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INSIDE

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Y2K isn't the last high-tech headache; HIPAA offers more of the same

Your best bet is to start before final rules are set

If you thought the dawning of the year 2000 means you don't have to worry about your computer systems anymore, you'd better think again. Even if your lights come on and your computers still work on Jan. 1, you still have the Health Insurance Portability and Accountability Act (HIPAA) to deal with. And some experts predict that's an exercise that will make Y2K compliance look like a cakewalk.

Even though HIPAA's administrative simplification and security and confidentiality measures won't be required until 2002, the regulations will be so comprehensive that you'd better board the compliance train as soon as possible, say experts in the field of electronic data transmission.

"The best time to have planted a tree was 50 years ago. The next best time is now," says **Christopher Assif**, CEO of Health Network Ventures of Chicago, operator of Health.Net, an on-line network for medical professionals and office staff.

"Our approach is that there are a lot of electronic data interchange and security measures you can refine or implement now to prepare you better for the future," Assif adds.

Taking these steps sooner rather than later will help you spread the cost over the next two years, he says. Even if there are changes in the requirements, you can make those over time.

The first step is to begin exploring electronic data transmission instead of paper documentation.

"Health care providers need to act more like a business and cut their administrative costs. If providers continue to be paper-based, the outstanding days in receivables will do nothing but go up," Assif says.

While the new regulations will hit the entire health care industry, physician offices are likely to be the most vulnerable, because fewer than 20% of them are even connected to the Internet, Assif asserts. He advises physicians to start integrating electronic data interchange capabilities into their everyday activities right now.

"The most important thing people can do is to become familiar with the standards that are on the horizon. They are expected to be adopted within the next month or two, but the drafts have been out for quite some time," says **Jim Klein**, director of HIPAA compliance services for EDS in Plano, TX.

Klein suggests that providers go to government Web sites and study the standards, particularly those relating to security regulations, identifiers, code sets, and transaction standards. **(For a list of Internet sources of information on HIPAA, see p. 182.)**

Even though you might not know the specifics of the regulations, there is enough information on the generalities for you to start your own internal compliance efforts.

Here are some tips for getting ready for HIPAA compliance:

• If you are already using software, find out what you need to do to be HIPAA-compliant.

"Our suggestion is that physician offices select a partner to supply them with electronic data interchange capabilities," Assif says.

If you have a practice management system in place, your vendor may be able to provide those services. Or, look for vendors that offer electronic data services and can provide you with a system that will meet your needs.

• Keep your Y2K compliance teams intact and shift their responsibilities to dealing with HIPAA compliance, advises **John Knapp**, an attorney with the Philadelphia law firm of Cozen and O'Connor.

• Get your staff involved. Make sure everyone in your organization understands the implications of HIPAA.

• Contact any practice management systems you deal with and ask them what they are doing to make sure they are HIPAA-compliant.

"They will play a key role in assuring that providers become compliant in the two-year time period," Klein says.

• Start working now to develop security policies and procedures so you will be in compliance with HIPAA's confidentiality and privacy provisions.

Even though the details of the regulations have not been disclosed, you can assume that you need to decide what categories of employees and staff need access to what information and how you are going to protect patient records, Knapp says. **(For more on security issues, see related story, at right.)**

Strictly speaking, health care providers are not required to comply with HIPAA regulations. If your practice is totally paper-based, you may be able to avoid jumping through the hoops the act will mandate.

But, for practical purposes, almost every physician in America is going to have to comply if they use computerized records in any way, shape, or form.

If you are using information technology, you fall within the guidelines and will need to implement additional controls and requirements.

"Everyone is going to have to comply with HIPAA. Virtually every doctor's office has a computer with a database that is used for appointment scheduling and billing records," points out Knapp.

Many health insurers are already mandating electronic transmission of medical records.

"Ultimately, providers will get into a situation where they won't get paid if they don't subscribe to HIPAA," says Assif.

It will get to the point that if you want to do business, you'll have to do it electronically, and that means being compliant with HIPAA, says **Jon Zimmerman,** solutions manager for Shared Medical Systems Corporation, a supplier of information systems and professional services for health care providers in Malvern, PA. ■

Security guidelines expected to be thorough

Start now to make sure your records are secure

Whatever final rules are issued, the Health Insurance Portability and Accountability Act (HIPAA) will mean that your office will have to beef up security of your patients' medical records.

The data you will need to transmit are not clinical; they involve eligibility benefits and claims. You don't need to communicate lab results, medical history, or physicals. But the law specifies that every bit of identifiable information about a patient be subject to strict security regulations.

"The standards are very thorough and wide of scope where security is involved," says **Jim Klein**, director of HIPAA compliance services for EDS in Plano, TX.

In addition to technological security, such as sign-ons and passwords, your practice will have

to ensure that all your records are secure. You also must put controls in place to assure that only the people who need patient information will have access to it.

The privacy regulations will deal not just with electronic transmission, but also with access of data that stay within the institution. In other words, if somebody looks at a patient's health records, you have to have a trail to know who looked.

Physicians need to start to look at the security procedures in their practices and come up with a formal compliance plan, the experts say. Even though the precise requirements are not yet in force, you should take action now.

"Providers may have to wait for definite standards before putting purchase orders into place, but my suspicion is that the final regulations will give a fair degree of latitude," says **John Knapp**, a health care attorney with Cozens and O'Connor in Philadelphia.

For instance, a large academic medical center with hundreds of affiliated physicians and several hospitals will need a much more sophisticated security system than a small group of physicians, he adds.

Christopher Assif, CEO of Health Network Ventures in Chicago, predicts that the Department of Health and Human Services will require:

1. that you use a user name and password;
2. that data be encrypted when they are transmitted;
3. that you have security policies in place;
4. that your processes can be audited.

Start working on overall security in your office to ensure that file cabinets are locked, records rooms have monitors, and access to records is limited. Develop policies and procedures concerning what level of information your employees and staff need to have. For instance, do pharmacy staff need access to a patient's medical records?

