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INSIDE

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Physician-hospital gainsharing plans violate federal laws, OIG says

Special bulletin advises providers to stop the practice

If your practice has any kind of financial arrangement with a hospital, you should review it immediately to make sure you're not violating federal laws against gainsharing.

In a July advisory that surprised many in the health law community, the Office of Inspector General (OIG) of the Department of Health and Human Services pulled the plug on gainsharing arrangements between hospitals and physicians.

Unless Congress changes the law, most gainsharing arrangements are illegal and could result in fines for physicians and hospitals of up to $2,000 per patient, the OIG special bulletin says.

The speed with which physicians and hospitals terminate their gainsharing arrangements will have a bearing on the punishment that could be levied in the future, the bulletin adds.

The other shoe has already fallen

"The clear message is that the health care community should immediately start analyzing all financial arrangements between hospitals and doctors. They should not sit and wait for the other shoe to drop because it's already fallen," says **John Knapp**, JD, a health law attorney at Cozen and O'Connor, a Philadelphia-based law firm with 13 offices across the United States.

Gainsharing is an arrangement in which a hospital gives physicians a

Executive Summary

Subject: Illegal gainsharing arrangements among hospitals and physicians
Essential points:
- The OIG has ruled that gainsharing arrangements are illegal
- Physicians are advised to review their financial arrangements with hospitals
- Fines may be up to $2,000 per patient for physicians and hospitals
- Speedy termination of contracts could alleviate future punishment

percentage share of any reduction in the hospital's cost for patient care that can be attributed to the physicians' efforts.

According to the OIG bulletin, the Social Security Act "prohibits any hospital or critical access hospital from knowingly making a payment directly or indirectly to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries under the physician's care."

Beware payments to 'limit clinical services'

The advisory bulletin stated that even though there may be cost-saving benefits to gainsharing arrangements without any impact on the quality of care received by the patients, such arrangements are clearly prohibited by law. The only way such arrangements can be legal is by a law passed by Congress, the bulletin advises.

"In short, any hospital incentive plan that encourages physicians through payments to reduce or limit clinical services directly or indirectly violates the statue," the OIG bulletin says.

Until the OIG special bulletin, the health care community had felt that gainsharing arrangements could be constructed to comply with the law and that such arrangements had been tacitly approved by the government, Knapp says. He estimates that thousands of gainsharing arrangements are currently in place.

"Even though the law has been on the books for years, the general thinking has been that it is the intent of the government to get hospitals to act more efficiently, so it is logical and appropriate to find ways to get physicians to cooperate with them and to deliver health care services more efficiently," Knapp says.

Following the OIG bulletin, Knapp has advised all his clients to begin analyzing all hospital/physician arrangements to make sure they are not gainsharing. Physicians who are employed by the hospital should seek advice regarding whether bonuses or other incentives to encourage efficiency may constitute gainsharing, he advises.

"An important point is that this doesn't mean all financial relationships are not permissible. It doesn't mean that hospitals are prevented from taking steps to make their care more efficient. What it does mean is that these arrangements have to be even more carefully structured than in the past," Knapp says.

In the past, many health care lawyers have advised clients that one-on-one gainsharing is not permissible, Knapp says. In other words, they advised hospitals and physicians not to set up arrangements whereby physicians are paid on an individual basis when patients are discharged early.

A more common arrangement is for the hospital to track all admissions by a physician or a group for a year and pay a bonus based on the average number of patients discharged before their target dates. Some arrangements specify that the physicians qualify for the incentive payments only if the hospital determines that the patients are not adversely affected by early discharges.

"The health care community believed that if the arrangements didn't relate to any one particular patient or any one particular doctor, they were OK," Knapp says.

However, the recent OIG advisory has stated that no matter what kind of arrangement is involved, it is illegal, he adds.

"The language in the special bulletin states pretty strongly that everyone has to analyze their current arrangements with hospitals, and if they have impermissible gainsharing arrangements, they have to be unwound immediately," Knapp says.

The ruling is frustrating to the health care community. On one hand, the OIG says gainsharing may be a good idea if it reduces the cost of patient care; but on the other hand, the OIG plainly states that gainsharing is illegal until Congress changes the law.

"The OIG recognizes that hospitals have a legitimate interest in enlisting physicians in their efforts to eliminate unnecessary costs. Savings that do not affect the quality of patient care may be generated in many ways, including substituting lower cost but equally effective medical supplies, items or devices; re-engineering hospital surgical and medical procedures; reducing utilization of medically unnecessary ancillary services; and reducing unnecessary lengths of stay," the OIG stated.

It added that achieving the savings might require a substantial effort on the part of participating physicians.

"Obviously, a reduction in health care costs that does not adversely affect the quality of the health care provided to patients is in the best interest of the nation's health care system. Nonetheless the plain language of section 1128A(b)(1) of the [Social Security] Act, prohibits tying the physicians' compensation for such services to reductions or limitation in items or services

provided to patients under physicians' clinical care," the advisory says.

The advisory notes that there are ways hospitals can offer incentives to physicians to achieve cost savings without violating the law.

"For example, hospitals and physicians may enter into personal service contracts where hospitals pay physicians based on a fixed fee that is fair market value for service rendered, rather than a percentage of cost savings," the advisory says.

However, such arrangements must meet the requirements of the anti-kickback (Stark II) statute, the OIG warns.

The OIG staff decided against examining individual gainsharing arrangements and issuing opinions as to their legality.

"Were the OIG to issue a favorable opinion to one provider, that provider would have a significant competitive advantage in recruiting and attracting physicians to admit patients to the facility," the report says. ■

Network gives specialists negotiating leverage

Physicians seek greater voice in care decisions

In order to deal with the unique challenges that specialists face in today's managed care environment, a group of Boston area surgical and medical specialists have formed a physician organization to give its members a greater voice in patient care and to enable them to work more effectively with hospitals and other tertiary care providers.

