

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Survey Shows Physician Dissatisfaction With HMOs

Some health plans achieve a balance between cost management and clinical autonomy, while others impose excessive restrictions that limit physicians' ability to offer high-quality care, according to a recent survey of physicians working with those plans. In an extensive survey, 30,000 physicians in 22 markets were asked for their opinions about the performance of 135 health plans across the country. The 100-question survey, called the Medstat Quality Catalyst Program, measures physician satisfaction with health plans in their markets and then makes the results available to those plans.

The goal of the survey is to improve plan performance and, as a result of the survey, some health plans are working to identify ways that they can be more physician friendly.

The Quality Catalyst Program, one of the largest national surveys of physician satisfaction with health plans, is conducted by The Medstat Group, consultants in Ann Arbor, Mich., in conjunction with J.D. Power and Associates and the New England Medical Center (NEMC), in Boston. The Medstat Group offers research and consulting services centered on the strategic application of health care information. J.D. Power and Associates in Agoura Hills, Calif., is a marketing information firm with expertise in customer satisfaction measurement. NEMC has extensive experience in surveying physicians through its Primary Care Outcomes Research Institute.

"The objective of the Quality Catalyst Program is to provide health plans with useful information that can be used to

drive performance improvements," says Dennis Becker, senior vice president of The Medstat Group. Three groups of stakeholders—health plan enrollees, physicians, and employers—offer insight into how a plan can improve quality. Medstat first surveyed all three groups in 1997, and surveyed enrollees and physicians again in 1998.

"If a plan is to be successful, its administrators must understand how the plan is performing in the eyes of these stakeholders, and then use that information to drive improvements," says Becker.

"The value of the Quality Catalyst Program is that it provides objective data that document the concerns physicians have with their plans," says Louis Diamond, MD, Medstat's medical director. "The availability of objective data has the very real potential to help physicians and plans focus their discussions on particular areas for improvement."

The first physician survey was distributed to 9,000 physicians in six health care markets. The 1998 version was expanded to profile 30,000 physicians rating 135 health plans in 22 markets; a survey of 77,000 enrollees was conducted in the same markets earlier in the year.

Physician participants were selected from a national list of physicians, and only physicians directly involved in patient care were identified. Then, researchers derived a random sample of these physicians based on the number of plans being profiled in the community and the size of the community. "In some small communities, such as Lansing, Mich., all of the physicians were surveyed," explains Becker. "In no commu-

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One Model Does Not Fit All Markets

Over the past several months, we have been writing extensively about global payments for episodes of care. This method of paying for and organizing health care has been tried in several markets and has had some success in controlling costs and improving health care quality.

We believe it is important to write about new methods of organizing care and we also believe in keeping all of these methods in perspective. Recently, for example, Sandy Lutz, a health care practice manager in the Dallas office of Pricewaterhousecoopers, CPAs and health care consultants, told us that the orthodox methods of managed care are changing. "We go through generations of management controls," she says. One reason narrow forms of managed care are changing is that consumers and physicians have begun to reject the management-from-above method, Lutz says.

In reaction, specialists have created global fees to treat particular diseases in their specialty, Lutz says. "The logic behind these systems is that when physicians organize in this way, they do not need some of the more distasteful functions of managed care such as preauthorization. Instead, they have the financial incentive to take responsibility for treating that episode of care, which has a sequence of events the specialists understand well."

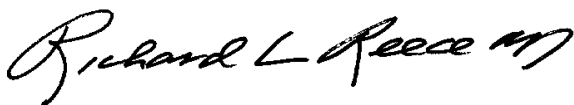
As a health care payment method, episodes of care are highly effective, Lutz says. One drawback, however, is that physicians would have to find payers willing to establish episodes-of-care systems. "Physicians would have to sell the payers on the idea that this is the most efficient way to deliver and pay for care. As a whole, I'm not sure the market is ready for global fees for episodes of care right now. That might change, because we're seeing HMOs that have lost money and are now merging and raising premiums by as much as 18% or 20%. If HMOs try to force premium increases that are unacceptable to employers, the employers may return to the days when they negotiate direct contracts with providers or carve out contracts for certain specialty care. If this is the case, employers may be willing to consider alternative forms of reimbursement, such as global fees for episodes of care."

Lutz is the author of *The For-Profit Health Care Revolution* (New York: McGraw Hill, 1995) and *Physician Group Management at the Crossroads: Developing, Operating and Growing Medical and Dental Groups* (New York: McGraw Hill, 1999).

When working on her latest book, Lutz found that there is not one health care system for all markets. "What I learned is that physicians are not a monolithic group," she says. "There's not one answer to how they should organize. Different models are going to fit different physician groups in different locations, of different specialties, and of different age groups.

"The assumption that there was one management answer for all groups was the seed of the problem in the PPMC movement," Lutz continues.

Regardless of the system being proposed to organize medical care, physicians need to consider carefully all of the different models and to determine which model will fit them best now and in the future.



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.

Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.

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
Chairman
Personal HealthMaps
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
UnitedHealth Group
Minneapolis

James G. Nuckolls, MD
Medical Director
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
Chairman
Sokolov Schwab Bennett
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

Physician Uses Web to Generate Referrals

By Richard Reece, MD, editor-in-chief

Many specialists are overwhelmed with patient requests for information about topics widely covered in the media. Recently, many urologists report being inundated with patient questions on topics such as impotence, the cost-effectiveness and clinical outcomes associated with prostate cancer screening, and treatments for prostate cancer.

Charles Myers, MD, professor of medicine and urology and director of the Cancer Center at the University of Virginia in Charlottesville, is no stranger to such requests. As a result, he has created a newsletter, called *The Prostate Forum*, to provide basic information to the general public about prostate cancer, treatments, drug therapies, and other prostate-related issues. In the course of providing a public service with his online newsletter (www.prostateforum.com), he also boosted his own business by generating patient referrals from all over the country.

"As a result of *The Prostate Forum*, I now have a very active business serving as a 'second opinion' in prostate cancer diagnosis and treatment," Myers reports. "Patients come from all over the United States to Charlottesville to get a second opinion about their prostate cancer disease management. If a physician wants to establish a national referral pattern, publishing his or her own written information on the Internet is the best way to do it today." But building his own practice was not his initial goal.

Myers spent 23 years in clinical pharmacology at the National Institutes of Health's National Cancer Institute (NCI) in Bethesda, Md., and served as NCI's director of clinical pharmacology from 1983 to 1994. "As a result of my experience at NCI, I have broad experience in drug development," Myers says. "While at NCI, I was involved in discovering new cancer drugs, reformulating current cancer drugs that were ineffective, and developing new drug combinations." In fact, Myers was the phar-

macologist on the team that helped to develop one of the most effective drugs used to treat AIDS patients.

Patients' Concerns

Seeing a need for an online newsletter about prostate disease, Myers started *The Prostate Forum* in June 1996. It currently has 2,600 subscribers. "I came up with the idea for the newsletter as a result of my lectures to prostate cancer activist groups in various communities, which I started to hold here in Virginia and then expanded nationwide," Myers says. "After I gave a talk, people would say they really enjoyed it. But soon I'd

could shorten the visit. This allowed the patient to get basic information that they could digest on their own time, without requiring an inordinate amount of the physician's time."

