AMERICAN HEALTH CONSULTANTS®

PHYSICIAN'S PAYMENT UPDATE™

INSIDE

JULY 1999

VOL. 11, NO. 7 (pages 97-112)

American Health Consultants® is A Medical Economics Company

Knock knock: Who's there? Fraud cops; what to do when the joke turns sour

Take these steps if investigators show up at your door

(Editor's note: This is the first of two articles presenting step-by-step guidance for responding to on-site search warrants, record requests, and subpoenas from federal and state investigators.)

You are working at your desk when the front office receptionist buzzes on the intercom and says a special agent from the U.S. Postal Service, along with a dozen rather stern-looking men and women, have just come in the front door and started searching your medical files and interrogating employees.

Within minutes, the investigators have cut off access to your outside telephone lines and are herding employees into the conference room for questioning. Other agents are loading records, including patient charts, into boxes and taking them away. A third team is trying to obtain access to your computers.

As far as you know, none of the physicians or other staff members in your office has done anything wrong — certainly nothing to warrant being the subject of a federal health care fraud investigation.

What do you do?

"Health care facilities are playing out this nightmarish scene across the nation," says **Philip L. Pomerance**, a health care lawyer with the Chicago firm of Hinshaw & Culbertson.

All kinds of providers, most of whom never before thought themselves subject to criminal scrutiny, are facing teams of federal and state investigators bearing search warrants, subpoenas, or medical records requests.

"Prosecutors believe that high-profile criminal and civil investigations are cost-effective and have a strong deterrent effect," Pomerance notes. The execution of search warrants — and, to a lesser extent, the delivery of administrative subpoenas with a demand for immediate compliance — allow the government the opportunity to seize critical evidence.

"But equally important, these tactics engender an atmosphere of fear and concern in a targeted provider that prosecutors believe enhances

their ability to successfully bring charges. These shock tactics are a critical step in many potential criminal or civil enforcement actions," he notes.

The playing field is rarely level when a team of investigators comes to execute a search warrant. The agents have the benefit of weeks of planning. In contrast, the target of the search is usually caught off-guard.

Again, what do you do? Below are a series of tips and tactics Pomerance suggests you consider if you ever find yourself in the position of having federal agents show up at your front door demanding to search your practice's premises.

• **Identify what is happening and who is doing it.**

"Your first reaction should be to call your lawyer," says Pomerance. "Next, identify who is conducting the search and on what authority."

Determine which agencies are participating in the search. Because a search team usually consists of agents from various agencies, there could be investigators from the FBI, the Office of the Inspector General, the Railroad Retirement Board, and the U.S. Postal Service, along with agents from the state police and Medicaid office.

"Finding out which agencies are conducting the search is relatively easy. Agents carry business cards, and will give you one if you ask," says Pomerance.

• **Identify the agent in charge of the search.**

The agent in charge will likely have the original search warrant, and should be the focal point of any discussions you have or complaints you make during a search.

If you object to anything during the search, make your case to the agent in charge and not to the agent whose actions you find objectionable. Remember, individual agents take instructions only from the agent in charge.

The agent in charge also is responsible for securing the premises, beginning the search, clearing the search, and delivering an inventory of all items taken during the search.

• **Ask for a delay.**

Next, ask the agent in charge to seal the premises and delay the search until your lawyer arrives. If the agent says no, "carefully monitor the search, but do not attempt in any way to impede or obstruct it," says Pomerance. "You do not want to draw a charge of obstruction of justice."

Ask the agent in charge not to speak to your employees until the lawyer arrives. While it's good to make this request, the agent in charge probably will not agree to it.

If the agent in charge starts to proceed with employee interviews, you have the right to tell workers that it is their choice whether they speak to the agents, and that they are under no obligation to answer any questions. **(For more on how to help your employees through this situation, see story, p. 99.)**

• **Identify the type of search document presented.**

The strongest authority an investigator can present is a search warrant, issued by a magistrate or judge. The warrant allows investigators access to specific physical premises (which must be identified in the warrant) to seek evidence of specified suspected violations of the law.

An agency subpoena or a records request, on the other hand, only requires that you produce information, but does not allow the officers presenting the document to search your office or home for that information.

"If no search warrant is presented, carefully question the investigators about what they want and when they want it. If your legal counsel is not at the search site, ask for a delay while you consult with your lawyer on the telephone," recommends Pomerance.

