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INSIDE

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Don't be the first on your block to sign that managed care contract

First, determine how your practice will benefit

If you're considering signing up with a managed care plan, the experts have some advice for you: Take a little time to think it through.

"Too many physicians sign almost anything that comes through the door. It pays to take a step back and think about all the ramifications signing with a plan could have on a practice," says **Marc Benoff**, MBA, director of Dan Grauman Associates, a Bala Cynwyd, PA, management and data consulting firm specializing in the health care industry.

Instead, Benoff advises physician practices to take a cold, hard look at the managed care plan, what it offers, what it requires, and how signing up or not signing up would affect the practice.

"We see a lot of examples of physicians being squeezed by managed care plans. In some areas, payment rates are at Medicare level or less. In other areas, they're not that low, but they're below where they have been, and physicians have to work hard to make the same," Benoff says.

"Before signing a contract, physicians should look at each plan as it comes, investigate it, evaluate it, and make a decision on an informed basis," adds **Jay Williams,** principal of Arista Associates, a health care strategy consulting firm based in Northbrook, IL.

"Physicians as a whole must be more analytical about signing up for managed care. So many people automatically think they must get into it

Executive Summary

Subject: How to decide whether to sign up with a MCO
Essential Points:
- Evaluate each plan individually
- Understand all aspects of the contract
- Analyze what effect signing will have on your practice
- Try negotiating better terms
- MCO could lower rates for all patients no matter what coverage they have
- Other providers could cut rates unilaterally

Accepting a lower price could deflate all your fees

Consider all implications before deciding

Even if the managed care contract you are considering affects a relatively small number of patients, it could have a much larger implication for your practice as a whole. Signing a new contract could affect your existing pay rates with almost every insurer in your area. That's why you should consider the overall potential of contracting with one plan at a reduced rate.

"If by signing up with a managed care plan, you immediately convert your existing business into managed care from a more lucrative reimbursement plan, what have you gained?" asks **Jay Williams**, principal of Arista Associates, a health care strategy consulting firm based in Northbrook, IL.

That's why he advises you to read new contract offers carefully to see how they could affect your existing contracts.

For instance, some payers that offer a multitude of products ranging from indemnity to HMOs have a clause in their contract that says the fee schedule is the same for all patients.

This means you will be reimbursed at the HMO rate for all patients covered by that insurer, even if the patients are in a plan that provides indemnity coverage.

"I've seen this clause at least 50 times," Williams says.

And, if you do sign on with one plan at a reduced rate, it may affect the rates you receive from other plans, adds **Marc Benoff**, MBA, director of Dan Grauman Associates, a Bala Cynwyd, PA, management and data consulting firm specializing in the health care industry.

"In theory, the plans don't know the reimbursement rates that other plans are paying, but in reality, in many markets, everybody knows everything. When contracts are in the same market, if Plan A has a fee schedule that is above Plan B's, Plan A is likely to cut their rates," he adds.

Many contracts have a clause that allows the insurer to unilaterally cut rates. This could have a dire effect on your bottom line, particularly if the plan from which you initially receive a lower rate brings in marginal business. ■

to stay in business, but that reasoning is absolutely incorrect. They need to know what it means," he adds.

Benoff says he knows doctors who regularly turn down managed care contracts and remain successful. For instance, he tells of one physician who won't sign if reimbursement is less than a certain amount, based on Medicare reimbursement.

Benoff doesn't recommend such hard-and-fast rules to his clients, but he does urge them to think twice before signing contracts — and to seek expertise among their own staff or through outside consultants before making a decision.

Williams adds, "Physicians need to have someone on their staff who makes sure they've got the wheels on their car before they start to drive. This must be someone who understands managed care — not just contract management, but negotiating." He advises examining what has happened to your practice in the past when you contracted with managed care and looking at what might have happened if you hadn't signed up.

"Physicians could be hurt in the long run if they don't consider the contracts in the overall context of their practice and the health care environment," Benoff says.

Williams tells of one practice that did an analysis of what had happened since it began participating in a major HMO two years earlier. The analysis showed that if they had said "no" to the plan, their patient load would have been down a little, but their revenue still would have increased because most of the growth in the practice had come from outside the managed care plan.

