

Capitation Rates & Data

Do the math before taking capitation risk for vaccines

Pediatricians have long wrestled with the challenge of deciding whether to accept risk for vaccines in their capitation contracts and, if so, how to structure the cost in their PMPM rates. With increased utilization and newer vaccines for the pediatric population, more PCPs now face this decision, and the choices aren't pretty.

Organizations should establish risk contracts to target services they can control, but neither providers nor carriers have control over immunization schedules, which are set by the American Academy of Pediatrics (AAP) in Elk Grove Village, IL, says **Courtney R. White, FSA, MAAA**, consulting actuary in the Atlanta office of Milliman, an actuarial and consulting firm.

"For the most part, if the American Academy of Pediatrics recommends these vaccinations, parents are going to follow that advice," White says.

Consequently, "we see fewer PCPs taking risk, in general, and in the majority of contracts, vaccines and

immunizations are carved out," he adds. "And that would be my general recommendation."

Compared to five years ago, the number of immunization doses required for children has increased by nearly 50%, White says.

For example, now a second dose of the varicella vaccine is recommended before a child enters school, following an initial dose when the child is aged 12–15 months.

Practices are facing an increase in the types of vaccinations recommended for children. In the past few years, these have included the rotavi-

"There continue to be new vaccines in the pipeline, as well as new indications for existing vaccines."

—*Michael J. Kinstler, MD*

rus and human papillomavirus. Thus, a \$2 PMPM rate for children's vaccinations that might have been sufficient five years ago could bankrupt a pediatrics or primary care practice today, White says. "Milliman looked at the vaccination trend from 2006–2007 and saw 75% increases in utilization, on average, due to all of these changes," he explains.

Under these conditions, pediatrics practices that accept risk for vaccinations could take a financial loss on every patient. In fact, the risk associated with vaccinations has become so great that White says he likens it to prescription drugs or maternal care—services that typically are carved out of capitation contracts and paid on a case rate or FFS basis.

Under the circumstances, "any physician organization or IPA would be crazy to take full financial risk for vaccines unless there's a built-in cost escalator," says **Michael J. Kinstler, MD**, president and chief medical officer of Quality Care Providers, Inc. (QCPI), a primary care IPA based in Atlanta.

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HCPPro

Vaccines

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Strike pediatric vaccines from global contracts

QCPI has seen the full range of financial exposure associated with vaccine risk. A decade ago, taking risk for vaccines was a no-brainer, since there were few childhood immunizations and the costs for most were only \$10–\$12, says Kinstler, a practicing internist. Today's vaccines include new indications and increasingly expensive drugs.

"When you see multiple doses of \$150 vaccines, there's no good way to predict your costs," Kinstler says.

QCPI has a pediatric infectious disease specialist who provides input to Georgia on the pediatric immunization requirements for students to enter public schools. "Even with his help, there was no way we could control this risk," Kinstler says. "When a new indication is introduced for every 13 year old in your plan and they need three doses, you've just spent hundreds of thousands of dollars that you didn't budget."

Part of the problem is that many manufacturers are sole sources for particular vaccines, enabling them to hike prices without competitive constraints—sometimes as much as 15%–20% twice per year, Kinstler says.

Despite evidence of frequent price changes, QCPI wasn't able to convince payers to build in risk corridors for PMPM rates associated with pediatric immunizations.

Thus, the organization has struck vaccines as a line item from all of its capitation contracts, although it retains risk for some other injectables. QCPI accepts global risk for primary care services, including inpatient and outpatient, office-based, and limited laboratory services.

Kinstler advises capitated provider organizations that still hold risk for vaccines to renegotiate their contracts, insisting that payers take back the risk by invoking a clause that every capitation contract should include to abrogate the contract terms if costs exceed a certain risk threshold. If capitation contracts have renewed annually with little adjustment in the terms, providers should arm themselves with historical cost and actuarial data and expect a fight, Kinstler says, adding that "if you're at risk for vaccines, you have to monitor them on a rolling monthly basis. Office visits swing seasonally, and vaccine utilization shifts seasonally as well. But the unit costs also keep changing—usually not in your favor."

Consider risk for administration costs

Although capitated groups should carve out the drug costs associated with children's vaccines, they might still opt to accept risk for the AMA's current procedural terminology (CPT) codes associated with administration costs.

