

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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California Groups Take Businesslike Approach

After prodding from state officials, medical groups in California are adopting more businesslike strategies, such as retaining earnings, building up reserves, conducting yearly financial audits, and identifying and reviewing poor-performing contracts.

At the beginning of last year, after years of financial hard times for groups, the California Department of Managed Health Care introduced a financial reporting system for more than 200 large groups and IPAs that accept managed care risk. The new system has radically changed the methods that practices use to manage their finances, says Don Crane, president of the California Association of Physician Organizations. The association, in Los Angeles, represents 75 IPAs and large groups. The lessons the California groups have learned after instituting the new practices are instructive for medical groups nationwide.

Reporting Requirements

California groups now must report their ability to track future debts, their record of payments, and their cash on hand to meet current liabilities. About 90% of the groups have performed well on the first two indicators, but only 60% had enough cash on hand, state records show.

The state does not penalize groups that fail to meet the standards, but low-scorers are feeling the consequences, Crane says. Some health plans are not assigning new patients

to them, he adds. To conform to the standards, groups are keeping cash on hand, say Crane and others. Many medical practices are ending the tradition of distributing cash to members at year-end, a tax-avoidance strategy that left nothing in reserve. Also, modest reimbursement increases this year are making it easier to build reserves; however, some experts say that some practices may have to cut physician pay if they want to keep more cash on hand.

Cash Is King

Retaining an adequate amount of cash is crucial because cash is king in California's heavily penetrated managed care market, says Chris Ohman, president of CapMetrics, managed care researchers in Emeryville, Calif. Ohman is also the coauthor of a new study on group solvency for the California Health Care Foundation in Oakland.

Unlike fee-for-service reimbursement, capitated contracts leave physicians open to huge financial risks, such as an unexpected rise in utilization or reduced payments at year-end from risk pools, which can amount to millions of dollars, Ohman says. "Without sufficient cash on hand, if a capitation check from a health plan comes in late or is short, or if there is a surge in claims, a group could be in a lot of trouble," Ohman explains.

Many medical groups in California have been forced to close due to unexpected liquidity crises, say

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New Sources of Revenue Open Up Possibilities

After practicing internal medicine for 25 years, Richard Vernick, MD, has worked for the past six years as a consultant, helping to turn around distressed hospitals. He often finds that hospitals are losing money on the practices they have acquired, as much as \$200,000 per physician per year, Vernick says.

“One factor contributing to these losses is that the revenue for the ancillary testing the physicians were doing before their practices were acquired now accrues to the hospital, causing the physician practices’ bottom line to look worse,” Vernick explains. “Practices simply cannot make it on the basis of patient visits alone.”

One solution to the hospital’s problem is to put acquired practices back into private practice but make arrangements that allow physicians to continue to refer to the hospital. This strategy may call for the hospital to arrange new sources of ancillary revenue for the physicians so that the restored practices can quickly become financially self-sufficient.

One option for new ancillary revenue is office dispensing of medication, which we discuss in this issue’s commentary. Several companies—including Allscripts Healthcare Solutions Inc. and Physicians Total Care Inc.—have developed software that permits physicians to stock a limited inventory of drugs in their offices and to dispense these medications for a profit of \$2 to \$6 per prescription. The additional revenue ranges from \$8,000 to \$90,000 per physician, depending on the system and the number of prescriptions written.

Besides increasing revenue, office dispensing increases patient compliance. When physicians hand patients their medications and explain how to take them, the odds that patients will follow these instructions go up about 30%. Office dispensing also saves time for patients, who no longer need to wait at a pharmacy to get a prescription filled. In addition, prescription costs may fall by 30% to 50% because when physicians purchase drugs for their own inventory, they begin prescribing less costly but equally effective drugs.

In past issues, we have written about other ways physicians can enhance revenue and cut costs, such as speech recognition for dictation, computer-generated patient histories, paper templates to document E&M guidelines for various diseases, coding software, and handheld computers to capture charges. Such options all require doctors to change their current practice habits, and such change can be painful. But as Allen Wenner, MD, a family physician in Columbia, S.C., and a leading advocate of new technology, says, “Doctors will change when they are hurting enough.”



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Will Dispensing Make a Comeback?

By Richard L. Reece, MD, editor in chief

Among the factors currently causing an increase in the number of prescriptions written and filled each year are the aging of the population and the proliferation of new and more effective medications for a wide variety of conditions. This increase in prescription volume is creating an opportunity for physicians who are seeking to increase profit by dispensing medications from their offices.

A survey by Scott-Levin, researchers in Newtown, Pa., shows that in 1999 physicians wrote an average of 2,060 prescriptions each, and primary care doctors were writing an average of three prescriptions per patient. Last year, pharmacists were filling 3.1 billion prescriptions per year, and they are expected to fill 4.0 billion by 2003.

Prescription drugs have become one of the fastest growing segments of medical costs. Princeton University health economist Uwe Reinhardt, PhD, writing in the September-October issue of *Health Affairs*, says that prescription drugs accounted for 8.2% of total national health care spending in 1999, or 1.4% of the gross domestic product. He expects such spending to account for 14% of national health expenditures, and 2.2% of GDP, by 2010.

Necessity and Invention

The increased prescription load and the leveling off of pharmacy school graduates are causing shortages of pharmacists, reducing the number of hours that drug stores are open, and causing concern about dispensing errors being made by overworked pharmacists. As a result, there has been a movement toward more cooperation and collaboration among physicians and pharmacists, as well as toward making pharmacists part of the treatment teams in larger medical

institutions and in nursing homes.

This new environment has led to innovative approaches to prescribing and reducing errors. Many e-health prescribing companies are lauding the benefits of handheld computers for writing prescriptions, for checking drug interactions, and for routing prescriptions electronically to pharmacies. Another approach to physician prescribing, which has the potential

to route prescriptions electronically to pharmacies.

For some physicians, dispensing medications makes sense. Doctors are complaining of a squeeze on reimbursements from managed care, Medicaid, and Medicare; and of various administrative hassles that are increasing overhead, decreasing profitability, and reducing productivity. Primary care physicians, who prescribe

A number of forces are reviving an interest in office prescribing.

to create economic and turf conflicts between pharmacists and physicians, features software systems that enable physicians to dispense prepackaged drugs at the point of care.

