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INSIDE

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Keeping the cash flowing: 5 ideas to save time and money

Here are some ways to avoid claims delays and denials

It seems to be an increasingly common complaint: Despite efforts to submit clean claims to payers, practices are seeing more and more denials and delays of payments. Some of the problems are blamed on technology, says **Layton Lang**, MBA, chief operating officer at the eight-physician Dallas Surgical Group.

"We see a trend now that payers blame scanners or data entry people for mistakes," he says. "We might have a consult on the same day of surgery that is global, but if the initial time you evaluate the patient is broken out, it gets dropped. We've had to meet with plans to deal with this issue. That can be time-consuming and costly. Maybe it's only $120, but if it's a constant fight, it really starts to add up."

And it's not just the denied and delayed payment that affects a practice, Lang adds, it's the staff time and the increased salaries that practices have to offer billing staff to attract people who can deal with the constant stress. And as payers put increasing demands on practices to submit more and more paperwork, there is a higher likelihood of errors, further exacerbating the problem.

He says the hot job market also is affecting claims. Plans are hiring people with no experience, giving them a two-week course, and calling them claims adjusters, he says. "But these people don't understand Medicare guidelines."

So what's a practice to do? Here are five ideas that might help.

1. **Define a clean claim.** Lang says this might differ from payer to payer, but you should ask in each case whether a claim should be based on Medicare guidelines or some proprietary system. This information should be included in a contract from the start.

Pat Aalseth, RRA, CCS, CPHQ, a consultant in Albuquerque, NM, says it's often the simple things that make claims unacceptable. For instance, if you have a conflict between the age of the person and the diagnosis, or if you get the gender of the patient wrong, payer computer systems will deny the claim automatically, she says. In another example, last October Medicare began requiring providers to include the full year

— 1999 — instead of simply "99" in the claim.

"There are simple edits built into most computer systems now that will query something they think is wrong," Aalseth says. But beware that some conflicts may not be evident immediately, such as when the physician goes to a hospital to see a patient, and the hospital calls it an outpatient visit while you call it an inpatient visit.

2. **Get approval when necessary.** You also should be clear on what the plan's referral protocol is, Lang says. "Some plans will say exam and treat, but we were really only supposed to examine the patient, and then sub-refer for something like a biopsy. Others say that the primary care physician has to circle the CPT code that the specialist can use. That is now illegal in Texas, but not everywhere."

Aalseth says it's important for practices to get prior approval for any service requiring it. "That means knowing each managed care program," she says. "Write a cheat sheet if you need it. Many insurance cards also have some description of what needs prior approval, or they have an 800 number. Call and ask if you need to. And if they say you don't need prior approval, document this, including whom you spoke to and what he or she said."

As rules and regulations change, you may even want to hold quizzes to make sure your billing staff knows them.

3. **Know your department of insurance rules.** Every state will have different rules, says Lang. For example, the law mandating which CPT codes a physician can use is specific to Texas.

4. **Develop specialists.** Lang says one key to avoiding problems is to make sure your front desk staff are adept at getting the right data from patients. "You have to know if a patient's claim will go through an IPA, and if so, what the IPA rules are." You also should make sure staff know to ask patients if any of their insurance information has changed since their last visit.

Since it is impossible for one person to know all the rules, consider dividing claims by payer among billing clerks, says **Elizabeth Woodcock**, a Charlottesville, VA-based consultant for the Medical Group Management Association in Englewood, CO.

For example, one clerk could be devoted full-time to Medicare, another to Medicaid and workers' compensation, and a third to the Blues and commercial insurers. By concentrating on just one payer, a billing person can better understand that payer's rules and know how to work the system when problems occur. And by developing a relationship with the payer, billing clerks often can get to the right people more quickly and, in some cases, circumvent bureaucratic rules, such as restrictions on the number of claims that can be discussed per call, advises the American College of Physicians-American Society of Internal Medicine.

5. **Pay close attention to filing time limits.** For some HMOs, Aalseth says, that can be as little as 30 days. If you have a backlog, make sure you do the ones first that have the shortest limits. The faster you file a claim, the faster you get paid. Some experts advise setting a filing target of within three to four days after service has been rendered. Others prefer to file more frequently. Frederick Internal Medicine, a four-physician practice in Frederick, MD, files its claims daily.

