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# PHYSICIAN'S MANAGED CARE REPORT™

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*cost management • HMO-PPO trends*

## INSIDE



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American Health Consultants® is A Medical Economics Company

# Empowered consumers and the Internet will dominate in the new decade

*Patient relations coming in for major changes*

One day in the not-too-distant future, you may spend almost as much time communicating with patients over the Internet as you do in the office. Patients may routinely set up appointments, ask questions, and discuss treatment options — all through e-mail.

You'll have instant access to all your patients' records, whether you're at home, in the office, or on vacation. Your patients will come to the office armed with information they've gotten from the Internet, and they'll expect you to work with them to come up with the best plan of care.

That's just a taste of what's in store for physicians in the 21st century, a panel of experts told *Physician's Managed Care Report*.

"Physicians are looking at a much different world in 2010 in terms of how they interact with their patients, how they use technology, and how they work with patients to prevent disease rather than just treat it," says **Sandy Lutz**, health industry analyst for the U.S. health care practice of London-based PricewaterhouseCoopers (PwC). Lutz is author of the organization's report "Healthcast2010: Smaller World, Bigger Expectations." **(For more predictions from the PwC report, see p. 6.)**

## Ready or not, here's the future

If the changes in health care during the 1990s have your head spinning, brace yourself for the next 10 years. As we enter a new century, *Physicians Managed Care Report* asks experts to predict what physician practices can expect in the future. In this special report, we'll tell you about how technology, medical advances, and the Internet will affect your practice, what to expect from managed care in the future, and what you can do to position yourself to succeed in the 2000s. ■

## Predictions for the future

Here are some predictions about what health care will be like in the next century:

• **There will be a new emphasis on quality, outcomes, and performance measures.**

"While cost has been a driving factor in health care during the last 10 to 15 years, we see a move in the future toward emphasis on quality of care and value," states **Thomas R. Reardon**, MD, president of the American Medical Association.

Purchasers want assurances that they are getting good value for their money, whether they are corporations, the government, or individuals, he adds.

The pendulum is swinging back to reward physicians based on quality and outcomes. Medicare, Medicaid, and health care accreditation organizations already are emphasizing patient satisfaction and quality health care, adds **Randall Killian**, MS, MBA, executive vice president of the National Association of Managed Care Physicians in Glen Allen, VA.

"As patients start paying more out of pocket, they are going to be more interested in costs and outcomes. They're going to want to know more about things that weren't measureable before," says **Sandy Lutz**, health industry analyst for the U.S. health care practice of London-based PricewaterhouseCoopers.

• **Health care will focus on managing wellness rather than treating illness.**

With the completion of the Human Genome Project, the availability of screening and diagnostic tests will further shift the health care emphasis to prevention rather than treatment.

Thanks to pressures by managed care companies, physicians already are monitoring chronically ill patients more closely to save health care costs down the road. Keeping patients out of hospitals and emergency rooms is clearly one way to save a lot of health care dollars, Reardon says.

"The statistics clearly show that when patients comply, take their medicine, and are under the care of a physician, the bed days go down and the emergency room usage goes down. This is true of all diseases, whether it's diabetes, hypertension, or depression," Killian adds.

• **Government involvement will increase.**

Physicians can expect more government involvement in managing the overall cost and manner in which health care is delivered, predicts **Ernest Berger**, chief operating officer of Physicians Strategic Resources, an Atlanta firm that assists physicians with the non-legal issues of terminating their contracts with physician practice management firms.

Many managed care firms take their cue from what Medicare is willing to reimburse for, whether it is a type of treatment or a particular drug, he adds.

• **Privacy and confidentiality will become big issues**.

The entire health care industry must tackle this issue to allow physicians to take advantage of the efficiency the electronic medical record offers while protecting the privacy and confidentiality of patients, Reardon says.

• **Physicians will have more business than ever**.

"We know that the single most important determination of use of health care is age. Physicians are going to have more business than ever before because of the 60 million baby boomers," Killian says.

• **Technology will enhance patient care.**

Electronic medical records will give doctors access to office records if a patient calls on a weekend or at night. Expect the wave of new devices and treatment options to continue, and expect to spend time learning about them and putting them to use, the experts advise. ■

The next 10 years will bring exciting breakthroughs in medical care, greater efficiency, and improved quality of care, but providers can expect major changes in the way health care is delivered and must shift their thinking to survive, the experts say.

How physicians handle the more informed, more demanding consumer is a barometer for how they will fare in the new health care world of the next century, Lutz adds.

"Physicians are starting to see more empowered consumers. There are very few doctors who haven't had patients come in with some bit of information off the Internet, or even hundreds of pages," Lutz says.

Consumers are more educated now, and they're used to doing research. Also, the Internet has made a wealth of medical information available.

"It used to be that the physician was the source of all medical information. That has changed dramatically. In some cases, patients may know more about their disease than their doctor because they've been on the Internet researching it," Lutz says.

As copayments, insurance premiums, and deductibles rise, consumers will have to pay a greater percentage of their health care costs, and they are going to want to be even more involved in decisions about their care. **(For more predictions of what managed care will be like in the future, see story on p. 5.)**

## *System may implement 'defined contributions'*

"We're going to move from a defined benefit plan for health care coverage to a defined contribution plan. Many employers are saying they're not going to absorb any more health insurance costs," says **Thomas R. Reardon**, MD, president of the American Medical Association. This means patients will be asking more questions about their care, he adds.

"Any time patients pay out of pocket, you get their attention," says Reardon. He says that in his 30 years of practicing medicine, the only times patients have questioned the necessity of a test or treatment was when they had to pay for it.

As a result, physicians will be expected to become more of a partner to their patients. As patients take a more active role in their health care, they will become healthier. Rather than expecting the doctor to do something to them, they'll want to work with their physicians to improve their health.

"In the health care world, it's been that patients take what they want rather than demanding what they think they need. That is changing fast," Lutz says.

