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PHYSICIAN'S MANAGED CARE REPORT™

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INSIDE

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American Health Consultants® is A Medical Economics Company

Internet becoming a key ingredient for growth and patient satisfaction

A Web site can save you time, educate your patients

How would you like to save time, increase communication with patients, provide comprehensive patient education, and market your practice to potential patients? The solution is not as difficult, miraculous, or expensive as it may seem.

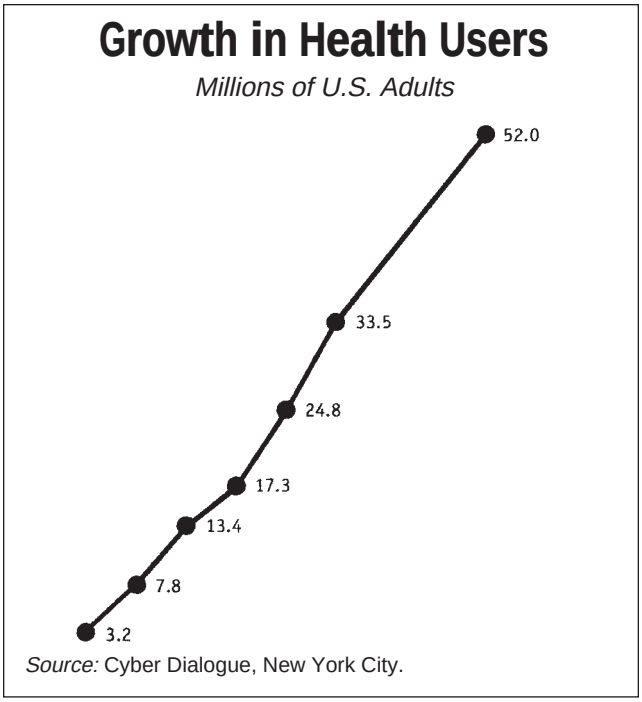
Physicians' practices across the country are finding that having their own Web sites on the Internet helps them communicate better with patients and fellow practitioners, and in some cases, market their services to potential referral sources and patients.

"The Internet and the World Wide Web are part of a fast-rising new technology that has a lot of promise for being a superb communication mechanism in any business. We believe physicians can use this technology to accomplish what they are trying to accomplish," says **Jerry Kelly**, executive vice president, physician sales and marketing for Salu.net, a Portland, OR, provider of Internet application services for physicians.

More physicians are jumping on the Internet bandwagon. According to a survey by the American Medical Association (AMA), the number of dedicated Web sites among physicians has increased more than 62% since 1997.

Will you be on-line, or left behind?

Like it or not, the Internet is quickly becoming the backbone of worldwide information. Physician practices have generally lagged behind the times in adapting to the still relatively new medium, but that will quickly change. According to one estimate, 52 million people will soon be using the Internet for their health care information. In this issue of *Physician's Managed Care Report,* we take an in-depth look at where this trend is headed and how physician practices can make the most use of it. ■



"More and more physicians are recognizing that the Web has the ability to access and distribute a wealth of valuable information that might not be readily available through traditional sources," says **Richard F. Corlin**, MD, an AMA trustee. "The findings of our study show that the process of integrating the fast-changing world of the Internet into the practice of medicine has significantly quickened."

To take advantage of the burgeoning Internet market and provide credentialed health care information, the AMA and six other medical professional organizations representing about two-thirds of the nation's physicians have announced the development of Medem.com, a supersite for health care information and links to physician Web pages. **(For details, see related article, p. 27, top.)**

So far, thousands of physicians have signed up for customized Web pages linked to the Medem.com site, which is expected to be launched later this year.

Is setting up a Web page the right move for your practice? Absolutely, says **Eric Golanty**, PhD, Oakland, CA-based editor and publisher of "Physician's Guide to the Internet," an Internet page for physicians.

"Patients expect it — if not now, in the future. It doesn't have to be fancy or expensive, but it is a sign that you are available. . . . very important both clinically and business-wise," he says.

Consider, for instance, this data from the Cybercitizen Health research released late last year by Cyber Dialogue, an Internet database marketing company with headquarters in New York City:

- 54% of people who use the Internet to retrieve health-related information say they would prefer information from their own doctors, but 50% of on-line users say they would be interested in using their doctor's Web site.
- 91% of those surveyed say they are unaware of a Web site for their doctor's office.
- 22% of on-line health users report using the Internet to retrieve doctor-related information, but only 4% have used it to access the Web site of their doctors' offices.
- 48% say they would be interested in e-mailing their doctors, but only 3% are currently communicating with their doctors by e-mail and only 11% are aware of their doctor's e-mail address
- About one-third say they would be likely to switch doctors to be able to use doctor-provided Web sites or to e-mail their doctors.

"Using the Internet to communicate with doctors' offices would allow consumers to find answers to many issues, such as questions about a treatment or drug side effects, without an office visit," says **Scott Reents**, manager of health care strategies at Cyber Dialogue. "A visit to a doctor's Web site or an e-mail could cut down on unnecessary office visits as well as make consumers more informed about their health."

A boon for private practice doctors

This can be a boon for physicians in private practice who feel threatened by cost-containment mandates from managed care and the dilemmas that result, Kelly points out. For instance, with the increasing pressures on physicians to pack more appointments into a day, you probably have less time to spend on patient education.

Yet, if you're in a capitated situation or have insurers pressuring you to keep costs down, you recognize the benefits of educating your patients about their disease or condition and how to manage it.

That's where the Internet comes in. Rather than go over the same routine information numerous times with every patient who has been diagnosed with a particular condition, you can include frequently asked questions and other information on your Web site. **(For other ways you can use your Web site, see related article on p. 19)**.

"The Internet is quite an effective method for patients to get information. Many times patients

can get more and better information than physicians would be able to provide in person," Munn adds.

Although most patients may not be on-line yet, the number is growing rapidly.

