

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Maximizing Reimbursement Requires the Right Systems, Properly Trained Staff

By Beth Freeman

As any physician will tell you, the billing process has become much more complex than it was in the past. Most practices have many payers, contracts, and fee schedules, and often individual payers have several coverage options. Reimbursement methods can range from full capitation to discounted fee for service, and many plans are hybrids with many differing components. As a result, an accurate and timely information system is a necessity today.

Since computers excel at storing and manipulating large amounts of detailed data, they are the tool of choice for managing the complex processes involved in billing and receiving payments. But successful management of the physician billing process requires not only selecting and implementing the right information system, but also hiring and training billing staff who understand the financing mechanisms of managed care.

An excellent office staff that understands billing, compliance, what codes can be billed, and what codes cannot is crucial to a physician's billing process. But if the staff is also unaware that both capitated and non-capitated services may be covered in the same contract, or if they assume—without verifying—that all payments are correct,

the practice could lose income to which it is entitled. It is never safe to assume that a physician is being paid correctly. What's more, since almost all managed care contracts say that the physician must appeal payments within 90 days, mistakes are more difficult to correct after three months than they are when the payment is received. Therefore, every physician practice needs to have a system that identifies mistakes quickly and acts on them immediately.

Whether a practice is evaluating its current billing system, planning an upgrade, or purchasing a new system, both the information system components and the billing processes are critical factors to be considered. All practices must be able to combine data from the billing and cost accounting systems to ensure that each contract is well managed and remains financially sound. At a minimum, each practice should perform the following five steps to ensure that all payments are received and recorded correctly:

1. Register all necessary data
2. Do accurate and timely billing
3. Collect the full amount due
4. Maximize income
5. Use reports to manage the practice

Register All Data

This step defines the key data that a managed care billing information system must collect. Multiple payers, products, and fee schedules, for example, must be identified and the necessary data entered. Often, not only are there numerous separate payers,

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Aetna's Drive to HMO Dominance Bears Watching

Richard L. Huber, chairman and CEO of Aetna Inc., faces a difficult task. Many physicians have rejected Aetna's prices and contracts, and the AMA is challenging Aetna's proposed purchase of Prudential HealthCare.

In December, the AMA asked the U.S. Department of Justice to investigate the proposed merger of Aetna and Prudential, arguing that the merger is anticompetitive and would limit the choices of patients and businesses seeking to choose a health plan. A department spokeswoman said the Antitrust Division is investigating the merger.

"The market power that would be created or exacerbated by this merger would ... further erode the ability of physicians to make medical decisions based on science and the medical needs of their patients, not share price," said the AMA in a letter to Joel I. Klein, head of the Antitrust Division. The merger would create the nation's largest insurer, providing health or dental coverage to 22.4 million Americans, almost 10% of the population. Aetna would be one of the top three insurers in Florida, Georgia, Maryland, New Jersey, New York, Ohio, Pennsylvania, Texas, and Virginia, the AMA said, and in Texas, the merged entity would provide coverage to 41% of the state's HMO enrollees. The closest competitor in Texas would be United HealthCare, with 10%, the AMA said.

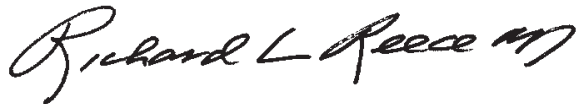
The AMA also criticized Aetna last year over the terms it uses in its contracts with physicians, calling those terms onerous and saying Aetna forces physicians into a "take it or leave it" position. Although Aetna has made changes in response to such criticism, the AMA believes more should be done to prevent Aetna from exercising its market power to control how medical care is provided.

Huber defends the company's actions in an article on the next page, "The Man Behind the 'New' Aetna," saying the merger will mean the combined entity can deliver more preventive care to patients and can standardize best practices among health care providers.

In January, *The New York Times* said Aetna U.S. Healthcare was the least popular HMO among doctors in the tri-state area because of Aetna's tough negotiating stance on rates. Also in January, *The Wall Street Journal* reported that a group of 600 physicians in California, the San Mateo County IPA Medical Group, had dropped out of Aetna U.S. Healthcare, forcing 20,000 patients to find other doctors. In quitting the health plan, the physicians said Aetna's offer to them for this year was too low. The group complained that Aetna had cut the rate it pays physicians by 24% over the previous five years, and that an increase of 8% for this year was insufficient.

Later in January, a jury in San Bernardino County, California, ordered Aetna to pay the widow of a cancer patient \$120.5 million in medical expenses and punitive damages stemming from a patient's case. The jury found Aetna committed "malice, oppression, and fraud and contributed to shortening the cancer victim's life." Calling the verdict an "egregious miscarriage of justice," Huber said the company intends to defend itself with the public and that Aetna plans to appeal.

All of these criticisms of Aetna indicate the company is practicing hard-nosed business tactics, but they also show that Aetna has much work to do to regain public trust and to engage physicians as allies.



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The Man Behind the “New” Aetna

By Richard L. Reece, MD, editor-in-chief

In the world of corporate mergers, where big fish eat little fish, Aetna is feasting heavily. With its billion-dollar acquisition of U.S. Healthcare and its proposal in December to buy Prudential HealthCare, as well as other, smaller purchases, Aetna has become the nation's largest managed care organization. The sheer size has physicians nationwide concerned about what such mega-deals mean for them, their patients, and the health care industry.

One person who can address these issues is Richard L. Huber, Aetna's chairman and chief executive officer. In February 1995, Huber joined Aetna. He was recruited, he says, to help the company develop a strategy for redefining its corporate goals. At that time, he explains, Aetna had been in insurance, in one form or another, for 145 years. For its entire history, the company had operated under the same name and had never been bought or sold. “It's unusual in America for a company that big to operate that long under the same name and in the same business,” he says. Although the company was providing an array of property, casualty, homeowner, automobile, life, and health care insurance, Aetna's board of directors and then-CEO realized that business as usual did not ensure continued success, Huber says.

“I came in—somewhat reluctantly at first—and became convinced that this could be a very exciting opportunity,” says Huber. “First, I worked with the board and the chairman on selling the property and casualty business, which we sold to Travelers in 1996. Next came the acquisition of U.S. Healthcare and a series of smaller acquisitions; the sale of the individual life business; the acquisition of New York Life's health care business; and most recently the proposed purchase of Prudential's health care business.”

The purchase of U.S. Healthcare represented a strategic repositioning for Aetna, and Huber was one of the prime movers behind that effort, he says. In explaining that strategic shift, Huber refers to the company's health insurance history. “Aetna has been in the health insurance business for 100 years,

having written its first health insurance policy in 1899,” he says. “Until our recent strategic repositioning, Aetna was operating under the old indemnity, fee-for-service model, even though it had bought some HMOs in the 1980s and early 1990s.

“I felt that we needed some capabilities we didn't have,” Huber continues. “Number one: We needed much better management in the stronger forms of managed care. Number two: We needed a best-of-breed system to integrate the HMOs Aetna had purchased. The reality was that Aetna's managed care business was being run on 14 different system platforms, none of which was good enough to be the standard to which we could convert the others. What's more, we were easily spending \$100 million a year trying to build from scratch a new managed care system, but we weren't getting the results we wanted.”