"They had no idea what effect their decision had had until they did the analysis. As a result, they decided not to participate in another managed care plan," Williams says.

However, there are two scenarios when it's almost always advisable for physicians to participate in a managed care plan, Williams says. They are:

- if a company is likely to dominate your marketplace, particularly in your specialty;
- if you are losing patients rapidly because they are going with a competitor who signed up with the plan.

What to ask about new contracts

Here are five questions you should ask before you sign on with an HMO:

1. Who are your patients, and are they likely to be part of the HMO? For instance, if half of your patients come from one big employer that is about to sign up with an HMO, it probably would be advisable for you to participate.

2. How many patients are you likely to gain from the plan? Remember that if you accept a lower reimbursement rate, you've got to be able to make up for it in volume. Consider how many patients the plan already has and how likely the plan is to succeed in your market. Calculate whether the new patients you are likely to get from the plan will make up for the reduction in rates.

3. What is the plan's marketing strategy? Many MCOs come into an area and get their members by signing up physicians and taking over their patients. If the plan isn't doing any additional marketing to sign up new members, you aren't likely to get any new patients by signing with them, points out **Jay Williams**, principal of Arista Associates, a health care strategy consulting firm based in Northbrook, IL.

4. What will you have to do from a business standpoint to participate in the plan? Your staff's time should be a big consideration, particularly if you are already dealing with 12 to 15 plans. Even if you get only a few patients or no patients at all from a managed care plan, your employees still have to learn all the plan's policies and procedures. Consider how this will affect your staff and the number of employees you'll have to hire to handle it.

"You'll need people to deal with follow-up, with referrals from the HMO, and to make sure you get paid. Focus on whether it's worth it from that angle," says **Marc Benoff**, MBA, director of Dan Grauman Associates, a Bala Cynwyd, PA, management and data consulting firm.

5. What does the plan require for you to get paid? If you have to call to verify that the member is covered and call again to get preapproval for treatment, participating in that plan could put a burden on your staff time.

Williams tells of a five-physician practice that contracted with 17 managed care plans, all of which require verification by phone for new patients and precertification for anything other than routine care. The practice had to hire three people to do nothing but certification, verification, billing, and reconciliation for those plans. The additional employees increased the office overhead by 35%.

Benoff notes that while some physician practices handle their managed care contracts with 1.5 to two full-time-equivalent staff members, most practices need more staff than that. ■

Many physicians fear that if they don't sign up with managed care plans immediately, they will be shut out of the network and won't have a chance to participate later, Williams says. Deciding whether to participate on that basis is a difficult decision that requires research, he adds.

"The real decision comes when a new player comes to town, threatens to play hardball, and says they are going to enroll half a million members and if you're not in the network, you'll never be in there," Williams says. This is when you need to look into what will happen if you don't get in the network a few years down the road, Benoff points out. If they don't let you into the network in a few years and the plan really does attract a lot of members, you could be worse off.

But, if you hold out now and you can get in the network in a few years, you won't be any worse off, he adds.

"It's not like the first physicians in the plan are going to have higher reimbursement rates in perpetuity. That's not what we've seen. HMOs have managed to drive rates down, but it's been across the board," Benoff says. Williams and Benoff recommend that instead of accepting the first contract the managed care company offers, you should negotiate. Whether you'll be successful may depend on your market.

"In certain markets, physicians have to contract with everyone and take what they can get. In others, they can fight to get better rates or turn down managed care contracts," Benoff says.

Generally speaking, if you are in a market with high managed care penetration and domination by only a few plans, you may not be very successful in your negotiations. But in markets where managed care penetration is still low or fragmented with no plans dominating the market,

physicians have been more successful in negotiating with managed care plans, Benoff reports.

"If there is a plan coming to town and they need to build a network, if a physician group has an important piece of that network, it gives them some leverage in negotiating their contracts," he adds.

It's possible to renegotiate your contract with a managed care plan, but it's not likely that payers will agree to negotiate in your favor unless your practice is critical to their business, Williams says.

However, he adds, if you decide to drop out of the plan, the managed care company may propose renegotiating.

While there's no doubt that managed care coming to the area can have a dramatic effect on your practice, physicians also can affect what happens to managed care companies, the experts say. For instance, if you have a large physician group with a strong role, you can make it difficult for the managed care plan to penetrate your market, Benoff points out.

