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INSIDE

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Disease management can improve patients' health and your bottom line

Take steps now to reduced complications down the road

If you have a lot of patients with chronic conditions and are facing the possibility of assuming financial risk for their care, a disease management program may work wonders for your bottom line.

A disease management program improves clinical quality of care by ensuring that the best practices for that condition or disease are actually used on a day-to-day basis. It reduces costs by keeping the disease under control, thereby reducing hospital days and emergency room visits. And, it can give your practice a positive image in the community.

"Patients and prospective patients view it as positive to know that the group practice has specific programs in specific areas," says **Richard Lopez**, MD, associate medical director for Harvard Vanguard Medical Associates, a fully capitated 550-physician multispecialty group practice in Boston.

Disease management programs are gaining in popularity as providers try to get a handle on health care costs. For instance, diabetics make up less than 3.5% of the population, but they account for almost 16% of all acute care hospital days and more than 11% of emergency room visits, according to data from the Sachs Group, a research organization in Evanston, IL. In 1997, diabetes accounted for $138 billion in health care costs and lost productivity, according to Sachs research.

Patient participation in disease management programs increased 300% last year, according to the statistics from the newly formed Disease Management Association of America in Wellesley Hills, MA.

A typical disease management program includes an educational component, regular clinic visits, and follow-up phone calls by clinicians who remind patients to follow their care plan, check their symptoms, and alert the physician if anything seems amiss.

Disease management case managers are the "eyes and ears of the practicing physician," says **Al Lewis**, association president and executive

Executive Summary

Subject: Disease management in physician practices
Essential points:
• Patients with chronic diseases consume vast amounts of health care resources
• Managing chronic diseases can save money in the long run
• Programs work best for capitated practices
• Typical program involves clinic visits, regular follow-up phone calls

director of the Disease Management Purchasing Consortium in Newton, MA.

"Disease management is designed to help patients improve their lifestyles and compliance between visits to the physician. It's one of the most important developments in health care delivery to emerge in the last decade," Lewis says.

Patients with chronic diseases that are under control are less likely to go to the emergency room or into the hospital.

Health plans have been reaping the benefits of disease management for years. As physician practices become larger and get more involved in capitation contracts, they're seeing the benefits of disease management programs for their chronically ill patients.

For instance, Harvard Vanguard Medical Associates has developed disease management programs for asthma, HIV, congestive heart failure, and secondary prevention of coronary disease.

The practice is piloting a depression management program and is about to launch programs for diabetes and chronic obstructive pulmonary disease, Lopez says.

Healthier patients

"The basic value from disease management is healthier people who cost the health system less money," says **Robert Stone**, president of Diabetes Treatment Centers of America in Nashville, TN. For instance, diabetes patients are admitted to the hospital with regularity, but almost never for diabetes itself.

"In reality, one in five people in a hospital bed usually has diabetes, but that's not why they are there," Stone adds. Diabetics often have longer length of stay because they have poor healing, higher infection rates, and comorbidities associated with diabetes.

He points out that people with chronic diseases tend to have multiple problems, and sometimes the people treating them don't have a total picture of what's going on.

"One of the objects of disease management is to make sure the patients don't fall into a gap between providers," Stone says.

Involving the patient's primary care physician is an important component of a disease management program, points out **Diane Gilworth**, RN, MPH, who directs Harvard Vanguard's congestive heart failure program.

"We're not here to replace the primary care provider. We're relieving them of the burden of frequent interface with patients," she says.

If you want to start a disease management program for your practice, your most important asset will be a physician who is willing to put the program together and talk it up among the staff, Lopez says.

Buy-in is a must

"Buy-in from your clinicians is essential for success," he adds. The programs at Harvard Vanguard have been developed by a small group of practitioners who are interested in those diseases.

"We haven't purchased any programs. It's not that we have excluded that possibility, but we've looked at our in-house capabilities and we feel we can do it on our own," Lopez says.

To develop the program, the Harvard Vanguard staff use guidelines from various sources, such as the Agency for Health Care Policy and Research, and draw on the resources of the specialists in the particular field. They also look to the chronic disease organizations, such as the American Diabetes Association and the American Heart Association, for other information on best practices.

In addition to staff to manage care and follow up with the patients, a successful disease management program needs a way to identify at-risk patients. You may be able to identify your at-risk patients by checking their medical records or by a system of alerts. For instance, when an asthma patient refills his or her inhaler frequently, the Harvard Vanguard Pharmacy alerts the asthma management program. Congestive heart failure patients are either referred to the program by a physician or identified while they are in the hospital.

You'll also need a computerized medical records system to track your patients. At Harvard

Vanguard, all documentation of patient care is entered into the system, including lab tests and prescriptions. The practice uses computers to track outcomes, document patient care, and identify patients who could benefit from disease management.

"It's a very powerful way to be able to give feedback to the practicing clinicians and let them know how the patients are doing," Lopez says.

Next year's high-cost chronic disease patient may be someone who isn't showing many symptoms this year, Stone maintains. That's why your disease management program should be geared to the entire population, not just patients with high cost or high acuity,

"The reason is that these diseases don't go away. If you provide only acute intervention and don't provide preventive interventions, a year from now you'll have a whole new crop of high-cost patients," Stone adds.

A comprehensive disease management program for all patients reduces the complications associated with the natural progression of the disease and increases savings over time. ■

Look at cost, utilization before starting DM program

Use of benchmarks helps ensure accuracy

Before you consider a disease management program for your patient population, look at the costs and whether you will benefit from the investment needed.

Disease management for just a few patients can be costly. You need staff to provide personal intervention with the patients, an electronic medical records system to keep all the information in one place, and a way to give feedback to the primary care physicians.