"I know of several searches which, in fact, were really just the delivery of a state agency subpoena for medical records. Nonetheless, the agents still demanded immediate compliance and began to search the client's office and interrogate their employees," says Pomerance.

Questioning authority pays off

"In one such instance, if the provider's lawyer had not thought to question the agents' authority, they would have closed the client's clinic for at least four hours during a busy day while they searched its records." Instead, the agents agreed to let the clinic deliver copies of the records they were looking for within three days of the delivery of the subpoena.

Rarely are state regulatory agencies empowered to issue subpoenas that demand immediate production of records. Therefore, it is important to determine if the document presented by the investigators entitles them to simply search for specific material or to take immediate possession of that material. Remember also that the statute authorizing an agency's subpoena power often gives the target of the subpoena a "reasonable amount of time" to produce requested records.

How to deal with staff if the feds come probing

Search warrant does not compel interviews

If federal or state agents show up at your office with a search warrant or request for records as part of a fraud and abuse investigation, remember that the warrant does not allow them to interrogate office employees.

"This does not mean that the agents will refrain from trying to interrogate the people on the premises," says **Philip L. Pomerance**, a health care lawyer with the Chicago firm of Hinshaw & Culbertson. "The agents executing the warrant will use the fear, shock, and confusion engendered by the search to talk with as many people at the site as possible."

In turn, he recommends asking the agent in charge to instruct his or her people not to talk to your employees. If the agents continue in attempts to interrogate the staff, continue stating your objection.

If you have not already done so, advise employees that they may, if they choose, refuse to answer all questions directed to them. Do not direct the employees not to answer; the investigators may construe that as obstructing justice or even witness tampering.

Explain to the employees that they have a choice whether they will answer any questions, both during the search and subsequently. Object strenuously if an agent intimidates anyone. If employees agree to be interviewed, you should insist that your lawyer be present during the interview. Record the interview, if possible.

Quietly — and as quickly as possible — send all nonessential employees home. Advise the agent in charge that you are sending the employees home for the day.

"In rare instances, you may want to stay open the rest of the day, but it is generally better to close during a search," says Pomerance.

Keeping some employees on the site may be valuable to help agents obtain computer information and other documents that are the subject of the search without risking damage to your property.

"Make it clear to the agent in charge that you are not consenting to the search, but that the employees are here to ease the disruption and damage to your business caused by the search," says Pomerance. "Then send all remaining employees home."

The agent in charge has no authority to detain the employees. The agent in charge may ask for a list of the employees' names, addresses and phone numbers. You are not required to produce this information, but the investigators will undoubtedly discover it during the search, so providing this information does little damage and may reduce employee contact with the agents.

Remember that because most employees will be confused or even afraid, you should reassure them that business will continue as usual. Also, talk with your lawyer about how to best educate employees about the allegations being brought.

"Clients often are very resistant to educating their staff about the nature of the investigation. However, I believe that it is far better for an employee to learn about the search from a supervisor or co-worker than to receive information by watching the 10 p.m. news," says Pomerance.

You may also get questions from employees about their need to hire a lawyer. "You must talk with your attorney about the right of employees to individual counsel — and whether the practice should pay for it— as soon as practical," says Pomerance.

"Remember that the investigators may contact key employees right after the search while the shock is still fresh. In turn, you may want to advise employees of their ability to retain counsel before an agent knocks on their door. Finally, make certain that no employee attempts to remove company property from the search scene, or to destroy or hide any property or materials." ■

Search warrants are a different matter. Whether issued federally or locally, "a search warrant allows the designated officer to search a specifically identified location and seize property that may constitute evidence of the commission of the alleged crimes described in the warrant," says Pomerance. "Except in the rarest cases, the search will continue under a warrant."

Ask the agent in charge for a copy of the search warrant and fax it to your attorney.

"You should then tell the agent in charge that you have asked your attorney to be present during the search, and that he or she is on the way," says Pomerance.

• Identify the supervising prosecutor and magistrate.

The agents, including the agent in charge, are not directing the legal aspects of the search. That is the job of the prosecutor who obtained the warrant, and that person will ultimately determine how the agents respond to claims of privilege, impropriety, or harassment during the search.

It is also important to remember that the prosecutor got the warrant from "a judge or magistrate who has the judicial authority [subject to appeal] on these same issues," says Pomerance.