"Sometimes companies move into a market and sign up half a million members, and sometimes it's much fewer. If you sign up, you are contributing to the provider's marketing strategy," Williams adds. ■

Technology increases efficiency, cuts staffing

Staff have more time for patients

Every time **Ruth Lander**, FACMPE, feels overwhelmed by her work as practice administrator at Columbus (OH) Oncology Associates, she tries to figure out how she can automate some of her daily tasks.

As a result, the practice operates so efficiently that its level of full-time-equivalent (FTE) employees per physician is far below the national average for oncologists in group practice with active chemotherapy departments. The national average for oncology group practices is 7.1 FTEs per physician, according to a recent benchmarking session for the Administrators in Oncology-Hematology Assembly, a special assembly of the Englewood, CO-based Medical Group Management Association. Lander's practice, however, has 5.14 FTEs per physician based on the practice's 1998 numbers.

Executive Summary

Provider: Columbus (OH) Oncology Associates
Subject: Using technology to create efficiency
Essential Points:
- Voice mail system eliminates need for additional receptionist
- Patient notification system cuts down on waiting time
- Automated lab results save physicians time
- Hand-held computer keeps needed data at hand

Columbus Oncology Associates makes use of the latest technology for everything from managing staff time within the practice to marketing the practice on the Internet. One new endeavor is sending letters to referring physicians via fax modem using voice recognition transcription software. **(For more on the technology the practice uses, see related article, p. 85.)**

"The goal of technology is not to eliminate patient-staff contact, but to enhance staff efficiency so they'll have time for the patients," Lander says.

For instance, instead of hiring an additional PBX to deal with the large volume of calls at peak times, the practice implemented a partial voice mail system for billing, scheduling, and administrative calls. The system gives callers a choice of using an automated menu and voice mail or speaking to a live person.

No nursing calls

Because Lander's practice provides oncology care, she feels it would be risky for patient care calls to go into voice mail.

"We don't let nursing calls go into voice mail. Those patients talk to the receptionist and nursing," she explains.

When new patients are being interviewed, staff tell them they can call a different number that will allow them to bypass the receptionist and go directly to voice mail for the department they are calling. Many patients choose to use this feature.

"We haven't made it a complete voice mail system. Other physicians and older patients don't like voice mail," Lander says.

Lander finds the technology useful for taking care of many business matters. "I'm often away from my desk, and so are many of the people I call. We often take care of things by using voice mail, fax, or e-mail," she says.

In the past, the receptionist often had problems contacting nurses to let them know patients had arrived. The nurses often were on patient phone calls, in the midst of other patient treatments, mixing, or talking to one of the physicians. The arriving patient either had to wait, or the receptionist had to leave her desk and let nursing know the patient had arrived.

Now, instead of using the telephone to notify nursing that a patient has arrived, the receptionist just types the patient's name into the computer and it pops up on a computer screen in the nurses' station. This keeps the phone lines free for the nurses to get patient phone calls and cuts down on the time the patient has to wait.

The practice uses an off-the-shelf software product and a personal computer for the notification system.

Automatic results

Before the practice installed an automatic lab result system, physicians often had to walk to the lab to get results before they saw a patient. With the new system, physicians and nurses can retrieve the lab results automatically via computer near a patient exam room or a chemotherapy treatment room. This has saved nurses many trips to the lab for results to check complete blood counts before starting a chemotherapy treatment.

"There's no wasted time. Nobody has to take the results back to them," Lander says.

Before the practice contemplates any major purchase, a cost-benefit analysis is performed. In fact, the practice was highlighted in the Medical Group Management Association's 1998 report, "Performance and Practices of Successful Medical Groups," for its superior performance, particularly in "productivity, capacity, and staffing."

Lander started learning about technology when she took her job with the practice in 1987. "I've seen the whole computer revolution in the workplace," she says. She claims no special computer expertise, just "a thirst for learning, efficiency, and organization.

"I believe in doing things the best way possible if it's in my control," she adds.

To keep abreast of the latest technology she might use in managing the practice, Lander attends trade shows and seminars, networks with fellow oncology administrators, and reads numerous periodicals. But she's careful that her forays into new technology don't take up all her time.

