

PHYSICIAN PRACTICE OPTIONS™

October 30, 1998

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Capitation Can Be Profitable or Precarious: Contract Preparation Is Critical

For physicians, capitation is a double-edged sword. A widespread form of physician reimbursement among managed care plans, capitation involves the prepayment for medical services on a per member per month (PMPM) basis. It is a controversial reimbursement method among some physicians because it places them at financial risk. They worry that they will end up performing many more services than they thought they would when they signed the managed care contract and lose money as a result, say health care analysts. For other physicians, however, capitation is a reimbursement method that allows them to operate free of the constraints of other forms of payment and it gives them a chance to make a modest profit as well.

"Capitation offers both benefits and disadvantages to physicians," says Gary Scott Davis, a health care attorney with Steel Hector & Davis, a law firm in Miami. "They should know about both and be very careful before signing a contract."

One benefit capitation offers to physicians is the predictability of cash flow, Davis says. Since the physician is at financial risk for services provided, capitation can increase the degree of autonomy in treatment decisions. A disadvantage is that the unpredictable can happen: A flu epidemic, for example, that results in a significant increase in patient load can damage profitability over a month or more, Davis says. Conversely, a managed health plan using a discounted fee-for-service contract to pay for physician services would be at financial risk.

James G. Nuckolls, MD, believes capitation can be a boon to a medical practice if it handles its contractual relationships responsibly by focusing on preventive care. "Physicians have to think in terms of controlling health care costs as a group," Nuckolls says, adding that he believes prepaid reimbursement systems that put physicians at risk for the amount of services they provide can be good for patients. "The incentive under fee for service was to keep everybody a little bit sick because the more people you saw, the more procedures you did, and the more money you made. Under capitation, physicians are encouraged to practice preventive medicine and to practice as a team." Nuckolls is CEO of Carilion Healthcare Corp., in Roanoke, Va., a medical group of 150 primary care physicians.

Not all physicians agree, however. William Andereck, MD, an internist in San Francisco and a lecturer on medical ethics at UCLA at Berkeley, says, "Under capitation, physicians are paid not to practice medicine. Any system that encourages physicians not to see patients is corrupt and should be illegal."

Rates Fall, Profits Rise

As managed care spreads and Medicare-risk HMOs proliferate, capitation is becoming an increasingly prevalent reimbursement option, according to the 1997 Capitation Survey by National Health Information, a health care research and publishing company in Marietta, Ga. The nationwide survey of more than 400 providers that have capi-

(Continued on page 4)

Interest in Physician Productivity Is Rising

Our Aug. 15 cover story, "Consultant Offers Unusual Advice on How to Thrive Under Managed Care," triggered a flood of phone calls from physicians asking where they could find more information on physician productivity. In that story, Greg Korneluk, founder and CEO of the International Council for Quality Care in Boca Raton, Fla., said solo practitioners and physicians in groups of three or fewer could be highly profitable even in mature managed care markets if they learned how to be more productive.

Among the physicians who called were:

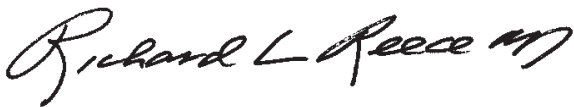
- A 40-year-old board-certified family practitioner in Milwaukee, who told us that although he is employed by an HMO, he wants to go solo and to be efficient enough to run a profitable practice.
- A 38-year-old medical subspecialist in Tampa, who said he owns a four-physician group that wants to remain financially strong enough to stay independent.
- A 40-year-old solo pediatrician and internist in Cleveland, who reported that he wants to stay on his own in the highly competitive managed care market in Ohio.
- A 39-year-old gastroenterologist in Chicago, who said he was employed by an HMO and was seeking to generate additional income by running an efficient solo practice outside the HMO.
- A 32-year-old internist in a large group in Southern California that is owned by a physician practice management company, who told us that he sees no opportunity for advancement in his group and wants to escape by buying an existing solo practice in his area.
- A 52-year-old board-certified, solo family practitioner in northern Michigan, who said he sees five to six patients an hour with the help of his seven-member staff and wants to be even more productive.

These physicians are seeking fulfillment and independence, and want to be economically self-sufficient outside of the constraints of large organizations. They seek solutions through increased individual efficiency and productivity.

At the same time I was getting these phone calls, I received a book for review entitled, *The Successful Physician: A Productivity Handbook for Practitioners* (Aspen Publishers, Gaithersburg, Md., 1998), by Marshall O. Zaslove, MD, director of the Zaslove Group in Napa, Calif. Zaslove is a psychiatrist who has given more than 500 seminars across the United States on personal and professional productivity. His 307-page paperback book, which sells for \$29, can be ordered by calling 800/638-8437.

Zaslove captures the essence of why physicians are focusing on productivity, saying, "Mostly by controlling patients' access to services, encouraging competition among providers for access to patients, discounting and capitating, and the like, managed care organizations (MCOs) routinely are able to take 20% to 30% off the top for their administrative costs and profit. This leaves providers to figure out how to provide optimum patient care with whatever is left over. The bottom line: Whether mandated by MCOs, by government payers, or by our own practice groups, increased speed and efficiency of health care delivery is here to stay."

In coming issues, *Physician Practice Options* will have more from Zaslove. And given our readers' interest in the topic, we will continue to produce articles on physician productivity.



Richard L. Reece, MD
Editor-in-Chief
Toll-free phone: 888/457-8800
E-mail: Rreece1500@aol.com

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Michael B. Guthrie, MD, MBA
Executive Vice President, Director
Center for Clinical Innovation
Premier, Inc.
San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, P.A.
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley
Vice President, Strategic Management
PhyCor Inc.
Nashville, Tenn.

Peter R. Kongstvedt, MD
Partner
Ernst & Young
Washington

Richard Liliedahl, MD
Health Care Consultant
Milliman & Robertson Inc.
Seattle

Lee Newcomer, MD
Chief Medical Officer
United HealthCare Corp.
Minneapolis

James G. Nuckolls, MD
Chief Executive Officer
Carilion Healthcare Corp.
Roanoke, Va.

Brooks G. O'Neil
Managing Director
Piper Jaffray Inc.
Minneapolis

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

Carl Schramm
President
Greenspring Advisors, Inc.
Towson, Md.

Jacque Sokolov, MD
Chief Executive Officer
PSO Development Corp.
Los Angeles

W.L. Douglas Townsend Jr.
Managing Director and CEO
Townsend Frew & Co., LLC
Investment Banking
Durham, N.C.

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Publisher
Premier Healthcare Resource, Inc.
888/457-8800
E-mail: phrinfo@worldnet.att.net
Publishing Address: Premier Healthcare Resource, Inc.
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

Editor
Joseph Burns
508/495-0246
E-mail: joeburns@capecod.net

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Analyst Critical of Physicians' Efforts

By Richard L. Reece, MD, Editor-in-Chief

When it comes to making money out of physician-organized, physician-consolidated, or physician-owned companies, Wall Street is at a loss. Wall Street-backed managed care companies, hospital chains, and physician practice management companies (PPMCs) that have physician employees have generally lost money and stock value trying to manage physicians in groups.

And it's getting progressively worse. Last summer, FPA Medical Management Inc., the third largest PPMC, whose stock was trading at less than \$1 after peaking at over \$40 last year, stopped paying physicians in parts of California, Nevada, and Florida because of insufficient cash. In July, FPA filed for bankruptcy. California Advantage, the HMO created by the California Medical Association, has filed for bankruptcy after two and a half frustrating years and \$11 million in losses. In tightening managed care markets, can anyone make money from physician services? Can physicians themselves do so?