According to Cyber Dialogue, the number of people using the Internet for health information is growing nearly twice as fast as the Internet population at large. As of July 1999, 24.8 million U.S. adults used the Internet for health information. The figure is projected to increase to 52 million by 2003. **(See graph, p. 18.)**

Cannot replace face-to-face contact

But, the Internet will never take the place of the personal relationship between patients and doctors. Medicine has been and always will be a relationship business, says **Peter Zazzara**, executive director for Superior Consultant Co. Inc., a Southfield, IN, consulting firm.

"There will be no substitution for a first-rate, in-person clinical encounter. Unwell people need a human healer," Golanty adds. ■

Web site should reflect goals of your practice

Here's how your practice can use the Internet

Physician Web pages have a multitude of benefits and uses, but what works best for one practice may not be what works best for you.

And after your Web page is launched and you start interacting with patients, you may come up with modifications that reflect the way patients are using your site.

"Each doctor has a style of communicating with his or her patients. It's very individual," says **Eric Golanty**, PhD, an Oakland, CA-based editor and publisher of "Physician's Guide to the Internet," an Internet Web site. "Doctors who educate a lot will have lots of information on their sites. Doctors whose patients need only a well brochure will provide that."

The way physician practices use a Web page depends on their affinity for technology, the patient population, and type of practice, says **Peter Zazzara**, executive director for Superior Consultant Co. Inc., a Southfield, IN, consulting firm.

Here are some of the ways physicians are using their Internet pages:

1. Increasing business.

Physicians who specialize in elective procedures such as plastic surgery and laser vision correction find Web pages a good way to increase their business, says **Michael Levine**, MD, cofounder of MD Web, a firm specializing in setting up Web pages for physicians.

One physician client of MD Web, a New York City surgeon who specializes in hair removal, says he gets three patients a day from his Web site, Levine notes. And a plastic surgeon who specializes in facelifts and breast augmentation reports that he gets two to three cases a month through his site, Levine adds.

2. Informing patients about procedures.

Specialists find their Web sites can be useful for informing patients and potential patients about procedures they may be considering, Zazzara says. "Reconstructive surgery, total hip replacement surgery, or dermatology procedures are among the procedures that people want to learn more about before they decide to have them."

3. Providing general information about diseases and procedures.

Physicians specializing in internal medicine are likely to find their Web site most useful as a source for patient information, Levine adds. His Web site includes information on diseases such as glaucoma and cataracts, as well as information on refractive surgery. "I use it basically to give my patients information, and if I pick up new patients, that's a plus," he adds.

4. Providing preoperative and postoperative information.

Patients typically are so overwhelmed by the prospect of surgery that they may not remember everything they need to know, Zazzara points out. But, if they can call up your Web page, either before or after the procedure, they can find the information they need. "If you're going in for a total hip replacement, you might not know that you'll need a stool for the shower. Nobody can remember everything," he says.

5. Using information to improve the patient experience.

A Web site can help guide patients through a procedure or condition. For instance, an obstetrics practice could create an interactive Internet site to educate young mothers-to-be about their pregnancy, what they can expect during each phase, and what they should be doing.

"A Web site can provide tremendous

educational benefits for obstetrical patients. You can design a series of interactions over the 40 weeks and give them time-specific information and instructions," Zazzara says.

6. Providing chronic disease management information.

A physician's Internet site with links to other sites is especially useful for patients who have chronic diseases and conditions. The information you provide on your site can help patients understand their disease, educate them on treatment, and increase compliance by reminding them of what procedures they need to follow, Zazzara points out. If you provide links to the correct information, you can make sure that patients don't get erroneous information when they do their own research.

7. Giving patients up-to-date information.

Allergists are increasingly using their Web sites to inform patients who suffer from seasonal allergies, according to **Jerry Kelly**, executive vice president for physician sales and marketing for Salu.net, a Portland, OR, provider of Internet application services for physicians. One allergy clinic tracks daily pollen counts on its Salu.net Web site and rates each day. For example, "very good" means it's OK for patients to be outdoors and "very poor" means allergic patients should stay inside.

8. Customizing instructions for drug compliance and detailed information on side effects.

You could set up your own set of instructions for drugs you frequently prescribe or your site could include links to other sites that allow users to download a drug interaction program or include detailed information on drugs.

9. Communicating with family members of patients.

If your practice specializes in conditions that affect the elderly, or in caring for chronically ill or disabled patients, you may be able to save your office a lot of telephone calls by setting up an Internet site, Zazzara says.

For the baby boomers and generations ahead, caring for older parents is going to be a huge part of their lives. And many people are managing the care of their elderly parents long distance. The same is true of people whose siblings or other relatives have chronic diseases or disabling conditions.

Zazzara suggests a site that includes frequently asked questions about various conditions, links to other Web sites, and a mechanism for communication through e-mail. ■

Information and advice keys to good Web sites

Include who, what, when, where, and why

In developing the content of your Internet Web site, remember the "5 Ws" of journalism — who, what, when, where, and why — and build your content accordingly, advises **Douglas Munn**, systems consultant for Superior Consultant Co. Inc. of Southfield, IN. Since the purpose of a Web page is to market your practice and inform your patients, you should include information that does both, he says.

Your Internet site can help patients get information on a particular practice, understand the types of specialties offered, and have questions ready when they come in for a visit.

Before you begin, decide what you want your Web site to do for your practice, then list the content you want it to include. **(See chart on p. 21.)** Understand the types of questions your patients ask you every day. Identify the top 10 types of information that would better prepare patients and help cut down on the work involved in manage their care, adds **Peter Zazzara**, executive director for Superior Consultant Co.

