

PHYSICIAN PRACTICE OPTIONS™

May 15, 2000

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Physician-Run Plan Affords Autonomy, Financial Benefits

Physicians practicing in areas characterized by heavy managed care enrollment lament the loss of some degree of clinical autonomy and control over premium income. To counter the effects of managed care and to regain some of the control they have lost in recent years, physicians have formed several types of organizations, including large networks and group practices, with varying degrees of success.

One organization that has enjoyed some early success is the 500-physician UCSD Medi-Cal Group, the faculty practice of the University of California San Diego School of Medicine. In seeking to preserve its patient volume and enhance clinical autonomy, UCSD Health Care, which includes the Medi-Cal group and the UCSD hospital facilities, created its own health plan. The UCSD Health Plan, while technically owned by the university, is controlled by the physician group. Such control has allowed the Medi-Cal group to develop a new senior managed care product focused on health prevention, and has permitted a larger percentage of the premium dollar to filter down to the group and to the Medi-Cal center than that received from other health plans.

Preserving Patient Volume

The UCSD Health Plan has been fully operational since September 1998, and has 15,000 Medi-Cal and 2,000 Medicare members. Besides including the 500 physicians in the UCSD Medi-

Cal Group, it also contracts directly with 350 physicians in community clinics and independent practices to serve Medi-Cal patients, and 150 independent physicians to serve its Medicare population. The network also includes several community hospitals.

The San Diego market is highly penetrated by managed care, according to Nancy White, director of the UCSD Health Plan. "Penetration is heavy across all lines of business," she says. About 50% of all Medicare beneficiaries are enrolled in managed care, and about 80% of the commercial market is so enrolled. In 1998, Medi-Cal, the state Medicaid program, made managed care mandatory.

UCSD Health Care's decision to start its own health plan was a defensive move, made to preserve its Medi-Cal patient volume, White explains. "The initial impetus to start the plan occurred when the state mandated that Medi-Cal recipients would have to receive services from managed care providers," she says. "UCSD is the largest provider of services to both Medi-Cal recipients and the uninsured. Medi-Cal is the source of a significant portion of our revenue stream as well as our patient volume, which we need to sustain our teaching and research mission. When Medi-Cal became mandatory managed care, the university was afraid we would lose this business."

Before starting its own health plan,

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A Simple Solution Helps Eliminate Fear of Medicare Prosecution

Federal efforts to eliminate one problem often cause other difficulties. This phenomenon is known as the law of unintended consequences. Recently, for example, efforts by Congress to stamp out fraud and abuse in the Medicare program have caused physicians to stop treating Medicare patients.

The government's guidelines about when a physician conducts an evaluation and management of a patient—the so-called E&M guidelines—are contained in more than 132,000 pages of regulations that are so complex and convoluted few experts understand them fully. When physicians match procedure codes against these guidelines, they need to sift through dozens of regulations to identify a code that is safe enough to produce revenue but does not violate any of the government's regulations and lead to federal indictments.

Since matching procedure codes against guidelines is so difficult physicians generally avoid the task altogether or are so conservative that they lose income needlessly, says John McDaniels, president of the Physician Management Group, consultants in New Orleans, who has studied thousands of physicians' coding patterns. Because they fear federal investigators, physicians often undercode and lose as much as \$20,000 each year, he says.

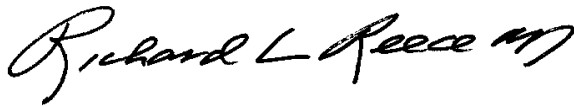
Hoping to avoid billing mistakes that could lead to a federal investigation, physicians close their practices to new Medicare patients. The Association of American Physicians and Surgeons, in Tucson, Ariz., conducted a survey of 331 physicians in July that showed that nearly 25% refuse to treat Medicare patients and more than a 33% have trouble referring Medicare patients to other physicians. The survey also showed that about 67% of respondents plan to retire early to avoid difficulties with Medicare billing and more than 80% of those physicians responding to the survey report fear of prosecution or investigation. Some 75% of respondents have made changes, including undercoding, to avoid running afoul of the government.

Most physicians are interested in treating patients and being paid a fair rate for their work. They would prefer not to turn away patients, particularly those who are older and most in need of prompt, capable medical attention.

In fact, some physicians have developed proprietary computer programs to ease the process of E&M coding. James Weintrub, MD, a plastic surgeon in Providence, R.I., is concerned about the difficulties physicians face in coding appropriately and has been working with a computer programmer over the past two years to match procedure codes with E&M guidelines in a program he is developing.

Many companies match codes and guidelines and most physician consultants, hospital systems, practice management firms, coding compliance companies, and health care law firms will educate and train physicians and audit their practices to ensure that physicians are in compliance.

Physicians seeking more information on Medicare compliance and systems designed to match codes and guidelines to optimize income are invited to call me directly or send an e-mail.



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E-Care Offers Possibilities for Growth

By Douglas Goldstein and Cheryl L. Toth

Health care is embracing the Internet. In the past 12 months, Medscape went public and Healtheon/WebMD has acquired a number of companies including a pharmacy, CVS.com, and a practice management system, Medical Manager. This push toward what's called e-health care stands to change the way medicine is practiced even more than managed care or physician practice management companies did. Despite the recent e-health care revolution, however, most doctors have been reluctant to participate.

A 1999 Healtheon/WebMD survey showed that 85% of 100,000 responding physicians used the Internet primarily for trading stocks, researching medical journals, sending and receiving e-mail, and buying products online. Although physicians are online in increasing numbers, few help their patients access online health information and medical decision support, or use Internet technology to improve patient care. At the same time, patients want access to health information and medical knowledge more than ever.

Preferred Relationships

Patients are developing preferred relationships with a number of health portals such as onhealth.com, webmd.com, drkoop.com, medconsult.com, and others. These health portals offer what's called "infotainment"—health care information, support groups, products, and chat—but cannot offer medical advice or care. Still, they are shifting traditional referral patterns by empowering con-

sumers with information previously available only to health professionals. The good news is that consumers still prefer health information from doctor-sponsored sites. Some 74% of consumers surveyed in a July 1999 study for Intel Corp. by researchers CyberDialogue (cyberdialogue.com) said that doctor-recommended Web sites are the most trusted.

Instead of allowing patients to get their health information from health portals, physicians should offer them a Web service that contains medical information,

vices advance, a link between the Web service and your practice management system will allow patients to register themselves directly into the system—eliminating the staff's need to do so.

3. Post answers to frequently asked questions (FAQs). Post pre- and post-operative instructions, financial policies, and the names of the health plans in which you participate. Doing so will begin to decrease phone volume, leaving staff free to focus on patients in the office.

Physicians should prepare to give patients online information, products, and services.

trustworthy medical decision support, and more. Rather than letting the health portals erode patient relationships, physicians should get online to support patients with information, products, and services so patients don't fill their health care needs with infotainment.