If physicians are not financially at risk for the patient's entire health care costs, there may not be a lot of incentive to provide disease management, says **Robert Stone**, president of Diabetes Treatment Centers of America in Nashville, TN.

"To make the value equation work, you need to work with the entire cost posture. Health plans and physician groups who have taken risk could develop a partnership so that some benefit flows back to the physician, " Stone says.

If your practice is new at managing risk for patient care, do some research to find out if disease management will work for you. Don't just rely on information provided by an HMO on the historic needs of your population, asserts **Dennis Dunn**, PhD, senior scientist and one of the founding members of the Sachs Group, based in Evanston, IL.

"HMOs have been tracking chronic diseases for years and have a good idea of what kind of resources their patients are consuming. But the information is not necessarily available for providers who are negotiating to provide health care for the HMO's covered lives. Anyone contracting with an HMO will need independent benchmarking," he adds.

Limited value

Claims forms have limited value because they often don't list comorbidities that may be the underlying cause of treatment. For instance, a physician treating a patient for vascular complications may record that code but may not note on the claim that the patient also has diabetes, he says.

So many HMOs are engaged in special contracting that it may be impossible to determine how many individual visits were made for any sort of specialty care, such as radiology.

"If you're contracting for a capitated contract, it's critical to know how many visits you have to support. That's not what a claims database is designed to do, and the information you need is not necessarily available," Dunn says.

It's good to look to national organizations, such as the American Diabetes Association and the American Heart Association, for good nationwide information on chronic diseases. But don't forget the peculiarities of your local environment, warns Dunn.

"You need to know if the disease is more prevalent in your area and if utilization patterns can help you determine if your patients will have higher hospitalization or health care usage rates than in other areas," Dunn says.

For instance, in some parts of the country, the average prevalence of diabetes is 2% to 3%, but in others it may be as high as 40% to 50%, Dunn says. "There are characteristics, such as how many times patients use the emergency room, that physicians may not have much control over, but they can help determine the amount of resources needed for a group of patients," he adds. ■

Combination of strategies cuts CHF readmissions

Sickest patients are targeted for visits, phone calls

In the first 18 months of its congestive heart failure (CHF) disease management program, Harvard Vanguard Medical Associates in Boston achieved a 77% reduction in hospital readmissions for the targeted patients.

The program, which includes a combination of clinic visits, education, and telephone calls, is designed to serve the sickest patients — those who are likely to be rehospitalized.

The initial recruitment begins in the hospital for patients with primary or secondary diagnosis of congestive heart failure (CHF).

"The ideal time to catch them is when they are being discharged for acute exacerbation. They have a higher motivation to change their behavior at that time," says **Diane Gilworth**, RN, MPH director of the program for Harvard Vanguard, a fully capitated 550-physician multispecialty group practice.

Gilworth and two nurse practitioners manage the care of 180 patients. Since the program started 2½ years ago, 245 patients have enrolled.

In the past, most patients were discharged from the hospital with little or no education about their condition. "They didn't understand their condition and symptoms. They were taking unfamiliar medication and didn't have a good sense of what their diet would be. It wasn't uncommon for them to end up in the hospital a month later," Gilworth says.

The CHF staff co-manage the care with the seven cardiologists and the primary care physicians within the Harvard Vanguard organization. The CHF practitioners try to optimize the patient's medication, looking beyond the CHF at comorbidities such as diabetes and chronic obstructive pulmonary disease (COPD).

"Our relationship with the primary care physician is critical. We couldn't run the program without close collaboration with them. We have taken [away] their burden of frequent direct interfacing with the patient," Gilworth adds.

For instance, if the CHF staff find that the patient's lipid levels are elevated or that they're using more puffers for COPD, staff refer the patient to the primary care physician.

The CHF team also makes sure patients are on the appropriate medication as outlined by consensus guidelines. By optimizing the use of diuretics, Gilworth and her staff try to get patients down to what an estimate of what their dry weight should be.

"If we can get patients to that dry weight, their exercise tolerance improves. They begin to work longer. We've seen substantive improvement in the distance walked for many patients after their medications were optimized," she adds.

When patients have become stable, the CHF team usually passes them on to the case managers in each center. The patients still receive a monthly surveillance call designed to catch any significant changes in health status.

The Harvard Vanguard staff based its disease management program on Agency for Health Care Policy and Research guidelines and elements of other disease management programs in other parts of the country.

"We looked at what other providers were doing where there is a large HMO penetration, and we picked elements we thought were most important and would fit with our culture. It's not a one-size-fits-all," Gilworth says. ■

Assessment and education keys to CHF program

Patients have 24-hour access to staff

When patients are identified for the congestive heart failure (CHF) program at Harvard Vanguard Medical Associates, they are scheduled for an assessment by the CHF staff.

The hour-long visit includes a full physical assessment, an assessment of all drugs the patient is taking, and an informational and teaching session. Patients are given information on their particular form of CHF, what caused it, what medications can help with it, and what symptoms to look for at home.

For instance, patients are told specifically to weigh themselves daily, and if their weight goes up by more than two pounds, to call the CHF program.

After the initial visit, patients come to the clinic weekly. As they improve, their visits are cut to monthly. The staff also call patients regularly to check on their weight status and symptoms.

"We have found that if you're not diligent in supervising the patients, they may fail to monitor their symptoms, stop weighing themselves daily, and start eating the wrong kinds of food," Gilworth says.

Patients initially are called weekly. That drops off to monthly when they become stable. They are encouraged to check in with the staff at regular intervals, depending on their condition and what works well for them.

