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Fed up with HMO as the middleman, physicians are reclaiming health care

Doctor-driven health plans bring care back to the community level

If you're fed up with managed care and the restrictions it places on your practice, consider setting up your own health plan and contracting directly with the big employers in your community. In communities across the country, physicians and hospitals are joining together to create locally based health plans, bringing control of health care back to the community.

In North Carolina, the state employees' and teachers' plan has been self-insured and has directly contracted with hospitals since the mid-1980s. Two of California's largest pension funds are considering contracting directly with doctors and hospitals and dropping their managed care plans.

In Madison, WI, 80% of the population is covered by managed care, but the majority of the HMOs are physician-owned and operated. The satisfaction level physicians in Madison have with managed care exceeds the satisfaction with fee for service, says **William DeMarco**, MA, CMC, president of DeMarco & Associates, a Rockford, IL, health care consulting firm. "The solution to America's health care crisis is a community-based operation that is professionally managed, driven by physicians, and based on the community's individual needs."

Direct contracting eliminates the middleman, the HMO, or other third-party payers. The employers take what they are paying the insurance company, put it in a fund, self-insure the risk, and pay the panel of health care providers, explains **David Main**, JD, of Shaw Pittman, a Washington, DC-based health care law practice. "Direct contracting is an effort by employers to eliminate the intermediary [the health insurance company] and pay for medical care for their workers directly with arrangements that look a lot like an HMO," he says.

Large companies want to take complete control of their health care budget and want to do it directly rather than pay an insurance company to handle it, says **Mary Beth Johnson**, a partner in Womble Carlyle, a

law firm in Research Triangle, NC.

"When they engage in direct contracts with health care providers, employers feel like they have more control over insuring their employees and getting the coverage they want if they're self-insured. Most will tell you that 15% to 20% of the premium dollars spent by HMOs are on administration," says Johnson.

In a direct-contracting arrangement, employers contract directly with a network of physicians and hospitals and pay them directly to provide care for their employees. Often employers are willing to split any savings with the physician group.

"A self-funded employer often has paid indemnity to these same doctors. Now the physicians are essentially saying that instead of doing unmanaged care, they will provided superior care management without compromising quality," says **Bo Bobbitt**, an attorney who leads the health law team at Smith Anderson LLP in Raleigh, NC. Physicians consume about 25% of the health care dollars and manage about 85% of the cost, Bobbitt says. "Community physician-driven medical management of that full 85% is basically untapped," he adds.

Bobbitt has set up physician networks across the Southeast that provide health care on a fee-for-service basis with an incentive bonus program attached. To qualify for the bonus, the whole group has to have achieved savings based on some kind of benchmark. For instance, a group might contract to split the savings over what an employer paid for health care the previous year. Individual physicians would have to meet established patient satisfaction, quality, and performance requirements to be eligible for the bonus. "You want to incentivize great medical care that is provided in a cost-effective fashion. If someone does that very well, they should be rewarded," he says.

Locally based health care works for everyone, Bobbitt point out. "The marketplace loves it. Patients are getting tender loving care. The employers like having happy employees. The financial people like it because everybody is working together to get the job done for the least amount of expenditures without cutting corners, and without being concerned with their stockholders like the for-profit companies are," Bobbitt says.

Physicians like it too. In a direct contracting relationship, there aren't as many controls over physicians as there typically are with an HMO relationship. For instance, doctors don't have to call for pre-certification to anyone but a system they helped design.

"Doctors have antipathy toward managed care if it's done by somebody to them. But it's different if they do it to themselves," Bobbitt says.

Physicians are more likely to accept peer review if it's a colleague they know who is looking at the long-term picture rather than merely trying to save money, Bobbitt points out.

"Calling a nurse out of state is unimpressive. But if a colleague in their specialty leans across the table and says, 'We don't do that,' it's more effective and palatable. And the doctor can reply, 'I know Betty Sue, and she's much sicker than you think'" Bobbitt says.

However, most employers have some kind of third-party administrator for their health insurance, Johnson points out. "It is the employer's dollar, and they decide what they will cover. It's not like an HMO with its own financial incentive. But physicians will not necessarily have carte blanche. Employers have got to control costs as well."

Patients' rights legislation pending before Congress may provide opportunity for physicians and hospitals to get into direct contracting if it includes the right to sue an HMO, DeMarco says.

If employees can sue a health plan, they also may try to sue the employer for contracting with the health plan, particularly if they don't get to see the doctor they prefer, he adds.

"There may be a floodgate for return to locally based health care. Where managed care is not working, this could be an opportunity for doctors and hospitals," DeMarco says. ■

Understand your market before you get started

Get a handle on costs before starting

Direct contracting with self-funded employers can be a lucrative venture for your practice, but only if you work hard, plan carefully, and keep in mind good business principles.

"Many physicians believe that by starting their own organization or their own insurance enterprise they can practice medicine the way they want and all the problems of health insurance will go away. That's unrealistic, not just in the terms of the way claims are paid but in the amount of money available. The market is there but they have to be willing to understand the market," says **David Main**, JD, of Shaw Pittman,

a Washington, DC-based health care law practice.

First and foremost, physicians need to get a handle on the fundamentals of cost management, asserts **Bo Bobbitt**, an attorney who leads the health law team at Smith Anderson LLP in Raleigh, NC. "Look at any other business, except government and health care, and cost management is done routinely." Learn from California and other locations where physicians attempted to take risk without a proper infrastructure.

"A common mistake providers make is entering into a risk-taking agreement without a clear idea of what it will cost. That's why so many become disillusioned and have gotten out of managed care. The HMOs have out-negotiated them on price, and they've lost a lot of money," Main says.