Three Steps

Offering services on the Internet is not as easy as switching suture brands or buying a fax machine. Thoughtful decisions must be made about leveraging your practice brand on the Web. But there are three practical steps that can get your practice involved quickly and easily:

1. Recommend sites you trust. Since patients are looking to you to help them make treatment decisions, create a service that connects them with the sources you deem credible. Instead of allowing patients to surf the more than 20,000 available health and medical Web sites, save them time by evaluating the most significant sites in your specialty and posting this information on your own site.

2. Offer registration forms online. Post registration and clinical history forms on your site and direct new patients there to print and complete the forms prior to the first visit. This step is the first one toward electronic registration. As your Web ser-

From Content to Care

Tackling the Three Cs—content, commerce, and connectivity—is one way to begin embracing e-health care. (See "The Three Cs of E-Health Care.") A well crafted plan, executed by an organized individual in the practice, can make the services you offer via the Internet useful and effective within six months.

But while health information, registration forms, and policies are useful, when patients are ill, they want advice and support that directs them to the right care. They want trusted information from their physician.

Finding a way to integrate office-based services with online services is the key to succeeding in e-health care. You might offer a list of frequently asked clinical questions and answers which are often provided by a nurse or left on the answering service after hours. Offer information about the difference between a virus and a bacterial infection, for instance, and which flu symptoms mean the patient needs to schedule an appointment. Or you might provide information about how to tell if a wound is infected and what grade of fever signals danger in an infant. Posting answers to these questions on your Web site, with an algorithm that

(Continued on page 4)

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(Continued from page 3)

appropriately steers patients to your office, the emergency room, or the local pharmacy for an over-the-counter medication, is an excellent way to offer online e-health care that is integrated with office services.

Another way is to offer those who suffer from chronic conditions a way to manage their conditions more effectively. Research by Harris Interactive (harrisinteractive.com) shows that patients with chronic conditions have indicated a strong demand for online health services. Among patients with diabetes who responded to the question, "How helpful would disease management software and Internet reporting to your doctor be?" some 47% said such services would be very helpful. Also, 43% of patients with heart disease, 43% of patients with depression, 38% of cancer patients, and 34% of patients with gastrointestinal disorders said such services would be "very helpful."

Taking Action

One way to meet this need is to integrate or suggest Web services that allow chronic sufferers—patients with diabetes, for example—to enter glucose levels online and send other information that can be reviewed by you or the clinical staff. Such self-monitoring can improve a patient's attention to daily tracking of critical indicators. Some Web services provide information about lifestyle changes, exercises, and diet. Directing patients to these services encourages them to participate in their own care.

Joseph Prendergast, MD, a 62-year-old endocrinologist developed DiabetesWell (diabeteswell.com) for patients interested in entering their blood sugar levels online so he could monitor them. Patients also can send e-mail questions to a nurse. For the service, his patients pay \$19.95 per month. If programs like this one are effective at reducing health care costs, many health plans will step in and begin paying for offering such services.

As your practice considers e-health care strategies, add discussions about the Internet to as many partner meetings as possible. Solicit the opinions of staff, nurses, and other providers and integrate suggestions from your office man-

Sites Offer E-Care Options

Patients with chronic illnesses may be interested to learn that there are services that support them in managing their conditions. Offer a link from your Web site to related sites or license certain applications and put them directly on your site.

Pdhi.com has developed Web sites for a number of conditions, including myasthma.com, myallergies.com, mydiabetes.com, and mybp.com. Patients can log the medications they take and add any self-monitoring information they have. Also, a patient can get a report in graph form to take to his or her physician. Other functions include condition-specific clinical content, ask-a-nurse services, and product purchases.

Dietwatch.com. Physicians seeking to license content might want to consider the online community dietwatch.com, a free, easy-to-navigate site that offers a daily diary and inter-

active tools for those who want to lose weight. The service offers discussion groups, chat rooms, and expert sessions, as well as health and diet news. User testimonials are compelling.

Medifor.com has a series of online and computer-based products to help physicians educate patients and support online doctor-patient communication. These products are licensed by each practice. The patient education area allows physicians to print out and deliver customized, trustworthy health information to patients. Medifor.com plans to allow physicians to create personalized Web pages for patients.

Lifemasters.net is an innovative company that uses a combination of nurse phone calls, data tracking software, communication, and pagers to help physicians improve the management between appointments of patients with chronic conditions.

agers. Adopting staff suggestions will help to weave the use of the Internet into the fabric of your operations. You may have a wonderful idea about allowing patients to download presurgical instructions from your Web site, for example, but your nursing staff or surgical counselors will need to modify the way they process surgical patients if implementing this step is to be a success.

Craft an action plan that begins by offering content, commerce, and community and moves toward integrating all practice services into your e-health care strategy. As you initiate e-health care in your practice, follow these five steps.

1. Find out what's being said about your specialty on the Web. Visit several of the large and most popular commercial Web sites and determine what is being promoted as health information in your specialty. Enter discussions and chat group areas. Read the questions visitors ask and monitor the answers they get. Notice what companies are advertising on these pages.

Use the major search engines such as Yahoo! (yahoo.com) and Excite (excite.com) to learn what comes up when

you do a search for your specialty. Type in a few of the diagnoses you treat most often and see which sites are listed. Keep in mind that it is likely that your Web-savvy patients have been to many of these sites.

2. Survey patients about what they want from your practice's Web services. Find out how many of your patients are online, and what they want your practice to make available to them on the Internet. Even if only 20% of your patients are online today, there is still an opportunity to decrease phone calls to your office by directing them to FAQs on your Web site or giving them the option of e-mail.

3. Collect patients' e-mail addresses. Rewrite your patient registration form and ask your practice management system vendor to add a custom field in the patient account screen for e-mail addresses. Once you have developed an e-mail database, send patients targeted e-mails about specific conditions such as flu shots or other seasonal information that may help increase patient traffic in your office.

4. Become a nexus of online health knowledge. Distribute a written list of sites you've reviewed, and provide links

on your Web service. Discuss during exams what patients have found on the Web and then share the customized information and advice that is available from your practice. Keep a computer with Internet access in the clinical area so you can show patients how and where to find key information about your specialty.

5. Find out what your local hospitals are doing. Many health systems are looking at ways to deliver health and medical information, products, and services to consumers and patients. The local hospitals may allow physicians a link to the hospital's Web service or a discount on Web content, design, or access to other Internet services.

As you proceed, continuously evaluate the services you offer on the Internet. Every Web service is a work in progress. Evaluate your service's information, products, and services regularly, and plan ahead for adding new features and functionality.

Consumers and patients are using the Internet to take control of their health and well-being. There is little time for physicians to analyze whether going online is the right step or whether it costs too much. Become informed about what's available online and start communicating with patients electronically. If you don't, someone else will. ■

The Three Cs of E-Health Care

Content and Community

Offer information about practice services, office hours, financial policies, health tips, and other information. Remember that your competition is not the physician on the next block, but consumer health portals. Use these sites as a benchmark when considering the design and navigation of content and community features.