Myers first posted *The Prostate Forum* on the Internet in December 1997. "Three years ago, when we started the newsletter, we imagined that the Internet was a place that only young people frequented," he says. "But shortly after we began the newsletter, I was contacted by a number of patient activists who maintain Web sites for prostate cancer. They offered to put my biographical sketch up on the Internet

"It's certainly much more efficient if physicians do not have to repeat themselves in front of each patient they treat."

—Charles Myers, MD, University of Virginia

start getting phone calls asking me to clarify certain points I'd made or expand on certain topics in the speech. So I realized that people had trouble understanding or remembering everything I said, and also had a thirst for more information. I started the newsletter solely for the purpose of addressing each major prostate cancer issue that concerns patients. I wanted to write about each issue clearly and simply, while still maintaining high academic standards."

Consumers are not the only market for the newsletter, however. "Additional markets for the newsletter have developed within the physician community," says Myers. "Physicians who treat prostate cancer patients often find that the first clinic visit with a patient can take a significant amount of time, because the patients have heard a lot about prostate cancer in the media, and they have many questions as a result. Often, up to two hours can be spent on that initial visit. Physicians discovered that by supplying a copy of my newsletter to the patient, they

along with several articles from *The Prostate Forum*. The sites began to get a lot of visits, and users of all ages would express interest in the newsletter."

Accordingly, Myers decided to start his own Web page that expanded on the prostate cancer theme. The site provides visitors with sample articles, a list of back issues, and information about how to subscribe.

Recent topics in the newsletter have included the management of localized prostate cancer, the effect of diet and lifestyle, and genetic predisposition to prostate cancer. While all topics related to prostate health are covered, Myers believes that prevention is a particularly important aspect of his newsletter and the information it offers to the public. "Men at high risk can proactively reduce the chance of developing prostate cancer," Myers says. "In the area of prostate cancer treatment, there is a significant lack of randomized control trials, but the one area where we

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have very solid randomized control trials with many men followed for many years is in the area of prevention.”

As an example, Myers explains that the most dramatic evidence of preventive success involves selenium yeast, at a dose of 200 mcgs. “In one trial, over the course of 10 years, the group of men taking selenium exhibited a 50% reduction

public and present the scientific view in a way that patients can understand, patients will remember the wrong message,” he says. “Unfortunately, the patients may not understand the scientific options the physicians offer. On the other hand, they will surely attach to the benefits touted by the alternative medicine practitioners, many of whom main-

drugs that patients are taking, and note when and if the drug seemed to work.”

The university does not provide malpractice insurance coverage to physicians in cases in which they give opinions via e-mail without having examined a patient.

in overall cancer mortality from lung, colon, and prostate cancer,” Myers explains. “Of these, prostate cancer was the condition most dramatically affected, with the death rate dropping by 65% in the people taking the selenium. Furthermore, the study found no side effects from this dose, and the cost is only 10 cents a day.”

Protecting the Public

The newsletter provides a wealth of helpful information in reader friendly terms. But Myers emphasizes the value of having physicians provide information in their communities. “Doctors treating cancer patients serve an important function by contributing to and speaking for patient advocacy groups and other community organizations,” Myers says. “In large part, this is because many cancer sufferers, such as prostate cancer patients, are inundated by unscrupulous practitioners of alternative medicine who are offering bogus products at astronomical prices. There are some good practitioners in the alternative medicine movement, but a surprising number of people are actually advocating harmful products.”

Physicians can serve as important patient advocates by presenting valid, scientifically based medical information in a clear and understandable manner, Myers says. “Unless physicians or other health practitioners from the medical establishment get out in front of the

tain excellent communication skills, and are proficient at speaking and writing to a lay public. Also, the more hopeful message presented by alternative practitioners, even if it is not scientifically based, is simply more attractive to a desperate patient than the truth. As a result, it is a formidable task for physicians who try to present the more scientific view. But the physician community must prevent false hopes, and should get out in front of the lay public or else patients will be less likely to follow established medicine.”

Increased Communication Skill
Writing the newsletter has helped his own understanding of prostate cancer as well as provided him with a venue in which he can contribute to society, Myers says. “The folk wisdom among the faculty here at the University of Virginia Medical School is that you never know a subject as well as when you have to teach it,” Myers explained. “Having to stand in front of people and defend your opinions, or to defend them in writing, as in the case of the newsletter, causes more discipline than people usually feel in presenting their opinions. Writing the newsletter has dramatically improved my own understanding of prostate cancer, and has forced me to be more comprehensive and to cover a broader area than a medical oncologist normally would cover. For example, I’ve had to read all of the primary literature on radical prostatectomy so that I can offer patients an opinion about whether they should undergo this procedure; under a normal course of events I would not have done that.”

The newsletter has helped Myers

“The more hopeful message presented by alternative practitioners...is simply more attractive to a desperate patient than the truth.”

—Charles Myers, MD, University of Virginia

There are some effective herbal products, Myers adds, noting that herbal remedies have a long history in medicine. “Physicians sometimes lose track of this fact,” he says, attributing his own awareness to his experience in drug discovery at NCI.

“Most of the current FDA-approved drugs used to treat cancer started from plant products, many of which were addressed in the folk literature,” Myers says. “So I’ve always regarded the responsibility of a private practitioner or a physician in academic medicine to take careful record of the alternative

develop his communication skills as well. He has written more than 250 articles and book chapters in the scientific literature, but reports that there is a difficult leap from writing for the scientific medical community to writing for patients. “It was very difficult for me to get away from ‘science speak,’ as my daughter calls it,” he says. “My tendency was to use medical jargon that, of course, patients could not understand. I have been averaging one paper in the professional literature every three weeks for 23 years, so I was very adept at writing scientific English. This is a common trait

among physicians: I've discovered that when I talk to patient groups, most of the other physicians on the podium with me simply cannot explain themselves in plain lay English. They can not translate their ideas into language patients can easily understand. It was probably a full year into the publication of the newsletter before I really began to enjoy any facility in writing for the public."

Time Considerations

Myers acknowledges that some physicians are apprehensive about publicizing information on the Internet or creating a newsletter, fearing that they will be overwhelmed by requests for information. "I feel that I've handled this extra pull on my time fairly well," he says. "I usually respond to requests in the evenings or on weekends. Also, I have a firm policy that I write the newsletter and I talk to patients, but I will not conduct medicine and provide opinions over e-mail." Myers avoids offering medical advice over e-mail for two reasons:

First, the malpractice insurance coverage he receives through the University of Virginia will not cover physicians in cases in which they give opinions without having examined a patient. The second reason has to do with licensure. "I'm

and state in a clear and concise way the descriptive information and his or her opinion on each topic," he says. "Then physicians do not have to repeat themselves in front of each patient they treat."

"I feel that an on-line newsletter is a

It took more than a year of writing for his patient newsletter for Myers to begin to explain medical problems in plain English.

licensed to practice medicine in Virginia. If I start managing the case of a patient in California via e-mail, then I am practicing medicine in California without a license," he says.