To keep from being inundated by phone calls from technology firms, she picks up literature instead of leaving her card or signing up for drawings for prizes at the trade shows.

"And, if the articles in the periodicals aren't helpful to me, I still will look at the ads to see new product offerings," she adds.

She conducts periodic operations audits to find ways to make improvements in the way the practice works. "I feel confident we can figure it out without hiring a consultant," she says.

She encourages employees to make suggestions on how to operate more efficiently and has a suggestion box for those who don't feel comfortable talking to management about changes.

"The way we have fixed a lot of things is by walking the halls and keeping our eyes open. If we see a problem more than once, we look at how it can be fixed," she says.

To manage her own job, Lander has "everything I could possibly forget" in her hand-held mini-computer. All the addresses and phone numbers she needs are stored in the mini-computer and can be exported to print out labels for mailings.

"Now I don't have to carry around a 50-pound day-timer, and I don't have to worry about losing it," she says.

Once she did drop her hand-held device on the pavement and broke it, but within a couple of days, she had downloaded everything from the main computer at the practice and was back in business. ■

How one practice puts technology to work

Systems save staff time, money

Columbus (OH) Oncology Associates, a seven-physician practice, relies on technology to give its staff more time to spend with patients and to make the practice more efficient, says **Ruth Lander**, FACMPE, practice administrator.

Here is a look at some of the ways the practice puts technology to work:

- **Internal pager system.** When a telephone call comes in to a physician or key staff member, the PBX operator pages that person with an alphanumeric message and a two-digit code. The

code identifies where the call is "parked." The recipient can dial the code from any telephone in the building and get the phone call.

Before the system was implemented, the operator called around to various locations trying to find someone. This created disruptions and noise similar to an overhead announcement system.

"The system disrupted everyone, physicians, patients, and staff. The new system is wonderful. I don't have to go back to my office to get a call. It saves time and it cuts down on the noise," Lander says.

• **Room lighting system.** The practice has been using a system that identifies which examining room each physician is to go into next. Each of the seven physicians in the practice is assigned a color, and each of the 11 examining rooms has a light bar with all seven colors on it.

When a doctor enters a room, he presses a button that indicates on a master panel where he is. When he leaves, he presses a button again, turning off his light. The room where he is to go next then lights up. A similar lighting system in the physicians' offices notifies them when patients are ready.

There are panels in key areas that also track where the physicians are.

"If a nurse needs to catch a physician, she can find him and not waste any time," Lander says.

Lander is looking into updating the system so it will track how long physicians are in each room, how long patients wait for a physician once they're in an exam room, utilization of each examination room, and lulls in the schedule. There are several such systems on the market, Lander says.

• **Voice recognition transcription.** The practice helped a company develop a voice recognition transcription system for oncology. The physicians speak into what looks like a normal hand-held transcription machine. Instead of a tape, it contains a small disk that captures a digital voice recording of the physician's speech. That digital recording is later downloaded into a PC with a voice recognition program, which transcribes the recording into words. The document is edited minimally by the transcription secretary before it is processed. The system includes a fax modem that allows the transcription to be faxed directly to a referring physician. The practice is in the process of implementing this system now.

In addition to saving time, the practice saves the cost of the letterhead and postage, Lander says.

"I love saving money. It costs a lot to send personal letters to the referring doctors, but we certainly want to keep them informed about their patients," she says.

The practice still prints out its progress notes because Lander hasn't found a satisfactory electronic medical records package yet.

• **Education.** Instead of traveling off site for continuing education, physicians and other practice staff often rely on audiotaped seminars, audio conferences, and Internet medical education services to earn their continuing education credits.

Learn while you drive

Lander often sets up audio conferences with the Medical Group Management Association in Englewood, CO, for several staff members at a time. Some physicians listen to audiotapes in their car going to and from work.

Not only does the technology save travel costs, it helps the practice work more efficiently, Lander says.

"Physicians can complete many of their CMEs this way. When the physicians are away from the office, they aren't making any money. What they really need to do when they are away from the office is take a vacation and not spend that time at educational programs," she adds.

• **Periodicals and books on CD-ROM.** Lander likes these because they take up less space than books and magazines and because they have search capabilities that save the staff time.