Commerce

Consider selling products online. Some primary care practices sell vitamins at the checkout desk. Why not do so online? Amazon.com has an affiliate program in which an online bookstore can be set up; recommended books generate a 15% commission.

Connectivity

Consider e-mail communication with patients who have billing or clinical questions. Review the American Medical Informatics Association's White Paper for implementation guidelines (amia.org). Ask your attorney for an opinion on how to avoid potential liability issues. Initiate e-mail newsletters that maintain contact with patients and communicate information about medical breakthroughs, new treatment options, and new physicians and staff.

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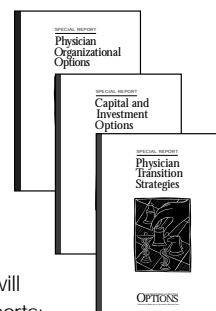
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Faculty Practice Plans Adapt to Change

By Thomas M. Gorey, JD

As health care has changed, so too have academic medical centers and their associated faculty practice plans. In recent years, faculty practice plans—the entities that handle the administrative responsibilities associated with the clinical activities of medical school faculty—have faced substantial pressures in areas such as reimbursement, managed care, and regulatory compliance. While the plans have lost market share and had payments reduced under managed care, the medical schools themselves have come to depend on the revenue from the clinics the plans run.

In response, practice plans have had to reexamine their fundamental mission and objectives and have sought to develop more efficient and more competitive clinical practice models. In many cases, this development has led to a reconfiguration of practice plan governance and administrative structure and to the implementation of new cash-flow models. Instead of fragmented, specialist-dominated organizations focused on research and acute care, a new practice plan model is emerging based on the group practice model. This new plan has an appropriate mix of specialists and primary care physicians and provides a full continuum of care, both in academic medical centers and in the community.

A recent study of faculty practice plans conducted by Policy Planning Associates for the AMA, the Association of American Medical Colleges, and eight other national and state medical associa-

tions, explores the varied forces for change affecting faculty practice plans and describes the types of initiatives being implemented to reposition practice plans.

The report is based on case studies of the faculty practice plans at seven leading academic medical centers: Weill Medical College of Cornell University, the Johns Hopkins University School of Medicine,

enhance configurations at faculty practice plans, in most cases the dean and the medical school department chairs play a central role in governance. There appears to be a growing recognition, however, of the importance of providing for broader input into practice plan policymaking and decisionmaking.

3. Billing and collections. The extent

New practice plans are emerging based on the group practice model and have a mix of specialists and primary care physicians.

the University of Michigan Medical Center, the Medical University of South Carolina, the University of Colorado School of Medicine, the University of Texas Health Science Center at San Antonio, and the University of Wisconsin Medical School.

As expected, these practice plans operate in a variety of ways, yet, the study identified 10 common themes.

1. Mission. Traditionally, faculty practice plans have had limited staff and a relatively narrow mission: to handle billing and collections for the medical faculty's clinical services. A major portion of the practice plans' responsibility continues to be to preserve and strengthen the academic mission of the medical school by furthering education and research. In response to increased market and financial pressures, however, practice plans are incorporating a broad range of business functions within their responsibilities, including providing a full range of business management services and information systems to support the medical faculty's clinical endeavors.

2. Governance. Practice plan governance remains a sensitive and evolving issue at many academic medical centers. Where the issue is contentious, a focal point of concern typically is the role of the medical school dean and the department chairs on the practice plan board.

While there are a wide variety of gov-

to which administrative functions are centralized within a practice plan remains a significant issue. The traditional and most fundamental function of a practice plan—billing and collections—is often at the center of debates over the appropriate role of the central administration and the clinical departments. While most practice plans have moved toward centralized billing, there have been cases of practice plans returning certain billing and collections responsibilities back to the departments when centralized billing failed to produce the desired effect. In instances in which billing and collections become a flash-point issue, practice plans generally have found it necessary to devote focused attention to resolving faculty concerns. Until this issue is resolved, it is difficult, if not impossible, for a practice plan to address other strategic goals effectively.

4. Funds flow and compensation. After billing, issues related to funds flow and compensation typically generate the most discussion and concern among faculty practice plan members. Such issues generally are centered around the nature and amount of the taxes assessed against clinical earnings by the dean, the university, and the practice plan; the subsidy of lower revenue generating departments by higher revenue producing departments; and the role of clinical productivity and other factors in the compensation formula.

Thomas M. Gorey, JD, is president and CEO of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development. More information on physicians' organizational options is available at mdoptions.com. The Case Study Analysis of Faculty Practice Plans can be obtained by contacting Kristin Sabec at the Michigan State Medical Society (517/336-5769). The cost of the report is \$95.

5. The role of primary care.

Traditionally, practice plans have been dominated by specialists and oriented toward serving their needs. With the growth of managed care, however, and the need to maintain a sufficient patient base to sustain medical education and research, the role of primary care in most practice plans has taken on increased prominence. The heightened awareness of and attention to primary care, however, has raised some difficult and sensitive issues, such as:

- How do PCPs fit into the traditional medical school, which emphasizes education and research?
- How does implementation of a primary care strategy affect relations with community-based physicians?
- What effect will an increasing number of PCPs have on compensation?

Practice plans have been addressing these questions in a variety of creative ways. Perhaps the most common strategy has been to increase primary care capacity by strengthening relationships with primary care physicians in the area, thereby complementing the faculty in the primary care disciplines. The goal behind developing such relationships is to build a network on a statewide level. The physicians in such networks often serve as volunteer faculty, thereby bolstering the medical schools' primary care education programs.

Many practice plans also are expanding their geographic reach by developing satellite offices. These offices have generally elicited a positive response from patients because they provide convenient access to high-quality medical care previously available only at a major university medical center.

6. Compliance. Ten years ago, the word 'compliance,' was not part of most practice plans' vocabulary. Today, it looms as one of the most significant issues faculty group practices face. In addition to consuming a substantial amount of staff and board time, regulatory compliance issues—primarily involving oversight of billing and documentation practices—represent a significant cost to most practice plans. As a result, most of these plans have hired full-time compliance staff to coordinate these efforts.

7. Practice plan-hospital relationships. In a dynamic, changing health care envi-

Practice plans will need to recruit faculty members who have business skills and are committed to clinical care.

ronment, maintaining positive, mutually rewarding relationships between faculty practice plans and teaching hospitals—including well defined, agreed-upon areas of responsibility for each party—is a key factor for both entities. Although in many cases there is a collaborative, supportive relationship between the practice plan and the hospital, there often is a certain degree of underlying tension in the relationship, particularly because the emergence of a well organized, centralized practice plan can pose a threat to traditional notions of hospital control. As a result, there is typically little if any operational integration between practice plans and university hospitals.