This new software actually revives an old tradition. In the 1880s, 80% of doctors dispensed prescribed drugs in their offices; in the 1920s, 20% of physicians were dispensing. Several trends changed that tradition. Sharp increases in the number of new medications made it impossible for physicians to maintain drug inventories, states imposed regulations forcing physicians to meet pharmacy requirements, managed care brought in pharmacy benefit managers, and organized medicine raised ethical concerns about exploiting patients for profit.

System Solutions

But many current technological, consumer, and health system forces are reviving an interest in office prescribing. User-friendly and affordable software has been developed to make it practical for physicians to manage inventory, to track their own prescribing habits, to maintain patient medical records, to check for drug interactions, and, in many instances,

53.5% of all medications, perceive themselves to be in a low-margin business. To increase margins, physicians are hiring nurse practitioners and physician assistants, seeing patients in groups, using computer technology to increase the number of patients seen, and turning to ancillary services (such as dispensing) to enhance revenue.

What's more, there is a looming shortage of physicians, particularly specialists, to care for an aging population. The AMA says the number of applications to medical schools has dropped 27% since 1994. Medical schools say managed care, a wider range of job opportunities in other fields, and medical school debts averaging \$100,000 have pushed students away from medical careers.

A New Paradigm

"Point-of-care medicine" (which includes office dispensing) involves using new software and the Internet in physicians' offices to meet the needs of the patient, to satisfy the needs of the physician, to meet and satisfy the needs of both the patient and the physician *during the office visit*; and to access the latest scientific evidence and document the office

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visit completely and accurately.

The current system for prescribing and dispensing drugs does not fit this paradigm because the prescription is not filled during the office visit. Instead, the process of filling a prescription now generally requires approval by an insurer or pharmacy benefit manager (PBM) and the patient must travel to a pharmacy to pick up the prescription. Briefly, the current pharmacy system and distribution paradigm works like this:

- The manufacturer sends the drugs to the distributor
- The distributor sends the drugs to the pharmacy
- The patient sees the physician and gets a prescription

dispensing for profit is unethical and results in overutilization. Some charge that dispensing physicians are guilty of lining their own pockets.

What's more, having physicians dispense medications raises difficult turf issues, since some pharmacists view office dispensing as physician trespassing. They argue that physicians will prescribe only the drugs they stock in their offices, thereby limiting patient access to newer and better drugs. In fact, this is already happening at managed care firms that limit access to brand-name drugs. And, as a practical matter, most physicians who do not carry an indicated drug will simply refer patients to retail pharmacies.

helps to avoid the \$100 billion cost per year of noncompliance and medical errors, and that it increases physician revenue.

A Rocky Road

Currently, only about 7% of practicing physicians dispense drugs in their office. Among the reasons is the established tradition of using retail pharmacies as the central distribution point for prescription drugs. But also, physicians have ethical concerns, and they may be worried that the rising number of new drugs means they would need to keep large inventories on hand. They may also worry about the lack of sophisticated software for managing inventory.

Office dispensing offers several advantages to physicians, but it also raises some difficult ethical and turf issues.

- The insurer or PBM approves or denies reimbursement for the prescription (either in the doctor's office or later at the pharmacy)
- The patient travels to the pharmacy to get the medication.

The new dispensing paradigm is simpler and more straightforward:

- The manufacturer sends prepackaged drugs to the distributor
- The distributor sends the drugs to physician clients
- The physicians dispense medication to patients.

Naysayers, Yea-sayers

Paradigm shifts often create controversy, and office dispensing is no exception. A paradigm is a philosophy or a pattern that forms a generally accepted conceptual framework within which social and scientific tasks are carried out. A paradigm shift occurs when one goes outside of the framework, which is what dispensing drugs from the physician's office rather than through retail outlets is. Naysayers argue that physician

Then there are those who argue that office dispensing gives physicians too much control over patients. This argument, however, does not give enough credit to assertive baby boomers and the consumers who often insist on receiving the drugs they have seen advertised or evaluated in the media or on the Internet, and who may even switch physicians if they are denied those drugs.

The yea-sayers argue that physician dispensing increases patient compliance. Since 21% of patients never get their prescriptions filled (according to a survey by AARP, formerly the American Association of Retired Persons) and 30% fail to get refills (according to a survey published in *The Internist*), when patients leave the office with medication in hand, compliance soars, proponents of office dispensing argue.

Champions of office dispensing also say that it ends the risk of errors from illegible handwriting or sound-alike drugs, that it reduces prescription costs by as much as 50%, that it

In addition, there are regulatory and legal barriers to contend with. Some states—including Massachusetts, New Jersey, New York, and Texas—either ban the practice or make it difficult for physicians to dispense drugs in the office. (The Federal Trade Commission, however, has indicated that it regards laws against physician dispensing as an illegal restraint of trade.) But some shift from retail to office dispensing is likely to occur because 15% per annum increases in prescriptions drug costs are politically and economically unsustainable; and because noncompliance and prescription errors lead to drug reactions and deaths.

Once physicians buy their own drug inventories, they become acutely aware of prescription costs and cut back on the volume of drugs they dispense. But the quick and widespread use of office dispensing will be hindered by a number of factors. Many physicians will be unable to keep a large number of drugs on hand simply

because they do not have the room for them. What's more, physicians are generally slow to change and have been particularly reluctant to install the new computer systems needed to manage the information and invento-

ry for such an undertaking. Many physicians also will be concerned about turf issues that surely rankle pharmacists. For some physicians, however, dispensing medications may make sense because it can increase

profit while also helping to serve today's demanding patients.

—*Edited by Paula Grant, in Lincoln, Va. More information on physician practice strategies is available on our Web site (see page 16).*

Two Approaches to Office Dispensing

Even among proponents of office dispensing, there are variations in approaches. Physicians Total Care Inc., in Tulsa, Okla., and Allscripts Healthcare Solutions Inc., in Libertyville, Ill., are two companies that market prescribing systems, yet each has a different approach to physician prescribing and dispensing services.