For the Wall Street perspective on these questions, *Physician Practice Options* turned to Kenneth Abramowitz, senior research analyst of Sanford C. Bernstein & Co., an investment research and management firm in New York. Abramowitz has long championed managed care as America's best means of reforming health care, cutting costs, and raising quality. He is considered an expert on medical device, HMO, hospital, and physician trends.

One reason for the current turmoil, Abramowitz says, is that there's not enough money to go around. Therefore, all health care providers are scrambling to improve their negotiating position to help ensure that they get their fair share. "Hospitals are doing the best job of improving their negotiating position by forming multihospital systems," says Abramowitz. "HMOs are doing second best by acquiring competitors. Physicians are a distant third because of their refusal to form large medical groups."

Among physicians, an entrepreneurial spirit is common, and that attribute has helped them in the past, but it may be to their detri-

ment today. "Physicians make bad employees," Abramowitz says. "After graduating from medical school, about 90% of physicians prefer to run their own businesses rather than work for somebody else." But forming or joining a group is crucial to a physician's future success, Abramowitz contends.

"If I were a physician in this market-driven health system, my goal would be to capture 10% of the market share in my city," Abramowitz says. "So, if my city has 1,000 doctors, I'd form a medical group or be part of one that has 100 doctors in order to reach that goal. And if I couldn't, I'd move to a city where I could." When physician groups have 10% of the market, Abramowitz rea-

care." How quickly? "Before the year is over," he says. "If physicians don't do that, they may be in the game all right, but they'll be in it at \$90,000 a year instead of \$300,000."

The failed merger between PhyCor and MedPartners has given physicians food for thought. The merger failed largely because MedPartners posted much bigger losses (\$840.8 million) than forecast in the 1997 fourth quarter and because MedPartners unexpectedly announced that it was closing 84 clinics involving 238 physicians. When physicians can't rely on even the largest PPMC, MedPartners, to make their clinics successful, which PPMC can they trust?

"I can't pretend that a PhyCor or a

Since managed care will grow to 100% market share, Abramowitz predicts physicians' only recourse is to form a group big enough not to be ignored.

sons, HMOs won't be able to ignore them because too many HMO members will expect access to their own doctor. Besides, with 10% of the market, groups will automatically have negotiating clout.

Managed care will grow to 100% market share, Abramowitz predicts, and physicians' only recourse is to form a group big enough not to be ignored. "That's stage one," he says. "Stage two is to form a medical group that's crucial to the success of an HMO. Step three is to gain market share from all the other individual physicians who refrain from recognizing the market impact of what's happening in health care."

Of course, that advice prompts the question: How does one make oneself indispensable to HMOs? "Twenty-five percent market share," Abramowitz is quick to reply. "And providing high-quality services that have the best outcomes."

"What disturbs me about physicians," says Abramowitz, "is that what they have to do is so clear, but their willingness to do it is so low."

Abramowitz contends that if physicians don't form major medical groups quickly, they'll "get their brains beaten in by managed

MedPartners is perfect," says Abramowitz. "But if the physicians thought about it carefully, they would see that organizations like PhyCor and MedPartners are their best hope for cutting costs, upgrading quality, and marketing to managed care companies.

"Physicians need patience," Abramowitz continues. "I can't blame people who lose their incomes or watch their incomes fall for being anxious. But the physicians should realize that on a 30-year basis, they may be better off by having an agent like PhyCor or MedPartners behind them."

Abramowitz sees no future for medical groups that are owned by either hospitals or insurers. "Hospitals and insurance companies don't care about doctors and they don't know how to manage them," he says. "The problem they have is that they have to cater to all the doctors in town."

It seems possible, therefore, that only physicians may be able to make money on physician services. If so, then Abramowitz may be right: It may be time for physicians to organize themselves into businesses that they own and control and that are large enough not to be ignored. ■

“Physicians have to think in terms of controlling health care costs as a group. Under capitation, physicians are encouraged to practice preventive medicine and to practice as a team.”

—James G. Nuckolls, MD, Carilion Healthcare Corp.

(Continued from page 1)

tated contracts found that the average number of such contracts among primary care groups increased from 4.8 in 1996 to 7.2 in 1997, a 33% jump. Among multispecialty groups and independent practice associations, the increase in the average number of capitated contracts was even greater: from 5 in 1996 to 7.8 in 1997, a 36% jump.

About one American in five is enrolled in a managed care plan, and two-thirds of those plans capitate some or all of their primary care physicians, according to the Advisory Board Co., a research organization in Washington, D.C. About half of what primary care physicians make from HMOs is prepaid, and half is paid on a fee-for-service basis. Capitation rates are lower in some areas of the country than they are in others. In California, average capitation rates for all physicians are only one-half to three-quarters of what they are in the Midwest and Northeast.

Capitation payments generally range from \$7 to \$15 PMPM, according to “Physician Earnings at Risk: An Examination of Capitated Contracts,” which appeared in the May/June issue of *Health Affairs*. Although such payments are much lower than what physicians might charge for a particular service, the physicians receive the payment every month regardless of whether they see the patient, and they receive payment for patients they may never see.

“If, for example, a physician is paid only \$7 for a physical examination that he would normally bill at \$120, it may look like he has lost \$113,” says James Bingham, MD. “But there are 100 or 200 other patients for which the physician is being paid on a PMPM basis who he is not going to see. That’s how the physicians make their money.” An internist in Cincinnati, Bingham says his capitated contracts have been profitable.

Although capitation rates are falling, according to the National Health Survey by

National Health Information, groups functioning under capitation contracts seem to be making more money. (See sidebar, “Capitation Rates Fall as Profitability Rises.”) “Physicians are becoming increasingly accustomed to the demands of capitated contracts,” says Davis. But he cautions that those who enter capitated contracts without adequate actuarial analysis and proper negotiations can suffer significant financial loss.

“Physicians have to examine carefully the size of a health plan’s panel, that is, the number of enrollees the plan has who are being capitated PMPM,” Davis says. “A panel that is too small can spell disaster because the PMPM payment will be too low.” In determining whether a panel is of sufficient size to allow a contract to be profitable, a physician should examine the demographics of the patient population and that population’s treatment history, says

David Wilson, managing director of the Apex Management Group Inc., a consulting firm in Princeton, N.J., that advises physicians on managed care financing.

Negotiating Contracts

In general, physicians sign capitated contracts either because managed care enrollment in their area is high and they have no choice or because they want a guaranteed cash flow. While not all capitated contracts may result in acceptable levels of profitability, physicians may accept an underpaying contract as a way to position themselves strategically for future managed care contracts that may be more lucrative. “This cannot be a long-term strategy, of course,” says Davis. “A physician can run into financial problems if he or she has too many unprofitable contracts for too long.” Other factors for physicians to consider in deciding whether to sign a capitated contract may

Capitation Rates Fall as Profitability Rises

Overall, capitation rates are falling, according to the 1997 Capitation Survey by National Health Information, a health care research and publishing company in Marietta, Ga. But at the same time, overall profitability from these contracts is climbing, according to the survey. The reason, says Gary Scott Davis, a health care attorney with Steel Hector & Davis, in Miami, may be that physicians are learning how to control costs and negotiate profitable contracts. The data in the table represent commercial-population payments covering all primary care services.