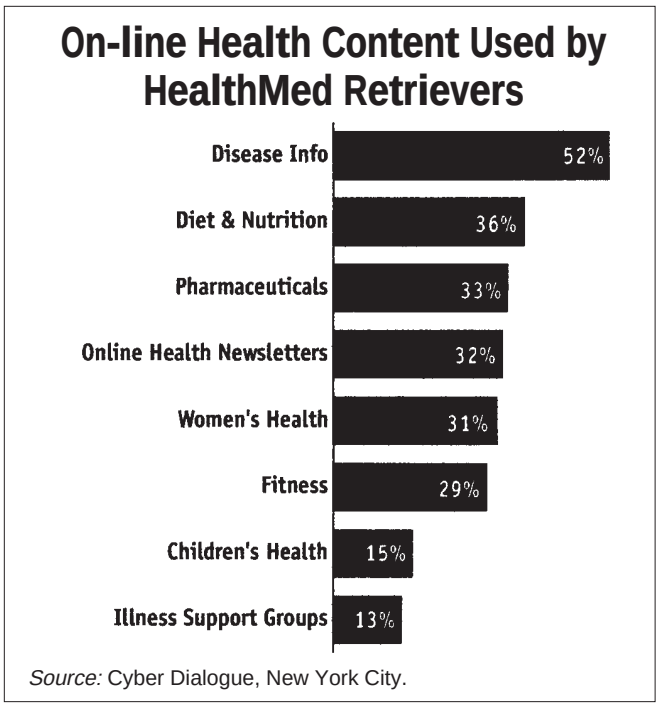
You don't necessarily have to develop a lot of content yourself, Munn points out. You can easily get a license to link with commercial medical sites, organizations, or disease information sties.

If you are a specialty practice, include links to sites regarding your specialty associations, he suggests. If you have a lot of patients in a certain category, you should visit Web sites that provide information on the particular condition or disease and check them out.

Include links on you site to the ones you find useful and informative. That way, you can be sure that your patients are getting the correct information.

"The whole premise of this section is to allow the physician to become the primary source of information for the patient instead of the patient going out and getting information that may or may not be relevant to the condition and may or may not be accurate," says **Jerry Kelly**. Kelly is executive vice president for physician sales and marketing for Salu.net, a Portland, OR, a provider of Internet application services for physicians

Most physician practices opt for a Web site



with five to 10 pages, according to **Michael Levine**, MD, of Stuart, FL, co-founder of MD Web, a company that specializes in creating physician Web sites. Physicians are asked to provide the content. "This is where my company is strong. If they don't have it all together, we can do it. We are doctors, and we are good at putting information together," he adds.

Levine says many doctors are too busy to put their Web page information together. In that case, he asks them to send photographs, biographies, any medical information sheets or brochures they have, and MD Web puts the page together.

If you have the resources and time to update your site regularly, consider including information that changes regularly. For instance, you might include reminders to schedule back-to-school checkups or flu shots.

A family practice might include immunization schedules showing what kids need at different grades in school or dates of upcoming health fairs. "The county health department is a good source for this kind of information. They love to share it," Munn says. However, he warns, if you have time-dated material, make sure it is current. "Nothing kills interest faster than for a patient to read in October about an event that happened last August."

Munn and other Web page experts recommend that you include these items on your site:

❒ **Personal information and photographs of every person on your staff, including the medical staff, the technical staff, and office workers.**

He recommends including trivia about staff members, such as hobbies and hometown, as well as educational and professional credentials. This information can help make patients feel more comfortable with you and your staff, he adds. For instance, if your nurse raises horses and a nervous patient is interested in animals, they have a common bond to discuss that will take the patient's mind off the treatment. "The more of this kind of information you have, the more likely you are to establish common ground with your patients." He recommends humorous touches to the pages, such as a medical school photo of a physician who sported a '70s hairdo. "People really respond well to funny, cutesy, nonmedical stuff," he adds.

❒ **Your office address, office hours, and a photo of the facility. Directions on how to get to your office.**

For this segment of your Web page, Munn suggests interactive maps, which allow patients to type in an address and get driving directions to your office turn by turn. "People are hooked on interactive maps. It will cut down on the telephone calls asking for directions. The maps are available from commercial map services, he adds.

❒ **Your philosophy of practice.**

❒ **Information about the health plans you accept.**

❒ **A list of hospitals where you practice.**

❒ **Medical information and links to other sites.**

Many physicians complain that their patients come to their offices armed with misinformation they gathered from the Internet. This is your chance to point them in the right direction, points out Zazzara. ■

Web host can guide you through the Internet maze

What you need to set up your site

If you want a place on the Internet, you'll need to contract with a host, or Internet service provider (ISP), to keep your site on the Internet.

In the early days of the Internet, anyone with a Web site had to have a personal computer with a phone line dedicated to the Internet so that when people called up the site, they connected directly to the Web site computer.

Those days are over, says **Douglas Munn**,

10 steps to establish a successful Web page

If you're thinking of creating a Web site for your practice, here are some steps you should take:

- ✔ **Determine the specific business, operational, and marketing goals you hope to achieve from a Web page.** Decide what you want it to achieve and how it will add value to your practice.
- ✔ **Find a site you like, and contact the person who made it.**
- ✔ **Check out the company before signing on.**
- ✔ **Read the contract carefully.** Make sure you're not paying a lot of hidden fees. Some companies, particularly those that create Web sites for big businesses, may charge you to register the name, or to make small changes down later on.
- ✔ **If it's free, you're probably not getting a bargain.** There are companies that will produce cookie-cutter Web sites that may not be much help.
- ✔ **Make sure you can customize your site to fit your own practice's needs.**
- ✔ **Look at all the aspects,** such as how often you'll need to update your page, who will do the updates, and how much time and money it will take.
- ✔ **Update your site frequently to keep the information fresh.** It reflects poorly on your practice if your Web site is still urging patients to get their flu shots in the middle of March.
- ✔ **Publicize your Web page to everyone you know.** Make patients aware of your presence on the Internet, but don't stop there. Ask the hospitals with which you are affiliated to set up a link to your Web page. After the site is up and running, get in touch with every organization you belong to, even organizations like the Rotary or Lions Club, give them your Web site address, and get them to put a link to your site on their Web site. If you belong to the chamber of commerce or the local medical society, ask them to put in a link to your Web site.
- ✔ **Come up with a way of tracking what the site has done for you.** Your Internet service provider will give you reports on how many hits your Web page has gotten and how long people stay on it, but you may want more information. For instance, if your site includes a form to make sure patient information is correct, track how often patients use the site to update their information instead of doing it in your office. You can extrapolate the savings in clerical time as a result. ■

systems consultant for Superior Consultant Co. Inc., a Southfield, IN, consulting firm. Now you can go to an ISP that will host your site for you. ISPs range from large organizations such as America Online or MindSpring to local companies that provide Internet services for a small number of clients, Munn says. "I've been on the Internet more than five years, and I've never hosted a site myself."