Physicians should be prepared for patients to ask more questions and demand to be part of the decision-making process, Reardon says.

"In the past 30 years, there's been a tremendous change in my practice. Physicians are going to have to accept that patients will have more information and will want to make their own decisions. They may not make the decision their physician wants, but we have to recognize that the ultimate choice is with the patient," Reardon says.

While patients are boning up on health care, preventive measures, and diseases on the Internet, it's likely that you'll be using the Internet in a number of ways to enhance patient care.

"We're heading into the information age in medicine," Reardon says.

Nearly 90% of the respondents to the PricewaterhouseCoopers survey predict that office visits will decrease as physicians offer Internet-based consulting services. The majority of respondents believe that by 2010, physicians will spend 20% to 30% of their time on Internet-related patient care.

While the Internet won't replace the face-to-face patient-physician relationship, the World Wide Web offers doctors the opportunity for more interactions with their patients, Reardon adds.

"We are concerned about diagnosis and treatment without seeing the patient. But on the other hand, we all tell patients to call if they're not feeling better. We could do that by e-mail, or instead of calling the office for a prescription to be refilled, patients could do it by e-mail," Reardon says.

"Physicians are going to have to accept that patients will have more information and will want to make their own decisions."

In the 21st century, physicians can expect to treat two categories of patients: e-health patients and traditional patients.

While physicians can expect to treat more patients via the Internet, they also must be prepared to accommodate patients who resist technology, such as those who refuse to use automated teller machines. Establishing a mix of health care products to please both types of consumers will be a challenge of the 2000s.

And bear in mind that even patients who use the Internet are still going to want personalized solutions and care, Lutz cautions.

The Internet has already created virtual communities of people with health problems, such as people with diabetes, people with asthma, and people facing specific surgeries.

"The Internet has a unique ability to find information and find people and sort things that we've never had before," Lutz says. "People share information much more quickly. It will change the whole medical education system, where physicians have learned from each other. It's going to change the doctor-patient-insurer relationship." ■

# Seven steps for surviving in the next decade

*Changing with the times is critical*

Here's the advice from our experts on what you need to do to survive and prosper in the next decade:

**1. Learn about the business side of health care.**

Being able to make sound business decisions will be critical in the future, says **Randy Killian**, MS, MBA, executive vice president of the National Association of Managed Care Physicians in Glen Allen, VA.

With cuts in reimbursement and increasing pressures to improve efficiency, medical practices will have to base decisions on good business practices, he adds. For instance, instead of hiring another physician, a practice might hire a nurse educator to work with diabetic patients because it makes more sense for their bottom line.

Physicians must know who the customers are and how to market their practices. They will need to understand the claims process and how to get claims paid correctly. Before they sign up for a managed care contract, they need to understand exactly what the contract means, he adds.

**2. Focus on patient satisfaction and customer service.**

Patient satisfaction and quality care will be increasingly more important in the age of the empowered consumer.

"In the 21st century, physician practices have got to focus on customer service. During my 30 years in health care, they've never looked at patients as customers. But that's got to change. Doctors have got to be the Ritz Carlton of health care to make it," Killian says.

In the future, expect your patients to want to know more about the treatments you institute, their effectiveness, and the track record of your medical team, says **Sandy Lutz**, health industry analyst for the U.S. health care practice of London-based PricewaterhouseCoopers (PwC) and author of the organization's report "Healthcast2010: Smaller World, Bigger Expectations."

PricewaterhouseCoopers advises physicians to improve communications by using interactive customer feedback systems, such as personalized Web pages for patients and dialogue through e-mail and chat sessions.

**3. Embrace new technology.**

Physicians will have to become more data-driven and technology-oriented to survive in the next century.

"Physicians must take advantage of every technology that helps in diagnosis and treatment, as well as being equally cognizant that administrative technology is a major contributor to efficiency," says **Ernest Berger**, chief operating officer of Physicians Strategic Resources, an Atlanta firm that assists physicians with the non-legal issues of terminating their contracts with physician practice management firms.

**4. Put the Internet to work for you.**

The Internet is a tremendous opportunity for physicians and hospitals to work together on protocols, scheduling of operating time, submitting claims, and communicating with patients. There is a whole crop of new doctors who know the Internet and are prepared to use it. If you don't keep up with the technology, you may lose patients to these Internet-savvy practitioners.

**5. Use alternative and complementary medicine.**

Whether it's chiropractic care, herbal remedies, or mind-body techniques, patients are demanding alternative and complementary medicine, and many are paying for it out of their own pockets. Employers are asking for it in their negotiations for health care insurance.

"Patients are looking for more than just drug treatment. They are interested in nutritional counseling, mind-body treatments, and other forms of mind-body medicine. If physicians can't help the patients who want this type of treatment, they need to be prepared to refer them to someone who can," says **William J. DeMarco**, MA, CMC, president of DeMarco & Associates, a Rockford, IL, health care consulting firm.

**6. Continue learning.**

Health professionals can no longer expect their initial medical education to be sufficient, the PwC report says. They must continue learning and adapt the latest technology in order to attract top-level staff.

The report cites Web-based and computer-based training tools as a way health care professionals can enhance their training. In addition to continuing their own education, physicians should give their staff incentives to become multi-skilled and base compensation on competency.

**7. Evolve into a larger organization.**

Physician practices must move away from being cottage industries that work alone and begin to operate in a larger, more efficient organization, Berger says.

"Physician practice management companies were one way to create economies and efficiencies, but it doesn't always work. We believe physicians ought to be merging their practices to make bigger practices instead of selling out to other kinds of entities," he adds. ■

# Managed care will stay, but who will manage it?

*More physician friendliness may be ahead*

If you're hoping that one of the changes your practice will see in the next century is the demise of managed care, you're out of luck, experts say.

"Physicians have to consider that managed care is here to stay, and its driving force is not going to go away. Even if the federal government regulates it, managed care is still going to be a force," says **William J. DeMarco**, MA, CMC, president of DeMarco & Associates, a Rockford, IL, health care consulting firm.