Ask your vendors to see what kind of changes need to be made in your system to put firewalls or passwords into your network that will allow different people access to different information. ■

Where HIPAA comes from, and where it's going

Sweeping changes coming in medical records

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires everyone in the health care industry to overhaul their methods of handling medical records electronically — and the effects are likely to be much more costly and far-reaching than the Y2K problem.

HIPAA includes regulations that standardize all electronic data interchange of health information and require protection of the security of electronic medical records. The standards, part of the Administrative Simplification portion of the act, apply to any health care provider or health plan that electronically maintains or transmits health information.

The U.S. Department of Health and Human Services (HHS) is expected to issue final rules for HIPAA compliance by early 2000. **(For a proposed schedule of HIPAA regulations, see table on p. 181.)** Providers will be expected to be in full compliance within two years after the final rules are issued.

Spokespeople for HHS have said that HIPAA will create the most sweeping changes in the health care industry since Medicare. The agency predicts that the cost of HIPAA compliance may exceed the cost of fixing the Y2K problem.

"HIPAA will have significant impact on every player in the health care industry," says **Bill Braithwaite**, PhD, senior advisor on health information policy at HHS.

HIPAA will set standards for health care providers that use electronic data interchange (EDI) solutions for common administrative functions. The rules will set out regulations for transactions and coding, national provider identifiers, national employer identifiers, and security. HIPAA does not mandate electronic data transmission, but providers who use EDI must follow the act's standards, or risk heavy penalties.

The law is intended to encourage development of standardized electronic transactions among all segments of the health care industry and to improve the efficiency and effectiveness of the health care system. Currently, more than 20 cents of every health care dollar is spent on administrative overhead, according to General Accounting Office estimates. HIPAA aims to cut those costs.

When the standards are in place, health care providers will be able to submit a standard transaction to every health plan, whether it's to check eligibility of a patient, authorization for treatment, request for a referral, or a claim. This means your clinical, billing, and financial applications should be simplified, and the cost of doing business should be cut.

In fact, providers should expect to save $9 billion annually and the health care industry as a whole can save $26 billion a year by using EDI, predicts the Workgroup on Electronic Data Interchange, an industry association located in Reston, VA, appointed to help HHS develop EDI standards.

However, before that happens, the health care industry has a lot of work to do. Providers have spent an enormous amount of money and time dealing with the Y2K issue. They've overhauled their computer systems and beefed up services just to be able to stay in business beyond Jan. 1. But now, those efforts are likely to be eclipsed by the effort required to become HIPAA-compliant.

"One of the hot issues for the year 2000 and beyond is going to be HIPAA compliance," says **John Knapp**, an attorney specializing in health care issues with the Philadelphia law firm of Cozen and O'Connor.

Under HIPAA, all health care organizations will have to make changes in the technology they use to exchange electronic health care transactions. The rules to be issued by HHS will set national standards for administrative and financial transactions, procedure and diagnosis code sets, unique identifiers for providers, employers, and health plans. New security rules will be issued to ensure that individually identifiable health information and records are accessible only to authorized people.

If you don't understand HIPAA and the implications it will have for your practice, you're not alone.

When **Jim Klein**, director of compliance services for Plano, TX-based information technology service firm EDS, talks to provider groups, he always asks how many people in the audience have heard of HIPAA. The results are not encouraging. Usually only one or two out of 50 people raise their hands.

"People simply aren't aware of what they're going to have to do," says Klein. "When I try to get the attention of the information services people and chief financial officers to get them to start thinking about HIPAA, I find that they are preoccupied with Y2K and that they feel that since Congress didn't pass any legislation, there is no law to comply with," Knapp says.

However, he adds, after the final rules go into effect early in 2000, providers will have just 24 months to put security measures in place, upgrade their practice management systems, and take other steps to make sure they are in full compliance with the regulations. ■

HIPAA may be a pain, but could produce a gain

Act should simplify your dealings with insurers

There's good new and bad news where the Health Insurance Portability and Accountability Act (HIPAA) is concerned.

The bad news is that you're going to have to make sweeping changes in the way you do business. The good news is that the changes could improve your bottom line.

"Nobody likes the government forcing them to accept new requirements, but the good news is that there is a positive return on your investment if you do transactions electronically," asserts **Christopher Assif**, CEO of Health Network Ventures in Chicago, operator of Health.Net, an on-line network for medical professionals and office staff.

One purpose behind HIPAA is to encourage providers to transmit claims electronically because it is cheaper and easier.

When HIPAA regulations go into full effect, all your transactions with all your third-party payers will be conducted in the same way. This means one method of checking eligibility, one set of treatment and procedure codes, and a standardized method of submitting claims. The cost savings could be substantial, Assif says.

"Physicians now spend money on operational expenses to keep people on their staff to call the insurance companies to verify a person's benefits. That will no longer be necessary. They will be able to dial directly into the computer," adds **Jon Zimmerman**, solutions manager for Shared Medical Systems Corporation, a Malvern, PA, supplier of information systems and professional services for health care providers.

When HIPAA standards go into effect, you should get the correct information about your patients up front and be able to follow the plan rules. It should eliminate all the reimbursement problems that occur after the service has been provided, Zimmerman says.

For instance, at present, every time you don't get the right eligibility or benefits information from the patient and your claim is rejected by the payer, it costs you money.

If a patient gives you the wrong plan number by mistake and he's not covered, the debt will sit on your balance sheet for months.

"It's not uncommon for outstanding receivables to go as long as 100 to 120 days, and in some cases, the cost of carrying the debt isn't worth what the value of the debt is," Assif says.

Not only is there a benefit to providers if they collect on their claims faster; patient satisfaction can be another issue. According to Assif, problems with the way their bill is handled prompt patients to find another physician.

John Knapp, a health law attorney with the Philadelphia law firm of Cozen and O'Connor, isn't all that optimistic about cost savings. "It has the potential to cut down on administrative expense, but that's often not the way things play out. I wouldn't be surprised if no one sees any resultant savings," Knapp says.

