AMERICAN HEALTH CONSULTANTS®

PHYSICIAN'S MANAGED CARE REPORT™

physician-hospital alliances • group structures
integration • contract strategies • capitation
cost management • HMO-PPO trends

INSIDE

AUGUST 1999

VOL. 7, NO. 8 (pages 113-128)

American Health Consultants® is A Medical Economics Company

Facing a heavy patient volume? Physician assistants may be answer

They can perform MD duties at a lower cost

Do you often feel like you need to be in two places at once to take care of all your patients' needs? Are you facing pressure to see more patients each day while your practice is squeezed by reimbursement cuts?

One prescription for relief may be to hire a physician assistant (PA) to work in partnership with your physicians to take care of patients.

If health plans are paying you less per patient, you're going to have to see more patients in a day in order to stay in the black. To avoid rushing patients through, many practices are hiring physician assistants who can handle a caseload of patients on their own without commanding the salary of an additional MD. What's more, reimbursement for PAs is becoming more widespread.

If you're fully capitated, having a physician assistant care for patients still can have a positive effect on your bottom line.

"The physician/physician assistant team is an effective way for physicians to compete in the managed care environment," points out **Ron Nelson**, PA-C, president of the American Academy of Physician Assistants (AAPA) in Alexandria, VA. "By working with a physician assistant, a physician can expand the scope of his practice and take care of more patients."

Physician assistants can provide the same type of services as a physician, but at less cost. The average salary for a physician assistant is $65,000 a year, according to the academy. New graduates start at about $55,000 a year.

And they practice in every medical and surgical specialty. By law, physician assistants may take medical histories, perform physical examination, order and interpret laboratory tests, diagnose and treat illnesses, suture wounds, and assist in surgery. They are authorized to write prescriptions in most states.

"We like to tout ourselves as being the right-hand person of the doctor," says **Diana McGill**, PA-C. McGill, who has been a physician assistant for nine years, recently started Pro-Search Medical Placement, a Houston firm that specializes in placing physician assistants with Texas

physicians. McGill works two days a week as a PA for a family practice, where she treats about 30 to 35 patients a day.

"We couldn't imagine running our practice without physician assistants. They add tremendous clinical depth and bring terrific skills and orientation to the practice," says **Peter Dreyfus**, spokesman for Harvard Vanguard Medical Associates, where 500 physicians and 90 physician assistants treat 290,000 patients at 14 sites.

Physician assistants and other allied health professionals are often called "physician extenders" because they act as an extension of the physician.

"It's almost like the surgeons can be two or three places at once," says **Barbara Kahwaty**, PA-C, of her role as a physician assistant in surgical specialties at Harvard Vanguard Medical Associates, a multispecialty group practice in the greater Boston area. For instance, if a patient is having a problem after surgery and the surgeon is not available, Kahwaty can see the patient, prescribe pain medication, and decide whether the patient needs to be seen by the physician.

"If I can't solve the problem, I page the surgeons," she says.

If a patient comes in with an acute injury, Kahwaty can deal with it in many cases. If the PA determines that the patient will need surgery, the PA calls the orthopedist, arranges for surgery, and meets the surgeon in the operating room.

Clinical depth

Kahwaty, who has been a PA for 19 years, practices in three specialties: orthopedics, general surgery, and urology. She has her own caseload and often is the only practitioner who sees a particular patient. She acts as first assistant in surgery and can perform minor surgery under local anesthesia.

As a PA specializing in surgery, Kahwaty is the exception rather than the rule. More commonly, PAs specialize in internal medicine, family practice, and pediatrics.

For instance, at Fort Collins (CO) Youth Clinic, three physician assistants and a nurse practitioner routinely see young patients for common childhood illnesses, says **Jeannette Perich**, CPA, administrator. The nine-physician practice hired its first physician assistant 15 years ago, added two more two years ago, and is hiring a fourth this year.

"There are so many childhood illnesses that aren't life-threatening but need to be treated. Having extenders leaves the physicians available for more critical care," Perich says.

Parents are always given the option to have the child see a physician, and the PA will pull a physician in immediately if needed, she adds. In some cases, physicians utilize PAs as they would a resident or a fellow, McGill says. The PA works up a difficult case, then presents it to the physician.

As an example of a complicated case, McGill cites seeing a patient with abdominal pain.

"I work up the patient, get a good history, and do a thorough physical. Then I present that patient to the physician, who comes into the examining room with me," she says.

Developing a partnership

The success of a physician / physician assistant partnership depends on how well the two can work as a team and how well the patients accept the physician assistant.

"I've seen all sorts of successes with physician assistants, and some failures," says **Marc Benoff**, MBA, director of Dan Grauman Associates a Bala Cynwyd, PA, management and data consulting firm specializing in the health care industry.

When an MD / PA relationship doesn't work out, it may be because the physician doesn't feel comfortable giving the assistant a lot of responsibility. That's why the AAPA recommends that when a physician and a PA begin practicing together, they should discuss how they should work as a team. The physician with whom the PA will work must be involved in hiring the PA so their personalities will be a good match.

"Arranged marriages" often don't work, points out Kahwaty. If you are an employee of a health plan that is hiring PAs, insist on being involved in the hiring process and carrying out the performance evaluation.

If you're considering hiring a PA for your practice, here are some other suggestions for making it a success:

• Check on how your payers reimburse for physician extenders, suggests Benoff. You want to make sure you can recoup the cost of the PA salary. **(For details on reimbursement issues, see related story, p. 115.)**

• Have the PA candidate shadow the doctors they are going to work with for a day to get an idea of how they would function in your office, says McGill of Pro-Search Medical Placement.

Reimbursement expands for work performed by PAs

Most third-party payers cover their services

The services of physician assistants (PAs) are covered by Medicare, Medicaid, TRICARE (formerly CHAMPUS), and most third-party insurance companies, according to the American Academy of Physician Assistants (AAPA) in Alexandria, VA.