Physicians Total Care

Physicians Total Care facilitates immediate dispensing of medications directly to a patient in the physician's office by purchasing prescription medications in bulk and repackaging them into individual prescription sizes for physician clients, who then dispense the medications by using the company's software.

PTC's software, says Warren Moseley, president of PTC, provides convenience for patients, lowers prescription costs, and allows physicians to earn \$4 to \$6 in profit per prescription. The software also processes refills. PTC provides all generic and brand pharmaceuticals, including over-the-counter products.

Physicians need the software, Moseley contends. "In any practice, you can find doctors who are spending 30 minutes to an hour each day on pharmacy issues alone," he says. "For every three doctors, one full-time equivalent is devoted totally to pharmacy issues at no additional revenue. Doctors are doing the work. They might as well deliver the product and get paid for it." PTC's system, he says, will help them to do just that. PTC focuses on the dispensing function and on having a high percentage of pharmacy benefit managers that process physicians' claims.

PTC charges a one-time licensing fee of \$4,000 per site, which can be paid back at \$1 per prescription. This fee does not include equipment costs—a handheld bar code scanner (\$150), a laser printer (\$300), and a PC, which most practices already own. There is also a \$175 monthly support fee.

Allscripts Healthcare Solutions

Allscripts Healthcare Solutions, a leader in the market

for physician dispensing with 12,000 users and \$55 million in annual revenue, has a larger and more ambitious vision that extends beyond just physician dispensing.

Over the last few years, Allscripts has acquired MasterChart (for handheld dictation and voice capture technology), Medifor (for customized patient education and care plans), and ChannelHealth (for clinical and productivity solutions for large physician practices and integrated health plans).

Allscripts has a series of physician productivity software applications, called TouchWorks, which are accessed using a wireless handheld device or desktop workstation. These applications automate the most common physician activities—including prescribing, capturing charges, dictating, ordering lab work and viewing results, providing patient education, and taking clinical notes—and enable a physician to take a modular approach to creating a complete medical record.

Allscripts charges an installation fee of \$2,000 per practice and about \$100 to \$350 per month for subscription fees, which depend on whether the practice already owns a handheld prescribing device, a desktop computer, and a printer.

A Return on Investment?

Measuring the return on investment for physician investment in dispensing is not easy; doing so involves looking at both profits on individual prescriptions and intangibles, such as the efficiency and productivity that result from the complex practice system changes required.

So, will the efficiencies and potential revenue promised by companies such as PTC and Allscripts lure physicians into office dispensing? Perhaps. Squeezed by managed care and Medicare, physicians are seeking additional sources of revenue. What's more, if the new software makes it easier to handle inventory, label prescriptions, and manage patient medications, as proponents claim it does, it may also make serving assertive baby boomers and other patients who demand more value-added services easier, too. —RLR

Get the Most From Receivables

For most physicians, one of their largest assets is their accounts receivable. Interestingly, a practice's poor financial performance often stems from a failure to manage this asset so that it provides the best possible return.

For most medical practices, the common thread of poor performance involves weaknesses with respect to appropriate accounts receivable management. Often, receivables are unmanaged, as opposed to mismanaged, many times because of understaffing in this most important area. Although many successful physicians are at maximum capacity with respect to their patient volumes, some physicians have shown that they can improve financial performance by managing receivables more closely, even in an era of increasing governmental regulations and declining reimbursement.

Strategic Priority

The Medical Group Management Association, in Englewood, Colo. (on the web at www.mgma.com), reports in its publication, *Performance and Practices of Successful Medical Groups: 2000 Report Based on 1999 Data*, that the most important strategic priority of successful medical practices involves appropriate accounts receivable management.

John W. McDaniel is president and CEO of Physician Management Group Inc., physician practice improvement advisers, in New Orleans. This article is the third in a series of articles on high-performance physicians. For more information regarding profitability profiles of high-performance physicians, readers may contact McDaniel by phone at 800/764-2633, or by e-mail at pmgcode@eatel.net. More information on practice management is available on our Web site (see page 16).

Yet, for the average medical practice, there are many reasons receivables get out of hand. Among them are the following:

- Neglecting critical information from insurers and patients
- Failing to examine claims and claims-edit reports
- Failing to monitor return mail
- Neglecting to closely monitor reasons for claim denials and rejections

Often physicians fail to manage accounts receivable, and typically the failure to manage these accounts results from understaffing in this most important area of operations.

- Misinterpreting performance indicators (such as percentage of total accounts receivable more than 120 days old)
- Failing to adopt a disciplined approach to the follow-up needed to manage collection calls and letters to patients and insurers
- Failing to send accounts to collection agencies promptly.

Since most claim rejections and denials are the result of processing errors in the front office, appropriate revenue cycle management must be obtained with respect to the following areas:

- Patient scheduling and registration
- Insurance verification and eligibility
- Over-the-counter collections for copayments, deductibles, and outstanding balances
- Coding validation
- Charge entry
- Referral management.

When managing accounts receivable, high-performance physicians use the 80-20 approach. In effect, 80% of accounts receivable comes from approximately 20% of all accounts. In particular, this rule holds

with respect to insurance accounts in excess of 60 days old.

Getting Prompt Payment

A two-pronged approach to managing accounts receivable is imperative. First, physicians should review separate aged trial balances by insurer each month for appropriate follow-up whenever an account is more than 30 days old. Second, the prac-

tice should be familiar with and use the appropriate state prompt-payment laws in order to ensure that it gets prompt and appropriate payment from all third-party payers.

When dealing with patient accounts, statements should be sent every 30 days. If no payment has been made after 90 days, the patient should be sent one final demand letter, either requesting payment in full or asking the patient to contact the office to make payment arrangements. If the patient does not respond within 10 days, the account should be referred for outside collection.

Indeed, high-performance practices typically have written financial policies and procedures to outline these approaches to accounts receivable. Furthermore, appropriate write-off processes should be defined and followed so that the practice can expedite the accounts receivable process.