On balance, Myers believes that producing an on-line newsletter is an efficient and effective way for physicians to handle the overwhelming flood of medical information available to consumers today. "It's certainly much more efficient if the physician must only sit down once

very effective and important way of communicating to a larger universe of interested people," concludes Myers. "Physicians who are apprehensive about doing something like this should remember that medicine gives us very broad training, and we are certainly able to retool ourselves along our careers to fit the new circumstances presented by the information age."

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

HHS Issues Gainsharing Warning

The Office of Inspector General (OIG) of the federal Department of Health and Human Services has issued a special advisory warning against hospitals rewarding physicians' efforts to reduce health care costs for Medicare and Medicaid patients with a share of the hospital's savings, a practice known as gainsharing.

Gainsharing refers to an arrangement in which a hospital gives physicians a percentage of any reduction in the hospital's costs for patient care attributable to the physician's efforts. These arrangements seek to align physician incentives with those of hospitals, says Charles Peck, MD, an internist and consultant with Arthur Anderson Healthcare Consulting in New York. "Given the myriad of legal issues relating to incentive compensation for physicians, any gainsharing program must be carefully examined for possible violations of federal law," says Peck. "Not all gainsharing arrangements are necessarily prohibited, but the legal areas governing gainsharing and physician referrals are sometimes unclear to hospitals and physicians."

"The actual practice of hospital-physician gainsharing is not very common because hospitals are unclear as to its legality under federal law," says Mary Greal, chief Washington counsel for the American Hospital Association in Chicago, "but it is a concept being looked into by many health systems as a way to encourage savings. This warning helps gain some understanding about the issue."

The OIG periodically issues special advisory bulletins to provide guidance to Medicare and Medicaid providers about suspect practices under federal anti-fraud and abuse laws. The bulletins are not legal rulings, but provide guidance to courts if criminal or civil action is taken against a hospital, physician, or medical group, says Keith Korenchuk, a health care attorney and partner with Davis Wright Tremaine, a law firm in Washington, D.C. "These bulletins should be taken seriously," he says. "Anyone considering entering into a

gainsharing arrangement should contact an attorney."

The bulletin addresses another issue related to incentives that may have implications for hospital-physician financial arrangements, but isn't directly related to gainsharing, says Greal. It warns hospitals and physicians that some clinical joint ventures also may run afoul of the prohibition against hospitals paying physicians to limit or reduce care for Medicare or Medicaid patients. Examples of potentially illegal joint venture agreements provided by the OIG include freestanding specialty hospitals (such as heart, orthopedic, or maternity hospitals) and arrangements in which a high-revenue unit or service of an existing hospital is carved out and recapitalized as a separate hospital with physician investors.

any hospital that "knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services" to Medicare and Medicaid patients.

Federal anti-kickback statutes under the Social Security Act of 1965 prohibit payments by health care systems to physicians in exchange for referrals of patients who are Medicare or Medicaid beneficiaries. Violations are felonies and also may subject offenders to civil monetary penalties of \$2,000 or more per patient. The same fine can be levied against hospitals and physicians for violations of gainsharing prohibitions, although such violations are not felonies.

Nothing in the special advisory bulletin prohibits hospitals and physicians from working together to reduce unnecessary

"Anyone considering entering into a gainsharing arrangement should contact an attorney."

—Keith Korenchuk, Davis Wright Tremaine

"These joint ventures may induce investor-physicians to reduce or limit services to patients to increase profits through cost savings in clinical care," said Inspector General June Gibbs Brown. "In addition, such arrangements may implicate the anti-kickback statute."

The inspector general said that although hospitals have a legitimate interest in enlisting physicians to help eliminate unnecessary hospital costs, existing federal law prohibits hospitals from paying physicians to reduce or limit care to Medicare and Medicaid patients. "With appropriate regulatory safeguards, the concept of gainsharing might be acceptable, but Congressional action would be required to change the existing law that prohibits hospitals from paying physicians to reduce or limit care to Medicare and Medicaid patients," said Brown in the advisory bulletin.

The Omnibus Budget Reconciliation Act of 1986, imposed a civil penalty on

hospital costs if they avoid kickback and gainsharing prohibitions, says Judy Holtz, a spokeswoman for the OIG. "What is prohibited, however, is hospitals paying physicians a share of hospital-based cost savings. Hospitals may encourage physicians to achieve cost savings through means that do not violate the law. For example, hospitals and physicians may enter into personal services contracts where hospitals pay physicians based on a fixed fee that is fair-market value for services rendered rather than a share of cost savings," she says.

Careful Consideration

Fear of civil penalties for violation of federal law should lead hospitals and physicians to tread carefully in considering any relationship that resembles a gainsharing plan, says Patrick O'Hare, a health care attorney and partner with McDermott, Will & Emery in Washington, D.C. "Many health care delivery systems, such

as hospital groups that enter into financial arrangements with medical groups, have been deliberating whether to initiate gain-sharing programs," he says. "These arrangements are generally designed to reward staff physicians with a portion of the cost savings hospitals realize when physicians use treatment protocols and other procedures to deliver quality care in the most cost-effective manner."

Health systems also have been interested in developing gainsharing programs as a way to prepare their constituent organizations for risk-based payment arrangements, says O'Hare. Under risk-based payment arrangements, physicians are paid a flat prepaid amount, usually per member per month, for providing care for a set number of a health plan's members. These arrangements can be financially risky for physicians, because if they provide more care than they are paid for, they risk losing money. Gainsharing can offset some of that risk by tying incentive payments keyed to meeting predetermined economic and quality care targets, such as reducing hospitalizations and medical tests such as mammograms.

But such arrangements need to be structured around four of sets of legal requirements delineated in the Social Security Act and the Omnibus Budget Reconciliation Act, says O'Hare. These include:

1. The civil monetary penalty statute
2. Physician self-referral prohibitions
3. Fraud and abuse prohibitions
4. Provisions relevant to tax-exempt systems

The civil monetary penalty statute. The civil monetary penalty statute prohibits a hospital from knowingly making a payment to a physician as an inducement to reduce or limit services provided to Medicare or Medicaid beneficiaries under the physician's personal care. It is the prohibition and penalty referred to in the July OIG gainsharing advisory. "Health care systems designing a gainsharing program can minimize their risk of violating the civil monetary penalty statute by carefully structuring their measurement criteria," says O'Hare. "For example, because the statute deals with the reduction of services to individual patients, measurement criteria for gainsharing payments might be based on aggregated costs for large groups of patients, including

"The actual practice of hospital-physician gain-sharing is not very common but it is a concept being looked into by many health systems as a way to encourage savings."

—Mary Grealy, American Hospital Association

patients not covered by Medicare or Medicaid. An additional safeguard would be to include one or more quality indicators in the measurement criteria."

Physician self-referral prohibitions. Another restriction having an effect on gainsharing arrangements is the law against physician self-referral, commonly known as the Stark legislation. The Stark legislation considers physicians who participate in gainsharing programs as having compensation relationships with the hospitals sponsoring such programs. Unless the arrangement qualifies for one of the exceptions specified in the legislation, physicians can be prohibited from making referrals to the hospital with which they have a gainsharing arrangement.