The use of diagnosis related groups has given the health care industry the ability to tabulate the cost of care and to link diagnosis, cost, and outcomes.

If you're contracting with managed care plans and have done your homework, you should already know what it costs to deliver care. But you also need data on the populations you will cover to get an idea of what types of patients you are likely to see and how many will have which diagnoses.

Before you embark on a direct contracting effort get patient data from the employer, the employer's former insurance company, or hire a good actuarial firm to get the information.

"Data are one of the most important commodities in health care. Not everyone has got it but if you've got it, you've got a lot," Main says.

This is where the experts come in. Rely on the expertise of consultants and other advisors to tell you what has and hasn't worked in other communities and to help you set up a delivery system that will work in your community.

Choose a consultant who has expertise in setting up community based health care plans and who is a physician advocate. Check his or her credentials and references carefully.

Seek expert legal advice before you sign any kind of contractual arrangement. For instance, when you enter into a five-year contract, you want to make sure you have an option to get out the contract if something goes wrong.

Consider starting out on a limited basis. For instance you might limit the number of people you cover, or limit the benefits package to items you know you can do well. For instance, you might have limits on the types of drugs you cover. Pharmaceutical costs can get out of control. Or you might limit the very specialized kind of surgeries.

Include a provision that in the case of severely ill patients, the employer pays the specialists directly. In addition to making sure the patients get the best care, this lets you off the hook financially for an extremely sick patient.

"It's the difference that working within a budget makes. With a budget you are compelled to find out who can do the best. It's a real cultural shift," DeMarco says.

Here are some other tips from the experts:

• Make sure you have good re-insurance so that if catastrophic events happen, you're not stuck with a catastrophic bill, advises **Mary Beth Johnson**, a partner in Womble Carlyle, a law firm in Research Triangl, NC.

• Insist the company assigns adequate co-payments and deductibles to the employees participating in the plan so they have some stake in controlling the costs.

10 Items Needed to Set Up Your Own Health Plan

1. Adequate money to make your plan succeed. Create a budget and have good sources of capital lined up.
2. A chief executive officer to run your health plan.
3. Good local leadership to move the plan forward.
4. A third-party administrator to meet the needs of self-funded employees who want you to handle all the paperwork and details.
5. An actuarial firm to help you determine the patient population and health care needs of the population you will cover.
6. An attorney to help you construct the contracts so they are in your best interest.
7. A consultant to help you set up your delivery system and health care plan.
8. Critical pathways to help you standardize care, track quality, and keep a handle on the costs. To be successful, the pathways must have buy-in from the physicians in your health plan.
9. An information system to track quality, cost, and patient satisfaction.
10. A mechanism to reward physicians to provide cost-effective, high-quality care.

• Make sure there is an easy way of determining if a person is still covered. The contract should include a requirement for timely notification if an employee is no longer employed or no longer covered by the plan.

• Make sure the contract specifies that you'll be paid in a timely manner. Include a clause that says that if you give a discount and you're not paid in the agreed-upon time frame, you get paid the full amount.

• Carefully study the compensation arrangement to make sure the contract doesn't hold you at risk, Johnson advises.

"You wouldn't want to be in a situation where you are paid a certain amount to cover an episode of care regardless of cost. Discounted fee for service would be preferable," she says. ■

Direct contracting needs physician leadership

Get local employers to see your vision

If you sense that your community is ready for direct contracting between health care providers and employers, don't wait for a hospital or a third-party administrator to make the first move.

Developing a locally controlled managed care plan, in effect, requires someone who can provide leadership and get the local employers to see the vision, says **William J. DeMarco**, MA, CMC, president of DeMarco & Associates, a Rockford, IL health care consulting firm.

"Physician-driven integration creates better products. What you have is an opportunity to show what physicians can do by taking a leadership role," DeMarco says.

Start by studying your market carefully. This includes taking these steps:

• Look at the makeup of your community and what the medical needs are.

• Find out what types of patients are in your area and what types of employers you will deal with.

• Decide what products you want to offer and to whom in the market do you want to offer your services.

"Physicians have to determine realistically what those patients and employers want and structure their organization to meet those needs from a marketing standpoint," says **David Main**, an attorney with Shaw Pittman, a Washington, DC-based health care law practice. "Every community really is different," he adds.

The practice works better in a medium-sized town than in a large metropolitan area, says **Bo Bobbitt**, head of the health team at Smith Anderson LLP, in Raleigh, NC.

Once you've determined that there is a need in your community, form a steering committee of community physician leaders to visit with local employers, particularly those that are self-insured, and discuss the benefits of a community-based health plan. Find out what the employers would like in the way of a health care plan.

Keep your steering committee small enough so it won't get bogged down. "You need to be willing to entrust the success of the organization to people who have expertise and give them the authority to move forward, rather than trying to make decisions as a large group," Main says.

Be choosy about which employers you choose to negotiate with. "It's much easier to deal directly with self-funded employers than with the small insured companies," Bobbitt says.

Whether an employer can self-fund a health care product depends on many factors. For instance, self-funding is easier if an employer has a large number of employees concentrated in one area rather than scattered across several states.

Ensure you'll be paid

Make sure the employer is financially viable. You want to be paid for all the services you provide. There generally is less risk of nonpayment with larger employers than smaller companies.

When you enter into direct contracting for your services, you won't have the protection of any government regulations to govern the solvency of the company with whom you contract. With an HMO there are state regulations requiring financial stability. It's up to you to make sure the company you deal with won't go out of business or have financial problems.