Capitation Profitability

	Average payment PMPM		Percentage of groups reporting a profit	
	1996	1997	1996	1997
Group practice	\$12.43	\$11.06	40	80
Multispecialty group/IPA	\$12.68	\$12.64	78	67
Physician-hospital organizations/ integrated delivery systems	\$12.17	\$12.49	34	50
Primary care average	\$12.39	\$11.98	48	52

Source: 1997 Capitation Survey, National Health Information, Marietta, Ga.

include the opportunities such a contract provides for

- Expanding the capitation contract in the future
- Gaining control of utilization review guidelines
- Learning how capitation works
- Preventing loss of patients and market share
- Capturing more referrals

Before accepting such a contract, physicians must negotiate for terms in the agreement that will help control expenses and protect their interests, such as guarantees of in-network referrals and provisions for periodic review of compensation levels. And regardless of why they sign—out of necessity or by choice—they should negotiate their contracts carefully, say health care experts.

“It is easy for physicians to overlook

interpretation of the contract. If, for example, a new and expensive medical treatment becomes available, is that treatment covered under the capitated contract? “Often, health plans believe that is the case,” Davis says, “while physicians believe that if the treatment was not available when the contract was signed, provision of the service is not included in the contract. This is a very common problem.”

Other important issues to consider when negotiating a contract, Davis says, include:

- Whether preexisting conditions are covered
- Whether physicians are allowed to sub-contract services
- Whether physicians are responsible for out-of-area coverage
- How and when physicians are paid
- How eligibility disputes are handled

"Under capitation, physicians are paid not to practice medicine. Any system that encourages physicians not to see patients is corrupt and should be illegal."

—William Andereck, MD, UCLA

something in a contract that can come back later and hurt them financially,” says Davis. “A successful contract review requires more than just purchasing actuarial services to make sure the numbers work. It requires expertise from a consultant familiar with how health care works.” (See sidebar, “Terms Used in Capitated Contracts.”)

The single most important issue in a capitated contract is a clear articulation of what services physicians are expected to perform, Davis says. Physicians should not assume they are responsible only for the services delineated in a contract. “Payers may assume that physicians will provide some health care services in addition to those that physicians are clearly responsible for,” he says. “For example, to what degree is a capitated physician responsible for emergency room visits or for member visits to an out-of-plan physician?”

Physicians also should consider carefully whether they are bound by the insurer’s

In addition to service-related issues, physicians should examine their traditional expenses, such as rent, salaries, and utilities. These “fixed expenses” can destroy the profitability of capitated contracts if they are not adequately considered in determining a contract’s profitability. Determining fixed expenses requires an historical review of costs over the past year or two, Davis says.

“In the end, there is no substitute for due diligence when forming capitated contracts,” says Davis. Due diligence requires carefully examining a contract’s provisions and often involves seeking the assistance of actuaries and consultants familiar with managed care. “Capitation can be a profitable way to do business, or it can cause financial loss. The best way to avoid problems is preparation, adequate information, and carefully examining the financial implications of a contract.”

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

Terms Used in Capitated Contracts

The following is a list of terms and definitions used in capitated contracts:

Fee-for-service—a traditional reimbursement method in which a patient sees a provider and the provider bills a health plan or the patient for the provision of that service.

Full-risk capitation—a capitation method that covers all professional services except institutional services, such as hospital service.

Global capitation—a capitation method that covers all medical expenses, including professional and institutional expenses. Global capitation, or global cap, may not necessarily cover optional services, such as drugs. Sometimes called total capitation.

Partial-risk capitation—a capitation method that covers some specified professional services; other services, such as laboratory fees, are covered on a fixed-fee schedule.

Stop loss—a form of reinsurance that provides protection for medical services above a certain limit, generally on a year-to-year basis. It may apply to an entire health plan or to a single component of the plan. It is purchased by providers concerned about making a profit under a capitated contract, and usually compensates the provider for a percentage of a loss (generally 80%) after the loss reaches a certain amount.

Withholds—a percentage, generally 10% to 20%, of a full-risk capitated payment that is withheld by a payer monthly and is used to pay cost overruns for institutional referrals. This tool is used by health plans to limit referrals.

Source: *The Managed Care Handbook* (Third edition), Aspen Publishers, Gaithersburg, Md., 1996, Peter R. Kongstvedt, MD, editor.

Residents Learn New Medical Lessons: How to Survive in a Managed Care World

In a 39-story office tower in midtown Manhattan, Craig Yeshion, MD, and other primary care residents from New York Hospital, receive training that doesn't involve a differential diagnosis or a bedside manner. Yeshion and colleagues are meeting with managed care executives of Empire BlueCross BlueShield at Empire's corporate offices. They follow claims from arrival in the mail to acceptance or rejection, and they contribute comments in private sessions on quality, credentialing, technology assessment, and practice guidelines.

The program's developers hope this two-week detour from clinical instruction will steer the residents toward considering the implications on cost and quality of their future decisions on care. The experience has already influenced Yeshion's thinking. "It's now in the back of my mind that my charts will be pulled and that I will have to cover health maintenance issues with my patients," says Yeshion, a 29-year-old internist. "Now, I look at patients not only from a physician's perspective, but from the managed care organization's standpoint as well. I know what the other side is thinking when it puts together its plans."

This training presents a face of medicine rarely seen by practicing physicians. The residents spend important bedside time in what some medical academicians have long perceived as the enemy's camp. But a growing number of educators and managed care executives believe that including such instruction is essential to transform American medicine and to equip new physicians to deal with the kind of world they will find in practice.

As such, the scene at Empire is being played out in managed care boardrooms across the country, courtesy of an \$8.3 million, three-year grant from the Pew Charitable Trusts, in Philadelphia. With assets of \$4.5 billion, Pew is one of the country's largest private philanthropies. It was started in 1948 by the children of Joseph Pew, founder of Sun Oil.

The Pew program, called Partnerships for Quality Education (PQE), allies more than

60 academic medical centers with their local managed care organizations (MCOs). PQE represents some of the country's most prestigious residency programs, such as those at Harvard, Duke, Stanford, and Mayo. It also includes the nation's largest managed care players, such as Aetna U.S. Healthcare, Oxford Health Plans, and Kaiser Permanente. It is the first major national initiative of its kind, according to the Association of American Medical Colleges (AAMC), in Washington, D.C.

"It seems unlikely at this time that these kinds of partnerships would have been developed without the venture capital provided by a philanthropy like Pew," wrote David Nash, MD, and J. John Veoloski in the May issue of the *Western Journal of Medicine*, a peer-reviewed journal published by the California Medical Association in San Francisco. Nash is director of health policy and clinical outcomes at Thomas Jefferson University School of Medicine, in Philadelphia, and PQE's associate director.

Four additional foundations gave financial support for Pew's program: the California HealthCare Foundation, the Kansas Health Foundation, the Robert Wood Johnson Foundation, and the W.K. Kellogg Foundation.

PQE's director, Gordon Moore, MD, MPH, director of teaching programs at Harvard Pilgrim Health Care, an HMO in Boston, is concerned that the Pew managed care training may be too futuristic in some managed care settings today. "We're giving residents future-oriented training to work in a system that doesn't get it and isn't working well," he says. "This is a mess. Our residents may not get the reinforcement they need." Since resistance to managed care is strong, newly trained Pew doctors may find themselves butting heads with physicians trained under a fee-for-service system, he says. Still, if managed care is to gain wider acceptance, inroads must be made somewhere, he argues, and the best place to start is with freshly minted physicians.

When the Pew grant runs out next year, it

won't be renewed. The philanthropy has other priorities, says Lauren Goldberg, Pew program associate. Nash and Moore say they are already seeking alternative sources to continue funding the managed care training.