The ISP can help you come up with and register your Internet address. The host will help you decide on the name and make sure someone else has not already reserved it.

One advantage is that the ISP knows how to get your site listed in search engines such as Yahoo!, Excite, and AltaVista, which means you are likely to attract more people to your site.

For instance, MD Web, a New York City-based firm specializing in setting up physician Web pages, helps market its sites by making sure they are linked to all the search engines that patients would be likely to use to find physicians, says **Michael Levine**, MD. Levine is a Stuart, FL, ophthalmologist who co-founded the company when he was in medical school.

Another advantage of using an ISP is that they have 24-hour power and backup equipment so they can recover any lost data.

The ISP will give you statistics on how many hits your Web site gets, and how long people stayed. In some cases, it's included in the fee for hosting the site. In other cases, there is an additional charge.

You can get extremely detailed reports, such as daily statistics broken down per hour. But most physician practices will need less sophisticated data that probably will be built into the basic fee.

"For most physician offices, a monthly or weekly report would be sufficient. They'll just want to know general traffic patterns and if they are growing," Munn says.

Expect to pay as little as $20 to as much as $100 a month to the host that will maintain your site on the Internet. "You can easily maintain a complex site with all the bells and whistles for less than $1,000 a year," Munn says.

MD Web charges $1,000 to develop a site and $50 a month to maintain it, says Levine.

Medem, an Internet Web site, which is wholly owned by seven physician groups, charges physicians $70 a month for the service, including setting up and maintaining physician office Web sites with links to credentialed health information from the main site. **(See story on p. 27, top.)** ■

Physician's Capitation Trends™

• Capitation Data and Trend Analysis •

Capitation audits check your payers' accuracy, integrity

Focus on contract elements, performance patterns

What's good about tax season? Often it's a good time for a medical practice to audit its carriers' capitation performance. Another good time might be just prior to contract renewal season. Or if you have capitation contracts, which involve intermittent settlements, you may choose that as audit time.

Whatever time period you choose, a financial checkup is an excellent management tool that should be approached systematically and with some advance thought as to what level of detail you need.

Auditing can be especially valuable if you have a significant number of capitation contracts — for at last two reasons. One, auditing for capitation calls for quite a different process from auditing other areas of your practice, advises **Jonathan W. Pearce**, MBA, CPA, a principal at Dan Grauman Associates Inc., a Bala Cynwyd, PA-based health care consulting firm. The elements of analysis and the level of detail you need can significantly differ for the capitation portion of your practice than for more traditional areas.

Secondly, there's nothing like a track record to assess your contractors' performance in one year to prepare you for advantages and pitfalls in the coming year.

Don't let the sometimes onerous image of an audit turn you off, advises Pearce. "This is not a financial audit like a CPA firm would do. You're only doing this if you think it would be financially advantageous for you to do. There are no FEC [Federal Economic Commission] requirements, or other regulatory requirements." Instead, this is an audit that amounts to a checkup or oversight of basic carrier practices.

Interestingly, another difference between capitation audits and internal audits you may have performed is that typically physicians serving capitated patients don't submit individual claims. That means the tried-and-true audit process of matching services with payment levels is much less applicable. So you need to look at other performance indicators.[1]

In capitation, the audit process is "testing the pieces of things," or checking patterns and elements of an insurer's payment methods, Pearce says.

He recommends taking these steps when auditing capitated contract records:

• **Re-check payment rates per contract.**

Payments made to physicians need to be checked against what the contract had specified it would pay — both the per-member per-month amounts (PMPM) and any fee-for-service payments made for exempt services.

Also, often primary care physicians are paid incentive payments for remaining within certain budget targets. If that's the case, your audit should distinguish which payments are PMPM and which are for incentive agreements. If they don't, Pearce recommends extrapolating from a sample of reports and in the future having the insurer provide this information in some format that you can use.

• **Review settlement calculations.**

Some capitation contracts pay a settlement at various intervals of the year — quarterly, twice a year, etc. **(See story on how settlements can work with arbitrage in *Physician's Managed Care Report*, January 2000, p. 7.)**

If you have this arrangement, this series of

payments should also be audited.

For example, in some cases, insurers will estimate payment levels, which may or may not be of benefit to your practice. Key factors to check for are what you determine to be the total of stop-loss payments, incurred-but-not-reported (IBNR) adjustments, and any medical expenses charged against the practice.

• **Recalculate member counts.**

With physicians and plans swapping names and agreements so often, it can be tricky to determine what plan a patient is covered by within one year, or from one year to the next and whether or not the doctor is in the plan claimed by the patient. **(Verifying effective enrollment dates can be sticky proposition with many changes and specifics, even for Medicare HMOs 2000. See related story, p. 25.)**

Don't assume that because the insurer holds the contract that it has all the information correct. To obtain your member count, establish the actual date a primary care physician started or stopped participating in a particular plan. Pearce recommends doing that by checking the signature dates of each physician with each plan — both beginning and ending any contract. Check that against what the insurers use for their member counts to obtain your projection of the appropriate PMPM payments the practice as a whole and each physician should be receiving.

• **Check insurer's use of countywide rates.**

Medicare HMOs always use a countywide factor in determining their payment rates; sometimes commercial insurers do, too.

In either case, it can be beneficial to check to see if the insurer is using the accurate county-specific number. Payers often use estimates based on the lowest paying county in the area, which isn't always a fair application to a specific physician practice or patient population.

• **Audit for accurate application of demographic factors.**

Demographic characteristics that the Health Care Financing Administration applies in payment calculations include the age and the gender of the enrollee, whether he or she has end-stage renal disease (ESRD), is institutionalized, and/or is eligible for Medicaid.