Point out to the employers that the care will be managed locally, not through an intermediary in another state. "Direct contracting changes the way health care is delivered. It usually takes a crisis or some event to trigger this change, or it can be done if your community has a good physician leader," Bobbitt says.

Approach the employers about long-term continuity of care and improving the standards of

care. Focus on improving quality, not just the prices, DeMarco suggests.

If there is interest in your community, set up a small corporation that is 100% physician-driven. When Bobbitt sets up an organization to do independent contracting, he makes sure it is totally doctor-owned and operates with an independent board of directors.

For instance, he worked with the physicians in Sandhills Physicians Inc. in Fayetteville, NC, to form a committee that approached the local plant manager's association about a direct-contract product to cover the employees of self-insured firms.

When the employers showed an interest, the physicians approached Cape Fear Health System and formed a partnership — Doctors Direct Health Care. **(For details on the venture, see story, p. 38.)**

"Physicians shouldn't wait for the hospital to do their bidding for them. The hospital's goal is to fill beds at the highest income level possible. They can show full occupancy and still lose money. The hospital could be dropped, and the physician could see their patients go to the doctor across the street without even being involved in the negotiations," DeMarco adds.

Employers are starting to realize that the contract can't be just with the hospital because physicians may not do what the hospital is dictating, he says.

Start out by inviting every high-quality, credentialed doctor in your community to participate in your health plan. "We start out being inclusive but we don't give anybody a lifetime membership," Bobbitt says.

Once the program gets going, start measuring the cost and quality of care each physician provides. Keep the good performers who are providing quality care and de-select those who are not, he advises.

"Make sure the doctors understand that they need to focus on getting people well with limited health care dollars," Bobbitt says. ■

Employers' interest grows in building coalitions

When **William J. DeMarco** wrote a book on setting up a community-based, physician-driven health plan in 1998, he did so with physicians in mind. But lately, most purchases of that book have been from employer coalitions.

"In the last two months, I've gotten more calls from employers than from doctors," says DeMarco, MA, CMC, president of DeMarco & Associates, a Rockford, IL, health care consulting firm.[1]

Employers who once bought services only from HMOs are now reconsidering and are looking for physician-hospital networks and physician networks, DeMarco says. "They want to go into direct contracting in exchange for higher performance and an improved clinical product."

Direct contracting is not a new concept, but it's been gaining attention for several reasons, says **David Main**, an attorney with Shaw Pittman, a Washington, DC-based health care law practice. Health insurance premiums are on the rise again, and many people believe that insurance companies, particularly those that are for-profit, are taking more profits than they should.

Providers and patients alike have had real problems with the way big insurers administer insurance claims. And many people are frustrated when their plan doesn't cover certain types of treatment, and they blame HMOs.

"The perception is that there is a big problem with HMOs and many employers with enough size are saying they can do a better job themselves," Main says.

Direct contracting is an idea whose time has come, adds **Bo Bobbitt**, a Raleigh, NC, attorney who has set up 70 physician networks in the Southeast. "People are ready for direct contracting. Employer reps are hungrier for it than the doctors are. As soon as self-funded employers get wind of it, they are the ones setting deadlines and asking when can the start."

The timing is good, Bobbitt says. "The physicians are already treating these people. They know them well and can feel good about taking charge of the physician-patient relationship again."

(DeMarco's book, Physician Driven Health Plans: Innovative Strategies for Restoring Physician-Community Integration, *is available from Amazon.com on their Web site: www.amazon.com.)*

Reference

1. DeMarco WJ, Hekman KM. *Physician Driven Health Plans: Innovative Strategies for Restoring Physician-Community Integration*. New York City: McGraw-Hill; 1998. The book is available from Amazon.com. ■

Direct contracting: A return to the community

Doctor, community input critical

When Doctors Direct Healthcare took over the care for 6,000 covered lives of a local employer in January, it represented the culmination of nearly two years of work to create a community-based health care delivery package for self-funded employers in the Fayetteville, NC, area.

Doctors Direct Healthcare is a 50-50 joint venture between Sandhills Physicians Inc. — a physician organization of about 257 primary care and specialty physicians — and Cape Fear Valley Health System.

Other contract negotiations are in the works says **Rita Graves**, administrator. "Direct contracting is one of the most exciting pieces of our organization. I have been in health care long enough to see it transition from community-delivered health care to where there was very little involvement and physicians were driven by managed care. Doctors Direct Healthcare allows the decisions to come back into our community," she says.

Doctors Direct was created to contract with self-funded employers. There are 56,000 self-funded lives in Cumberland County, Graves says.

In the early stages of developing the direct contract model, a group of physicians met with members of the Fayetteville area's plant managers' association and asked what the employers wanted in the way of a health care delivery system.

Direct contracting plans are driven by the employers in some communities, but the Fayetteville employers were not prepared to create such a product, Graves says. The employers told the physicians that they wanted a one-stop shopping opportunity that included both physician services and hospital services.

The physician's committee, primarily from the executive committee of Sandhills Physicians, proposed the joint venture to the hospital administration and helped move it forward, Graves says. The Sandhills physicians spent

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Focus your health plan on back-to-work issues

Take advantage of a common agenda

Employers and physicians have a common agenda, which insurance companies and other third parties may not share. It's getting the patient well and back to work.

"The end point in a good health care program is not just getting the employees home from the hospital. It's having them productive and happy," says **Bo Bobbitt**, a Raleigh, NC, attorney who heads the health law team at Smith Anderson LLP.

That's why employers are eager to partner with physician organizations that can help them keep their health care costs down while keeping their employees healthy.