One little known strategy that can be useful for practices in this area involves Form 1099-C from the Internal Revenue Service. Under this strategy, a physician may notify the debtor (that is, the nonpaying

Form 1099-C from the Internal Revenue Service can be useful for physicians seeking to report income to an individual regarding cancellation of debt.

patient) that the cancellation of debt is being reported as income to the patient unless payment in full is received or appropriate payment arrangements are made.

In order to report income to an individual regarding cancellation of debt, the following conditions must be met:

- The account must be at least \$600
- The account must be canceled and returned from a collection agency
- The physician must have determined the account to be uncollectable during the current year
- The practice must be giving up on trying to collect the account
- The practice must be writing off the account or removing it from the books.

Since most people do not relish the thought of being reported to the IRS, nor do they want to pay taxes on "phantom" income, such as when a debt is canceled, this strategy may be useful in collecting large outstanding balances.

Making Arrangements

Another technique practices use involves making structured patient payment arrangements. Since some patients may have difficulty in satisfying their account balances on a timely basis, the practice can establish structured payment plans and monitor the frequency at which the patient has promised to pay the respective account. Such an account should be suspended from any collection activities as long as the patient makes monthly payments under the prearranged agreement with the practice.

Since there is a wealth of management reports available to most practices with respect to the appropriate monitoring of accounts receivable (such as days in accounts receivable or percentage of accounts receivable in excess of 90 days), the practice should ensure that its respective accounts receivable fall within acceptable parameters. The practice also should use these benchmarks to monitor all management personnel within the practice.

High-performance physicians invest in areas with the greatest opportunity for return on investment, such as the time and talent necessary to maximize one of the greatest assets within the practice. ■

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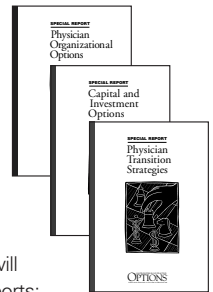
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Changes Sweeping Over Medicare

By Kristin Crosby, MD

Not long ago, the typical Medicare beneficiary was likely to be characterized as a grandmother knitting in a rocking chair. Soon, that beneficiary will likely be stereotyped based on a new reality—one resulting from the millions of baby boomers who are passing age 50 and beginning to retire. These new Medicare enrollees—whose lives often involve remarriages, new careers, and various hobbies—join the most rapidly growing segment of the Medicare population; that is, senior citizens aged 65 and older—referred to as the “old old”—who frequently have multiple diseases and related illnesses.

This trend—involving both the “new old” and the old old Medicare enrollees—will force physicians to adapt to the myriad changes affecting these beneficiaries. In addition to providing the health care and customer service that these patients need, physicians will have to understand the complexities of Medicare plans and ensure that their practice systems and office procedures meet both their own operational needs as well as federal, state, and other regulatory and compliance mandates.

Kristin Crosby, MD, is chief medical officer of the Sterling Life Insurance Co. in Bellingham, Wash. In December, Health and Human Services Secretary Tommy G. Thompson appointed Crosby to serve on the Secretary's Advisory Committee on Regulatory Reform, which will help guide HHS' efforts to streamline unnecessarily burdensome and inefficient regulations. Readers may contact Crosby by e-mail at Kristin_Crosby@asg.aon.com. and by phone at 360-647-9080. More information on physician practice strategies is available on our Web site (see page 16).

Expanding Services

The demographic information on people aged 65 to 75 who are eligible for Medicare today shows that they differ vastly from their counterparts in previous generations. Today's seniors are likely to be informed health care consumers who have an active lifestyle and are interested in exploring ways to stay vigorous. These seniors need a health plan that addresses such a lifestyle. At the other end of the Medicare life-span spectrum are the seniors who need information on home health care, as well as health plans that provide extended hospitalization, low copayments for office visits, and affordable prescription drug coverage.

To help ensure that they have the programs and provide the services to

Physicians should also scrutinize what a visit to their office is like from their senior patients' perspective. In addition to gauging the typical length of time patients spend in the waiting room, physicians should determine whether the chairs in the waiting room are comfortable for seniors and are arranged to allow them to maneuver safely and easily. Other factors to consider include whether the room temperature is warm enough and whether brochures and other information are legible and easy to read.

The Types of Plans

Since the Balanced Budget Act was enacted in 1997, the Medicare marketplace has experienced a number of changes. The Medicare+Choice pro-

The typical Medicare beneficiary will soon be stereotyped based on a new reality resulting from the millions of baby boomers who are passing age 50 and beginning to retire.

meet the needs of all Medicare-eligible seniors, physicians should conduct an audit of their patient records. Many automated patient record systems can compile reports on the average age of patients, the types of illnesses or diseases that present most often, and the average number of visits and waiting time. If an analysis of these records indicates that a significant number of patients in the physician's practice are over age 65 and have diabetes, congestive heart failure, coronary artery disease, hyperlipidemia, or other illness, physicians can obtain standardized educational materials, including brochures and videos, to provide these patients with additional information on their conditions.

gram, which was authorized by the BBA, has had a dramatic effect on both the type and the scope of Medicare plans. The initial goal was laudable: to increase the health care choices available to beneficiaries by giving private health insurers more options and incentives to provide Medicare coverage. By 1997, 15% of those eligible for Medicare belonged to a Medicare HMO, and 90,000 were signing up to join each month.

Initially, Medicare HMOs provided rich benefits, including prescription drug coverage and low premiums. However, rising prescription drug costs and increased medical utilization, coupled with reimbursement levels that many physicians and

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Initially, Medicare HMOs provided rich benefits. However, rising prescription drug costs, increased medical utilization, and reimbursement levels that many physicians and health plans believed were inadequate soon caused many plans to exit this market.

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health plans believed were inadequate, soon caused many plans to exit this market. In other cases, some Medicare+Choice HMOs raised premiums and reduced benefits. This volatility in the Medicare market resulted in more than 500,000 Medicare beneficiaries being dropped by their health plans in January, leaving 5.6 million enrollees in 179 Medicare+Choice plans.

Now that a significant number of Medicare+Choice HMOs have left this market, many Medicare enrollees must find new health plans and therefore new physicians or find plans that will allow them to stay with their current doctor. This exodus of Medicare plans also has significantly affected many physicians nationwide. They must now determine which Medicare plans they will accept and which ones no longer meet the needs of their practice or their patients.