"Some check in on a daily basis, and have since they entered the program. Others check in monthly," Gilworth says.

When patients' symptoms exacerbate, they can get in touch with their primary clinicians via beeper 24 hours a day. All staff members have access to a database that includes pertinent information on all patients, including weight and medication, allowing the three staff members to cover for each other.

Every quarter, all patients fill out a quality-of-life assessment form that rates how they feel about their symptoms. Also, each patient does a six-minute walk designed to test functional capacity. The walk gives the staff an idea of how short of breath the patients may be as they carry on their activities of daily living. "Unlike the treadmill, which tests exercise capacity, this tests daily living capacity," Gilworth says. It's an objective measure that allows patients to see how they improve over time, she adds.

The program is designed to fit each patient's individual needs. "Patients don't fit in a little box. It depends on their personality. Some have difficulty with the beepers. In that case, we have them call our voice mail, or we call them," she says. ■

Bringing patients together can help them and you

Model works well for chronically ill, worried well

If your practice has a huge backlog of patients waiting for appointments, many of whom are chronically ill and need reassurance, professional hand-holding, and follow-up care, you might try what some California physicians have found to be a successful solution: See your patients in a group.

Drop-in group medical appointments (DIGMAs) are the brainchild of **Edward B. Noffsinger**, PhD, a Santa Cruz, CA, consultant who retired recently after 26 years as a health psychologist for the Permanente Medical Group. He developed the DIGMA model at Kaiser Permanente Medical Center in San Jose, CA.

"Access to care is a huge problem nationally in both primary and specialty care. The DIGMA model offers a new cost-effective tool that can allow primary and specialty care physicians to solve the access problem without hiring additional staff," he says. Much of the same medical care that normally is provided during routine office visits can be provided during a DIGMA, he says.

If your practice is capitated or otherwise at risk for patient care, you may be able to realize financial savings with DIGMAS while handling your backlog and improving patient care. **(For tips on how to adjust the DIGMA model when your reimbursement is largely fee for service, see p. 166.)**

Under Noffsinger's model, 10 to 20 patients and their friends or loved ones attend a weekly 90-minute session led by their physician and a behavioral health professional. The behaviorist may be a psychologist, social worker, nurse, or health educator.

Most of the physicians with whom Noffsinger has worked have one 90-minute DIGMA a week, usually during office hours.

Physicians who have started DIGMAs report that their backlog of patients has decreased, the number of phone calls from patients has dropped, patient complaints about accessibility have been reduced, and they feel like they are better able to manage their large practices and deliver better care.

"The DIGMAs enabled me to get a lot done in a short time without feeling like I was going through a revolving door from one room to the

Executive Summary

Subject: Group medical appointments
Provider: Kaiser Permanente Medical Center, San Jose, CA
Essential points:
- Drop-in group appointments increase patient access to care
- Process works best for chronically ill patients
- Groups are led by physician, behavioral health professional
- Appointments are 90 minutes long for 12 to 20 patients
- Physicians reduce backlogs, calls from patients

Tweak the DIGMA model for your practice

Strategy can be adapted for small organizations

When **Edward B. Noffsinger**, PhD, conceived of the drop-in group medical appointment (DIGMA) model, he envisioned it for a large capitated practice that is fully or largely at risk for patient care. However, the model can be adapted for smaller practices and for those that are largely fee for service, he says.

If you want to start a DIGMA in a small practice that is largely fee for service, you may need to be creative. For instance, third-party payers don't have any payment codes that allow you to bill multiple patients for the same block of time.

Noffsinger recommends medical groups that are not capitated contact their third-party payers and ask for suggestions on how they can bill for the services.

"It won't take long for third-party payers to see that seeing 10 to 15 patients in a group setting saves everybody time and money," he says.

Other options might include billing for patients that are actually examined or charging fee-for-service patients nominal fees for the additional service.

If your offices aren't big enough to have a conference room for your DIGMAs, considering holding DIGMAs after hours in your waiting room.

The behavioral health professional who co-leads the DIGMA could be a person with whom the physician has worked in the past and who attends the group sessions on a contract basis. Another suggestion would be for a nurse who knows the patients to take over the role.

Oncologists, nephrologists, and other specialists whose patients have a high incidence of emotional and psychosocial needs should consider enlisting the aid of a psychologist to work with their groups, Noffsinger suggests. ■

next," comments **Lynn A. Dowdell**, MD, an endocrinologist with Kaiser Permanente Medical Center in San Jose.

When she started her weekly DIGMA, Dowdell was able to get through a very large backlog of patients, who often had to wait two to three months or more for an appointment.

Because of staffing changes in Dowdell's office, her DIGMAs are on hold at present, but she hopes to start them again soon. "The patients miss the group," she says.

DIGMAs address psychosocial issues

The group appointment model works best for relatively stable chronically ill patients, the worried well, or other patients who typically take a lot of the physician's time and require a lot of professional hand-holding, Noffsinger adds.

"Patients with significant behavioral health and psychosocial issues are overutilizers," says Noffsinger. He adds that research has shown that 40% to 60% of all medical visits are driven by behavioral health and psychosocial issues rather than medical need.

Joseph E. Mason Jr., MD, an oncologist with Kaiser Permanente Medical Center in San Jose, holds a weekly DIGMA that is usually attended by 12 to 15 cancer patients and their family members.

Most of the people who come to Mason's DIGMAs are people who have recently been diagnosed, who have had a change in condition, or who need ongoing support.

"I don't have any hard statistics, but I have a sense that it has decreased the number of phone calls my office receives. I know that it is an enormous patient satisfier. It really increases people's approval of the care they're receiving," Mason says.

