior physician has the clinical skills to evaluate whether an outlier physician has higher-risk patients or other extenuating circumstances that justify numbers outside the practice averages.

5. Compare your practice's results with standards set by the major managed care organizations with whom you contract. If the managed care organizations you contract with generate practice report cards, dig out the last one you received to determine how your practice has performed in the past. Also, the MCOs you contract with may provide the information to you, although it will likely be standards for overall referral patterns rather than referral patterns for each specialty.

After your practice generates at least six months of referral tracking data, you can then compare your internal reporting figures with your own internally generated numbers, Connelly says.

6. Don't be afraid to brag about your results. Use the data generated by your monthly reports to show your practice can handle capitated patients in a cost-effective manner that generates good clinical outcomes. This may help in your next round of contract negotiations with payers.

[Editor's note: The American College of Physicians-American Society of Internal Medicine sells a benchmarking service, "Practice Management Check Up: Examining the Business Health of Your Practice," that allows practices to compare their performance in referral patterns and 23 other key indicators against established benchmarks for internal medicine practices. For more information, contact ACP-ASIM customer service at (800) 523-1546, ext. 2600.]

Reference

1. Smith P. The whys and hows of referral tracking. *Today's Internist* 1998; 12:5. ■

Physicians show their clout with Texas MCO

CIGNA drops unpopular coding system

Texas physicians are working to be on the front lines of a trend in which doctors fight managed care changes and actually win.

Houston-area specialists convinced CIGNA Healthcare of Texas in Houston to drop a coding system that would pay physicians an across-the-board Level 3 CPT code rate for all office services. Before CIGNA agreed to overturn the change in October, the new coding system had been put into effect for several months for about 300 general surgeons, urologists, plastic surgeons, and otolaryngologists.

The battle over downcoding, as it's called, is symbolic of the struggles physicians have had in recent years with managed care organizations (MCOs) and their attacks on reimbursement rates, one Texas physician leader says.

"Basically, MCOs have cut reimbursements dramatically, and that has resulted in a deepening of the health care crisis," says **Paul B. Handel**, MD, urologist and president of the 8,000-member Harris County Medical Society in Houston. Handel also is vice chairman of the Council for Social Economics for the Texas Medical Association (TMA) in Austin.

Handel says he's dealt with MCOs that want to reimburse physicians at rates lower than what Medicare pays. Yet Medicare rates already are so low that some Houston internists have closed their offices because their practices were dependent on Medicare patients, and they couldn't meet their overhead costs, he adds.

Downcoding is particularly galling to physicians because it means they will be paid the same amount for every office visit whether they spend 10 minutes or an hour with a patient, Handel says.

"Physicians need to be paid for the services they render," Handel says. "If they render a service of $75, they shouldn't be paid a $25 code."

CIGNA also dropped its third-party administrator (TPA), Miami-based Allied Health Group, which is owned by Magellan Health Services, a publicly traded company based in Atlanta. Allied had received a capitated fee from CIGNA, and the TPA paid specialists on a fee-for-service basis.

Allied Health Group had proposed a Level 3 coding system to solve a common specialists' complaint of having too much overhead, says **Erin Somers**, director of media relations for Magellan in Columbia, MD.

A physician panel assembled by Allied Health Group proposed billing specialists one CPT coding level instead continuing with the Level 1 through 5 CPT range.

With the Level 3 coding change, specialists would not be required to submit documentation to support their claims, which would cut down on paperwork.

"Physicians told us they were spending too much time reviewing charts to see if someone had coded it incorrectly," says **John Seidenfeld**, MD, vice president and medical director of CIGNA HealthCare of Texas.

Handel says managed care has made medical documentation much too complex. "We have added 1.5 full-time employees to our practice just to deal with administrative headaches, hassles, and hoops that we have to jump through because of managed care," he says.

However, one payment rate is not the solution, Handel says. "When physicians found out about this change, they were very unhappy."

So Handel and other physicians began to complain about the change, convincing CIGNA to meet with the doctors, the Texas Medical Association, and Texas insurance department officials to discuss the problem.

The Texas Medical Association polled specialists, asking them if they'd prefer the Level 3 system or

the five CPT levels. They clearly indicated they wanted to be paid for the work they did, says **Bradley Reiner**, assistant director of health care financing.

Seidenfeld says he believes physicians were equally divided between supporting and opposing the Level 3 coding system. But CIGNA decided to switch back to the five-level system to maintain good relations with Houston-area specialists.

CIGNA's cooperation gives more clout to physicians who continue to face battles over downcoding, Reiner says.

"TMA has had success with other payers in rescinding their downcoding policies," Reiner says. "We're trying to set a precedent here with CIGNA's being receptive to changing their policy." ■

Congress may try to stop Medicare HMO exodus

Senator introduced bill in last session

Congress has taken an interest in stopping managed care organizations (MCOs) from terminating their contracts to provide Medicare plans under the Medicare+Choice program.

More than 40 Medicare risk plans have decided not to renew their Medicare contracts in 1999, and another 50-plus plans chose to reduce their service areas. This has affected more than 410,000 beneficiaries nationwide.

Roseland, NJ-based Prudential Healthcare, Oxford Health Plans of Norwalk, CT, and Foundation Health Systems of Woodland Hills, CA, are among the HMOs that ceased Medicare operations as of Dec. 31, 1998.

Senator **William V. Roth** Jr. (R-DE) may reintroduce legislation to prevent more than 40 MCOs from terminating Medicare contracts.

Roth made a last-ditch effort in October to stem the flow of MCOs out of Medicare risk sharing, but his bill came too late in the session and was lost in the fray of budget bills and election preparation.