"If I wait until the end of the week, I'm looking at 200 claims," explains **Robin Laumann**, the practice's office manager. "If I file daily, there's not as much paperwork. Instead of getting a check once a week from an insurer, I get checks daily. Our accounts receivable stays low."

It is not uncommon for as much as 25% to 30% of physician office insurance claims to be delayed, rejected, or simply vanish inside the black hole of an insurer's payment office. And with so much practice revenue coming from insurance companies, cutting that percentage by any amount becomes increasingly important. ■

COMING IN FUTURE MONTHS

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When 'good enough' doesn't cut it anymore

Here are some strategies for lingering claims

Even if you are doing everything you can to avoid delays and denials for claims, you still may have persistent problems. What can you do to solve them?

According to **Layton Lang**, MBA, chief operating officer of Dallas Surgical Group, a lot depends on the reason given for the persistent problems. If your payers say it is because you aren't filling out paperwork completely or correctly, you have to remedy the situation by defining what a clean claim is.

If the problem is the time it takes to file a claim, check to see if your computer billing system has a tool that allows you to run reports on pending claims. Run those daily or weekly to see what claims still have to be sent within what time period, says Lang.

If you have to appeal a denial, try using the telephone instead of a letter. That gets the money in faster, he says. However, if you need to send a written appeal, again check your computer program to see if there is an automatic claim letter program. There are also companies, such as Appeal Solutions in Lewisville, TX, that sell software programs designed for just such purposes. (Appeal Solutions can be reached by calling [888] 399-4925.)

You may have to resort to a meeting with the payer, Lang says. "They may be defensive about the situation, but you have to be persistent and find out what the issue is. They may be the problem." It might take several meetings to find out what the issue is, and some payers may promise action but not deliver.

If that happens, you may have to send a formal grievance to your state's insurance commissioner. The Texas Department of Insurance has an alternative dispute resolution (ADR) program to review grievances. "Here, half the cases are overturned in favor of physicians, so if you have an ADR program, use it," Lang says.

Your state medical society also may have some resources for you. In Texas, for instance, there is a service that mediates between payers and practices. Even if it doesn't have any services, the state society may trend complaints against payers and should be informed of any problems. Your last resort is to cancel or not renew a contract, he says.

There are few resources for people wanting to learn about this topic, he adds. "This is all just real life. Sit down with your peers. Organize a lunch at your hospital and exchange advice. What works with particular plans? And never assume that the company is right. Do your own research. We have to appeal 40% of our cancer cases because they are so complex."

Pat Aalseth, RRA, CCS, CPHQ, a consultant in Albuquerque, NM, says follow-up on claims denials is vital. "Read the remittance advice you get from the payer and know why they aren't paying you." She says many will have cryptic codes. "Medicare has a list of some 350 acronyms it uses. You have to be able to look at what they send you and figure out why you aren't being paid. That means investing some time and effort."

Lastly, be sure you document everything you do — from the date you send the claims to the name of the person you talk to when you call a payer.

Some practices may feel the additional work isn't worth the few extra dollars they may collect, she says. "A lot of how worthwhile you think it is depends on the size of your practice. But regardless of what you do, you should never dump these problems back on your patients. It will kill your patient satisfaction, and if you don't understand it, what makes you think they will?" ■

Better billing statements lead to faster payments

Keep it clear, understandable

The clearer and more understandable a patient's billing statement and payment options are, the more likely you will get paid in time and in full. Here are some suggestions for improving the billing process developed by **Bob Richards** and **Jeanan Yasiri** of the Medical Group Management Association in Englewood, CO:

• Provide a line-item billing statement. Many health care billing statements still reflect the use of traditional balance-forward accounting, in which payments made by patients or payers are applied to the oldest balance on the account. This makes it extremely difficult for patients to determine later what specific charges account for a particular balance that still may be due. Instead,

produce a billing statement telling patients on a line-by-line basis which charges have been paid and which ones remain.

• Provide a folder with monthly pockets designed to help with benefit coordination. Many people don't pay immediately because they're waiting to see how much their insurance plan or plans will pay. While they wait, they're getting billing statements from their health care providers. A clear, easy-to-use billing statement, providing information that can be compared with insurance plan benefits, is a huge first step toward meeting the patient's needs and expectations.

• Verify the patient's address and insurance company information regularly to prevent mail returns and billing errors.