Meanwhile, through PQE, an estimated 250 primary care residents will learn how to deliver cost-effective medicine and become familiar with such terms as "disease management," "clinical protocols and pathways," "referral guidelines," and "pharmacy benefit management companies." Major

Pew Major Partnerships

The following is a list of the eight major residency programs that have received grant funding from Pew Charitable Trusts for its Partnerships for Quality Education program. In addition, 55 residency programs have received smaller grants from Pew and four other foundations.

- Cornell University Medical College, New York Hospital, and Empire BlueCross BlueShield
- Georgetown University Medical Center and Kaiser Permanente
- Harvard Medical School and Harvard Pilgrim Health Care
- Case Western Reserve University School of Medicine and Henry Ford Health System
- Legacy Health System, Regence BlueCross BlueShield of Oregon and Northwest Group Practice Association
- Tufts Managed Care Institute
- University of Pennsylvania Health System and Independence Blue Cross
- University of New Mexico School of Medicine and Lovelace Health System

"We are the Henry Kissingers, shuttling back and forth between these two cultures, trying to create the doctors of tomorrow."

— David Nash, MD, Thomas Jefferson University School of Medicine

program goals include profiling resident practices, establishing teaching in community settings rather than in hospitals, and rotating residents through the administrative offices of MCOs, such as Empire.

Pew gave the funding to oversee Harvard Pilgrim. In turn, Harvard named five other collaborative partnerships and two associate partnerships (see sidebar). It also named 55 additional affiliate residency-MCO alliances. All received various amounts of cash to start managed care training programs. Medical schools that wanted to receive the funding submitted proposals. The main criterion they needed was to have an established relationship with an MCO. Each medical school delineated how much money it needed to carry out a specific teaching task. The major programs got most of the funding (in varying amounts); each of the alliances also got funding of about \$10,000.

Considering there are 7,800 residency programs in the United States, according to the AAMC, 63 being directly involved in managed care is a small proportion of the total. But it's a start. Moore, an internist and a professor at the Harvard Medical School, hopes the initiative will spark a growing movement.

Adversaries Unite

The PEW grantors were most interested in linking teaching facilities with MCOs—the two groups perhaps furthest apart philosophically of any other group of physicians and insurers. MCOs see patients as customers; teaching facilities see them as opportunities for learning. "This is not easy work," Nash says. "It involves the coming together of two different cultures that don't even speak the same language. We are the Henry Kissingers, shuttling back and forth between these two cultures, trying to create the doctors of tomorrow."

Academic health centers have long been bastions for spending, shrouded from managed care. Of late, academic centers have come under fire for high costs, overproduc-

tion of specialists, and a lack of commitment to local communities.

"Make inroads here—that is, between academic physicians and MCOs—and you can do it anywhere," Nash says.

Michael Stocker, MD, president and CEO of Empire BlueCross, supports the Pew project because he says it helps physicians understand managed care objectives. "When residents can see how managed care is practiced, we feel they come away on our side," agrees John Hurley, MD, the director of clinical education in the Mid-Atlantic region for Kaiser Permanente.

Moreover, as criticism of HMOs rises, MCOs need all the support they can get. Politicians seem to be tripping over each other this year to push through legislation that would expand the benefits for persons enrolled in managed care plans. It also did not help that the July 13 *Time* magazine cover story was titled, "What Your Health Plan Won't Cover."

Clearly, the two factions need each other. "Academic medical centers need the patients that MCOs have, and MCOs need the intellectual resources of academic medical centers," says Moore. "Previously, academic and managed care leaders distanced themselves from each other, but their futures are inexorably linked."

Pew's managed care instructors are often physicians who work for insurers. William Osheroff, MD, vice president and chief medical officer for Empire, teaches a course on medical ethics for Pew residents. Hurley teaches the history of managed care.

Previous Experience

Scattered efforts have advanced over the past 30 years to involve teaching facilities in managed care education. Such terms as "economic grand rounds" have been used for years and are not uncommon. However, those attempts were spotty, according to the *Western Journal* article cited above. Even when residents rotated through managed care clinics, the educational emphasis was on clinical objectives rather than on managed care specifics.

"Both young physicians and industry leaders report that the current system of medical education is not preparing graduates for a practice environment increasingly dominated by managed care," wrote the authors of "Medical Education in Managed Care Settings," in the Sept. 4, 1996, issue of *JAMA*.

Some medical students clearly have no clue about managed care but are hungry for information. When asked how well prepared they felt they were to function in a managed care environment, a large national sample of students who graduated in the 1990s recommended more experience in a managed care environment for all medical students, according to the November 1995 issue of *Academic Medicine*.

Outpatient Training

The Pew initiative seeks to move parts of medical education out of teaching hospitals and into ambulatory managed care settings. Inpatient care in traditional primary care residency programs generally accounts for 80% of a resident's training, Moore says. That training, he adds, leaves new physicians who go into practice ill prepared for their work because they spend 90% of their time with outpatients. "It's like trying to study forestry by working in a lumber yard," Moore says. Teaching hospitals also don't provide opportunities to learn about the power of prevention.

Harvard's program with Pew increased time spent in outpatient settings to 65%, says third-year resident Anna Berkenblit, MD. The exposure has heightened her managed care awareness. "All I really knew about managed care before medical school was that there were some problematic components," she says. "Now I've learned what it's like to function in managed care, to work in a system where teams of providers are critical, and to keep an eye on costs."

Another part of the Pew program is creating a physician profiling system to help residents analyze their practice patterns and trends. Residents such as NYU's Yeshion report the feedback is invaluable.

(Continued on page 8)

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CASE STUDY

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"Interns and residents—house officers, that is—never before had detailed feedback like this on their performance," Nash says.

Some Pew partners have taken on special managed care projects, and have posted the results on the PQE Web site, www.pqe.org. One offshoot of the Pew initiative is that managed-care-trained physicians may complain less about restrictions HMOs place on access to care when they understand the limits of resources, says S. Ray Mitchell, MD, program director for the Georgetown University Medical Center/Kaiser Permanente Pew partnership in Washington D.C.

"A level of trust may be developing between former adversaries," Mitchell says. For the partnership to flourish, staff members in both organizations had to leave their biases and assumptions behind. "Kaiser thought big academic medical centers were inefficient and

"The program could be a real recruitment tool. The residents would fit into our culture well."

—John Hurley, MD, Kaiser Permanente

doctors weren't motivated to change," Mitchell says. "Nothing could be further from the truth. We may be mired in inefficiency, but clearly we have the motivation to change."

Still, Mitchell says, some critics worry that students will be taught cost-cutting rather than high-quality medicine. "Cost effective—rather than cost-cutting—is the correct description," he says.

Besides Pew, other organizations also are preparing new physicians for managed care. Eighteen medical schools aligned with managed care insurers split a grant of \$6.5 million given in July by the Health Resources and Services Administration of the federal Department of Health and Human Services.

Measuring the Training

The effectiveness of the Pew training will be examined by an independent evaluator hired by the Pew trusts. The evaluator, Michael Yedidia, PhD, a sociologist and health services researcher at New York University, plans to survey Pew residents in 28 managed care areas next month. The Pew residents will be compared with residents from programs that did not provide formal managed care training.

The participants in the Pew program may have a running start on other new physicians. HMO managers estimate that it takes one to two years of additional experience to prepare graduates of U.S. residencies for practice in a managed care environment, according to Kenneth Shine, MD, president of the Institute of Medicine, in Washington, D.C.