Reimbursement rates vary from state to state and insurer to insurer, says **Diana McGill**, PA-C, president of Pro-Search Medical Placement, a Houston firm specializing in placing physician assistants. In Texas, most insurance companies reimburse for PA care at 85% of what a physician is paid for the same services, McGill says. In the case of surgery, the reimbursement is 85% of the cost of an assisting surgeon. Medicare reimburses at 100% if the physician is on site, she adds.

Fort Collins (CO) Youth Clinic bills the same for a visit to a PA as for a visit to a physician, says **Jeannette Perich**, CPA, administrator. As managed care has increased, the practice has increased the number of physician extenders, she adds.

Harvard Vanguard Medical Associates, a fully capitated multispecialty group practice in Boston, uses more than 90 PAs who work with its 500 physicians, says **Peter Dreyfus**, practice spokesman.

"Physician assistants provide care at a lower cost and often enhance the care patients receive," he adds.

There are a number of ways to structure PA compensation. Some receive a straight annual salary; others receive a salary and a bonus based on productivity; still others are partners in the practice and are compensated based on revenues.

At Harvard Vanguard, the PAs, nurse practitioners, and other advance practice clinicians are all voting members of the practice. **Barbara Kahwaty**, PA-C, a physician assistant, also serves on the board of the practice.

"We had to put our salary at risk, but it aligns all of us on the same team," she says.

Some states allow PAs to work as independent contractors and receive an hourly wage for whatever time they spend in the office, McGill says. However, in all cases, the practice, and not the individual PA, is reimbursed by the third-party payer.

[Editor's note: The AAPA sponsors a course on reimbursement for PAs and similar providers. The day-long course covers coding and documentation, credentialing, avoiding fraud and abuse pitfalls, and working with private insurance and the Health Care Financing Administration. Courses are scheduled for Aug. 9 in Boston and Oct. 29 in Chicago. More locations will be announced later. Information is available from the academy meetings department at (703) 836-2272, ext. 3405.] ■

• Consider hiring a PA on a temporary basis, McGill suggests. This allows the physician and the PA to get an idea of whether they can work together without a binding contract.

• Have the physician introduce patients to his or her new PA partner and tell patients that the two of them will work as a team, says Dreyfus of Harvard Vanguard Medical Associates.

• Give your patients a choice about what practitioner they prefer to see.

Never force patients to see a PA if they don't want to. It's a decision the patient has to make. Some patients want to see a doctor, not a PA. Some practices report that patients would rather see a PA sooner than wait for an appointment with their physician. Some patients see a PA because they can't see their doctor and wind up asking for their next appointment to be with the PA. ■

PAs gain status, popularity as a profession

Managed care makes them an asset to practices

Since the advent of managed care, the role of physician assistants (PAs) has been expanded and the profession is growing by leaps and bounds.

The U.S. Bureau of Labor Statistics projects that the number of PA jobs will increase by 46.6% between 1996 and 2006. Total employment is projected to grow by 14% during the same period.

The number of programs to train PAs has almost doubled this decade, according to the American Academy of Physician Assistants

(AAPA) in Alexandria, VA. In 1990, there were 50 programs nationwide to train PAs. Now there are more than 90 accredited programs and an additional 20 programs with provisional accreditation.

Diana McGill, PA-C, of Pro-Search Medical Placement in Houston, reports she is getting a lot of calls from physicians who have never worked with a physician assistant but who are interested in hiring one. McGill, who still practices as a physician assistant two days a week, specializes in placing physician assistants in Texas.

Most PAs have bachelor's degrees

The AAPA estimates that 34,000 people are in clinical practice as PAs nationwide, and that about 8,000 students will be enrolled in PA programs this fall. The typical program is 24 to 25 months and requires at least two years of college and some health care experience prior to admission. According to the AAPA, the majority of students have a bachelor's degree and 49 months of health care experience before admission to a PA program.

PA education is modeled after physician education, and typically is about two-thirds the length of medical school. The course of study includes course work in medical principles and basic sciences including anatomy, physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory science, behavioral sciences, and medical ethics. Second-year clinical rotations include family medicine, internal medicine, obstetrics, gynecology, pediatrics, general surgery, emergency medicine, and psychiatry. The typical PA completes more than 2,000 hours of supervised clinical practice prior to graduation.

Almost every state requires physician assistants to be certified by the National Commission on Certification of Physician Assistants. They must earn 100 hours of continuing medical education every two years, and pass a recertification test every six years.

The District of Columbia and all states except Mississippi recognize PAs. The scope of practice varies by state, but all states license PAs to treat patients on their own under the supervision of a physician.

The American Medical Association and the American Academy of Family Physicians have both issued guidelines on how physicians and physician assistants should work together as a team. The AAPA has endorsed the guidelines. ■

Larger practices coming, says new MGMA chief

High degree of organization urged

Medical practices must move away from being a cottage industry made up of solo practitioners with no back-up support and take a highly efficient, highly organized team approach to providing patient care, says the new chief executive officer of the Medical Group Management Association (MGMA) in Englewood, CO.

"I believe that all the forces are pushing physicians to group practice. The future of medical practice is in group practice," says **William Jessee**, MD, in a wide-ranging interview with *Physician's Managed Care Report*.

On July 1, Jessee, an experienced association executive, took the reins of the MGMA and its two inter-related organizations, the American College of Medical Practice Executives and the Center for Research in Ambulatory Health Care Administration.

For the past three years, he has served as vice president for quality and managed care at the American Medical Association, leading the development and implementation of a new physician standards and accreditation program.

"I see the group practice getting larger in the future," Jessee says. "It may not, however, be the traditional large group model. It may be more of a virtual group where smaller practices are linked together for common purposes. But whether physicians merge into a large group practice or link with others to create virtual groups, they need size to negotiate deals and run the practice efficiently," he says.

Jessee suggests that physician offices link together to get a better deal when purchasing supplies, buying health coverage for employees, creating centralized billing systems, or to get bargaining leverage with managed care plans.

"The larger the group, the more economic clout it has," he adds.

Over the long haul, physicians in group practice also stay more clinically current because they can sit down and talk with their colleagues, Jessee says.

"Peer interaction helps you continue to be the best kind of doctor you possibly can be. Putting three brains together is always better than one," he says.

Following are Jessee's answers to other questions from *PMCR*.