• Offer regular training for your staff about changes that affect coordination of benefits.

• Negotiate tape-to-tape claims adjudication with your clinic's major third-party payers.

• Be willing to create separate accounts for children of divorced parents. Typical divorce judgments include provisions that hold both parents equally responsible for the health care bills of their children. If the clinic continues sending the child's bill to only one of the parents, however, the parent who gets the bill can quickly find him or herself with an account that is difficult to decipher and quickly becomes past due. The other parent, meanwhile, gets only information filtered through the ex-spouse.

• Prepare information you can disseminate to community groups regarding your billing policy for children of divorce.

• Interact regularly with insurance and other government regulators regarding billing issues. Provide a means for patients to make co-payments on the day of their visit. ■

Medical group mergers show a slowing trend

Larger groups are now the targets

The number of medical group mergers has fallen for the first time in four years, according to a new survey. Publicly announced mergers among medical groups dropped by 16% to 262, while acquisitions fell by 28% to 369 in 1998, according to Irving Levin Associates, a research firm in New Canaan, CT. "Not every year can be a record breaker," says **Stephen M. Monroe**, a partner at the firm. "Nevertheless, 1998 is still the second most active year we have seen in the medical group [merger and acquisition] market when measured by the number of physicians involved."

"The shift in the number of groups acquired, coupled with the relatively large number of physicians involved, indicates that buyers are now favoring larger groups and networks like independent practice associations [IPAs]," observes **Sanford Steever**, one the consultants who worked on the study. The volume as well as the nature of these transactions is changing. "Rather than buy a practice outright, the practice management companies and other players are now seeking to forge looser arrangements such as IPAs or a management service organization as a basis for their relationship," says Steever.

The merger and acquisition market for physician medical groups cooled off significantly the second half of last year. Of the 20 most expensive deals of 1998, 80% took place in the first half of the year. "The deal volume also fell off because of a number of well-publicized bankruptcies in the physician practice management (PPM) business, as well as several PPMs deciding to get out of the business altogether," Steever says.

"We expect the volume of physician medical group [merger and acquisition] activity in 1999 to remain close to the levels established in the second half of 1998. With continued fragmentation in this sector as well as pressure from payers, physicians will want to bolster their position in the health care delivery system by aligning themselves with companies that represent their professional and financial interests," Monroe says. ■

SOURCES

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Guest Column

10 steps to contain health care stress

How to get off the stress treadmill

By **Diane Cate**
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The recent changes in health care have brought with them increased stress levels for all people involved in the medical field. Predictions indicate that this rapid pace of change will continue for the foreseeable future. There is, unfortunately, a resulting epidemic level of fear and stress among health care providers and their support staff.

The following tips are designed to be helpful to physicians, nurses, and medical practice staff, as well as any hospital or treatment staff exposed to this toxic problem.

1. **Provide positive reinforcement for those around you.** When co-workers (in your practice, in the hospital, professional peers, etc.) do a good job or appear to be having a difficult day, compliment them on their work or on how well they handled a situation recently.

You will feel less stressed and more confident when you give and/or receive a compliment. Not giving or getting positive reinforcement can cause "hardening of the attitudes."

2. **Be willing to ask for and take a "timeout."** We all need brief stress-reduction breaks during hectic days. Productivity and overall effectiveness increase when you take a moment to clear your head and collect your thoughts. Everything and everybody are likely to be right there waiting for you after you take a quick timeout.

3. **Shift discussion and concentration from the problem to all the possible solutions.** Stress is diminished when you concentrate on the positive rather than the negative. While you may not be able to control changes that come your way, you do have control over how you act or react to change.

Encourage those working around you to discuss solutions and concentrate on your own ability to come up with creative methods to cope with changes. When using a solution-oriented approach to serious problems, you are likely to feel less stress and more resilience.

4. **Reach out to others and ask for help.** You are not the only one in the medical field experiencing extreme stress at this time. No one person can possibly have all the answers. Ask fellow professionals and experts for ideas and assistance.

Given the independent nature of most physicians (and their staff), this may be foreign and therefore take some real effort. Synergy, teamwork, and continuing education are effective medicine for stress.