Today's physicians are under so many productivity and time constraints that they barely have enough time to deal with a patient's physical needs, much less their psychosocial needs or the patient-physician relationship, he adds.

Noffsinger doesn't recommend the model for initial evaluations, one-time consults, most procedures, or for patients with acute illnesses or rapidly evolving medical conditions. However, the concept does work well for patients who are fearful about their medical condition. For instance, diabetics who require insulin but fear needles or patients who are facing dialysis are reassured by others in the group who feel better

(Continued on page 171)

Physician's Capitation Trends™

• Capitation Data and Trend Analysis •

Hard times in California warrant caution flags elsewhere

Will changes avert national 'capitation epidemic'?

Rigid capitation formulas combined with enormous for-profit managed care companies are creating one simple result for physician practices in California, according to the state's leading physician advocacy group: bankruptcy.

That's the wicked bottom line for physician groups teetering on the verge of obliteration, says the California Medical Association (CMA), in a white paper that served as the focal point of a health care summit in the state in early September.

At least 34 medical groups or independent practice associations will fail before the end of 1999, CMA officials predict. As many as 90% of California physician organizations are poised for bankruptcy or closure.

This isn't crying wolf, nor is it a "new millennium" or a Y2K catastrophe, the CMA insists, but rather a grim reality based in large part on a report produced by New York City-based accounting firm PriceWaterhouseCoopers. The report, titled "Healthcare: An Industry in ER," was released at a CMA summit on medical group insolvency on Sept. 2. **(For the latest developments, see story, p. 174.)**

If the prediction comes true, don't expect this phenomenon to spread rapidly across the country. Rather, view it as a wake-up call, suggest practice managers across the nation.

"This isn't a national trend yet, but it is sending a clear message of what could happen in the future in other parts of the country," says **Cindy E. Fears**, MPH, practice administrator for St. Louis Pediatric Associates. "The situation in California is more extreme than it is in the rest of the country, but the issue of mergers creating large HMOs is making it difficult for physicians to effectively negotiate."

For example, Fears sets a limit of accepting a capitation rate no lower than one that will cover 80% of costs, but the practice has reluctantly accepted rates as low as 64% when the HMO in question holds major market share. Too much of that kind of concession can lead to trouble similar to California's, she notes. Fears is an expert on practice costs and serves as a board member of a major national survey of practice costs released annually by the Medical Group Management Association in Englewood, CO. Low payments are proving to be particularly risky for the pediatric population, Fears points out.

Four factors combine for deadly equation

CMA officials are urging state and federal lawmakers to take legal action to stem this kind of practice erosion. In short, the combination of these factors are killing practices, the physician organization says:

- dangerously low capitation rates driven by market rather than patient factors;
- market domination by the five largest insurers in the state who are big enough to keep competing insurers at bay;
- for-profit insurers who keep the profits and pass off rising costs to physicians;
- lack of data provided to physician groups by insurers to ensure appropriate administrative management;
- incorporation of pharmacy costs in many capitation rates.

By themselves, none of these factors are new nor necessarily devastating, but what is new is the claim that in combination, they are creating such a significant financial blow to physicians, who argue the ultimate impact will be upon patient care. The situation also is significant because California has often set the standards for capitation for the rest of the country.

"There's a world of difference between California and Iowa, but a lot of what we see in California is mirrored in Minneapolis, and could well become a reality in other more urban areas," says **Robert Poetting**, clinic administrator for Burlington Area Family Practice in West Burlington, IA. While Poetting's region is not experiencing much capitation, it is witnessing some merging of insurers, which is troublesome in terms of healthy competition. But, in more rural areas, he says, "I figure I have at least a two-year head start to prepare."

Payments fall as costs increase

CMA officials point to less luxury of time and a convergence of a number of frightening trends regarding the viability of their practices. Here are three highlights of the difficulties specific to capitation payments, the group says:

• California physician capitation rates have fallen from a high of $45 per month for each HMO member in 1990-1995 to a low of $29 per member per month in 1997-1999, a drop of 35%, according to the PriceWaterhouseCoopers study. This occurred over the same period that the Consumer Price Index reflects a 25.2% increase.

• Physicians receive an average $24.24 per child per month, according to a 1998 CMA survey of the state's pediatricians. But, physician costs for treating this same age group average $47 per child per month, according to a Towers Perrin study in 1998. "This means that California pediatricians lose an average of $270.96 per patient per year," the group says.

• Some California pediatricians report that they receive as little as $10 per child per month. "This amount is not enough to cover even the cost of vaccines all children must, by law, receive," CMA officials say.

There is no question that California's intensive HMO markets have affected standards elsewhere. In many cases, California's standards form the basis for benchmarks in many other markets. There is no better example of that than the highly touted "hospital days" measure. With the advent of tighter capitation models, the length of stay in hospitals has declined significantly — more so in more capitated, highly competitive areas.

Beyond capitation itself, there are other high-pressure market dynamics in the state, the CMA says. They point to these three in particular:

• **Excessive HMO administrative costs and profits.** The largest for-profit health plan dedicates nearly 25% of the premium dollar to profit and overhead, while the largest not-for-profit insurer dedicates 5% to profit and overhead. These compare with the 15.2% average for all HMOs in the state.

• **Large employer purchasing pools.** Several major employer insurance pools, like Pacific Business Group on Health, are making clear inroads toward keeping already low health insurance premiums from increasing. For example, recent California premium rates are 40% less than northeastern states with similar costs of living. California health plans receive an average of $135.19 per enrolled member, while in northeastern states, HMOs receive $174.86 per member per month. California premiums average $120 per month compared to a national average of $127 per month. That equates to $83 million less per month, almost $1 billion less per year in the health care system in a state with the highest cost of living in the nation.