While it is unlikely that either the prosecutor or the magistrate will be at the search scene, the magistrate is usually reachable if your lawyer has a dispute with the prosecutor and feels the issue needs to be argued immediately.

In federal cases, the name and phone number of the supervising prosecutor (most often an assistant United States attorney) is on the warrant. "If you or your counsel does not have that information, ask the agent in charge for the name and phone number of the prosecutor, and when possible during the search, your lawyer and the agent in charge should place a call to the prosecutor," says Pomerance.

Conflicts can arise at 1 a.m.

It is imperative that you obtain the prosecutor's home telephone in order to raise issues of privilege, any claims of illegal or improper search, or any other issue affecting the search.

"I have defended searches that went reasonably well for seven hours, and then had a major issue of attorney-client privilege surface at 1 a.m.," says Pomerance. "The agent in charge will not deviate from the search because of your legal objections or claims. Just as the other agents defer to the agent in charge, the agent in charge will defer to the prosecutor. Therefore, an open channel to the prosecutor — and, if necessary, to the magistrate — is critical."

(Editor's note: Part two of this series will appear in the August issue of Physician's Payment Update. *It will cover records and computers, what is subject to seizure, Fifth Amendment protections against self-incrimination, the physician-patient privilege, attorney-client privilege, and the self-evaluation privilege.)* ■

AMA responds to HCFA's 'senior cop' effort

Letter states the physician case

The American Medical Association has started a counteroffensive against a federal effort that recruits the elderly to watch their doctors for fraud and abuse activities.

Reacting to the Health Care Financing Administration and the American Association of Retired Persons (AARP) joint effort to recruit and educate seniors to spot and report questionable Medicare billing practices by their physicians, the American Medical Association has responded with an "open letter" of its own that is it encouraging doctors to send to patients.

"The letter is intended to show that physicians are concerned about 'true' fraud, while educating patients about the effects of burdensome Medicare regulations and overzealous fraud activities," says AMA spokesman **Robert Mills**.

Objecting to a 'simplistic approach'

The letter says that while physicians are concerned about Medicare fraud, doctors are also "concerned about the simplistic approach the federal government is currently taking towards addressing Medicare fraud. In press releases and policies, the federal government frequently lumps honest billing mistakes together with intentional fraud. The result is that the patient-physician relationship is harmed and physicians are buried in paperwork.

"As you know, Medicare is extremely complicated. Today, physicians must comply with more than 100,000 pages of Medicare rules and regulations. As a result of the complexity of the program, billing errors do occur. My first and foremost duty is to provide you with the best medical care.

"AMA physicians are urging the federal government to simplify Medicare regulations and to educate physicians on what we need to do to comply with the requirements. We are hopeful that the federal government will tone down its rhetoric that labels honest physicians as criminals, and instead focus on identifying those individuals who are truly committing intentional fraud and bilking the taxpayers.

"Inadvertent billing errors are bound to occur in a program as complex as Medicare. Like most physicians, I am trying my best to comply with the extremely complicated Medicare program. If you believe you have found an error, please bring it to my attention. I want to be helpful and answer your questions. You should feel confident and comfortable about the medical care that you receive from me. Thank you for listening to my concerns. I am always available to listen to yours." ■

Feds tap private companies for fraud/abuse help

HCFA contracts for outside services

Making good on a long-time goal, last month the Health Care Financing Administration selected 12 companies to compete for so-called Program Safeguard fraud and abuse prevention contracts as part of the agency's new Medicare Integrity Program (MIP).

HCFA expects to award approximately $500 million in Medicare fraud prevention contract assignments over the next five years to the MIP Program Safeguard contracting pool, which includes information technology and accounting firms, as well as current Medicare contractors.

Participating companies will compete this summer for six Medicare fraud and abuse prevention contracts involving:

- development of a national education program for Medicare providers;
- on-site reviews of providers to verify their compliance with HCFA agreements;
- cost-report audits for large health care chains;
- prevention of potential Y2K computer problems;
- on-site reviews of community mental health centers;
- fraud and abuse detection activities in six New England states for Medicare Part A.

This new force of private fraud detectives is expected to use high technology and powerful statistical methods to drastically reduce the $12.6 billion a year in both improper and outright illegal Medicare payments the agency estimates it makes each year. ■

MD pay continues to slip, but MCO income heads up

Premiums on upswing again

The median income for the nation's doctors declined for the fourth consecutive year in 1997, according to a report from the American Medical Association.