Executive Summary

Subject: A specialist referral network
Provider: Specialty Care, LLC of Scituate, MA
Essential points:
- More than 80 specialists at six hospitals formed a physician organization
- Aim is to achieve more leverage with managed care organizations
- Specialists have better communication among themselves and with primary care physicians

Specialty Care, LLC, based in Scituate, MA, is made up of more than 80 surgical and medical specialists who are on staff at six hospitals in communities on Boston's south shore. Members are specialists in four areas: cardiothoracic surgery, general and vascular surgery, orthopedic surgery, and gastroenterology.

"We're doing a lot more networking and working harder in ways we are not accustomed to, but we're getting good at it," says **Robert Driscoll**, MD, a general and vascular surgeon who is president of Specialty Care.

"We were surprised to find that many of us across different hospitals in our region were having the same problems with managed care organizations and primary care groups."

The organization has brought together specialists who previously didn't know each other but who realized the benefits of joining together in today's health care environment. "We were surprised to find that many of us across different hospitals in our region were having the same problems with managed care organizations and primary care groups," Driscoll says.

The organization is the state's first surgical/medical specialty care organization.

The physicians in Specialty Care say having an organization will strengthen their position in the managed care market and give them greater leverage in the process of making decisions about patient care.

"Patients are looking for us, the specialists, to assume a more active and up-front role in the management of patient care. There is genuine concern and anxiety about the direction that managed care is taking. Patients are concerned that nonphysicians or employees of managed care organizations are making decisions about their care," Driscoll says.

The organization expects to be able to negotiate risk contracts with other physician networks and health care organizations as well as save money on malpractice insurance rates and other expenses by purchasing as a group. The organization is structured so members share information

Allow time to start a specialist network

Here's how one works

If you would like a physician networking organization like Specialty Care, LLC, in your city, start working on it now, advises **Robert P. Driscoll**, MD, president of the Scituate, MA-based physician organization.

"Be the first one in your region. Don't be afraid to be the leader," Driscoll says.

It took about 18 months for Specialty Care's steering committee to come up with the organization plan, recruit the initial members, and get the organization up and running. The organization started operation in June.

All members were required to make a capital donation to provide funds to get the organization started.

Specialty Care's steering committee began its recruitment efforts by deciding on the medical specialties that would be included, then talking to physicians in the region who practice in those specialties.

"Most of the specialties are in the surgical area, but we have an eye toward adding other medical specialties," Driscoll says. At present, Specialty Care operates with no paid staff members. All the officers and committee chairs are volunteers.

Specialty Care is organized in a two-tier system, Driscoll says.

The members are divided into "pods" or subgroups that are aligned along the specialties represented. Within each pod is a group of managers and three officers. Each pod sends two representatives to the Specialty Care organization meetings.

The umbrella organization has a president, vice president, and secretary-treasurer as officers.

Each pod has subcommittees that deal with issues facing those physicians. For instance, the general and vascular surgery pod has developed subcommittees on quality improvement and utilization management, credentialing, and contracting.

The Specialty Care umbrella organization negotiates contracts with the primary care or managed care organizations. Reimbursement in the area is mostly discounted fee for service.

The group has hired a public relations firm to publicize the new organization to the public through newspapers and periodicals. Members are marketing themselves to primary care organizations through direct discussions and are planning a marketing campaign with managed care organizations. ■

on best practices and communicate regularly with the patients' primary care physicians.

"Very smart and experienced specialists are talking about the best way to manage care. There is real value added for the patients as well as for the HMOs because they know what to expect and they don't always have the resources or the expertise to manage diseases," Driscoll says.

Improving care by sharing information

One benefit of the organization is that it brings together groups of specialists who can share information and come up with the best practice models, Driscoll says.

"We can discuss how we can best manage patients with a certain disease and share information on the best techniques and the newest innovations that will allow us to get the patients through our offices quickly and efficiently, to the operating room, through the operating experience, and to educate them," Driscoll says.

The specialists share their experiences on techniques that have worked well for them. "There is a comprehensive series of things that need to be done on the patient's behalf. One member might do one thing particularly well and share the information with the others," he adds.

The specialists also sit down and review cases weekly with the primary care physicians at each hospital where they practice. "It has opened the lines of communications," Driscoll says. "We talk regularly rather than having to wait several days for a referral letter to be generated."

The face-to-face contact benefits both the physicians and the patients, Driscoll says.

"The primary care physicians can tell me directly what the patient needs. It gives me a better understanding of which patients have more critical problems, and I am able to see the patients with more acute needs more quickly," he says.

Having a comprehensive discussion with the primary care physicians helps the specialists establish patterns of treatment and makes it easier to treat the next group of patients, he adds.

"We discuss patients who are going to have surgery, those who have had surgery. We talk about how they are doing, their expected length of stay, and how we might improve them with therapy or alternative care, such as discharging them to transitional care or home with a visiting nurse service," Driscoll says.

The specialists intend to pool their knowledge and experience to develop their own best practices and critical pathways. Each of the hospitals where the specialists practice have critical pathways and patient outcomes plans, but the specialists want to write their own.

"The best practices change on an ever-present basis. We want to make sure that we are able to introduce innovations that are better for patients, such as minimally invasive technique," Driscoll says.

For instance, some innovations, such as laparoscopic surgery, are better for the patients but raise eyebrows with insurers because initially they seem more expensive, he adds.