• **On-line payables.** Lander pays as many of the practice bills as possible on-line.

"The actual cost is about the same as a postage stamp, but it has saved my time. When I am on vacation, I don't have to worry. The payments go out on the day they are supposed to," she says.

Drug companies still send hard copy, but Lander is working with many of her major suppliers to set up on-line invoices.

• **Automated ordering.** Many items the practice uses, including all its equipment and supplies and much of its drug supply, are ordered electronically. "There's no way I'd ever put anything in the mail," Lander says.

• **Marketing.** The practice maintains an Internet Web page that markets the practice and provides information to patients, including a program that writes out directions from the patient's

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home. There also are multiple links to major cancer sites.

The Web page includes information on the practice, including physician biographies and photos, clinical trial information, and new forms that patients can print and fill out rather than having to wait for a packet in the mail. ■

Internet helps track chronic disease status

Physicians alerted when there are problems

Congestive heart failure patients in California are using the Internet to track and monitor their conditions, making daily contact with a disease management program that alerts their physicians when anything is amiss.

"The program has been very well-accepted by our senior population," says **Les Cordes**, MD, medical director of Physicians Medical Group of Santa Cruz, CA, an organization of 225 physicians participating in a full-risk insurance product for 5,500 senior citizens. "Not only do they find the computer easy to use, but they like the entire medical management process,"

Physicians Medical Group is part of a pilot project being conducted by LifeMasters Supported SelfCare, a Newport Beach, CA-based disease management company that has developed an Internet component combining high technology with traditional disease management programs.

"Because of the structure of our organization, we are concerned about chronic disease management and are looking at ways to manage these patients more efficiently with a better cost model and with high-quality service," Cordes says.

The Internet provides a low-cost way to create customized disease management programs, says **Chris Selecky**, president and chief executive officer of LifeMasters.

The company has been marketing its interactive voice response disease management program for two years to manage a range of diseases including congestive heart failure, asthma, chronic obstructive pulmonary disease, diabetes, hyperlipidemia, hypertension, and coronary heart disease.

The Internet pilot project is being funded in part by an investment from Intel Corp., which has given personal computers to the patients in the pilot project.

The project began about six months ago using 50 congestive heart failure patients who are being treated by Physicians Medical Group. It will soon be expanded to include 50 diabetic patients being treated by another group, according to Selecky.

The program aims to compare compliance among patients using the Internet program with compliance among patients who are using LifeMasters' integrated voice response disease management program, and with those in a control group who receive calls from staff nurses.

Although it's too soon to see any definitive results, the Physicians Medical Group has found that 85% to 90% of the patients enrolled in the Internet program are supplying the requested information every day.

Here's how the Internet program works: All patients whose diseases are managed by LifeMasters are assigned a nurse who acts as a "personal trainer" in disease management, helping the patients make lifestyle changes, Selecky says.

Every day, patients log onto a LifeMasters Web site and go to their own personalized home page, which contains a customized list of questions based on accepted disease management guidelines and input from the patient's physician. The program starts off with standard questions and adds whatever additional areas the physician wants to monitor.

For instance, guidelines from the Agency for Health Care Policy and Research say a five-pound weight gain in a week may indicate problems for a patient with congestive heart failure. However, a physician may want a call if a particular patient's weight fluctuates by just two pounds.

Executive Summary

Subject: On-line disease management pilot project
Essential Points:
- Congestive heart failure patients report symptoms on Internet
- Program includes customized education in disease management
- Physician is alerted when database shows abnormal signs

The patients enter the data into the LifeMasters database. If the data show any problems, the LifeMasters nurse assigned to that patient will be alerted. The nurses are alerted in two ways: by a message on the computer screen and by pager in case they are away from their computers.

"Generally, it's not an emergency problem. It's something that requires the nurse to get back to them within the day," Selecky says.

The nurse calls the patient to determine whether the doctor needs to be notified. This happens in about 10% of the cases, she adds.

LifeMasters faxes or e-mails the physicians a report that includes a list of all the drugs the patient is taking, two weeks' worth of vital sign information, and a note from the nurse about what she had found.

"In the other 90% of the cases, the alert gives the nurse the opportunity to coach the patients and reinforce the information they need to manage their disease," she adds.