It doesn't matter what physicians think about managed care; the employers, who are paying the majority of health care costs, love it, adds **Ernest Berger**, chief operating officer of Physicians Strategic Resources, an Atlanta firm that assists physicians with the non-legal issues of terminating their contracts with physician practice management firms.

"The question is not if we're going to have managed care, but who is going to be managing the care," says **Randall Killian**, MS, MBA, executive vice president of the National Association of Managed Care Physicians in Glen Allen, VA.

For instance, even in the wake of a plethora of horror stories, managed care enrollment increased 6.5% in the past year. There are 30 large health care markets that already report more than 50% penetration by managed care.

"There are a lot of managed care patients. The physician has to reconsider why managed care exists. It exists because employers don't believe that hospitals and physicians will work together for cost-effective care. And, until recently, they didn't have to," DeMarco says.

But, while managed care will continue, the managed care of the 21st century may be very different.

"There will always be managed care, but I seriously doubt if the managed care we know today will be the managed care we know tomorrow," predicts **Thomas R. Reardon**, MD, president of the American Medical Association.

For instance, the patient backlash against managed care will continue, prompting companies to return decision making to physicians, he says.

"Insurers have been spending more money to micromanage physician practices than they were saving. They're realizing that what they were doing wasn't working," Reardon adds.

A prime example was when UnitedHealth Group, the second-largest health insurer in the country, recently announced with great fanfare that it will give doctors the final say on what treatments are medically necessary. Other insurers are expected to follow that lead.

As a result of the consumer backlash, you can expect your relationship with health plans to improve in the future.

Health plans aren't going to be more physician-friendly as far as reimbursement is concerned because they still want to hold down costs, but they may approach the relationship in a friendlier, less adversarial manner, Killian says.

### *Community partnerships could increase*

He sees an emerging partnership with the patient at the center of care, and an increasing tendency for physicians, pharmacies, hospitals, health plans, and employers to work together.

"Because health care delivery is community-oriented, you are going to see markets where health plans, hospitals, and physicians come together as partnerships, along with the employees who pick up the tab," Killian says.

DeMarco foresees an increase in regional health plans as big companies begin to decentralize their services. The most successful plans may be run by physicians and hospitals, he adds.

"We are seeing a shift to decentralization and bringing control back to physicians and hospitals locally," he adds.

Local plans have the advantage over large national plans because they are more customer-friendly, DeMarco says.

For instance, in Madison, WI, 80% of the population is covered by HMOs, the majority of which are physician-owned and -operated. Physicians in Madison have a higher satisfaction level with managed care than they had with fee for service, according to a study conducted by researchers at the University of Wisconsin, DeMarco says.

Physicians who want to succeed in the future should work together with other health care entities in the community to create a local solution to the community's health care needs.

"Somebody needs to provide leadership in the community, to get employers to see the vision of locally controlled health care," he says.

### *Consider sidestepping the health plan*

The physician-hospital partnership could consider contracting directly with employers, rather than going through a health plan, DeMarco suggests. More and more employers are open to direct contracting with physicians and hospitals, he adds.

At the very least, physicians should improve their relationships with a select number of managed care companies and negotiate with managed care companies, employers, or an employer coalition.

"There are things that physicians can control by negotiating effectively with health plans. If physicians don't step up to the plate, their options will be limited," DeMarco says.

"Physicians should think in terms of creating a new, re-engineered version of managed care for themselves," he adds. "They should improve their clinical product and contracts with three or four really good health plans and build a solid relationship with them."

Here are some other suggestions for coping with managed care in the future:

• Be selective about the managed care plans with which you contract, DeMarco advises. "Stop signing up for everything and giving your practice away," he adds.

• Read all your managed care contracts and decide what you like and don't like. DeMarco suggests that physicians take time off to carefully read their managed care contracts and come up with their own modified agreement, based on the good and bad features of each plan.

• Develop your own modified agreement and start talking to two or three managed care plans.

• Develop a core strategy for where you will be five years from now and how managed care fits into your plan. ■

# The new century brings genetic maps, e-business

*Report outlines a vision for 2010*

Consumerism, e-business, and genetic mapping will cause dramatic changes in the way health care is delivered and paid for during the next decade, according to a new report by London-based PricewaterhouseCoopers.

The report, "HealthCast 2010: Smaller World, Bigger Expectations," is the result of a survey and interviews with 400 policy-makers, health system executives, employers, physicians, insurers, and medical supply leaders in the United States, Europe, Canada, and the Pacific Rim.

Some of the more critical predictions from the report:

• **The Human Genome project will drastically alter health care delivery.**

Thanks to the success of the Human Genome Project, consumers may be able to get their own individual genetic maps by 2010. This will spawn a plethora of screening and diagnostic tests as well as a whole new industry, the genetic mapping business. Third-party genetic mapping businesses will be the primary source for an individual's genetic map, according to 38% of the U.S. respondents. Physicians were next, with 36% of respondents citing them as the likely primary sources for genetic maps.

• **New ethical issues will arise as a result of medical breakthroughs and the aging of the population.**

In the United States, society is going to have to figure out how to take care of the medical needs of the elderly with a smaller working population. In 1999, working taxpayers outnumbered retirees 3 to 1 in developed countries. By 2030, the ratio will be 1.5 to 1.

### *How much should we spend at the end of life?*

The combination of an aging baby boomer population and the possibilities offered by medical science will create dilemmas as to how much the government, insurers, and individuals should spend to extend life or improve quality of life.

The Human Genome Project and new medical devices and drugs are among the advances that

*(Continued on page 11)*

Physician's Capitation Trends™

• Capitation Data and Trend Analysis •

# 'Float your own boat' by wise use of capitation arbitrage

*Look beyond the contract's payment levels*

When negotiating capitation contracts, physician groups often get so focused on the actual capitation payment amount that they forget other key factors that can affect their contract's viability just as much.