• **Little indication of passing on recent premium increases to patient care.** Business reports show that HMOs are doing well financially. For example, second quarter profit earnings were up 19% for WellPoint (BlueCross), 41% for PacifiCare, and 12% for Aetna over the same time period last year. While premiums fell from 19% in 1989 to 5.6% in 1994, they are inching back up since 1997. "But not enough of this increase is being dedicated to patient care," the CMA says.

Instead, profits are created by shifting costs to physicians, CMA officials argue. "These front-line providers must try to deliver more care to more people while receiving very low capitation rates."

What needs to change? California physicians are making four recommendations:

1. Establish patient-driven capitation rates rather than market-driven rates. Medical groups are plunging into insolvency because they are providing medical care but not meeting costs, the group says. They attribute this to the fact that capitation rates currently are determined more by what the market will bear than what the patient needs clinically. Rates should be actuarially based,

which is actually required by law in the state but apparently not enforced. Congress is looking to mandate this by requiring some level of clinically adjusted cap rates, but it is uncertain when this will materialize. **(For details, see *Physician's Managed Care Report*, July 1999, pp. 104-105, and April 1999, pp. 55-56.)**

2. Prohibit folding pharmacy in with capitation payments. The popularity of a pharmacy benefit with managed care needs to be handled in some other way besides merely leaving it to physicians to incorporate the costs into existing reimbursements. **(See related stories in *PMCR*, October 1999, pp. 151-153, and July 1999, pp. 103-105.)** With the second year of double-digit inflation for pharmacy, costs are exceeding payments for drugs, the group says. And, in some contracts, physicians have to pay the difference if they exceed the pharmacy payment levels for patients.

3. Ease administrative burdens and provide better data support. Physicians feel that in many cases, HMOs require more reporting but fail to provide the data physicians need to make sound reports and decisions. Practices need basic insurance data in a timely fashion, including financial and utilization information on risk pools, regular reports for coordination of benefits receivables, third-party recovery receivables, pharmacy rebates, retroactive additions and deletions in enrollment, and changes in benefits. Some independent practice associations now estimate that they need at least 40% of the physician portion of the capitation payment to cover administrative costs.

4. Empower physicians to have some leverage with large HMO corporations. In California, insurers have become so large that they overpower physicians and patients, the group argues. The five largest health plans control nearly 90% of the market. That leaves little competition for ensuring patient interests, physicians argue.

Congress clearly is listening and focusing on major managed care reform. Yet despite legal interventions, practice managers recommend keeping in mind that capitation is complex and that focusing on costs is critical. Also, stay on top of changes that can occur in contracts, suggests Fears.

For example, one major change looming in her region is a requirement not only for individual physicians to be credentialed, but for an entire practice to be credentialed as well. That's another administrative complexity that affects which physicians can serve on which contracts. ■

HCFA blame misdirected, agency tells Congress

Nationwide financial tumult fingered as culprit

Medicare officials have a message for HMOs: Don't blame us for your problems. You may be dropping out of Medicare HMO contracts, but you're dropping out of other markets, too.

In a sharply worded report to Congress in early October, Health Care Financing Administration (HCFA) officials made their case that despite some declines in beneficiary enrollment in Medicare+ Choice (the Medicare HMO plan), the system is alive and well and merely reflecting the private sector's overall market swings.

HCFA cites industry's overall difficulties

"Volatility in the marketplace is not confined to Medicare," the report says. "Program withdrawals, reduced benefits, and premium increases are not unique to Medicare. They reflect the industry-wide difficulty organizations have faced in the last few years in controlling costs while attempting to maintain quality and profit levels."

These ups and downs have been widely reported in the professional and popular press, HCFA officials note. Here are four examples they cite:

- PacifiCare is withdrawing from both Medicare and commercial markets in several Washington state counties.
- Group Health Cooperative in Seattle is pulling out of Medicare and non-Medicare markets in 14 counties in eastern Washington and northern Idaho, citing a variety of reasons.
- In the northeastern area, Kaiser Permanente is withdrawing from Medicare, Medicaid, and its commercial business, affecting 500,000 enrollees. "Kaiser [officials have] specifically said that its withdrawal from these markets cannot be attributed to changes in Medicare payments," the report says.
- The Federal Employees Health Benefits Program (FEHBP, with 9 million federal enrollees) has witnessed changes similar to Medicare+ Choice. At the end of 1998, about 20% of participating HMOs withdrew from FEHBP. At the end of 1999, a 13% withdrawal rate is projected.

The dropout rate is not the only barometer of volatility, say HCFA officials. Rising premiums

and reduced benefits are two other key indicators, both of which are occurring in commercial plans as well as in Medicare+Choice. One of the more stubborn advocates of holding the financial line — the California Public Employees Retirement System, with one million insured employees — agreed to an average premium increase of 7.3% for 1999 and more than 9.7% for 2000, representing the largest premium increase since 1991.

Overall, HCFA estimates, commercial premium rate hikes will average 9% in the year 2000, much like the 9.5% already established for FEHBP. The New York City-based Towers Perrin consultancy reports that large employers experienced a 7% average premium increase in 1999 — the same level for fee-for-service as for managed care products.

Officials say Medicare subsidized other payers

Large increases in the private sector follow years of Medicare underwriting the private sector to some extent, HCFA officials argue. In the same years when commercial rates remained steady, 1991-1998, "Medicare increases were two to three times higher than private sector increases, and in fact some financial analysts have pointed out that Medicare revenues subsidized premiums of other payers. Those years of excessive Medicare payment increases greatly contributed to the ability of organizations to provide generous benefits packages."