Risk and Reward

Based on these needs, and with the wish list to fill them, Aetna went acquisition shopping. “We were looking for candidates that had a best-of-breed system, a strong managed care management, and a strong sales and marketing culture,” Huber says. “In the old indemnity world, there was really only one sale and that was to the plan's sponsor. That is, once you made a sale to a plan sponsor—say, Pepsi-Cola or Citicorp—what you were actually getting was all of the sponsor's employees, since it was, in effect, hiring the insurer to manage its health care program. In the new world of managed care, where employers offer a much greater choice, a second type of sale takes place after the first. That sale is to the individuals—that is, the employees and in some cases, retirees—in the plan. The ‘old’ Aetna was quite weak in its second-sale capability, which is why we were looking for a company that had a strong sales and marketing culture for the ‘new’ Aetna.” Aetna found that U.S. Healthcare was the ideal candidate to fill those very specific strategic needs, says Huber.

Now that those needs are filled, Huber has other goals. “We want to be able to risk-

Biography in Brief: Richard L. Huber

Richard L. Huber has been chairman and CEO of Aetna since July 1997. Born and raised in western North Carolina, he did his undergraduate studies at Harvard. A chemist by training, he was in the banking business, first with the First National Bank of Boston (now BankBoston), and later with Citibank, Chase, and Continental Bank. Huber handled the sale of Continental, which went bankrupt, to Bank of America, a deal that closed in late 1994. He then joined Wasserstein Perella, investment bankers in New York, to set up a merchant and investment banking operations in Latin America, where he had previously spent some 15 years.

stratify our membership in an effort to identify people who are on the verge of having an acute attack of a particular disease and to try to do something about it before it happens,” says Huber. “For example, we can now identify fairly well the 5% to 6% of our membership who've been diagnosed with congestive heart failure and are likely to have an acute attack in the next quarter. So, we can do something about that today. We can assign a nurse or a case manager to those members, and we can make sure that all the preventive care steps that are part of the accepted treatment protocol are being applied. Through these actions, we can reduce the number of members who have an acute attack, which obviously is cost effective, but more important, we can help to improve the lifestyle and wellness of our members.”

The capabilities of this immense database will lead to the next managed care trend, Huber says. This trend is the ability to do outcomes management and achieve performance standardization for the health care

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delivery system. "There are no set standards applied to this huge industry," says Huber. "So, the standardization of best practices across America to minimize regional variations presents an immense opportunity and is the ultimate future of the industry."

Huber's optimism for the industry and Aetna's role in it has not been tempered by the AMA's challenge to the Aetna-Prudential merger as anticompetitive and monopolistic. "We're surprised that the AMA would enter into this realm, and a little bit hurt and disappointed, since we have made some real efforts to reach out to the AMA and some state medical associations as well. One of my personal goals is to improve our relationship with the provider community significantly, and we've taken a number of steps in that direction. We think it's senseless to have an adversarial role with an organization like the AMA, when clearly our objectives are the same."

Reaching Out

Asked what steps Aetna has taken to reach out to the AMA and to physicians, Huber cites the Academic Medicine and Managed Care Forum, a \$15 million fund established by the Aetna Foundation and Aetna U.S. Healthcare about two years ago to promote innovative research aimed at improving health outcomes. Currently, he says, it counts some 40 of the top academic medical institutions in America as members, including the University of Pennsylvania School of Medicine. In addition, Aetna funds grants to seek ways to measure the performance of health care delivery systems, Huber says. Aetna also has rewritten its provider contract, partly in response to complaints from the AMA, "to make the contract simpler, clearer, and more user-friendly." What's more, Huber says, Aetna is implementing a new provider payment system whereby physicians who file claims with Aetna electronically are guaranteed to be paid within 15 days. Aetna introduced this system last year, first in northern New Jersey, then in metropolitan New York, and plans to have it available nationwide this year, says Huber.

Aetna's efforts to get doctors to like it better may be sorely tested in some areas of the country, such as California, Georgia, Ohio, and Texas, where doctors have been threat-

Managed Care Evolves in 'Waves'

Managed care requires preventive care, explains Richard L. Huber, the chairman and CEO of Aetna. In describing the benefits of that care for both Aetna and the clients it serves, he says, "Our objective is not only to make a good business out of it, but also to provide better health care, better life expectancy, and a better quality of life for our members at a more affordable cost. To me, managed care is about trying to anticipate and provide steps to prevent illness—rather than simply treating it once it becomes acute, which has been the classic form of health care."

Characterizing the overall direction of the health care industry, Huber speaks in terms of waves of movement. The first wave consisted of a wholesale buying trend. "We, the health care companies, could buy wholesale, as opposed to retail, from providers and then pass the savings on to our clients, the plan sponsors. The second wave, which we are well into now, is the medical utilization phase, which involves an overview of utilization and a questioning of certain procedures that don't seem to be appropriate or medically necessary. The third wave involves disease management, the application of preventive medicine, and risk-stratification of our membership. It involves identifying today who will get sick tomorrow and doing something about it today so that they don't get sick, or at least, as sick. This is an area that, through technology databases, we will perfect and extend over the next few years."

With its proposed purchase of Prudential HealthCare for \$1 billion, Aetna hopes to perfect and extend its third-wave effort at disease management. That's because with the Prudential purchase came 5 million enrollees—bringing Aetna's total to 22 million enrollees—and reams of associated health care data that can be instrumental in building a database to enable Aetna to identify and treat proactively risk-prone individuals, Huber says.

ening to leave or have left Aetna networks. But Huber is both philosophical and practical about the matter. "Let's start off with the fact that we now have more than 300,000 providers in our network," he says. "If, for whatever reason, 1% of those physicians leave our network, that's 3,000 doctors. Although it would not be abnormal to have some turnover in a network as large as ours, we would hate to lose any of them. The fact is, our network grew 10% in absolute numbers in 1998, so some doctors in some places must feel that we're doing something right. But having said that, we regret any time that we have a dispute. We have a policy of trying to have the largest, widest network of any player in our business, and so we want to be inclusive, not exclusive. But we can't always solve everybody's complaints. Inevitably, we will have some turnover, but we try to keep it as low as possible."

If some physicians are troubled by their dealings with Aetna, the managed care provider is experiencing pain of its own because, says Huber, Aetna set overly ambi-

tious goals for itself when it acquired U.S. Healthcare. "If any one person is to blame, I'm that person. I set most of those goals. And it was because I believed then, and I believe now, that the gain is in the value of the outcome of this integration, which is going to be so great that it will be worth the inevitable pain of getting there quickly. It is true that we had more pain than we had expected or bargained for. But the fact that all of our managed care membership is now on a single system and in a single database will provide tremendous advantages in our ability to manage our business better; to give providers timely, meaningful, and detailed feedback on their performance; and to practice disease management. These are huge benefits."

As Aetna struggles to streamline its operations and meld all of the new parts together, Huber believes the company ultimately will be more effective at addressing complaints from its providers. Meanwhile, physicians are taking a wait-and-see approach.

—Edited by Paula Grant, in Lincoln, Va.

Group Puts Preventive Care Into Action

Twenty-five years ago, a young, inquisitive resident asked an attending physician why a particular blood test was being done for every patient. The physician answered, "What else would you do?" Paul Frame, MD, found that response to his question to be unsatisfactory. Now, a rural family physician and member of the U.S. Preventive Services Task Force, Frame says the attending physician's question reflected the state of the art of clinical preventive medicine in the early 1970s.

"At the time, there was this dogma of the 'complete annual physical,' which involved many tests," Frame says. "Not much thought was given to whether the tests were useful. You just did what was easy to do and whatever the patient could afford."