5. **Develop positive affirmations, verbalizations, and visions of change.** Because you can't escape it, you must learn to envision change itself differently. Use Post-it notes to reinforce new attitudes and repeat positive phrases in your mind that allow you to transform the stress (or threat) you feel from change into a vision of change as an opportunity and a challenge to grow, learn, and evolve along with your chosen field.

Change can be an antidote for high stress levels. Use positive statements to strengthen your resolve to succeed.

6. **Get out of the office at lunchtime (or some other mid-work period).** Even if you end up at a meeting, get air, get perspective, and remind yourself that there is something beyond the pressure of telephones, patient demands, and managed care craziness.

7. **Today's problems may not be solved with yesterday's outdated solutions.** Each day, new books, continuing education workshops, newsletters, form templates, magazines (i.e. *Medical Economics*), and other resources come across your desk.

Although those items may include news you don't really want to hear, they also regularly feature practical, ready-to-use tips and tools that can help reduce stress and improve time management.

Use *all* the resources that are available to you — particularly those you already have paid for or those that may be free. Make "let's try a

new way" your motto for both new and old challenges.

8. **Use a regular exercise program to reduce stress.** Research has proven that when you exercise, you experience an increased sense of well-being and a reduction in stress. If some form of exercise doesn't get written into your appointment book, you probably are not prioritizing it high enough. You can't blame anyone but yourself for not exercising.

9. **Set realistic goals and limits in your work and write them down.** Your self-confidence and the way you set goals will greatly affect the level of stress you experience. Maximized work output is critical in health care now (and always has been as far as most of us are concerned).

However, allowing yourself to think you can "do it all" or that you are indispensable will set you up for added stress and, ultimately, serious disappointment. Be realistic as you make a list of your short- and medium-term goals. Goals should be challenging yet attainable, written and measurable, clear and unambiguous.

10. **Avoid the contagious nature of the stress epidemic.** Never forget that, in most interactions, what you give out dynamically effects what you get back. If your tone communicates stress, resistance, displeasure, or impatience, you can expect to experience those same reactions from the person with whom you are communicating. The result is generally an increase in intensity and a stressful experience for both parties.

When you have the ability to meet stress exhibited by others with calm and understanding, you prevent stress from being contagious. Don't be infected by stress and don't be responsible for infecting others with it.

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Itemized statement push could affect practices

Here's what needed and recommended

As part of its attempt to involve Medicare patients in identifying potential billing fraud and abuse, the Health Care Financing Administration (HCFA) has started notifying beneficiaries they can request an itemized statement of medical services they have received from their physician to check for possible discrepancies.

The program has its basis in the Balanced Budget Act of 1997, which gives Medicare beneficiaries the right to submit written requests to their provider or supplier asking for an itemized statement for any Medicare item or service. This provision was included to encourage beneficiaries to carefully review their medical bills and to enlist them in fighting fraud and abuse, says **Brett Baker**, a third-party billing specialist with the American College of Physicians-American Society of Internal Medicine in Washington, DC.

The key elements

Baker says these are the key elements involved:

❑ **Notice.**

Medicare contractors will issue beneficiaries an Explanation of Medicare Benefits (EOMB) or a Medicare Summary Notice (MSN) to inform them of Medicare's payment decisions regarding claims submitted on their behalf by their physician or other health care provider. HCFA recently instructed its contractors to include language on all EOMBs and MSNs informing beneficiaries of their right to request an itemized statement.

As of April 1, most carriers began including the following language on EOMBs and MSNs: "You (the beneficiary) have the right to request an itemized statement which details each Medicare item and service which you have received from your hospital, physician, or any other health care supplier or health professional. Please contact them directly if you would like an itemized statement."

❑ **Content of itemized statement.**

HCFA expects providers and suppliers to provide beneficiaries an itemized statement using their internal billing or accounting system. While the law does not specify what information should be included in an itemized statement, HCFA

recommends they contain the following elements: name of beneficiary, date of service, description of item(s) or service(s) furnished, number of services furnished, provider / supplier charges, and an internal reference or tracking number.

HCFA also says providers can include the following additional information if the claim has been adjudicated by Medicare: amounts paid by Medicare, beneficiary responsibility for co-insurance, and Medicare claim number.

HCFA also recommends that responses include the name and telephone number of a contact person beneficiaries can call if they have any questions.

❑ **Charges**.

You should not charge a beneficiary for an itemized statement, Baker recommends.