The most relevant exception protecting gainsharing payments under physician self-referral laws involve "personal services arrangements," says O'Hare. Personal services arrangements involve contracts between physicians and hospitals that specify what services physicians will perform for a specific, prearranged fee. Examples include emergency services and medical specialty consultations. To qualify for this exception, the gainsharing contract must meet the following five criteria contained in the Stark regulations:

1. The contract must be written, executed by the parties, and specify the services to be performed.
2. The contract must cover all services to be provided.
3. Covered services may not exceed those necessary to accomplish the parties' business purpose.
4. The contract's term must be for at least one year.
5. The contract must provide that the compensation be set in advance, not exceed fair market value, and not take into account the volume of referrals or

other business between the parties.

The fifth criterion is the most troublesome, says O'Hare, because the amount of compensation payable to any one physician under a gainsharing formula cannot be set in advance, but has to depend on the physician's performance as measured over a large group of patients. "Many attorneys advise that organizations' gainsharing arrangements can qualify for the personal services Stark exception if the payment formula is set in advance, assuming an otherwise fair market amount and the use of a formula that is not based on referrals," he says.

Fraud and abuse prohibitions. The third legal requirement that gainsharing arrangements must satisfy is compliance with the anti-kickback statute. Exceptions to the statute have been specified for narrowly defined business transactions, known as "safe harbors," such as personal services and management agreements, says O'Hare. "But because gainsharing arrangements are essentially formulaic, with the level of payment varying as specific target objectives are accomplished, this criterion cannot be satisfied for those arrangements," he says.

Provisions relevant to tax-exempt systems. The final requirement to consider, applicable only to tax-exempt entities, relates to the general principles governing rules applicable to tax-exempt financing. As a rule, tax-exempt entities can use gainsharing arrangements as long as the arrangements do not provide more than reasonable compensation for the services provided by the participating physicians.

"Physicians must understand clearly the premise under which they are being paid in gainsharing arrangements," says Peck. "Carefully structured and aligned arrangements can be successful."

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

(Continued from page 1)

nity did we survey less than 25% of physicians, and most communities we surveyed 50% to 60%.”

Physician Opinion

Becker believes the physician survey is important because physicians are crucial to the success of any health plan. Accordingly, plans should ensure that physician opinions on plan performance are sought and heeded. “Physicians have a unique insight into the quality of a plan, and consumers seek physician opinions on local plans for this reason,” says Becker. “Furthermore, if physicians are dissatisfied with a plan, they have the option to leave the plan.”

The study revealed that half of physicians who are dissatisfied with a plan’s overall treatment of physicians would either probably or definitely remove the plan from their practice. “When this happens, it is extremely disruptive to the enrollees who use that physician,” Becker says.

Furthermore, Medstat’s analysis of the enrollee survey determined that half the factors most important to enrollees in evaluating a plan were physician-related, including choice of physician, care provided, time pressures, and physician decisionmaking style. “Plan administrators might assume that the most important factors to enrollees are customer service and access to care,” says Becker. “But while those factors are important, our survey suggests they’re not nearly as important as physician-related factors.”

Do physicians influence enrollee opinion? Probably, to some degree. Another interesting finding of Medstat’s analysis was the strong correlation between enrollee confidence in the plan—interpreted as whether the enrollee believed the plan would cover treatment for catastrophic illness—and how physicians ranked the same plan on items such as administrative hassle factors and limitations on physician practices.

“The correlation we see is that if the physicians are hassled for approval of routine services, then enrollees were more likely to doubt that the plan would cover them in a catastrophic situation,” explains Becker. “Physicians and

The study found that morale was low for 36% of physicians, and 53% of respondents reported that their morale had worsened over the year before the survey was completed.

enrollees are likely to influence each other’s opinions. We know from other industry studies that when consumers want information about the quality of a plan, they tend to ask their physicians. So we’re not surprised to see some correlation of opinion.”

Plan Performance

Although this correlation exists, physicians tend to be much more critical of plan performance than enrollees are. “Physicians rate plans lower than enrollees by about 20 points on the questionnaire’s 100-point scale,” says Becker. “This might occur because physicians have more ‘insider knowledge’ of how the plans work, or because they must deal with the plans on a daily basis and accordingly are more frustrated. Or it could simply be a matter of personality.

“Physicians are fairly independent, and a managed care environment requires examination of physician practice patterns,” Becker continues. “A low rating might indicate that the plan has adopted fairly onerous policies, or it might reflect that physicians in general simply feel that having someone looking over their shoulder is distasteful.”

When physicians in the 1997 survey were asked to rate the effect of plan policies and procedures on the physician’s ability to deliver high-quality care, the average score was 66 out of 100. “While on average, managed care plans scored lower than fee-for-service plans, several individual managed care plans scored above their fee-for-service counterparts,” says Becker. “These findings imply that it is not necessarily the managed care model itself that causes concern, but how it’s implemented.”

The survey revealed five major factors that drive physician satisfaction with health plan performance. The two most important were satisfaction with financial

reimbursement and satisfaction with administration. “Of course, it’s not surprising that financial aspects of the relationship drive satisfaction,” says Becker. Financial factors can include everything from how much the physicians are paid to difficulties in receiving reimbursement or receiving payment promptly.

Administrative factors include issues such as the amount of paperwork required by the plan, as well as quality-related issues such as the difficulty of getting approval for specialist referrals. “The opportunity for improvement in the administrative area is significant,” says Becker. “For example, 29% of physicians indicated that getting help with appeals for denied claims was a ‘major hassle,’ and 27% indicated the same about the paperwork burden.”

Problems With Care

The other three factors include limits on care, policies affecting quality of care, and support of clinical practice. “These factors indicate what physicians believe plans are doing to either interfere with or support the practice of quality medicine,” says Becker. “For example, physicians might point out that plans provide a report card which is helpful in determining relative practice patterns. Or, physicians may indicate that plans institute approval requirements that the physicians believe to be unnecessary.” Among respondents, 77% dislike justifying clinical decisions, and 51% dislike being profiled. Almost one-third of respondents indicated that “being pressured to withhold specific services that could improve care” is a serious problem with their plans.

“The finding that a significant number of physicians are concerned that plan policies have a negative impact on clinical decisionmaking has a crucial implication for care quality,” says

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Survey Fosters Discussions at Several Health Plans

Most health plans are still deciding how to act on the information provided by the Quality Catalyst Program, but others are using it to work with physicians and employers to improve conditions for physicians. The 100-question survey, called the Medstat Quality Catalyst Program, was used to measure physician satisfaction with health plans. Medstat is a consulting firm in Ann Arbor, Mich.

"Some plans are less likely to react, believing that relationships with physicians will always be antagonistic since the plan's role is to be the manager of care," says Dennis Becker, senior vice president of The Medstat Group. However, other plans believe fundamentally that physicians are key to their success, and they are assessing how to improve their performance.

Earlier this year, representatives from the Medical Society of the District of Columbia met with representatives of six health plans in the Baltimore and Washington, D.C., area. They used the study results to prompt a discussion about how to improve plan performance for physicians.