"We've seen groups go both ways on the administration," which is a more predictable number, White says. "It's not that children are coming in for more visits," he adds. "It's just that they're getting more done at those visits."

A 2006 statement issued by the AAP's private payer advocacy advisory committee emphasized the need for physicians to be reimbursed for the full direct and indirect costs of pediatric immunizations, including the purchase price of the vaccine, personnel costs for ordering and inventory, storage costs, insurance against loss of the vaccine, wastage and nonpayment, and lost opportunity costs associated with the up-front investment in vaccines. Combined, the AAP estimated the total costs of providing a vaccine at approximately 17%–28% above the direct vaccine purchase price.

"It's a big strain on a practice even to stock vaccines," says **Steven A. Robey, MBA, MBH**, QCPI's medical economist. He advises provider organizations to negotiate arrangements in which payers supply the vaccine products directly "so there's no middleman."

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Small practices with lower volume also need to account for vaccine packaging that may require them to spend thousands of dollars up front to purchase multiple units of an expensive vaccine that may not be fully used for four months or more.

In addition, many new vaccines must be stored in special refrigerators, “and if the power goes out, you can lose thousands of dollars’ worth of product,” Kinstler says.

But the administration expense “is separately reportable from the vaccine product,” the AAP statement added. “Some payers mistakenly believe that inadequate vaccine payments can be made up by nominal immunization administration fees. However, these are two separate expenses.” The CPT includes eight codes for immunization administration, ranging from 90465–90474, depending on the route and age.

“The administrative fee we kept as a flat fee, because we still had control over that,” Kinstler says.

Don't be lulled by one-year trend

Looking ahead to 2009, White says he doesn't expect to see the same number of changes in children's

immunization schedules as during the past several years, although providers are still likely to see higher trends for this service than the overall medical trend.

“There's probably going to be some catch-up from the 2008 schedule or because there are regional shortages in certain vaccines, such as hepatitis A or varicella,” he says. However, even a more predictable one-year trend doesn't make childhood immunizations a safe bet for capitation.

“There continue to be new vaccines in the pipeline, as well as new indications for existing vaccines,” Kinstler says.

“Even if there's not a material change over the next five years, you're still going to have shortages that pop up from year to year, so you'll have gains and losses within your capitation rate,” White says, adding that carriers may still try to put healthcare providers at risk for this service, “but vaccines are truly out of a provider's control.” ■

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Guided Care plan reduces costs for chronically ill seniors

Seniors with chronic illnesses represent an especially challenging subset of patients, especially for capitated Medicare Advantage HMOs. In a program designed by a multidisciplinary team of clinicians and researchers at Johns Hopkins University Bloomberg School of Public Health in Baltimore, specially trained nurses work in PCP offices to coordinate the care of older adults with multiple chronic illnesses, facilitate transitions in care, and serve as patient advocates across healthcare and social settings.

Although developed in an FFS environment, the model, called Guided Care, could be adapted to payers and to integrated delivery systems in which physicians and hospitals share global risk.

Each Guided Care nurse (GCN) coordinates the care of 50–60 adults aged 65 and older who have multiple

complex chronic conditions, explains **Tracy Novak, MHS**, director of communications at Johns Hopkins' Roger C. Lipitz Center for Integrated Health Care. The patients are identified through a review of 12 months of health insurance claims using Medicare's hierarchical condition category predictive model to identify the 20%–25% of older patients who have the highest predicted need for complex healthcare in the near future. Without intervention, these patients would be expected to have high healthcare costs and utilization in the near term, Novak says.

“We happen to be testing it in older people, but it certainly would be applicable to younger people who have multiple chronic conditions,” Novak says. The program

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Guided Care

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was designed primarily for internal medicine and family practice settings.

Supported by an electronic health record (EHR) and using established care management techniques such as disease management, case management, transitional care, lifestyle modification, caregiver education and support, and geriatric evaluation and management, specially trained RNs serve as GCNs. Each GCN works with two to five PCPs, plus specialists, caregivers, and community resources to coordinate and improve care for the complex seniors across providers and settings.

GCNs use a secure Web-based EHR that was designed for the program to enter new information about their patients, check each patient's medications for possible adverse interactions, generate new and revised evidence-based care guides for providers and action plans for patients, and document contacts with patients and providers.

Patients are enrolled for life, Novak says. "This population isn't going to get healthier. Our job is to help them manage their conditions and keep them out of the hospital setting."