For instance, the cause of elevated blood pressure may be that the patient missed his or her medication or ate a high-salt meal the previous day.

Regular phone calls

Some patients are so forgetful that the company gives them pagers to alert them when it's time to take their medication. The nurses also make regularly scheduled telephone calls to check on the patients.

"It's a combination of tech and touch," Selecky adds.

Patients also use the Web page for weekly disease management lessons, to review past lessons, and test their proficiency on disease management techniques. In addition, the Web page contains a list of frequently asked questions about the disease and links to other medical sites. If patients don't find answers to their questions, they can send their questions to the nurse by e-mail.

The Internet makes it possible to custom-tailor a disease management program to each individual patient, Selecky points out. For instance, one diabetes patient may have a weight problem, while another may have normal weight but needs help in cutting down on sugar in his diet.

The program for the first patient can include weight loss education and questions about weight, while the second patient's program would have information about sugar content of foods and recipes without sugar. ■

Broaden skill levels with cross-trained staff

Absences no longer interrupt cash flow

When a key staff member's two-week absence resulted in a massive decline in the amount of Medicare payments posted, causing a big decline in practice cash flow, **Bill Willis**, practice administrator at Medical and Surgical Associates of South Boston, VA, decided to take action.

He embarked on an aggressive program of cross-training business office personnel to make sure more than one staff member was up to speed on posting payments.

"When the key employee was absent, only about 20% of the Medicare checks were posted. That made a big difference in our cash flow that month and pointed out the need to do more cross-training," Willis says.

Now, the nine business office employees who are involved in billing and collection for the multispecialty group have been cross-trained. **(For details on how cross-training works, see related story, p. 93.)**

"In the past, if somebody was out sick, that job didn't get done until they got back. This caused some unacceptable swings in our cash flow. It was feast one month and famine the next," Willis says. The cross-training has helped in getting payment posted and making cash flow more predictable.

Improved cash flow

"Cash flow is the life blood of any practice," Willis points out. The practice has now trained a number of people who can function in each of the vital areas involved in running the business aspect of the practice, Willis says.

Executive Summary

Provider: Medical and Surgical Associates of South Boston, VA
Subject: Cross-training of business staff
Essential Points:
- All staff are cross-trained in billing and collection
- Jobs are covered during sickness, vacation
- Practice cash flow has improved

Cross-training done without additional cost

Employees train each other, share the tasks

Cross-training the nine business office employees at Medical and Surgical Associates of South Boston, VA, did not necessitate any additional staff or additional expenses, reports **Bill Willis**, practice administrator. The training was done in-house with personnel already on staff.

Here's how the cross-training program works:

Willis chooses the employee to be cross-trained for a particular job based on the employee's abilities and interests. "It's kind of a trial-and-error process. I observe employees and what they seem to be best in doing and utilize their talents in similar areas," he says.

For instance, someone who works well with people would be trained for the receptionist job. "Or if they are particularly good with numbers and catch on very quickly to CPT terminology, we'll cross-train them to post hospital or outpatient charges. Different people seem to have a better aptitude for doing certain things, but all our employees are trained to do multiple tasks."

The person who is already doing the job teaches the other employees to do the job.

After the cross-trainee is proficient, the two employees share the responsibility for the job, usually working it out so one does the job one week and they swap the next.

"Everybody will probably agree that the single largest cost is personnel. I try to walk that fine line of keeping personnel costs as low as possible by having the fewest number of people we can function with," Willis says.

The practice has a good track record of retaining employees, particularly in the business office. Many of the business office employees have been with Medical and Surgical Associates 35 years or more.

The practice's current employees have been enthusiastic about the cross-training process, but it hasn't been popular with everyone. One new employee quit after just one day, telling Willis that at her last job in a physician's office, she had to do only one thing. ■

For instance, four employees have been trained to work at the reception area; two are proficient in posting Medicare and Medicaid payments and are cross-trained to post inpatient and office charges; two also are cross-trained to post third-party insurance payments as well as patient personal payments.

"Rather than having one person who does only one job and nothing else, I have cross-trained my employees so if someone goes on vacation or gets sick, their job doesn't come to a grinding halt," he says.