"We want to look at our experience and be able to freely discuss those operations with our patients and with the insurance companies," he says. ■

When a full waiting room means business is bad

Better scheduling means happier patients

If your office typically has patients who sit in the waiting room for more than a few minutes or has a backlog of patients waiting for an appointment, act now to alleviate the problem before you lose your patients to a more efficient provider or you lose your contract with a health plan that emphasizes access to care.

When patients fill out patient satisfaction surveys, they often complain of waiting too long for appointments and spending too much time in the physician's waiting room.

For instance, in a recent survey conducted by *Consumer Reports* magazine, one-fourth of readers responded that their primary care provider "typically kept me waiting too long."[1]

Executive Summary

Subject: Improving patient scheduling techniques
Essential points:
- Long waits for appointments or in the physician office can decrease patient satisfaction
- Improving scheduling can improve staff efficiency
- Failure to act can result in a snowball effect

"All over the world, and specifically in this country, patients tell us a very consistent story about what they want from their health care providers," says **Mark Murray**, MD, MPA, of Murray, Tantau and Associates, a Sacramento, CA-based consulting firm that deals with health care efficiency and scheduling issues. Murray has worked as an independent consultant and on projects with the Boston-based Institute for Healthcare Improvement.

He says the things patients value most are:

- the opportunity to choose their primary care doctor;
- a chance to get an appointment at the time they choose;
- a good experience in the physician's office. This means a short waiting time and a good relationship with their provider.

If a physician office is crowded all the time, the problem should be addressed, says **Randolph D. Smoak Jr.,** MD, president-elect of the American Medical Association.

"The office should run on time. It's a problem that should be addressed, whether it's because of scheduling or because the physician is always late getting back from the Rotary Club," he adds.

Smoak cautions his fellow physicians to remember that a patient's time is valuable, just as a physician's time is valuable.

"Some patients have to lose time at work to make an office visit, or they may have a ride only at one certain time. There are many reasons why it is important to them to be seen on time," he says.

Less waiting means increased productivity

"You can improve patient satisfaction by decreasing patient waiting time. At the same time, you also increase productivity so that patients can get in to see the physician sooner for non-urgent care," says **Julie Elmore Jones**, MBA, MHA, a consultant with Atlanta-based Gates, Moore, and Co.

Six common causes for office backlogs

If your office has a constant backlog of patients waiting for appointments and waiting to see the doctors once they arrive, here are some potential problem spots:

1. Appointment scheduling.
Some practices schedule in 20-minute time slots regardless of why patients are coming in, and despite the fact that some physicians work less quickly than others. This can cause backlogs and idle time for physicians, says **Julie Elmore Jones**, MBA, MHA, a consultant with Gates, Moore & Co. in Atlanta.

2. Inappropriate staffing.
Where the staffing problem lies is unique for each practice, Jones says. It may be that there are too many people in checkout and not enough lab technicians to handle the volume of laboratory procedures. Or it could be that physicians can't complete their examinations in a timely manner because there aren't enough medical assistants.

"They're flipping on the light and no one is there to assist them. Instead of having everything they need, the physicians have to go and get it themselves," Jones says.

3. Inefficient handling of medical records.
Sometimes the patient gets to the exam room long before the medical record. This leaves the physicians standing around with nothing to do. "It's extraordinarily wasteful and expensive and upsetting for the physicians," Jones says.

4. Double- and triple-booking.
Booking several patients for one appointment time may seem like a good solution, but if all patients show up at the same time, you get even further behind.

5. Delayed test results.
These may be caused by a backup in the on-site lab or communications problems with the off-site lab.

6. Inefficient use of physicians' time.
Some delays occur when a physician has to spend time on patient care issues that don't need a physician's attention, according to **Doug Hough**, PhD, partner at Arista Associates in Fairfax, VA. ■

In the managed care environment, an increase in productivity is a major goal for most practices, and providers should take steps to achieve efficiency, Jones points out.

The problem could be scheduling, poor use of staff time, or not enough personnel. **(For a list of potential causes of patient backlogs, see story above.)**

But, whatever the cause, the adage, "A stitch in time saves nine" could apply to solving the problems of patient waits. If you get behind this week, the problem could snowball so you'll be even more behind in the future. If it does get worse, you could lose patients, who will choose another provider who doesn't make them wait, or you could lose a contract with a health plan that puts a high premium on access to care.

Doug Hough, PhD, a partner with Arista Associates in Fairfax, VA, provides this scenario that illustrates the snowball effect of patient waiting time:

The physicians get behind, and patients have to wait for their appointments. Eventually, the patients start coming in late because they know they'll have to wait when they get there. Then, the physician office overbooks to compensate for the late patients. "And if everybody shows up at once, they're in big trouble," Hough says.

Or, if you have problems with an appointment backlog, the problems will only get worse unless you take steps to solve it, adds Murray.

When a patient calls a primary care physician whose schedule is completely booked, the staff may refer the patient to an urgent care center, Murray says.

Many times, the patient wants to be seen again by his or her own doctor after the urgent care visit. This increases the cost of treatment and causes a lot of dissatisfaction, he notes.

"When patients have to be referred to an urgent care center because the schedule is backlogged, this means practices have failed to develop a system that ensures that patients see their own doctor when they are ill," Murray says. "The result is additional cost to the patient or the insurer and ill will toward the physician."

Reference

1. Rating the HMOs. *Consumer Reports* 1999; 64:23-28. ■

Physician's Capitation Trends™

• Capitation Data and Trend Analysis •

Like the weather, capitation is everywhere

HMO use of it tops 75%

Survey after survey tries to determine just where and how capitation fits into the overall financial scheme of managed care — many with little success at pinning it down. A recent survey of the 25 largest and fastest-growing HMOs does an excellent job of documenting capitation's presence.

The study, released by the Minneapolis-based research group InterStudy Publications, finds capitation is virtually everywhere that large and growing HMOs exist, and it has pretty much equal footing with other, more conventional payment schemes.