❑ **Inquiries**.

HCFA says this information will enable beneficiaries to reconcile an itemized statement with the corresponding EOMB or MSN. Contractors will direct beneficiaries with questions to the appropriate provider. The provider is expected to assist the beneficiary in understanding any discrepancies between the two documents. Meanwhile, customer service representatives at Medicare carriers will attempt to resolve any questions by explaining applicable Medicare reimbursement rules.

Beneficiaries may ask their carrier to review a claim based on information contained in an itemized statement. Beneficiaries must submit requests to the carrier in writing and should identify the specific item(s) or service(s) the beneficiary believes was not provided as claimed.

Contractors may ask providers for help in examining the itemized statement as they review beneficiary complaints. When appropriate, carriers will seek to recover overpayments. The government also can impose penalties. ■

Trust and good data keys to physician change

Physicians respond to leaders one-on-one

As medical groups strive to improve care, they invariably face their most difficult question: How can you change physician behavior?

There is no simple answer. But trust and loyalty, combined with data on evidence-based medical practices, form the foundation for change, says **Jeffrey Lenow**, MD, JD, medical director of JeffCare, a physician hospital organization for Thomas Jefferson University Hospital in Philadelphia.

In fact, Lenow says he was so committed to physicians accepting him as their peer, he put his administrative career on hold while completing a residency in family medicine. An obstetrician, he had spent 13 years as a medical director of various organizations. “You have to establish trust and credibility. You’re only as good as your credentials in the eyes of your peers.

“You have to show that you know what you’re doing; you have to show you are one of the group,” he says. “That’s why I still practice in the academic setting. I think it’s important to the people with whom I have to share performance and management data to be able to say, ‘I’m one of you.’”

Loyalty among physicians may come from standing up for them on an issue they care deeply about. Physicians should be involved in creating internal “report cards” and even deciding what data elements will be measured.

After all, the feedback is designed to help physicians improve care for their patients. “Merely providing high-quality data is a potent motivator among many physicians,” says **Tom McAfee**, MD, chief medical officer for Brown & Toland Medical Group in San Francisco.

Starting with physician input

What data should you give physicians, and how should you present the information?

In an effective feedback system, the physicians themselves largely determine that, says Lenow, who is chairman of the disease management committee for Jefferson Health System. “We involve our physicians as much as we can on our committees in which we design disease management and study evidence-based practice. If we get their buy-in early, they become partners in the cause. They become standard-bearers.”

At Brown & Toland, primary care physicians receive quarterly score cards showing what percentage of their patients have received certain types of care, such as mammograms for women 52 to 69 and cervical cancer screening. They also receive a list of patients who haven’t been screened and letters they can sign to send to

those patients asking them to come in for care.

In the beginning of the feedback program, the screening percentages and lists included all patients assigned to the physician. But some of those patients signed up with a primary care physician and never came for a single office visit.

"There may be a whole lot of reasons why people don't come in to see their physicians," says **Sharon Katz**, RN, ND, corporate director of quality and care management with Brown & Toland Physician Services Organization. For example, a patient may sign up with Brown & Toland as part of a secondary insurance plan while seeing a primary care physician with another practice.

So now, Brown & Toland physicians learn how many of their active patients they've screened. The Brown & Toland physician services organization tries to contact the other patients to encourage them to come for an office visit and receive necessary screening.

Physicians also have a chance to correct the information on the score cards and accompanying lists, notes McAfee. "If, in fact, our records are wrong, we allow the doctor to send us some kind of proof. Then they can improve their score."

The medical group voluntarily publishes some of its overall Health Plan Employer Data and Information Set (HEDIS) measures, which are indicators required for health plan accreditation by the National Committee for Quality Assurance (NCQA) in Washington, DC. Those HEDIS measures have improved for the past three years the medical group has reported data to physicians.

Financial incentives don't work

Financial incentives aren't a key motivator for changing physician behavior, says Lenow. And if they have a punitive aspect, they won't work, he says. "Physicians are so worn out by the promise of financial incentives, I don't think they're thinking about it that much."

In fact, the incentive is inherent in providing good care, Lenow says. Physicians see their patient outcomes improve, while the medical group receives cost savings from early diagnosis and chronic illnesses that are better managed.