"We wanted to improve the working relationship between the plans and local physicians," says Louis Diamond, MD, Medstat's medical director. Diamond also is a past president of the society and a current member of its board of trustees. Each plan sent to the meeting several high-level representatives, including medical directors or quality improvement directors, to discuss the study and its findings.

As a result of that meeting, follow-up meetings were scheduled with each of the plans to identify specific projects that the plan and the society can pursue together. "The plans preferred to work with the medical society on a one-on-one basis," says Diamond, who reports that process improvements generated from each project will be shared among all the plans. The first such meeting was held in July. "Success with one project will prompt the other plans to move forward with projects as well," says Becker. "Once projects are ongoing, plans can use them as a marketing tool, highlighting that they

are working with physicians to improve these issues. That's an attractive message to send to enrollees."

Projects will be selected based on Quality Catalyst Program data received from surveys of physicians in the area. Based on the data, potential projects that might be considered include improving patient referrals, examining drug formularies, and obtaining physician support for using practice guidelines.

"For instance, a project to improve the referral process might examine the problems physicians encounter in referring patients for diagnostic work or to specialists, and the reasons for the current process from the plan's perspective," Diamond explains. "Have the plans created obstacles to diagnostic testing referrals due to abuses in referring high-cost, low-volume procedures or low-cost, high-volume procedures? Arriving at an understanding of the issues will enable us to jointly develop an improved process."

Following the initial meeting with the plans, the society officials met with representatives of five large area employers to discuss how employers might want to act on the study findings. "The employers are interested in having the plans drive the improvement efforts but are thinking about what role they can play in prompting the plans to move forward," Diamond says. In the future, a combined meeting of physicians, plan executives, and employers may be convened to prompt further quality improvements.

Diamond has three suggestions for physicians interested in using Quality Catalyst Program data to work with plans in their communities. "First, focus on using objective data to frame discussions, as opposed to anecdotal stories, which can be written off as one-time occurrences," he says. "Second, take action—choose a project to work on rather than continuing to simply talk about the issues. Third, select a simple project that is conceptually possible and can reasonably achieve success, and use that success to build the relationship."

—DJN

(Continued from page 8)

Diamond. "For some time, anecdotal evidence has indicated that physicians in a managed care environment have been concerned about their ability to provide care according to the scientific evidence, their own best judgment, and patient preference. The study confirms that anecdotal evidence." The study results suggest that quality of care is less than it could be, Diamond says, citing as one example the finding that both physicians and enrollees are frustrated by the inadequate length of patient visits.

Physician Morale

One of the most disconcerting findings of the analysis is the low level of physician morale. The study found that morale was low for 36% of physicians, and 53% of respondents reported that their morale had worsened over the year before the survey was completed. Furthermore, 46% of physicians say they often think of leaving clinical practice.

Becker is particularly concerned about the consequences of low physician morale on health care quality. "If we look at the issue of morale in any work force, when morale is low the

quality of the product suffers," he says. "We should probably be a little more frightened about the implications of this than we are." For Becker, this implication further emphasizes the fact that plans should act on physician feedback.

While the main purpose of the survey is to offer health plans data on which to base improvements, the study findings are also shared directly with consumers through *Health Pages*, a consumer health publication in New York.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md.

MSOs Offer Options for Physicians

By Thomas M. Gorey, JD

As physicians seek to adapt to managed care and increased competition, one option many are considering is affiliating with a management services organization (MSO). As with most organizational models, the definition of an MSO can vary considerably from one market to the next. A workable definition of an MSO is “an entity owned by physicians, hospitals, private investors, or a combination, that provides contract management or practice management services to physicians and medical groups.”

In most cases, MSOs provide a blend of managed care and practice management services to individual physicians, group practices, IPAs, and other types of physician organizations. In highly developed managed care markets, MSOs tend to focus on services related to managed care contracting. In predominantly fee-for-service markets, MSOs often emphasize services designed to increase efficiency and relieve physicians of the day-to-day business-related responsibilities associated with their practices.

At Your Service

The contract management services that MSOs provide may include negotiation of managed care contracts, physician network development, credentialing, quality and utilization management, member enrollment, referral authorization, claims administration, and physician payment. Practice management services from MSOs usually include billing and collections, group purchasing, practice assessments, staff training and development, marketing, and information systems.

In theory, an MSO should be able to provide the administrative infrastructure to enhance physicians' ability to deliver

high-quality, cost-effective care, but not all MSOs are capable of delivering on this promise equally. Therefore, physicians considering affiliating with an MSO should keep in mind a number of important considerations.

Experienced Administration

To be successful, an MSO must have qualified, experienced administrative personnel. Because most small MSOs have minimal administrative resources, they often rely on a few key staff persons to deliver needed services. For example, the administration of a small MSO may consist simply of an executive director, a director of contracting, and an administrative assistant. With such limited human resources, this type of MSO is usually focused almost exclusively on securing managed care contracts and administering payments to physicians. As MSOs

Single-specialty MSOs often operate successfully in this manner. However, in many competitive managed care markets, more extensive services may be required—particularly if the payer contracts involve capitation. If so, a physician group may want to affiliate with an MSO that has a larger, more elaborate administrative structure.

Establishing and operating an MSO requires substantial capital, typically a minimum of \$1 million. As with any business venture, inadequate capitalization usually portends doom for an MSO.

Ownership and Control

Related to the question of capitalization is the issue of ownership. The mission, goals, and operations of an MSO can differ depending on whether it is owned by a hospital, a group of physicians, private investors, or some combination. Although

The decision to affiliate with an MSO should be based on a careful assessment of the physician's short- and long-range goals.

increase in size and critical mass, the number and competencies of their administrative personnel usually increase. Therefore, a larger MSO may have an executive director, a director of contracting, a medical director (either full- or part-time), a finance director, a human resources manager, a management information systems director, and a practice operations coordinator.

Since more management personnel means more overhead, it is important for physicians to assess carefully the range of services they need to execute their practice development plan. If the physicians' main objective is to increase the number of contracts they have and to relieve themselves of some of the responsibility of negotiating those agreements, a smaller MSO with lower overhead and more limited services may be appropriate.

physicians often elect to affiliate with an MSO owned by nonphysicians, it is important to consider the tradeoffs involved in affiliating with a physician-owned versus a nonphysician-owned MSO.

One advantage of affiliating with an MSO run by a hospital or other entity is that it obviates the need for a physician investment in the venture; the tradeoff, however, is a lack of control over the MSO operations and decisionmaking. Forming a physician-owned MSO, on the other hand, provides the maximum measure of physician influence and control, but demands that physicians provide a substantial amount of the capital required to start the MSO. The need to capitalize a physician-owned MSO can be an obstacle for many physicians, particularly in markets in which reimbursements are declining and physician incomes are threatened.

Thomas M. Gorey, JD, is president and CEO of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development.

As a result, many physician-owned MSOs are inadequately capitalized and are not positioned to compete effectively against other, more highly capitalized entities.