Many companies currently provide Medicare supplement plans, which cover expenses not covered under Medicare Parts A and B (such as an \$812 deductible for hospital admissions in 2002 and 20% coinsurance for physician services). Some health plans are moving from an HMO approach to a PPO or a POS plan design for Medicare coverage. These plans are allowed under the Medicare+Choice regulations. One of the newest plans is called private fee for service. PFFS plans are offered by private insurers. Currently one PFFS plan, Sterling Option I, has been approved by the federal Centers for Medicaid and Medicare Services (CMS).

The current PFFS plan reimburses providers on a fee-for-service basis—

typically at standard Medicare levels. Among the benefits for physicians are that they are not required to join a network, and there are no requirements for utilization review or prior authorizations for hospital admissions and specialty referrals. In addition, patients, who make a \$20 copayment to their physician, are allowed to go to any physician or other provider that accepts Medicare and agrees to the plan's terms and conditions. Although the PFFS plan does not provide pharmacy benefits, it does make available a discount drug card. It also has disease management programs, voluntary care coordination, a nurse advice line, and unlimited hospital days.

Uncertainty in the Medicare marketplace and the number of plans still available leave physicians with important decisions to make regarding their participation in this market. Many physicians who have a small population of Medicare beneficiaries may simply choose not to accept Medicare at all. For other physicians, the decision may be more complex. Among the factors physicians should consider in their evaluation of this market and the plans included in it are those discussed below.

Plan Suitability

In evaluating the available Medicare plans, physicians should conduct a careful analysis of the companies behind the plans and the features being offered in order to determine which plans are suitable for their practices and will meet the needs of their patients. For example, is the company offering the plan financially viable, experienced, and reputable? Even new

plans could be the products of companies that have considerable experience in this market. What's more, as many Medicare+Choice HMO plans move toward a PPO option, physicians who have been unhappy with the service provided by the HMO may want to consider whether to join the PPO or POS version of the company's Medicare program. In general, these plans will likely have many features that are attractive to both physicians and plan members.

A second factor for physicians to consider in evaluating a plan is whether they would be required to join a network in order to participate in the plan. For example, must they sign a long-term contract or a contract with restrictions and limitations? Many Medicare+Choice plans require long-term contracts or have network restrictions. Under CMS guidelines, PFFS plans do not require physicians to join a network or to sign a contract. Also, they allow physicians to stop and start seeing enrollees whenever they want to do so.

Billing and Coding

Proper billing and coding are crucial factors affecting a practice's cash flow and profitability, therefore, a plan's claims-paying procedures are an important part of the plan review. What, for example, is the plan's claims-paying experience? Some plans have a history of promptly paying all clean claims; others continually request more information or use similar tactics to delay payment. Typically, the less oversight the plan requires, the more readily claims are paid.

Physicians who process claims

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Ohman and others. The California Medical Association (CMA), in San Francisco, reports that since 1998, 41 groups have gone out of business due to financial problems.

But the California groups chafe under the new state requirements, blaming their liquidity problems on low reimbursements from health plans. In the 1990s, Ohman and others report, California HMOs reduced premiums by 16.5%, meaning they were paying physician groups 20% to

“All of a sudden you get a new leak in the bucket” in the form of interest payments on the loans, he adds.

To be sure, it will take years for groups to amass the required reserves, says the CMA. In statements issued previously, the CMA says that many groups were not designed to accumulate capital because they were meant to be “financial pass-through organizations” that enabled small practices to contract with HMOs. Despite its stand on the reserve issue, however,

Bryn Henderson, DO, president of ITA Healthworks, a practice management consultancy, in Orange, Calif., recommends specific levels of working capital for immediate crises and long-term reserves for deeper emergencies. One rule of thumb for adequate working capital, he says, is to retain enough to cover anticipated expenses for one month plus 30%. Alternatively, adequate working capital could be enough to cover anticipated expenses for one month plus the average margin of error resulting from projecting the practice's anticipated expenses in the previous 12 months.

To build reserves, Henderson suggests that groups set aside the equivalent of three months of gross income, which the group can do over two years. To avoid taxes on retained earnings, Henderson says, reserve funds could go into a tax-deferred account. If the practice needs its reserves, a bank can issue a line of credit against the account for that amount rather than move the funds out of the account.

Unfortunately, physicians may have to take a pay cut to establish reserves, but many can afford to do so, says Unger. “Physicians are still very well compensated within society's structure,” he comments.

Two-thirds of the groups Ohman studied could meet solvency standards if they set aside less than \$2.50 per member per month out of a capitation rate of \$10 to \$60 PMPM, he says. Since reimbursements are currently rising, this amount would not have to come from reducing medical expenses, he adds.

A Business Mentality

But financial experts say the struggle among California groups for financial health goes deeper than simply building reserves: It requires physicians and group administrators to approach their practices as a business.

“Having managed care contracts means that you are in the business of

To conform to new state standards, medical groups are keeping cash on hand, in part by ending the tradition of distributing cash to members at year-end.

25% below what many groups were getting in other parts of the nation. Reimbursements rose modestly in 2001 for the first time in years, and experts do not expect to see big increases in the future.

Just Passing Through

California medical groups will need to set aside \$190 million to reach adequate reserve levels, Ohman predicts. He advises the groups to pump this year's enhanced reimbursements into their reserve funds. But the groups counter that they have other needs for this cash, such as purchasing new equipment and hiring new staff.

“There is no need to retain \$10 million in earnings,” says Michael Gam, chief financial officer for Talbert Medical Group, a 110-physician multispecialty group in Costa Mesa, Calif. “All that is needed is to have some money tucked away for a rainy day.” He would not reveal Talbert's reserve level, but he did say it had met state requirements.

Some groups have had to borrow money to meet state liquidity levels, creating yet more debt, says Crane.

the CMA did not challenge the need for reserves.

The CMA is challenging a provision that would allow state officials to reveal details about groups' finances rather than just saying whether they have met reserve levels, as they do now. The CMA is suing the California Department of Managed Health Care to prevent this action, claiming that full disclosure would give health plans access to too much information for contract negotiations. In September, a state judge ordered the case to trial and temporarily barred the department from releasing the information.