He points out that when personal computers came on the market 15 to 20 years ago, many predicted that it would cut down on the use of paper.

"In reality, the use of the computer has multiplied the use of paper. With a computer, you have to deal with the inevitable glitches and problems," Knapp adds.

However, leaving HIPAA aside, it's beginning to be financially prudent for physicians to submit their claims electronically, he points out.

One big issue, the lack of speed with which third-party payers process claims, figures largely in the issue of electronic transmission.

As providers renegotiate their contracts with managed care payers, many are addressing the issue of how often they get paid, Knapp says. "One of the inevitable compromises is that if they want to get paid quicker, they have to submit their claims electronically," he adds.

Some states already have passed laws that say payers can't hold your money if you submit your claims electronically, Zimmerman says.

In some areas, Medicare carriers have put a 50-cent surcharge on paper claims, according to **Jim Klein**, director of HIPAA compliance services for EDS in Plano, TX.

"That practice is gaining popularity. Paper claims mean an increased cycle time. If providers send in claims electronically, they get paid in 14 days. If the claims are on paper, it's a full month," Klein says. ■

Roots of act trace to Clinton health plan

Final rules to be in place by February

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has its roots in President Clinton's plan to provide universal health insurance for all Americans.

When those efforts failed, Congress passed HIPAA, also known as the Kennedy-Kassebaum Act. The act originally was intended to make it easier for people to move their health insurance from one employer to another. However, in passing the act, Congress considered the underlying problems in the infrastructure within which health insurance is provided and managed.

"The basic issue is that the health insurance industry operates much the same way any other free market for-profit sector does. It is made up of competing private institutions that don't always do things in the same way," says **John Knapp**, an attorney specializing in health care issues with the Philadelphia law firm of Cozen and O'Connor.

"This puts a tremendous burden on health care providers to deal with a myriad of different requirements for maintaining records, filing claims, and interfacing with insurers," he adds.

A major issue was the fact that there were no

HIPAA Regulation Schedule

The U.S. Department of Health and Human Services has issued a schedule for Health Insurance Portability and Accountability Act regulations. First, the department will issue a Notice of Proposed Rule Making (NPRM), which is the draft of the regulations. The time between the NPRM and the publication of the final rule is used to review and analyze the comments received before the final rule is made. The standards will be implemented within two years of the effective date of the final rule, which is generally 60 days after publication.

	NPRM Published	Final Rule Expected
Standard Transactions and Coding	5/7/98	11/99
National Provider Identifier	5/7/98	12/99
National Employer Identifier	6/16/98	12/99
Security	8/12/98	12/99
NPRM in Development		
National Health Plan Identifier	12/99	5/2001
National Individual Identifier	?	?

rules about privacy, security, and confidentiality measures, or who had access to patient information, how it could be shared, and what patient consent was needed.

Congress decided that the health insurance portability issue needed to be addressed immediately, and passed the bill with a three-year deadline (Aug. 21, 1999) for Congress to pass subsequent legislation on protecting privacy and ensuring confidentiality of electronically stored medical information.

"Congress recognized that administrative simplification was in some ways going to open a Pandora's box. As you move insurers and providers to utilize electronic exchange of information, this would mean that more and more private, sensitive information about people's health status would exist on electronic databases," Knapp says.

The administrative simplification standards have been developed and released in several stages, beginning in August 1997. The act stipulated that if Congress failed to act by the deadline, the secretary of Health and Human Services would release privacy and confidentiality standards, which would become final by February 2000.

HIPAA Resources

Here's where to look for more information on the Health Insurance Portability and Accountability Act:

- **Healthcare Informatics.** Web site address: www.healthcare-informatics.com
- **Workgroup for Electronic Data Interchange**, a Reston, VA-based industry association designated in HIPAA legislation to assist the Secretary of Health and Human Services in development and implementation of electronic data interchange standards. Address: www.wedi.org
- **HIPPA Central**, a Web site operated by Shared Medical Systems that deals with HIPPA issues. Address: www.smed.com/hipaa
- **EDS** Web site on HIPAA contains articles, events, resources and assistance. Address: www.eds.com/hipaa
- **Department of Health and Human Services** HIPAA Web site: aspe.os.dhhs.gov/admnsimp/
- **Electronic Health Care Network Accreditation Commission** Web site, which includes security assessment tools. Address: www.ehnac.org

Because Congress failed to act before the August 1999 deadline to set privacy and confidentiality standards, Secretary of Health and Human Services Donna Shalala proposed the privacy standards in late October. The proposed standards will be open for public comment for 60 days, with the final regulations scheduled to be published by Feb. 21, 2000.

The Clinton administration has urged Congress to pass legislation that will give HHS authority to protect all medical records, including those that are maintained in paper form, and to pass legislation that will give the public the right to sue when their medical information is used inappropriately.

One sensitive issue that has not yet been decided is whether federal standards will preempt state standards, Knapp says.

And, he adds, don't count Congress out yet.

"They still may extend the deadline or come up with standards that put their own point of view into place," Knapp says. ■

Hand-held computers bring data into treatment

Program aims to improve efficiency of care

When **David Slawson**, MD, was examining a 2-month-old baby with a high fever and bladder infection, he recalled reading an article that compared the recovery of children with similar problems who were hospitalized and treated at home.

He punched a few keys on his hand-held computer and instantly had the details of the article at his fingertips. Instead of hospitalizing the patient, he decided to treat the baby at home. Next, he looked up the recommended drug dosage and checked the patient's insurance company's formulary — all in about three minutes.

"I was able to keep the patient out of the hospital and send him home with the right information. In just a few minutes, I knew I had the most up-to-date information available," says Slawson, a family practitioner with the University of Virginia Medical Center in Charlottesville.

Slawson's hand-held computer is equipped with InfoRetriever, a database program that

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Physician's Capitation Trends™

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'California blend' uses both FFS and capitation methods

IPA study shows mix-and-match approach works

If men are from Mars and women are from Venus, perhaps fee for service and capitation are from separate and distant planets as well.