Governance and Systems

Successful MSOs recognize the importance of providing a significant role for physicians whenever decisions are made that could affect patient care. Therefore, physicians often play active roles on MSO boards and committees. However, to be successful in a competitive market, an MSO must be run as a business, which means that physicians affiliated with an MSO must be willing to grant broad authority to the MSO leadership to make decisions and to carry out the business affairs of the organization. Therefore, despite giving physicians a strong voice in decisionmaking, the MSO leadership must be empowered to act in their best interests, and must not be hampered by an elaborate, cumbersome governance structure. In short, an MSO that is overly democratic is not likely to be successful in a competitive business environment that favors decisive action.

Before affiliating with an MSO, physicians should inquire about the MSO's information systems and any planned enhancements. Since a number of excellent vendors and software applications can support MSO operations, it is important to assess carefully the MSO's information system needs and determine which applications are most appropriate to meet those needs.

In evaluating an MSO's information system capability, physicians may wish to inquire whether the MSO's system can:

- Enhance administrative efficiency through billing, accounts receivable, and other applications
- Link the MSO's physicians to each other and to local hospitals
- Compile a database on the cost of providing medical services, thereby facilitating the MSO's ability to manage costs under capitation
- Develop a physician profiling system, revealing practice patterns and enabling the MSO to manage risk more efficiently
- Adjudicate and pay claims
- Process referrals
- Review outcomes data and track

patient response to treatment protocols

- Develop and implement guidelines

To be competitive, MSOs must provide payers with information on the quality of care provided by the physicians. To do so, MSOs need to have their own database to ensure that they have the information needed to perform effective quality management. Most MSOs also should have a physician-driven quality management committee and, if resources permit, a full- or part-time medical director to oversee all quality-related initiatives.

Because physicians tend to be data-driven, MSOs seeking to change the behavior of affiliated physicians will need to provide them with patient outcomes data. At first, physicians may resist the MSO's quality management initiatives, but if they have an opportunity to review credible, convincing data, they tend to become increasingly comfortable with the process, and slowly, practice patterns begin to change.

Utilization Management

In addition to having a sound quality management process, MSOs need to have an effective approach to utilization management, because proper management of utilization is vital to the ultimate financial success of an MSO. As a result, virtually all MSOs either have, or are implementing, a medical management program. Primary responsibility for utilization management usually rests with the MSO's medical director and utilization management committee.

MSO utilization management efforts often include the following components:

- High-risk case management
- Collection of data on physician utilization patterns
- Physician education
- Prospective, concurrent, and retrospective review
- Development of practice guidelines

For most MSOs, an important part of the utilization and quality management process involves the retrospective review of physician practice patterns. As such, most MSOs are actively involved in compiling and analyzing data on each of their physicians. Doing so usually involves reviewing utilization data provided by payers or compiled by the MSO itself,

identifying physician outliers, and undertaking educational efforts to effect needed change in physician practice patterns. Simply providing each physician with his or her practice profile often is enough to bring about change, as physicians attempt to bring their statistics more in line with group norms. In some cases, however, MSO medical directors find it necessary or beneficial to initiate one-on-one discussions designed to influence change.

Contracting Efforts

The increasing burden and complexity of managed care contracting means MSOs can provide an important value-added service to physicians by taking on this important function. Depending on the market, MSOs may be involved in negotiating both discounted fee-for-service arrangements as well as a broad array of risk-related contracts. In evaluating an MSO, it is important for physicians to gather as much detailed information as possible on the number and nature of existing contracts with payers, as well as the methodology for physician payment.

Unless a physician is interested in affiliating with an MSO simply to take advantage of its practice management services, it is important to assess whether the MSO can negotiate and administer favorable contracts. Also, physicians need to assure themselves that they are comfortable with the types of contracting arrangements the MSO pursues. Physicians who are risk-averse, for example, would be advised to exercise caution when considering an MSO actively pursuing capitation agreements.

As with all physician practice options, choosing to affiliate with an MSO is an important business decision that should be based on a careful assessment of the physician's short- and long-range goals, and a determination of the best strategy by which to accomplish those goals. For many physicians, MSOs offer important business and administrative services that can both enhance practice efficiency and provide critical managed care contracting support. Selecting the right MSO can be facilitated by a careful consideration of the MSO's management, capitalization, governance, information systems, quality and utilization management initiatives, and contracting strategies. ■

Author Explains How Episodes-of-Care Systems Would Help Empower Physicians



Douglas W. Emery, MS, is president of Zoadigm Health Systems Inc., in Salt Lake City and is a researcher in market-oriented policies for health reform at the Institute of Political Economy at Utah

State University. In addition, he has served as an executive at Prime Source Inc., a company in Salt Lake City that designs episodes of orthopedic care; and as network development manager for the Public Employees Health Program in Salt Lake City, where he developed a global fee reimbursement program. Emery is the editor of *Global Fees for Episodes of Care: New Approaches to Healthcare Financing* (New York: McGraw Hill, 1999). This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q: What are global fees for episodes of care?

A: Global fees for episodically organized care are part of a new paradigm for managed care. The global fee packages all clinical care processes required to treat a patient's injury or diagnosed condition, covering all aspects of treatment from beginning to end.

Q: What is the main problem with orthodox managed care?

A: Orthodox managed care represents a model that stipulates that health insurance and health care can be integrated. The economic model we've developed shows that this is not possible. The logic governing health insurance and the logic governing medical care processes are fundamentally different. They represent different types of risk factors and different types of economic factors. Trying to integrate health insurance with health care results in an inefficiency that contradicts the fact that in any market consumers are sovereign. In an HMO, especially one that uses capitation, consumers are not sovereign. Moreover, in many of those relationships neither are physicians.

The fact that neither patients nor physicians are sovereign is one of the social tensions feeding the current consumer and physician discontent with managed care. Patients and physicians rightly perceive that the autonomy they need to make decisions at the point of service has been taken from them. From the beginning, that failing should have been something everyone should have foreseen as problematic, and in fact impossible to implement into the future.

Q: Is this why you say in your book that "HMOs, integrated delivery systems, and other creatures of orthodox medical care are kaput"?

A: The orthodox manner of organizing the care of a population around HMOs was never something the American public asked for. It was something that was conceived by a few insiders who thought this would be a solution. There are better ways of achieving the aims that were desired through looking at the fundamental laws of economics that govern health care relationships.

What we've really had for the past 15 to 20 years is not managed care, but managed insurance. Managed care is how the providers of care manage the production processes that add value to patients' lives. But health care systems have been notoriously awful at deriving useful information about the processes of care and its value.

The point of global theory is to build a sound economic model of managed care, which not only explains the flaws of orthodox managed care, but outlines the details of how we move to the next stage.

Q: Why do you think that capitation is such a rare payment mechanism?

A: Despite prognostications that capitation would be nearly universal by now, it is still rare, hovering at 9%

10% of overall hospital and physician income. Global capitation has been doing even worse, stagnating since 1994 at about 6% of all integrated delivery system income. The only real growth products HMOs have are those offering choice at the point of service, such as point-of-service plans and open-access options. Capitation is a highly artificial payment mechanism that has nothing to do with the production processes of care, but rather relates to creating the economic means of indemnifying assets. It is inherently impossible to purchase discrete goods and services efficiently through an insurance mechanism.