From the employers' standpoint, the cost of medical care is just the beginning. They also look at the cost of the time that a machine isn't being used, the replacement cost to get another employee to take over a job, and the overall downtime when the employee is away from the job.

"That adds to the cost or sometimes exceeds the cost of the actual treatment the employee is getting," explains **William J. DeMarco**, MA, CMC, president of DeMarco & Associates, a Rockford, IL healthcare consulting firm. It pays off for both sides if physicians and employers form a partnership to provide community-based health care for their workers.

Taking the long view

Employers can help physicians with strategic planning, marketing, and operations. From a strategic planning point of view, they are starting to see a real value in identifying specific disease groups and managing long-term solutions rather than just fixing the problem when it occurs, DeMarco says.

"In the long term, employers want to improve the overall quality of care. That saves money. A discounted price may not," he says. ■

Physician's Capitation Trends™

• Capitation Data and Trend Analysis •

HCFA delivers its promise: Risk adjustment for capitation

Payment changes will span four years

The year 2000 marks the beginning of technical shift in Medicare capitation payment methodology that — over the next four years — will move payments toward a significant conceptual change aimed at reducing capitation's riskiest aspects.

You may not notice much difference so far this year in your Medicare capitation payments. A 5% increase is projected overall, although that varies widely by county.

But over the next four years the new payment system, which factors in principal inpatient-diagnostic cost groups, or PIP-DCGs, will pay you higher rates for patients statistically predicted to be at greater health risk. **(See phase-in schedule section, p. 42.)** Simultaneously, payments will be lower for HMO enrollees who do not clinically qualify for a PIP classification.

Until Jan. 1, 2000, all Medicare HMO patients were paid under the adjusted average per capita costs (AAPCC) method, which essentially amounted to an average Medicare fee-for-service rate adjusted for geographic location. Other adjustments also existed — age, gender, Medicaid eligibility and institutional status.

Each patient has an assigned risk score

Starting in the new calendar year 2000, all Medicare HMO beneficiaries were assigned a "risk score" based on their clinical history. Those who are predicted to be at the greatest risk for intense services are identified as such and assigned a risk category (PIP-DCG).

The following formula, and accompanying examples, explain how to make the new capitation calculation:

- Add Part A and Part B aged rates (basic Medicare payment levels), or the Part A and Part B disabled rates (for enrollees with disabilities); **the chart on page 40 shows an example drawn from four counties in Kansas**, with "rescaling factors" representing demographic adjustments.
- Multiply the corresponding re-scaling factor.
- Multiply by the risk score. **(See examples of the risk scores for DCGs 5-20, for males, p. 40.)**
- Apply the blend percentage (10% for the year 2000, with rising percentages over the next four years).

Here are two examples the Health Care Financing Administration (HCFA) offers in its "45-day Notice letter for 2000 Medicare+Choice Payment Rates":

Example #1. Beneficiary A was hospitalized twice during the base year (1999). The diagnoses assigned were asthma (PIP-DCG 8) and staphylococcus pneumonia (PIP-DCG 18). The highest PIP-DCG category for the beneficiary would then be PIP-DCG 18. As the sample PIP score chart indicates, PIP-DCG carries a factor of 2.656. The beneficiary would also be placed in its demographic group. In this case, the patient is male, aged 82. This age group carries an age factor of 1.077.

Also, the patient had been Medicare eligible because of a disability, which carries a factor of 0.287, but he is not eligible for Medicaid (so no Medicare factor is applied). Adding these incremental factors, the risk factor for Beneficiary A is 4.02, which indicates a high expected cost individual.

2000 Medicare+Choice Monthly Capitation Rates and Re-scaling Factors*

State County Code	County Name	Aged Rates			Disabled Rates		
		Part A	Part B	Re-scaling Factor	Part A	Part B	Re-scaling Factor
17000	ALLEN	$233.53	$178.55	0.972505	$214.10	$182.02	1.011688
17010	ANDERSON	$231.51	$177.02	0.980956	$214.10	$182.02	1.011688
17020	ATCHISON	$243.82	$186.43	0.931435	$214.10	$182.02	1.011688
17030	BARBER	$254.70	$194.74	0.891665	$214.10	$182.02	1.011688

* Example shown is for four counties in Kansas.

Source: Health Care Financing Administration, Baltimore.

Medicare's New Capitation Formula Adds PIP-DCG Factors

Factors for People with One or More Years Experience					PIP SCORES	
Male	Age cate.	BASE	PREV. DISABLED	MEDICAID	DCG	Factor
	0-34	0.367	-	0.125	5	0.375
	35-44	0.380	-	0.283	6	0.458
	45-54	0.487	-	0.370	7	0.697
	55-59	0.615	-	0.397	8	0.822
	60-64	0.760	-	0.418	9	0.915
	65-69	0.541	0.415	0.440	10	1.170
	70-74	0.705	0.398	0.457	11	1.271
	75-79	0.907	0.334	0.461	12	1.662
	80-84	1.077	0.287	0.445	14	2.000
	85-98	1.258	0.237	0.404	16	2.438
	90-94	1.376	0.189	0.331	18	2.656
	95+	1.357	0.141	0.242	20	3.392

Note: This chart illustrates risk adjustments for male Medicare populations and only for DCGs 5-20. Separate factors exist for female populations.

Source: Health Care Financing Administration, Baltimore.

Example #2. Beneficiary B had no inpatient admissions during the base year. Thus, no specific PIP-DCG would be added. Beneficiary B would be placed in the appropriate age and sex grouping and any relevant Medicaid and disable factors would be added.