"The issue arose very late in the Congress, and frankly, we just ran out of time," says **Brian Tassinari**, Roth's spokesman. "We're definitely going to be looking again at the issue in the 106th Congress."

Tassinari says Roth may introduce the same bill, which was co-sponsored by Sens. Joe Lieberman (D-CT) and Connie Mack (R-FL). The bill essentially would do the following:

- require the Baltimore-based Healthcare Financing Administration (HCFA) to reconsider the premium and cost-sharing packages of health plans that have terminated their Medicare contracts in 1998;
- change the date by which a Medicare+Choice organization must submit information on proposed premiums, costs, and benefits to HCFA from May 1 to July 15;
- change the date by which a Medicare+Choice organization must notify HCFA that it intends to terminate a contract for the following year from May 1 to July 15.

Roth says in a news statement that legislation is needed to instruct HCFA to allow plans to restructure their costs where justified, because HCFA decided not to allow Medicare+Choice plans to update their cost and benefit filings for 1999.

"This would give many of the health insurance providers the flexibility they need to go back into these markets," Roth says.

A spokesman for the American Association of Retired Persons (AARP) in Washington, DC, says HCFA is not entirely to blame for the problem.

"What we're seeing here is an insurance company reaction to what's going on," says **Greg Marchildon**, AARP spokesman. "They want everyone to believe it is all about reimbursement rates, when there's not any really compelling evidence that that's the case."

Marchildon says HMOs are pulling out of Medicare markets for a variety of reasons, including increased competition in saturated markets. ■

COMING IN FUTURE MONTHS

- Benchmarking your length-of-stay figures
- Year-end earnings of major MCOs
- Disease management programs that work
- Managed care contracting trends

Provider choice among 1999 managed care issues

Some say payers becoming less rigid

As medical groups ring in the new year, it's tempting to look for predictions of the shape of things to come in the managed care industry. Here is a short sampling based on an informal survey *Physician's Managed Care Report* conducted of consultants and practice leaders:

1. After a year of skimpy financial earnings among MCOs, many are passing along premium hikes to employers.

The amount of premium increases varies depending on the importance of the employer as an MCO customer and market conditions, says **Peter Kongstvedt**, MD, a partner in Ernst & Young's Washington, DC, office. Most premium increases are in single digits, although in rare instances small employers with high-risk employees or a history of high medical costs are seeing premium hikes as high as 20%. Kongstvedt expects this trend to continue. Huge employers (called "marquee clients" by some consultants) may be able to keep cost increases down to a few percent, but some larger employer groups whose medical costs have increased significantly can expect premium hikes in the neighborhood of 8% to 10%. In response to provider choice issues (see point No. 4), medical costs for most companies are rising, and employers are more willing to pay the corresponding hike associated with greater choice.

2. Many payers are lessening provider cutbacks.

Although this trend certainly will not lead to a corresponding increase in physician reimbursement, practices can expect payers to back off somewhat from previously inflexible negotiating tactics. "In terms of contracting, we'll always see pressures from health plans to lower reimbursements. That is not going to be as much of the case as in the past," Kongstvedt says.

Gary Erskine, FACMPE, executive director of the 125-physician Arnett Clinic in Lafayette, IN, says he has noticed an increased flexibility among payers in his market. "We had one payer that we were butting heads with for four to five years. Now, we are seeing an openness to see how we can work together," he says. Both Erskine and Kongstvedt are quick to note, however, that conditions vary greatly from market to market. "Payers will have to find ways to improve administrative and medical efficiencies. There's plenty of room to go in both of these, and anyone who doesn't think so is dead wrong," Kongstvedt says.

3. Employers are passing along an increasing percentage of medical costs to employees.

Because the economy is doing well, companies don't want to cut back on benefits despite rising premiums, Kongstvedt says. But many have decided to pass along more medical costs to employees through increases in copays, deductibles, or payroll deductions.

4. Most payers will adjust their provider panels in response to increasing consumer demand for provider choice.

In response to market pressures, HMOs are broadening their networks, Kongstvedt says,

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but that will come at a price to employers. There are costs associated with collecting the data required by groups like the National Committee for Quality Assurance, and more providers means more administrative work in data collection and other paperwork required between health plans and providers. At some point, the cost cycle, if passed on to employers, may lead to health plans "reintroducing" products with tighter physician networks. This essentially is just recycling the HMO products that have been out there for years to see if employers are driven away from open-access health plans due to cost constraints.

5. The managed care backlash over the past year will make employers even more leery of HMO products.

"We've got the biggest [provider] choice of any health plan in our market, but the HMO name is a problem," says Erskine, whose clinic operates its own HMO in addition to contracting with other payers. "People hear things about HMOs and the backlash kicks in." Erskine believes there is more antipathy toward HMOs in his market among employers than consumers. "We finally got one employer contract [after several years of trying] with a company that offered us as one of several options. But we got 70% penetration among their employees."

6. Practice guidelines will become more popular.

Guidelines that offer a preferred treatment pathway for the major type of cases a practice handles are becoming more important, says **David Astles**, executive vice president of OB/GYN Management in Dayton, OH. His practice, which also provides management services to other OB/GYN practices, has guidelines for cesarean section, Down syndrome, and fetal fibronectin cases. He admits that the guidelines took a lot of work, but he says he believes more practices will implement them given the cost and utilization pressures of managed care. "The intent is not for them to pull the guidelines out when they're next to the patient's bed, but to keep them in mind as they are treating [patients]," he says.

7. Disease management will become increasingly common.

Astles says many practices are trying to grasp this concept, but few have implemented it to date due to the changes in methodology and processes. Although his practice is not doing it yet, he sees it as an important consideration for many practices in the future. ■

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