What plans do you have for the three MGMA organizations?

Jessee: My first plan is to get to know the organizations better. I am a firm believer in "ready" and "aim" before "fire." I plan to spend the first few weeks learning where the three organizations are now and what we need to do to get them where we want them to be.

Membership is my No. 1 priority. One of the strengths of any organization is its members. I stressed to the board that, even though the MGMA membership curve has been quite positive, we can't become complacent. The way you keep your growth curve going up is to provide service to your members and give them a reason to be members.

Organizations shouldn't try to get members just because they want more dues. Instead, they should look upon members as valuable assets. Each member has knowledge and insight to share with other members. An organization should act as a clearinghouse to pluck that good idea from one brain and share it with another. I look at each member as a very valuable asset.

How do you plan to increase membership?

Jessee: I want to focus on expanding student and faculty members. If you get them early on, they're more likely to remain members. I also want to assure that the membership in MGMA is not only valuable to the practice administrators but also to the physicians. If you are a practice administrator and your physicians don't find your membership valuable, they may be reluctant to pay membership dues. I want to make MGMA valuable not only to its members but also to the physicians for whom they work.

How will you make the MGMA more valuable to its members?

Jessee: We are going to be doing a lot of innovative things in terms of expanding our educational offerings. This will not necessarily be more programs, but will involve more innovative delivery mechanisms. Every association is seeing a drop in participation in educational programs. Travel costs are going up. We are going fairly aggressively into Internet-based education, expanding our CD-ROM programs, and similar activities.

We will be evaluating our own practices and making sure that we continue to be positioned as the most trusted resource for information about group practice.

We will establish a benchmarking series that will identify best practices in a variety of areas. For instance, how do you maximize patient satisfaction? How do you maximize productivity and minimize time-wasting? For every question, there is someone out there who has found a really great answer. One of our goals is to get the details and help our members learn what others are doing.

What should physicians do to position themselves to succeed in the next century?

Jessee: It gets back to benchmarking the best practices. Those are going to be the key. It is going to be a real challenge for physicians and practice administrators to find a way to make the practice as efficient as possible. But efficiency can't be at the expense of quality and patient satisfaction. You can do both, but you need to be careful that you measure both.

Efficiency gives physicians more time

Today's practices need behind-the-scenes efficiency, but not at the expense of the traditional warmth of the one-on-one physician-patient relationship. If you are more efficient in how your practice runs in terms of getting rid of wasted time and effort, you allow the physician to spend more time with patients who need more time.

MGMA's members are key members of the practice team. The physician and a knowledgeable administrator are much more capable of dealing with today's environment as a team than either is by themselves.

What do you think will happen with managed care in the future?

Jessee: Change is already taking place. Managed care is mutating. Closed-panel HMOs are giving way to point-of-service products. What we are seeing is that there has been a highly visible public backlash against some of the more aggressive negative practices of managed care. Many plans are bending over backwards to clean up their acts. You still hear stories of abuse, but there is much less than even a year ago. At the same time, we hear a fair number of success stories of well-run managed care plans.

Managed care is making a favorable impact on the public health with its emphasis on preventative services. It's what the AMA has said for years. It's not managed care we're against; it's poorly managed care. Some poorly managed care has given way in the face of public backlash.

What will physicians have to do to continue to prosper under managed care in the future?

Jessee: It's still a tough time for doctors. The bottom line is that everybody wants the best medical care possible as long as they don't have to pay for it. Everywhere in the country, we hear of another round of premium increases. The for-profit insurers have to raise premiums to earn the profits Wall Street expects them to earn. If medical expenses are going up, the only way to increase profit is to lower reimbursement. They are squeezing doctors and hospitals to make their profits.

My bet is that sooner or later, people are going to come around to the idea that there are benefits in dealing with not-for-profit managed care companies as opposed to publicly owned managed care companies. That issue is starting to become more visible.

Physicians are going to have to continue to be more efficient. But they also are going to have to join together to be able to bargain more efficiently in order to maintain their economic position and the freedom to do what is best for their patients.

The topic of physician unions or bargaining groups for negotiating with managed care has been much in the news recently. What are your thoughts on the subject? *(Editor's note: This interview took place a few days before the AMA House of Delegates endorsed unions for doctors employed by medical groups, hospitals, and HMOs.)*

Jessee: My personal feeling is that much of the clamor for unions is borne out of the frustration physicians feel. They are under more and more pressure. Their reimbursement is squeezed more and there is more regulatory paperwork and harsher enforcement. We hear stories of federal agents with drawn guns going into hospitals to seize records. It's enough to make people nervous. I think physicians, particularly physicians in small groups or solo practices, are saying, "I've got to have some relief." They are reaching out for a union because they see it as a salvation.

It's like trying to negotiate with General Motors about a car. As an individual, you don't have the kind of leverage that Hertz does. They get a much better price. For most physicians, the same applies to looking to the union to give them the kind of leverage they need. What they really need, however, is more economic leverage, not necessarily a "union."

In my mind, the best vehicle physicians have for getting economic leverage is IPAs or group practices. IPAs, when they work well, are able to get much better deals than individual physicians or small groups. Short of striking, they can do virtually everything a union can do and are much more acceptable in the eyes of the public.

How can physicians cope with ethical issues that arise because of managed care?

Jessee: The only answer from the ethical point of view is to put the payer and the payment out of your mind and do what the patient needs. Where the ethical dilemma arises is if you allow yourself to make reimbursement a primary issue. Physicians should ask themselves why they went into this profession. It was to do the best they could to improve patient well-being. The problem we get into as a profession is that we argue for reimbursement on the grounds of patient need when it may be, "I think I deserve to get paid this." You are on much firmer moral ground if you do what the patients needs, then fight for reimbursement afterwards to adequately pay the cost and fairly compensate the physician. ■

Is your practice ready for a JCAHO survey?

Network accreditation can put you in the spotlight

If your practice is part of a health care network seeking accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), your office may be selected for a site review as part of the accreditation survey process.

JCAHO, based in Oakbrook Terrace, IL, includes a sample of practitioner sites in its survey activities to determine if the network is meeting the standards for communicating with and providing oversight to its components.