The median physician income in 1997 was $164,000, meaning half the physicians surveyed earned more than that and half earned less. The median income the year before was $166,000, the AMA said.

After adjusting for inflation, median net physician income has fallen 1.4% every year since 1993, says the medical association.

According to another AMA survey, physicians are also working less — a median of 48 hours a week in 1998, down from 56 in 1997.

Joel Shalowitz, MD, director of the health services management program at Northwestern University's business school, credits managed care for most of the fall in physician income.

"For example, the allowable reimbursement for cataract surgery went from $1,500 to $1,600 down to $900 over the past decade,'' says Shalowitz.

> "We haven't increased starting salaries in internal medicine for the last four years."
>
> *James Foody, MD, University of Chicago School of Medicine*

Salaries at teaching hospitals are also dropping, points out **James Foody**, MD, of the University of Chicago School of Medicine. "We haven't increased starting salaries in internal medicine for the last four years,'' he says.

The recent rise in managed care premium rates should continue at least through the rest of the year, analysts say. If so, this up-turn should provide more room for providers to negotiate a corresponding bump in their pay schedules.

"I think things are very much turning around,'' says **David Olson**, vice president of investor relations for Woodland Hills, CA-based Foundation

Profits are rising for managed care firms

The financial picture for HMOs apparently is improving. Here's a list of managed care organizations and the profits they have recently reported:

• RightCHOICE Managed Care Inc., St. Louis, reported first quarter net income of $4.7 million, a 385.5% improvement from the first quarter of 1998.

• Oakland, CA-based Kaiser Permanente posted net income of $61 million for the first quarter of 1999, including a one-time non-operating charge of $28 million for a change in accounting principles. This compares with a restated $54 million net loss in 1998's first quarter.

• Santa Ana, CA-based PacifiCare reported $74 million in net income for the first quarter, a 79.2% improvement from the first quarter of 1998.

• Bethesda, MD-based Coventry Health Care reported $8.3 million in net income, a 76.6% increase from the prior-year period.

• Woodland Hills, CA-based Foundation Health reported a 59.9% increase in net income, to $41.9 million.

• Hartford, CT-based Aetna US Healthcare, which includes the managed care, indemnity, and group insurance products and services of Aetna Inc., reported $133.5 million in first-quarter operating income before Year 2000 costs, which was a 32.8% improvement over the prior-year period.

• HMO and indemnity operations of Philadelphia-based CIGNA Corp. reported operating income of $157 million in 1999's first quarter, up 19.8% from the same period last year.

• UnitedHealth Group in Minnetonka, MN, reported $132 million in net income, the same as the prior-year period.

• Los Angeles-based Maxicare Health Plans reported a $7.7 million net loss, including $8.5 million in special charges, vs. a $2.7 million loss for the comparable quarter a year ago. ■

Health Systems. "I think that we are seeing pricing improving significantly. At the same time, that is a reflection of the fact that costs are going up, and I expect costs will continue to go up, largely as a consequence of pharmacy costs."

Many employers appear "more accepting of the underlying cost trends and the factors driving the price increases that they're agreeing to, and that would be chiefly drug costs," says **David Erickson**, director of investor relations for PacifiCare Health Systems in Santa Ana, CA.

Indeed, pay increases granted by the giant California Public Employees' Retirement System (CalPERS) to its managed care providers last May served to set the tone for other employer groups, note industry insiders.

CalPERS is the nation's second-largest public purchaser of employee health benefits behind the federal government. It buys health coverage for more than 1 million California public employees, retirees, and their families, paying some $1.7 billion in annual premiums.

Under its announced schedule, the 10 HMOs that service CalPERS will received an average 9.7% rate hike in the Year 2000. CalPERS officials say they expect the HMOs to pass along much of this increase to their physician groups.

This year's negotiations also produced several multiyear contracts ensuring HMOs a stable premium stream in exchange for inserting two new patients' rights provisions into their agreements.

Two of the most sought-after items on almost everyone's proposed HMO "Bill of Rights" — independent, third-party review and assurance that legitimate emergency room fees will be covered — will now be available in all CalPERS plans.

Each CalPERS plan will have to offer a neutral, independent, third-party review whenever health care services are denied because the HMO felt the services were not medically appropriate. In addition, all HMOs will also be required to adopt the "prudent layperson" rule for emergency room coverage. This rule authorizes emergency room treatment for conditions that any prudent layperson would believe to be reasonable.