But the truth is, according to a West Coast professor, that the best of both physician payment worlds lies in learning how both capitation and fee for service can live peaceably together and contribute to each other's well-being.

Here are four serious questions about managed care payment you've wrestled with for some time:

- **Does capitation push physicians too far to reduce services?**
- **Does fee-for-service influence physicians to "over" provide?**
- **Should primary care physicians be capitated, but not specialists?**
- **Or, should the reverse be the case, so that primary care physicians receive fee for service, while specialists are capitated?**

Experts can tell you why each of the above questions should be answered yes and when given situations are good or bad for your practice. But while practitioners do battle with the ills of capitation or the dire consequences of fee for service for both specialists and primary care providers, California IPA officials are finding that the best approach lies in a smart combination of the two.

"While there exists no problem-free method of reimbursing physicians, it appears that blended approaches can offer meaningful improvements over pure fee for service or pure capitation," writes **James C. Robinson**, PhD, MPH, a public health professor at University of California-Berkeley. **(See specifics on how blended methods are working, pp. 184-186.)**

Robinson recently conducted a survey of payment methodologies at seven of California's largest independent practice associations (IPAs), which collectively treat 826,000 HMO patients.[1] He also spoke with *Physician's Managed Care Report* about his findings.

These current capitation changes may contain a silver lining, suggests Robinson, although physicians are bound to be unconvinced at first. "The unfortunate part of [any] changes in payment method is that they are often accompanied by a reduction in overall payment level, as purchasers hold down their premiums to the plans and then plans hold down their capitation payments to the IPAs," Robinson says. "So doctors are understandably skeptical about payment method changes, even if the changes actually make sense."

But the toughest of times may be changing. "If we are now on the upswing of premiums and hence capitation rates, perhaps further changes in payment methods will be accompanied by overall payment increases rather than decreases, which will help the transition," Robinson says.

IPAs are a good place to study capitation, notes Robinson, because they often apply a wide range of payment strategies for physician groups. In fact, they can act as a buffer to soften of the harshness of capitation financing by dealing with payment issues more holistically rather than on a contract-by-contract basis, Robinson says. For example, IPAs at their best level of performance can function as an intermediary between physicians and health plans and bring these key advantages:

- **Receive and manage all payments from all the health plans in which member physicians participate — capitated or otherwise — and then disburse payments to members in systematic and well-thought-out ways.** For example, an IPA may receive the bulk of its payments on a per-member per-month basis, but it need not pass the risk and responsibility to its individual IPA members. Instead, the IPA can pay its members by using any of a number of methods, including fee for service,

primary care capitation, specialty department capitation, and various blended forms.

• **Focus on paying IPA members more on an actual cost basis.** Costs are predicted based on a variety of possible measures, such as actuarial prediction, patient history, epidemiological data, or professional and / or specialty-driven cost surveys and analyses.

• **Seek a middle ground between capitation and fee for service by blending payment methodologies for best results.** Blended methods allow capitation payment streams to do what they do best: reduce costs. They also open up room for fee-for-service payment streams to motivate physicians not to underserve their patient populations, thus guaranteeing high quality of care.

• **Offer practice management leadership to physician members by constantly integrating revised payment methodologies with other practice disciplines.** These disciplines include arriving at more ideal practice patterns and incorporating preventive and early disease detection services.

Leading California IPAs are discovering that the best of all worlds is not to abandon either capitation or fee for service, but rather to use them both at the right time and in the right combinations, Robinson's research suggests. In fact, this approach already is time- and theory-tested in what now are seen as solid business practices, he says, but they are applied using different terms.

IPA financial directors who use this "blended payment" approach think of it this way, drawing upon tried-and-true business and economics principles: Capitation is to fee for service as "fixed costs" are to "varied costs", as a salary is to a commission, or as a manager is to a salesperson. For example, an IPA may use incoming capitation payments to cover fixed costs and use doctors' fee-for-service payments for less predictable, variable costs. Business practice has leaned this way for years, Robinson says.

In the same way, sales people are paid on a commission or a fee-for-service basis. Managers, who must rely on the successful interaction of a number of people, are paid an overall salary and expected to carry projects from beginning to completion, much like capitation, which is expected to cover all of a patient's needs from the beginning to the end of the contract year. In the real world of medicine, Robinson notes, neither salary nor commission works adequately by itself. Combining the two produces the best results. In addition, he sees the combination working in certain ways for primary care doctors and in different ways for specialists.

"In the health care sector, elements of capitation encourage physicians to develop a cost-conscious style of practice, while elements of fee-for-service encourage them to accept especially sick patients and to maintain a broad scope of practice," Robinson says.

Reference

1. Robinson JC. Blended payment methods in physician organizations under managed care. *JAMA* 1999; 282:1,258-1,263. ■

IPAs defect from pure capitation for primary care

How blended methods work for PCPs

Primary care and capitation seem to go hand in hand — to be almost synonymous. But in regions where capitation has matured, independent practice association (IPA) officials are finding that some clear reversals of the well-known capitated primary care / noncapitated specialist model are creating better results.

That's a key finding from a survey of seven IPAs in California completed recently by **James C. Robinson**, PhD, MPH, a public health professor at the University of California-Berkeley.

That's not to say that capitation has been ditched for primary care, but it can be modified. In six of the seven IPAs surveyed, Robinson found that primary care physicians are paid per-member per-month (PMPM) amounts based on how many patients selected the physician as their principal caregiver.[1] **(This is sometimes referred to as population-based or market-based capitation. For details, see *Physician's Managed Care Report*, September 1999, pp. 137-138.)**

Overall, the PMPM amount operates much like a part-time salary for primary care doctors. For example, a doctor who belongs to two IPAs would receive two monthly payments, derived from the physician's two capitation contracts. That's in contrast to a physician who works in a multispecialty clinic. In that case, the physician would receive a monthly salary based on all the contracts within the organization. Also, in most of the IPAs, the primary care doctor is subject to various year-end bonuses if certain goals are met, but in the past two years, these bonuses rarely if ever were meaningful, Robinson says.