Each year, insurers are required to forward up-to-date enrollee data to HCFA for risk factor analysis. HCFA computes the risk factor for the beneficiary as well as the capitation payment for that patient. The risk factor is computed for each individual beneficiary for a given year. That factor follows the beneficiary regardless of which insurer the beneficiary chooses.

The current DCG-PIP classification currently has 15 capitation payment categories for 89 different diagnoses. **(See listing of these 15 classifications and related diagnoses, p. 41.)** HCFA experts expect that the current PIPs will represent about 12% of Medicare HMO beneficiaries. More are likely to be added in the future as the PIP-DCG system is tested over the next four years.

(Continued on page 42)

Assignment of Diagnoses (DxGroups) for Each PIP-DCG

PIP-DCG 5

Dx Group	14	Breast cancer (b)
	131	Ongoing pregnancy with complications
	132	Ongoing pregnancy with no or minor complications

PIP-DCG 6

DXGroup	18	Cancer of prostate/testie/ male genital organs (b)

PIP-DCG 7

DxGroup	1	Central nervous system infections
	39	Abdominal hernia, complicated
	64	Alcohol/drug dependence

PIP-DCG 8

DxGroup	16	Cancer of uterus/cervix/ female genital organs
	36	Peptic ulcer
	77	Valvular and rheumatic heart disease
	79	Hypertension, complicated
	80	Coronary atherosclerosis
	84	Angina pectoris
	86	Atrial arrhythmia
	92	Precerebral arterial occlusion
	96	Aortic and other arterial aneurysm
	110	Asthma
	153	Brain injury
	158	Artificial opening of gastrointestinal tract status

PIP-DCG 9

DxGroup	21	Other cancers (b)
	32	Pancreatitis/other pancreatic disorders
	82	Acute myocardial infarction
	93	Transient cerebral ischemia
	145	Fractures of skull and face
	146	Pelvic fracture
	147	Hip fracture
	150	Internal injuries/traumatic amputations/third degree burns

PIP-DCG 10

DxGroup	11	Colon cancer (b)
	59	Schizophrenic disorders
	81	Post-myocardial infarction
	82	Unstable angina
	97	Thromboembolic vascular disease
	116	Kidney infection
	143	Vertebral fracture without spinal cord injury

PIP-DCG 11

DxGroup	42	Gastrointestinal obstruction/perforation
	45	Gastrointestinal hemorrhage
	87	Paroxysmal ventricular tachycardia
	109	Bacterial pneumonia
	133	Cellulitis and bullous skin disorders

PIP-DCG 12

DxGroup	4	Tuberculosis
	10	Stomach, small bowel, other digestive cancer
	12	Rectal cancer
	19	Cancer of bladder, kidney, urinary organs
	22	Benign brain/nervous system neoplasm
	26	Diabetes with acute complications/hypoglycemic coma
	41	Inflammatory bowel disease
	48	Rheumatoid arthritis and connective tissue disease
	49	Bone/joint infections/necrosis
	56	Dementia
	60	Major depression
	73	Epilepsy and other seizure disorders
	91	Cerebral hemorrhage
	93	Stroke
	98	Peripheral vascular disease
	111	Pulmonary fibrosis and bronchiectasis
	113	Pleural effusion/ pneumothorax/empyema

PIP-DCG 14

DxGroup	2	Septicemia/shock
	29	Adrenal gland, metabolic disorder
	58	Delirium/hallucinations
	61	Paranoia and other psychoses
	63	Anxiety disorders
	66	Personality disorders
	70	Degenerative disorders
	144	Spinal cord injury

(Continued on next page)

PIP-DCG 16		
DxGroup	8	Mouth/pharynx/larynx/other respiratory cancer
	13	Lung cancer
	34	Cirrhosis, other liver disorders
	89	Congestive heart failure
	95	Atherosclerosis of major vessel
	105	Chronic obstructive pulmonary disease
PIP-DCG 18		
DxGroup	17	Cancer of placenta/ovary/ uterine adnexa
	55	Blood/immune disorders
	72	Paralytic and other neurologic disorders
	75	Polyneuropathy
	108	Gram-negative/staphylococcus pneumonia
PIP-DCG 20		
DxGroup	27	Diabetes with chronic complications
	76	Coma and encephalopathy
	112	Aspiration pneumonia
	115	Renal failure/nephritis
PIP-DCG 23		
DxGroup	9	Liver/pancreas/esophagus cancer (b)
	33	End-stage liver disorders
	88	Cardio-respiratory failure and shock
	134	Decubitous and chronic skin ulcers
PIP-DCG 26		
DxGroup	7	Metastatic cancer (b)
	20	Brain/nervous system cancers (b)
PIP-DCG 29		
DxGroup	3	HIV/AIDS (a)
	15	cancers/neoplasms

(a) includes principal and secondary inpatient diagnoses of HIV/AIDS

(b) includes principal diagnoses and secondary diagnoses when the principal diagnosis is chemotherapy

Source: Health Care Financing Administration, Baltimore.

Under PIP, capitation payments will be based on a combination of diagnostic and demographic factors, with increasing emphasis on diagnostic factors as the phase-in moves toward its fourth full year.

Phase-in schedule

In summary, here is how HCFA will roll-out the new payment system in its first year:

• Assign each Medicare HMO enrollee risk adjusters, or PIP-DCGs, based on inpatient data;

• Apply individual enrollee risk scores to determine fully capitated payments

• Utilize a prospective PIP-DCG risk adjuster to estimate relative beneficiary risk scores;

• Apply separate demographic-only factors to new Medicare enrollees for whom no diagnostic history is available.

• Use six-month old diagnostic data to assign PIP-DCG categories (as opposed to using the most recent data and making retroactive adjustments of payment rates part way through the year.