The individual premium rate increases for the year 2000 approved by CalPERS include: Maxicare — 3.9%; Cigna — 5.6%; PacifiCare — 6%; Aetna US Healthcare — 6.5%; Blue Shield HMO — 8.5%; Health Net — 9.9%; Health Plan

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of the Redwoods — 10.5%; Lifeguard — 10.9%; Kaiser — 11.7%.

While analysts are optimistic about this year, prospects beyond 1999 are hazier. Due to a robust economy, managed care companies can expect a steady stream of improved profits from a round of premium hikes throughout the rest of this year, predicts **Patrick Finnegan**, senior vice president at Moody's Investors Service, New York. Beyond an 18-month horizon, however, Finnegan is uncertain whether employers will continue to accept a repeat of recent rate increases.

Notes **Michael Barry**, a director at the New York credit rating agency Fitch IBCA, "The rate increases that managed care companies are getting appear to be more than enough to offset medical cost inflation. Add in the efficiencies achieved from the continuing consolidation trend, and I have a positive outlook for the remainder of this year.''

"We think the improvement in performance is largely a function of increased premium rates and a little less to do with cost containment,'' says **Arun N. Kumar** of Standard & Poor's in New York City. ■

More clinics may qualify for small business loans

Proposal could help 5,000 providers

A proposal being pushed by the U.S. Small Business Administration (SBA) would qualify some additional 5,000 health care providers — particularly offices and clinics operated by doctors — for government programs and services such as loan guarantees and management assistance based on the agency's so-called size standards for classifying a small business.

Currently, the SBA has a one-size-fits-all standard that applies to the entire health care services industry, stating that an operation is considered "small" if its annual revenues are $5 million or less.

The current SBA proposal would preserve this standard for eight subdivisions within this overall health care services category, but increase the dollar figure for others. For example, a new upper limit of $7.5 million is being proposed for specialty outpatient facilities, health and allied services, and offices and clinics operated by medical doctors.

A $10 million threshold is being considered for skilled nursing care facilities, medical laboratories, and home health care services, while the SBA proposes to increase the size standard for most hospitals and kidney dialysis centers to $25 million.

The remaining sectors, including offices and clinics operated by dentists, chiropractors, optometrists, podiatrists, health care practitioners, and doctors of osteopathy, would continue to operate under a size standard of $5 million. Nursing care facilities and dental labs would also remain at the $5 million level.

"Like so many parts of our economy, the health care services industry has changed rapidly in recent years," says SBA administrator **Aida Alvarez**. "The SBA is proposing new size standards that more accurately reflect these changes. The new standards will provide these growing firms with continued access to SBA's small business development assistance, helping them succeed and serve their customers into the 21st century." ■

Most Medicare MCOs not Y2K-ready

Fewer than 25% of Medicare managed care organizations are prepared to deal with potential Year 2000 computer problems, reports the Office of the Inspector General.

According to a May survey, 78% of MCOs say they are not now Y2K-ready. However, 65% say their systems will be ready by Dec. 31, 1999. Another 34% of MCOs report they will be 67% to 99% Y2K-compliant by New Year's Day.

This lack of preparation raises questions about possible breakdowns in Medicare managed care billing, medical information, and membership enrollment and disenrollment systems. If you have not done so already, now is the time to check with any Medicare MCO your practice deals with about their Y2K status, and prepare contingency plans should parts of their system be bitten by the millennium bug. ■

How to choose capitation software that works for you

Systems are an investment in future productivity

If you've ever delivered newspapers, you might remember pondering when the best time would be to buy a new bike. If your delivery route was growing, you knew that soon you could use better baskets, more gears, a more comfortable seat.

A farmer may set aside some of his earnings to buy a better tractor after a good harvest. A printer may search for a faster copier. Regardless of the occupation, the economic maxim of saving some profits to invest in future business viability remains fundamental. Yet it is sometimes overlooked in a business climate too anxious for short-term gains.

Doctors, too, are well-advised to reserve some of their economic success so they can invest in their future successes, says **Pamela Waymack**, an independent computer consultant who specializes in physician practice systems. In capitation, this means investing in the tools for innovation — both software and staff who know how to make creative use of new and emerging technologies, recommends Waymack, managing director of Phoenix Services Managed Care Consulting in Evanston, IL.