Also in the conventional approach, primary care physicians refer specialist care, laboratory and radiology testing, ambulatory surgery, inpatient care, and other nonprimary care services to other providers. The problem with this model, however, is that it carries an incentive for primary care doctors to refer virtually everything, even borderline cases (those that may be able to be treated by the primary care doctor) to other sources, Robinson says.

To mitigate that concern, three techniques are working for IPAs, he says:

- making sure physicians have stop-loss insurance to cover unexpected crises under capitation;
- adjusting capitation payments to some extent, based on age and sex of patients, and offering different levels of payments for newborns, women of childbearing age, senior citizens, and other groups (these subgroups converted to fee-for-service payment after reaching certain thresholds);
- carving out specific types of care for fee-for-service payments to ensure certain accreditation-specific treatments are performed and to keep a primary care physician's scope of work broad enough not to "over refer" to specialists.

Carve-outs are proving to be the biggest innovation. While you're probably familiar with carve-outs in HMO contracts, in this scenario, the IPA is using them in actual payment decisions. Key kinds of care are paid for by fee for service to encourage physician participation and better record keeping, Typically, these services include those that are deemed especially important by the National Committee for Quality Assurance, such as:

- preventive care and early detection screening such as mammograms and vaccinations;
- physician visits to patients outside the office — including the emergency department, subacute facility, skilled nursing facility, and home settings — to address continuity of care;
- office procedures and services that involve expensive supplies, such as injectable medications and durable medical equipment, to help cover costs (in some cases, special budgets were provided to HIV and neonatal patients);
- borderline services, i.e., services that fall on the borderline between primary and specialty care. These were paid fee for service to buffer the tendency for primary care doctors to reduce their scope of practice by over-referring to specialists.

Special care is given to borderline payments. There is no difference in payment amounts between primary care physicians and specialists. Also, some risk adjustment is made based on severity, so more complex procedures received higher payments.

Examples of these borderline services are flexible sigmoidoscopies, suturing and wound treatment, drainage of abscesses and cysts, removal of benign lesions, and arthrocentesis.

Given the scenario of PMPM for core services and fee for service for outside the core services, one IPA in Robinson's survey is taking the blending process a step further by reversing the techniques. Here's how that works: Primary care physicians are paid on a fee-for-service basis according to Medicare's resource-based relative value scale (RBRVS). This was done to encourage doctors to keep their practice scope broad.

However, now the practice is piloting a system in which all services remain RBRVS-based, but they are paid at a lower rate. The lower payments are supplemented by a monthly capitation amount. All physicians receive the same fee for each procedure, but the capitation amount varies according to measures of practice efficiency, patient satisfaction scores, and service on organizational committees.

The approach is very similar to the old business practice of prospectively paying for "fixed costs" (via capitation) and retrospectively for "variable costs" (via fee for service).

Doctors tend to resist payment changes

How are physicians reacting to these payment changes? "Doctors tend to resist change in how they're paid," says Robinson. "So out here [in California], where most PCPs are paid capitation by the IPAs, they are resisting the transition back toward partial or full fee for service. Elsewhere, of course, they are resisting a transition from fee for service toward capitation."

Yet, chances are these changes will ultimately make sense to doctors. "Generally, PCPs tend to understand the logic of fee for service for a variety of services, such as preventive care, time-consuming procedures they could refer out such as sigmoidoscopy, or out-of-office visits like ER or subacute," says Robinson.

"Anyone who has experienced primary care capitation for a while comes to understand the unintended effect it has on encouraging a narrower scope of practice and increased referral to specialty care for procedures that PCPs could do themselves," Robinson says.

Reference

1. Robinson JC. Blended payment methods in physician organizations under managed care. *JAMA* 1999; 282:1,258-1,263. ■

Specialists use blends for better results

How blended methods work for specialists

Just as primary care doctors typically face the rigors of pure capitation, specialists traditionally are preserving their fee-for-service status, only to see their referrals sometimes overloaded and inappropriate.

This dichotomy is changing in several leading California independent practice associations (IPAs), where specialists, too, are experiencing creative blends of both capitation and fee-for-service payment methods — all aimed at realizing the best of both worlds: the efficiency of capitation and the comprehensiveness of fee for service.

That's what **James C. Robinson**, PhD, finds in his survey of seven leading IPAs in California. Robinson, a professor of public health at the University of California-Berkeley, surveyed payment patterns in IPAs that collectively serve 826,000 HMO patients.[1]

By 1998, Robinson found that all seven IPAs were beginning to steer away from pure fee for service and tinker with various blends of capitation and fee for service for their specialist members. Here's what was happening: The IPA assigned individual specialists to one of up to 28 specialty-specific departments and established a budget for each department. These departmental budgets were then distributed among the specialists based on either fee-for-service, subcapitation, or some other blend.

The departmental budgets were initially based on historical expenses incurred by fee for service, with adjustments for IPA professional services. Over time, the budgets were changed in light of actual utilization and expenses, and specialists received instead a per-member per-month (PMPM) payment based on those data. These PMPM payments were to cover all visits and procedures seen by that specialist for all IPA patients. Exceptions were granted to "super specialists" who provided rare, high-cost services; they retained their fee-for-service payments.

Or, as another alternative, specialty departments pay out their physician members by choosing one of these three blending options:

• **RBRVS payments drawn from a preset (or capitated) budget.** This approach paid physicians on a fee-for-service basis for visits and procedures they performed using Medicare's RBRVS or a modified version of RBRVS. Then the total number of relative value units generated by all the specialists in the IPA was divided into the departmental budget to obtain the conversion factor for each unit of service. This way, the actual payment was adjusted continually so that it was inverse to the total number of services provided by the physician. Payment levels were not, however, affected by utilization or expense patterns because each department had its own preset budget.

• **"Contact" or referral-based capitation.** Most IPAs are going with this method, Robinson says, which pays doctors based on the number of patients for whom they are responsible rather than based on the services they provide their patients. Robinson calls this analogous to "case rate" payments or even diagnosis-related groups. In this method, a patient referral triggers a capitation payment to be directed to the specialist for a designated period of time. Time periods vary from three to six or even 12 months. When major procedures are called for, however, fee-for-service payments often kick in.