Moore believes the Pew residents may find it easier than their counterparts graduating from traditional programs to get a job. Hurley agrees, saying, "The program could be a real recruitment tool if residents would consider joining Kaiser. They would fit into our culture well."

—Reported and written by Maureen Glabman, in Miami

Strong Relationships May Prevent Deselection

At its best, a relationship between a health plan and a physician is like a good marriage: characterized by mutual respect, commitment to shared goals, and clearly defined roles and responsibilities. But just as couples do not anticipate the possibility of divorce on their wedding day, most physicians do not expect when they join a health plan that they could be terminated before their contract expires, a process known as deselection. Initially, physicians and health plans may view each other as attractive partners, but they may have different expectations for the relationship, which, left unspoken, may result in a dissolution of the alliance.

"All physicians need to be concerned about deselection," says Joan Roediger, JD, LL.M., an attorney and consultant for the Health Care Group, practice management consultants in Plymouth Meeting, Pa. Health plans terminate contracts not only with physicians whose quality does not measure up, but even with physicians whose quality is beyond reproach, she says. "Some of the best physicians may attract sicker patients because patients with more serious health conditions often seek out doctors with the highest level of skill and expertise," says Roediger. As a result, utilization rates among more skilled physicians may be higher than those of their peers, giving a health plan a possible reason for deselection, she says.

In 1995, Thomas W. Self, MD, a pediatrician specializing in digestive disorders, was fired from the Children's Associated Medical Group, a physician group practice associated with Children's Hospital in Kearney Mesa, Calif., even though the quality of care he rendered to patients was never in question. The medical group terminated Self because his utilization rates, such as the amount of time he spent with

patients during office visits and the number of laboratory and diagnostic tests he ordered, exceeded those of other physicians in the group, according to published reports.

In April, a jury found Self had been wrongfully terminated and awarded him \$1.75 million, and the case was later settled for \$2.5 million prior to the hearing for punitive damages. Unfortunately, it took nearly two and a half years to settle the case. The decision in *Self v. Children's Associated Medical Group* was the first verdict under a 1993 California law that prohibits health care organizations from retaliating against physicians who advocate appropriate care for their patients. In this case, however, the medical group, as a subcontractor for a managed care organization, was held liable for the wrongful termination rather than the MCO. Therefore, it is unclear whether the verdict has set a precedent that can be applied to MCOs that deselect physicians. Although some 25 states have statutes similar to the law in California, so far Self is the only physician to argue successfully that the cost of providing care should not dictate the nature or amount of care patients receive from their health care practitioners, the reports said.

Self's case was bolstered by the discovery of a letter written by a top official of the MCO to the president of the medical group. The letter stated that the MCO did not want its patients to be referred to Self because he ordered too many costly tests; it also claimed that Self did not understand the concept of managed care, the reports said. Self was fortunate to have documented evidence to support his claim of wrongful termination, but most contracts allow the MCO to deselect a physician without providing a reason, a process commonly known as "termination without cause."

The lesson from the case is that even when

the judicial system offers a means of fighting deselection from a health plan, such an avenue is time-consuming and trials do not guarantee a positive outcome for plaintiffs.

The Negotiation

It may be possible to avoid the need for litigation and deselection if physicians discuss their individual circumstances with health plans during negotiations, says Roediger. Neil Caesar, JD, president of the Health Law Center, a law firm in Greenville, S.C., advises physicians that the best way to minimize the possibility of being deselected is to prevent such an action. Since poor negotiations are at the root of most deselections, he advises physicians to be tough, but fair negotiators. "Contracts are almost always negotiable to a far greater extent than physicians expect," he says. Negotiations should never become a power struggle or a battle of egos, he advises. "Actually, much of the value of the negotiation process comes from what you learn, not just from what you negotiate," comments Caesar.

From their experience in helping physicians negotiate contracts with health plans, Caesar and Roediger offer these suggestions for productive negotiations:

Clarify contract language. "Although health plans may not be willing to negotiate every substantive issue, they will almost always negotiate language issues," Caesar says. "Many contracts don't address the turnaround time for payment, and if it isn't addressed, the plan and the physician will each have different assumptions and expectations about what will happen."

Assess your ability to comply with contract terms. Contracts can vary considerably in the time frame allowed to submit claims, for example. "One contract may require that all claims be submitted within 15 days,

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"A physician who has invested time and money in an outcomes management data system, or who can demonstrate the ability to track and use operational and clinical data should make sure to market these strengths to the managed care plan."

—Neil Caesar, the Health Law Center

(Continued from page 9)

while another may give the provider 90 days," says Roediger. "If a physician who agrees to the 15-day agreement does not have enough staff to meet this deadline, he or she may get deselected not because of the quality of medical care provided, but because the office could not generate claims fast enough."

Get to know the health plan. "Much of the negotiation process involves getting a feel for each other, and determining how to satisfy needs that may be hidden behind conflicting demands," says Caesar. Face-to-face meetings are useful because they provide an opportunity to develop a qualitative impression of the plan. "Frankly, it's harder for health plan managers to characterize someone they have spent many hours over several weeks looking at, talking to, and maybe even sharing a joke with as 'provider number 247' when they are making deselection decisions," Caesar explains.

Help the health plan get to know you. "A physician who has invested time and money in an outcomes management data system, or who can demonstrate the ability to track and use operational and clinical data should make sure to market these strengths to the managed care plan," says Caesar. "By doing so, the physician shows a concern for cost effectiveness and clinical efficiency."

Physicians should also explain the unique characteristics of their practice, says Roediger. An internist whose practice includes many geriatric patients should raise this issue early because it will result in higher utilization rates.

Be board-certified or be working toward becoming so. "Physicians who are not board-certified are setting themselves up for deselection," says Roediger. Under rules from the National Committee for Quality Assurance, a health plan accreditation organization in Washington, D.C., health plans seeking accreditation need network physicians to be board-certified.

Ensure that the contract is explicit about termination. Contract termination language tends to be vague, says Roediger. The contract should state exactly what criteria will be used to evaluate physician performance, and what circumstances would constitute grounds for termination. The contract also should explain the termination process, including a physician's right to appeal the

Losses Compounded for Groups

In a group practice, the patients and revenue lost not only affect the individual physician who is deselected, but the other members of the practice as well. As a result, a deselected physician's value to other physicians in the group may be greatly diminished, especially if the health plan represents a large portion of the group's patient base and revenue. For example, the deselection of a physician from a group practice may affect the practice's:

- **Ability to provide patient coverage.** Physicians who have been deselected by a plan cannot receive reimbursement for caring for another physician's patients covered by that plan. Therefore, a deselected physician's ability to provide coverage for other physicians in the practice during vacations or illness may be very limited.
- **Reimbursement and compensation structures.** If the payer mix of a group practice is predominantly one large health plan and Medicaid patients, a physician who is deselected from the health plan would no longer be able to treat patients covered by the plan. Therefore, he or she would provide care primarily to the practice's Medicaid patients, and would most likely generate less revenue.

decision and the right to get a written explanation for the termination.

Join a larger group. Being part of a large group practice or an IPA is likely to give a physician leverage during negotiations, especially with regard to termination clauses. Further, sometimes a solo practitioner is deselected simply because a plan decides to contract exclusively with a large physician group.