Physicians also may qualify for outside recognition, such as the Provider Recognition Program sponsored by the NCQA and the American Diabetes Association in Alexandria, VA, indicating the physician met quality goals for diabetic patients.

Brown & Toland's Managed Care Quality Incentive Program previously offered a financial incentive for physicians. But that has been canceled for this year, and McAfee doesn't expect its absence to change the physicians' attitude toward quality improvement.

Katz notes that previous feedback on patients receiving diabetic retinal exams wasn't included in the financial incentive, yet that indicator improved significantly. "Physicians, when all is said and done, want to do a good job," she says. "When they see their score compared to other physicians', it is a motivator. Also, when they see people who haven't had preventive health screening, and they have a tool that can help encourage that, I think they're big supporters." ■

How JeffCare changed its physicians' behavior

PHO takes different approach to education

Medical groups use many methods to educate physicians about guidelines and protocols and to encourage their use. But those strategies aren't always successful. A systematic review of literature found proven success with reminders, patient-directed interventions, and educational interventions that included opinion leaders and one-on-one visits to physicians.[1]

Without linking them to other strategies, the review found, traditional continuing medical education conferences had little impact.

JeffCare, the physician-hospital organization for Thomas Jefferson University Hospital in Philadelphia, took those findings to heart and used them to shape a program to influence physician behavior. Here are some of the strategies the program uses:

1. **Primary care physicians receive one-on-one preceptorships with specialists.** Instead of attending didactic sessions, physicians learn from experts while they are tending to their own patients, says **Jeffrey Lenow**, MD, JD, medical director of JeffCare and chairman of disease management committee for Jefferson Health System.

For example, primary care physicians may schedule appointments for several diabetic patients back-to-back on a particular morning. "We'll have one of our specialists come out and

spend time with them while they're seeing patients," he says. "It's a different approach to education. It's part of what we call our physician-champion model. If you can influence key decision makers, they will disseminate good practices, and ultimately you'll be able to reduce variation."

Both the specialist and primary care physician receive a token compensation for their time in the preceptorship, but Lenow notes that the money isn't of primary importance to them. The program has other ancillary benefits. "It's a way for our specialists to get out and meet our primary care doctors, and relationships can develop that wouldn't have otherwise."

2. **Educational programs are interactive and problem-oriented.** Sometimes it's best for physicians to share information in a group setting. But JeffCare makes sure these sessions remain focused on the real-life problems of physicians and how they can solve them. For example, a half-day symposium for physician leaders gave them a forum for working through problems with improving compliance to guidelines and quality improvement goals. "We focused on problems related to evidence-based medicine and application to problems they specifically brought with them to the symposium," he says.

3. **Physician leaders share detailed data twice a year.** While data alone may capture a physician's curiosity, he or she will have questions. Lenow spends much of his time visiting offices to discuss individual performance profiles and what they mean. "You're only as good as your data and you're ability to explain it in a user-friendly way," he says.

For some disease-management programs, teams of nurses pull every patient's chart and use the data both for benchmarking and drafting specific suggestions for intervention. One site targeted 65 pediatric asthmatics in a Medicaid population. Nurses designed classes for parents, home visits, and family counseling to help them manage the asthma.

"With eight months of physician training and focused intervention and patient outreach, they reduced their [emergency department] admissions by 80% and missed days from school by 60%," he says. "It's not that a lot of physicians don't know what to do. They're not organized enough. They're not getting enough help identifying the patients at need, and things start falling through the cracks."

4. **Guidelines are provided in a simple format that is easy to use in clinical practice.** Guidelines that are wordy and difficult to read simply won't be effective, Lenow says. JeffCare reworks guidelines to place them in a format that provides true guidance to a busy primary care physician. "You can just narrow the choices of therapy or show a physician the 11 things that need to be done with a diabetic on a regular basis. They're straightforward. All we're looking for is support measures. We're looking to reduce clinical variation."

5. **Physician leaders influence their peers on targeted clinical issues.** If you want change, start at the top. A study of physician leadership found that their strong support of a certain protocol, such as beta blocker use after a heart attack, could improve adherence.[2] "The best practices out there need to be disseminated by the people who have the most influence," says Lenow. "That is a very key strategy for modifying physician behavior."

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Medicare capitation faces massive changes in 2000

Watch for acuity-based capitation rates

Sweeping changes proposed for Medicare's capitation payment system on Jan. 1, 2000, will emerge into a huge story by year-end, and the capitation changes will be good news for physicians.