Capitation as a provider payment model has experienced erratic growth trends, typically growing from 1993-1995, taking a dip in 1997, and climbing back up in 1998. Currently, data indicate you'll see about as much capitation as you'll see fee-for-service schemes, and you'll see Medicare's relative value scale (RVS) covering most of the Medicare population. Salaried doctors — those hired as full-time HMO physicians — remain the smallest portion of the payment pie.

As of July 1998, 78.7% of HMOs use capitation and 69.7% use fee-for service for primary care physicians, while 27.2% offer RVS. **(See chart on p. 136.)**

The totals are higher than 100% because they represent all the plans in each HMO that use any form of the payment method indicated, explains **Tammy Lauer**, the study's co-author. For example, one HMO may have both fee-for-service and capitation arrangements in a single contract.

"The numbers are showing there is a great deal of mixing and matching of payment methods," Lauer says. "And, there is more capitation overall this year than last year."

In the domain of primary care physicians, the new ratios reflect substantial increases over the year before, where the ratios were 56.6% capitation, 32.7% fee for service, and 7.1% RVS.

Specialty care physicians are similarly involved in multiple payment arrangements, with capitation on the upswing after a dip in 1997. Data show that 56.4% of HMOs are engaged in capitation with specialists, compared with 75.5% fee for service and 32.2% RVS. Those numbers are up from 1997, when respective ratios were 32.8%, 48.6%, and 17.6%.

Surprisingly, hospitals are relying strongly on per diem rates (86.2% of HMOs using these with hospitals) and less on capitation (32.5% of HMOs offering them cap payments).

Here are other key findings relative to capitation trends:

• Since InterStudy began tracking reimbursement data, the industry has split into two groups — those that use capitation for a large portion of services, and those that predominantly use fee schedules. The two reimbursement methods may be used by the same plan, but usually they are substitutes for one another.

• More than half of all HMOs reimburse more than 60% of primary care services through capitation contracts. Many HMOs use capitation for primary care, but in many cases it is used for a small portion of all primary care provider services.

Data indicate a sharp increase in the numbers of HMOs using multiple methods for provider reimbursement. "This can be viewed as a renewed willingness by HMOs to investigate and experiment with new arrangements that yield better financial results," the report suggests.

Percentage of HMOs Using Each Provider Reimbursement Method

Showing the percent of HMOs using reimbursement methods for any portion of provider payments.

	July 1993	July 1995	July 1997	July 1998
PRIMARY CARE PHYSICIANS				
Capitation	64.3%	65.9%	56.6%	78.7%
Fee for Service	21.7%	17.9%	32.7%	69.7%
Relative Value Scale	5.2%	4.7%	7.1%	27.2%
Salary	8.8%	10.5%	3.6%	9.8%
SPECIALTY CARE PHYSICIANS				
Capitation	47.4%	49.1%	32.8%	56.4%
Fee for Service	39.0%	35.6%	48.6%	75.5%
Relative Value Scale	9.7%	9.2%	17.6%	32.2%
Salary	3.9%	6.1%	1.1%	3.3%
HOSPITALS				
Fee for Service	NA	16.9%	15.8%	71.7%
Per Diem Rates	NA	42.9%	53.2%	86.2%
Diagnosis-Related Groups	NA	14.1%	12.0%	49.5%
Capitation	NA	26.1%	19.0%	32.5%

Source: InterStudy Publications, Minneapolis.

Of all HMOs, 72% use two or three methods to reimburse hospitals, while 69% use two or three methods to reimburse primary care physicians. In contrast, specialty care reimbursement is most unified, with 93% of HMOs using one or two methods.

Overall, HMO enrollment is slowing significantly, the InterStudy report shows. If HMOs were graded on a bell curve, you'd see their highest growth scores mid-range, and a lowering effect on the beginning and ending poles of the curve.

As of July 1, 1998, there were 652 HMOs servicing a total of 78.7 million HMO enrollees, the InterStudy report states. The current HMO growth rate is 7.9%, which is pretty low compared to the 15.5% rate in 1997 and the 18.5% rate in 1996. "This represents a significant decline in the [past] growth rates," the study says.

"The slowdown in growth is associated with an increase in commercial premiums and a lack of growth among the largest health plans," the InterStudy report postulates.

"The sharpest slowdown is in the growth of traditional commercial products," InterStudy researchers say. "During this decade, traditional [pure] HMO products have been the driver of growth. Other products have been added as competition spurred diversification and as infrastructure developed for commercial plans was transferred to new products. With HMOs seeking to restore financial health with increased commercial premiums and a demonstrated link between growth and price inflation, it is likely that industry enrollment growth will continue to slow."

Here are a few other interesting growth trends:

• **Big guys are still winning.** HMO enrollment continues to be concentrated in the largest and oldest plans. Over 80% of all HMO enrollment is in plans that are at least 10 years old and have at least 100,000 members. Less than 1% of all HMO enrollment is in plans with fewer than 10,000 members.

• **Staff model HMOs are declining.** Once the icon of the gatekeeper model, pure staff model HMOs compose only 1% of total enrollment, and half the plans offering the option in 1998 quit offering it that year.

• **West is still best in capitation presence.** The Pacific region accounts for one-fourth of all HMO enrollment, followed by the mid-Atlantic and South Atlantic regions, each with 16% of all HMO enrollment.