Unwilling to accept these practice methods blindly, Frame questioned whether evidence existed to support the use of the so-called preventive interventions that he saw performed routinely. During the last year of his residency—in 1975—Frame and coauthor Stephen Carlson, MD, published in *The Journal of Family Practice* a series of articles titled, "A critical appraisal of periodic health screening using specific screening criteria," which examined the feasibility of screening procedures for 36 selected diseases. "In those articles we advocated doing away with a lot of sacred cows—such as complete blood counts, chemistry profiles, urinalysis, and electrocardiograms—that were part of a typical annual physical," says Frame. Instead, they suggested that practitioners replace the concept of the annual physical with the practice of performing specific evidence-based preventive procedures.

"There has been a trend in primary care medicine toward evidence-based preventive care and away from the traditional annual physical," says Allen J. Dietrich, MD, clinical professor in the department of community and family medicine at Dartmouth Medical School in Hanover, N.H. "Physicians are becoming more selective when choosing preventive care interventions for their patients, and they are focusing on those with evidence of efficacy."

Today, Frame practices what he preaches as medical director of Tri-County Family

Medicine, a 10-physician group practice with six offices in rural towns surrounding Davisville, N.Y., about 50 miles south of Rochester, N.Y. "When I started my practice, I wanted to systematically apply what we had written about," he says.

Frame has installed in TCFM's offices a system that ensures that all providers deliver 15 evidence-based preventive services to patients. Some of the measures are implemented annually, and some only once every four years. But the point is that TCFM has a system that delivers more than the required minimum of preventive services as defined by managed care organizations, thus helping to ensure that in the Davisville market, patients being served by the group are getting a complete dose of health maintenance.

"Although many managed care plans

job with our flow charts, but we discovered that 55% of our patients who developed preventable cancers had not been screened," Frame says. "We realized that the flow chart system was useful only when patients came into the office. And we did not see most of those patients regularly."

After identifying this flaw in their manual system, TCFM physicians began to investigate computer-based health maintenance tracking systems. "When we couldn't find a system that suited our needs, with the assistance of a grant, we developed our own," Frame says. In his 1994 study published in the *Archives of Family Medicine* (Vol. 3, No. 7), "Computer-based vs. manual health maintenance tracking," Frame reported that TCFM's system, called HTRAK, improved provider compliance with health maintenance protocols by 15%, while a manual

"It's gratifying when a patient tells me he got a tetanus shot when he was in the emergency room last week and to check it off the list because then we're working as partners."

—Paul Frame, MD, Tri-County Family Medicine

want our practice to comply with preventive care measures, so far they have asked only for our data on mammograms and pap smears," says Frame. In addition to these two services, TCFM can demonstrate that it has data on 13 other measures as well.

An Evolutionary Process

Frame's systematic process for integrating preventive care into his practice, which includes eight physician assistants, has undergone several evolutions. "For many years we used manual flow charts attached to patient charts to track preventive care," he says. But in 1986, when a medical student conducted a study of the practice's patients who had developed potentially preventable cancers, TCFM physicians discovered that, despite their diligent efforts, their preventive care process was inadequate.

"We thought we were doing a pretty good

system improved performance by only 4%.

But developing an office system for preventive care requires more than a computerized tracking system, says Frame. "Many people confuse having tools, which might or might not be used, with having a system that measures and ensures compliance," he says.

Protocols Needed

The first step in creating such a system, Frame says, is to develop specific written protocols, which he recommends should be as simple and sparse as possible. "When you're sitting in a conference room trying to figure out what preventive interventions to do, you tend to get grandiose," he says. "But that's a different scenario from being in your office and having only 10 minutes to spend with each patient."

Protocols should simply spell out which preventive procedures—such as obtaining

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the patient's weight or history of alcohol use—should be offered to patients at specified intervals—such as annually or every four years—depending on the particular procedure and the age of the patient. TCFM's protocols include obtaining blood pressure readings for all patients every two years, for example. Physicians discuss advance directives every 10 years and annually administer influenza vaccines to patients over age 65.

Protocols also should be based on what Frame calls the least common denominator. "In a group practice, physicians commonly have different ideas about which procedures should be in the list of protocols and which should not," he says. Therefore, Frame says, it's important that the group reach consensus about which protocols constitute the minimum acceptable standard for the practice. "If some doctors want to do more, that's fine," he says. "But everyone should agree on a minimum standard below which no one will fall." For example, some TCFM physicians prefer to obtain blood pressure readings more often than every two years, as the protocol indicates.

Of course, protocols for patients with specific risk factors, such as diabetes or a family history of heart disease, are also modified to accommodate particular health problems. "The minimum standard is based on the premise that the patient is healthy," says Frame. "If a patient has hypertension, for example, we're going to monitor his blood pressure much more frequently."

Audit Charts

The next step is to audit patient charts. "The purpose of a chart audit is to measure what you are actually doing," says Frame. "If you ask doctors what percentage of their adult female patients have had pap smears, almost all will say 90%," he says. "But when you audit their charts, the results tend to be in the 40% to 50% range. We all have this vision of the good, compliant patient whom we see regularly," Frame says. "In fact, our practices are made up of much larger populations of patients we see infrequently."

A chart audit provides a benchmark for physicians to measure their performance over time, and it can identify specific areas of weakness. As a result of a chart audit, TCFM discovered that serum tests for syphilis were

being done infrequently. "We decided that this wasn't a worthwhile test to do for our particular patient population," Frame says. "When you discover areas of weakness in your performance, you have two options. If you don't believe the procedure is benefiting your patients, eliminate it; if you think it is important for your practice, develop a strategy to improve your performance."

Accountability

Another key component of integrating preventive care into a practice involves assigning someone to be accountable for the entire process, including its results, Frame says. Unless at least one person is ultimately responsible for results, the procedures and audits are simply a collection of tools. "There must be someone responsible for making sure that audits are completed and that information from the audits is fed back to the providers," he says. "In short, you need someone to make sure the process actually happens."

At TCFM, Frame is responsible for the group's results, although the most accountable person need not be a physician. "Often, ownership of the process resides with a practitioner who has an interest in prevention," Frame explains. "And often nurses are given responsibility—and the necessary authority—to oversee the process." But, cautions Frame, when delegating responsibility for preventive care to other clinical staff, physicians must ensure that staff are given the necessary time to devote to this additional work. "There's a tendency to say, 'I'm too busy to do prevention, so I'll have my nurses do it,'" says Frame. "That's fine. Nurses can do prevention if you give them the time, but if you just add it to their already overburdened workload, it won't happen anymore than if you tried to do it yourself." Further, he says, physicians who delegate preventive care responsibilities without giving staff adequate time to perform them send a message that preventive care is a low priority.

Biggest Challenges Come First

Paul Frame, MD, medical director of Tri-County Family Medicine, a 10-physician group practice in Davisville, N.Y., acknowledges that implementing a thorough preventive care system may seem overwhelming at first. "There is a substantial start-up investment of time, money, and effort in this process," he says. "And some practices never get past these hurdles."

From 1990 to 1992, Frame studied the operating costs associated with his practice's computerized preventive care system. Publishing his findings in the same 1994 study that showed how such a system could improve provider compliance, he revealed that it also cost 78 cents per patient to operate. "This might not sound like much, but when you multiply 78 cents by 20,000 patients per year, that's \$15,600," says Frame. And that cost was incurred more than seven years ago. While more recent cost data are unavailable, expenses—such as labor and postage—have continued to rise, he says.