Involved Partners

After joining a panel, physicians should take an active, visible role in improving quality and cost efficiency "to show that they are interested in and responsive to the plan's concerns," Caesar says. Meeting regularly with the medical director is one way physicians can strengthen their relationship with the health plan. Joining a standing committee, such as a committee on utilization review or quality assurance, is another way physicians can demonstrate their commitment, he adds. Such memberships enhance a physician's reputation as a team player and can afford an insider's view of what the plan wants from its physicians.

Most health plans send periodic report cards to each network physician, showing how utilization rates, hospital days, out-of-network referrals, emergency room usage, and other practice patterns rank against expected norms and against their peers. These reports should be reviewed immediately, not only to identify areas for improve-

ment, but also so that physicians can determine whether the reported information is accurate. "Although deselection decisions are based on these types of data, the data are rarely evaluated for accuracy," says Caesar.

A Valued Asset

Physicians should collect their own data that could prove useful in a dispute with a payer, and they should conduct their own patient satisfaction surveys. "Physicians who work at fostering relationships with patients and ensuring that patients are satisfied will have a higher degree of patient loyalty than physicians who are always running an hour behind schedule or whose office staff members treat patients rudely," Roediger says. Patient satisfaction data can be used as leverage with a health plan because patients' loyalty to physicians can be stronger than their loyalty to a health plan, Roediger adds.

Physicians who can demonstrate their ability to contain costs while practicing high-quality medicine will have the greatest leverage with health plans and are therefore less likely to be deselected. "Cost is still a major consideration," says Caesar. "Even if a physician does everything right, there's no guarantee against deselection. There's always another physician group willing to do it cheaper in exchange for an exclusive arrangement," he says.

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

PSOs Present a Dilemma, Lawyer Says



Gary Scott Davis, JD, is a partner at Steel Hector & Davis, a law firm in Miami, and he co-chairs the firm's Health Care Group. Recognized by the National Law Journal as one of the nation's leading managed

care lawyers, Davis has been involved with the organization of various types of health-related firms, and serves as counsel to many physicians and hospitals regarding affiliations with managed care plans. He co-chairs the Managed Care Law Institute of the American Health Lawyers Association, and is a recipient of the Follmer Bronze Merit Award for Outstanding Service from the Healthcare Financial Management Association. Davis is also a frequent contributor to health-related publications, and is author of *Managed Care Contracting: Advising the Provider* (Bureau of National Affairs, 1996). Davis received his undergraduate degree from the State University of New York at Binghamton, and his law degree from George Washington University.

Q. Mr. Davis, Humana, which has a significant presence in Florida, has launched an initiative through a new subsidiary called MedStep to partner with provider-sponsored organizations, which were created as part of the new Medicare+Choice program. What do you think of this movement by major HMOs to partner with PSOs?

A. At the risk of sounding cynical, but not intending to be so, I'll quote a line from *The Prince* by Machiavelli: "Keep your friends close and keep your enemies closer." The modern-day equivalent of that line may be, "If you can't beat 'em, join 'em." The movement is essentially a marketing stroke of genius on the part of the HMOs. They have an incredible knowledge base of how to deal with the Health Care Financing Administration and with the Medicare beneficiary population in markets in which PSOs are most likely to form and to succeed. To take your example: Suppose that MedStep uses its administrative and marketing expertise to benefit the providers forming the PSO, and the PSO becomes a pre-eminent provider of managed care services

to Medicare beneficiaries. Through its management of the PSO, Humana, which, as an HMO, may have had difficulty penetrating that market, may be able to make it difficult for other independent proprietary Medicare HMOs to establish significant market penetration in the same area.

The providers forming PSOs have to understand that many of their operational parameters will be identical to those of HMOs. For a long time, providers have been unable to make the hard decisions inherent to a successful managed care plan, such as those relating to medical management. Maybe by bringing in an independent third-party manager that has this experience, while enabling providers to retain decision-making authority over the clinical aspects of the PSO's operation, those involved will be able to create a successful plan.

Q. How many signed PSO contracts are there in Florida and elsewhere?

A. I don't know of any that have been approved, nor am I aware of any ground swell of application activity in Florida for PSOs. There is likely to be interest in some markets, but in South Florida in particular and in some of the other major Florida markets, the proprietary HMOs that are extremely well capitalized have fairly good penetration in the managed care market. Therefore, the provider systems forming PSOs will be playing catch-up, and catch-up requires a significant commitment of capital.

"The provider systems forming PSOs will be playing catch-up, and catch-up requires a significant commitment of capital."

So, the dilemma providers face is whether to compete with the HMOs that are already in the marketplace or whether to enter limited contractual risk arrangements in which they aren't assuming all of the responsibilities, financial or otherwise, that they would have to take on if they become a PSO. Now that providers have the authority to form PSOs, the question is whether they can make them financially feasible.

Q. Has the dismantling of Columbia contributed to the turbulence of health care in Florida?

A. Columbia was and still is a major presence in Florida. At a minimum, the indictments, investigations, and subsequent reorganization of Columbia's corporate governing structure had somewhat of a chilling effect throughout the industry. It would be hard to think otherwise.

Q. These investigations involve the terms under which major for-profit systems acquired physician practices and whether, in making such acquisitions, antitrust or other violations of the law occurred. What is the status of those investigations?

A. The current focus is more on fraud and abuse issues than on market aggregation or antitrust issues. But those investigations are still going on, so other investigations may be initiated ultimately. The government has consistently articulated a concern that if hospitals overpay for physician practices or overcompensate physicians, even if there was no fair market value concept under the employer-employee exception for federal fraud and abuse laws, any of that excess compensation constitutes some sort of incentive. That is, enforcement officials see the overpayment as compensation for future referrals that the physicians would bring to the hospital or as a reward for past performance that hopefully would engender

continuing goodwill between the doctors and the hospitals.

The government seems to be advocating a position that after a hospital and physicians are integrated into a single corporate entity, the physician component somehow has to stand economically on its own. So, if a loss occurs on the physicians' side but a gain is recognized on the hospital's side, the government argues that the loss the hospital is suf-

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“Physicians have to fully understand what they are obligating themselves to provide in exchange for this fixed amount of money; that is, what risks they’ll be assuming for events that are not fully within their control.”

(Continued from page 11)

fering from its physician component is inappropriate because it is being made up on the hospital’s side. To enforcement regulators, that situation is inherently suspect, if not a violation of the law. There may be some credibility to the government’s argument if there was simply an overpayment upfront when a physician practice was bought. But that leads to a battle of experts as to what constitutes a fair market value and what methodology determines the price.

There will always be second guessing because the government has the benefit of looking back three years after the fact. When the hospital bought the practice, all the indicators may have led it to believe that that it was paying a fair market value price. Later, however, when the hospital is losing money, it may turn out that the economics weren’t what the hospital thought they were or would be, and maybe it wasn’t the best business decision that it could have made. I think we’re seeing just the beginning of this debate.

Q. *You’re known as an adviser and a watchdog and a champion of providers insofar as helping them negotiate capitated contracts. What advice would you give, in general, to physicians considering such contracts?*

A. Physicians have to fully understand what they are obligating themselves to provide in exchange for this fixed amount of money; that is, what risks they’ll be assuming for events that are not fully within their control. When they assume responsibility in their capitation agreement for services that they don’t provide, they are essentially going into a form of insurance risk-taking. That type of analysis is clearly outside the scope of what most physicians have been taught and it’s outside the scope of what most attorneys know how to do as well. It requires a financial consultant or an actuary who has experience in this area to help assess the real risk being assumed because the bottom line on capitation is that physicians are going to receive a fixed amount of money for providing a potential-

ly undefined amount of services. If those services exceed the amount of money allocated to them, that difference comes out of their pockets, which is why great care is always warranted when physicians negotiate capitation agreements.