The presence of any of these factors is applied in the Medicare HMO payment formula along with geographic payment rates. You can check for institutional status by scanning for codes which reflect physician visits to nursing homes and other nonoffice settings. ESRD status can be checked by scanning for dialysis treatments. Sometimes payers fail to take into account these factors, or they estimate them even though you may be aware that your patient base may not be "average" for the nation.

Review age factors in Medicare enrollees

Conversely, your audit may find your practice did not account for Medicare HMO enrollees who are younger than typical Medicare enrollees. If that's the case, you can make more accurate projections for your costs in the coming contract period. The same omission could be true for other patient factors. More accurate assessment of all of these factors can only make your financial projections for capitation more reliable.

• **Recalculate commercial capitation revenue.**

The level of difficulty for checking back on insurer commercial HMO payments varies significantly based on how much latitude state insurance regulations allow insurers. In some states, insurers are limited to certain standard HMO rate formulas, and in other states they aren't regulated that tightly.

Also in some states, discounted services are not disclosed or regulated, making it difficult to audit. In those cases, about the best you can do is ask the payer to tell you how rates are calculated, or to make projections based on other state's published formulas.

To take on a capitation audit, you need to have certain data available. Here is a list of minimum data requirements that Pearce recommends:

— Complete listing of all patients specifying whether the member is covered by Medicare, Medicaid, or a commercial plan. This list should at a minimum contain each member's health plan ID number, primary care physician identifier, and the date of enrollment with each primary care physician.

— All claims billed under the risk contract (when claims are used), including information for tracking their accuracy such as member and provider ID numbers, service dates, payment amounts, claim numbers, benefit codes, service or CPT codes, and the setting of care.

— Estimates of provider payment rates, the amounts actually paid to providers according to each capitation contract, and current payment rates for enrollees under Medicare HMO contracting.

Overall, this sort of financial checkup is a cost itself, notes Pearce. And, there is no magic formula for how much should be devoted to any

particular practice for audits. Cost benefit is the key guideline to consider.

"With one client, we decided that the things [the insurer] did as a normal course of business they probably did right, and we wouldn't audit that," Pearce says. "Check how they [your contractors] generally are handling their business."

You may have an experience like this, says Pearce: "These guys are almost always paying us wrong — using 1998 fees instead of 1999 fees." If their daily practices suggest weaknesses, don't presume you are being paid at the right amount, he says.

This often is the case with the smaller payers, Pearce adds, and it may mean that investing time in an audit is worth it. On the other hand, in the case Pearce described in which the payer seemed to be efficient and timely with payments, an $80,000 investment in staff time or consulting fees was not worth it. Overall, your practice's level of confidence in the payers' ability to administer contracts appropriately is the key factor in assessing just how comprehensive your audit needs to be.

Reference

1. Pearce JW. Annual audits of IDS risk contract settlements improve payment accuracy. *J Healthcare Fin Management Assoc* 1999; 53:31-34. ■

HCFA releases new member count rules

Effective dates make big pay difference

A seemingly simple matter of record — determining exactly when a beneficiary is enrolled or disenrolled from a particular plan — has huge ramifications for capitation contracts. That's because monthly payments are based upon enrollment, and large capitation plans can often involve thousands of these bits of enrollment and disenrollment data. Multiply that by six to 10 capitation contracts you might have, and you have a major amount of money at question and a sizeable task.

You can't always depend on your insurer to get enrollment dates correct — sometimes because effective dates can differ from dates a patient actually signed on, and computer codes sometimes can omit the information or report it incorrectly, notes **Jonathan W. Pearce**, MBA, CPA, principal of Dan Grauman Associates Inc. in Bala Cynwyd, PA. Because so much money can ride on effective dates of enrollment and disenrollment, it behooves practices to occasionally audit these data to make sure insurers are implementing the requirements correctly.

The Health Care Financing Administration (HCFA) recently announced that effective Jan. 1, 2000, new rules apply to Medicare HMO enrollment verification. Other payers may be revising their rules as well, making a review of other payers just as important.

Beginning Jan. 1, 2000, here are HCFA's guidelines:[1]

• Completed elections (i.e., enrollments and disenrollments) made on or before the 10th day of the month are effective the first day of the first calendar month following the date the election is made.

• Elections made after the 10th day of each month are effective the first day of the second calendar month after the election is made.

• An election is made only when it is received by the insurer and completed.

HCFA offers three examples to clarify these three new provisions:

• If a completed enrollment form is received by the managed care insurer on May 10, 2000, the effective date is June 1, 2000. If that same completed enrollment form were to be received on May 11, 2000, it would be effective on July 1, 2000.

• If a completed written request to disenroll is received by the managed care insurer on July 8, 2000, the effective date is Aug. 1, 2000. If that same written request were to be received on July 20, 2000, the effective date would be Sept. 1, 2000.

HCFA's system processing cutoff rates are not affected by these changes, which were required by Congress' most recent budget. As has been in effect since the Balance Budget Act, the date a completed election is received by an insurer determines the effective date. The system processing cutoff date does not determine the effective date.

• If an insurer receives a completed enrollment form on May 2, then the effective date of the enrollment is June 1. The insurer has up to 30 days from May 2 to submit the transaction. But submission of the transaction prior to the May systems cutoff date will ensure more timely payment for the June 1 effective date. (Monthly cutoff schedules are provided to insurers.)

Reference

1. Department of Health and Human Services. Operational Policy Letter #111, OPL2000.111. Washington, DC; Jan. 6, 2000. ■

Nation's health bill spending holds steady

Drug costs penetrate other cost ceilings

National health expenditures increased by 5.6% from 1997 to 1998 — the government's most recent data — but the good news is that this marks the fifth year in a row that the growth rate remained below 6%.

In fact, the growth closely matches overall economic growth, say officials with the Health Care Financing Administration (HCFA) who released the data. The result is stable spending patterns for health and all other goods.

Interestingly, public sector spending continued to slow down in most years since 1991 — increasing 4.1% in 1998. The private sector did the reverse. It increased from 4.8% in 1997 to 6.7% in 1998.