"Implementing a preventive care system will cost a practice money that may never be recouped," Frame explains. "There's no doubt that preventive care is good care, but it's rarely a money-maker."

Another problem practices face when beginning to establish a preventive care system is that all patients appear to be overdue for all preventive measures. "For every patient you see, you have to determine which of the protocols have been done and update your records," Frame explains. Once a preventive care program is underway, however, on average only about one in five patients will require any preventive care on any given visit, Frame says.

To meet all the requisite challenges, preventive care must be institutionalized within a practice. In the January 1998 edition of the *Journal of the American Board of Family Practice*, Frame wrote, "Faith and good intentions will not get the job done. Systems must be developed in each primary care practice to define a process that ensures high-quality preventive care for all patients."

—L.N.

“A system of preventive care must be organized so that providers think of prevention at every visit, not just when a patient comes in for an annual physical,” says Frame. Strategies for implementing preventive care procedures tend to vary depending on the philosophy, staffing, and resources of a practice. Therefore, a specific process for delivering preventive care must be defined and each member of the practice must understand his or her role and responsibilities.

“Our philosophy is that preventive health care is very important, so we integrate it into the everyday practice of medicine at our offices,” says Frame. TCFM’s eight physician assistants—like the practice’s physicians—serve as providers in that each one has a panel of patients.

Each time a provider sees a patient at one of TCFM’s five offices, a page containing a list of the practice’s preventive care procedures is generated by the group’s computer. Next to each procedure is a code denoting the patient’s current status. For example, a “U” next to the procedure “obtain pap smear” alerts the provider that the patient is due for this procedure within the next two months; an asterisk next to “obtain tetanus shot” indicates that the patient is overdue for this immunization.

“In a matter of seconds after walking into the exam room, I can see from the status sheet what preventive care the patient needs,” says Frame. In most cases, even patients with several overdue health maintenance procedures can be quickly brought up to date, without scheduling an additional office visit, he says.

After completing a preventive care procedure, the provider marks the relevant item with a “D,” meaning done. Finally, the paperwork is forwarded to the billing clerk, who enters the patient’s updated status into the computer. “We’ve incorporated our preventive care process into our procedures, so that it’s part of the practice’s operations,” says Frame.

Not only does TCFM involve staff in the preventive care system, it also encourages patients to participate by sending them a reminder letter during their birthday month. “We send a letter to every patient on our billing system—regardless of whether they’ve been in the office—telling them which procedures they are overdue

Tri-County Family Medicine’s Preventive Care Protocols

Protocol	Frequency	For Patients Age (in years)
Obtain history of tobacco and alcohol use	Every 4 years	21-100
Record blood pressure	Every 2 years	21-100
Record weight	Every 4 years	21-100
Obtain total serum cholesterol	Every 4 years	21-70
Administer fecal occult blood test	Annually	60-100
Administer tetanus booster	Every 10 years	21-100
Conduct complete physical	Once	50-55
Discuss injury prevention	Every 10 years	21-100
Administer pneumonia vaccination	Once	65-100
Administer influenza vaccination	Annually	65-100
Discuss advance directives	Every 10 years	21-100
Obtain pap smear	Every 2 years	Female patients age 21-70
Order mammogram	Every 2 years	Female patients age 50-100

for,” says Frame. “The letter also asks them to call their provider for an appointment if they don’t have one scheduled.” The letter closes with another request: ‘Please show this letter to your provider at your next visit.’ “Some patients ignore the letters or throw them away,” says Frame. “But the patients who bring them in help to remind providers that preventive care is a priority.”

Another benefit of the annual reminder letters is that they may prompt patients to tell a provider when they have received preventive care, such as an influenza immunization, elsewhere. “It’s gratifying when a patient tells me that he got a tetanus shot when he was in the emergency room last week and to check it off the list, because at that point, we’re working as partners to protect his health,” Frame says.

Reinforcing Behaviors

For Frame, developing a partnership with patients is one of the rewards of implementing a preventive care system in his practice. “Establishing relationships with my patients and providing care to them over a period of time make it even more important to me that I do what I can to keep them healthy,” he says.

Like Frame, Dietrich, believes it is important for primary care physicians—especially those who know their patients well—to implement such systems. “Primary care physicians are in the best position to tailor preven-

tive advice, to have patients comply with that advice because they trust their physician, and to help patients overcome barriers to obtaining preventive care,” he says.

In practices with a lot of patient turnover, a provider may see some patients only once, and therefore may not see the benefits of the preventive care they provide. Even in practices in which continuity of care is the norm and patient participation is a positive reinforcement, incorporating preventive care into everyday medical practice is challenging, Frame says. “Changing your behavior is always difficult,” he comments.

But measuring performance is only half of the equation. “We use peer cajoling and peer pressure to encourage performance improvements,” says Frame. Although Frame is interested in using financial incentives to bolster compliance, the practice has not yet used them.

“Physicians have been committed to providing preventive services but until now have often lacked the support resources, such as computerized reminders, that help them identify patients who need these interventions,” says Dietrich. “But today health plan administrators and clinic managers now have an incentive to design and implement office systems like Frame’s that assist primary care physicians in providing these services to patients.” he says.

—Reported and written by Laura M. Northup, in Mashpee, Mass.

“Despite initial denials by the payer, we proved that we needed payment for those patients. If we had been unable to produce this evidence or had failed to track these patients, we would not have been able to retrieve this money.”

—Judiath S. Luke, Memphis Otolaryngology Consultants

(Continued from page 1)

the same payer may have different plans, such as an HMO and a point-of-service (POS) plan. In such cases, the payer has to be listed twice to reflect separate products with potentially different fee schedules, and potentially different utilization of services because of copayment differences between products. Patients with a zero copay may come in more often, for example, than those with a \$10 copay.

The ability to gather other essential elements, such as patient demographics, copay amounts, and to gain access to the World Wide Web, also is important. Practices with existing systems should determine whether these capabilities are in place and if their system is being used to its maximum. If not, physicians should find out from their system vendors if the vendors plan to provide these capabilities and if not, the cost for doing so or to buy a new system.

Other factors also may affect system selection. For example, a practice may want to purchase a system from a local vendor, or one that has billing and an eligibility database, or that has scheduling and billing, or simply billing alone.

Do Accurate and Timely Billing

Failing to collect patient copayments when the patient is in the office for a physician visit is an easily avoided pitfall in managed care reimbursement. To collect copayments, most offices spend between \$10 and \$20 to send out a bill that produces an average collection return of only \$5. One reason staff do not collect the copays when patients are in the office may be that they don't know the amount of the copay required of each patient. This information, however, can usually be obtained from the patient's identification card or it may be available on the insurer's Web site.

Lili Gamelin, MD, a nephrologist and medical director of Valley Physicians Organization, an IPA in Renton, Wash.,

says that if a patient can't make the copay on an office visit, the system should be set up to indicate a copay balance forward so that it can be requested on the next visit.

Collect the Full Amount Due

It is essential to review payments to confirm that they are consistent with the payer contract. Consider this example: Memphis Otolaryngology Consultants, a group of seven physicians and four audiologists in Memphis, Tenn., contracted with a payer to deliver care to adult patients on a capitated basis and pediatric patients on a fee-for-service basis. MOC's system could be programmed to recognize pediatric services and bill them as fee for service. The payer's system, however, could not differentiate pediatric patients from adults and therefore viewed all patients as capitated. The result: Once the payer made a payment, from its perspective no additional fee was due. To get paid the proper amount, MOC officials had to meet with the payer's representative to review each pediatric case.