In particular, the following four elements play a critical role in capitation contracts and should be identified and negotiated to a practice's best benefit, even though they aren't as obvious on the contract's pages when you first study the proposal:

- **settlement interval;**
- **withhold amount;**
- **which party holds the withhold;**
- **incurred but not reported (IBNR) expenses.**

That's the recommendation of **Andrew J. Sussman**, MD, MBA, and colleagues at Brigham & Women's Physician Hospital Organization in Boston. Sussman is on a key managed care team with two other physicians and an administrator at Brigham & Women's Hospital, which is distinguishing itself as a leader in the scholarship and practice of capitation. **(See article on a study conducted by another managed care team at Brigham & Women's Hospital to assess physician views of capitation, *Physician's Managed Care Report*, October 1999, pp. 153-154.)** Sussman's team published an article on managed care negotiation strategies in a recent issue of the Westchester, IL-based Healthcare Financial Management Association's professional journal.[1]

Sussman recently spoke with *PMCR* regarding the four key contract elements listed above. Overall, the key here lies in an accounting term known as arbitrage, or in lay terms, "the float."

"We use the word 'arbitrage' rather loosely, but the notion is holding on to withhold dollars so that something is happening to the money while care is being provided," Sussman advises. "Who holds the money and for how long has an impact on overall performance outcome. It is superior to have control over those dollars prior to settling."

## 'Budgeted capitation' requires withholds

Sussman and his team are referring to a second generation of capitation models, which they call "budgeted capitation." First-generation capitation is the system wherein a physician simply contracts for a set per-member-per-month (PMPM) amount. In budgeted capitation, however, participants go a bit further by setting aside a withhold account in case payments for care go over or below projected levels. At various intervals, insurers then either pay back or get paid back, based on physician expenditures on patient care.

Here are the recommendations of Sussman and his team regarding these contractual elements (beyond PMPM amounts) for physicians engaged in budgeted capitation:

- **Settlement interval.**

In some capitation contracts, a "settlement" process and the frequency of the settlements is agreed upon up front. Settlement refers to a pay-back to either the provider or the insurer of medical payments once expenses are covered.

For example, a contract may call for insurers to make regular, timely payments to providers. Then, at regular intervals — quarterly, semiannually, or annually — total medical expenses are compared with the capitation budget. If the

insurer's expenditures for patient care exceed the amount budgeted via the capitation rate, the physician group pays back that excess amount to the insurer. If medical spending is less than the capitated amount, the insurer pays the difference to the physician group so the agreed-upon cap payment level is met. The difference in those two amounts represents the settlement and is paid on whatever interval schedule is negotiated in the contract.

Thus, there is a financial penalty for physicians if utilization drives expenditures beyond the forecasted level set by the capitation rate. By contrast, there is a financial gain for physicians if expenses are kept below the capitation payment level.

### *Focus on how often you settle up*

But the key point here is less about the settlement amount than about the intervals at which the settlements are made. You might call it "capturing the float." Settlement intervals can have a major effect on the practice's cash flow, Sussman points out.

For example, a large integrated health system may provide inpatient care for 1,000 patients per week and receive payments of $6,000 per case. For each $6,000 payment, it may cost the practice $5,000 to cover patient expenses, leaving a $1,000 surplus per case. When the total $6 million payment is made to cover the whole system's cost, the organization has access to $5 million to cover their costs and $1 million for investment. Keep in mind that the $6,000 paid per patient is not paid immediately when the patient is treated; these payments can trickle in at varying times.

At settlement time, however, the insurer will compare claims paid with the capitation amount agreed upon. If the agreed-upon capitated amount was $5 million, then the physicians would have to make a $1 million payment to the insurer. But the practice could be earning interest on the $1 million float for as long as the interval is determined to last by the terms of the contract — it could be for three, six, or 12 months. Even if the practice has to pay back some money at the end of the interval, it has compensated for that disbursement by investing the capitation payments prior to settlement. These earnings probably won't erase the whole settlement, but they do help defray some losses, Sussman says. It's a system Sussman and team refer to as "capitation arbitrage."

So which settlement interval is best for your practice? Say your practice expects to only break even or take a loss with a particular capitation contract. For example, if the practice is inexperienced in capitation or its leaders took a low capitation rate because they felt it would be good for market share or other reasons, a loss or break-even stance might be reasonable to expect. In that scenario, Sussman suggests the practice negotiate for fewer settlement intervals and low withholds, held by the physician group if possible.

In contrast, if the practice leaders feel confident they can earn a surplus from the contract, then frequent settlements are better.

The longer the settlement interval, the longer you have for the float to earn interest and the more room you have to delay losses in the capitation payment process. The shorter the interval, the less time you have to earn interest but the quicker you gain your surplus, if in fact you're making money on the contract.

If the physician group controls the withhold funds, the group can invest that money during the course of the contract. If the insurer holds it, the insurer gets those investment benefits.

• **Withhold amount and who controls the withhold.**

While the example above assumes that physicians will receive full capitation payments, some contracts actually include a withhold clause, which means some of the payment will be withheld or set aside in a separate pool in case of revenue shortfalls. In many cases, the withhold amount is 10% of the capitation payment, and it may be held by either the insurer or the physician.

Control over the withhold amount can be hotly contested, but it's worth fighting over, Sussman says. If the physician group controls the withhold funds, the group can invest that money during the course of the contract. If the insurer holds it, the insurer gets those investment benefits. In addition, if the payment settlements are slow in coming to the physician group, then not having the withhold earning interest can make the penalty even greater.

There is one technique you can try if it might help your withhold situation, Sussman says. Some insurers will agree to adjust the percentage of the withhold amount during the course of the contract based upon certain performance variables, such as utilization levels.

• **Incurred but not reported expenses.**

The IBNR is the estimated cost for health care services that have been provided to patients in a capitation contract but have not yet been paid for by the insurer. In many large organizations, even though the group is operating on a capitation contract, doctors will file claims as a way of tracking medical costs and utilization. In that scenario, the IBNR may be reflected as accounts receivable.