• **Medicare HMO enrollment is declining, but not nose-diving.** Erratic is the word for Medicare HMO growth rates since 1991, too. InterStudy shows growth from 1990 to 1991 at 6.7%, compared with 25.0% in 1992, 10.0% in 1993, 35.5% in 1996, and down to 18.6% in 1998. The most recent flap from the industry was Congress' Balance Budget Act of 1997. The Act varied Medicare capitation rates, and it will be phased out over the next four years and replaced by a risk-adjusted system. ■

Major fallout expected from managed Medicare

Feds expect 99 plans to step back

Look for significant movement of Medicare patients next January when 99 Medicare+ Choice plans will reduce or abandon service areas. This is expected to affect nearly 250,000 Medicare patients, and nearly 80,000 managed Medicare clients may opt for traditional fee-for-service programs.

These latest moves are setting up a congressional free-for-all in the fall surrounding the need to postpone implementation of the Health Care Financing Administration's Medicare+Choice proposed risk adjuster, an idea House Ways & Means Health Subcommittee Chairman Rep. Bill Thomas (R-CA) seems to like.

On July 1, when M+C plans submitted adjusted community rate proposals for 2000, 41 plans withdrew from the Medicare program entirely, while 58 reduced their service areas. About 5% of the 6.2 million M+C enrollees were affected, HCFA estimates. Plans must notify beneficiaries of their options by Sept. 15. Withdrawals take effect Jan. 1, 2000.

While 33 states will experience managed Medicare reductions and withdrawals, Louisiana, Maryland, Virginia, and Florida are each expected to have over 10,000 seniors return to traditional Medicare, according to HCFA. States most affected by the M+C beneficiary changes are New York (39,000), Louisiana (34,000), Texas (32,000), Arizona (31,000), and Florida (29,000).

Medicare HMO spending won't increase much

The American Association of Health Plans (AAHP), an HMO lobbying group, says Medicare HMOs are pulling out of the program because they are not paid enough. Noting an analysis by PricewaterhouseCoopers, AAHP estimates that 46% of beneficiaries live in areas where Medicare+ Choice payments will increase by 2% or less after risk adjustment. Some 69% of beneficiaries live in areas where payments will increase by 4% or less. By contrast, Medicare fee-for-service spending is expected to grow by nearly 6% next year.

HCFA counters this criticism by pointing to a recent GAO report finding M+C reimbursement rates to be "more than adequate," while some plans may even be overpaid. ■

'Market capitation' takes sting out of referrals

Try this variation on 'contact capitation'

There's a new twist on "contact capitation" that has the potential to take the headache out of capitation for specialists — it's called "market capitation."

Designed specifically for specialists, market capitation is a form of contact capitation, according to actuary **Brent Greenwood**, a principal in the Atlanta office of Towers Perrin, an actuarial and health care consulting firm. It works on the same principal of contact capitation — an "it's who you know that counts" approach. But instead of being production-based, as the typical contact capitation approach is, it's population- or market-based, Greenwood says. It bases payment on a proportion of patients treated by specialists, rather than on the number or type of services provided to patients referred for specialist care.

Mixing capitation with fee for service

For example, typical contact capitation arrangements work this way: The primary care physician serves as a gatekeeper, referring patients to physician specialists within the contract's panel of doctors. The primary care doctor receives a capitation payment for each patient he or she sees.

From that overall capitation payment (per member per month, or PMPM, payment), a portion is set aside for specialist services. When specialists are called upon to care for a patient, the specialist typically is paid from that set-aside pool on a fee-for-service basis. The fee-for-service amount typically is determined by Medicare's resource-based relative value scale (RBRVS) or some variation of RBRVS.

Contact capitation refers to the referral mechanism. When the primary care doctor refers a patient to a specialist, he or she "makes contact" with that patient. Usually, however, specialists have been immune from accepting a capitated payment for these "contacts," or patients.

In the market capitation scenario, however, capitation does extend to the specialist — with some exceptions. Instead of being paid per service, the specialist receives a PMPM payment each month based on the percentage of the market, or enrollees in the health plan.

"If a group sees 20% of the patients in a 12-month period for that particular specialty, the group receives 20% of the monthly capitation," Greenwood says. "This corresponds to an average per patient reimbursement model."

Exceptions would be granted for high-cost and/or high-tech specialist services when they are needed. "Only those services provided by select 'super-specialists,' such as retinal surgery, or those services identified as low-frequency, high-unit-cost, and low-discretion can be reimbursed on a fee-for-service basis," he explains.

To make this approach work, you select prospectively the high-frequency, lower-cost or lower cost-variability specialist services by CPT code and earmark them as part of the capitated category of services. In Greenwood's experience, codes for these kinds of core procedures make up between 80% and 90% of total specialty cost.

Overall reaction in group practices testing market capitation has been excellent, Greenwood says. Physicians say the system is more fair and equitable because individual physicians' results aren't totally dependent on the performance of their peers in the specialty pool.

For example, sometimes so-called "withhold amounts" are set aside as payment targets. When specialists exceed targets by "over-servicing," all the specialists stand to lose their full payment share. That system penalizes high-tech providers or specialists who care for intensive cases, and disgruntles those who keep costs in line.

By contrast, the market capitation approach allows fee-for-service payment for high-cost services, and those services don't count against a physician or pool of physicians. At the same time, there is an incentive for judicious use of specialist services because more services don't automatically translate into higher reimbursement.

This mixed-model approach also is attracting some international attention. Researchers at The Hebrew University Medical School in Jerusalem recently released a study analyzing the value of what they call "soft contracts" in capitation.[1] Soft contracts look remarkably like the market capitation method in that both fee-for-service and PMPM approaches are used. In their study, researchers Amir Ahmueli and Jacob Glazer say soft capitation should incorporate a phasing-in of capitation for physicians to ease them into the system.

Also, soft contracts should vary or "soften" the length of time that a particular PMPM is in effect, leaving room to adjust after gaining more experience with the patient population, Ahmueli and Glazer suggest.