But be ready for major, raucous political debates regarding many aspects of health care. More than likely, you'll hear more about extending the "Patient's Bill of Rights" than you will about the idiosyncrasies of risk contracting. No doubt, patient-centered politics may cloud what actually occurs in the technical and financially laden aspects of capitation. Although not as

rhetorical, the regulatory aspects of Medicare's capitation system will affect physicians powerfully — as much if not more than any other changes Congress will deliver.

That's the overview from one of the nation's most respected capitation experts speaking from a state that now has more capitation than California, and from a physician practice long experienced with managed care.

"We've been capitated for years, and for years we've been working with HCFA to get reimbursement rates better," says **Harry K. Stathos**, MBA, business manager for Northwest Permanente in Portland, OR.

Introducing PIP-DCGs

That's what physicians will be getting with the proposed new primary inpatient diagnostic cost groups (PIP-DCGs). PIPs are the product of years of research and input from capitation experts who have pushed for a better capitation system, Stathos says. The current proposal is at least a major step in the right direction, he predicts.

"In Oregon, the better you get at capitation, the lower your payments are the next year," he notes, referring to the current capitation formula as self-defeating. In that formula, cap payments are largely determined by determining 95% of a locality's past year's fee-for-service payment amount. In addition, cap payment levels suffer huge gaps across various localities, making it lucrative in some areas and virtually impossible in others.

Stathos sees these changes on the horizon as long-awaited good news. They are described in several current documents. (For the most recent, extensive regulation, see the Feb. 17, 1999, *Federal Register,* pp. 7,967-7,982,[1] and the Jan. 15, 1999, "Advance Notice of Methodological Changes for FY 2000 Medicare+Choice Payment Rates, comprehensively outlined on HCFA's Web site at www.hcfa.gov / stats / hmorates / 45d1999 / 45day.htm. You also can find commentary in the "Report to Congress: Medicare Payment Policy," released in March by the Medicare Payment Advisory Commission.[2])

While effective deadlines vary, physicians can be certain they will see these three changes soon in Medicare capitation and probably private insurance capitation, as well:

• a more refined per member per month (PMPM) payment structure that will individualize PMPM payments on a more patient-specific, clinical basis;

• more administrative requirements, including individual patient "treatment plans" and clinical "risk scores" for calculating PMPM capitated payments;

• more consumer and physician protections against arbitrary physician deselection.

Most directly affecting physician pocketbooks will be the new risk adjustment system In effect, the PIP-DCG system will pay varying amounts based on different projected needs for a patient's clinical care.

That begs the key question: What will it mean to payments? Here's the answer to that question from the March 1999 report to Congress from the Medicare Payment Advisory Commission (MedPAC): "Other things being equal, adoption of this new system on Jan. 1, 2000, will change payments for individual organizations and reduce overall Medicare+Choice payments. The possibility of reduced payments may discourage some organizations from participating in Medicare+Choice or cause others to withdraw from the program."

The report goes on to say that the precise effects will be more predictable when more 1999 data are available. The impact will be lessened somewhat by the five-year phase-in of PIPs.

A better system

HCFA officials will respond in more detail to public questions on the PIP system in another regulation later this year. Overall, if HCFA is successful with PIPs, physicians will see a fairer, more sensible capitation payment system that pays more for needier patients, as opposed to current payments, which are virtually the same for all HMO patients.

"Because organizations will be paid more appropriately for the risks they take on, the new system is intended to encourage organizations to compete on the basis of how effectively they manage care and not to reward plans for attracting favorable risks," say MedPAC officials in their annual report, which endorses the PIP system.

"The current system, which is based on beneficiaries' demographic characteristics, rewards organizations that attract healthier enrollees because it does a very poor job of accounting for predictable differences in health spending," the report states.

To get this better payment system, however, providers will have to pay for it in the form of more administrative work, which some fear will be costly. Physicians and insurers will be required to develop individual treatment plans for patients and perform initial care assessments for each patient so that a "risk score" for that patient can be calculated for appropriate capitation payment.

Beyond the financial issues, the good news is the regulation makes it tougher for insurers to drop physicians from their networks arbitrarily.

Here are the highlights of administrative requirements providers will have to meet to qualify for PIP payments:

• **Key clinical indicators and treatment plans**.