“We were able to prove that we needed payment for those patients, despite initial denial by the payer,” said Judiath S. Luke, MOC's administrator. “If we had been unable to produce this evidence or had failed to track these patients, we would not have been able to retrieve this money.”

A practice's office staff also should not make assumptions about billings for patients covered under capitated arrangements. In instances in which inpatient visits aren't covered under capitation—for example, if a patient is seen in the hospital—a physician could bill for such a visit and be paid in addition to the capitation amount. Another example is a practice operating under a capitated contract that is unable to track when it should bill for a particular item of service, resulting in a potential loss of income. For example, administering pediatric vaccinations is typically covered under capitation, but many plans

pay an additional fee for the vaccine itself.

Another source of income involves coordination of benefits. If done correctly, COB can range from 3% to 7% of a practice's income. But COB income is often not pursued. While one spouse is often covered under the other spouse's policy, for example, frequently both spouses—if both are employed—have insurance coverage through their employers and one of their insurers is usually designated the primary insurer. Primary insurance payments would be kept in addition to the capitation received under the secondary insurer's policy.

Maximize Income

Many physicians are finding that access to the Internet is an important part of doing business today. Many payers or vendors that maintain payer eligibility databases allow physician staff to verify eligibility for covered members online. Verifying eligibility, copayments, and authorization requirements prior to a patient visit can improve collections by decreasing the delay in getting information from patients after they have left the office. Also, many pharmaceutical formularies are now available online, giving physicians access to what can be prescribed for patients.

In addition to billing for services that are not covered under the capitation agreement, physician staff should review the payer contract for the services allowed on a fee-for-service basis for which the practice does not normally bill. Many payer contracts allow a payment in addition to capitation for venipuncture, yet many offices do not bill for this service because they consider it to be included in the payment for the office visit.

Use Reports to Manage the Practice

“To thrive in managed care, physicians who have multiple contracts at multiple different rates must have the ability to track their business by health plan in order

to know whether they are losing money or making money," says Don Fleischli, MD, a radiologist and senior vice president of integrated delivery systems for ScrippsHealth, a physician hospital organization in La Jolla, Calif. The PHO was formed through a joint venture between the hospital system and its physician group, ScrippsPhysicians.

Performing an analysis and having this information led Memphis Otolaryngology Consultants to drop one of its capitated contracts last year. "They wanted to renegotiate to a lower cap under which we did not feel we could see patients without either losing money or realizing a marginal return," explains administrator Luke.

What's more, physicians must examine their practice patterns to see if they need to change their practice methods. Under fee-for-service medicine, physician income was derived from seeing patients: The more patients seen, the more income generated. Under managed care, physicians need to think critically about whether an additional encounter truly enhances patient care.

"We need to get to the heart of what needs to be done for a patient," says Gamelin of Valley Physicians Organization. "After placing a patient on antibiotics to treat pneumonia, I say to the patient, 'If you are not better in three days, call me,' instead of saying, 'I want to see you in a week to make sure you are better.' I don't need to see that patient, all I have to know is that the patient is getting better, which the patient can tell me by phone."

Once a practice can track the number of encounters per member per year, it should calculate the fee-for-service equivalency. Physicians often need to compare capitated income to what they would have been paid under fee for service in order to compare income from current years to income from years past. When the otolaryngologists at MOC saw their largest capitated contract revert to fee for service, for example, their revenue from that contract dropped. This type of information is critical to the success of physician practices under managed care and can be derived only when the appropriate information systems and educated staff are in place.

—Additional reporting and writing by Danae Manus, in San Francisco.

Otolaryngology Group Systematizes Accounts Receivable

Nearly five years ago, when Memphis Otolaryngology Consultants began seeing an increased presence of managed care in Tennessee, members of the group of seven physicians and four audiologists decided to market themselves to gain capitated contracts.

But, in order to do so, MOC needed to make some changes. "When we looked at our existing systems, we found that we were not set up to manage capitated contracts," says Judiath S. Luke, MOC administrator. "First, we needed to establish a cost accounting system that would enable us to model projected reimbursement against practice expenses to determine which contracts made sense, and then we needed a way to bill and track separate contracts, each with its own unique fee schedule."

The cost accounting system was developed internally and allows MOC to predict costs by details, such as practice location, physician, and procedure. After making a list of the functions deemed essential in a system designed to track managed care contracts, such as separate fee schedules, MOC selected and implemented a product from Medic Computer Systems, a systems vendor in Charlotte, N.C., that specializes in physician practice management systems. The Medic system allows MOC to enter an unlimited number of different capitated contracts and fee schedules. But the key to the success of any information management system lies in effective utilization. MOC has procedures in place to ensure that the eligibility of all patients is confirmed prior to treatment, out-of-pocket expenses are collected up front, and reimbursement rates are verified.

The Medic system was customized for MOC to link the administrative office with the seven practice locations. All patient telephone calls are received and appointments made through the Memphis administrative office, which also collects and enters demographic information, including the type of insurance and referral number so that these data are available when patients show up for their appointments. Three of the practice offices are in Memphis, and the others are in nearby communities. Information is rechecked and verified at several steps along the way. At the time of the appointment, for example, each patient presents his or her insurance card, which is either scanned or entered by account number into an online system provided by Envoy Corp., a company in Nashville, that develops such systems. The system verifies eligibility, referral number, and the patient's copayment amount.

MOC's policy is that patients must pay all copayment amounts either before or on the day of the visit. "Because we've actually asked them to go the bank next door and get it, they understand it's important to pay," says Luke. "If for some reason they don't, when they check out we give them an unstamped envelope with our address on it and ask them to mail the copay to us." In general, these systems ensure that MOC collects patients' copayments without the need for a patient to take a bill home. If a patient is scheduled for surgery, the Medic system alerts the accounts receivable staff in the administrative office to contact the insurer, once again determining eligibility and the patient's responsibility for presurgery deposits and out-of-pocket expenses. Unless it's an emergency, MOC does not perform surgery until the patients pay their out-of-pocket portion.

Once services are performed, the accounts receivable staff continues calling insurers about claims that aren't paid to find out why. When claims are paid and posted, the Medic system, which tracks fee schedules by individual payer, shows what MOC expected to be paid under each contract and what was received. When discrepancies are noted, the claim is resubmitted to the payer with supporting evidence and a written notice.

Since 35% of practice revenue comes from managed care patients, MOC has in place the information systems and procedures to monitor the accuracy and flow of its reimbursement continually across all payer types from capitated contracts to fee for service.

—B.F.

Aim for Profit Detracts From Patient Care, Says Connecticut Medical Society Director



Timothy B. Norbeck has been associated with organized medicine for 32 years. For the past 21 years, he has been executive director of the Connecticut State Medical Society, which has a membership of 7,000 physicians. Previously, Norbeck served in various capacities at the American Medical Association, and was executive director of the Rhode Island Medical Society. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q. There has been a lot of media coverage about the angst among seniors regarding the withdrawal of Medicare HMOs. How do you react to that kind of news?

A. There's no question that there is much concern about Medicare HMOs after all the promises that have been made about them. In fact, recent statistics show that some 444,000 Medicare recipients are now basically being abandoned by their HMOs, including about 12,000 seniors in Connecticut. I don't blame it all on HMOs; the confusion and timing concerning the Health Care Financing Administration's regulations are also to blame.