Integrated delivery systems are beginning to recognize that the market for health insurance and the market for health care are essentially separate. Orthodox managed care tried to integrate these two markets on the assumption that people could choose HMOs on the basis of price and quality. That seems to make sense, but what it asks lay people to do is to examine thousands of permutations of medical needs that may or may not occur over their lifetimes and make qualitative decisions about relative efficiencies before they need care.

Well, that's not how things work. People do not buy things they have contingent needs for; they buy things and seek information to satisfy real-time needs. This fact underlies today's powerful surge for consumer choice. Capitated systems cannot meet consumers' needs because the crux of capitation is provider exclusivity. In order to capitate a group of physicians or any integrated delivery system, the insurer has to sign a contract that's based on exclusivity. What capitation does, in essence, is make patients the tradable commodity. Payers use that com-

"Under the episodes of care model I don't see much use for the traditional gatekeeper."

modity as the bargaining chip, and it's the payer who then decides, at the point of service, where patients are going to receive their care. That model saps the sovereignty of the patients to choose where they receive care. Moreover, it does the same thing to physicians. So the capitation model is antichoice. The result of all this is a rapid movement away from capitated systems and HMOs to less restricted systems of care.

Q: *Why is the global theory paradigm so powerful?*

A: It's powerful because it asks the question, "What is the reality of health care and what is the reality governing the economics of health care?" The underlying reality of health care is that people seek care for certain purposes that fall within certain sequences, and those sequences are all inter-related to varying degrees. That's an essential insight that led to the development of the episode-of-care concept. This concept assumes there's essentially a clinical logic governing the way medical services are rendered for patients. Physicians have a powerful understanding of the forces that govern clinical logic—indeed, they are really the only people who understand that logic—which is why it is so ironic that health insurance systems have been imposing these top-down command-and-control protocols on doctors as if payers know how to manage care.

Q: *How does global theory incorporate definitions of different types of economic risk?*

A: Global theory shows us that there are three types of economic risk in health care that are only tangentially related to one another. The first is probability risk, which is defined as the effort to price future unresolved states of medical demand; this has traditionally been the bailiwick of insurance.

The second is technical risk. Technical risk simply describes the risk of pricing integrated episodes of care—these essentially are the risks physicians have the technical skills to control. They don't have the ability to govern and control probability risk. That's a business that they can't efficiently manage and shouldn't be asked to manage in the first place.

The third is utility risk. This is the risk consumers face when they choose to purchase a certain service, whether it will

meet their expectations or not.

Q: *Why doesn't this new paradigm of care require gatekeepers?*

A: Gatekeepers were just a way for insurers to queue up patients so that they wouldn't have access to specialists. Under episodes of care, I don't see much use for the traditional gatekeeper, but if a gatekeeper is defined as a primary care physician who sees patients and

care for this patient. The key is to get providers, especially physicians, to integrate around episodes of care.

Q: *Are many payers actually using global fees for episodes of care now?*

A: The movement is nascent but beginning to gather momentum. The federal Health Care Financing Administration (HCFA) has been working on this idea since 1988 and currently is in

"Capitation is a highly artificial payment mechanism that has nothing to do with the production processes of care."

understands their problems, helps them if they need to be referred to specialists, that makes a lot of sense. Episodes of care provide a continuum of information that helps both patients and primary care physicians make those decisions.

Q: *Can global fees be flexible in terms of reimbursement structure?*

A: Yes. For some of them there is a set fee for an episode, but there are other less well-defined diseases and services that can be handled on a discounted fee-for-service basis. It's not so much about finance; it's about getting health systems to do the right thing for the patient. And that's an information problem. What I'm arguing is that, until we organize around integrated episodes, we're not going to be generating information that helps us to understand those relationships.

There are a number of ways to reimburse episodes, of course. For acute episodes, you have a global fee. But what about patients who have chronic diseases? There are a number of programs, including Lovelace Health System in Albuquerque, N.M., which use episodes of care in organizing disease management programs for conditions such as diabetes mellitus. It has had a great deal of success because episodes of care have helped to rationalize the processes of care for one disease category at a time. Lovelace pays its physicians on a salary basis, as does the Mayo Clinic, another innovator using episodes of care. But chronic episodes of care can be paid through maintenance fees, which provide periodic payments to

its third expansion of its global fee demonstration program. Anthem Health Plans in Ohio has implemented global fees for episodes of care for its cardiovascular services. Oxford Health Care in Norwalk, Conn., attempted to implement it for an array of common episodes and events, but its implosion on Wall Street prevented it from bringing the program to fruition. Despite some rough starts, the usage of this structure is beginning to evolve.

In 1997, the Advisory Board Co. completed a study that profiled numerous systems that, instead of trying to pay for populations, were beginning to center reimbursement to providers around sickness or illness. This idea makes a lot of sense because that is where the value is created. The study also tracked new niche companies, such as HealthSouth in Birmingham, Ala., that organize around some specialized area of health care, such as rehabilitation care, and then organize doctors and infrastructure around discrete care episodes so that they can sell the episode-of-care product to payers. These organizations have been attractive to specialists, because they actually build an operational context that suits physicians' needs according to the way they want to care for patients. This development has been alarming mainstream hospitals because they haven't been able to keep up with this type of evolution, although they now are beginning to respond in ways that are productive.

Q: *What are the results to date of HCFA's pilot program?*

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A. HCFA has conducted demonstration projects at St. Joseph's Hospital in Atlanta; Boston University Hospital; St. Joseph's Hospital in Ann Arbor, Mich.; Ohio University Hospital in Columbus; St. Luke's Hospital in Houston; Methodist Hospital in Indianapolis; and St. Vincent's Hospital in Portland, Ore. In all of these demonstration projects the global fee has been a qualified success and has reduced the overall cost of care for HCFA, the payer. Because of these results, HCFA's research and demonstration division is currently expanding projects with global payment systems. In its current expansion of the program, called the Participating Provider Demonstration Project, HCFA has statutory authority to cover 95% of diagnosis related groups (DRGs), and has now contracted with six physician-hospital organizations on the East Coast to conduct the next phase of the expansion. This expansion is significant because HCFA is the largest payer in the country, and within a year or two, it may want to move forward aggressively in this direction.

When HCFA implements a program, its actions tend to have repercussions for the private sector as well. HCFA is not going to implement this program and then force everyone to do it. It wants synergism growing around a concept, so that all parties voluntarily move toward it. HCFA's job is to show that it can work.

Right now, HCFA has the statutory authority to expand the episodes-of-care program to as much as 95% of all inpatient DRGs. Next year, HCFA will start expanding into full global payments for the entire episode of care. Right now, all it is doing is paying for the physician and hospital components. It many want to integrate all components of an episode of care, include pharmaceuticals, physical therapy, and skilled nursing.