Another advantage built into the standard contact capitation approach — providing an incentive for specialists to win patient satisfaction — also remains intact with market capitation, Greenwood says. As in contact capitation, a patient can leave one specialist for another in the market capitation system, which would then decrease the dropped physician's PMPM payment.

Reference

1. Ahmueli A, Glazer J. Addressing the inequity of capitation by variable soft contracts. *Health Economics* 1999; 8:335-343. ■

Brace for impact from Medicare reform

President Clinton's recently proposed Medicare reform plan could have a significant impact on medical groups — but experts are not exactly sure what that impact will be because so many of the plan's particulars are "still to come."

For instance, the administration wants to:

• Allow HCFA to negotiate alternative flexible administrative arrangements with providers and suppliers such as simplifying claims processing, reducing billing payment cycle time, and alternative claims and cost settlement processing.

The downside: These simplification measures would only benefit providers willing to offer price discounts to Medicare and demonstrate "better" performance and "higher" quality," notes an analysis of the proposal by the Medical Group Management Association (MGMA) in Englewood, CO.

• Authorize bonus payments for large physician group practices. The question is whether the still-unknown accompanying paperwork burden will outweigh potential financial incentives.

• Create a Medicare preferred provider option (PPO).

The MGMA notes that the PPO proposal, while interesting, comes with more questions than answers. For instance, would only a segment of beneficiaries have the PPO option? Would this provision force providers to contract with managed care entities? Would this influence provider contracts with existing managed care PPOs? ■

Easing patient backlog takes work and ingenuity

Here are some solutions to consider

It's possible to eliminate a patient backlog, but it takes work, experts say.

"It takes everybody in the whole practice to work together and look at how they can treat the greatest number of patients most efficiently," says **Tom Aug** of Development Partners, a Cincinnati-based firm that specializes in patient satisfaction improvement for physician group practices.

Here are some suggestions for improving patient flow that Aug and other consultants have put into practice:

• **Spread out your complicated appointments.** For instance, don't schedule back-to-back physicals or other procedures that take physicians a long time. In scheduling, medical offices need to set some time aside for extended office visits as well as the limited visits. **(To learn how to tell how many of each kind of visit to expect, see related article at right.)**

• **Add examination rooms.** Have enough examination rooms so people don't have to wait long for an open spot. If the wait is going to be 20 minutes, have patients wait for 10 minutes in the waiting room and 10 minutes in the examination room, Hough suggests.

"Psychologically, it tells them they're moving along. It may require additional expense to have more examination rooms, but in terms of patient satisfaction, it goes a long way," he adds.

• **Standardize the examination rooms.** This enables each room to be used for flexible purposes and ensures that staff know where all items are located, suggests **Mark Murray**, MD, MPA, with Murray, Tantau and Associates, a health care consulting firm in Sacramento, CA, specializing in efficiency measures for physicians and hospitals.

• **Consider hiring midlevel providers.** Hough suggests that practices consider hiring a physician assistant or nurse practitioner to handle some of the routine patient care.

"Some people say they can't afford the additional expense, but I can demonstrate that within a reasonably busy physician practice, a nurse practitioner will earn her keep two- to threefold," Hough says.

CPT codes can help solve scheduling woes

Study shows number of limited, extended visits

If you look at how your patients are distributed according to CPT codes, you can determine your "ideal patient hour" and come up with an efficient way to schedule them, declares **Doug Hough**, PhD, a partner in Arista Associates in Fairfax, VA.

An analysis of your CPT codes can point out the types of patients each physician in your practice is seeing and help you come up with a schedule that makes the best use of each individual physician's time, he adds. You can determine how many patients each physician is seeing for limited visits vs. extended or comprehensive visits, and the number of new and established patient visits.

"If you look at the distribution, you can construct what your ideal patient hour is so that if you're seeing a lot of patients for extended office visits, you can schedule fewer patients," he adds.

For instance, if 80% of your patients are CPT codes 99213, 99214, and 99215 (intermediate, extended and comprehensive) and only 20% are minimal and brief visits, you should schedule five patients in an hour, expecting that three will take 15 minutes and the other two seven and a half minutes each, Hough says.

Hough suggests analyzing the visits scheduled in a typical month, not the busiest or the slowest month. "A good practice ought to be looking at the distribution of CPT codes for billing purposes, anyway," he adds.

Your analysis should include a separate analysis for each physician in the practice.

"Each physician has a different patient load and different requirements, and each physician takes a different amount of time depending on his or her practice style," he adds.

For instance, a CPT 99213 should be a 15-minute visit, but some physicians take 20 minutes while some take 10 minutes, Hough says.

"Younger physicians typically haven't been broken of the habit they learned as a resident: It takes half an hour per patient. But established practitioners have different practice styles, and their schedules should reflect it," he adds. ■

Keep it simple when scheduling appointments

Too many variations can exacerbate your backlog

The existence of multiple appointment types and corresponding appointment times has impeded access to care, says **Mark Murray**, MD, MPA, a consultant with Murray, Tantau and Associates in Sacramento, CA.

"As physicians, we have created categories of appointment types in a vain attempt to control demand. What we ultimately do is increase waiting time. We create a lot of variation and increase waiting time in a vain attempt to control demand," he says.

"Wave scheduling" may be the solution to some office backlogs, says **Doug Hough**, PhD, a partner at Arista Associates in Fairfax, VA.

If a physician typically sees five patients in an hour, the classic way to schedule is to set one appointment on the hour, the next at 10 minutes after the hour, and so on.

Instead, Hough has found it effective in some practices to schedule patients in waves. This means scheduling three patients on the hour and two on the half-hour. "Many times, patients won't show up on time. This way, the first one that gets there gets in immediately," Hough says.