HCFA officials credit the government's performance to increased fraud and abuse efforts and the early effects of the Balanced Budget Act of 1997. The biggest economic blow for both the private and public sectors can be attributed to drug costs, HCFA officials say. **(See related stories on the controversies surrounding capitation contracts which include prescription drugs in *Physician's Managed Care Report*, October 1999, p. 151, and July 1999, p. 103.)**

The rising number of new, higher priced drugs and an increase in consumer demand stimulated by direct to consumer advertising are two trends driving higher drug costs, officials point out.

Traditionally, hospital and physician expenditures have accounted for most health care spending. In recent years, these two areas of expenditures have declined, as have payments for home health care. But drug costs moved into center stage to garner the most attention for sharp economic impact.

In the area of costs, experts are predicting even more cost hikes for the private sector — as much as a 12% increase on average in 2000. Specifically, they're pointing to increases in what purchasers will have to pay for their health care insurance.

William J. Falk, a principal with Towers Perrin, a New York City-based employer benefits consulting firm, predicts these cost increases will characterize both fee for service and managed care contracts, with little difference between the two, he says.

For active employees, Falk predicts an 11% rise among indemnity plans, a 10% increase for preferred provider arrangements, and 10% for HMO contracts. ■

Compliance guidelines will cover physicians

The Office of the Inspector General (OIG) is working on draft compliance guidance for physicians and small practices it plans to unveil for comment in either February or March, say sources. Final implementation is expected this summer.

Along with the traditional elements common to all its compliance guidance, OIG has pinpointed the following risk areas for special attention:

- unbundling (e.g., billing multichannel set of lab tests to appear as if individual tests were performed);
- soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., paying for a referral of patients, getting a kickback for ordering diagnostic tests);
- routinely waiving co-pays and deductibles, regardless of need;
- billing for services not rendered ("no shows");
- upcoding;
- double-billing (Medicare and beneficiary / insurer);
- billing for physician services rendered by nonphysicians / teaching physician requirements;
- medical necessity (documentation to support);
- misrepresenting diagnoses to justify services;
- completing certificates of medical necessity for patients not personally and professionally known by the physician;
- billing Medicare / Medicaid for investigation research, medications, and procedures without proper authorization;
- billing for a noncovered service as if it were covered. ■

Associations launch health info site

Seven professional groups join forces

Concerned about variances in the quality and accuracy of health care information available on the Internet, a group of seven professional associations representing two-thirds of the nation's physicians has launched its own Internet site.

The associations have formed a new company, Medem, which stands for "medical empowerment," and will make its Web site, medem.com available later this year.

The medem.com Web site will include comprehensive health care information written or credentialed by representatives of participating organizations, as well as a mechanism through which physician partners can set up their own sites that will be linked to the Medem.com site.

The site is the result of a two-year venture by these groups:

- American Academy of Ophthalmology;
- American Academy of Pediatrics;
- American College of Allergy, Asthma, and Immunology;
- American College of Obstetricians and Gynecologists;
- American Medical Association (AMA);
- American Psychiatric Association;

Put best foot forward on your Internet site

You wouldn't expect a computer programmer to be able to diagnose and treat strep throat or remove a mole from someone's arm. That's why physicians shouldn't expect to be able to create an effective Internet Web site, the experts say.

Of course, it's possible to buy a book and some software and create your own Web page, but you may not be happy with the results.

Doctors should stick to medicine and leave the Web site development to the experts, says **Douglas Munn**, systems consultant for Superior Consultant Co. Inc. of Southfield, IN.

"Physicians could lose potential patients by not putting their best foot forward. My advice is that unless you're prepared to do a first-class job, don't do anything," adds **Peter Zazzara**, executive director of Superior Consultant.

Your site should reflect the quality of clinical care your patients can expect to receive. Just as you wouldn't set up a strictly utilitarian office with vinyl flooring and straight-backed chairs, you don't want a Web site that looks like it was created by an amateur.

"The Web is visual and is a direct reflection on the provider's attention to detail and image. Doctors have the same challenges that Amazon.com has. If the site doesn't look good, a competitor is only a click away," he adds.

That's where the experts come in. They can guide you though the process, suggest content, and create an attractive and interactive Web page for your practice. "A doctor doesn't need to be proficient in the Internet to have a good presence if he finds someone to create and maintain his Web site," Munn says.

If your practice is large enough to warrant it, hire a consultant who understands health care and medical needs to design your site. The consultant can provide recommendations for the most cost-effective ways to maintain and market the site.

Contact the hospital with which your are affiliated, find out who the Webmaster is and see if he or she will set up the Web page for you. Or consider computer-savvy students who work part time to set up your page and update it to keep the information fresh.

There are a number of organizations that will set up a site for you and maintain it for a fee. **(For more on physician Web site developers, see related story, p. 21.)** This may be a cheaper alternative to developing your own site.

Jerry Kelly, executive vice president for physician sales and marketing for Salu.net, a Portland, OR, provider of Internet application services for physicians, estimates that it would cost a physician practice up to $5,000, plus monthly fees, to develop and maintain a Web site on its own.

Salu.net and other Web site developers will do the work for a fraction of the cost, he adds.

You may be able to get help with your Web site from a hospital, your community or state medical association, or a national professional organization to which you belong.

Munn recommends that doctors look around their community or practice areas for resources that can help them create an Internet Web page. A hospital or a professional organization with which your practice is affiliated may help you create a Web page and include you in their directory of physicians and practices. It cuts down on the cost of having to go to an Internet service provider and renting space if you are part of someone else's site.

If your site is part of a large site, it will be easier for people to find you. "This means your site will get more traffic, and you won't have to promote it since the hospital marketing department will be promoting its site," Munn says. ■

• American Society of Plastic and Reconstructive Surgeons.

Medem is wholly owned and controlled by the societies. Each organization put up funds to create the site and has appointed members to the Medem board of directors.

Medem officials cite several reasons why they chose to set up a health care Web site. Those reasons include variances in the quality and accuracy of health care information, growing concerns about health care information security, disenfranchised physicians whose patients are receiving information of questionable quality, and "a gold rush of entrepreneurs looking to make fast money in e-health."