But HMOs weren't complaining too much when they were making healthy profits and, as many suggest, were doing so because they were signing up healthy seniors. As more legislators become involved in this issue and more patients understand what's going on—and combined with other health care factors—we are likely to see significant managed care reform in this area at the federal level. Physicians have been shortchanged by HCFA on Medicare for years, but you don't hear much about that.

Q. Another factor affecting Connecticut is the steep increase in the state's

managed care population, which has resulted in a sharply increased awareness among patients of what HMO care really means; namely, rationing of or justification for some services, and patients are not pleased by the denials.

A. You're absolutely right. But HMOs pull out their patient satisfaction surveys to show that as many as 96% of members are perfectly satisfied with the care they receive. Yet, there are perhaps only about 6% of the public who need medical care at any particular time. The other 94% have to be satisfied because they're not using the system. So, I don't put a lot of stock in patient satisfaction surveys and they don't survey those who voted with their feet by finding other sources of care.

Q. You've been an activist not only for patients and their rights, but also for

"We were not interested in buying up physicians' practices. We were hoping to provide physicians with the services that would enable them to keep their practices."

physicians. For example, in 1986, the society formed the MD Health Plan, the first physician-owned HMO to be formed by a state medical society. Could you tell us the story behind this plan?

A. That endeavor remains a source of great pride and great disappointment. In the early 1980s, we saw that managed care was taking hold and thought that in 10 to 15 years only three or four major players might be left in the state. Also, we were concerned about the way managed care was minimizing the influence of physicians and their medical judgment, and felt that physicians, looking after patients the way they do, must be one of the players in the managed care arena.

That's why we formed MD Health

Plan. Physicians capitalized it. We believed—as all doctors do—that nobody should come between patients and their doctors. But it's difficult to capitalize health plans, particularly when you are competing with the big insurers in our state that have countless millions of dollars to invest. In the early 1990s, the plan was moving along pretty well but more capital was needed. So, an effort was made to get that capital from the physicians in the plan. That effort was unsuccessful. Then, an attempt was made by some to convince the physicians that the only way to save the plan was to sell it in its entirety.

Unfortunately, when the plan was sold, the physicians were falsely characterized as having been greedy because they sold out when they were acting only to save the plan and had been led to believe that

their only option was to sell. After the sale, when I would go to medical meetings around the country, physicians would say, "We are so disappointed. Connecticut was the great hope for us and you let us down." That sentiment was fostered by those who characterized the physicians as just wanting the money, which was absolutely false. And I resent that.

Q. Two very positive results of the MD Health Plan were that you raised \$6.9 million from 3,000 doctors in 1985, and second, that the plan grew to have an enrollment of 162,000. What has happened since the HMO was sold to Foundation Health Systems in 1995? Has the plan continued to function in the manner that the physicians thought most appropriate?

“Any eye-popping profits are bound to come directly from patient care at the expense of sick people and their caregivers and go directly into the pockets of investors who may view the nation’s patients as just another commodity, either to yield a profit or to be sold short.”

A. No. The physicians are not happy with the way things are going. The discounted physician fees, the red tape, the hassles—all those things annoy physicians. Our plan merged with Physician Health Services, also purchased by Foundation Health, and as of Jan. 1, the newly formed group will be known only as Physician Health Services. However, the society does own the IPA that negotiates with PHS. But as any IPA will tell you, negotiations with a health plan are difficult, to say the least.

Q. *Two years ago, you launched another business initiative on behalf of physicians—a statewide management services organization (MSO). What was the reasoning behind that effort and how has it worked?*

A. Several years ago, it was apparent that physicians and their offices around the state needed assistance in dealing with managed care. Michael Deren, MD, who was the society’s president then, approached the society’s council for money to conduct a feasibility study of physician practices in Connecticut to find out what physicians wanted and needed. The study revealed a number of needs. One was that there was much confusion in physician offices relative to billing for services. There was over-billing, under-billing, flat-line billing, and coding errors. None of it was intentional. It was simply due to confusion caused in adapting to managed care, understanding regulations from the federal Health Care Financing Administration, and the fact that many of the physicians’ staff members were not properly prepared for the transition from fee for service to managed care.

We also found that overhead costs ranged from as low as 31% to as high as 77%, and that none of the practices had substantial retained earnings to invest in their practices. In fact, they needed help in contracting and negotiating with managed care organizations and in establishing medical information systems, in billing and collection, and in practice administration, among other areas. Some IPAs needed strengthening; others had no infrastructure whatsoever.

In light of these findings, the council authorized the society to put together an MSO. At that point, we had to figure out how we were going to capitalize it. We decided to seek a financial partner that was “physician-friendly” and that shared our goals for empowering physicians. That was very important to us.

Q. *Describe for us that search for a financial partner.*

A. We had a consultant who helped us seek out possible partners. One—Med 3000 in Pittsburgh—stood out above all the rest. Med 3000 is a strategic physician management company, the largest nonventure, privately capitalized firm in the industry. We had many discussions with both the company and its clients around the country because we wanted to be sure that we were getting the right people. We found it to be a physician-friendly company that was interested in empowering physicians, not just extracting dollars from them.

Q. *How did Med 3000 differ from the typical publicly traded PPMC, which acquires the assets of the doctors and takes 15% to 20% of their income in a*

management fee?

A. Ours was not an acquisition model, which basically all the others have been, but rather an equity model in which there is a real sharing with physicians—a partnership, if you will. That was attractive to us. We were not interested in buying physicians’ practices. In fact, we were hoping to provide physicians with the services that would enable them to keep their practices.

Q. *What types of services does Med 3000 offer to physicians?*

A. In addition to coding, billing, and other administrative services, it assists in contracting, negotiating, and integration, and in establishing medical information systems, as well as strengthening IPAs.

Q. *Are there plans to extend your particular model to other states?*

A. We’ve talked with several state medical societies about doing the same kind of model because they are fighting basically the same battles we are. We’re all trying to stretch our societies to the limit in our efforts to help our physicians. So I think they’re looking at all the options, and certainly an MSO is a viable option. It has helped us. Although it involves a time-consuming process, we are in the business of helping our physicians with the transition to managed care. Our feasibility study indicated that making this transition is difficult for many office staffs. Therefore, we see this effort as a way for us to help them do it.

Q. *Also, since the physicians retain autonomy and ownership, they’re basically supported in their business needs, right?*

(Continued on page 12)

The author of a new book argues that managed care in its current form is unsustainable and will cease to exist in a few years.

(Continued from page 11)

A: Absolutely. That's very important.

Q: Let's switch from the state to the national organized medical scene. The AMA has played a major role in compelling Aetna, which is headquartered in Connecticut, to revamp the language of its managed care contracts. What is the importance of changing the language of these contracts?

A: In some of the Aetna plans, the contract language is onerous and compromises physicians. For example, the Texas attorney general has sued Aetna for violations of the Texas insurance code and deceptive practices act. Gag clauses and abuses in interpreting emergency care are cited in the complaint. The AMA has written to the U.S. Department of Justice about Aetna's acquisition of Prudential HealthCare, complaining that it will limit patient choice and undermine quality of care.

Q: About two years ago, when it acquired U.S. Healthcare, Aetna was viewed as a stately, traditional HMO, operating mostly on a fee-for-service basis. Now, Aetna's culture is likely to change; namely, by becoming much more aggressive about discounting and so forth. Have Connecticut physicians felt the effects of that cultural change?