Q. *Let’s speak about the Florida Board of Medicine’s order concerning physician practice management company (PPMC) contracts with affiliated physician practices. Please tell us about the brief you filed with regard to that ruling.*

A. In that case, which has been very controversial, a physician asked the Board of Medicine to issue an order on whether a management agreement that a group practice has with a PPMC violates the fee-splitting law. He raised the question under the guise that he was considering joining a group and did not want to join a group that had entered into a contract that may have, in fact, constituted a fee-splitting arrangement.

After two hearings and much questioning as to who the real parties were and what their true interests were, the Board of Medicine issued a final order in which it concluded that the arrangement in the management contract in question did constitute an illegal fee split. The order even went so far as to state that, in the board’s view, any percentage arrangement between a management company and a physician practice violates Florida’s prohibition on fee-splitting.

The board’s position has been challenged on appeal, and there are several grounds under which the appeal is going forward. One is that the board acted improperly under the scope of its authority to issue declaratory statements. Another challenge to the ruling is that the arrangement itself does not constitute an illegal fee split. Clearly, there are two camps of thought on the case. The physicians who support the board’s decision do not, in general, support the development of PPMCs and would like to use the board’s order as a tool to drive out the companies in the PPM industry or force

them to restructure how they operate.

On the other hand, many physicians who do not support the board’s decision have entered into arrangements with PPMCs and have found them to be extremely beneficial. In fact, the original petition to the Board of Medicine that was filed on behalf of the physician was written in such a way as to almost state to the Board of Medicine: “We believe this arrangement is illegal, don’t you agree with us?”

There has been much controversy concerning the motivation for the filing of the petition, and a lot of discussion over the fact that the group involved in the original petition was looking for the board to give it the legal hammer, if you will, to get out of its arrangement with the PPMC in question. But even after the appeals court rules in this case, it’s very possible that it may not be the last word on these issues.

Q. *Speaking of PPMCs, is there a contest going on among hospitals and PPMCs for the allegiance of physicians?*

A. PPMCs definitely play a role, and depending on your viewpoint, they may or may not threaten that integration. The whole concept of hospital-physician integration is evolving. I’ve never believed that one particular model would fit all, and certainly many of the systems are continuing to develop their models and are constantly re-evaluating where they need to be. Beneath it all is a desire to find ways that physicians and hospitals can work together to maximize their respective individual and mutual interests.

Q. *Is there a stampede toward physician consolidations going on in South Florida?*

A. Not a stampede, but rather a heightened awareness to it. As in other situations where a lot of people who have worked in an industry that has historically consisted of smaller groups of players, it takes time, a lot of vision, and a lot of effort to coalesce into larger groups. Some physicians have tried it; some have succeeded; others have failed. That effort and the push by unions to aggregate physicians will continue. ■

Moving to Electronic Claims Processing

By Michael Heppner

For physicians, the objective of processing medical claims electronically is to get paid more quickly for services provided, while at the same time reducing costs. This goal is equally applicable whether one is an administrator of a small group or planning to consolidate to a larger organization, as is the industry trend. However, physicians should be wary; moving from paper to electronic claims requires much more than just purchasing and installing computer hardware and software. It requires a three-phase approach that involves understanding current claims flow, choosing an electronic claims configuration, and installing and testing the electronic system.

Analyzing Performance Indicators

The first step in the process is to evaluate current billing practices and compare their effectiveness with accepted standards. To do this, a practice would need some benchmarks for comparison. Regional and industry averages for specific performance indicators can serve as a yardstick. Commonly studied indicators include:

- Volume and state of accounts receivable by payer
- Ratios of claims rejections, bad debt, adjustments, and expenses
- Percentage of credit balance to accounts receivable
- Costs per full-time equivalent (FTE) employee, per physician, per square foot, and per claim or encounter

Once a group has reviewed its performance indicators, it will need to identify and correct any bottlenecks or gaps in functional areas that may impair electronic claims production. Even a cursory review may reveal procedures that need to be improved before computer system changes are made. Keep in mind that automating a bad process will not improve the situation

and may make it worse. Whenever possible, address processing problems where billing originates—in the office—and not further downstream at a point where a claim could be denied.

Just as patients flow through the office, information flows through the system. The steps in the process are intertwined and not independent of one another.

The Correct Configuration

Step two involves understanding how billing procedures work and sets the stage for determining the configuration a group will use to transmit claims electronically.

Electronic claims can be submitted directly to individual insurers, indirectly through an intermediary, or with assistance from value-added networks that will handle the connectivity. Each has its own costs and benefits.

There is no recipe to use when determining which system is best for each organization. The factors that should significantly influence the choice of a system are the staff's technical capability, the enterprise's business requirements, claims volume, dollar values, and the level of control administrators want over the submission process, from beginning to end.

Essentially, there are three ways to submit electronic claims: directly to individual insurers, indirectly through an intermediary, or with assistance from a value-added network that will handle the connectivity. Each configuration has its own costs and benefits.

Submitting claims directly to individual insurers. This option offers the most control over the process, but a group needs the technical resources, such as information technology

personnel with expertise in programming and network connectivity, to deal with proprietary file formats and other related issues. If the group opts for direct submission, administrators should be selective about which insurers would be involved, being careful to identify companies that represent the greatest return for the practice in terms of dollar turnaround, reduction in manual effort, or sheer volume of claims.

Individual insurers may have their own proprietary file formats. If a group chooses direct submission, therefore, the group may need to cope with multiple processes for submission and balancing, and some dupli-

cation of effort will be inevitable. Not all insurers will have sufficient volume, incentive, or technical resources to make it worthwhile to support the group's switch from paper to electronic claims.

The advantage of submitting claims directly to individual insurers is that the group will know exactly when claims have been submitted to an insurer, when the process goes awry, and in most instances, why. Of course, the group is responsible for setting priorities and scheduling resources such that the group can meet the requirements of each insurer involved.

Submitting claims through an intermediary. With this option, the group may have fewer problems related to issues with specific file formats, but may be at the mercy of the intermediary's ability to contract with insurers and to resolve file format and connectivity problems. Not all insurers may be willing or able to work with the chosen intermediary. For all those that can comply, however, the group generally will need to deal with only one file format.

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Michael Heppner is an executive director in the Healthcare Integration Division, Ambulatory Care Systems practice of Superior Consultant Co. Inc. in Southfield, Mich. He has extensive experience with ambulatory care systems and project and interim management.

In a relatively short period, the new electronic process, tools, and billing functions should allow the group to meet and exceed the accounts receivable, cash management, and profitability goals established when the group decided to move to electronic claims processing.

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Typically, an intermediary will supply the necessary software and translate submissions to meet various insurers' specifications without any additional efforts by the group. Thus the group's claims-related procedures can be standardized and usually reduced to one submission and reconciliation. The downside is that if the intermediary misses a submission to an insurer, the group may not be told when or why. Therefore, the group should ask about the company's claims-processing track record and its procedures for communicating about and dealing with missed submissions.

Using a value-added network to handle connectivity. With this process, transactions are standards-based; that is, based on such formats as HL-7 and ANSI X.12, which have been defined specifically for health care transactions. Since common electronic transaction formats have been designated for claims and for receipts, file-format issues are minimized. If the group's claims fall outside the network's standards, however, the requisite programming could be difficult.

Before a group opts for claims submission through a value-added network, administrators should be sure they understand the costs involved. If the transaction cost per claim is more than the group currently spends for manual efforts, the group may reexamine the reasons for going electronic.