JCAHO's Network Accreditation Program, begun in 1994, offers accreditation to health care networks, including integrated delivery networks, health plans, and preferred provider organizations. JCAHO standards state that networks must have a process for selecting and continuously evaluating the performance of its contractors. The networks must evaluate the

(Continued on page 123)

Physician's Capitation Trends™

• Capitation Data and Trend Analysis •

New rules help you size up capitation partners

OIG releases 'best practices' compliance plan

What does the ideal, most ethical HMO look like? The Health Care Financing Administration (HCFA) is attempting to paint that picture through its most recently proposed voluntary compliance plan, a detailed, 55-page description due to be finalized by Jan. 1, 2000.[1]

Most provider-sponsored HMOs are exempt from federal compliance such as the one in this proposal — and other federal fiduciary requirements required of major insurers — thanks to special legislation passed by Congress. But the elements of a first-rate commercial HMO are of great interest to physicians whose financial futures lie in the balance of complicated capitation contracts.

As of July 1998, 78.7% of HMOs had capitation arrangements with primary care physicians, 56.4% with specialists, and 32.5% with hospitals, according to a recent national managed care study.

Accompanying the new proposal are questions about how much of it will be incorporated into HCFA requirements, or if two separate plans — one voluntary and one required — will result.

Either way, from HCFA's point of view, the first thing to determine when assessing the integrity of an HMO is whether or not the insurer has its own internal compliance program specific to capitation's many permutations. As the proposed plan explains, such a program would include a mission statement, a whistle-blower's hotline, routine training and education for all employees and providers, an executive-level compliance officer, and protection for whistle-blowers. There also must be operational and information system support necessary to process financial information accurately, to make necessary corrections, and to ferret out problems early on.

That kind of infrastructure is the best indicator of an organization's commitment to ethical practices, the proposal says. And, it's not enough for the program to simply refer to the standard Medicare fee-for-service fraud and abuse detection requirements. It must be specifically targeted toward handling capitation's multiple payment variations.

Such an infrastructure could pay off handsomely in the long run. The Office of Inspector General (OIG) will view a pre-existing compliance program as a mitigating factor when making decisions regarding punishments and penalties resulting from an investigation, HCFA officials note. However, superficial compliance programs or those hastily assembled and poorly monitored "could expose the Medicare+Choice organization to greater liability than no program at all," HCFA says.

The overall objective is for the HMO "to establish a culture within an organization that promotes prevention, detection and resolution of instances of conduct" that do not meet federal and state regulations, and to enforce appropriate ethical and business policies, HCFA notes.

At minimum, a compliance program should have these seven elements, all of which are useful features for providers to inquire about when assessing an HMO for a capitation contract, HCFA officials recommend:

1. Written standards of conduct, as well as written policies and procedures, that promote the organization's commitment to proper conduct and that address specific areas of potential fraud.

2. Designation of a chief compliance officer and corporate compliance committee charged

with operating and monitoring the compliance program.

3. Development and implementation of regular, effective education and training programs for all affected employees and providers. At minimum, the HMO should send a copy of its compliance program to all of its health care providers.

4. Establishment of regular lines of communication between the compliance officer and all employees and providers, including such tools as a hotline, to receive complaints and protect the anonymity of complainants.

5. Use of audits or other risk evaluation techniques to monitor compliance and assist in the reduction of identified problem areas.

6. Development of disciplinary mechanisms to consistently enforce standards and policies.

7. Development of policies to respond to detected offenses and to initiate corrective actions to prevent similar offenses.

That's the model to look for, OIG officials point out. They also describe at length numerous "hot topics" and buzzwords to be wary of in reviewing HMO capitation contracts and practices. **(See related story, p. 122.)** Here are highlights of those danger zones:

• **HMO marketing materials often have spurious claims.** A recent General Accounting Office study examined 16 managed care organizations and found that all had distributed materials containing inaccurate or incomplete benefit information, the proposal points out. In fact, HCFA had approved the marketing materials prior to their release, which means HMOs ultimately are responsible for what they print.

• **"Lock-in" features often elude beneficiaries.** This concept needs to be clearly explained to potential beneficiaries, OIG officials say. "Many Medicare beneficiaries are unfamiliar with the notion that managed care may limit their health care provider choices," the proposal states. Despite the name of the program, "Medicare+Choice," there is limited choice, OIG points out. "Describing the process of selecting a primary care physician and the limitations that this places on a Medicare+Choice enrollee's choice of provider will significantly reduce the unmet expectations of Medicare beneficiaries."

• **Be wary of outsourced marketing personnel.** If a marketer visits you to discuss contracting, find out if he or she is a full-time employee of the insurer. The OIG strongly encourages HMOs to rely on full-time, in-house marketing personnel rather than outsourcing that responsibility. This makes it more feasible for the insurer to control marketers' claims and activities.

• **Don't accept marketing responsibilities for the HMO.** HCFA strongly discourages the use of physicians as marketing agents because they do not have thorough knowledge of the plan and because it may cause confusion among patients.

Reference

1. Draft OIG compliance program guidance for certain Medicare+Choice organizations. 64 *Fed Reg* 33,869-33,887 (June 24, 1999). ■

Ethicist: Compliance plan is a 'Band-Aid' approach

Basic structure encourages undertreatment

(Editor's note: Physician's Managed Care Report *invited* ***Howard Brody****, MD, PhD, from the Center for Ethics and Humanities in the Life Sciences at Michigan State University in East Lansing, to offer his insights on the Office of Inspector General's proposal for HMO best practices. Brody recently co-wrote an analysis of gag rules, trade secrets, and other managed care contractual issues in the* Archives of Internal Medicine.*)*

PMCR: How do you view OIG's general assumption that self-policing is an appropriate approach to ensure best practices among HMOs?

Brody: I generally applaud the idea that managed care organizations can and should be self-regulating at least to some extent, and I have for a while been an advocate of in-house ethics committees, modeled somewhat after hospital ethics committees (so long as plan enrollees are well-represented on the committee). I think having such an ethics committee and giving it substantive internal support would be a good sign of integrity within an MCO. I am aware of some model efforts of this sort in New York state some years ago, but few plans today have ethics committees to my knowledge.