### Specify payment deadlines in contract

Here's where physicians need to be cautious about insurers using the arbitrage process to their benefit. By delaying capitation payments to the provider, the insurer can hold on to their funds longer, leaving the practice with high IBNR and no opportunity to invest the payments due to them. The greater the IBNR expense and the longer the payments can be delayed, the more benefit the insurer gains. In negotiating, physician groups should aim for specific deadlines for payments to be made so IBNR can be kept as low as possible.

Overall, say Sussman and colleagues, be sure to explore all the arbitrage (cash flow and investment) opportunities that capitation contracts can provide. It's not only the capitation payment amount, but the flow of the funds and your investing skills that can make a big difference.

In the future, Sussman expects more capitation variations, particularly for specialists. "I can't speak for the country, but in my area, I'd call capitation stable. But insurers are looking beyond the gatekeeper model." Contracts increasingly are calling for budgeted capitation for both primary care and specialists, he says.

"Basically, you are setting a budget and comparing performance over time," says Sussman. And because specialty costs are less contained right now than primary care services, that's where the capitation focus is likely to go.

### Reference

1. Sussman AJ, Fairchild DG, Brennan TA, Coiling MC. Realizing the financial benefits of capitation arbitrage. *J Healthcare Financial Management Assoc* 1999; 53:48-49. ■

## Calculate utilization rates before you sign contract

*Don't assume insurer has better numbers*

Just because you don't know the latest utilization numbers for your specialty's primary procedures, don't assume the insurer has any better knowledge than you do.

That's the advice from **Al Ferry**, PhD, administrator of Fresno, CA-based Health Care Systems and capitation editor for the Peoria, IL-based American Society for Dermatology's (ASD) newest capitation guide. The ASD's guide includes excellent contracting tips that are useful not only for skin specialists but for other specialist physicians as well.

Having some idea of what utilization will be is the key to establishing a realistic capitation rate, notes Ferry.

In Fresno, most insurers still are compiling utilization figures for dermatology in discounted fee-for-service arrangements, he says, so don't consider yourself necessarily behind the pack with capitation data. That may well be the case for other high-level specialists, too.

Based on Health Care Systems' track record, Ferry projects dermatologic services to range between 16% and 18% of all services. In tighter systems, utilization can be as low as 14%, he says. But don't expect to ever hit the mark exactly, he warns.

Here's a series of calculations Ferry recommends to assist you in projecting (though not nailing down) a realistic capitation rate:

Start by asking the carrier for utilization data, i.e., number of office visits per 1,000. If the insurer cannot supply that, you can find generic industry standards from your specialty organization. For dermatology, the generic number of 190 is often used for utilization, says Ferry. Example: Start with the assumption that the plan's utilization rate for dermatology is 19%, which is equivalent to 190 visits per 1,000 patients per year.

Compute the per-visit revenue in your practice by dividing the total annual income by the total expected number of patient visits. Example: Say patient revenue in your practice is $500,000 per year. Divide that by 6,500 patient visits, and the result is $77 annual revenue per visit.

Next, figure a tentative capitation rate for your practice by multiplying your per-visit revenue by

the number of visits per 1,000 enrollees. Then divide by 12 months to determine the per member per month (PMPM) capitation rate. Example: $77 per-visit revenue X 190 / 1,000 utilization rate divided by 12 months = $1.22 PMPM.

Now look at the general distribution of services you provide relative to the income generated from them. If you have an automated billing system, this information is available from your frequency reports. Example: Say you perform 160 Mohs skin cancer reconstructive surgeries per year at $700 per patient. That amounts to $112,000 per year in revenue. Thus, if your total annual revenue is $500,000, Mohs surgeries amount to about 22% of your revenues. Make these calculations for each of your major types or groups of procedures.

If you don't have a computerized billing system, don't panic, Ferry says. Simply select by hand 100-150 patient ledgers for analysis. Tally the times each procedure is performed in that batch and the revenue collected. Then add them up and determine revenue per procedure, just as described above.

With these basic figures at hand, you are on solid ground to negotiate with any HMO, Ferry says. If the insurer wants to capitate all but one type of procedure, you'll know what level of income — and comparable PMPM level — you'll need to derive for all capitated procedures. Then you negotiate fee-for-service amounts for excluded services.

Ferry offers two more important but sometimes neglected tips:

• Never accept the same capitation rate for Medicare enrollees as you would for non-Medicare enrollees. An insurer may ask you to fold in the seniors, but by doing that, Ferry estimates, you'd be at risk for two to four times the cost of commercial enrollees' care.

• When establishing referral guidelines in the contract, get as specific as stating by ICD-9-CM code which services you will perform and which ones you will refer to other physicians. In addition, Ferry recommends negotiating for increased compensation when referral rates to you — as a specialist — increase. If your referral rates increase by 10%, that should be matched by a 10% increase or decrease in your capitation rate.

*[Editor's note: For more information on the ASD's* Capitation Guide, *contact the organization at 411 Hamilton Blvd., #1006, Peoria, IL 61602. Telephone: (309) 676-4074.]* ■

# California MD touts drug-guided capitation

*Interventional pharmacy model works*

Pharmacy-guided capitation payments are a practical way of getting closer to managing capitation risk, says a California physician who oversees the process in his 22-physician practice.

In a practice where about 40% of the patients are enrolled in capitation, tracking pharmacy costs has been a key to staying prosperous, says **Leonard Fromer**, MD, a family physician with Prairie Medical Group in Santa Monica, CA.

Fromer's practice uses an interventional pharmacy model in which pharmacy staff identify patients who are most at risk and whose drug costs could be expected to be higher than average.

For example, patients with diabetes and hypertension are prime candidates for high drug costs. The group then attempts to intervene proactively to maintain optimal health in these population groups. They include them in stepped-up educational programs and compliance monitoring with drug regimens.