• Allow for a reconciliation after the payment year to account for late submissions of encounter data.

• Phase-in effects of risk adjustment, beginning with a blend of 90% of the demographically adjusted payment rate and 10% of the risk-adjusted payment rate in the first year (CY 2000).

• Implement processes to collect encounter data on additional services and move incrementally to a full risk adjustment model.

One of the areas of controversy for PIP-DCGs surfaced in the clinical area of congestive heart failure. "We have received many comments raising concern about the need to reimburse plans for the outpatient management of certain chronic conditions, especially congestive heart failure (CHF)," HCFA officials explained. "As one of the most frequently billed inpatient diagnoses, CHF is unique in its prevalence and to the degree to which it can be successfully managed on an outpatient basis."

Some experts are urging HCFA to make special capitation payments for CHF treated in outpatient settings, but to date, HCFA says it needs more time to research how that could be done in the PIP model. ■

(Continued from page 38)

long hours and were not paid for their time.

"It has to be something the physician believes in," she says.

A committee that included three physicians and Graves, and representatives from the hospital met every other week beginning July 1998. The committee hired an attorney to advise them on the procedures they should take.

Throughout the entire process, the physician team continued to meet with the local employer, showed them the proposed products, and asked for their advice.

Graves and Belinda Weaver, director of managed care / network development at the hospital developed, negotiated, and reviewed the contracts, with assistance from the law firm.

"Through it all, we involved the employers and local insurance brokers and got input and direction from them," Graves says.

Doctors Direct relies on locally based medical management including critical pathways to help ensure that patients receive quality care in a cost-effective manner.

"We made the decision to do our own medical management locally and hired an experienced nurse who lives in Cumberland County to guide it." Graves says. In addition, local primary care and specialty physicians participated by serving on medical management committees, clinical pathway committees, utilization management committees, quality management committees, and credentialing committees, she adds.

Physician input on guidelines

The utilization management guidelines were developed with direct input from physicians. "We had a lot of physician input on how policies were designed, and that has made a significant impact," Graves says.

Committees of physicians helped create 60 critical pathways. The physicians looked at the standard clinical pathways that were already on the market and adapted them for their special populations. "Not only did we create pathways specific to our patient population and our health care delivery system, but we gained a lot of knowledge and education from each other," Graves says. **(See articles, pp. 44 and 45.)**

Physician involvement is the key to creating a successful community-based health plan, she asserts.

"You have to have a huge amount of physician involvement. I've talked to a number of groups, and they've told me that physician involvement is the key piece," Graves says. ■

The timing is right for coalition ventures

Options may be limited if you don't act now

More change is coming to the health care delivery arena, and unless physicians take a proactive stance, it may not be for the better.

"Faced with a 20% rate increase for insurance, some large employer coalitions in the Midwest are at the point of wanting to have the government come in and do something," says **William J. DeMarco**, MA, CMC, president of DeMarco & Associates, a Rockford, IL, health care consulting firm.

"If physicians don't step up to the plate and take the lead in bringing care back to the community, their options may be limited down the road. If we don't have some real success stories in the next five years, we may see mass regulations and a single-payer system," he warns.

Lawmakers in a number of states are starting to discuss setting up a single-payer system as a way to control spiraling health care costs and stem complaints about HMOs, he adds. "If we don't have a market-based solution, we are open to the potential of having a government-based solution in three to five years."

A government administered single-payer system is likely to be more restrictive than many HMOs and will probably mean stronger price controls for physician services, DeMarco says. "State legislation on patient protection, Medicaid choice, and other health care issues are very strict on oversight and control."

If one or two states go to a single-payer system, their experiences could trigger a move toward a national type of single-payer system, he points out.

If the idea of a single-payer system arises in your state, you'll be in a better position if you already have a direct contracting program up and running, DeMarco says. "The state doesn't want to ruin anything that's working. The state wants to take care of people who are unhappy with their health care plans." ■

Critical paths a key to better care, bottom line

Develop your own with local input

If you're looking for ways to improve patient care and control costs, developing critical pathways may be the answer you need.

Critical pathways have been somewhat of an anathema to many physicians who may have viewed them as "cookbook medicine" that was crammed down their throats by HMOs. But some practices are finding that critical pathways help them track costs, improve patients care, and take a proactive stance with managed care.

"From the beginning to the end, it helps to better guide patient care," says **Rita Graves**, administrator of Sandhills Physicians Inc., a Fayetteville, NC, physicians organization and its community health plan, Doctors Direct Health Care.

The organization is in the process of completing 60 critical pathways.

Pathways are written documents that include step-by-step guidelines for treating a particular condition or disease. They can be attached to a chart or come to a physician for review when a patient presents with a particular diagnosis.

"What has happened in the past is that HMOs have come up with critical pathways without the help of physicians and foisted them on physicians without getting their input," says **William J. DeMarco**, MA, CMC, president of DeMarco & Associates, a Rockford, IL, health care consulting firm.

But when physicians have input into the development of the guidelines, they can be a boon to their practice. For instance, in Madison, WI, where 80% of the population is covered by HMOs, the majority of HMOs are physician-owned and operated, DeMarco says.

"The guidelines are phenomenal because physicians have had adequate input. It's a good example of what you can do at a local level," he says.

Sandhills Physicians created pathways specifically for its new community health plan, but has received interest from managed care plans as well. "Managed care organizations have expressed an interest in our ability to do this. What they have found is that it's very difficult to get compliance nationwide. They find ours very attractive," Graves says.

When managed care organizations look at a group of physicians and see that they are taking steps to improve care and cut costs, the physicians benefit when they are negotiating contracts, she adds.