8. Clinical process improvement. Many practice plans make clinical process improvement part of their mission, and are developing practice standards, clinical pathways, and protocols that promote the delivery of high-quality, cost-effective care. Among the initial clinical redesign initiatives practice plans undertake are the development of uniform credentialing policies for clinicians, clinical guidelines for high-cost disease conditions, and practice standards and performance guidelines. Other practice plans have interdepartmental teams developing medical management and disease management models that coordinate care for specific patient groups.

9. Fostering a group mindset. With clinical care becoming increasingly interrelated, it is more important than ever for practice plans to break down traditional departmental lines and be more group-like in their organizational structure and operations. Full implementation of a group practice model, however, is likely to be slow and gradual for many practice plans. Some may never fully implement a group practice model because of their institutional culture and traditions. The starting point is to get the faculty to begin thinking as a group, rather than strictly along department lines, and to accept the

notion of centralized management through the practice plan.

10. Developing physician leadership. In light of the significant challenges ahead, there will be a growing need for experienced, well trained physician leaders to guide the evolution of faculty practice plans. Most practice plans draw their physician leaders from among the department chairs. Therefore, changes in the skills of clinical chairs will influence hiring decisions. Practice plans will need to recruit faculty members who have business skills and are committed to clinical care, recognizing that expertise in patient care is as important as expertise in research. By recruiting such faculty, plans will create a larger pool of physicians with the core competencies needed to tackle the issues that plans will face in the years to come.

Looking Ahead

Fundamentally, practice plans afford a mechanism to manage the practice of medicine in academic settings. These plans provide an essential base of administrative support for the faculty's clinical activities and enhance the faculty's ability to compete effectively in the market by expanding primary care, by implementing clinical and administrative information systems, by facilitating the development of clinical pathways, and by enhancing contracting and marketing efforts.

Almost all practice plans are struggling with the issue of how to maintain an appropriate balance between furthering the traditional education and research missions of the medical school, while also seeking to generate more clinical revenue. Also, they are facing many of the same problems community-based practices face. Medical schools and practice plans will need to reexamine the nature of academic medical practice and to articulate clearly to a new generation of physicians the continuing attractiveness of careers in academic medicine. ■

(Continued from page 1)

UCSD tried to partner with one of the big health plans in the San Diego market. “The university preferred to focus on providing Medi-Cal education and health care services,” says White. “Rather than creating our own plan, we would have preferred to create a good partnership with an area health plan that would have assured us that we would retain our Medi-Cal patient volume. But since we could not negotiate such a partnership, we started our own plan.”

Technically, UCSD Health Plan is owned by the regents of the University of California, the governing body of all University of California campuses. Physicians govern the plan, however.

“The board of directors comprises primarily physicians,” White says. “We have 11 voting members on the board. Three are community physicians. Four are UCSD Medi-Cal Group physicians, including the chair of the Medi-Cal group governing board. The remaining four are UCSD Health Care administrators. Thus, the direction of the health plan is controlled and driven by physicians.”

High-Quality Care

Beyond preserving its Medi-Cal business, the UCSD Medi-Cal Group saw the health plan’s opportunity to make the tenets of managed care work toward its own benefit and that of its Medicare patients.

“In today’s environment, many physicians are ambivalent about managed care,” White says. “With the development of the health plan, however, our physicians can make managed care do what it was intended to do: manage a population’s health and focus on preventive care.”

By serving its Medicare population through its own health plan, the UCSD Medi-Cal Group realized the opportunity to apply a high-risk care management program to bring better quality care to the elderly by focusing on illness prevention. “The geriatricians and preventive health specialists in the UCSD Medi-Cal Group had been very interested in implementing a senior program that aggressively sought out seniors

“Our physicians can make managed care do what it was intended to do: manage a population’s health and focus on preventive care.”

—Nancy White, UCSD Health Plan

either at high risk for becoming ill or who already had some health complications, and then offering aggressive case management to this population,” White says. “By managing its Medicare population through its own health plan, the Medi-Cal group could maintain the clinical autonomy to manage that population without having to ask permission of an outside health plan to implement this intervention.”

As part of the high-risk care management program, all Medicare enrollees receive an initial health screening questionnaire and phone evaluation to identify those plan members who are either at risk for deterioration in health status or currently need additional support. About 60% of enrollees fall into the high-risk or potential-high-risk categories. That subset of individuals is interviewed by a nurse practitioner who specializes in geriatrics.

“The nurse practitioners may execute a number of measures,” White explains. “They can schedule the patients immediately for a primary or specialty care visit. They may perform a home assessment. They ensure that the patients have all their medications, and understand how to take them.” White notes that while some health plans say they have such a program and identify high-risk patients, there is no real integration with physicians’ treatment and case management of this population.

To ensure that it delivers quality care, the Medi-Cal group is carefully tracking patient outcomes and utilization. “One statistic we are tracking is bed days,” says White. “We believe that we are attracting a more acute population of seniors. Our bed days for this group of UCSD Health Plan patients, however, are better than those for Medicare patients in our contracted plans.”

Too many barriers would exist if the Medi-Cal group tried to implement this intervention with patients from a contracted health plan, White says.

“Knowing that we can drive our programs ourselves as opposed to living with another program imposed from the outside makes a big difference in terms of our autonomy,” says Ted Ganiats, MD, a family physician with UCSD Medi-Cal Group and the director of the UCSD Health Outcomes Assessment Program. “We don’t have to get anybody’s approval to implement programs. For example, in deriving outcomes measurements for the high-risk care management program, two of my physician colleagues and I sat around a table and decided what elements would be part of the outcomes measurement project. At a later time, one of us sent an e-mail to the others about a suggested change. It made sense, so we did it. Most of the bureaucracy can be eliminated, control over the program is localized, and we can adapt more rapidly.”

Retaining the Premium

Another reason the UCSD Medi-Cal Group used the health plan to cover its Medicare patients and its Medi-Cal population is because it reduced administrative costs, meaning more of the premium dollar could be allocated to physicians.

“Many California health plans and Medi-Cal groups operate within a delegated model whereby the health plans capitate the Medi-Cal groups and then delegate administrative functions to them,” says White. “Physicians want more control over patient care; therefore, health plans delegate the utilization and quality management functions to the physi-

(Continued on page 9)

“Knowing that we can drive our programs ourselves as opposed to living with another program imposed from the outside makes a big difference in terms of our autonomy.”

—Ted Ganiats, MD, UCSD Medi-Cal Group

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cian groups so they could make their own utilization decisions. Delegation of these functions, however, does not reduce health plan administrative costs by much, but it does add to physician group costs.” As a result, the health plans still take a portion of the premium for administration and profit, and physician groups have an additional layer of administrative costs to cover.

“By having our own health plan we cut out a whole layer of administrative costs,” says White. “The premium payments come directly to us as the health plan, we take out as little as we can to cover administrative costs, and then pass the rest along to the providers.” As a result, the UCSD Health Plan passes along a per-member per-month payment that is approximately 10% higher than what other health plans pay physicians.