Providers must have a system in place that will identify individuals with serious or complicated medical conditions, assess and monitor those conditions, and establish and implement treatment plans. This stems from the Patient Bill of Rights debates you heard about in Congress last year. These kinds of consumer protections were folded into the Budget Balancing Act, which requires implementation by Jan. 1, 2000.

• **Assigned physician per patient**.

While a provider will have to be assigned to each beneficiary so continuity of care can be assured, HCFA will not require that provider to be a primary care physician. Instead, bowing to patient and physician requests, that primary physician can be a specialist, the regulation states.

• **Initial care assessments**.

These patient assessments will be due within 90 days of a patient's enrollment. Exactly how burdensome this will be remains to be seen, although regulators say the intent is not to go beyond what is reasonable.

"We believe that requiring initial assessments is consistent with current industry practices and need not result in burdening M+C organizations with additional administrative responsibilities," the rule states. How realistic it is that providers already do extensive clinical assessments of each enrollee already, however, is not clear. The weight of the new "care assessment rule" will depend on how involved HCFA requires providers to be.

References

1. 64 *Fed Reg* 7,967-7,982 (Feb. 17, 1999).
2. Medicare Payment Advisory Commission (MedPAC). *Report to Congress: Medicare Payment Policy*. Washington, DC; March 1999, pp. 21-22. ■

News Briefs

Book helps diagnose health of your practice

Practice Marketing & Management board member Reed Tinsley, CPA, has released his latest book, *Performing an Operational and Strategic Assessment of a Medical Practice.* Co-written by Joey Havens, a colleague of Tinsley's at the Houston-based Horne CPA Group, the book guides readers through the essentials of diagnosing the health of a medical practice.

In order to survive and thrive, says Tinsley, practices need to perform at maximum efficiency. That means knowing the strengths and weaknesses of your organization.

The book, published by John Wiley & Sons, retails for $89. Tinsley is also the author of *The 1999 Medical Practice Management Handbook.* For more information on his book, contact Tinsley at (713) 975-1000. ▼

Agencies team up to form measurement council

As part of an effort to prevent overlapping and conflicting requirements, the American Medical Association's accreditation program, AMAP; the Joint Commission on Accreditation of Healthcare Organizations; and the National Committee for Quality Assurance have formed the Performance Measurement Coordinating Council (PMCC).

According to **Robert Mills**, spokesman for the Chicago-based AMA, the group hopes to ensure that performance measurements are set by the medical community, not the private sector, and that the efforts of the three individual organizations don't put conflicting requirements on medical practices, hospitals, or other health care organizations.

"The benefit is that we will be able to provide a feedback loop to physicians through peer review," he says. "We are getting in on the ground floor of this and will be able to direct national efforts to create performance measurement systems."

In the future, the PMCC will merge the participating organizations' expert panels in selected areas, such as cancer care. The first step was taken when the PMCC appointed Carolyn Cocotas as staff director. Previously with the Health Care Financing Administration in Washington, DC, she led efforts to develop the Health Plan Employer Data and Information Set.

A complete list of panel members is available at any of the participating organizations' Web sites: www.jcaho.org, www.ama-assn.org/amap, or www.ncqa.org. ▼

MGMA upgrades Web site

MGMA Online — http://www.mgma.com — has a new look. The remodeled site includes areas to search for a job or fill a physician position. It also has an on-line member directory and discussion groups to speed networking. A new practice solutions section provides weekly tips for administrators, as well as an archive of past articles. A catalog of Medical Group Management Association products is available in the Library Resource Center, and education programs are now available on line through an Internet distance learning program. The first course is one on cost accounting. For more information, contact MGMA at (303) 799-1111 or visit the Web site. ▼

Key to success: Better patient care

It may seem like a no-brainer to physician practices, but a new study has shown that if health plans want to be successful in the long term, improving patient care is more important than efficient administration and customer service.

The study, conducted by the Ann Arbor, MI-based MEDSTAT Group, ranked 11 plan performance categories as most important to health plan enrollees. The three most important are choice of providers, physician care, and the appearance of physicians and staff being overworked or rushed. Those three alone accounted for almost 42% of the overall plan ratings by enrollees.

For more information on the study, contact the MEDSTAT Group at (734) 913-3000. ■

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