A study released in September calls for "pharmacy cost groups," or PCGs, which would more precisely quantify Fromer's approach. With PCGs, patient groups would be categorized according to several clinical groups based on drug needs. Statistical weights would be assigned to these groups, and payment levels would be adjusted based on those weights. ■

# Dual database available

A new database that combines comprehensive hospital data with the latest managed care information is now available from the Chicago-based American Hospital Association's (AHA) subsidiary Health Forum and InterStudy, a Minneapolis-based supplier of managed care data.

The database provides information about hospitals and managed care in local markets at every metropolitan statistical area level. The hospital information comes from the AHA annual survey; the managed care data come from InterStudy. The database is available in three formats at varying prices. To order, call (800) AHA-2626 or Interstudy Publications at (800) 844-3351. ■

(Continued from page 6)

will raise questions of medical necessity, personal responsibilities, and rationing, the study says.

• **The Internet will dramatically change the way health care is delivered.**

The Internet will have a tremendous impact on the way medicine is practiced, the report concludes.

"The Internet gives the advantage of speed over size, and bureaucratic health care organizations could fail in this race to smaller, adaptive entrepreneurial ventures," says **David Chin**, MD, principal-in-charge at PricewaterhouseCoopers' health and welfare practice in Boston.

### *Internet use could displace office visits*

For instance, Chin adds, 35% of U.S. respondents believe that within 10 years, patients will store their electronic medical records on a source that is not part of the current health care system.

By 2010, physicians will spend more than 30% of their time on Internet-based activities, the respondents predict.

More than 20% of office visits could be eliminated if patients could communicate with physicians or be monitored through the Internet, the respondents say.

• **E-businesses will crop up in the health care industry at a rapid pace.**

Examples of health care e-businesses include a virtual health plan that links providers in numerous markets and a virtual medical records warehouse. Paperless transactions will become the norm.

• **A movement toward national or international standards of care will begin.**

The report predicts that health care may experience some type of standardization efforts such as ISO 9000, the standards credentialing process created by the manufacturing industry. The report predicts that the government, purchasers, and insurers will support standardization because they provide benchmarks for judging quality, targeting inefficiency, and stemming the increase in costs of medical care.

The study predicts a vast increase in rules, protocols, and care paths "aimed at the overuse, under use, and misuse in health care processes" and urges physicians to perform outcomes studies and work to create more efficient systems for delivery of care. ■

GUEST COLUMN

# Tips to surviving shift to the empowered consumer

*Providing service and satisfaction is the key*

By **Ruth Colby**
Vice President-Account Management
Sachs Group
Evanston, IL

Given the speed and complexity of change in today's health care environment, physicians may be tempted to view their challenge as one of survival. Our research shows that at least one of these changes, increasing consumer choice, is creating new opportunities for physicians.

Physicians who understand and meet the needs of empowered consumers will do more than just survive — they will thrive.

Today's health care consumers have more choice than ever before. They have choice in plan type, and most plans have broad provider panels. Sachs' research shows that 70% of surveyed respondents in HMOs had choice of plan. We also found that 51% of respondents in indemnity plans, 62% in preferred provider organizations, and 65% in point of service plans had choice.

We also found that the type of plan determines key physician selection criteria. In commercial risk populations, "close to home" and "referred by friend" are top criteria for selecting a primary care provider. But that figure drops for commercial non-risk populations, with only 29% saying "close to home" and "referred by friend" are important selection criteria.

Health plans nearly always form the link between the physician and patient, but the key relationship is the one between the physician and the patient, without involvement of the health plan.

As plans offer wider panels of physicians and more hospital choices, the patient has a choice of whether or not to remain with a particular physician. If the physician is not meeting the patient's needs, that patient can and will seek another physician.

Patient satisfaction is key to loyalty. A look at findings from the Chicago market reveals the

# More physicians join the ranks of the employed

*Hospitals key buyers of practices*

By **Ruth Colby**
Vice President-Account Management
Sachs Group
Evanston, IL

An increasing number of physicians are employed. Our research shows that 21% of physicians were employed by institutions in 1988, and in 1997 that percentage had risen to 32%. In contrast, 8.1% of employed physicians in 1988 were in physician-owned groups, a figure that climbed to 10.2% in 1997.

Hospitals continue to post the fastest rate of physician acquisitions. Of the 615 acquisitions during mid-1997 to mid-1998, 71% of physician practices that were purchased were purchased by hospitals. Only 12% were purchased by physician practice management companies, and 12% were purchased by medical groups. The fastest institutional growth was in for-profit systems. In a single year (1996 to 1997), for-profit systems posted a 22.2% increase in the number of physician practices they either acquired outright or were managing.

Although 80% of the systems acquiring physician practices lost money on those practices, physician practices overall generate as much as 25% of hospitals' gross revenues through office visits and hospital referrals. Because hospitals are still losing money on physician practices, retention and acquisition of new patients for owned practices is equally important to the hospital owner. ■

impact of less-than-satisfied patients on physician practices. Chicago is a typical Stage Three market. Managed care dominates the market, and five major hospital systems have emerged from a wave of consolidations. Despite the high levels of managed care, consumers in Chicago have choice and they use it.

Sachs' research shows that 42% of the surveyed population in Chicago changed primary care providers last year. Although 26% of these consumers changed primary care providers because insurance required them to do so, 20% changed because they were dissatisfied with care and 16% were dissatisfied with the physician's manner. On three criteria — wait time for appointment, in-office wait time, and physician manner — Chicago had the lowest satisfaction scores in the nation.

Satisfaction drives loyalty and retention, and tremendous opportunity exists for improving patient satisfaction in Chicago and nationwide. Yet, merely satisfying patients isn't enough to create loyalty. In fact, consumers who are merely satisfied are shown to be rather indifferent. Only by moving satisfaction levels from "satisfied" to "very satisfied" can physicians create the kind of loyalty that results in retention.

Loyalty also tends to be age-linked. In the Chicago market, the over-55 population is less likely to change primary care physicians than younger patients, especially those in the 25-34 range, who are especially volatile.