He adds that wave scheduling often helps physicians use their time more efficiently so they are behind less often. One potential drawback is that if all patients show up at the same time, one of them has to sit in the waiting room for 20 minutes.

However, that's not likely to become a problem, Hough adds, "because most of the time patients don't show up exactly on time." ■

• **Track the waiting time for every patient, every day.** Just tracking the waiting times so staff can see them may be a way to alleviate some holdups, Aug says.

He suggests having a space at the top of the encounter form that tracks the time the patient arrives, when the patient is called into the examination room, when the patient is seen by the physician, and when the patient checks out. "If the physician looks at the form before they see the patient, they can apologize for the delays and be aware that they are running behind," Aug adds. Sometimes, if other staff notice the delays, they'll make an effort to improve the patient flow, he says.

• **Consider extending your hours.** Look at how your practice as a whole can be available to patients for more hours in the week, Aug suggests. "Physicians should look at their patient population to see how they can create a schedule that will benefit the most number of patients," he adds.

For instance, physicians in the office could rotate working late on certain days to see more patients, Aug suggests.

• **Schedule additional appointments for patients with multiple problems.** If a patient makes an appointment to take care of one problem and then mentions three or four other problems to the medical assistant, that visit can disrupt the entire day's schedule, Aug points out. He suggests that the medical assistants ask the patients to make another appointment for their less urgent complaints.

"It doesn't sound patient-friendly, but it can disrupt things for the rest of the patients if one person is allowed to monopolize the staff's time," Aug says.

He suggests that the medical assistant tell the patient: "These problems require a lot of time to deal with, and we're on a tight schedule today. We can schedule another appointment so you can get the attention you need."

• **Synchronize your systems.** Take steps to make sure the patient, the provider, and the paperwork all start at the same time, Murray suggests.

• **Reduce the need for unnecessary visits.** "The key linkage to eliminating unnecessary visits is between the doctor and the patient. There are a lot of strategies you can put into place," Murray adds. Some suggestions include increased telephone triage and doing more with each visit to decrease the total number of visits.

• **Work longer hours to catch up on your current backlogs.** "This takes work. Basically, physicians have to work more for a short period of time to get the backlog eliminated," Murray says.

"Our mantra is, 'Do today's work today.' What we see in most organizations is that they're doing last month's work today," Murray adds. ■

If they have to wait, tell them why

Honesty will pay off in happier patients

Sometimes, no matter how hard you try, patients are going to be faced with a lengthy wait to see a physician. When this happens, keeping patients informed and giving them the opportunity to reschedule can go a long way toward keeping them happy, the experts say.

When patients get to the office, they should be told how much time they can expect to wait before seeing the physician and the reason for the delay, says **Doug Hough**, PhD, a partner with Arista Associates in their Fairfax, VA office.

Like airlines, physician office personnel are getting a bad reputation for "lying" about how long the delay will be, Hough says.

In today's market, a physician's business integrity is almost as important as his or her professional integrity, he says. This means that every staff member should be honest about the length of the delay and the reason for it, Hough adds.

Physicians and their staff should keep in mind that patients often have to lose time at work to see a doctor; patients may be depending on someone else for transportation; or they may have an appointment at another doctor's office.

"It seems simple for the receptionist to inform the patient who is waiting if the doctor is running late. Keeping the patients informed and giving them an opportunity to reschedule is good office management and good public relations with the patients," adds **Randolph D. Smoak Jr.**, MD, president-elect of the American Medical Association.

Hough's clients have reported that patients are usually understanding if they are told the doctor has had an emergency.

"If they are informed, their psychological clock doesn't start ticking until the physician is back in the office," he adds.

Hough recalls a physician client who came up with an amazingly simple way to keep his patients happy while they were waiting to be seen.

The office was set up so that when the physician went from one examination room to another, he passed by the waiting room, made eye contact with the patients there, and told them he'd be with them soon.

"One of the things that drives patients crazy is when they have no idea whether the physician is even there. They think he's on the phone or out to lunch. If they can see that the doctor is there and working hard, their frustration level goes down," Hough says. ■

Analyze patient flow to solve scheduling woes

Methods help you identify the bottlenecks

A patient flow analysis can track the experiences of both patients and providers and give an overview of what is happening during clinic hours, says **Julie Elmore Jones**, MBA, MHA, a consultant with Gates, Moore & Co., an Atlanta-based health care consulting firm.

The process can give you internal management information such as staff mix and utilization, an analysis of your appointment scheduling methods, and problem areas or glitches in the way patients move through the system.

"It's a relatively easy thing to do and it gives you a wealth of great information," Jones says.

Here's how a patient flow analysis works:

Each staff member who comes in contact with patients fills out a personnel registration form that includes their job and an assigned code number. The staff members log in when they begin seeing patients, and log out when they take a break. This tracks each staff member's actual time on the job.

A patient registration form is attached to the medical chart and follows the patient through the visit. Every time someone who works in the practice comes in contact with the patient, even if it's for 10 seconds, they enter their code and log in the time their face-to-face contact starts and ends. For instance, if the medical assistant calls a patient in, takes the history, weighs the patient, and sends the patient to the lab, the assistant logs his or her time in and time out with the patient.

The person who is the primary caregiver for the patient, in most cases the physician, initials

the form and records the time in and time out, and also includes the reason for the visit.

Once the study is complete, Jones checks the data for accuracy, then enters them in a computer program that analyzes the schedule and pinpoints bottlenecks.

"Often, practice managers and administrators already have a sense of what the problem is. When you get statistical tables and graphical representations of where the problems are occurring, you see not only what is happening to the patients but what is happening to the physician," Jones says.

The studies give you the tools to determine where the bottlenecks are occurring and how to eliminate them.