Building Reserves

While many groups question the need for big reserves, practice management advisers embrace the idea. A lack of adequate reserves is “one of the largest single mistakes a medical group can make,” says Walter Unger, a practice adviser at Unger & Associates in Laguna Niguel, Calif. “Any business needs retained earnings because at some point it will probably be in a liquidity crisis. Retained earnings give the group financial resiliency.”

Consultants recommend specific levels of working capital for immediate crises and long-term reserves for deeper emergencies. One rule of thumb for adequate working capital is anticipated expenses for one month plus 30%.

managing care,” says Beau Carter, executive director of the Integrated Healthcare Association, a firm in Walnut Creek, Calif., that is run by health plans, IPAs, and others to better understand managed care.

Audit Standards

But many physicians do not view their practices as businesses, Carter adds. Although state officials instruct groups to conduct an annual financial audit, an accepted norm in other industries, some groups balk at the expense of doing so, he says.

“It staggers me that physicians say, ‘I don’t want to pay the \$40,000 that it will cost me to conduct an audit,’ when \$40,000 is a fraction of what a group could lose by failing to track its finances,” he says.

Ohman’s study found that groups conducting annual audits had generally better liquidity. Though an audit will cost money that may have to come from cash reserves, Ohman says, simply having an audit performed may indicate that a group is committed to a sound financial strategy.

An audit can cost as little as \$1,000 for a small group, but it can cost much more if a group’s finances are disorganized, comments Henderson. Henderson suggests that groups hire a certified public accountant—who may charge \$150 an hour—to conduct a quarterly review, an annual visit, and an audit.

Another step California groups can take to improve their financial situation is to gain more control when negotiating a managed care contract, an important ingredient of financial success. At one time, groups would sign any contract, Carter says.

“They thought, ‘I’ll sign the bad contracts but I’ll make up for doing so with another commercial carrier or in Medicare,’” he explains. When the good contracts did not come, groups had significant losses, he adds.

But after feeling the consequences of having negotiated poor contracts in the past three to five years, Carter says, groups are examining contracts more closely, forcing plans to remove bad risks. They are even eliminating

manage, and most groups have abandoned it, Unger says.

Contract Leverage

Groups that want to continue holding difficult risks should buy reinsurance so that they can share catastrophic losses with an insurer, Unger advises.

As many physicians have found, monthly capitated payments offer some financial stability, but they tend to be lower than an equivalent fee-for-ser-

Groups that want to continue holding difficult risks should buy reinsurance so that they can share catastrophic losses with an insurer, Unger advises.

contracts when they can afford to do so. Today, groups have better tools at their disposal, he adds. Many still do not hire actuaries to help them set payment levels because such consultants are expensive. But some groups are using Web-based calculators to help them negotiate more equitable capitation rates.

Groups should also consider dropping pharmacy risk from capitation contracts, Unger says. In addition, they should not provide out-of-service-area care or contract for small books of business, he adds. They also may want to eliminate hospital risk, depending on the contract. These difficult risks not only raise a group’s total capitation payment, but also have the potential to increase losses sharply. In particular, pharmacy risk is difficult for a medical group to

vice reimbursement, Henderson says. For this reason, he advises groups to limit their HMO business to 30% of patients whenever possible. “A primary care physician should be getting 10% to 12% of the HMO premium, but these days a PCP is lucky to get \$10 on a \$130 premium,” Henderson says.

In any case, no physician should rush or be hurried to sign a contract, Unger adds. “Don’t sign under duress, without legal, financial, or actuarial advice,” he advises. “I have seen contracts that were written in the 11th hour just before expiration of the existing contract or without legal counsel. These are absolute recipes for disaster, and they frequently go into litigation.”

—Reported and written by Leigh Page, in Oak Park, Ill. More information on physician practice strategies is available on our Web site (see page 16).

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electronically should also determine whether the plan does so as well. If it does, physicians should ensure that the two systems are compatible. If the systems are not compatible, the plan may be willing to help offset the cost of such compatibility.

Proper billing and coding involve not only software systems but also the office staff. Physicians must determine whether their staff understands how to bill the various plans and how to code claims properly. PFFS plans, for example, require a copayment. To receive this fee promptly, physicians should make sure that their staff collects the fee when patients register for their office appointment.

Physicians and their staff must also stay on top of Medicare coding changes, which promise to become more complex in the coming years. ICD-9 codes, for example, are scheduled to change completely in 2003.

Recognizing the complexity of

resources for finding out more details about recent Medicare changes.

There are other changes for physicians to consider as well, such as those required to meet the new privacy guidelines under the federal Health Insurance Portability and Accountability Act (HIPAA) or the new compliance rules from the federal Office of the Inspector General. Since many physicians are concerned about the possibility of penalties for innocent billing errors, it is of vital importance that physicians and their staff understand and comply with all new regulations. As a first step, physicians can conduct an audit, preferably through a reputable consultant, to identify any problems in their practice.

Physicians should also be prepared for their Medicare patients to change plans. Whether by necessity or by choice, thousands of Medicare enrollees will be changing plans over the next six to 12 months, so the

tion drug program, although some of these plans have recently reduced their benefits or switched to a generic-only formulary. For many patients, access to some type of prescription drug coverage could be an important feature in their health plan choice.

Factors to Consider

Cost, however, is the critical issue for most patients. Many Medicare HMOs offer low monthly premiums but provide limited hospitalization or limited coverage in skilled nursing facilities. Therefore, plans that have higher premiums but richer hospitalization benefits may be much more affordable in the long run. Patients should consider all the advantages and disadvantages of each plan. In helping their patients determine the important factors to consider in selecting the right plan to meet their needs, physicians should be honest regarding their potential plan choices, particularly regarding plans the physicians will not accept. Often, patients would rather switch their plan than change their doctor.