Large payers may have their own protocols but often the physicians are not aware of them, Graves says. "Most managed care payers use the standard protocols. What we've done is streamline that for our own community."

Critical pathways help you keep costs under control while giving a comfort level to the practitioner that there is no lessening of quality of care, says **Mike Boguszewski**, manager at Hamilton HMC, a health care consulting firm in Minneapolis. "Critical pathways enable physicians to see that they can standardize and use low cost options without jeopardizing the overall quality," he says.

In addition to saving money, pathways also help you identify the most effective but cost-efficient courses of treatment or decision. They allow a comparison among the various ways by which a certain disease or condition can be treated from both a quality and cost perspective, he adds.

Just the mere practice of developing critical pathways can generate savings by helping your practice identify supplies or devices that can provide the same functionality at a lower price and take advantage of volume discounts from vendors, Boguszewski says.

In an orthopedic practice, some surgeons may be using a prosthetic device that costs less than others but works just as well. Your practice may save money by switching to the lower cost item and save again by asking the manufacturer for volume discounts.

How to save money

Boguszewski gives this example of how following a critical pathway can save you money:

Historically, when a patient comes in with a diagnosis of suspected hormonal deficiency, the physician has blood drawn and orders about 25 tests. A critical pathway might specify the physician to order only four or five tests that would confirm the most probable diagnoses. If the results of those tests were negative, the pathway would specify a second and third tier of tests. Some patients still would have to have all 25 tests, but for many patients, their problem would be pinpointed with the first few tests.

"Maybe 60% of patients need only the first tier, and 80% need only the first and second tiers.

When you've treated 1,000 patients, you've made significant cuts in the number of analyses and cut down overall on lab charges," he says.

As costs and charges change over time, you may see bigger or smaller savings. "In the end for all 1,000 patients, everybody ultimately gets the proper treatment, and if it's done right, not much time passes," Boguszewski adds.

However, there must be a mechanism for exceptions to the pathway. For instance, if you're treating pediatric patients or other people who are sensitive to having multiple needle sticks, you may have to decide whether the cost savings is a good trade-off with an unhappy patient, he explains. "Physicians have to remain advocates for their patients and have the flexibility to divert from the pathway when they feel there is a justifiable reason, whether it's medical, psychosocial, or other."

On the other hand, you need to monitor the exceptions, he points out. The danger is that if everybody is making exceptions for their patients, you've wasted your time creating the pathway.

Here 's a list of some changes you may need to make in order to ensure your pathways work:

✔ Create new contractual arrangements with vendors.

✔ Redesign some of your procedures or operations involving nursing or ancillary support staff.

✔ Establish different relationships with local support such as home health therapy or medical equipment providers.

✔ Conduct specialized training or inservices for your staff. For example, if a physician has never used the prosthetic device your pathway specifies, he or she may not be comfortable with it. ■

Successful pathways need physician input

Study existing protocols, modify for your practice

The No. 1 rule to follow when developing critical pathways for your practice is to involve your physicians every step of the way, experts say.

"For the process to work, it has to be led by a physician practitioner. The success depends on physicians having buy-in. If they feel they have been left out of the process, they may not follow it," says **Mike Boguszewski**, manager at Hamilton HMC, a health care consulting firm in Minneapolis.

Although nurses, clinical specialists, and nurse practitioners should get involved helping identify alternative treatments or courses of action, the success of a critical pathway depends on physician buy-in.

Pathway development works best if the physicians who treat patients with each particular condition lead the process. For instance, when Sandhills Physicians Inc., a physician organization in Fayetteville, NC, began developing critical pathways for its new community-based health plan, Doctors Direct Healthcare, 40 physicians were on the committees, which developed 60 pathways.

A representative of each of the three urology groups in the physician network worked on development of the pathways for urological conditions, according to **Rita Graves**, administrator of the 250-physician organization. They tailored the pathway to the specific needs of their community.

"We're known as the kidney stone belt of the United States. That is a significant issue here. Our physicians understand the dietary patterns of our population that come into play in trying to treat kidney stones," Graves says.

The critical pathway committee dealt with some of the issues that may arise between primary care physicians and specialists. Each pathway designates what testing specialists want done in primary care. So far, 42 out of about 60 proposed critical pathways are complete. Each physician has received a copy of each protocol, whether or not it's specific to his or her practice.

"The protocols are designed for Doctors Direct, but all patients get the benefit of them. You can't discriminate against patients based on what type of insurance they have. You have to select the best clinical guidelines to create the best outcome for that patient," she says.

If your practice is considering developing critical pathways, Boguszewski advises taking these steps:

❒ **Compile a list of the top disease groups in your community.** You may want to work with a local employer coalition to determine the key disease management areas, such as low back pain, asthma, diabetes, and depression.

❒ **Decide what areas would benefit from pathways.** Look at your internal data to determine what areas have the opportunity for cost reduction through standardization.

For instance, if there are widely varying costs for hip replacement surgery, you might select this

as your initial pathway. Examine the cost of prosthetic devices and why there is a wide variation in costs.

Determine if there is a link to the patient's age or lifestyle and the choice of prosthetic device, or if there is a difference in functionality among patients who receive the less-expensive device. If not, you might consider standardizing through development of a pathway.

Your practice may choose not to have a pathway for every single patient you treat. "For low-volume types of conditions or where the cost isn't very high, it might not be worth the effort to have a formalized process," he says.

Instead you may choose to start with the largest volume or high-cost procedures or conditions and attack those first. Then you can make sure their process works and they show some success before tackling other areas.