PMCR: Why are HMOs reluctant to establish ethics or compliance committees?

Brody: You cannot have an ethics committee that means anything unless you are willing to admit openly a basic feature of managed care:

The incentive structure tends to reward you for undertreating patients. An ethical plan will be aware of this and guard against this tendency. Many plans will not form ethics committees (except under duress from HCFA, which is another interesting question) because their current marketing strategy is to deny the existence of any such conflict. This may be an example of where marketing and ethics are in direct conflict.

PMCR: What do you think of HCFA / OIG's overall model plan proposed in the June 24, 1999, *Federal Register*?

Brody: I am skeptical of the HCFA picture of the ideal plan. They are focusing on "compliance issues" and not quality-of-care issues. HCFA would like to imagine that these are identical concerns, but they are not. A plan of integrity, I would allege, would provide high-quality care and not commit fraud. But the problem with compliance is that too often these days it is in the eye of the beholder, and plans have to try to eliminate not just the fraud, but also the appearance of fraud.

In primary care, for instance, one way to eliminate the appearance of fraud is to code each office visit as a low-level ("brief") visit. This could lead to serious under-reimbursement for the office and the need to lay off such important personnel as nurses, social workers, dietitians, etc., whose activities add a good deal to quality of care. I read the OIG / HCFA proposal, between the lines, as much more worried about federal dollars not being ripped off by plans, and much less worried about patients getting what they need. But the end result of this strategy, in a highly competitive and fluid marketplace, could easily be lesser quality of care.

This is not to say that MCOs ripping off the system is a small problem. It is a big problem. But the real solution would have to lie back with Congress' ill-considered efforts to save a ton of money for Medicare by shifting the huge majority of Medicare clients to managed care overnight.

PMCR: Where does this proposed compliance plan fit into OIG and HCFA's experience with capitation to date?

Brody: [Congress' strong hopes that Medicare HMOs would cut costs] opened up the gates for profit-minded MCOs to rush in and game the system. Now, two or three years down the road, HCFA has caught on to how it is being ripped off. That's only about one or two years behind all the rest of the world. It is ready to close the gate, but the managed care horse has already run away with the windfall profits and is now getting out of the Medicare Plus business as fast as it can. So, these "voluntary" guidelines are a pretty small and belated Band-Aid on top of a pretty big problem.

PMCR: What would be some best practices you would recommend for managed care organizations to adopt?

Brody: The further take-home message is that managed care in the U.S. today is largely a fraud. Real managed care would constrain the costs of health care, while giving high-quality care to patients, because it really knows how to manage care. That is, if you truly don't need it, you get a kind and thorough explanation why; and, if you truly do need it, you get it fast and efficiently. No hassle, no micromanagement, no games, just good quality management and good quality care.

> "You cannot have an ethics committee that means anything unless you are willing to admit openly a basic feature of managed care: The incentive structure tends to reward you for undertreating patients."

But this sort of management requires that the business-suit guys truly know a lot about health care (not just about selling insurance). And, it requires that the health care providers are in constant communication with each other and pull together as a team. That structure takes a good staff model HMO some years to achieve. You simply cannot achieve it overnight with a network model. But . . . the old-time staff model plan is now only 1% of the market.

PMCR: What are the positive indicators of MCOs appropriately handling capitation and other aspects of managed care?

Brody: If this sounds like shameless managed care bashing, I want to again applaud the handful of plans that have adopted the ethics committee approach. I know personally of some plans, mostly in the nonprofit sector that would like to move in this direction and really step up to the plate in terms of integrity and ethics. I applaud their goals and would like to support them. ■

OIG's lexicon of sleaze shows what not to do

'Creative' marketing tactics often signal problems

As federal officials plow through the complaints — real and imagined — regarding HMO practices, several prominent poor practices emerge to the top of the list.

Here are examples and descriptions provided by the Office of the Inspector General (OIG) in its proposed compliance plan for HMOs. These examples, some old and some new, offer excellent guidance to physicians and patients for assessing the character of a risk-bearing contract:

• **Cherry-picking.** This refers to efforts by an insurer to enroll healthy patients and avoid the more costly, sicker patients. "For example, organizations should prohibit employees from conducting medical screening, i.e., asking the beneficiary medical questions prior to enrollment," the OIG says.

Insurers often use cards or coupons requesting medical information as part of a survey for potential enrollees. Alarmingly, the OIG officials point out that in a 1996 survey, the OIG found that such screening for health status at application was reported by 18% of beneficiaries, and as many as 43% in a 1993 OIG survey.

Trolling for members at the health club

Another method of targeting healthier enrollees is marketing their plans in places where healthier people would be found, such as health and exercise clubs. These plans might offer inducements such as free gym memberships or kayaking or other sporting lessons that would appeal to healthier people. Other examples OIG has noted:

— targeting newly enrolled Medicare beneficiaries who theoretically would be younger and healthier;

— tracking costs of current enrollees and re-enrolling only the healthier patients;

— disenrolling beneficiaries prior to receiving inpatient hospital care (a tactic that cost Medicare $220 million in 1996 alone).

• **Stinting.** This is any tactic aimed at preventing patients from receiving services. It can take many forms, investigators say, including:

— delaying and forbidding approval of certain services;

— failure to employ or contract with sufficient institutional or individual providers to accommodate all enrollees;

— failure to provide geographically reachable services;

— establishing utilization review procedures that are so burdensome that an enrollee could not reasonably be expected to fulfill the requirements;

— categorical denial of payment of claims;

— gerrymandering, or drawing geographical boundaries intentionally to exclude certain high-risk populations.

• **Gag rules.** These are provisions that interfere with a health care professionals' advice to enrollees. This can extend to any advice regarding the patient's health status, medical care and treatment options, the risks, benefits, and consequences of treatment or non-treatment, and the opportunity for the individual to refuse treatment and to express preferences about future treatment options.