To achieve the kind of satisfaction levels that result in loyalty, physicians must enlarge their understanding of what matters most to health care consumers in their market.

For example, many physicians think a degree from an impressive institution is of primary importance to consumers. But our research shows that excellence in physician education and training are givens in the minds of most consumers. Convenience (of hours and location), office wait times, and ease of communication have a bigger impact than the diploma on the wall.

Based on our research, we recommend that physicians who want to acquire, retain, and satisfy today's health care consumer must:

- **Offer services at times convenient to the consumer.**
- **Make sure the environment the consumer comes into is comforting and comfortable.**
- **Ensure that office staff treat the consumer in a manner that enhances their experience.**
- **Understand the importance of a good bedside manner.**
- **Develop excellent communication skills.**

The development of excellent communication skills deserves special attention. Dissatisfaction with care and with a physician's manner is closely related to communications, so it is critical that physicians understand the power of good communication skills.

By taking the time to listen to patients, collect their feedback, and engage in meaningful dialogues, physicians are enhancing patient satisfaction and loyalty. The physician who responds to patient needs is more likely to be the physician patients choose and the one they stay with. As patient choice grows, the physicians who engender this kind of loyalty will thrive. ■

## Breaking a PPMC contract difficult, but doable

*Be prepared to start a practice from scratch*

If your practice is mired in a stormy, unprofitable relationship with a physician practice management company (PPMC), you're not alone. Many physician practices signed up with PPMCs in the early 1990s hoping the arrangement would diminish their administrative burden, confer leverage in managed care negotiations, and allow doctors to concentrate on caring for patients rather than taking care of business operations.

But for many physicians, the pot of gold they anticipated at the end of the PPMC rainbow turned out to be something far less valuable, and they're looking for ways to get out of their long-term contracts with practice management companies.

About 5% of the 75,000 physicians affiliated with PPMCs started the arduous process of unwinding their contracts in 1999, according to **Bob Healy**, president of Physicians Strategic Resources, an Atlanta-based firm that assists physicians in terminating their contracts with PPM companies.

He estimates that an additional 10% of PPMC-affiliated physicians will sever their relationships in 2000.

"Many doctors joined PPMCs in response to managed care growth. However, many have not received the promised benefits and rewards," Healy adds. Instead, physicians with PPMC contracts may find that they are working harder for less money.

Healy and his partners, all former PPMC and physician network executives, formed a company that deals exclusively with "acquisition unwinds" because of the increasing unhappiness physicians have with their practice management contracts.

Physicians Strategic Resources gets involved after the physicians have started the legal process

## What to do when you end your PPMC contract

*Legal issues are just the tip of the iceberg*

There's more to disengaging from a physician practice management company (PPMC) than just terminating your contract. When you regain your independence, you have to start all over and set up a new practice.

"The whole unwind is much more than just a legal transaction. Many physicians think they just have to contact an attorney to get out of the contract. In reality, when you deconstruct a practice and reconstruct another practice, it becomes an operational issue," explains **Bob Healy**, president of Physicians Strategic Resources, an Atlanta company that helps physicians disengage from PPMC arrangements.

In addition to getting out of your contract, here are some things you may need to do if your practice withdraws from a PPMC:

- **Recruit a new management team.** The existing team may opt to stay with the PPMC.
- **Restore the central business office.**
- **Purchase and set up a new information system.** Both the operational and financial systems are owned by the PPMC.
- **Renegotiate all of your managed care and vendor contracts.**
- **Secure operating capital, because, in most cases, the PPMC will retain your accounts receivable.**
- **Secure capital to repurchase your assets — everything from your desk to the medical equipment.**
- **Negotiate with the PPMC on the purchase price of the assets.**
- **Set up new committees to run the practice.** Healy suggests a governance committee, an operations committee, a marketing committee, and a human resources committee to deal with compensation and benefits. ■

to withdraw from a PPMC. The company works with attorneys to coordinate all aspects of the process except for the legal issues. **(For details on some of the non-legal issues, see related story on p. 13.)**

Healy cites three major reasons that physicians want to get out of their PPMC contracts:

**1.** Many of the transactions were a combination of cash and stocks, but heavily weighted on the stock side, particularly for the younger physicians in the practice. With PPMC stocks plunging in value, doctors are concerned about their investment.

**2.** When physicians signed up with the PPMCs, they had hoped to reduce their administrative load and see significant increases in net incomes in exchange for giving up a percentage of their revenue for management fees. But many are working harder for less money.

**3.** Physicians tend to be very independent people and don't fit well into a corporate culture.

### *Early happiness turns into disillusionment*

In Healy's experience, physicians typically are happy with their PPMCs in the early stages of the relationship. Costs often drop because of savings in national purchasing agreements for supplies and malpractice insurance. The PPMC also may install sophisticated information systems, take a hard-nosed approach to negotiating with managed care entities, and establish long-range marketing initiatives.

"In the early stages of the relationship, the physicians may see benefits and savings, but as time goes on, they may not see an improvement in their bottom line," Healy says.

But not all physicians are unhappy with their practice management companies.

"There are a few PPMCs that are fulfilling their promise, and if the relationship works, the doctors ought to stay in it," notes **Ernest Berger**, chief operating office of Physicians Strategic Resources. "We don't try to persuade the doctors to disengage. We enter the process after they've made the decision." ■

# Expect a tough opponent when you depart a PPMC

*There is a silver lining to starting over*

If you're unhappy with the contract you have with a physician practice management company (PPMC), you can expect to encounter some difficulties in getting out of it. But it may not be as acrimonious as you think, asserts **Bob Healy**, president of Physicians Strategic Resources, an Atlanta-based firm that specializes in helping physicians disengage or "unwind" from PPMCs.

"Every unwind is unique. The common belief is that these unwinds are inherently adversarial, but we're seeing some changes. Many PPMCs are reinventing themselves by getting actively involved in clinical trials or other areas. Because of that, the unwind process is moving a little quicker," Healy says.