Not everybody at Medical and Surgical Associates is cross-trained in every area. For example, only three employees out of nine in the business office have been trained to post hospital charges. If the person who usually posts the hospital charges is absent, Willis splits the job between the other two employees who know how to do it.

"If they normally would be posting payments, I ship the payments to someone who otherwise has been doing some kind of bookkeeping function. Any time somebody is out, we lose a certain amount of efficiency. What this does prevent is several days when a particular job isn't done by anybody," he adds.

Willis began his initial cross-training project when the practice moved to a new, larger facility where staff were more spread out.

"When everybody was in one room, it was easier to cover the job if someone was out. Once we got spread out, it became necessary to have people who could do multiple things, particularly when there was an absence," he says.

Large Medicare population

The practice is in a rural area with a large Medicare population, meaning Medicare is a significant portion of its total revenue. "For that to sit on somebody's desk for a couple of weeks and not be posted caused a real cash crunch," Willis says.

There's little managed care, primarily because the area's population is too small to support an HMO, and there are too many older people to make it profitable, Willis says. However, the practice participates in preferred provider plans that pay a 10% to 15% discount on normal services. ■

Measurement reporting may be coordinated

Aim is to increase efficiency, coherence

A task force of representatives from the country's three leading health care quality oversight organizations is working to coordinate efforts to promote greater accountability in health care.

The American Medical Accreditation Program in Chicago, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, and the National Committee for Quality Assurance in Washington, DC, have established the Performance Measurement Coordinating Council (PMCC) and have appointed **Carolyn Cocotas** as staff director to manage the efforts.

The organizations have pledged to work together to find efficient ways to meet increasing demands created by often divergent measurement reporting systems, Cocotas says.

The PMCC is made up of five representatives from each of the three organizations. The three organizations have committed to work through the PMCC to address a range of performance measurement issues.

Each of the organizations currently defines performance measurement at its own respective level of the health care system, and each supports its own performance measurement efforts.

The three large accrediting organizations have committed to work together to coordinate — and, if possible, integrate — appropriate performance measurement development activities, Cocotas says. "At the provider level, this could have the effect of making providers' lives easier by streamlining and minimizing the differences in the multiple requests for information they get from different parties," Cocotas adds.

The purpose of the PMCC is to coordinate activities so a set of performance measures will relate to each other, whether they apply to a physician, a hospital, or a managed care organization, Cocotas says.

Although a hospital may not be concerned with exactly the same measures or use them the same way as a physician or a managed care organization, the measures would be devised to permit useful comparisons and / or quality improvement measures across all entities, she adds.

"We think this can make a major contribution to the long-term efficiency of performance measurement in the health care sector. There is a lot of money being spent on performance measurement activities that are similar but have a lot of differences. If we coordinate these activities, we could reduce the amount of money spent on administrative activities and increase the amount spent on improving health," Cocotas adds.

The panel has recently released "Principles for Performance Measurement in Health Care," a consensus statement from the three organizations.

The next step is to develop a consensus on the attributes of measures and priorities for measurement, with other important work to follow, Cocotas says. ■

Physicians oppose required use of hospitalists

24 groups join to protest new staffing plan

A coalition of physician groups is calling for an end to the mandatory hospitalist programs required by some managed care companies.

The managed care plans are denying patients the right to have their personal physician care for them in the hospital by establishing mandatory hospitalist programs, says a letter sent to managed care organizations by the American College of Physicians-American Society of Internal

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Medicine in Washington, DC, and 23 other physician groups.

Mandatory hospitalist programs require that a patient's regular physician transfer complete responsibility for patient care to a hospital-based physician. The policy prevents primary care physicians from either admitting patients or caring for them after they are admitted.

Managed care companies in Florida, Maryland, Missouri, and Texas have established mandatory hospitalist programs. "Mandatory hospitalist programs are bad public policy, just as they are bad for individual patients," says the protest letter sent to the American Association of Health Plans, the Blue Cross, Blue Shield Association, CIGNA HealthCare, and Prudential Health Care.

"Patients must have the opportunity to discuss the potential advantages and disadvantages of the hospitalist programs with their physicians and be free to choose," the letter says.

The groups don't oppose hospitalists as long as their use is voluntary, says **Harold Sox**, MD, professor of medicine at Dartmouth School of Medicine in Hanover, NH.