Fortunately, your options for doing this are growing. A few years ago, your software choices were limited to the five or so that existed on the market, or you wrote your own program. Most of those systems were better suited for insurers than physicians. Now the market has expanded, offering some 40 systems for physicians involved in capitation.

If your practice is ready for capitation software support or if you need to expand upon what you already have, Waymack has useful strategies both for getting started and for the actual process of selection. To begin with, she recommends taking these two key steps:

• **Define your needs**. It's easy to get overwhelmed quickly when you begin studying new capitation systems. Before vendors tell you what you need, make sure you have your own idea of what you need and build from there. Here are some key questions to start with:

— Are you dealing with capitation yet? If not, what data would be useful to help you prepare to bid for a contract? If you already participate in a capitation contract, does your practice only accept capitation payments, or are you performing other cap-related functions such as referring patients to other providers?

— Are you billing employers directly for services?

— Are your stop-loss limits easily accessible?

— Can your system make payment comparisons to fee-for-service payments? "You need to know if you're making 20% more than Medicare pays, or equal to Medicare, or 120% below Medicare," Waymack points out. "Systems are now available to automate that process for you."

• **Determine your limitations**. For example, you typically want to stick with software and hardware that fit with your existing equipment. In addition to your functional limits, you'll need to establish budget limits as well. Physicians often err on the side of being too conservative in this area, Waymack says. For instance, banking companies typically reinvest 5% of earnings into information systems. Physicians would do well to invest at least 3%, she suggests. That would include both equipment and personnel to optimize its use.

Consider using 'remote data centers'

If you get this far and decide it's getting to be too much, consider outsourcing part or even all of your information system needs. You're probably familiar with using insurers as third-party administrators to do administrative work, but another option is becoming increasingly popular: "remote data centers." This is a vendor who assumes nearly all the practice's information management needs and provides on-line access to all your data from your desktop, Waymack says. This leaves most of the hardware, software, and staff training investment and maintenance to the vendor. The practice administrators then tap into the information as they need to.

Also, administrators often use their own in-office decision support software — which relies on all the other data linking up to it — for strategic planning, reporting on trends, and all sorts of overview functions**. (See related story on software and programs beyond core capitation, p. 109.)** This allows administrators and physicians to stick more to planning and positioning rather than attending to daily operations, although they have ready access to any daily operations information they need.

Whether you are opting to purchase and/or upgrade your systems or to evaluate potential vendors to function as remote data centers, here are three facts of life you need to know to cut through the vendor rhetoric and identify your key success factors:

• **All information systems automate routine tasks.** You need to know answers to these questions: How quickly can data be manually entered into the system? What level of data checking does the system do to ensure accuracy? Does the system accommodate electronic billing? If claims can be received electronically, what percentage can be automatically adjudicated without someone needing to intervene? (The higher this percentage, the lower the level of staffing you will need in your back office.) You need to know not only how quickly these functions can occur, but perhaps even more important, what kind of staff support you'll need in your office to back up these systems.

• **All systems come with standard reports.** The trick is to figure out which reports you need and what it takes to modify them for your practice's specific purposes. Ask these questions: Are the standard reports developed in a way that meets your needs, or do you need to customize them by using some sort of editing tool? How easy is that tool for you or your staff to use? If the tool requires you to export data, what process is involved in that? A good example would be a system that could readily report how you're performing financially compared to Medicare's resource-based relative value system and conversion factor payment levels.

• **All systems will lack particular features you want as standard options.** There will always be features you need that don't come standard. No one vendor will have it all. A key here is knowing how well the product you're considering is designed to hook up with other outside parties. Look at the areas in which your preferred vendor has developed relationships. Maybe the system you like does not do credentialing, but the vendor has a good relationship with others who do. Or, they may have good relationships with a system that does claims code unbundling. Keep in mind the value your practice places on some of these beyond-the-basic applications before you make decisions.

Numerous articles on information systems for capitation as well as other health information systems, written by Pamela Waymack, are accessible on her firm's Web page, Phoenix Services Managed Care Consulting, at www.boundary.net. ■

Beyond basics: Looking ahead at cap systems

Not just for the big guys anymore

Practices not already involved in capitation but that hope to be in the future are in an ideal position to begin establishing report mechanisms that capitation requires. They can already use these skills in attracting insurers and patients.