Q. How can providers create a global fee?

A. Providers could put together a system of global fees for all of the common procedures performed in a community hospital, including those for gynecology, urology, cardiovascular services, and obstetrics. For example, the global fee for a breast biopsy would include mammography, the biopsy, the operating room

fees, the anesthesiology fees, and the pathology fees. Providers who know and understand the natural history of breast cancer could form an organization such as a PHO, and calculate this fee.

Q. For providers, what are the benefits of global fees?

A. What is exciting to providers is that organizing this way will not require massive amounts of capital, as an integrated delivery system would require, and it won't require significant regulatory oversight, either. Massive capital is necessitated by the fact that under orthodox managed care, arrangements are not organized around health care, but around health insurance. We want doctors to organize around health care.

Before HCFA put this project into place, providers were losing money on DRGs. However, under the episodes-of-care project, even though HCFA was taking a 3% discount off of what it was

because they are only ones who have the knowledge and experience that make it possible to organize around a global fee structure. Most physicians already have an intuitive grasp of the concept because that's how they manage patients. What's been lacking is that, although we've always implicitly managed patients this way, we haven't explicitly organized the payment of care and delivery around it.

Q. How are we going to get masses of physicians to consider a new model of managed care?

A. That's a tall order. It's an educational process, a matter of providing an alternative vision. So far physicians have been dissatisfied with managed care, but they have not been provided with a powerful economic rationale for an alternative. Physicians need a model that gives them the power to say to payers, 'If you want managed care,

"Most physicians already have an intuitive grasp of episodes of care because that's how they manage patients. Although we've always implicitly managed patients in this way, we haven't explicitly organized the payment of care and delivery around it."

paying for DRGs, the hospital and the physicians made more money because they were working together within the episode. They figured out ways to make their treatment for a patient in an episode of care more efficient. For instance, St. Joseph's Hospital in Atlanta lowered variable costs by 40% without affecting quality and outcomes. In fact, there was a great deal of evidence that quality was enhanced. According to one poll, patients who went through the episode-of-care program were happier with their care than those who didn't.

The reason global theory is good news for physicians is because it implies that a true system of managed care delegates patient management to physicians,

this is how we want to provide managed care. We think it is most appropriate for us to organize around clinically integrated episodes and we are willing to go at risk for those episodes of care once patients get sick. This is a better idea than having you build an HMO or an integrated delivery system, or capitating us. It's not our job to handle the insurance risk of whether a patient is going to get sick or not, or if a patient is going to have a catastrophic episode. That's the insurer's job. Our business is to take care of patients, and we want to be remunerated on that basis.' Such a system would enable physicians to be responsible only for what is under their control.

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

Most Blue Cross Blue Shield Affiliates Losing Money

More than 80% of the nation's Blue Cross and Blue Shield affiliates operated at a loss in their core underwriting business last year, according to a study released in August by Weiss Ratings in Palm Beach Gardens, Fla.

The study included all 55 of the Blue Cross Blue Shield affiliates in the United States. Weiss Ratings, which provides financial safety ratings on health plans, says 45, or 82% of the plans, incurred losses last year. However, 34 of the plans covered their losses through investment income and securities gains.

The total underwriting losses for the Blues affiliates in 1998 were \$835 million compared with \$790 million in 1997. Total investment income for the affiliates was \$1.2 billion, unchanged from the prior year. The plans were losing money in all areas of underwriting except for dental care and Medicaid, according to the study.

The magnitude and pervasiveness of the losses are surprising, said Tom Brownstein, director of insurance safety at Weiss. The losses could result in cost-cutting measures, downsizing, and higher premiums for consumers, he said.

Losses and profits among the Blues affiliates used to occur cyclically, but that has changed since managed care began to make inroads in the U.S. insurance market, Brownstein said. Over the past several years, the plans that posted a profit or loss varied by region and were influenced by the managed care market in their particular areas of operation, he explained.

Nurse Practitioners, Physician Assistants Writing More Prescriptions

Drug prescriptions written by nurse practitioners and physician assistants have risen substantially over the past five years, according to the results of a recent study conducted by Scott-Levin, consultants in Newtown, Pa.

The data show that over the past five years, the number of prescriptions written by physician assistants grew more than 45% and the number written by nurse practitioners grew more than 75%. Nurse practitioners wrote approximately 15 million prescriptions in 1998 compared with 9 million in 1997, while physician assistants wrote 12 million prescriptions in 1998 compared with 9 million in 1997. Reflecting the trend, some 30% of pharmaceutical sales representatives' office visits involve meetings with staff other than physicians, most of whom are physician assistants or nurse practitioners.

The increase in prescriptions written by physician assistants is primarily the result of two factors: The profession has grown and more physician assistants are seeing more patients, and 46 states now allow physician assistants and nurse practitioners to write prescriptions, says Nancy Hughes, a spokeswoman for the American Academy of Physician Assistants.

Many Graduates of Internal Medicine/Pediatrics Residencies Practice Both Specialties

Eight of ten graduates of four-year combined internal medicine/pediatrics training programs become board-certified in both specialties, and 70% say that they spend most of their time in direct patient care, according to a survey reported in the August issue of *Archives of Pediatrics and Adolescent Medicine*.

Carole M. Lannon, MD, of the University of North Carolina School of Medicine in Chapel Hill, and co-authors there and at the American Board of Internal Medicine (ABIM) and the American Board of Pediatrics (ABP), used the boards' databases to identify 1,482 persons who completed "med/peds" training programs between 1986 and 1995 and had applied to one or both boards for certification.

The survey results are the first evidence that most med/peds graduates are fulfilling the goal of having physicians provide primary care without regard to patient age, the investigators said. In addition, the fact that 80% of graduates achieve dual board certification suggests that these physicians are well qualified to care for the spectrum of health care needs of both children and adults, the researchers said.

AMA Blasts Federal Panel's Ideas on Medicare Funding of Graduate Medical Education

Medicare should pay more for health care services in teaching settings only when the value of the care is justified by its higher costs, and such payments for graduate medical education should be based on "efficient" providers' costs, the Medicare Payment Advisory Commission says in a new report.

The commission, which advises Congress on the federal health insurance program, said Medicare would be better served financially if policymakers "reorient their thinking about Medicare's payment for graduate medical education."

"Specifically, we believe that payments to teaching hospitals for the direct costs of operating approved medical residency programs should be viewed as payments for patient care, not as payment for training," the report said.

The commission recommended to Congress that the two payments now made to teaching hospitals for medical education should be folded into one payment "that better accounts for the higher costs of the enhanced patient care" delivered to beneficiaries.

The AMA called the report "gravely disappointing." AMA President Thomas R. Reardon, MD, said, "If enacted, the recommendations contained in the report would fail to guarantee the continued availability of well-trained physicians to treat Medicare beneficiaries and other Americans. They would also threaten the financial viability of the teaching hospitals that provide cutting-edge care to the nation's sickest and most frail Americans."

(Source for all items: Reuters Health)

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- How do I evaluate my organizational options?
- Where should I go to get capital?

We are available to answer all such queries from readers. If we don't know the answer, we have vast resources at our disposal and will help to locate the appropriate expert.

To reach us, readers are invited to call toll-free: **888/457-8800**. The service is *free* to readers.

Richard L. Reece, MD
Editor-in-Chief
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