GCNs provide action plans to participants

The GCNs are responsible for managing the following eight clinical processes:

- **Comprehensive assessment.** During an initial two-hour home visit, the GCN performs an assessment of the patient's medical, functional, cognitive, affective, psychosocial, nutritional, and environmental status and enters the information into the program's EHR. The GCN also asks the patient to identify his or her health and quality-of-life priorities. Caregivers are encouraged to attend the session.
- **Evidence-based care.** Using data from the assessment and evidence-based guidelines programmed into the EHR, the GCN and PCP work collaboratively with the patient and caregiver to develop an individualized care guide and action plan. The two-page care guide (see the e-tool on pp. 5–6), which is placed in

the medical record and shared with other healthcare professionals, covers medications, diet, physical activity, self-monitoring, health goals, and follow-up care requirements. The action plan (see the e-tool on pp. 7–8) is a simplified version of the care guide that the older patient is asked to display on his or her refrigerator door or another prominent location. The tool reminds the patient when to take medications, provides guidance on recommended diet and exercise, displays weight and blood pressure goals, offers follow-up care reminders, and lists disease-specific warning signs.

- **Patient self-management.** The GCN promotes each patient's ability to manage his or her chronic conditions by referring individuals to a free local chronic disease self-management course. The structured course, led by two trained and certified lay leaders, consists of six two-hour weekly sessions for 10–15 patients.
- **Monitoring of patient conditions.** With reminders from the EHR, the GCN monitors each patient at least monthly by telephone to quickly address emerging problems. When problems appear, the GCN discusses them with the PCP and takes appropriate action. The GCN also uses motivational interviewing techniques to encourage patient participation in his or her care.
- **Coordination of provider efforts.** The GCN coordinates the efforts of all healthcare professionals who treat Guided Care patients in EDs, hospitals, rehabilitation facilities, physician offices, nursing homes, and at home. Using the care guide as a tool, the GCN ensures that all providers are aware of the patient's medical status and care plan.
- **Transitions.** The GCN smoothes the patient's path among care sites and providers by sharing his or her care plan with providers, monitoring hospitalizations, preparing him or her for discharge, conducting a home visit on the patient's return, and keeping the PCP in the loop about the patient's status.

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E-TOOL Care guide

Chronic conditions

Condition: _____ Descriptive information: _____

Chronic prescription medications

Name: _____ Dose: _____ Route: _____ Frequency: _____

Overall adherence: _____

Important allergies and adverse reactions to medications

Substance: _____ Reaction: _____ Year: _____

Management

Health maintenance due

Immunizations: _____
Tests: _____

Contacts

Name: _____ Relationship: _____ Phone type: _____ Phone number: _____

Caregiver information

Durable power of attorney for healthcare or healthcare agent

Full name: _____ Relationship: _____ Phone type: _____ Phone number: _____

Hospitalizations in the past two years

Date: _____ Details: _____

You are required to ensure that your request for data is consistent with the HIPAA policy on minimum necessary uses and disclosures.

Name: _____
Date of birth (DOB): _____

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Care guide (cont.)

Recent providers

Name: _____ Discipline: _____ Phone type: _____ Phone number: _____ E-mail: _____

Services being used

Service: _____ Agency: _____ Phone type: _____ Phone number: _____ Notes: _____

Referrals planned

Devices being used

Spirituality (in relation to health)

Religion: _____

Religion's importance in health: _____

Insurance coverage

Carrier: _____ Policy number: _____ Effective date: _____ Notes: _____

Financial strain related to using health services

Financial strain for hospital/home care? _____

Financial strain for physician services/tests? _____

Financial strain for prescription medications? _____

Increased risks

Indicator value: _____

Health problems of greatest importance to patient

Targets

Condition: _____ Description: _____

Red flags

Condition: _____ Description (almost out of any medication): _____

You are required to ensure that your request for data is consistent with the HIPAA policy on minimum necessary uses and disclosures.

Name: _____

DOB: _____

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E-TOOL **My action plan**

*****NOTIFY JANE IF I GO TO THE HOSPITAL!!!!*****
Guided care nurse: Jane Doe, RN: 202-XXX-XXXX
Primary physician: Dr. Smith, MD: 202-XXX-XXXX
Pharmacy: Rite Aid: 202-XXX-XXXX

Take these medications, even if I feel great:

	Morning	Noon	Afternoon	Bedtime	Notes
Sertraline				One pill	For my mood
Nabumetone	Three pills		Three pills		For joint pain
Acetaminophen	One pill		One pill		For joint pain
Metamucil	1 teaspoon				For constipation

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My action plan (cont.)