• **Combination PMPM and fee for service.** In this approach, the initial referral triggers a base payment for a specified set of services. Then, if the patient needs additional or especially expensive care, the department budget would cover it on a fee-for-service basis.

For both specialists and primary care physicians, offering a blend of capitation and fee for service carries nonfinancial messages as well as financial ones, Robinson says. "The shift to capitation budgets for specialty departments was conceptualized in part as a way to encourage closer clinical cooperation among members of each specialty, who otherwise often thought of each other as competitors rather than as colleagues," Robinson writes.

When capitation kicked in, physicians often would elect a medical director for the specialty department, who then reviewed specialty-specific clinical protocols as well as general oversight of the capitation budget. This helped bridge communication and culture gaps between the IPA management and physicians, as well as among the physician members themselves.

Reference

1. Robinson JC. Blended payment methods in physician organizations under managed care. *JAMA* 1999; 282:1,258-1,263. ■

(Continued from page 182)

allows doctors quick and easy access to the best available information on a topic.

InfoRetriever contains diagnostic calculators that help determine the advantages of different treatments, summaries of the latest published papers, systematic reviews of the best available evidence, treatment guidelines, and a customized database of formulary information for each insurance plan with which doctors contract, along with prescribing information for more than 1,100 medications.

Before he started using the computer, Slawson asserts that he probably would have ended up putting the child in the hospital.

"Most of the time, if there's a question about treatment, physicians just guess at it, and they may end up spending money and subjecting patients to unnecessary and potentially harmful treatments and tests," he adds.

He cites a recent study at the University of Iowa that showed that physicians seek answers to questions regarding patients care less than half the time. **(For details on the study, see p. 188.)**

Slawson and his colleague **Mark Ebell**, MD, a family practice physician and associate professor at Michigan State University in East Lansing, are among the developers of the InfoRetriever database. The program is being tested by 200 physicians at Michigan State and the University of Virginia. Other developers are Henry Barry, MD, associate professor of family practice at Michigan State University, and Allen Shaughnessy, MD, director of research at Harrisburg (PA) Family Practice Residency.

"Doctors have ever-increasing demands placed on them, not only to improve the quality of care, but to improve the efficiency of care, to keep costs down, and to see more patients more quickly," Ebell says.

He cites an example of a patient who comes in with a sore throat, and the physician has to determine if it's a strep infection. The physician can feed information on a patient into the computer and determine the patient's risk of strep. Then he or she can decide whether to treat the sore throat presumptively as strep throat until the results of a culture come in three days later, use a rapid strep test, or just wait until the test results are in to prescribe treatment.

"Instead of having to remember all of this, instead of having to find a published paper, it's all right there at the fingertips. It makes it very easy to apply the results of research and individualize care to a patient's needs," Ebell says.

Patients benefit by getting better treatment and avoiding tests and procedures that may involve risk, Slawson says.

"Every time a patient goes through a test they don't need, there is harm. We want to make sure the patients get the best treatments they possibly can," he adds.

Computers in a physician's office are nothing new, Ebell asserts. The difference is that the computers are in the treatment room.

"The people who have used it at UVA are constantly saying how useful it is. The residents who have tried it say they can't imagine practicing medicine without it," Slawson adds.

Eliminating the hassle of formularies

In addition to providing the latest information on treatment and practice guidelines, the database aims to solve one of the biggest frustrations today's doctors have: coping with the different drug formularies for the managed care firms which they contract.

"Every January, I get several booklets, each about 100 pages long, listing the drugs each HMO says I can use to treat every disease and every diagnosis. When I'm seeing a patient every 12 to 15 minutes, there's no way I can find out exactly which drug their insurer will approve," Slawson says.

Using InfoRetriever, in less than 40 seconds, he can find out which drugs an HMO approves for a particular condition. Then he can click again and get information on the drug's dosage, side effects, and cost.

The drug formulary section gives practitioners information on how to download the information from their HMOs into the program. At UVA, it took a secretary about two hours to download the information, Slawson says.

The software currently is available for computers that run on Windows CE. The company is in the process of creating other packages for other types of hand-held computers.

"The current database is geared toward people in family practice or general practice. Our vision is to create a database of each specialty," Slawson says.

Developers of the program have formed a company called InfoPOEMS, Inc., which markets the program. POEMs stands for Patient Oriented Evidence that Matters, Ebell says. The company

also maintains a Web site containing journal articles, information on the InfoRetriever, and other information on evidence-based medicine.

To create the database, which is updated periodically, a team of physicians reads 92 medical journals containing about 1,500 articles each month. They review the information and include the valid information on the Web site and in the database.

People who want to try out the program without purchasing it can download it from the Web site and use it 30 times for free. The Web site address is www.infopoems.com. ■

The textbooks consulted by the doctors in the study did not always contain the information the physicians needed, Ely says.

Common question topics were prescriptions, infectious disease, obstetrics, and gynecology.

"We need to find better ways of answering physicians' questions. Although computers fared poorly in this and other studies, improvements in their speed, portability, and user-friendliness are making them more useful to doctors," he adds.

Ely proposes a continually updated database of questions from physicians along with answers.

"Doctors need bottom-line answers to their questions, and they need them quickly," the study concluded. ■

Physicians slow to seek answers on patient care

Study cites need for easy-to-find information

Family physicians often have questions about patient conditions and procedures but don't pursue the answers, according to a University of Iowa Health Care study.

The study, by **John W. Ely**, MD, associate professor of family medicine at the University of Iowa in Iowa City, concluded that there is a need for sources of easy-to-find information for physicians.

Ely and his research team studied 103 family physicians in Eastern Iowa. They followed each doctor for two half-days and asked the doctor to share any questions he or she had about patient conditions and patient care. Researchers tabulated a total of 1,101 questions during the 21-month research project. The researchers found that 64% of the questions were not pursued immediately.