Inadequate payment levels are not the only — perhaps not even the driving — reason HMOs choose to pull out of Medicare HMO contracts in certain areas, the report states. Even in counties where there are zero premium plans, some insurers are bailing out, HCFA argues. (By zero premium, HCFA is referring to plans in which there is not a monthly charge beyond the regular Part B Medicare premium to enroll in the Medicare HMO plan of a particular area.) "If Medicare payments were insufficient for the revenue needs of organizations, one would expect to find zero premium options being limited to the highest payment areas," HCFA says. "The data do not show that to be the case."

David F. Thomas, chief executive officer of Midwest Physician Group in Olympia Fields, IL, agrees with HCFA that many of Medicare+Choice's ups and downs are reflective of managed care overall. The troubling trend Thomas is keeping a close eye on is the merger of major HMOs so that competition dwindles.

"It's not capitation itself; it is the lack of competition, the small number of insurers who control a major part of the market," says Thomas. "When that occurs, you can't recruit physicians. Why should they work in your area if they can go somewhere else and be paid 30% more?" The issue becomes low unit payment, not the capitation payment structure itself.

Referring to California physician concerns about practices closing, Thomas says this phenomenon — as well as Medicare bailouts in many markets — is a reality. "I thought, 'Wow!' when I learned about California's situation," he said. But he then he recalled recently working with a physician practice in northern Michigan where the HMO market became so conglomerated that the practice folded, mainly because of its inability to recruit and maintain physician participation. That's the same kind of scenario HCFA is depicting in its report on Medicare+Choice, Thomas says. ■

Magistrate nixes 'down payment' challenge

A federal magistrate has ruled that Medicare acted reasonably when it decided to use 1998 rather than 1992 as the base year for calculating the so-called "down payment" which kicks off a four-year transition to Medicare's new relative value-based fee schedule.

Eleven provider specialty organizations had challenged the decision, arguing that the Health Care Financing Administration did not have the authority to take the action it did. They also argued that federal law required that the earlier 1992 time frame be used as the base year.

The difference between the two dates translates into nearly $500 million in additional payments to primary care-oriented doctors during base year transition, which mainly came out of the pockets of surgical specialties. Also, the later date acts as a multiplier increasing future payments to office-based practices at a faster rate than if 1992 as used.

While awaiting the final decision from the U.S. District Court in Chicago, specialty groups are also waging what some consider to be an uphill battle to convince Congress to delay implementation of the practice expense transition process. ■

(Continued from page 166)

as a result of the treatment.

In a DIGMA, the physician has the additional help of the behavioral health professional and the group itself for dealing with noncompliant patients.

"There's nothing more helpful in persuading noncompliant patients to comply than another patient who has the same condition, didn't comply, and got into trouble," Noffsinger says. "They always advise the patient to comply and avoid making the same mistakes."

Dowdell found DIGMAs useful when patients needed a follow-up appointment for a test or procedure, or when a patient started on insulin or a new medication and needed a short-term follow-up. Seeing the patient during her regularly scheduled DIGMA worked better than trying to fit an individual appointment into her busy schedule, she adds.

Occasionally, Dowdell wouldn't be able to

The inner workings of a DIGMA

Here's what you can expect

The drop-in group medical appointment (DIGMA) usually follows the scenario below, according to **Edward B. Noffsinger**, PhD, a Santa Cruz, CA, psychologist who developed the model while he was with Kaiser Permanente Medical Center in San Jose, CA:

When patients arrive, they are seen by a medical assistant who takes vital signs, pulls the medical chart, and looks for medical services and preventive tests that are due, such as a mammogram or a retinal check for diabetics. The assistant assembles any referral forms needed, fills them out as much as possible, and attaches them to the chart. The physician finishes completing the form during the meeting and discusses the importance of following through with the patients.

The physician and a behavioral health professional, usually a psychologist or social worker, attend the entire session. The behaviorist usually opens the meeting with a discussion of how DIGMAs work and their benefit to patients. The physician talks to each patient, making notes on the chart, dealing with the referrals, and delivering appropriate care.

The physician uses a custom-designed progress note that is largely preprinted in check-off form so the amount of required handwriting is minimal.

If a patient requests a private discussion or needs a brief private physical examination, the physician steps out at the end of the meeting and examines the patient while the behavioral health person runs the group and focuses on any psychosocial issues that interest the group. If a patient needs a more extensive examination, the physician schedules a private appointment.

"A DIGMA is like an individual appointment in the sense that it is an extended medical appointment with the patient's own doctor that focuses on medical issues that patients bring in with them," says Noffsinger.

Patients can get access to a DIGMA in three ways: by invitation from their physician, by a phone call from a scheduler who calls patients from the physician's waiting list, or by simply dropping in when they have a question or medical need. Although drop-ins are welcome, patients should be urged to call a day in advance so their medical records can be pulled, Noffsinger advises.

Most physicians that Noffsinger has dealt with say their practice is so diverse that they want to break their DIGMAs down into categories.

Here's an example of how family practitioners may arrange their DIGMAs to cover all their patients in a month:

- **week one:** cardiopulmonary patients;
- **week two:** weight management patients and diabetics;
- **week three:** chronic pain patients, including headaches, fibromyalgia, and arthritis.

A drawback to having groups during the day is that some patients are reluctant to take time off work and visit the doctor for an hour and a half at a time, says **Lynn A. Dowdell**, MD, an endocrinologist with Kaiser Permanente Medical Center in San Jose.

However, the groups were popular with retired people who had the time, she notes.