"Today, millions of Americans are turning to the Internet to find answers to their health and medical questions. The problem is there are thousands of sites claiming to provide health information. It's difficult to know what you can believe or what you can trust. With the development of this unique, new Web site, the same kind of credible health information you expect from your own physician is just a click away," says **William Mahood**, MD, AMA trustee.

He points out that the Web site will never be a substitute for an in-person visit to physicians when needed. "But between visits to the doctor's office, this new site will allow patients and their doctors to strengthen their relationship by assuring that patients get the best, most up-to-date, and most credible information from their own doctors."

Thousands have signed up

Thousands of physicians have already registered for customized Web services, according to a Medem spokesman. Members of the physician organizations had the opportunity to sign up for Web sites in late 1999 and responded enthusiastically. In the first month it was offered, more than 4,000 physicians attending their professional organizations' meetings signed up for Medem Web page assistance.

To sign up for the service or for more information, physicians may contact their specialty society or contact Medem directly at partners@medem.com. Physicians who want to participate may have their fee covered by a sponsoring company or may pay $70 a month for the service. Web pages will be available that can be tailored to individual physicians or physicians in group practices.

Medem has set up a template that physician partners can use to create their own customized Internet sites.

The template includes these features:

• physician information including photographs and curricula vitae;

• practice hours, parking information, maps, and information on the health plans the practice accepts;

• physician specific clinical content, such as preoperative and postoperative instructions and patient education information;

• Medem-generated clinical content and applications;

• links to other sites, including the Medem Web sites and pages of the participating professional organizations;

• a secure system for messages between physicians, their patients, and referral sources.

Medem is made up of three segments: an independent editorial operation run by representatives of the participating organizations, a separate business unit, and a health care charitable foundation.

The launch of the fully complete Web site will be later this year, but comprehensive information on Medem and its founding organizations are included on the Web site at http://www.medem.com. ■

You've got mail — or at least you could have

E-mail saves time, and patients love it

Here's what's bound to be a familiar scenario: Jane Jones calls your office with a question about the medication you prescribed. A staff member takes a message and leaves it for you. You call her back several hours later when you have a break. The phone is busy, or no one answers.

This could go on for hours. It's frustrating for the physician and the patient.

The problem of playing phone tag with nonurgent medical questions can be solved for many patients by e-mail. If you have a Web site, you automatically have e-mail capabilities.

Studies show that many patients use e-mail daily for personal and business communications, but few have used it to communicate with their doctors.

Researchers at the University of Michigan Health System in Ann Arbor found that although 40% of general medical clinic patients regularly use e-mail, only 14% have used it to communicate with their doctors.

The survey of 320 patients and 75 resident physicians also found that 70% of patients, both e-mail users and nonusers, would like to communicate with their health providers via e-mail.

In the same survey, 83% of patients' physicians said they think e-mail is a good way to answer patient's nonurgent medical questions, but only 27% were currently using it.

A different study, by Santa Clara, CA-based Healtheon Corporation, showed that 33% of physicians were using e-mail to communicate with patients, an increase of 200% in a year.

E-mail is like other technology; it takes time for people to realize how effective it can be, says **Jerry Kelly**, executive vice president for physician sales and marketing for Salu.net, a Portland, OR, provider of Internet application services for physicians.

"Some of the more progressive physicians are communicating with their patients and colleagues with the e-mail package. Some are more cautious and are nervous about getting inundated with too much e-mail," Kelly says.

E-mail between physicians and patients may grow slowly simply because many patients don't have computers, adds **Peter Zazzara**, executive director for Superior Consultant Co. Inc., a Southfield, IN consulting firm.

One potential problem with e-mail is that problems may arise if patients use it in an emergency and the physician doesn't see it immediately, Kelly points out. To solve that problem, Salu.net has build into its e-mail system an auto response mechanism that instructs patients to call 911 in case of an emergency. Or, if a physician is out of the office, the patient is referred automatically to another physician or a triage nurse.

Initial use of e-mail is more likely to be between physicians or between physicians and hospitals and clinics than between physicians and patients, Zazzara says.

He has worked with physician practices to develop a clinical messaging system so that when lab results are completed, an e-mail with the results is sent immediately to the physician. "They know the results immediately instead of having to call and ask if the labs are back. They can forward the message on with specific instructions to another physician for consultation," he says. ■

Open-model plans please more patients

Study ranks staff-model HMOs lowest in plans

Patients are more satisfied with their primary care and more trusting of doctors who are not tied to a single health plan, according to a study of state employees in Massachusetts.

The study was conducted by a team of researchers led by **Dana Gelb Safran**, ScD, director of the Health Institute of the New England Medical Center in Boston and funded by the U.S. Agency for Healthcare Research and Quality.

"We found that patients rank their physicians' performance the highest when doctors remain in their private offices and contract with as many plans as they care to, rather than when the doctor and the plan function as a single entity," she says.

The study compared five models of managed care:

1. managed indemnity insurance;
2. point-of-service plans;
3. IPA/network model HMO;
4. group-model HMO;
5. staff-model HMO.

Participants were 6,000 Massachusetts state employees enrolled in any of 12 health plans available to state workers. Overall, the indemnity insurance system performed most favorably, and staff-model HMOs performed less favorably. Group-model HMOs performed mostly at intermediate levels.

The researchers administered the Primary Care Assessment Survey, a 51-item questionnaire, which asked the patient to rank their physicians' performance in 10 categories:

1. access to care;
2. duration of relationship;
3. visit-based continuity;
4. physician's knowledge of the patient;
5. preventative counseling;
6. integration of care;
7. communication;
8. physical examination;
9. interpersonal treatment;
10. trust.

They followed up with interviews with senior

health plan executives concerning the results of their study.

Patients in staff-model HMOs rank their physicians the lowest in nine of the 10 categories. The only category in which those plans didn't score the lowest was in preventive health counseling. Staff-model HMOs employ salaried physicians to treat only their plan members.

