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, M.D., 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, M.D., 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 and to practice as a team.” Nuckolls is CEO of Carilion Healthcare Corp., in Roanoke, Va., a medical group of 150 primary care physicians.

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 capitated.
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 (Apen Publishers, Gaitersburg, Md., 1998), by Marshall O. Zaslove, M.D., 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. It is 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, M.D.
Editor-in-Chief
Toll-free phone: 888/457-8800
E-mail: Rreece1500@aol.com

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, N.J. 07054

Editor
Joseph Burns
800/495-0246
E-mail: jobeburns@capecod.net
Subscription Price: $299, 12 issues
Issue Price: $25 each

© Copyright 1998 Premier Healthcare Resource, Inc., Parsippany, N.J. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.
COMMENTARY

Analyst Critical of Physicians' Efforts

By Richard L. Reece, M.D., 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. The HMO created by the California Medical Association, has filed for bankruptcy. A new medical management company, FPA Medical Management Inc., 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 detriment 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 reasons, they own and control and that are large enough not to be ignored.

"I can't pretend that a PhyCor or a 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."

A 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)
ated 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 Information, groups functioning under capitation contracts seem to be making more money. (See sidebar, “Capitation Rates Fall as ProfitabilityRises.”) “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.

<table>
<thead>
<tr>
<th>Capitation Profitability</th>
<th>Average payment PM PMPM</th>
<th>Percentage of groups reporting a profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group practice</td>
<td>$12.43</td>
<td>$11.06</td>
</tr>
<tr>
<td>Multispecialty group/IPA</td>
<td>$12.68</td>
<td>$12.64</td>
</tr>
<tr>
<td>Physician-hospital organizations/ integrated delivery systems</td>
<td>$12.17</td>
<td>$12.49</td>
</tr>
<tr>
<td>Primary care average</td>
<td>$12.39</td>
<td>$11.98</td>
</tr>
</tbody>
</table>

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 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 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 subcontract 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

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.

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 Veleoki 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 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 aren’t 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

CASE STUDY
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.”

A cademic health centers have long been bastions for spending, shrouded from managed care. Of late, academic centers have come under fire for high costs, overproduction 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. “A cademic 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,” 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.”

A nother 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)
“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 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

8 Physician Practice Options/October 30, 1998
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
Becoming so.

Higher utilization rates.

Raise this issue early because it will result in

Includes many geriatric patients should

Roediger. An internist whose practice

Characteristics of their practice, says

Effectiveness and clinical efficiency."

So, the physician shows a concern for cost

Managed care plan," says Caesar. "By doing

Make sure to market these strengths to the

And use operational and clinical data should

In an outcomes management data system, or

Physician who has invested time and money

Physician Practice Options/October 30, 1998

Physician group."

A physician who has invested time and money

In an outcomes management data system, or

Physician who has invested time and money

Physician group."

In a group practice, the patients and revenue lost not only affect the individual

Physicians who are not board-certified or be working toward

Contract termination language

Ensuring that the contract is explicit about ter-

Reimbursement and compensation structures.

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 cov-
ered by the plan. Therefore, he or she would provide care primarily to the prac-
tice's Medicaid patients, and would most likely generate less revenue.

Contract termination language

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 cov-
ered by the plan. Therefore, he or she would provide care primarily to the prac-
tice's Medicaid patients, and would most likely generate less revenue.

Ability to contain costs while practicing

High-quality medicine will have the greatest

Physicians who can demonstrate their

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 sat-

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

Losses Compounded for Groups

In a group practice, the patients and revenue lost not only affect the individual

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:

Much of the

Negotiation process involves getting a feel

Face-to-face

Meetings are useful because they provide an

Developing a qualitative impres-

Frankly, it's harder for

Health plan managers to characterize

They have spent many hours over several

Making sure to market these strengths to the

Operational and clinical data should

An outcome management data system, or

Physician who has invested time and money

Physician Practice Options/October 30, 1998

Physician group."

In a group practice, the patients and revenue lost not only affect the individual

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 cov-
ered by the plan. Therefore, he or she would provide care primarily to the prac-
tice's Medicaid patients, and would most likely generate less revenue.

Ability to contain costs while practicing

High-quality medicine will have the greatest

Physicians who can demonstrate their

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 sat-

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

Physician Practice Options/October 30, 1998

Physician group."

In a group practice, the patients and revenue lost not only affect the individual

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 cov-
ered by the plan. Therefore, he or she would provide care primarily to the prac-
tice's Medicaid patients, and would most likely generate less revenue.
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 is 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.

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 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 suffering (Continued on page 12)
“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.”
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-

(Continued on page 14)
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.

(Continued from page 13)

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 decentralization 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. 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 system 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 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.
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’s sale of its practice management operations, and operational difficulties at several other PPCMs, 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.
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.