For instance, if it appears the well-patient visits are taking too long, you could find that there is a back-up in the lab, or that the examinations were not scheduled appropriately for the physician who was doing them that day.

"Some physicians work more quickly than others. Some practices schedule 20-minute appointments regardless of who is doing them. The patient flow analysis can point out these problems and help you schedule for maximum efficiency," Jones says.

Consultants provide fresh perspective

While you can do a patient flow analysis yourself, Jones recommends using a consultant or external advisor to give a fresh perspective to the problems and issues in your practice. "Much of the survey deals with observations and interviews with the physicians and key staff. Often people who work every day in a practice have difficulty seeing that things could be done differently. It's the same with all of us," Jones says.

If you decide to conduct the analysis in-house, choose the practice manager or someone else who does not normally come in contact with the patients, Jones advises. "If you come in contact with patients, you are part of the study. You can't be in the study and implement it," Jones says.

The purpose of a patient flow analysis is to see what happens under normal circumstances. If one person is removed from the normal process, you can't get a good sense of what is happening, she adds. ■

AMAP helps improve operations, reward staff

Accreditation program available in more states

When **Randall Smoak Jr.,** MD, and his office staff went through the American Medical Accreditation Program (AMAP) review, the Orangeburg, SC, surgeon's office staff already had the reputation of being on top of things.

"Even so, going through the process of AMAP, our office staff learned some things and improved further. The most important thing to me was that when we were assessed, our office staff had a great sense of reward. Not only did they have the reputation of being excellent; the staff knew they were, based on national standards," says Smoak, who is president-elect of the American Medical

Executive Summary

Subject: American Medical Accreditation Program
Essential points:
- Accreditation program shows physician offices meet national standards
- Environment of care review is biggest stumbling block to accreditation
- Purpose is to improve the way physician offices operate

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Association (AMA) and chair of the AMAP governing body.

Smoak's office was the first in the nation to go through the accreditation process.

"As chair of the AMAP governing body, I felt like I should go through the process and know what it was like before suggesting that other physicians go through it," he says.

The AMA introduced its voluntary accreditation program in 1997.

New Jersey was the first state to implement AMAP. So far, medical societies in nine states and the District of Columbia have entered into an arrangement with the AMA to offer AMAP, with more expected to come on board soon.

The organization's goal is for AMAP to be available in all 50 states by 2005.

"It's an opportunity to let patients know that their physician meets some national standards that would indicate that the physician and his office are operating at a very high level," Smoak says.

AMAP is a voluntary accreditation program that measures and evaluates individual physicians against national standards, criteria, and peer performance in the areas of credentials, qualifications, and environment of care. Eventually, the standards will be expanded to include clinical process and patient outcomes.

Combining assessments

AMAP officials are trying to persuade health plans and hospitals to use AMAP for their physician credentialing and evaluation.

Physicians, on average, belong to 10 health plans. This means 10 similar forms to be filled out and 10 different site visits every few years.

"The concept is to combine all that into one and carry out a more extensive, detailed assessment of the environment of care as well as an assessment of the physicians," Smoak says.

Most physicians who are not awarded AMAP accreditation fail because they do not pass the environment of care section, an on-site review of office procedures and policies, says **William Jessee**, MD. He is chief executive officer of the Medical Group Management Association (MGMA) and led the development and implementation of AMAP as the AMA's vice president for quality and managed care.

Some key areas where offices often need improvement include:

- **Written office policies and procedures.**

"Many times, we take for granted that the staff knows what to do in certain situations," Smoak says. For instance, physicians don't always know the level of triage that takes place because the nurse handles it. But in some cases, the nurse may be going beyond what the physician thinks is appropriate, rather than calling in the doctor, he adds.

"If you have to go through the mechanics of addressing such things as how you handle after-hours telephone calls, it points out the instances in which clearer directions are needed. Going through this exercise is helpful to more clearly define how everyone's roles should function," he says.

- **The ability to respond to an emergency.**

If an emergency occurs, a practice should have trained personnel to respond to it. For instance, Smoak tells of a situation in which a patient's spouse had a heart attack while the patient was

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being treated in an ophthalmologist's office. The physician and a nurse, who was certified in CPR, responded, called the paramedics, and got the spouse to the hospital in time to save the spouse's life.

"That's the kind of thing we never expect to occur in some offices. If it happens on a street corner, we'd say that was just that person's luck. In a physician's office, we'd expect some level of emergency care to be given appropriately to save the patient's life," he says.

• **Safety measures.**

"Physicians need to make sure that the office is not only an inviting place but a safe place. The whole issue of patient safety is of more concern as more and more services that used to be done in the hospital are being done in the office," Jessee says.

Before anyone goes through the accreditation process, they know exactly what criteria will be used. The AMA has the standards on its Web site (www.ama-assn.org) and they are available in booklet form, along with helpful suggestions on how to improve in the areas that will be judged.

Generating self-imposed improvement

"This is important, because we're not trying to generate a punitive situation. We are trying to generate a self-imposed physician improvement," Smoak says.

A highly trained nurse who has experience in judging the quality of the indicators conducts the office visits. The conclusions are reviewed by a physician panel.

For instance, if the practice has a written escape plan in case of fire or calamity, and the nurse sees that it's in place, that's all that's necessary. If the nurse has some questions about the charts, the physician panel reviews them.

The people conducting the office visits have years of experience in judging criteria from other accrediting organizations, such as the Joint Commission on Accreditation of Healthcare Organizations, Smoak says.

The office site review takes between two and three hours, depending on how many physicians are in the office.

"We are sensitive to the things that physicians fall down on during site visits, and we will re-examine them periodically to see if they are too stringent," Smoak says.

Practices that do not pass the accreditation criteria have an opportunity to make an appeal and reapply. ■

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