• **Inappropriate physician incentive plans (PIPs).** PIPs automatically raise a red flag of concern because they can directly or indirectly reduce or limit services to patients. Not all PIPs are unethical, but they must meet certain criteria, OIG officials state. These criteria include:

— not offering payments or other gifts of monetary value in exchange for reducing or limiting medically necessary services;

— not placing the physician at substantial risk for referring patients to specialist services;

— having adequate stop-loss insurance;

— disclosing information regarding PIP arrangements.

• **Over-claiming administrative costs from the capitation payment.** Insurers should have clear criteria regarding what counts as their administrative costs (their part of the capitation payment) and direct patient care costs. One spurious tactic some insurers use is a multiplier. "Computing an administrative rate based on the use of a medical utilization factor could generate a payment that is almost three times what would be charged on the commercial side," the OIG says.

• **Swapping.** This refers to any practice set up to use capitation as a way to steer more fee-for-service patients to the insurer; i.e., swapping a low capitation rate for a more open-ended stream of patients in fee-for-service plans.

Reference

1. 64 *Fed Reg* 33,869-33,887 (June 24, 1999). ■

(Continued from page 118)

clinical records and office practices of practitioners being appointed and reappointed to the network.

All sites with which the network contracts are held to the same performance and quality standards applied to the network.

"We're not looking at the actual decisions being made about clinical care or what the practice is doing with a particular patient," says **Gina Val Zimmerman**, executive director of network accreditation surveys for JCAHO. "We are looking for issues around the communication and linkage of the practice site and the network or health plan."

Joint Commission surveyors pick up to eight physician office sites during a network survey, says Zimmerman. Networks are notified of what physician office sites will be surveyed at least six weeks prior to the survey. It is up to the network to notify the practice sites involved in the survey.

Performance issues that will be addressed by the surveyors include:

- level of integration of health care treatments and services throughout the network;
- availability and accessibility of care and services;
- communication between the network and practitioner sites;
- involvement of the practitioner site in network performance improvement activities.

Survey includes interviews, observation

At most physician offices, the surveyors will be looking at four months' worth of records. This is because most of the networks seeking accreditation are doing so for the first time since the network accreditation program was established in 1994. When the JCAHO does its second survey, three years down the road, surveyors will look at a year's worth of data, Zimmerman says.

The survey process includes interviews with staff, observation of how the physician practice operates, and an examination of medical records.

"Surveyors generally spend most of their time with the office staff. At some point during their visit, they want to have an opportunity to talk with the practitioners, even if it's just for a few minutes," Zimmerman says.

Surveyors are likely to ask the physicians about their experiences with the health plan or network, she adds.

"We're not looking at clinical care, but at issues relating to communication, documentation, and what the patient experience is," Zimmerman says.

When the Joint Commission chooses physician offices to review during a network accreditation survey, your office is more likely to be selected if:

- you had a lot of patient volume related to the health plan or integrated delivery network in the 12 months prior to the survey;
- your office is among the sites that have been reviewed by the network during the previous 12 months.

"We won't go to a site with no activity for that particular network, nor would we select a site that hasn't been reviewed by the network," says Zimmerman.

The number and type of physician office sites chosen for review as part of the accreditation survey process is based on the number of sites in the network or health plan and the types of practitioners in the network.

For instance, if the network includes between one and 200 physician office sites, the surveyors would visit up to four practice sites. If the network has more than 500 physician office sites, the surveyors would choose eight for a site visit.

"We based our selection on a representative sample of the types of practitioners in the network. For instance, if the network has primary care and specialty care sites, we look at both types of sites," Zimmerman says. ■

Here's what JCAHO will be looking at

Network linkage is a key issue

When the Joint Commission on Accreditation of Health Care Organizations (JCAHO) visits a physician office site, the surveyors are checking on compliance with eight network accreditation standards.

Most of the standards deal with whether the network communicates with and oversees the practice sites with which it contracts, according to **Gina Val Zimmerman**, executive director for network accreditation standards.

Here are some of the issues that the surveyors address:

• **Communication and linkage issues.** The surveyors make sure the practice site is familiar with the network's policies and procedures and how they are to be implemented.

• **Performance improvement activities.** The surveyors determine whether staff at the practitioner site know the network's performance improvement priorities and if the physician offices participate in performance improvement activities.

"We look at the networkwide process for performance improvement, and how it incorporates physician offices and all other sites where patients receive care," Zimmerman says.

Among the things the surveyors look for is how physician offices receive data and information from the health plan and how they send information to the health plan.

• **Patient rights.** The surveyors will check to see that staff at the practice sites are familiar with the policies and procedures the network has in place regarding patient rights.

"A big area in the network practice site office relates to respect of the members of the network," Zimmerman says.

"One issue that has come up in recent years is the possibility of someone walking into the reception area and reading the list of patients who have been treated that day."

Among the areas the surveyors will look at are:

— How does the network handle confidentiality of member information?

— How does the practice site protect patient privacy and security? For instance, the surveyors will check to see if the physician office takes steps to ensure that other patients do not know who is visiting the office and for what reason.

"One issue that has come up in recent years is the possibility of someone walking into the reception area and reading the list of patients who have been treated that day," Zimmerman says. Some physician offices have complied with this part of the JCAHO patient privacy issue by asking patients to sign in on an index card, as opposed to logging in on a list.

— How are the medical records maintained? For instance, the surveyors will check to see if the records are secured in a back office that is locked at the end of the day.

• **Grievance procedures.** The surveyors look at how the physician officers are linked with the health plan or network. Does the practice site know how to handle complaints and grievances? Is there a toll-free number to call? Does everybody in the office from the receptionist to the physicians know what it is?

• **Continuum of care in the practice site.** The surveyors examine how well the services the health plan or network provides are integrated. Do the physicians know how to make a referral to another provider? Do the physicians understand what other sites are included in the network? Do the physicians know how to access the referral process? Do they have forms or instructions for referrals? If they need to communicate with the network, do they know whom to call?

• **The referral process.** Surveyors will examine how the various settings in the health plan or network are linked. They want to know how the patients' records or other information is transmitted; what information is forwarded with the patient; and how the sites share information.

Are you documenting your education efforts?