"And for a lot of people, an hour-and-a-half group session was preferable to waiting a month or more for an appointment," she adds. ■

answer a patient's questions, but others in the group could. For instance, when one diabetic asked where he could get special shoes, several patients gave him useful suggestions.

Another time, a patient expressed concern about taking a treadmill test for her cardiac symptoms. "Another patient who had been through the test explained what it was like and was reassuring, so the patient was willing to comply," Dowdell says.

Because physicians are concerned about confidentiality, Noffsinger suggests that participating patients sign a confidentiality release form when appropriate. But confidentiality is rarely a problem, he adds.

"In reality, I've participated in more than 8,000 DIGMA patient visits, and I've never had a problem in this area," he says.

Instead, patients often feel free to discuss their individual test results and conditions. DIGMAs give the physicians an opportunity to discuss areas of common interest one time and in greater detail instead of repeating the same information over and over during individual office visits.

"Doctors are working too long and too hard. They need to find a tool to leverage their time so they can manage their practices and still have a life. This model enables them to improve access, increase productivity, manage large groups of patients, improve quality of care, provide better follow-up care, and do it all with existing resources," Noffsinger says. ■

It takes a 'champion' to set up a DIGMA

Coordinator takes care of all the details

Before you start a drop-in group medical appointment (DIGMA) program, your practice needs to designate a person who is responsible for designing, setting up, and taking care of the details involved in implementing the program.

Edward B. Noffsinger, PhD, a Santa Cruz, CA, psychologist who developed the model while he was with Kaiser Permanente Medical Center in San Jose, CA, calls this person the "DIGMA champion" for that group practice.

"This person knows the DIGMA model, can handle group dynamics, understands the psychosocial needs of medical patients, and should be someone the physicians will respect and trust enough to be willing to deliver medical care in a dramatically different manner," he says.

He cautions that physician practices should select their "champions" carefully because of the high level of skill the job entails.

When he was with Kaiser Permanente, Noffsinger was the "DIGMA champion" for the hospital's groups. As a consultant who set up DIGMA pilot groups for practices, he acts as a temporary "champion" until he can train someone to take his place.

A "DIGMA champion" does all the legwork involved in setting up the model, educates the staff about how it works, and prepares flyers, posters, and brochures to let patients know about the drop-in appointments.

Here's what else you'll need:

- a place to hold the group appointments (Noffsinger recommends using a conference room that can hold 15 to 22 people comfortably);
- a well-equipped examination room, preferably close to the meeting room;
- a medical assistant to check patients in, take their vital signs, and assemble the referrals and other paperwork;
- a behavioral health professional to assist the physician in leading the group;
- a scheduler with adequate time each week to telephone patients and send a follow-up letter with details about the program.

Here are some other tips for setting up a DIGMA for your practice:

- Make sure the highest level of administration is behind the program.
- Give the person who acts as champion adequate time to take care of all the details involved in setting up the groups.
- Make certain you have adequate space available in the room for the patients and their support people, who may be family members or caregivers.
- Set aside a small budget to pay for wall posters in the waiting room and examination rooms, along with flyers to tell patients about the DIGMA.
- Provide time for a scheduler to telephone patients and invite them to attend. ■

Docs admit to practicing deception to get coverage

'Exaggeration' becoming more common

Almost 40% of physicians say they have exaggerated a patient's condition to an insurance company to make sure the patient has coverage for needed treatment or time in the hospital, according to a recent survey conducted by the American Medical Association (AMA) in Chicago.

"Physician deception of third-party payers is prevalent and may be rising," according to AMA investigators.

The most common forms of deception include:

• exaggeration of severity of the patient's condition in order to avoid early discharge from the hospital;

• changing the billing diagnosis to help secure services;

• reporting symptoms the patient did not have in order to obtain coverage and treatments.

Overall, 39% of physicians reported that they had "sometimes," "often," or "very often" used one of the three forms of deception, according to the 1998 survey of 724 doctors in primary care medicine.

Only 28% of physicians said they had never used any of these forms of deception within the last year, and 53% reported they "rarely" used them.

In addition, 37% of physicians reported that their patients asked them to deceive third-party payers, and this was the group of physicians that was most likely to have used deceptive strategies.

Some 31% of physicians had "sometimes" or more often refrained from offering useful or needed services to patients because of a lack of coverage by the patient's plan.

The data were collected by the AMA from its survey of physicians on "Meeting Patients' Needs in the Modern Era."

The report also found physicians who reported using deceptive strategies were:

— less satisfied with the practice of medicine;

— less financially secure themselves;

— less likely to try to talk patients out of unnecessary procedures;

— more dissatisfied with the amount of time available during patient visits;

— more likely to voice annoyance at intrusion of insurance companies into their practice.

Overall, 55% of physicians said they "would be more aggressive in cost control efforts if they knew that money saved would go towards serving more needy patients."

"While physicians' use of deception may benefit individual patients, using deception may also damage the patient-physician relationship, cause moral discomfort for physicians, subvert resource allocation systems, and risk prosecution for fraud," researchers concluded. ■

Credentialing hassles may become a thing of the past

Recent innovations are likely to cut paperwork

If filling out credentialing forms for numerous managed care organizations is one of your practice's biggest paperwork nightmares, you soon may be able to rest easier. Consider these recent announcements:

• Three of the nation's largest managed care organizations have joined to develop a universal application to credential medical providers for their networks.

• Aperture Credentialing, the nation's largest credentials verification service, has introduced an on-line application process for physicians it credentials.

• An automated credentialing form that eliminates the need to fill out multiple applications has been developed by Caredata.com, a provider of health care content on the Internet. The application is included on the Web site Physiciansite.com, an Internet portal site for physicians.