Risk-Adjusted Rates

Financial concerns also dictated another decision UCSD Health Care made: to participate in the Medicare+Choice’s demonstration project for provider-sponsored organizations (PSOs) run by the federal Health Care Financing Administration. HCFA accepted the UCSD Health Plan as one of 25 original physician-run organizations in the project.

Through the PSO project, HCFA is testing a variety of risk-adjustment methodologies. Risk-adjustment allows HCFA to pay higher rates to physicians who treat patients who are more ill than other patients.

For a university provider such as UCSD, risk adjustment is particularly important, especially under capitated reimbursement systems. “In 1997, one of our contracted health plans hired an independent third party to study the acuity of our patient base,” White says.

“The study showed that the UCSD Medi-Cal Group treated more patients with certain high-acuity diagnoses than other area Medi-Cal groups. Because we knew we had this adverse selection, the opportunity to participate in a demonstration project that would adjust our payment based on health status was very attractive to us.”

Preserving Revenue

Physicians often are reluctant to form their own health plan because they fear a backlash from competitive managed care organizations. “We contract with all the major health plans in the area: PacifiCare, HealthNet, Kaiser, Aetna-US Healthcare, Prudential, and CIGNA,” White says. “Those plans contribute a significant amount of our revenue, and by forming our own health plan we didn’t want to alienate any of these business partners. Accordingly, in setting up our health plan we made a commitment to our health plan partners that we would not try to get members by converting our patients who are members of other health plans. Since we want to get net new business into UCSD, we concentrate our marketing efforts at non-UCSD Medicare beneficiaries still on fee-for-service coverage. As a result, the other plans did not respond negatively when we created our own. I don’t think they saw us as a big threat.”

The university maintains a management services organization (MSO)—UCSD Managed Care—that serves both the physicians in the Medi-Cal group and some community physicians. UCSD Managed Care provides a variety of managed care management services, including health plan contract negotiations, claims processing, member services, quality and utilization management, and credentialing.

Cautionary Words

One of the disadvantages of being in a physician-run plan is that physicians sometimes face conflicts regarding strategies for the Medi-Cal group and for the plan. “For example, for the health plan to be marketable we need to expand to geographic regions that are beyond the Medi-Cal group’s areas of practice,” White explains. “So we’ve had to bring physicians into the panel who are outside of the UCSD system. That strategy can be viewed as a drain on the group’s resources and as a risk. But we need to do that to preserve the health plan’s growth and viability.”

What’s more, developing a health plan requires a significant amount of capital. “It’s very expensive to develop a health plan,” White says. “The physicians must be prepared to run at a loss for two or three years. We are still struggling with slower than anticipated growth in enrollment, which negatively affects revenue levels. As a result, UCSD Health Care is continually evaluating the health plan as an appropriate growth strategy.”

A New Dimension

It is likely, however, that the advantages of having physicians run a health plan would outweigh any disadvantages. “I would strongly advocate that physicians give the development of a physician-run health plan serious consideration,” Ganiats says. “But physicians have to undertake a strategy like this seriously. It adds a whole new dimension to the practice of medicine, one that is not easy or apparent. My advice to physicians who are interested in starting their own plan is, don’t underestimate the commitment it takes and respect the kind of responsibility you’re taking on.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on practice options is available at mdoptions.com.

The Persuasive Logic of Global Systems

By Douglas W. Emery

Health care is like few industries in the world. Either directly or indirectly, physicians control or influence 80% to 85% of the spending that governs resource utilization, yet physician profits are derived from the 20% of the health dollar that goes to them as direct compensation. This is largely the legacy of fragmented fee-for-service. We may safely conclude, therefore, that physicians are receiving only a fraction of the potential revenue they could receive.

From the physician's perspective, the potential revenue is yet another element in the persuasive logic behind physician risk assumption. Yet, the only way to capture this potential increase in revenue is to link compensation to total production.

Like a general contractor in a building project, a global delivery system acts as a single point of contracting accountability between payers and all the various elements needed to complete an episode of care.

There are two ways to do so. One is to shift some or all of the insurance premium dollar to doctors before care occurs in a capitated system. The other is to allow physician-owned global delivery systems to control the full global dollar for episodes of care during or after care occurs on a prospective pricing basis.

A global delivery system can be defined as a technical risk-assuming entity designed to manage, market, and operate integrated episodes of care. In the same way that a general contractor is the coordinating intermediary between those

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who finance the project and those subcontractors required to complete the project, a global delivery system acts as a single point of contracting accountability between payers and all the various elements needed to complete a self-contained episode of care.

Cursorily, such firms may act like integrated delivery systems (IDSs). But two important factors set them apart. First, an IDS is in the business of assuming probability risk or insurance, and a global delivery system is not. Second, a global delivery system can encompass the full range of medical services across the spectrum of care, or it may be a highly specialized operation concentrating on only one type of episode of care. There can be many

variations on the theme.

For physicians, there are several salient arguments that can be used to justify the creation of global delivery systems. Among them are autonomy of physician practice, what might be called purity of art, lower capital requirements, and increased income.

Autonomy of practice. Once technical risk has been delegated through global fees, there is no reason for insurers to meddle in the episode of care. Moreover, as genuine competition matures, the design and content of episodes will become the absolute purview of the medical community.

Purity of art. Although it is true that for physicians to capture their rightful gains, they must accept the financial risk of delivering care, there is no reason to adulterate the practice of medicine with the business of insurance. Providing health care and offering insurance are contradic-

tory and mutually exclusive domains. Global delivery systems give physicians the capability to manage technical risk, and the institutional power to veto probability risk. Thus, they may remain true to their traditional fiduciary obligations.

Lower capital requirements. Since a global delivery system does not manage probability risk, it is not in the business of insurance. Therefore, it does not need to meet the requirement for statutory reserves or assemble a huge, regional system of productive assets to deliver a full benefits package. Since it is free of such encumbrances, the global delivery system has flexibility. Not having to organize around a benefits package, a global system can organize around any episode or group of episodes of care that the physicians desire.

Increased income. A global system and its owners capture all profits associated with the efficient management of integrated episodes. This result derives from the fact that a global system functions as a general contractor, either owning or subcontracting the elements of care within an episode. Since the global system captures the full dollar for each episode of care, it also can capture any remaining surplus.

Ownership and Structure

Given that physicians dominate the health care supply curve in that they make the decisions about what the health care system will produce for each patient, it follows that they should hold all or most of the equity positions in global delivery systems. This fact explains much of the logic behind the insistence of the federal Health Care Financing Administration, which runs Medicare, that physicians should have a significant ownership position in the physician-hospital organizations in which it has chosen to expand its global fee demonstration projects.

A fully mature global delivery system has three basic elements: a panel of physicians and allied providers, an integrator (which operates at three different stages), and a governance structure.

Panel of physicians and allied providers. The physician panel or network of affiliated physicians includes those professionals and organizations required to deliver the various elements of care for each episode, such as physicians, nurses, diagnostic and other equipment, and supplies. Participating physicians and allied affiliates can be full or partial owners or merely contracting partners.