A: Physicians here aren't any happier with Aetna than physicians are anywhere else. Aetna has been aggressive in terms of its dealings with physicians and in pursuing other plans. In talking about Wall Street's influence on health care, some people claim that it's good for the economy; that may be so, but it surely isn't good for patient care. Wall Street's demand of hot-growth companies—that profits increase by eye-popping amounts year after year—doesn't quite jibe with the business of delivering first-rate health care to the public. Any eye-popping amounts are bound to come directly from patient care at the expense of sick people and their caregivers and go directly into the pockets of investors who view the

nation's patients as just another commodity, either to yield a profit or to be sold short. That is certainly one of the real serious problems that we have with managed care and for-profit companies.

Q: Those eye-popping profits were a strong factor in the collapse of the physician practice management industry and caused a tremendous erosion of the trust physicians may have had for businessmen.

A: That's true mainly because of the acquisition model, where no effort was made to partner with physicians but only to acquire them. That was the big weakness in that model. The erosion of trust was predictable because physicians were understandably turned off by such blatant attempts to own them. One irrefutable lesson to be learned from history is that excesses inevitably lead to one's undoing. The tide is turning on managed care because it can't exist in its present form much longer. If it does sur-

vey statement that companies make a defined contribution to health benefits and let each employee pick the coverage that is most appropriate for him or her. Those who argue against this proposal say that if the company makes \$4,000 available to an employee, that employee may, particularly if he or she is young, pocket the money rather than use it for health benefits. But the benefit could be tailored so that the company can direct that the money be used only for the health benefit. This proposal is positive and would give patients real choice.

Another approach has been proposed by J.D. Kleinke, chairman of Health Strategies Network, researchers and consultants in Denver. In his book, *Bleeding Edge: The Business of Health Care in the New Century* (Aspen Publishers: 1998), Kleinke argues that managed care in its current form is unsustainable and will cease to exist in a few years. He also says

"Instead of companies picking an HMO or providing employees with limited choices among HMOs, some have suggested that companies make a defined contribution to health benefits and let each employee pick the coverage that is most appropriate for him or her."

vive, it will certainly have to be more patient- and more physician-friendly. There are many people—patients, physicians, and legislators—who are working to make sure that happens.

Q: Can you tell us what is the best approach society can take in delivering health care?

A: One possibility that the AMA is arguing for involves employers adopting a defined contribution health benefit. In other words, instead of companies simply picking an HMO or providing employees with limited choices among HMOs, the AMA has suggested in a pol-

physicians have an intellectual competency that will not only reign in the end, but also stands in sharp contrast to the naked ambitions and hollow advertising of managed care marketers. So that's positive too.

Another positive is that federal regulation is definitely coming. Some doomsayers are likely to say that such regulation will make managed care less profitable. Well, so be it. It might also rid us of some of the people who are in the business only to turn a fast buck. And some of the anti-patient buyouts, such as Aetna's purchase of U.S. Healthcare for \$1 billion, and now another \$1 billion to buy Prudential

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"Another positive is that federal regulation is definitely coming. Some doomsayers are likely to say that such regulation will make managed care less profitable. Well, so be it. It might also rid us of some of the people who are in the business only to turn a fast buck."

HealthCare. That's unconscionable. Those are the kinds of things that make us all cringe.

Q. *The irony in what you're suggesting in terms of the defined benefit is that the federal government offers that very model to 9 million federal employees through the Federal Employees Health Benefit Plan.*

A. Yes, but it also raises the issue of the Employee Retirement Income Security Act, or ERISA, which limits to a great extent the right of employed Americans to sue their health plans, and the arguments about the costs of all the lawsuits that would result from allowing people to sue their HMOs or to hold them accountable. A recent study conducted for the Kaiser Family Foundation, a research organization in Menlo Park, Calif., says that this argument is baloney. Based on the experiences of public programs in California and Colorado, which have long given enrollees that right, the right to sue will cost no more than pennies per member per month. So, another big argument against accountability is dashed. As we get more into health care issues, we're going to see calls for more accountability, and the feeble arguments against it will fall on deaf ears.

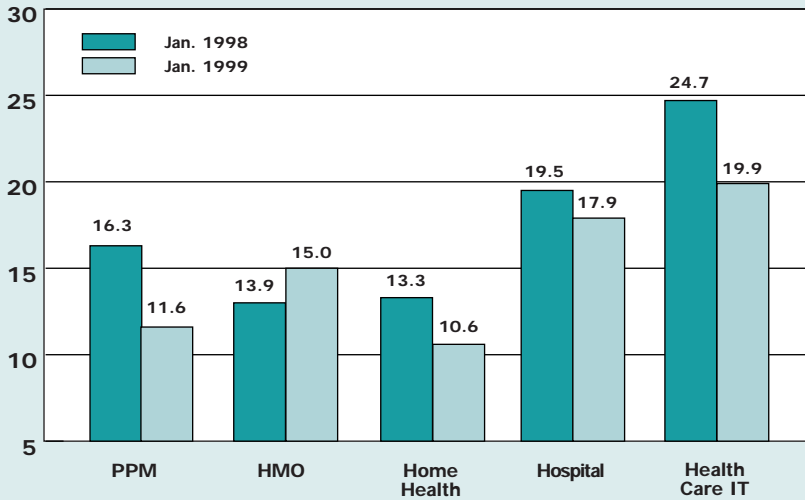
Q. *To conclude, I'd like to ask you how patients and physicians can work together. How can physicians protect patients' rights and how can they win back the public's trust?*

A. To a great extent, they can do so by being involved in medical associations and in organized medicine. Through the Connecticut State Medical Society, for example, we have been able to achieve significant managed care reform in this well-heeled, belligerent, and hostile cradle of the insurance industry called Connecticut. I don't suggest that the society deserves all the credit for this achievement, but we did form a formidable coalition of caregivers and patient groups that have worked well together. And many of those patient groups saw physicians at their very best, taking leadership roles and standing up for patients in the hearing rooms of the state legislature. Many employers were against us in this effort, but I don't think that they truly understood the battle. Although many of them stand steadfastly for improving the quality of care, often they don't realize the extent to which managed care has managed cost instead of care. The Connecticut legislature deserves a great deal of credit for its courage.

—Edited by Paula Grant, in Lincoln, Va.

Capital Market Activity at a Glance

Price to Next 12 Months Earnings ratios
(P/E ratios for selected health care industry segments,
January 1998 versus January 1999.)



Announced Transactions
(Number of announced transactions by
industry segment, January 1999.)