That's the recommendation of **Pamela Waymack**, managing director of Phoenix Services Managed Care Consulting in Evanston, IL. For physician groups now involved in capitation, several useful capabilities are available if you want to expand your expertise. These are now available in much more customized formats for smaller practice settings.

Here are examples:

• **Patient report cards.** Even if you're not capitated yet, automating this process can go a long way toward getting you up to date in the market and prepared for more sophisticated managed care arrangements.

• **Demand management.** These systems were first developed for large hospitals and managed care organizations as a way to refer patients more efficiently. Now, they are being applied on smaller scales and are helpful to some physician organizations — particularly those dealing with capitation and that need to provide a wide range of patient care within a specific panel of doctors, Waymack says.

These applications also can provide after-hours clinical advice and triage, physician referral, and medical advice. A new feature also includes an instant "fax service," which provides a library of patient information that can readily be delivered to patients by phone or through the mail.

• **Claims auditing software.** These systems not only automate the process of checking claims for accuracy and appropriate payment; they also bring more powerful tools into the auditing process. Many offices still use staff personnel to perform audits, but technology increasingly is believed to make the process pay off better. These systems can readily screen for a wide variety of inappropriate billing patterns. They also can more easily audit electronic claims. And, they are equipped to provide consistent checks for unbundling, upcoding, medically inappropriate or duplicative services,

logical errors, and other difficulties. Waymack's experience suggests that in most cases, these kinds of products pay for themselves by reducing claim overpayments.

Providing protocols for care

• **Case management.** These systems go beyond the basic tracking of patients among various providers and patient care locations. Case management software offers much more sophisticated automation of case or care management. A key piece is to provide the clinical protocols that strengthen patient care from one setting to another. Case management software also targets cases for disease management and prevention programs, maintains ongoing patient tracking, and supports a variety of outcomes reporting. Case management software can be an invaluable tool for nurse reviewers because it can incorporate clinical guidelines and protocols to ensure the use of consistent criteria in both inpatient and outpatient referrals, she points out.

• **Credentialing.** Organizations with several hundred providers or more are finding they can't support the manual effort required to request and then authenticate all of a provider's training and performance. Software systems can at least automate some of the basic information: tracking down demographic data; initiating the credentialing process; identifying providers ready for recredentialing; and automating correspondence needed for both providers and their affiliated institutions, Waymack says. Beyond that, more sophisticated systems can integrate reference checks into the National Practitioner Database. Also, some can record office visit and chart review information required by the National Committee for Quality Assurance (NCQA).

• **Decision support.** This is the kind of software that goes beyond basic operations and instead moves a practice toward learning and innovation. Most core capitation systems have reporting methods and tools, but they lack the flexibility, ease, and sophistication of separate decision support applications, Waymack points out. In general, decision support typically offers you lots of different ways of looking at the world; it enables the user to apply his or her own creativity and thought processes to any given scenario to help create new ideas and paths to take.

Some software can handle HEDIS data

These systems typically offer superior ability to perform such tasks as ad hoc reporting, data analysis, and graphic representation of that analysis. They offer many different ways of presenting information and many ways to monitor, query, analyze, and report on multiple key measures such as cost, utilization, resource consumption, and financial performance. Some applications can provide for reporting of the Health Plan Employer Data and Information Set (HEDIS) data, and some also integrate provider profiling and risk adjustment tasks.

• **Provider and/or practice profiling**. Most physicians are quite familiar with this kind of reporting on their activities via insurers. Now, the same technology is available to practices for internal use, which might help fend off similar reporting issues from external sources, such as payers. These programs analyze referral patterns, costs, utilization, profitability, and resource consumption in just about any way you want to slice it — by individual physician, specialty, clinic, risk group, total network or IPA, etc. The systems are geared to evaluate clinical appropriateness, frequency, and intensity of professional services via statistical comparisons, Waymack says. They are designed to help identify inappropriate and/or unnecessary patient care, adjustment of risk in capitation arrangements, evaluation of choices needed in making physician selection decisions, and generation of HEDIS measures by provider. They also can help you negotiate with payers in showing your patient care effectiveness. ■

COMING IN FUTURE MONTHS

■ What to do if the fraud police show up: Part II

■ Lawmakers look at changing antitrust rules so independent practices can bargain with HMOs as a group

■ Update on move to revise Stark anti-kickback regulations

■ More providers are opting to re-purchase their practices from physician management companies

■ Easy-to-use data mining and storing techniques

Price controls pondered to tame pharmacy costs

Pharmacy capitation proves difficult

Should Congress regulate the pricing of drugs to protect elderly patients? Or is regulation too much interference with natural market processes?