Since the transactions supported by a value-added network are universal, insurers participating in a given network should be able to handle the same format. If some claims require additional documentation outside the typical submission process, however, the group may need to ensure that the network has transactions to support the extra steps involved. In general, standards-based transactions are less flexible but more portable than using proprietary formats.

Once a group has chosen a claims submission process, it will need to decide whether the control will be centrally managed in a

central billing function or distributed (decentralized), meaning individual departments would be responsible for submitting and reconciling claims. If the process is to be distributed, the group will need to decide if claims will be grouped by insurer, by type of service (such as internal medicine, pediatrics, anesthesia, or radiology), or in some other fashion.

The benefits of centralization include reduced FTE requirements and better control over procedural changes. The downside includes a perceived loss of control by physicians when billing functions are not located in clinic areas, less flexibility to vary policy, and the possible perception among patients of having less than a personal relationship with the physician office. The benefits of decentralization include the perception among physicians of greater control over billing and collection efforts, flexibility of policy, and the perception among patients of a more personal relationship with the physician and office staff. The downside includes the possibility of conflicting procedures, inconsistent application of policy, and staff not being current on billing regulations and internal requirements.

Whether management is centralized or distributed, the group will need to develop and implement new procedures to support the electronic process.

Assessing Support

Once the group chooses a method of submitting claims, the next step is to acquire the computer and communications hardware and software necessary to support the configuration. After the hardware, software, and connectivity equipment have been installed and tested, the group can begin translating claims into electronic specifications. The specifications and rules governing claims transactions will vary depending on which trading partner or partners the group has selected.

Specifications define how data are mapped from the practice management sys-

tem to the transaction format. Rules define how the data are treated, specifying edits for validity (such as determining whether a number is in a number field and text is in a text field), consistency (such as determining whether a procedure is valid on a male patient), and activity (such as when a certain value is present, other information may be required for the transaction). The group will need to be prepared to do a significant amount of testing with a variety of claims to ensure that claims information is being formatted correctly, that the data are being transmitted, and that the companies receiving the data are processing the information accurately. The final step in the transition is to go "live" with the new system.

Patience Required

Making the transition will require some patience because as with any new system, delays and frustration are inevitable. Discrepancies between the computer specifications recommended and the actual equipment in use are bound to occur. The group also may experience information gaps, such as denial of a claim because provider-specific codes are needed, or because of an unforeseen need to provide paperwork and signatures along with an electronic claim.

Don't expect an electronic process to eliminate all paper claims processing. The set-up costs for electronic transmission to a particular insurer may not be justified if claims volume to that company is low. Manual processing also may be more appropriate to ensure accuracy for claims that involve documentation not supported in electronic format.

The key to ensuring that electronic claims submission works effectively is to invest significant effort in the transition away from a manual system. By not rushing the process, the group can avoid costly mistakes and get the system working properly on the first try. ■

The Pitfalls of the Partnering Process

By W.L. Douglas Townsend Jr. and Jill S. Frew

Deciding to choose a partner is one of the biggest decisions in the life of any physician clinic. Once the decision is made, the clinic must navigate the sometimes-rough waters of selecting a partner. There are several types of approaches that can add structure to this process. They include:

- **Negotiation**—the clinic negotiates exclusively with one potential partner and aims to consummate an affiliation
- **Auction**—numerous potential partners are invited to submit proposals according to a specific format
- **Selective bid**—a core group of serious potential partners submit proposals, from which the clinic selects two to four candidates to pursue final negotiations

As the physician practice management company (PPMC) industry has matured, the process used to select a partner has changed. With the bankruptcy of FPA Medical Management, PhyMatrix' sale of its practice management operations, and operational difficulties at several other

PPMCs, the range of qualified partners has narrowed. Therefore, we expect to see a shift away from auctions and toward negotiated deals. Although the number of potential partners is important, a clinic's particular financial and market positions also determine which approach will work best. Negotiation is appropriate if a partner has offered a preemptive value, the clinic has limited market appeal, or the clinic's situation requires extensive explanation. An auction is appropriate if numerous potential partners exist or monetary objectives are important. Selective bids are appropriate if a core group of three to eight potential partners exists and monetary objectives are important

Simply applying these approaches does not guarantee a smooth partnering process, or that a group will avoid making mistakes along the way. Among the areas in which the process can break down are failing to examine the clinic's qualitative needs, failing to develop physician consensus, using an unorganized procedural approach, and seeking too

many, or too few, partners (see table).

In our work with clients, we follow four guidelines in the partnering process:

- **Competition.** Creating competition among several potential partners that want to affiliate with the clinic can help maximize the clinic's value.
- **Quality information.** By providing potential partners with accurate and timely information about its operations, the clinic helps the potential partners to bid with confidence.
- **Equality and fairness.** Making sure that all potential partners receive the same information, have adequate time to evaluate the information, and have equal access to the key participants helps ensure equality and fairness in the process.
- **Multiphased process.** Asking for initial bids from a group of potential partners and then inviting a few of them to rebid often generates more aggressive bids.

While these guidelines do not guarantee that the process will run smoothly, they provide a solid base from which to begin.

Common Mistakes and Typical Results

Common Mistakes

Failure to examine specific qualitative needs (such as strategic direction of clinic and potential services provided by PPMCs)

Failure to develop physician consensus on partnering

Unorganized procedural approach to potential partners with poor quality information

Approaching too many partners

Approaching too few partners

Typical Results

- Purchase price drives the partnering decision
- Failure to consider other aspects of the partner's proposal could lead to dissatisfaction after the deal closes

- False starts costing the clinic time and money
- Reduced credibility in the marketplace

- Many partners could get frustrated and drop out of the process
- Process could become political as prospective partners lobby individual physicians
- Clinic appears unpolished

- Clinic can acquire reputation as a "price hunter," leading to declining values
- Quality partners could exit the process

- Difficult to realize the full potential value of the clinic
- May miss good strategic fits

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

W.L. Douglas Townsend Jr. is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., that specializes in health care transactions. Also, he is a member of the editorial Advisory Board of Physician Practice Options. **Jill S. Frew** is managing director of Townsend Frew & Co.

PacifiCare Issues Reports on Quality of Medical Groups in Response to Consumer Demands for More Health Care Information

PacifiCare of California, an HMO based in Cypress, has released a public report on medical group performance that rates many of PacifiCare's contracted medical groups and IPAs in such areas as medical screenings and treatments, member complaints, and satisfaction. The medical groups and IPAs rated in the report treat more than 1.3 million Californians.

Known as the Quality Index, the report was issued in response to demands from consumers for more useful and understandable health plan and provider information. The HMO thus became one of the first health plans to publicly release information on how medical groups and IPAs fare in clinical and member-service areas. To date, most such reports by health plans have focused primarily on member satisfaction.

"The Quality Index is designed to raise the standard of health care by identifying the variations among medical groups and IPAs, highlighting the top performers in various measures and encouraging the sharing of best medical and service health care practices among medical groups and IPAs," said Sam Ho, MD, corporate medical director for PacifiCare Health Systems, the parent company of the HMO.

Comment: Each of the 14 measures used in the index was calculated over the past 12 months for PacifiCare's contracting medical groups and IPAs that serve at least 1,000 commercial members and 500 Secure Horizons (or Medicare) members. Groups that ranked in the 90th percentile or above in any of the measures received a "best practice" designation for that measure.

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Richard L. Reece, MD
Editor-in-Chief
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