Guided care nurse: Jane Doe, RN: 202-XXX-XXXX
Primary physician: Dr. Smith, MD: 202-XXX-XXXX
Pharmacy: Rite Aid: 202-XXX-XXXX

<p>Medicine: Order refills before running out of medications Inform Jane of any medication changes Only take medicine prescribed to me</p>	
<p>Diet: Drink four glasses of water every day Eat more fruits and vegetables</p>	<p>My personal health goals: 1. Reduce my back pain 2. Have more energy</p>
<p>Physical activity: Walk 10 minutes, three days per week Practice light stretching in the morning</p>	<p>Check myself: Keep daily pain journal Keep track of my mood</p>
<p>Target: Do all my daily activities</p>	<p>Red flag: More pain, falling, confusion More depression, feeling hopeless</p>
<p>Checkups: Call my guided care nurse first Tuesday every month Regular checkup with Dr. Smith every three months</p>	<p>Specialists: See physical therapist every Friday morning Chronic disease self-management class at Glendale Baptist Church, September 5–October 10, Wednesdays, 10 a.m.–12:30 p.m.</p>
<p>Preventing problems: Get flu shot in the fall Screening scheduled November 1, 2009, 10 a.m., Washington Hospital Center</p>	
<p>Other: Bring action plan to all appointments with medical professionals</p>	

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Guided Care

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- **Caregiver support.** The GCN offers individual and group assistance to family and informal caregivers, including an in-person assessment, monthly support group meetings, and ad hoc telephone consultations.
- **Access to community resources.** The GCN serves as an intermediary for each patient's and his or her caregiver's access to services within the community such as transportation, meals, and adult day care services.

Savings accrue from reduced hospital visits

During an initial 2003–2004 pilot study of 150 patients enrolled in a partial version of the program at a single site, Guided Care patients rated their communication with physicians and their PCP's knowledge of their care approximately 10 points higher on a primary care assessment survey than did older patients at the site who received usual care. Average costs for the Guided Care patients, measured by insurance payments for services,

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Guided Care model could spur interest in medical home

The Guided Care program requires few changes to an existing primary care practice structure, yet produces lower costs, says **Chad Boulton, MD, MPH, MBA**, professor and director at the Roger C. Lipitz Center for Integrated Health Care in the department of health policy and management at Johns Hopkins University Bloomberg School of Public Health in Baltimore. Lessons learned from the Guided Care pilot study and early results of the randomized trial include:

- **Identifying older patients who are most likely to benefit.** Maximizing the program's value requires the use of predictive models to identify individuals with multiple comorbidities and complex healthcare needs.
- **Systemizing Guided Care nurse (GCN) recruitment, training, and practice.** Nurses from a wide variety of backgrounds can provide Guided Care, but a consistent training program is essential for daily teamwork with PCPs.
- **Ensuring an adequate caseload.** Since 50–60 older patients with multiple chronic conditions are required to support a GCN, PCPs should have a geriatric population of at least 300 members to make the program work, although a GCN could potentially be shared across two practices.
- **Allowing sufficient startup time.** GCNs need three to five months to become fully integrated into a primary care practice and to build up their caseload of patients and caregivers.
- **Providing an adequate infrastructure.** GCNs need office space in the practice that allows easy access to the

PCPs and a laptop and Internet connection to update patient information and the EHR.

- **Establishing a protocol for notification of hospitalizations.** The practice needs to create a mechanism to notify GCNs about the hospitalization of a Guided Care patient through the practice or a partnership with local hospitals.

From 2009–2012, CMS plans to conduct its Medicare Medical Home Demonstration project in practices in eight states. Practices participating in the demonstration project will receive a PMPM care management fee to manage the chronically ill seniors on top of their FFS payments for primary care. Some are expected to use the Guided Care model, says Boulton, who is presenting a session about the model in October at the 2008 Medical Group Management Association annual meeting in San Diego. The program's architects say they hope that its use in the demonstration project will build a case for additional PMPM payments to cover Guided Care for seniors with multiple chronic conditions.