Stage I integrator. A Stage I integrator is a basic network of physicians, facilities, and ancillary providers bound loosely together by contractual relationships. The integrator assembles the internal contracts as a corporate umbrella of bundled services to be offered to payers for external contracting. It can receive global payments (or any type of related payments) and distribute them internally to all the relevant contributors involved in the contracted episode. But its ability to coordinate episodes is limited to bloc-like actions; that is to say, each element of care, the office practice, for instance, or the facility, remains a distinct, autonomous corporate entity unto itself while acting in concert with the other entities.

A Stage I integrator sets out to accomplish the doable. In this stage, the integrator makes a frank assessment of what is possible without having to raise tens of millions of dollars to build systems that may or may not work as designed. An industry as complex and yet in many ways as archaic as health care cannot be rushed into full maturation. The business of integrating episodes is a new frontier, and those building these systems still have much to learn. The type of information systems needed to coordinate episodes effectively do not yet exist. Therefore, wisdom and experience suggest a policy of incremental advancements.

Stage II integrator. A Stage II integrator takes the intermediary steps necessary to get from a Stage I integrator to the ideal Stage III integrator. The governance mechanism, which in the Stage I phase limits itself primarily to periodic activities of governance, general contracting matters, and some compliance and outcome issues, can begin to delve more deeply into developing protocols and tracking individual compliance. Assuming increased importance at this stage, the

By collecting information at the point of care, global systems gather data on medical decisions as they occur and can then project their effect on resource consumption.

integrator manages the day-to-day affairs necessary to coordinate episodic care, develop contracts, and handle physician credentialing, billing, fund distribution, purchase of supplies, clinical feedback, resource utilization, case management, marketing, and network development. In Stage I, systemic integration is minimal and capabilities are limited, meaning these matters require relatively few people to administer the entire operation.

In Stage II, the integrator assumes more important duties and managerial intensity increases. In Stage II, the information system and its ability to penetrate into all the elements of care begins to assume the shape and form it will take in an idealized Stage III. The system will operate with increasing levels of reporting sophistication for both internal and external needs. It will begin to take billing functions away from the office and clinic staff members, and it will begin to handle accounting and finance functions.

Stage III integrator. In Stage III, a global delivery system can act as a highly competent general contractor with dynamic contracting at the payer level and dynamic contracting at the subcontracting level. Purchasing and resource utilization tracking occur in real time.

A Stage III integrator places in all clinical production sites client-server work stations and palmtop computers so that the information system flows from provider rounds and activities. In this manner, the integrator can collect data on medical decisions as they occur and project their effect on resource consumption. The fragmented medical management systems of Stage I and Stage II integrators will be replaced with innovative, new, Internet-based information systems that perform all the functions of earlier systems and the new functions required for data management and clinical integration. All parties throughout the global

delivery system will have access to necessary information and communication links so that duplicative services and waste can be reduced significantly. A fully mature integrator will require six major divisions, each carrying out basic functions necessary to operate globally priced episodes of care efficiently. The six divisions are: episode coordination, finance, credentialing, contracting, purchasing, and information systems.

Governance structure. More than a physician-governed board of directors, the governance structure is also a panoply of specialty-specific review panels that have the power to design and measure hypothecates of care and physician compliance and to incorporate evolving standards of care. The board and review panels are populated by revolving physician leaders who are compensated for their time and who work with the full-time medical director to direct a collegial, peer-reviewed environment in close collaboration with individual physicians and allied professionals.

The governance structure resembles the type that the AMA proposed for HMOs and IDSs, but which have yet to be implemented. Its purpose is to give physicians sovereign policymaking authority over the global delivery system while allowing a professional lay administration to manage the day-to-day operations, which physicians as a rule do not have time to perform.

It is not the intent of a global delivery system to buy up physician practices (which is counterproductive) or any other series of physical assets. The great untapped potential for physicians in managed care lies not in owning assets or insured lives, but in owning the production process involved in the delivery of each episode of care. The global delivery system concept is designed to fulfill that potential. ■

Anthem Finds Quality-Based Network Reduces Costs and Improves Care



Payers and providers share a common desire to improve health care quality while also lowering costs. Anthem Blue Cross/Blue Shield, a managed care organization in Cincinnati, is seeking to attain these goals by developing a network of high-quality cardiology providers, called Coronary Services Network. Derek van Amerongen, MD, Anthem's national medical director since 1996, outlines how this network has reduced cardiac care costs while also enhancing quality significantly. Van Amerongen received his medical training at Rush Medical College in Chicago, and completed his residency in obstetrics and gynecology at the University of Chicago. He practiced for more than 13 years in both community settings and academic centers, including Johns Hopkins Hospital. Author of numerous research, professional, and management articles, Van Amerongen lectures extensively on managed care and health policy topics. He has written Networks in The Future of Medical Practice (Health Administration Press, Chicago, 1998). Richard L. Reece, MD, conducted this interview. More information on cost control and quality improvement is available at mdoptions.com

many were performing a very low volume of cases and were obviously trying to get in on what was perceived at the time as an important way to generate revenue for hospitals.

The other issue that prompted the development of the Coronary Services Network was the fact that cardiac surgery represented a substantial portion of our medical costs. Approximately 20% of every health care dollar we spend pays for bypass procedures and coronary services. Of course, that's consistent with what happens nationally—about 20% of all dollars spent on medical care in the United States goes to bypass and other cardiac procedures.

We were not necessarily trying to ratchet those costs down, but we wanted to have a greater comfort level that the money being spent represented appropriate care. In effect, we were faced with both quality and cost concerns. So, Berman, in conjunction with Michael Pine, MD, a cardiologist and biostatistician at the University of Chicago, built a sophisticated risk-adjustment model to examine cardiac outcomes at the hospitals where we had contracts.

We wanted to examine the data from every bypass patient and every percutaneous transluminal angioplasty (PCTA)

patients, because that was the setting in which we have the greatest leverage in being able to direct patients to the institutions that we felt provided good care.

Approximately 30 hospitals in Ohio were evaluated for inclusion in the network. Some of these hospitals were not approved for network participation based on insufficient volume; approximately five hospitals did make the volume cut, but were not considered to be of sufficient quality. Ultimately, 17 hospitals were included in the network; two hospitals passed the quality hurdle, but we weren't able to reach contracting agreements with them.

Q: Why did you consider procedure volume in determining network participation?

A: Studies have consistently shown that, especially with sophisticated procedures such as bypass surgery, high volume is correlated with high quality. In other words, if an institution is performing a large number of cases, there is a greater likelihood that the quality of performance will be high. On the other hand, if an institution is not performing a certain number of cases, it's much more difficult to achieve high quality levels, simply because they don't develop the technical skills and the

"The network results prove that high-quality providers are, in fact, lower cost providers."

Q: What was the genesis of Anthem Blue Cross/Blue Shield's Coronary Services Network?