Physician practices have long complained about the time involved in filling out credentialing applications to become a part of managed care networks. Some practices contract with as many as 15 managed care plans, all of which have different forms for gathering what is essentially the same information. Because the credentialing process must be repeated every two years, the paperwork burden can become onerous.

"In the past, each health plan had a different twist to their application. For the provider, it was nothing but a headache," comments **Kathy Welter**, manager of corporate communications

for Aperture Credentialing, a Louisville, KY, verification firm.

Aperture has announced the introduction of App-One.com, a Web site where practitioners can store and update their credentialing information in one secure location. The Web site uses encryption technology to ensure that all data are kept secure and confidential, Welter says.

App-One is an extension of Aperture's universal application, recently implemented by Humana, Oxford Health Plans, and UnitedHealthcare for physicians who want to be part of the three MCOs' medical networks.

"Many doctors have too much paperwork, leaving too little time for what matters: their patients. By honoring one set of paperwork, we can lighten part of that load for physicians, allowing them more time to deliver care," says **Lee Newcomer**, MD, senior vice president of health policy and strategy for UnitedHealthcare's parent company, UnitedHealth Group.

The universal application doesn't mean physicians who meet the criteria of one health plan will automatically be accepted by the others, notes **Pam Atherton**, chief executive officer of Aperture.

"Each company will apply its own participation criteria and make its own decision about whether to add a physician to its network, " she adds.

Humana's chief medical officer, **Jerry Reeves**, MD, calls the cooperative agreement "unprecedented. Everybody wins with this type of arrangement. Doctors with less paperwork can deliver more personalized care to patients, and a single process means greater efficiency for health plans," he says.

Any practice in the Aperture database can fill out the App-One information and submit it on-line, then print it out, sign it, and submit it to any other health plan, Welter adds.

Meanwhile, Caredata.com has introduced appStat, a Web-based application that provides on-line access to credentialing applications. Providers fill out a single form one time and then choose from a list of health plans to which they want to submit the application.

The Caredata.com program automatically produces the proper credentialing form, based on which health plan will receive it.

"Health plans all ask for essentially the same credentialing information, but it's in a gazillion formats. All they have to do is fill out the appStat form once, and it will produce the form based on where it's being sent," says **Andrea Kofl**, RN, chief operating officer for Physiciansite.com. ■

MedPartners begins reimbursing physicians

Bankrupt IPA makes $3.5 million payment

MedPartners has agreed to begin paying thousands of California physicians the more than $50 million it owes them for caring for patients from as long as a year ago, according to the California Medical Association (CMA) in San Francisco.

The agreement, facilitated by the CMA and California Gov. Gray Davis' office, may resolve a key impasse in the MedPartners bankruptcy settlement negotiations.

Under the agreement, physicians with the oldest claims will receive partial payment of the claims until the total reaches $3.5 million. MedPartners says it may continue to make chronological payment of claims and release another $3.5 million within a few weeks.

Whether the bankrupt independent practice association will pay any further claims depends on whether California physicians return release forms that waives their right to sue MedPartners and the health plans that contracted with MedPartners.

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MedPartners has mailed release forms to 6,000 California physicians, who have until Nov. 30 to return them.

The insurer will not disburse any money beyond the initial $3.5 to $7 million unless physicians whose claims represent at least 70% of the claims against MedPartners return the releases. Physicians who receive the initial payments and endorse the checks will be automatically agreeing to the terms of the release.

Association representatives have urged their physician members to sign the release, saying it represents their best chance to get paid.

"CMA and the Davis administration have spent an unprecedented amount of energy putting the MedPartners negotiations back on track. We are optimistic that the physicians will be paid and we can all begin to put the whole MedPartners debacle behind us," says **Jack Lewin**, MD, CMA executive vice president.

The CMA stepped in when the settlement agreement was in real danger of collapsing, Lewin says.

"Frankly, between squabbling by health plan and MedPartners attorneys and their persistent lack of resolve to conclude this process, the entire settlement agreement had languished," he adds.

In October, the CMA filed suit against eight HMOs, asking that they reimburse physicians for unpaid bills submitted to the health plans' intermediaries that have gone out of business.

Named as defendants in the suit are: Aetna U.S. Healthcare, Blue Cross of California, Blue Shield of California, HealthNet, MaxiCare Health Plans, PacifiCare of California, Prudential Healthcare (recently merged with Aetna), and United Health Care of California.

The suit, filed in San Diego Superior Court, accused the HMOs of avoiding their responsibility to reimburse physicians who care for insured patients.

The suit came on the heels of a report by the CMA expressing concern that millions of Californians may face interruptions and delays in medical care because the state's health care system is underfunded. The report cited statistics from a PriceWaterhouseCoopers report that predicted the collapse of at least 34 independent practice associations.

The CMA report cites the recent collapse of FPA Medical Management and MedPartners Provider Network, which led to disruption or delay in care for more than two million patients and left physicians with more than $100 million in unpaid bills for HMO patients. ■

Aetna creates unit for physician relations

In an effort to build relationships with the 250,000 physicians in its network, Aetna U. S. Healthcare has created a physician relations unit.

The physicians relations unit, headed by John T. Kelly, MD, PhD, a faculty member at the University of Pennsylvania Medical School, is charged with expanding communication with physicians and addressing their concerns.

"The vast majority of our relationships with providers are positive, but there clearly has been a vocal minority of physicians who have concerns. It simply made sense to us to create a separate organization that does nothing but focus on provider relationships," says **Arthur Leibowitz**, MD, chief medical officer for Aetna. ■

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