In addition to ACP-ASIM, the letter was signed by medical associations, academies, and societies. ■

Study disputes claims about drug treatment costs

Adding an unlimited substance abuse care benefit to managed care plans would raise the cost by only $5.11 per member per year, a study has concluded.[1]

Putting a $10,000 limit on the annual substance abuse care benefits would reduce the cost by only 6 cents, down to $5.05 per member per year, concluded researchers at the RAND Corporation in Santa Monica, CA.

The study disputes insurance industry estimates that insurance payments would go up by as much as 9% if unlimited substance abuse payments were included. Concerns about cost have prompted state and federal legislators to exclude substance abuse treatment from laws mandating equal benefits for mental health and medical care.

"These concerns were based on actuarial simulations using treatment patterns from 10 or 20 years ago, not actual claims and services from a managed care company. In contrast, our study compared data from 25 managed care plans with unlimited substance abuse benefits for 1996 and 1997," says **Roland Strum**, PhD, the senior economist at RAND who led the study.

The study covered 25 plans managed by United Behavioral Health. The plans included comprehensive benefits, covering outpatient care, day treatment, residential, inpatient care, outpatient care, and recovery homes, and had no limits on substance abuse benefits. Copayments ranged from $0 to $10 per outpatient session.

The researchers compared the data with 200 employee-sponsored plans with annual dollar limits for substance abuse. The Substance Abuse Policy Research Program of the Robert Wood Johnson Foundation funded the study.

Reference

1. Strum R. Weiying Z, Schoenbaum M. How expensive are unlimited substance abuse benefits under managed care?" *Journal of Behavioral Health Services and Research* 1999; 26:205-210. ■

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Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Executive Editor: **Glen Harris**, (404) 262-5461, (glen.harris@medec.com).
Senior Production Editor: **Brent Winter**, (404) 262-5401.
Editor of **Physician's Capitation Trends: Reba Griffith**, MPH.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

NEWS BRIEFS

AMA to develop medium-length descriptors

The Chicago-based American Medical Association (AMA) is adding new medium-length clinical descriptors to its Year 2000 version of the Current Procedural Terminology (CPT) manual.

The new descriptors will be made available as part of the fall 1999 release of CPT 2000. The new medium-length descriptors take advantage of increased computer capacity to provide more informative clinical detail in condensed descriptors, according to an AMA spokesman.

Because the length of some of the CPT descriptors may exceed the capacity of some data and reporting systems, the AMA has maintained a set of 28-character short descriptors. These have not always been able to convey the desired level of clinical information.

To prevent disruption for existing users, the AMA will retain the current short descriptors as an option.

Intelligent Medical Objects, a software development and management consulting firm in Northbrook, IL, will provide consulting services to the project. ▼

Physician use of the Internet grows by 42%

Regular use of the Internet by doctors has increased by 42% in the past three months and 875% since 1997, according to the results of a survey conducted by Healtheon Corp.

More than 63% of the physicians surveyed say they use e-mail daily, and 33% have used e-mail to communicate with patients, according to the study results.

The study showed that doctor-patient communication via e-mail has jumped 200% in the past year and nearly 20% in the past three months. A similar survey in 1997 showed virtually no electronic communication between doctors and patients.

Healtheon, based in Santa Clara, CA, provides Internet commerce services that link providers and consumers to health care institutions. ■

SourceKit

Following are names and contact information for sources quoted in this issue:

Marc Benoff, director, Dan Grauman Associates, Bala Cynwyd, PA. Telephone: (610) 667-8782. Fax: (610) 667-8633. Web Page: www.dga-hds.com.

Jay Williams, principal, Arista Associates, Northbrook, IL. Telephone: (847) 564-9880. Fax: (847) 564-9899.

LifeMasters Supported SelfCare, Newport Beach, CA. Telephone: (949) 721-0330. Fax: (949) 721-0352. Web page: www.lifemasters.net.

Ruth Lander, practice administrator, Columbus (OH) Oncology Associates. Telephone: (614) 442-3130. Fax: (614) 442-3145. Web page: www.coainc.net.

Bill Willis, administrator, Medical and Surgical Associates of South Boston (VA). Telephone: (804) 572-2961. ■