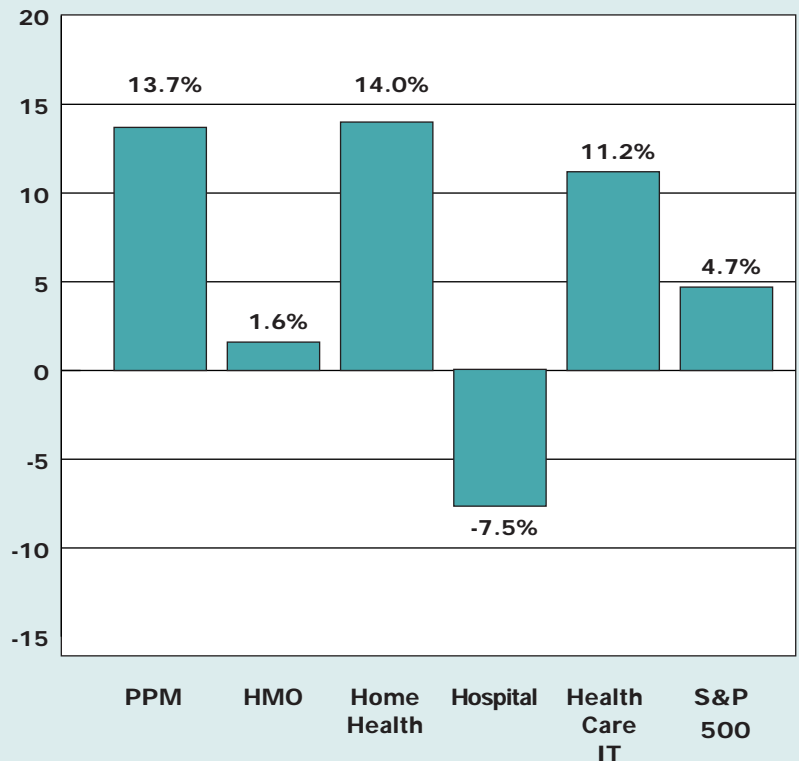
PPM	8
HMO	1
Home Health	1
Hospital	3
Health Care IT	4
Total	17

Most Active Health Care Stocks
(Change in stock price Jan. 1 to 31, 1999)

Largest Gains	% Change
Core Inc.	31.3
Health Risk Management Inc.	29.7
Apria Healthcare Group Inc.	17.5
Oxford Health Plans Inc.	16.4
Aetna Inc.	14.6

Largest Declines	% Change
Health Management Associates	-41.9
Quorum Health Group Inc.	-34.3
Columbia/HCA Healthcare	-26.8
Healthplan Services Corp.	-26.1
Foundation Health Systems	-22.6

Average Change in Stock Price
(For selected health care industry segments, Jan. 1 to 31, 1999.)



Source: Townsend Frew & Co., Durham, N.C.

Psychiatrist Seeks Capitation Rate Data

Question: I am a psychiatrist in a large midwestern city, and a member of a 100-person group with 10 psychiatrists. How can I get information about whether capitation is common among psychiatrists in my area and, if so, what are the typical capitation rates for psychiatrists?

Answer: One of the first places to start when seeking information on capitation is *The HMO Salary Survey*, published by Warren Surveys, a division of DeMarco & Associates Inc., in Rockford, Ill., (815/877-8794), according to Richard Lilledahl, MD, a health care consultant with Milliman & Robertson Inc., actuaries and consultants in Seattle. We asked Lilledahl and his colleague, Oscar Lucas, ASA, MAAA, an actuary, to address this question.

The most recent issue of the survey was published in the fall of last year. It includes salaries for 24 physician specialties in managed care settings.

Another source of information on capitation is the newsletter, *Capitation Rates and Data*, published monthly by National Health Information in Atlanta (800/597-6300). "This publication focuses on capitation, and from time to time, it publishes cap rates being paid by specialty," says Lucas.

"These sources provide benchmark information that will give a sense of whether what is being offered is reasonable," says Lucas. "But physicians often make the mistake of assuming that if a payer pays the amount of money taken from one of these publications, they should sign a contract. They fail to think through all the other issues involved in setting a capitation rate."

Researching survey data is but one step, say Lilledahl and Lucas. "With our clients, we try to build an understanding of what scope of services the doctors are being asked to deliver under capitation," says Lilledahl.

Editor's note: Readers of *Physician Practice Options* are invited to call our toll-free line to speak with Richard L. Reece, MD, editor-in-chief. Often, Reece poses questions from readers to members of the newsletter's editorial Advisory Board.

"For example, what is the frequency of those services, and what type of average payment per service will the physicians get?" With such information, physicians will have an understanding of what goes into setting a capitated per member per month rate.

The components of a capitation rate are projected utilization and average reimbursement per utilization, says Lucas. Physicians need to know these components in order to understand how capitation rates relate to fee schedules and what, if any, discount they will be asked to accept. In addition, of

understand was part of the package. Often, these physicians—and let's say they're specialists—had thought initially that they were getting a great capitation rate, but after they started seeing the patients being referred to them, they began to think that perhaps a PCP should be doing those services for these referred patients. At that point, it's probably too late to do much about it for that contract period.

"Each capitation rate is contract-specific," Lucas continues. "You need to know the scope of services you're being asked to

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course, physicians need to know the level of health care management they would be expected to deliver. This calculation is done by itemizing what services—as defined by CPT codes—the contract requires physicians to deliver, says Lilledahl.

"When we do these calculations for clients, we usually develop two models," Lucas says. "One is a loosely managed scenario and the other is tightly managed. That gives us a range of utilization." Other factors to consider include the age and demographic makeup of the target population, and whether patients are covered under a commercial plan, Medicare, or Medicaid. The final component is a fee schedule that may be loosely based on the RBRVS method, the Medicare rate, or some other reimbursement system.

My Best Friend's Rate

Setting a capitation rate is not simply a matter of matching a rate to a ZIP code. "Often we will get a call from a physician group that has based its capitation rate on what another physician group got," says Lucas. "Unfortunately, clients who come to us after the fact realize too late that they are being asked to deliver services that they did not

deliver, who are the patients you're going to see, and what type or level of reimbursement is appropriate."

One often-overlooked element when setting a capitation rate is the level of stop-loss insurance coverage for cases that exceed a certain threshold, Lucas says. If there is no stop-loss coverage, the physicians might have an unlimited level of financial risk that could result from a catastrophic illness, for example. The physicians should identify what type of stop-loss protection is available and whether they should buy it themselves or the HMO will provide it, he explains.

For psychiatrists, the question of setting limits may be particularly important. Patients with chronic, incurable, and costly conditions, such as schizophrenia, may require treatment that would be inappropriate for a capitated contract, for example. Or, patients who have other, less severe conditions may need to see lower level providers rather than the most expensive specialists in the group.

"You may have patients who are seeing a psychiatrist because they have an anxiety or adjustment disorder, and, in fact, they may need to see a psychologist or a social worker, or they may need group therapy rather than a psychiatrist," Lilledahl says. "Since

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QUESTIONS FROM READERS

"It's likely in this multispecialty group that utilization is high among high-level providers, such as psychiatrists."

—Richard Lilledahl, MD, Milliman & Robertson

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the question posed here comes from a psychiatrist in a multispecialty group, it's likely that utilization is high in the group and that utilization is high among high-level providers, such as psychiatrists."

Psychiatrists seeking another approach to patient management may want to consider providing care that follows a path prescribed by case management software, Lilledahl says. Upon seeing a patient with a mental health problem, a primary care physician would enter the appropriate data into a case management system, and the computer would develop a treatment plan designed to resolve the problem efficiently and effectively. The group can then track the patient's progress electronically and refer the patient as needed to the appropriate providers, whether mid-level or high-level. One company that has developed such software is Integrated Healthcare Partners Corp., in Seattle, notes Lilledahl. For information, call Suresh Bungara, MD, president, at 425/881-1211.

Finally, one other approach the group may consider is to use case rates by diagnosis. Under this method, an annual case rate is established for each diagnosis, and then as patients are diagnosed, a case rate rather than a regular capitation amount is paid. When the frequency and severity of illness vary greatly, case rates may expose physicians to less financial risk than capitated payments do. ■

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Richard L. Reece, MD
Editor-in-Chief
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