A: The Coronary Services Network was established in 1994. The idea for the network was prompted when our chief medical officer at the time, Joseph Berman, MD, recognized two trends in cardiac care. First, in the late 1980s and early 1990s, the number of coronary bypass units was proliferating dramatically. It seemed like every institution was building an open-heart unit. As a result, there was grave concern on our part as to the quality of some of these units, since

patient that an institution treated over an entire year, in order to determine the institutions to which Anthem would direct its cardiac patients. Our goal was to identify the institutions that were doing high-quality work and then direct patients to those institutions and also to reward, in some sense, the institutions that were exhibiting high-quality care in treating Anthem's patients. The program was designed primarily for managed care

institutional skills to do the procedures well. That's not to say that it's not possible, but it's far less likely. And, of course, high volume does not guarantee high quality.

Q: How many data elements besides procedure volume do you collect?

A: In order to maintain and enhance quality, we collect data from the network hospitals on a regular basis. The original model required almost 500 data

elements from every single chart of a bypass and PCTA patient. Not surprisingly, the hospitals complained that the level of data gathering was excessive; so we trimmed it down. We still look at almost 300 data elements from every chart, however. So if a hospital performs 300 bypass procedures annually, we look at 90,000 different data elements from that hospital in a given year.

Q: *How has inclusion in the network affected the quality of providers?*

A: The hospitals that have performed at a superior level are paid a 10% bonus per case as a reward for their high level of performance and also as an incentive to the other hospitals to continue to raise their quality levels. While initially, only two hospitals received this bonus, during the last review of our network, four hospitals were eligible to receive the bonus based on their quality performance.

“For their part, the physicians have to understand that they are part of a team. They cannot go off and do their piece and then send in a separate bill, basically divorcing themselves from the ultimate outcome of the case.”

This increase in quality is an important validation of the network.

Also, over time the mortality rate for bypass surgery patients in our network hospitals has dropped from about 5% before the network went into place, to slightly more than 1%. Several hospitals in the network have a mortality rate below 1%. This is remarkable considering that nationally, mortality for this procedure remains in the 3% to 5% range. We've also seen a dramatic decrease in infection rates in our network hospitals. Lengths of stay have dropped by about 25% in the network hospitals. We've had fewer returns to surgery, where the patient would require a second surgical procedure during the same admission. We've had fewer postoperative complications, such as pulmonary embolisms and other side effects. Those statistics also represent a dramatic demonstration of the value of the network.

Q: *What is the level of savings that Anthem has been able to achieve with the network?*

A: Anthem has saved \$20 million over a four-year period, from 1994 to 1998, on this program. Anthem's annual heart surgery expenses in Ohio total about \$20 million to \$25 million. So over four years, we saved \$20 million on \$100 million in expenditures, a substantial savings.

The important thing to keep in mind is that at the same time we've seen quality improve. The network results prove that high-quality providers are, in fact, lower cost providers. We can give bonuses to the high-quality institutions and still save money for Anthem. And the quality and cost savings have a ripple effect for society. Not only are people having fewer complications and being discharged sooner, but also once they get home, they

return home in a better condition medically, they're more likely to return to work or full activity sooner. And during that convalescent time, they're going to require fewer resources. That means that spouses are less likely to have to leave their jobs or other activities to care for these patients. So employers of patients and their spouses are incurring fewer costs as well. We've seen dramatic savings for Anthem, but we think that the true benefit to society is many times what we've actually been able to calculate.

Q: *Did the model's risk-adjustment methodology persuade hospitals and surgeons that you were taking a balanced approach to assessing quality and costs, even for very sick patients?*

A: We have hospital participants from all around the state, from inner-city academic medical centers to community-based suburban hospitals. Although we have a variety of hospitals, we have

been able to generate data that all believe are statistically valid and that more or less accurately reflect the severity of their patient base.

It is absolutely critical that data be credible to the hospitals, the physicians, and the public. So, we recognize that severity adjustments are crucial. For example, when we set up the network, we created a scorecard and gave various quality measures a point value, summing to 100 points. When started in 1994, for example, we gave 30 points for the risk-adjusted data, 10 points for Joint Commission review, and 10 points for office reviews of surgeons' charts and facilities. If hospitals scored 70 points, they were eligible to participate in the network.

When we revised the scorecard in 1996, we decided that we needed to allocate greater weight to severity adjustments. Having risk-adjusted data is now 50% of the score. On the other hand, we eliminated the Joint Commission review as an element because we felt it was not really directly related to our effort. So, we take the concerns of the hospitals about the issues of severity adjustments very seriously.

On an ongoing basis, we try to ensure that the network participants understand and agree with the risk-adjustment system. As part of the network, we have quarterly meetings with all the hospitals. The hospitals are required to attend and must send an administrator, a surgeon, and a nurse (typically the ICU or OR nursing director). They get five points for attending these meetings. Meeting attendance is important in order to promote cross-fertilization of ideas and to discuss important issues. One of the features of every meeting is a presentation by Pine, who reviews the latest data, discusses the statistical aspects of the data, and answers questions.

We try to convey that nothing is etched in stone. One of the reasons Pine attends this meeting every quarter is to discuss changes, updates, and new issues that have arisen. In many respects, the model looks different than it did in 1994. That reflects the increasing sophistication of the cardiology specialty, but it also reflects the experience we've had in the past six years.

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“Once it becomes clear that managed care is here to stay, I hope physicians will assume the autonomy that is waiting for them to grasp.”

(Continued from page 13)

Over the course of the year, we solicit subjects from the hospital administrators and surgeons that they wish to discuss at the meetings in order to ensure that everyone agrees with the statistical approach. Certainly, everyone is going to have criticisms, suggestions, and modifications that they would like to see, but generally, over the last six years, the hospitals have supported our risk-adjustment model and believe that it has leveled the playing field.

Q. *How important was it that you used global fees for episodes of care as a driving force in the quality enhancements and cost benefits?*

A. It was very important. One thing a global fee for an episode of care does is oblige the hospital and the physicians to focus on the entire episode of care, and their associated responsibilities and accountabilities.

We give one check to the hospital. In effect, we are saying to them, “Here is your reimbursement for the bypass procedure on Mr. Jones. It is up to you to divide that up among all of the physicians, units, and other providers who participated in that care.” So it becomes important for the hospitals to have good relationships with the physicians. It really creates a great incentive for the hospital to get the care delivered in the most efficient manner possible, and to make sure that the people who are involved in the care are the ones who truly will be able to change the outcome.

This fee structure has also marked an important change in the traditional philosophy of hospitals, back to when hospitals first became important parts of the medical system 50 or 60 years ago. The philosophy then was that the hospital was simply a place that doctors came to do things to patients; the hospital had no responsibility, it was simply a venue, and the hospital had no involvement in physicians’ medical decisions. Today, the sophistication and intensity of services delivered in hospitals is such that each

hospital is intimately involved and has a central role to play in terms of how care is delivered and how decisions are made. Under the global fee model, hospitals are recognized for that fact.