The most common reason for not pursing the answer was that the doctor felt a reasonable decision could be based on his or her knowledge.

Ely says the goal of the study was to find better and faster ways for doctors to answer the questions they have about their patients and the care they need.

According to the researchers, 80% of the questions physicians followed up on were answered in two minutes using textbooks and colleagues. On only two occasions did the physician being observed perform a formal literature search.

Follow-up phone calls benefit cancer patients

Program can cut costs, improve satisfaction

A program of telephone counseling and education by nurses has the potential to save money, improve patient satisfaction, and improve outcomes in cancer patients, says **Merle Mishel**, PhD, a University of North Carolina at Chapel Hill (UNC-CH) researcher who is conducting three psycho-educational intervention studies with cancer patients.

During the eight-week program, trained nurses call cancer patients once a week to answer questions, educate them about their disease and the potential side effects of treatment, and give them resources. The phone calls typically last 15 to 20 minutes.

"Managed care has decreased the amount of time health care providers spend with their patients by placing a premium on seeing more patients in less time," says Mishel, who is Kenan Distinguished Professor of Nursing at UNC-CH and a member of the UNC Lineberger Comprehensive Cancer Center.

The result is that patients are discharged from the hospital without enough information. Cancer patients frequently complain about the difficulty of getting questions answered, she adds.

"This is a service that patients want that isn't readily available. This gives them a tie to help them over the most difficult periods," Mishel says.

The study, funded by the National Cancer Institute and the National Institute of Nursing Research, involves three groups of cancer patients: African-American and white men with localized prostate cancer and their family members; older white, Mexican-American, and African-American women with breast cancer; and younger African-American women with breast cancer.

Preliminary results of the study have shown that the telephone intervention can cut down on the frequency with which cancer patients call their physician's office, identify serious complications early on, improve compliance, and increase the patients' quality of life, Mishel says.

The program saves costs by identifying complications early on before they become severe and costly to treat, she notes. For instance, the nurses were able to identify symptoms of spinal cord compression in prostate cancer patients who didn't realize the condition was life-threatening.

"Physicians may not emphasize the result of complications because they don't want to scare the patients, but if no one follows up, the patients may not realize how severe the problem is," Mishel says.

The follow-up program has "great potential" for cost savings in managed care and capitated systems, Mishel says. Her team is working with several HMOs on implementing a similar program for them and is willing to work with physician practices to help them set up a similar program, she adds.

The UNC-CH study employs practicing nurses who take on the project as a part-time job. The nurses went through a 30-hour training program to teach them the follow-up protocol and to educate them on cancer treatments and side effects.

When a patient enters the program, the nurse and patient agree on a time for the nurse to call the patient. The same nurse calls each patient throughout the follow-up program.

The nurse addresses a list of problems specific to each diagnosis category. Treatment decisions, side effects, uncertainties, social relations, and financial concerns are among the topics addressed.

The nurses use telephone counseling and supplementary materials to teach patients how to manage the uncertainty they may be experiencing because of the cancer diagnosis and treatment.

Patients are asked to monitor themselves for symptoms and side effects and to generate a list of questions before the weekly call. The nurses teach patients how to phrase their questions to get the attention of their health care provider.

"We teach them the words to use to get the health care patient's provider, how to phrase the problem to avoid being triaged out by the office nurse," Mishel says.

The follow-up calls have reduced the number of patient problems, helped patients manage the side effects of their treatment, and increased compliance, Mishel says.

For instance, the prostate cancer patients report improved control over urine flow, increased satisfaction with sexual relationships, and better family relationships.

The nurse always asks prostate cancer patients if they are practicing their Kegel exercises.

"The doctor may teach them Kegel exercises, but if no one checks up on the patients, they may do them incorrectly or sporadically, neither of which is effective," she adds.

If your practice is considering a similar program, Mishel recommends hiring a part-time nurse whose sole responsibility is making the follow-up calls.

"If a nurse has multiple responsibilities, she may not have a chance to make the phone calls on schedule. Then the program doesn't work as well. Follow-through is very important," she says. ■

Here's last-minute help with your Y2K issues

Safety net for health care providers launched

The RX2000 Solutions Institute has set up a Y2K Rapid Response, Recovery and Communications Center to help health care organizations make a smooth transition to the year 2000.

"While we aren't predicting catastrophic failures, our extensive research tells us that in the U.S. alone, many health care organizations haven't done all they should to prepare for the Year 2000 changeover," says **Joel Ackerman**, executive director of the Minneapolis-based institute. "Now, add inadequate preparation on an international basis and last-minute Y2K upgrades from product and systems suppliers and manufacturers, and the possibility of significant problems increases."

The Recovery Center will allow health care organizations to share their experiences in Y2K failures and their success in working around

problems. The Web site will contain notification of changes in participating manufacturers' Y2K compliance information, problem statuses and fixes, resources to resolve product and service failures, Y2K "storm tracking" information and reports from the health care sector, and information on alternative supplier matching, supply shortages, and surplus reallocation.

The Recovery Center will maintain a participant software and product database ensuring that registered organizations only receive information that is specific to their needs.

For more information, e-mail the Center at Safetynet@rx2000.org, call (612) 835-4478, or visit the Web site at www.rx2000.org. ■

Roundtable offered on doctor unionization

Labor representatives, researchers, and managed care executives will face off Dec. 11 at a roundtable discussion on physician unionization at Kennesaw State University in suburban Atlanta.

The roundtable is part of Kennesaw State University's MBA for Physician Executives program. The 21-month program at the Michael J. Coles College of Business always includes a roundtable discussion on a controversial topic that is open to physicians not participating in the MBA program, says **Gary Selden**, PhD, director of executive programs.

"The topic of physician unionization is a hot topic right now," Selden says. "We have invited some participants who are very passionate on both sides of the issue. We expect that the pros and cons will be thoroughly discussed."

The participants will debate issues such as whether insurance companies put cost concerns ahead of patient care and physician compensation; the balancing act between providing quality care and appeasing stockholders; and fears that doctors may strike, leaving lives in the balance.