• **Education and communication.** Surveyors want to determine if staff know what types of education they should be providing and if they provide it. Surveyors also look for documentation within the clinical records showing that education was provided.

• **Leadership issues.** Are the physicians involved in decisions made by the health plan? Do practice sites know how to contact the health plan and how to provide input on strategies and procedures the plan may be implementing?

• **Management of human resources.** The surveyors want to determine if staff are competent to perform the skills they have been hired to do and if there is sufficient staff to handle the workload. They look at education, training and orientation to the job, competency assessment, and credentialing and licensing of staff.

• **Information management.** This section of the survey includes determining if medical records are being maintained for each patient and if the physician office is carrying out policies and procedures on documentation set by the network or health plan. ■

Sources for on-line CME courses

• **cmeWEB**, from American Health Consultants, publisher of *Physician's Managed Care Report*, offers a Web-based CME program that covers 15 areas of medical specialty, including internal medicine, cardiology, oncology, emergency medicine, travel medicine, neurology, OB/GYN, and alternative medicine. The site offers more than 850 hours of Category I CME. Physicians can answer CME questions, receive immediate feedback, and, if necessary, retake the quiz. For more information, contact customer service at (800) 688-2421 or visit the Web site: **www.cmeweb.com**.

• **CEU Online** provides Category I continuing medical education for physicians and other health care professionals using customized CD-ROMs and the Internet. Most of the courses are sponsored by businesses, such as pharmaceutical companies, and are offered at no charge. For other courses, CEO Online charges a nominal fee that is levied only on users who take the exam. For more information, contact Sharyn Lee, chief executive officer, at (603) 432-7099. E-mail: **Sharyn.lee@ceoncd.com**.

• **HealthStream**, a Web-based training company in Nashville, TN, offers more than 500 hours of CME in family practice, internal medicine, and emergency medicine. Visit the Web site at **www.ahn.com**.

• **Physicians' Online**, the leading medical information and communication network, currently offers 17 CME programs, mostly in primary care. After taking the courses, physicians answer the CME questions on-line and receive immediate feedback. For more information, contact David Danar, MD, vice president for content, Physicians' Online, 560 White Plains Road, Tarrytown, NY 10591. Telephone: (914) 332-6100. Web site: **www.pol.net**.

• **The University of Washington School of Medicine** offers seven on-line CME programs, mostly for primary care physicians. The programs were developed by physicians and put on the Web by a staff physician who does the Web work on his own time. For more information, contact Edward A. Oshira, executive director. Telephone: (206) 543-1050. Fax: (206) 221-4525. E-mail: CME@U.washington.edu; or visit the CME department's Web site at **www.dom.washington.edu/cme/index.html**.

• **Virtual Lecture Hall** offers more than 50 CME hours sponsored by the University of Arizona College of Medicine. Participants can earn from one hour to as much as 23.9 hours of credit, depending on the course. Participants can earn credit for some courses for free. Others are $9 or less per credit hour. Contact: John M. Harris Jr., MD, president, Medical Directions, Inc., 6101 East Grant Road, Tucson, AZ 85712. Web site: **vlh.com**. ■

Your next CME class could be in cyberspace

Earn on-line credits conveniently, cheaply

When the medical staff at Columbus (OH) Oncology Associates work on their continuing medical education (CME) requirements, they're likely to listen to a seminar on audiotape or compact disc in their car or go on-line for a study session on the Internet.

"We are avid users of technology for CMEs," says **Ruth Lander**, FACMPE, practice administrator. "We do audio conferences for several staff or get CMEs through Internet services. It saves travel time and dollars."

The seven-physician practice is not alone. More and more health care professionals are fulfilling their CME requirements at home, in the car, and in the office. Today's technology allows them to learn at their own pace and at a time and place that's convenient for them.

"We all know that the time out of the office for a physician to attend a course is very expensive. Under the present health system, there is more pressure for doctors to stay in the office and see more patients. Our idea is to make continuing education available to physicians at their convenience," says **Ed Oshira**, executive director of the CME program at the University of Washington School of Medicine in Seattle.

Oshira's department provides continuing medical education for physicians and other health care professionals in Washington, Alaska, Montana, Idaho, and Wyoming.

"Most of these doctors are in remote areas.

Distance learning is a good way for them to get CME credits," Oshira says.

Physicians have earned more than 10,000 hours of Category 1 CME credit in the past year through courses offered by Medical Directions at its Virtual Lecture Hall Web site, says **John Harris**, MD, president of the Tucson, AZ, firm.

"Internet learning may be better. It's definitely more convenient and costs less than traditional CME programs. The only thing our program doesn't do is to allow you to go to a nice place where you can swim in the pool after the lecture is over," Harris says.

Physicians' Online, with more than 200,000 physician members, has 17 CME courses among its services that include medical and pharmaceutical databases, on-line discussion groups, bulletin boards, and archives of information covering 20,000 to 30,000 topics, according to **David Danar**, MD, vice president of the Tarrytown, NY, company.

"CME is a requirement we would like to satisfy in a convenient way. Through on-line services, people can dial it up directly in all 50 states when they're sitting at home in their bathrobe," Danar says.

The company does not create its own courses, but relies on other sources, such as hospitals, research facilities, and Harris' Virtual Lecture Hall.

For instance, when a state medical society offered hundreds of board review questions to Danar, he called Harris, whose firm developed an interactive quiz show with the material. The information is available on both Web sites.

While the future of CME clearly lies in technology, for the present physicians need to carefully match their own technology with that of companies that offer CME, notes **Marcus Underwood**. He is director of new media for Medical Economics, a publishing company in Montvale, NJ, that offers both CME and nursing-based continuing education programs.

"One of the problems doctors face is that some companies rely very heavily on sophisticated multimedia interactive technology for their CME

How on-line CME courses work

If you'd like a sample of how distance learning programs work, just log onto an Internet site and try it out.

Access to the Web-based continuing education programs is free, and there usually is no charge for programs with commercial sponsors. A nominal fee, usually less than $10 per credit hour, is levied only if you want to receive CME credit.

"Any individual or group who wants to take any of our content is welcome to download it, listen to it, and print it. They incur expenses only if they want evidence of taking the course to meet their continuing education requirements," says **Sharyn Lee**, president and chief executive officer of CEU Online in Londonderry, NH.