Patients gave the highest rankings to their physicians when they were members of a managed indemnity insurance plan, traditional fee-for-service insurance with controls such as pre-authorization. Other forms of open-model plans such as point of service and network-model HMOs also fared well. In fact, in most cases, the rankings of open-model plans varied only negligibly.

"One reason we believe we find these things consistently is that doctors who are in an open model know and recognize that it is their responsibility, and theirs alone, to ensure that they have a patient panel who will support their livelihood," Safran says.

Involvement with all aspects of patient's visit

Physicians who are in an open-model plan concern themselves with all aspects of the patient experience from making sure patients have access to the quality of the patient encounter, she adds. "When the doctor and the plan are a joined entity, the doctor has limited responsibilities and may come to view it as the plan's responsibility to make sure they have a patient base."

The study results also suggested that among network model HMOs, some strategies to manage care, such as financial incentives for patient satisfaction and use of clinical practice guidelines, had a positive effect on how patients rated their physicians and the care they receive.

The researchers examined whether the duration of the relationship was affected by employer actions, such as changing plan offerings, or physician actions, such as leaving a plan. However, they found that all the plans except one, the point of service, have been offered for at least seven years; the majority of participants had been enrolled in their plan for at least three years; and the physician turnover has been negligible. This led the researcher to conclude that physician shifting, which occurred most frequently in the staff-model HMO and the group-model HMO, was because of patients' voluntary actions.

"[This] suggests that patients in these models of care are failing to establish primary care relationships that they consider worth maintaining," the study says.

The results mirror those from a similar study that Safran led 12 years ago when researchers studied three types of plans: indemnity insurance, independent practice association network model HMO, and staff or group HMO.

"Managed care has expanded tremendously in the last 12 years, and there are new forms of the model system that didn't exist before. Yet, everything we looked at is consistent with what we found in our Medical Outcomes study in 1986-88," Safran says. "As we found before, this study shows that there is not a single form of managed care. There are different models, and they do appear to perform differently." ■

AMA files lawsuit over undervalued Medicare pay

Sustainable growth rate at issue

The American Medical Association (AMA) has filed suit in federal court in an attempt to get the Department of Health and Human services to correct errors in the system used by Medicare to pay physicians.

The suit, filed in the U.S. District Court for the Northern District of Illinois, charges that the department acted contrary to the wishes of Congress by refusing to alleviate problems in the system used to calculate reimbursement for physician services.

At issue is how the sustainable growth rate

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(SGR), part of the methodology used to adjust Medicare payments, was calculated in 1998 and 1999 by the Health Care Financing Administration (HCFA).

The AMA says that by using projections instead of actual values, HCFA has underestimated the growth in Medicare spending and has undercompensated physicians by an estimated $3 billion. The suit charges that HCFA has reneged on its promise to correct its erroneous projections.

Patient care without reimbursement?

"Physicians have faced years of undercompensation without ever abandoning Medicare patients. HCFA's ongoing refusal to use actual values in calculating the SGR is the equivalent of asking physicians to care for approximately 1 million Medicare patients annually without compensation," says **Thomas R. Reardon**, MD, AMA president.

The AMA contends that Congress never intended the SGR to be based exclusively on projections without any way to tie physicians' payments to real data or compensate for shortfalls in calculations.

"It will be increasingly burdensome for physicians to provide care for the elderly through the Medicare program each year the uncorrected projection errors are allowed to carry over into subsequent years," Reardon says. ■

Group purchasing plan helping independents

Vendors offer discount to physician organization

A Fayetteville, NC, physician organization has been able to save its members big money by negotiating group purchasing arrangements with vendors.

Sandhills Physicians Inc., a multispecialty organization of about 250 physicians, has negotiated group purchasing arrangements for its members for almost everything needed for a medical practice from printed materials to medical malpractice insurance to laboratory services.

"Group purchasing has been very valuable in terms of financial savings," says **Rita Graves**, an administrator who initiated the group purchasing plan when she began managing the organization in the summer of '98.

Members, all of whom are physicians in independent practice, say they are thrilled with the results. For instance, one large physician group reported saving $800 on laboratory services the first month; a solo practitioner saved 50% on his first order of medical-surgical supplies under the new system.

"Vendors are very open to group purchasing because it brings them volume, and in the business world, everything, including price, is driven by volume," Graves says.

Before Graves began negotiating for the group purchasing discounts, she sent out a survey to each of Sandhills Physicians' practices, asking what they were purchasing, how much they were purchasing in each category, and who their vendors were.

From the results of the survey, Graves was able

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to design a group purchasing plan. She found that 80% of the physicians used the same local office supply vendor and that the practices were spending a lot of money on office supplies. "That was a directive for us to talk to them and negotiate a discount."

For her first contacts, she chose the vendors that already were doing the most business with the physicians and those with whom the physicians were most satisfied.

Here's how the program works:

Sandhills Physicians Inc. contacts each vendor, gives it information about the organization, and negotiates the discounts. Graves makes sure the vendors understand upfront that the organization does not mandate full compliance. "We tell them we'll put the word out to the physicians, but we cannot force them to order from these vendors. These are independent practices, and if they don't want to use the medical surgical supply company we negotiate with, that's their privilege," Graves says.

Most participants buy from program vendors

However, she notes, almost 100% of the practices in the organization do choose to purchase from the vendors.

"If it didn't happen immediately, they started hearing from the other doctors about the savings and made the decision to move their business. Our physicians understand dollars and cents and that it is more important and more difficult to keep costs down in a market when reimbursement is not going up," she adds.

The physician practices order individually and identify themselves as a member of the group in order to get the discount. The vendor ships directly to each practice and invoices each individually.

The discounts vary with each vendor, and the savings vary for each medical group since the large groups already had big discounts.

Sandhills Physicians Inc. has negotiated with 11 companies that supply medical and surgical supplies, office supplies, laboratory services, medical records storage, printing, medical malpractice insurance, office equipment, medical waste, pharmaceuticals, patient charting, and medical furniture.

"We were lucky in our community because we don't have as much competition as some communities. It might not work as well in another community," Graves says. ■

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