For their part, the physicians have to understand that they are part of a team. They cannot go off and do their piece and then send in a separate bill, basically divorcing themselves from the ultimate outcome of the case.

And it’s very efficient from the payer’s point of view. We’re not receiving 15 or 20 different bills for the care that each patient receives.

Q. *Since the hospital divides the check, does that help to bridge the chasm of mistrust between hospitals and physicians?*

A. Actually, the future for global pricing is somewhat in question because there has been a lot of resistance from physicians regarding hospital disbursement of payments. In Ohio, legislation passed recently that might make it difficult for us to do global pricing and that’s a trend in others states too. The legislation permits physicians to bill for any service they render, regardless of hospital contracts. The medical societies are saying that physicians don’t want to have to go through a third party to get paid—they want to be able to bill directly. Of course, that sort of negates the mechanism that prompts the physicians and hospitals to work together.

There has to be a certain level of trust between the hospital and the physicians to execute a global fee system properly. There also has to be an understanding for providers to accomplish quality outcomes. We all have to cooperate, collaborate, and focus on how to create a reimbursement system that will foster better outcomes rather than develop a reimbursement system designed to maximize individual incomes. This fact is especially true in areas in which providers are dealing with sick patients and complicated procedures such as bypass surgery.

Q. *Couldn’t you cut the check to the physician organization, which in turn*

would distribute funds to the hospital?

A. Perhaps this may be happening in a few years. I don’t discount the potential for that at all. The problem now is simply that the sophistication in terms of contracting, reimbursement, and the organization of care delivery lies with the hospital more than it does with the physician group.

But as physician groups continue to consolidate and become more sophisticated, that will be the natural next step. It will also be a positive development, because if an organized medical group is focused on how to customize care for an individual patient rather than how to figure out how to work through each hospital that it’s linked into, quality for patients will increase. The group could choose whatever facility it believes would optimize care for a particular case.

There is a tremendous opportunity today for farsighted medical groups and physician leaders. By shifting the focus—and the reimbursement—to the large sophisticated medical groups, we will see the kind of customization of care that would be better suited to delivering high-quality outcomes.

Q. *You have said as physicians regain control of the core process of health care delivery, autonomy will increase. Do you see that happening now to any extent?*

A. It has not occurred as much as I would like. There’s a lot of hesitation right now on the part of physicians and physician groups. A lot of people are waiting to see what’s going to happen in the next year or two as large health plans go through more consolidation and what’s going to happen on the legislative front. But once it becomes clear that managed care is here to stay and that we’re ready for the next stage of evolution, I hope that hesitation on the part of physicians will diminish and they will be able to move into the central role of the delivery system and assume the autonomy that is waiting for them to grasp.

—Edited by Deborah J. Neveleff, in North Potomac, Md.

Consumerism, Technology Will Shape Health Care Profession's Next Decade

As consumers become more demanding, as the Internet speeds communications, and as the work of the Human Genome Project unleashes a new pipeline of drugs, the health care profession is in store for monumental change.

That is the conclusion of a "strategic assessment" published by the national hospital and health system alliance, VHA Inc., and the health care practice of accounting and consulting firm Deloitte & Touche LLP. The report, *Health Care 2000*, identifies eight forces that are likely to alter the health care landscape.

"Health care consumers are devouring information about their health conditions as never before, particularly from the Internet," the report notes. "This increase in knowledge changes what consumers expect of their health care providers, from

a relatively helpless 'tell me what to do' perspective, to a more empowered 'help me decide what to do' perspective."

With the growth of consumerism will come more action by government to protect patient safety and privacy and to improve health care and access to insurance, according to the report.

Overall, the report portrays a massive growth industry, expected to account for roughly \$2.2 trillion in national expenditures, or 16.2% of the gross domestic product, by 2008.

For providers, the trends pose significant challenges, said Daniel P. Bourque, group senior vice president with VHA. "The real challenge is, 'How do you meet the demand but keep your pricing low?'" he said. "We've got to change the model; the chassis is outdated."

Another difficulty, he said, will be

recruiting and maintaining a work force capable of meeting growing demand. Bourque noted that the profession is having trouble filling jobs in information technology as health care competes with telecommunications for workers. Nurses, too, are in short supply.

The way health care providers approach disease also is changing as the profession moves toward systems of early diagnosis and prevention, Bourque observed.

While genomics is paving the way for better treatment, lower health care costs are not likely. Costs to purchasers and providers will continue to rise for the foreseeable future, fueled by the aging population, more complex medical technology, new drugs, better disease detection, and increased demand for service, the report predicts.

States' Physician Credentialing Laws Vary Widely

State laws vary considerably on the types of credentials physicians are required to have and what managed care organizations must do to verify those credentials, according to two new studies by an accrediting organization.

The accrediting body, URAC (also known as the American Accreditation HealthCare/Commission), said the studies are a step toward its goal of fostering a national discussion about credentialing.

Beginning in July 1999, URAC polled state medical boards and managed care regulators in all 50 states about physician

licensure and relicensure processes. The surveys, completed earlier this year, received a 100% response rate.

The number of physician credentials a state medical board requires ranges from two in some states, including New Hampshire and Ohio, to 10 in others, including Arkansas and Arizona, URAC found. On average, medical boards want five credentials, the most popular being training, licensure history in other states, education, history of sanctions, and hospital privileges.

A URAC survey of state managed care regulators uncovered similar dispar-

ities in the quality checks that HMOs and PPOs may be required to make of their participating physicians. Only 32 states require managed care organizations to do physician credentialing. In 18 of those states, credentialing requirements apply only to HMOs, not PPOs. Twenty-seven states specify which credentials a plan must check.

Eleven states do not specify how often a plan must re-credential a physician. Among those that do, the interval is usually every two or three years. Illinois, however, requires annual re-credentialing.

AMA, Pennsylvania Physicians Seek Blues' Antitrust Probe

The AMA and the Pennsylvania Medical Society announced on March 22 that they have asked the U.S. Department of Justice to investigate two Blues plans, contending that those plans have restricted patient choice by agreeing not to compete with each other.

The physician groups said that they have asked the Justice Department's antitrust division to look into the "anti-competitive practices" of Independence

Blue Cross, in Philadelphia, and Highmark Inc., in Pittsburgh.

In a joint letter dated March 16, the groups asked the government to probe whether the plans "maintained their dominance by virtue of a division of markets agreement, by which they have agreed not to compete in each other's territory."

Highmark, they said, controls more than 60% of the Pittsburgh market, while Independence Blue Cross has more than

50% of the Philadelphia market.

The AMA and the medical society say that by wielding market power the plans have restricted choice, dictated contract provisions, and realized substantial profits while raising premiums for patients.

"To suggest that we restrict choice is absurd," Highmark spokesperson Brian Herrmann said. Subscribers have a wide range of products and providers from which to choose, he said.

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