The on-line courses are set up so you can take them at your leisure, mark your place, and come back to finish when it's convenient. Participants go through the content of the program, then take the CME exam.

Virtual Lecture Hall requires participants to go through the contents page by page before they get to the CME exam. The program tells participants how many hours of credit they are eligible for and asks for a credit card number if they want it posted to their CME transcript.

Physicians participating in the Physicians' Online courses answer the CME questions online and receive immediate feedback. The firm's technology retains the answers as the test is taken, allowing physicians to complete the exam when it's convenient. After the exam, the company tabulates the answers and forwards them to the educational institute, which then mails out the appropriate CME certificate. ■

COMING IN FUTURE MONTHS

- Would your office pass a work site safety inspection?
- How practices deal with the psychological side of illness
- AMA accreditation and what it could mean for your practice
- Using technology to create a more efficient practice
- Avoiding the pitfalls of fraud and abuse

programs," he says. "That's great if the physician is sitting in his office with a full-power PC that can handle multimedia. But if the doctor is sitting at home with even a slightly old PC, he might as well go out to dinner while the computer loads the program he'll be taking the test from. Not everyone is ready for multimedia."

Another downside is that Internet learning is in the early stages. Because of the expense of creating interactive programs (some estimate it costs as much as $20,000 to produce one accredited hour), some Web-based content is basically a book or newsletter on a computer screen.

That's why some distance learning providers, such as Londonderry, NH-based CEU Online, look for sponsors to pay the expense of creating educational programs.

CEU Online's educational products for health care providers use a combination of audio, video, and text. Health care providers can listen to a CD at their leisure and access the mastery component on the Internet, or they can take the entire course on-line.

"We find physicians particularly enjoy audio components that they can plug into their car CD player," says **Sharyn Lee**, president and chief executive officer of the company.

The CDs are purchased by sponsors who give the CDs to the physicians within their sales territory through a network or by direct mail.

The company is building a Web conferencing center that will enable it to provide live interactive sessions as a component of an educational course. ■

Patients going on-line for medical information

Take a proactive approach and recommend sites

Your patients may be turning to the Internet to learn about their conditions, diseases, and fitness because they aren't getting the information they need in your office, a new study shows.

Some 17.5 million adults in America are using the Internet to search for health information, according to the *1999 Environmental Assessment: Rising to the Challenge of a New Century*, by New York-based Deloitte & Touche, LLP, and VHA, Inc., a nationwide network of 1,800 community-owned health care organizations and physicians based in Irving, TX.

Of the consumers who use the Internet to find health care information, 81% say they consider the information to be useful or very useful.

More than half are looking for information on specific disease or conditions. Other reasons include educational services, dietary information, medication and drug information, and wellness programs.

The study also reports that 66% of patients don't receive written information about their condition or their child's condition and only a third of patients receive information about their medications.

Patients say they are visiting the Internet for health care information because they don't get the information they need at their physician's office. The physician may not have the time to give patients all the information they need orally, or the written material that is available is not

Physician's Managed Care Report™ (ISSN 1087-027X) 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 Managed Care Report**™, 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. E-mail: customerservice@ahcpub.com. Web site: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $429. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $257 per year; 10 or more additional copies, $172 per year. Call for more details. **Back issues**, when available, are $72 each. (GST registration number R128870672.)

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

specific enough, says **Merlin Olson**, principal at Deloitte & Touche.

However, Olson points out that there are risks to patients getting health care information on-line because there is no guarantee that the information or advice is accurate.

"Unfortunately, patients don't always come away particularly well-informed or better educated. They don't understand the information, or they misinterpret it, or they only get part of the important information. Just because they are assessing the data, it doesn't necessarily make them more informed," Olson says.

Physicians have reported to Olson that they have to schedule longer office visits to clear up the misunderstandings patients have gotten from the Internet.

Olson suggests that physicians encourage their patients to use the Internet for health care information, but to be prepared to recommend specific sites they feel are credible and well-presented.

Rather than physicians going through all the available sites themselves, they should have someone on their staff pre-screen all applicable health care sites. Then physicians can look through a short list of sites and find those they can endorse, he says.

"The individual practitioners would want to be familiar with the content and quality of the sites they recommend," he says.

The lists of sites a physician might recommend would vary by diagnosis, Olson says. He suggests checking out sites of organizations that deal with specific diseases and conditions. Most of these Web sites have links to other health care sites. ■

Auditors rap HCFA

The Health Care Financing Administration needs to supervise its fraud cops better, according to a report from the General Accounting Office (GAO).

The report says six of HCFA's contractors have had to pay $235 million in penalties since 1993 for reasons including improper payment of claims, destroying backlogged claims, and failing to recoup money owed Medicare. All the contractors reviewed by the GAO failed to completely document the amount of money providers owed Medicare due to overpayments and claims that should have been paid by other insurers, says the GAO. ■

SourceKit

Following are names and telephone numbers of sources quoted in this issue:

Medical Group Management Association, 104 Inverness Terrace East, Englewood, CO 80112. Telephone: (888) 608-5601. Fax: (303) 397-1824. Web site: www.mgma.com.

Joint Commission on Accreditation of Health Care Organizations, Department of Standards, One Renaissance Boulevard, Oakbrook Terrace, IL 60181. Telephone: (630) 792-5900. World Wide Web: www.jcaho.org.

Diana McGill, PA-C, president, Pro-Search Medical Placement, Houston. Telephone: (281) 890-9660. Fax: (281) 890-5983. E-mail: diana4ps@aol.com.

Peter Dreyfus, Harvard Vanguard Medical Associates, Boston. Telephone: (617) 730-7907. Fax: (617) 730-7512.

Marc Benoff, MBA, director, Dan Grauman Associates, Inc., Bala Cynwyd, PA. Telephone: (610) 667-8782.

Merlin Olson, principal, Deloitte & Touche, New York. Telephone: (212) 436-2970. Fax: (212) 436-5961. E-mail: MOlson@DTTUS.com. Web site: www.us.deloitte.com. ■