"Guided Care isn't economically feasible for every older patient," Boulton says, adding that "it's designed specifically for individuals who are at highest risk of being the high utilizers during the coming year. It's very well suited to risk-bearing integrated delivery systems, but small practices contracting with fee-for-service Medicare, Medicare Advantage plans, or commercial HMOs will need to receive supplemental care management fees."

Guided Care

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were 23% lower during a six-month program than for patients who received usual care. The savings accrued from 44% lower hospital admissions, 67% lower hospital days, and 52% lower ED visits.

“The biggest savings are coming from reduced hospital days, reduced skilled nursing facility days, reduced home health visits, and fewer emergency visits,” says **Chad Boulton, MD, MPH, MBA**, professor and director at the Roger C. Lipitz Center for Integrated Health Care in the department of health policy and management at Johns Hopkins Bloomberg School of Public Health. Costs associated with testing and specialty care actually increase under Guided Care but are more than offset by the other program reductions. Currently, Guided Care is being tested in a randomized controlled trial at eight sites in the Baltimore-Washington, DC, area involving more than 900 patients, 300 family caregivers, and 49 PCPs. The study is examining the program’s effect on outcomes for physicians, patients, caregivers, and insurers.

Early data suggest that the program reduces costs, improves quality outcomes, and generates high levels of satisfaction among physicians and nurses, Novak says. “We recognize that, for Guided Care to be diffused nationally and be a model of chronic disease care, there must be a reimbursement mechanism, which doesn’t currently exist,” she explains. “The results from the randomized control trial show that Guided Care helps Medicare to save money while improving the quality of care.”

The Guided Care team also developed a course to teach RNs the skills needed to practice in the program. The training is designed to equip nurses to care for older adults with complex conditions through self-learning material and interactive workshops. The curriculum encompasses 34 modules covering chronic disease management, patient preferences, case management, geriatric assessment and care planning, transitional care, information technology, motivational interviewing and patient education, use of evidence-based guidelines, cultural competence, community resources, communication with physicians, and

managing insurance benefits. Successful GCN candidates were required to complete the training course, which the Guided Care team is converting to a 40-hour online course. The ideal GCN candidate is an RN with at least three years of home care, case management, community health, or equivalent nursing experience in geriatrics, Novak says. GCN nurses should have an affinity for working with chronically ill seniors and their caregivers, plus flexibility and good communication and problem-solving skills. The nurses also must be comfortable using EHRs.

Program compatible with global risk contracts

GCNs are integrated into primary care practices during a three- to five-month period, with the goal of enabling them to become effective members of the practice team and to educate practice staff members about the GCN role. As they settle into the clinics, GCNs build up their caseload of patients. The cost of Guided Care to a practice is approximately \$96,000 annually—basically the cost of supporting one GCN, including salary, benefits, office space, and equipment, Boulton says. Physician practices also need an EHR to support Guided Care.

The Guided Care program could be integrated into delivery systems with global risk contracts, which could budget the cost of the GCNs and still accrue net savings from the provision of healthcare at a lower cost than the actuarially projected capitation rates for the high-risk member population. However, primary care and multispecialty practices that accept capitation only for professional services “would have no way of paying for it,” Boulton says.

“You could separate it from the cap rate for professional services, but it would probably need to stand as a separate capitation arrangement paid on a per-member-per-month basis,” he explains. GCNs are required to perform so many functions that increasing the documentation requirements would reduce the program’s effectiveness. ■

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E-visits improve efficiency for capitated physicians

Payers are recognizing the power of the Internet, and capitated provider organizations stand to benefit.

According to the New York City–based Manhattan Research’s *Taking the Pulse* v8.0 telephone and online survey of 1,832 practicing U.S. physicians conducted during the first quarter of this year, 36% of physicians communicate with patients online, up from 31% in 2007 and nearly double the 19% who used secure messaging five years ago. Twenty-five percent of physicians reported communicating with patients via the Internet.

Among physicians who have not yet used a secure online messaging service, 24% indicated they intend to start using one in the next 12 months. Among physicians who communicate with patients online, the most popular activities include answering clinical questions, discussing symptoms and treatment options, and determining whether an office visit is necessary.

Lack of reimbursement for these virtual visits is one of the biggest stumbling blocks cited by physicians who continue to shun online communication. Some doctors also worry that, by e-mailing with patients, revenue from traditional visits may decline.