❒ **Collect pathways from other physician practices, professional associations, organizations concerned with specific diseases and conditions, or the federal Agency for Healthcare Research and Policy.** Review the pathways as a group, and get an idea of the structure and whether you'd like to modify one or build your own. The committee should write out each step in how they currently treat those patients and compare that to pathways from other groups as a benchmark.

In addition, the committee should examine the best performers in the practice. "If a practice has 12 people doing one procedure and one is ahead in cost per treatment but nothing says clinical care is compromised, it should look at what this physician does and see if it could incorporate that into a standardized pathway," Boguszewski says.

❒ **Design your pathways with all the physicians in your practice.** "If physicians feel restricted or feel they have been left out, or if the pathway doesn't allow them enough flexibility to make the best decisions for their patients, they won't follow it," he says.

❒ **Once you have created a standard pathway, add in secondary characteristics, such as age, life expectancy, and comorbidities.** Those characteristics can be addressed by splits or branches on the pathway. It doesn't have to be one way for all people, Boguszewski says.

❒ **Monitor compliance with the pathways.** This doesn't just mean tracking variances from the pathway. There should be a peer review team that looks at pathway compliance and why variances occur.

❒ **Monitor the outcomes.** It's not enough to monitor compliance. You need to determine whether you are actually getting benefits from the pathways. ■

Sick of managed care? You're not alone

Studies show doctors are fed up

Two recent studies confirm what you've probably known all along — America's doctors are fed up with managed care and feel that it has adversely affected the way they practice medicine.

Physician hostility to the health care system and managed care has reached an all-time high, according to an annual study by Strategic Health Perspectives, an alliance of the Harvard School of Public Health, Harris Interactive, health care futurist **Ian Morrison** in Menlo Park, CA, and **Bill Rosenberg**, director of Pricewaterhouse-Coopers in New York City.

At the same time, evidence shows that managed care has impaired the doctor-patient relationship, according to a different study conducted by the Medical College of Wisconsin's Center for the Study of Bioethics.

Consider these statistics from the two studies:

Fully 83% of physicians polled by Strategic Health Perspectives believe that "fundamental changes" need to be made in the nation's health care system or that the system needs to be completely rebuilt (11%). This compares with 51%

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who felt that way in 1984 and 67% in 1997.

Only 10% of physicians and 43% of the American public believe that managed care has improved the quality of care. This contrasts sharply with 57% of employers and 86% of health plans that feel managed care has succeeded in improving care.

Three-fourths of physicians responding to the Medical College of Wisconsin study said that managed care organizations influenced their ability to order diagnostic tests at least occasionally. Half of the respondents reported that they have changed their clinical behavior since they have begun participating in managed care.

About 65% of physicians reported authorization denials for tests and treatments were "never" or only "occasionally" reversed.

Only about 44% of physicians and 40% of the American public agree that managed care has been at least somewhat successful in containing costs.

Health care experiencing 'a sea change'

"There is a sea change in American health care. No longer are doctors happy and their patient disgruntled; now physicians are as unhappy as their patients," says Morrison. A comparison of data from the early 1990s and 1999 shows how managed care has changed the political map and produced new alliances, he adds.

For instance, in the early 1990s and during the debate of the Clinton health care proposal, most employers and most of the public wanted to change the health care system. At that time, physicians were happy and saw the government and not private health insurance and managed care as the enemy, the study shows.

In 1995, 79% of the public believed the health care system needed changing or rebuilding, compared to only 57% of physicians.

The Center for Bioethics study was the result of an eight-page survey of 2,711 physicians who were licensed in Wisconsin in 1995.

The study, led by **Robyn Shapiro**, JD, director and professor of Bioethics, was designed to analyze the prevalence and type of managed care arrangements and to find out what impact the arrangements have on physicians and their relationship with patients.

"Over the past several years, there have been frequent anecdotal reports about managed care's effect on health care delivery, but little data had been collected or analyzed. While some of our findings regarding the impact of managed care were predictable, the degree to which managed care has changed physicians' practices was something surprising," Shapiro says.

The researchers concluded that under managed care:

- Physicians have a greater likelihood to discharge patients prior to full recovery.
- Physicians now have a greater reluctance to make treatment decisions regardless of cost.
- Physicians now have a greater reluctance to refer patients to specialists or emergency departments.
- Physicians now have a greater reluctance to spend a comfortable amount of time with patients. ■

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NEWS BRIEF

AMA program provides compliance instructions

The American Medical Association (AMA) has launched a new on-line program to education physicians and their staffs how to comply with laws, regulations, and policy shifts that govern federal fraud and abuse enforcement activities.

The Compliance Interactive Tutorial System (CITS) provides guided instruction for physician practices on how to navigate America's highly regulated health care industry.

The program, which is for AMA members only, provides an Internet-based tutorial and reference system that offers up-to-date information on current fraud and abuse regulations.

"The vast majority of physicians are honest, hard-working professionals, who in the context of their demanding workload, face a considerable challenge in complying with 100,000 pages of health care regulations," says **Randolph D. Smoak Jr**., MD, president-elect of the AMA.

Program includes training modules

CITS provides a compliance training program that can be used without hiring outside consultants, he adds.

CITS includes training modules that provide a series of lessons on fraud and abuse guidelines. For example, the first module contains four lessons covering government audits, Medicare reviews, search warrants, and subpoenas. The lessons include questions that provide feedback for the user.

Users can obtain additional information through Internet links to other resources such as OIG Fraud Alerts, HCFA advisories, compliance integrity agreements, government regulations, and other sources.

Access is limited to AMA physician members and their staffs. Users can log onto CITS through the AMA Web site at: http://www.ama-assn.org/members.cits. ■

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