This is a major debate lawmakers are now conducting in response to growing complaints about the drug industry's competitive approach to pricing — different prices for different groups of people.

It's a critical business issue for physicians as well. That's because many physician groups are tackling "pharmacy capitation" — risk contracts that include not only medical services but also all drug benefits for enrollees. These contracts pay one lump sum (the per member per month, or PMPM) to cover drugs as well as other patient care.

Drug prices vary widely

Pharmacy capitation contracts are popular, marketable programs for patients, but they have proven incredibly difficult to manage financially because of the highly variable nature of drug pricing. As physicians in pharmacy-cap contracts are well aware, certain drug customers get low prices while others pay more. Recently, the "more favored" were large HMOs with a sturdy base of beneficiaries. HMO officials negotiated deep discounts in exchange for delivering high volumes of patients. That left the higher prices to Medicare, some lawmakers contend. Overall, it's hard to know the "true price" because there is so much variation, physicians say.

A bill recently introduced in the House of Representatives, the Prescription Drugs for Seniors Fairness Act, proposes to eliminate the drug industry's practice of charging different prices to different purchasers.

In a report prepared for Rep. Tom Udall (D-NM) in March, staffers found that seniors were paying an average of 112% more than favored customers for five top brand-name drugs. Favored customers included groups such as HMOs, large insurance companies, and certain federal government purchasers.

In a May seminar sponsored by the American Enterprise Institute, a business-oriented research group in Washington, DC, several economists warned that the staff report was based on too small a sample to be valid. In addition, discounts for groups with negotiating power are a natural process of the competitive market place, they argued. To tamper with that would hurt all consumers down the road by reducing industry's ability to invest in cutting-edge research. **(For more details, see the American Enterprise Institute's Web page at http://www.aei.org.)**

One solution Congress is considering is providing a drug benefit for seniors, but lawmakers expect that to cost $20 to $40 billion. In the meantime, they might try prohibiting the practice of variable discounting. ■

Physician's Payment Update™ (ISSN# 1050-8791), including **Physician's Coding Strategist**™, is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Physician's Payment Update**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $419. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $335 per year; 10 or more additional copies, $251 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $70 each. (GST registration number R128870672.)

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National provider ID moves one step closer

Eight-digit code is coming

The reality of a national provider identification (NPI) system where all physicians would have their own unique provider ID number moved another major step forward with a recent Health Care Financing Administration proposal to implement an NPI system.

Authorized by the Health Insurance Portability and Accountability Act of 1996, NPIs are intended to facilitate the use of electronic provider payment systems. The IDs will first be used by Medicare and Medicaid providers, then will expand to all providers and commercial health plans.

Under HCFA's proposal, the NPI would be a unique eight-digit alphanumeric code that would be issued to individual providers, medical groups, health care organizations, and plans.

According to the proposal, the national provider system would collect and store a variety of information about health care providers.

In its proposal, HCFA noted that it is possible that not all of the information will be included in the final NPI because it must "consider the benefits of retaining all of the data elements . . . versus lowering the cost of maintaining the database by keeping only the minimum number of data elements needed for unique provider identification." ■

Medium-length descriptors coming with CPT 2000

Taking advantage of increased computer capacity

The American Medical Association (AMA) says it will add new medium-length clinical descriptors to the year 2000 version of the Current Procedural Terminology (CPT) coding system.

The clinical descriptors for each CPT code precisely define the services provided to the patient. Because the length of long descriptors may exceed the capacity of some data and reporting systems, the AMA also maintains a set of 28-character short descriptors. Although more compatible with the limitations of some systems, the short descriptors are not always able to convey the desired level of clinical information.

To meet end-user needs, the new medium-length descriptors will take advantage of increasing computer capacity to provide more informative clinical detail in condensed descriptors. This enhancement is expected to improve the transmission of clinical information between physicians and payers by allowing more effective use of CPT in health care software, including payment systems, coding applications, and electronic medical records.

The new descriptors will be made available in various electronic media as part of the fall 1999 release of CPT 2000. To prevent disruption for existing users, the current short descriptors will be retained as an option for CPT users. ■