"The patient, the doctor, the business owner, and the stockholder could all feel the impact of unionization," says **Rodney Alsup**, associate dean of graduate programs. "The MBA for Physician Executives is the perfect forum for discussion since many of our students face daily conflicts between providing good care and operating their businesses."

Roundtable participants include Jack Seddon, executive director of the Federation of Physicians and Dentists; Dave Shafer, United HealthCare vice president for Ohio; Suhail Kahn, aide to Congressman Tom Campbell of California, sponsor of legislation that would lift the antitrust prohibition against collective bargaining; Grace Budrys, PhD, professor of sociology at DePaul University and author of *When Doctors Join Unions*; and Andrew Thomas, MD, a trustee of Physicians for Responsible Negotiation, a division of the American Medical Association.

Physicians who want to participate should call Kennesaw State's executive MBA program at (770) 423-6087. ■

HCFA publishes schedule for year 2000 fees

With the publication of its Medicare physician fee schedule for 2000, the Health Care Financing Administration is continuing its move to tie physician reimbursement to actual resources consumed rather than historical charges.

HCFA estimates that 15 of the 35 major medical specialties will receive payment increases, 19 will experience decreases, and one specialty will experience no change under the new fee schedule,.

By the year 2002, reimbursement should be fully based on resources used.

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The fee schedule specifies payments to physicians for more than 7,000 services and procedures, ranging from office visits to surgery. Payment for the year 2000 will be based 50% on the resource-based practice expense system and 50% on the old charge-based practice expense system.

"The 2000 fee schedule represents a further refinement in the way Medicare pays physicians by making the payments more equitable," says HCFA Deputy Administrator **Michael Hash**. "HCFA will continue to work with the American Medical Association, physician specialty groups, and others to make further refinements over the next two years."

When the resource-based practice expense formula is fully implemented, all components of the fee schedule will be resource-based.

The new system was prompted by studies showing that the old charge-based systems did not fairly compensate physicians for practice expenses. For instance, under the old system, physician payment for coronary bypass surgery was more than 100 times greater than for an office visit, although costs for the surgery were only about 40 times higher. ■

NEWS BRIEFS

MGMA launches patient safety initiative

Maximizing patient safety in group practices is the target of a new initiative by the Medical Group Management Association (MGMA).

The patient safety initiative will include educational programs, research, communications and advocacy.

Education programs for members of MGMA are currently in the works, according to **William F. Jessee**, MD, president and chief executive officer of the Englewood, CO-based organization.

The aim of the patient safety initiative is to help member organizations understand and control incidents and accidents in group practice and ambulatory care settings, systems failures that lead to patient injury, organizational and human factors associated with accidents, delivery system changes, and other mechanisms for achieving maximum safety.

Issues such as treatment side effects and complications, quality of care, and malpractice or tort law reform will not be addressed.

"The safety of patients in health care organizations is a visible and growing concern to both the public and the profession. Yet, little or no research data have been developed on patient safety and risks of injury in ambulatory group practice settings," Jessee says.

He stressed that the initiative does not imply that medical practices are unsafe, but that it is part of MGMA's commitment to "serve and improve the health of our communities." ▼

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Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Executive Editor: **Glen Harris**, (404) 262-5461, (glen.harris@medec.com).
Editor: **Mary Booth Thomas**, (770) 394-1440, (maryboothtt@aol.com).
Senior Production Editor: **Brent Winter**, (404) 262-5401.
Editor of **Physician's Capitation Trends: Reba Griffith**, MPH, (rocky.top@worldnet.att.net.)

Editorial Questions

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

Feds exploring physician-hospital ties

If your physician practice is owned by a hospital, you may be in for more scrutiny from the Health Care Financing Administration.

A recent report by the federal Office of the Inspector General (OIG) of the Department of Health and Human Services has recommended that HCFA require hospitals to report all physician practice and clinic purchases and declare how the operating cost of physician practices are handled in hospital cost reports.

The OIG estimates that 62% of for-profit and not-for-profit general short-term hospitals own a physician practice but that the Medicare fiscal intermediaries know about the ownership only half of the time.

At issue is the hospital practice of designating the physician practice as provider-based instead of freestanding. This provider-based designation allows the hospitals to include the cost of operating the physician offices in the hospital cost report, which can result in higher reimbursement than if the physician practice is designated a freestanding entity.

The OIG recommends that HCFA change its policy and eliminate the provider-based designation for hospital-owned physician practices and that hospitals be sanctioned if they fail to report their ownership of physician practices. ▼

NCQA adds external appeals requirement

Starting in July 2000, health plans must establish procedures that allow patients to appeal medical decisions to an outside body and permit patients to continue to see a physician who has left the plan if the plan wants to be accredited by the National Committee for Quality Assurance.

Under the proposed standards, a patient who exhausts a plan's internal appeals process will have the right to a hearing before an independent review organization. Patients already have that right in about 20 states, as do all federal employees and Medicare beneficiaries enrolled in managed care plans.

The draft also stipulates that members who are currently under an active course of treatment, such as new mothers, pregnant women, or patients receiving chemotherapy, must be allowed to continue seeing their physician for up to 90 days after the physician leaves the health plan. ■

Chris Assif, Health Network Ventures, Downers Grove, IL. Telephone: (800) 468-4678. Web site: www.hnv.com or www.go-health.net.

John Knapp, JD, Cozen and O'Connor, Philadelphia. Telephone: (215) 665-4660. E-mail: jknapp@cozen.com.

Jim Klein, EDS, Plano, TX. E-mail: jim.klein@eds.com.

Jon Zimmerman, Shared Medical Systems Corporation, Malvern, PA. Telephone: (610) 219-8274. Web site: www.smed.com.

David Slawson, MD, University of Virginia. E-mail: dslawson@virginia.edu. Web site for InfoRetriever: www.infopoems.com.

Merle Mishel, University of North Carolina-Chapel Hill. E-mail: mishel@email.unc.edu. ■

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