Make no mistake: PPMCs are still hard-nosed negotiators when it comes to terminating contracts with physician practices they have purchased. But it's to their benefit to reduce the length of the unwind process, partly because they're moving on to new ventures and also because of the unfavorable press coverage they've received in the past, Healy adds.

Contracts with PPMCs typically cover 20 to 40 years and may have restrictive exit clauses that make disengagement difficult. For instance, some contracts say the physicians cannot exit the agreement unless the PPMC is bankrupt or in default. In other contracts, physicians can disengage from the PPMC, but it will cost them money. Most contracts have non-compete clauses with geographic and time restrictions that limit the physician's ability to continue treating his or her patients.

Deconstructing a practice management contract is a lengthy and expensive process. But there is a silver lining — in fact, two silver linings — in an otherwise difficult situation, says **Ernest Berger**, chief operating officer of Physicians Strategic Resources.

## COMING IN FUTURE MONTHS

- Everything you need to know about setting up a Web page for your practice
- How new medical technology can help you treat patients more effectively
- Physicians who took a stand against managed care
- How to make your clinic operations work more smoothly
- The most effective ways to treat a more diverse patient population

First, there is a whole new generation of doctors who have the sophisticated knowledge of information systems and business acumen to take the practice where it needs to go in the next century.

The second silver lining is that the smaller practices that were purchased and became a part of a large PPMC can regroup and form larger practices that can dominate the market.

"Maybe a practice had six or seven physicians when it was bought but is accustomed to working with many other physicians in the PPMC. They can unwind as a 40-doctor practice and come up with a much more efficient organization that allows them to have a presence in the market and take advantage of economies of scale," Berger says. ■

# Readmissions plunge with resident house calls

*Residents visit at home the day after discharge*

A Downey, CA, medical practice has found that old-fashioned physician house calls dramatically reduce hospital readmissions of elderly patients.

The preliminary study of 100 patients showed that the one-day readmission rate dropped by more than 70% and one-week readmissions fell by 41% when discharged patients were visited in their homes by a medical resident, says **Donald S. Furman**, MD, director of medical affairs for CareMore Medical Group.

CareMore is a group of more than 150 primary care physicians and 200 specialists in 25 offices throughout the Los Angeles area. The group provides care to more than 10,000 senior citizens through a proprietary managed care plan.

The house calls effort is an offshoot of the group's Comprehensive Care Clinic, which provides intensive medical care to patients who are chronically ill with conditions such as diabetes, heart disease, and pulmonary problems.

Targeted patients receive at least one house call by a medical resident, beginning the day after discharge. The resident visits the patient along with the regular home health team and consults by telephone with a CareMore hospitalist who treated the patient in the hospital. The resident and the hospitalist make any medical decisions.

During the home visit, the physicians often find problems the home health nurses missed, partly because they are seeing the patients for the first time. "The first day, the home health nurses have 20 pages of regular paperwork. They haven't seen the patient in the hospital, so they don't know if they are worse or better," Furman says. The residents are familiar with the patients because they have treated them in the hospital, he adds.

Because the practice uses resident physicians, there is no cost to the medical group.

"But there is a huge benefit to the residents. They are used to working in the office and hospital environment, and they have no idea of what is going on in the home," Furman says.

The medical group started the house calls program at the beginning of 1999 after discovering that 53% of patients who were readmitted to the hospital were within a week of discharge and

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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, (marybootht@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

that 24% were readmitted within one day.

The length of stay for the team's patients was half that of similar patients from other medical groups in the area.

"We were looking for what was missing. We wanted to find out why they were being readmitted," Furman says.

At CareMore, the treatment team for the elderly patients includes a hospitalist, a case manager, a social worker, and a clinical pharmacist, as well as physicians who see patients in the clinic and a home health nurse.

"This allows us to envelop the patient with care. Most of our senior patients need social, psychological, and functional care. We try to give them the highest quality of care at the level they need," Furman says.

The hospitalists are a key part of the program, Furman adds. The hospitalist team sees the frail elderly patients at clinics as well as in the hospital. Hospitalists see all frail diabetics in the diabetic clinic and supervise the anticoagulation clinic.

When an elderly patient is admitted to the hospital, the hospitalist, case managers, social workers, and home health staff meet every day to review the patient's care and condition. Those who are deemed frail are selected for the physician house call program. The resident and the home health team arrange to meet at the home.

"There's no question that it's made a difference having a physician visit them at home," Furman says.

The elderly patients are readmitted for a multitude of reasons, Furman says. During the initial visits, the residents have discovered that some patients were taking the wrong medication or the wrong doses because they hadn't read all the written discharge information.

"We can see first-hand how patients function in their own home. We can make sure the home is safe from objects like throw rugs and misplaced electrical cords, which could cause a patient to fall and break a hip," Furman says.

When patients do get ill within the first week, the medical team can intervene to prevent hospitalization or cut the length of the hospital stay, Furman says.

The house calls work well because there is a comprehensive team approach to care, Furman says.

"Just sending a physician out with no case management or home health wouldn't work. Our program works so well because it is within the whole spectrum of programs for the elderly," he adds. ■



# SourceKit

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

**William J. DeMarco**, President, DeMarco & Associates, Rockford, IL. Telephone: (815) 877-8781.

**Randall Killian,** executive vice president, National Association of Managed Care Physicians, Glen Allen, VA. Telephone: (804) 346-0270.

**Thomas Reardon**, MD, president, American Medical Association, Chicago. Telephone: (312) 464-4490.

**Sandy Lutz**, health care analyst, PricewaterhouseCoopers, Dallas. E-mail: sandy.lutz@us.pwcglobal.com. "HealthCast 2010" is available on the Internet at www.pwchealth.com/healthcast2010.

**Ruth Colby**, The Sachs Group, Evanston, IL. Telephone: (847) 475-7526. World Wide Web: www.sachs.com.

**Ernest Berger**, chief operating officer, Physicians Strategic Resources, Atlanta. Telephone: (678) 443-0656. ■