The exodus of Medicare+Choice plans from several major markets nationwide and the uncertainty over Medicare regulations and future plans will continue to have an effect on physicians across the country. As the patients who are eligible for Medicare seek advice and reassurance from their physicians, some physicians may see the ongoing changes in the market as an opportunity to retain existing patients and add new ones. The physicians who take the steps necessary to ensure that they and their staff understand the changing needs of Medicare patients and the Medicare market will accomplish two important goals. First, they will help to ensure the financial viability of their practice; and second, they will be able to continue to provide the services these patients require.

—Edited by Paula Grant, in Lincoln, Va.

Some physicians may see the changes in the Medicare market as an opportunity to retain existing patients and add new ones.

Medicare billing today, some physicians may opt to use an outside billing service. Such a service can be particularly useful for physicians who want their office staff to focus on patient care rather than on administrative activities.

More Changes Ahead

In addition to the characteristics of individual plans and their specific offerings, physicians should also be aware of changes to medical testing and other services that Medicare will cover. For example, in July, Medicare began to cover screenings for colonoscopies, even for patients not considered high risk. CMS, national and state medical associations, and private consultants offer information and

front office staff should make a point of asking Medicare beneficiaries if their plan has changed and verify plan identification cards every time a patient visits the office. (In this regard, copayments may be required now whereas no copays were required in the past.) If the patient has changed plans, the office staff should be sure to have the patient sign a release of information form giving the practice permission to provide patient information to the insurer so that the bill can be paid.

Physicians should be familiar with the features and benefits of a plan to determine how it will meet the needs of their patients. Take prescription drugs, for example. Many Medicare+Choice plans still offer a prescrip-

Some Groups Offer Important Lessons for Success, Consultant Says

Walter J. Unger, MBA, is a principal of Unger & Associates, a health care consulting group, and president and CEO of the Stratos Institute for Healthcare Performance, both in Laguna Niguel, Calif. An expert in the financing of health care services, Unger has spent 32 years in health care. He served as special assistant to the president at the National Academy of Sciences' Institute of Medicine and as associate director at the Healthcare Financial Management Association in Washington, D.C. Unger discussed the latest issues in health care with Richard L. Reece, MD, editor in chief.

Q: Can you describe the Stratos Institute for Healthcare Performance for us, please?

A: The institute creates, produces, markets, and distributes high-level health care education programs for physicians, nurses, and other health care professionals in the United States, Canada, and England. All programs are fully accredited continuing education programs that incorporate a video program, a lesson guide, and a facilitator's guide. The programs allow health care professionals to take "visual field trips" to see America's benchmark facilities and practices.

The Stratos Institute (on the web at www.stratosinstitute.com) also produces, markets, and distributes Medical Group Focus, a series of continuing education programs that seek to provide role models for medical practices so that they can learn the processes used by some of America's most successful medical groups to achieve extraordinary results. In this context, a medical group is defined as an organization that is devoted to pro-

viding patient services that meet the health care needs of individuals and families and is an organization that employs three or more physicians under common ownership with a common distribution of financial results.

This video education series is based on the empirical research performed by the Medical Group Management Association (MGMA) in Englewood, Colo. The research is published in an annual report, *Performance and Practices of Successful Medical Groups*.

The report provides statistical data comparing the results of the most successful medical groups in this country with all others, based on a large survey data collection effort that has been ongoing for years. The report examines costs and profitability and delineates medical groups that are the most successful financially. It is important to note, though, that we cannot posit from this information that these groups are the most successful clinically or produce the highest quality results.

In the majority of medical groups, economic success translates into extremely high incomes for the participating physicians, particularly the partners. Inasmuch as the vast majority of medical groups in this country are organized as private for-profit businesses, all physicians—and particularly physicians who are in medical group practice—should be keenly interested

in the report's results and in understanding the role models that Medical Group Focus provides. Physicians can use this series for staff development and training and to motivate their entire team to achieve economic success. Financial success, along with human resources, is a key element in making innovation and quality improvement possible.

Q: One group highlighted in the videos is the Hedges Clinic in Frankfort, Ill. What lesson for business success does it offer?

A: The Hedges Clinic has been in the top tier for several years in the category of profitability and cost management. It has done well in other criteria as well, including accounts receivable and collections management, productivity, capacity and staffing, and managed care operations.

Hedges Clinic is a relatively small clinic in a relatively small town. It includes one part-time and eight full-time physicians, and a staff of 60. The patient coverage mix is 73% point of service or PPO, 13% Medicare, 11% capitated, and 3% IPA. It is a primary care-based group that includes family practice, internal medicine, pediatrics, and ob-gyn, and has one general surgeon.

Because of its size, the Hedges Clinic is representative of many medical groups nationwide. But a major factor that has made it successful is that it budgets for profits. In other

(Continued on page 14)

"A major factor that has made the Hedges Clinic successful is that it plans to make profits and has a business plan that specifies profits as a specific element of its business objective."

Without using the powerful tools that exist today—sophisticated computers, software programs, and the electronic transmission of data—physicians can't manage billing and collections optimally. The age when financial management can be done on paper is past.

(Continued from page 13)

words, it plans to make profits and has a business plan that specifies profits as a specific element of its business objective.

Q: Another group that is profiled in the video series is the Collom & Carney Clinic Association in Texarkana, Texas. What lesson does this group offer?

A: The Collom & Carney Clinic Association is a multispecialty practice with 13 locations, 69 physicians, and a staff of 450. In selecting doctors to join the clinic, its physicians place a high priority on doctors who have a strong work ethic and a value structure that emphasizes quality of care and patient satisfaction. The extraordinary success of this group is largely due to its extremely careful selection of physicians.

Q: What is the lesson offered by the Valley Medical Center PLLC, another subject of the videos?

A: The Valley Medical Center in Lewiston, Idaho, has had extraordinary success in managing its accounts receivable and in collecting funds from patients who have asked to have either themselves or their third-party insurers billed for the services. This group includes 27 physicians, three mid-level practitioners, and a staff of 121. Its revenues total about \$12 million a year.

This group, which has achieved an incredibly low number of days outstanding in accounts receivable, has used multiple strategies to attain this success. First, it places an enormous emphasis on front-line staff to collect all of the third-party payer data necessary for billing and to ensure that these data are updated during every patient visit. That is important because

patients often move, change jobs, or work for employers that may frequently change insurance contracts. Ensuring correct data requires vigilant front-desk personnel and an alert nursing and medical staff. Furthermore, a group should have an ombudsman who can assist patients who have gaps in insurance coverage or are without insurance to identify possible sources of public or charitable funding for payment of their medical bills.