But GreenField Health, a primary care practice in Portland, OR, relies on e-mail and telephone communication for approximately 80% of patient contacts, freeing up staff to see patients who need in-person care on a timely basis. Patients can contact their provider at any time by e-mail, telephone, or through an online system, and lab results are reported to patients via e-mail or telephone. The strategy allows the clinic’s nine physicians at two sites to provide walk-in and same-day appointments to any patient who needs them.

“The challenge in the traditional fee-for-service environment is that most plans pay for visits, and they pay for volume,” says **David Shute, MD**, a partner at GreenField Health. “Consequently, all kinds of things get pushed into visits so that they’re reimbursable. That’s actually inefficient, in terms of utilization.” For example, e-mail is more efficient than an office visit, without any

reduction in the effectiveness of clinical care, for medication adjustments, diagnostic test results, arrangement of consultations with specialists, and many follow-ups for recent clinical services.

“The other problem is that a doctor’s day tends to be very, very busy with visits, and that doesn’t leave time to provide care in other ways that may make more sense in the big picture,” Shute says. For example, practices with greater scheduling flexibility can provide patients with better ongoing care management, including preventive and screening services and education on self-management.

Use e-mail exchanges in capitated systems

To make the system work, GreenField Health matches each patient with a health coordinator, who interacts with consulting physicians, hospitals, laboratories, and other ancillary services on behalf of the patient. Health coordinators are trained as medical assistants and serve as the point of contact for referrals, ordering tests, and other services. The program requires one health coordinator for every 500 patients.

Some regional payers in Oregon reimburse for the e-mail and telephone consultations, but payment is not yet universal, Shute says.

To support its electronic communication and research and development, the practice charges an annual patient fee ranging from \$170 for children under 10 to \$350 for those 60 and older, with discounts available for multiple members of the same family and employees at certain local companies. Such reliance on e-mail to enhance care could have an even greater effect on medical groups that accept capitation.

“If anything, we make this system work in a fee-for-service world, but it’s an ideal way to provide care in a capitated environment,” Shute says. “When you’ve got a fixed pot of money to provide someone a set of services, it frees the providers—in this case, primary care

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E-visits

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doctors—to do what is most efficient and what makes sense.” For example, when Shute treats a patient for high blood pressure who is capable of generating reliable blood pressure readings and e-mailing the data to him, he reviews the information and simply replies electronically with instructions to maintain or adjust medication dosages.

“That’s a concrete example of something that most people would agree is clinically safe and appropriate, yet in a more traditional setting, it winds up being a visit,” Shute says. “In a capitated setting, it’s a more efficient system for the practice and a much more efficient system for the patient.”

Document e-visits in patient charts

For noncapitated providers and those operating in a mixed reimbursement environment, a payer’s decision to reimburse Web or telemedicine consultations should automatically be recognized in managed care contracts with in-network providers unless a healthcare organization has negotiated an exclusion that requires prior review and approval of payer policy changes, says **Susanne Madden**, president and CEO of The Verden Group, a healthcare consulting and research firm based in Nyack, NY. In any event, “the actual medical policy decision-making is going to override some of those clauses,” she says.

Practices that provide critical care or chronic disease management (e.g., endocrinologists and internal medicine physicians that care for individuals with complications from diabetes) should seek to negotiate more aggressively with payers to include electronic consultations in their capitation rates, especially in new contracts, Madden adds. When a severely ill diabetes patient doesn’t need to travel to a physician’s office for a visit, “it can only benefit the insurance company because it does substantially reduce costs,” she says, adding that “just because you have the technology doesn’t mean you’re capturing the right information.” The patient’s chart must

be updated following an electronic encounter, she notes. Practices that don’t document e-visits appropriately will be on dangerous ground if they bill for them, she says.

Finally, providers can’t bill for an electronic consultation using the AMA’s new CPT 99444 if it’s related to an office visit that occurred within the previous seven days. Many patients have questions following office visits, and e-mail is an efficient and convenient way to respond to these queries. “But if you’re going to bill for them, you’ve got to follow the rules,” says **Elizabeth Woodcock, MBA, FACMPE, CPC**, a healthcare consultant, author, and principal of Atlanta-based Woodcock & Associates.

Physician organizations also need to use an established Web portal that offers the requisite security and communication infrastructure, as well as the abilities to retrieve e-mails on a timely basis and to capture billing data. Organizations should work closely with vendors before choosing a communication platform to ensure that it meets their goals, Woodcock says. ■

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