Second, the Valley Medical Center sends its claims out fast and clean, which means that the claims are paid quickly. This means that all of the data on the health insurance claim are correct when the claim is submitted, and the claim is submitted electronically. An enormous number of medical groups fail to get their claims out promptly. But if physicians don't bill quickly, they can't collect quickly. Furthermore, the longer an account remains outstanding, the less likely it is to be paid.

Third, on the collection side, this group has devised a host of operational policies for collecting from patients, especially in many areas that represent enormous challenges for medical groups, including patients who have filed for bankruptcy, and minors of divorced parents who are in conflict over who has financial responsibility. The Valley Medical Center has policies and procedures to deal with such issues, and holds regular ongoing staff training to ensure that everyone in the medical group is familiar with them.

By employing these as well as other strategies, the group has tremendously expedited its cash flow, a fact that

has also materially contributed to its profitability.

Q: How important are computer systems to this multi-pronged approach?

A: Computer systems are fundamental to the process. We often notice that the less successful medical groups underinvest in core productivity and proficiency-enhancing technologies. Both hardware and software are important, but the greatest emphasis should be on the software. We are, after all, dealing with very substantial amounts of data.

Without using the powerful tools that exist today—sophisticated computers, software programs, and the electronic transmission of data—we can't manage billing and collections optimally. The age when financial management can be done on paper is past.

Q: How important is thorough documentation of the patient-physician encounter?

A: Careful documentation on the patient chart of all services provided is always one key to success in a medical group's financial transactions. Technically, from the third-party payer's point of view, a service was not performed if it was not documented in the patient's chart.

In fact, it is important to document all diagnoses on the chart because payers require that physicians document the procedures performed as well as the relevant clinical conditions. Most third-party payers have software that matches clinical conditions using ICD-9 codes to the CPT codes for the procedures that were performed. If the codes do not match,

then the claim will be rejected.

This documentation requirement means that it is of paramount importance for medical groups to have sophisticated computers systems. Most of the advanced automated medical billing systems have a field that will pop up and indicate whether there is a match between the procedure or procedures performed and the diagnosis. This allows the medical group to correct any discrepancies before the claim is submitted.

That function enhances the probability of generating a clean claim, which then generates a quick payment. In addition, doing things right the first time can substantially reduce costs. It is extremely costly when a claim is rejected because it was inherently flawed or incomplete, because refiling that claim will require pulling the medical chart again and sending attached files that may require paper submissions to support the claim.

These steps take time and effort and, most important, delay the collection of reimbursement owed to the physicians for services provided. It is important that the records be maintained contemporaneously so that no services are inadvertently omitted during the documentation process.

Q: Finally, let's discuss Alton Multi-Specialists in Alton, Ill., which the video highlights because of its systematic approach to negotiating and monitoring managed care contracts. What are the key factors in this group's success?

A: Alton Multi-Specialists has two practice locations and 22 physicians. It receives 49% of its net revenue from capitated payer sources. This group has organized itself well in order to contract for managed care services, perform those services, and assess its performance for the purpose of determining whether the group should recontract or modify the contract.

The group is sophisticated in terms of its management and analysis capabilities and its clinical and financial

data collection. In addition to these internal capabilities, it has taken significant advantage of external consulting services. For example, prior to entering into any contract, the group uses actuarial consultants who review and assess the risk that entering into that contract might involve for the practice.

Q: What are the most important things for physicians to understand in terms of managed care contracting risk?

A: Carefully considering risk is crucial to any medical group that is involved in managed care contracting. Remember, managed care

can unfortunately have a very small number of patients in a defined population who can consume an enormous amount of medical resources, and often a very small number do consume the bulk of all resources. One premature birth, for example, can ruin a practice's finances.

Medical groups must try to determine in advance the probability of having high-cost users in the defined population, and create a system for managing such patients. One such system is to reinsure for excess liability in order to offset the risk that the medical group is assuming. Unfortunately, a remarkable number of medical

“Medical groups should employ actuaries and insurance consultants before entering into any managed care contract.”

contracts inherently transfer underwriting risks from the insurer to the medical group, and they might transfer several types of medical risks as well.

The most dangerous type of risk is utilization risk. If the amount of services being consumed by the defined population specified in the medical group's contract far exceeds what the group has budgeted, the group will incur a loss.

If, on the other hand, the group can provide all of the services required under the contract for fewer resources than what was budgeted, the group profits from the contract. To determine utilization risk in advance, physicians must understand the risks they are assuming as well as have a system in place to manage those risks.

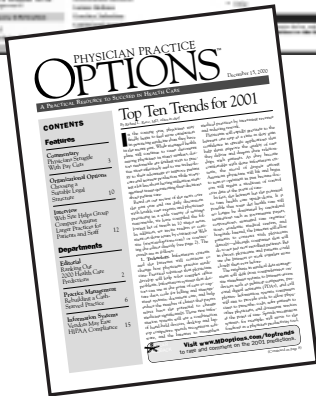
The inherent problem in all risk contracts is the law of large numbers versus the law of small numbers. Any medical group that is assuming underwriting risk for a relatively small number of people increases its risk because of the greater possibility of adverse selection. Medical groups

do not consider reinsurance, which is widely available for medical groups that want to offload a portion of the financial risk of having a relatively small number of high-consuming patients. Therefore, medical groups should employ actuaries and insurance consultants before entering into any managed care contract.

Finally, some groups also contract for pharmacy risk, which is extremely hazardous in a contract due to highly unpredictable swings in drug costs. Recently, there has been an explosion in pharmaceutical costs, particularly brand-name and new drugs. Pharmacy risk is beyond what most medical groups are truly able to manage. I recommend that most medical groups avoid contracting for pharmacy risk unless they are very large, are dealing with very large patient populations, and have a substantial track record for managing their contracts well.

—Edited by Deborah J. Neveleff, in *North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

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