

CME ARTICLE

A New Physician's Guide to Evaluating Managed Care Opportunities

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AUDIENCE

This article is designed for new physicians and administrators who evaluate and negotiate as providers with managed care organizations.

GOALS

To provide a review of the major issues impacting on medical practices as they develop contractual relationships with a managed care organizations.

OBJECTIVES

1. To review the four major types of health maintenance organizations, providing some general detail about the financial policies of each.
2. To outline how utilization review and quality assurance policies can affect individual physician practice.
3. To discuss risk-sharing arrangements employed by managed care organizations, including their financial and clinical impact, and to outline the issues a new physician should consider when evaluating a contract.

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A recent article in the *Journal of the American Medical Association* reported that more than 6% of all resident physicians entering practice were still unemployed more than 6 months after completing their residencies or fellowship training.¹ The 94% of physicians who do find practice opportunities, however, are not guaranteed a secure future. Today's environment is increasingly competitive, and it is estimated that as many as 50% of all new physicians change their practice location within the first 3 years.

This may be due in part to increasing financial insecurity. A few years ago, physicians were becoming increasingly discontented with the long hours and economic risk of solo practice and opted for the shorter hours and economic security of participating in a group practice environment, such as a managed care organization or hospital. However, corporate employment has not produced economic security for physicians. In 1998, some of the largest physician employers in the United States—including Kaiser Permanente, MedPartners, FPA (in California), and the Allegheny Medical Systems in Pennsylvania—reported financial loss or declared bankruptcy.^{2,3}

As a result, the new physician who locates a practice opportunity must evaluate the opportunity carefully in terms of income, patient care responsibilities, employment contract considerations, partnership potential, and economic viability. When assessing economic viability, the physician should evaluate credit ratings, reputations, recent history, annual reports, and, very importantly, managed care involvement. A recent *Medical Economics* survey found that from 75% to more than 90% of all medical groups participate in managed care, with the average medical group earning from 38% to 50% of its income from managed care contracts.⁴ Most medical practices that experience financial difficul-

ties do so because of managed care, either because they have lost out in the growing shift of medical care to managed care or because they have poorly negotiated managed care agreements.

This article is intended to enable the new physician to evaluate what involvement in managed care will mean.

The Evolution of Managed Care

Managed care has been a part of the American medical system since early in the twentieth century. Kaiser Permanente in California and the Health Insurance Plan of New York are managed care programs that began in the 1930s and continue to this day. The real impetus for managed care, however, came in the early 1980s when a series of state and Federal laws and policies were implemented to lower the cost of medical care in the United States.

In 1995, more than 58 million individuals participated in health maintenance organizations

(HMOs), and a similar number participate in preferred provider organizations (PPOs). Managed care is most prevalent in large cities and in such states as Arizona, California, and Massachusetts. These states have the highest degree of HMO penetration, with over 50% of the population participating in HMO plans. In many other states, more than 30% of the population participates in HMO plans.

Health Maintenance Organizations. There are four major types of HMOs: individual practice associations (IPAs), staff-model HMOs, group-model HMOs, and network-model HMOs. Table 1 provides an overview of these four HMO types, although the distinctions between them are increasingly blurred. For example, the staff-model HMO, by definition a closed system with most physicians employed by the HMO, is beginning to open up and contract with a few independent physicians. Staff-model HMOs now comprise slightly more than 10% of all HMOs, and this growth is due to the ability of this model to

control costs. By contrast, the IPA model, originally characterized by its "loose" physician control, is beginning to require more stringent utilization and quality assurance. A growing number of HMOs are also offering their subscribers an open-ended option that allows patient members to receive services outside the provider network for a higher deductible or copayment.

HMO reimbursement methods are also changing. While Table 1 outlines the more traditional reimbursement scenarios, many HMOs are now using capitated agreements with secondary specialists, and some are using capitation to force primary care physicians to adapt the "managed care style of practice." (Capitation will be discussed in more detail later in this paper.) Then, once the capitated structure successfully contains costs, the HMO may reintroduce a fee-for-service method of payment or base the capitated rate on patients treated rather than patients assigned.

Table 1. The Four Basic Types of Health Maintenance Organizations

HMO Type	Definition	Reimbursement
Individual Practice Association (IPA)	Association of independent medical practices (solo practitioners, medical partnerships, and medical groups) formed to negotiate agreements with managed care programs. These also serve non-HMO patients.	IPAs usually have capitated contracts with HMOs but may reimburse member physicians based on a fee-for-service schedule. Fees are usually 20% to 50% below the physician's standard fees.
Staff-Model HMO	HMO that directly hires physicians to serve their members.	Usually salaried; physicians have very prescribed duties and are often prohibited from earning outside income.
Group-Model HMO (captive group or independent group)	Fully integrated medical groups that contract with HMOs and are often very dependent on the HMO patient base.	Captive groups are dedicated to one HMO, whereas independent groups may have numerous managed care as well as fee-for-service contracts.
Network-Model HMO	Independent medical groups that contract with one or more HMOs while continuing to provide fee-for-service care to other patients.	A mix of capitation and fee-for-service arrangements.

The fastest growing type of HMO is a variation of the IPA model that involves direct contracting with independent practices. These agreements are similar to IPA agreements, although the HMO deals directly with the physician. A relationship of this type can be advantageous because the physician can remain in control of the practice.

Preferred Provider Organizations. Preferred provider organizations—networks of providers brought together by legal contract to provide healthcare services to insured individuals at discounted fees—have been a major part of the managed care movement since the early 1980s. These organizations can be quite successful because they offer specialty services that the large HMOs often do not. For example, some PPOs provide expert coverage in hard-to-treat areas (such as workers' compensation or mental health).

Unlike HMOs, PPOs usually do not require the physician to share financial risk. More than 80% of all physician PPO participation involves negotiated fee-for-service payments, although reimbursement is usually 20% to 50% lower than standard fees.⁵ PPOs may contract individually with physicians or offer a standard discounted fee-for-service rate.

Nevertheless, today's PPO is changing rapidly. PPOs are adapting many of the cost containment features previously associated with HMOs—such as risk assumption for physician providers and strict control over utilization of services. Discounted fee for service is beginning to give way to capitation—a payment method that puts the physician at financial risk. Further, more employers are setting up their own PPOs, especially in areas where physicians and hospitals are merging.

When considering a PPO contract, it is important to review the anticipated increase in practice expenses. The physician should request a "menu of plans," which includes all possible involvements that can result from signing the PPO contract. For example, although the physician may have one contract with the PPO, he or she may have 20 different agreements with 20 employers. In this case, the physician would be required to comply with all 20 agreements.

Goals of Managed Care

Amid the ongoing discourse about MCOs and their relationships with employers, subscribers, and providers, we occasionally forget that managed care has 3 objectives—all of which are equally important to making a provider-MCO relationship succeed. These objectives are to minimize the cost of provid-

ing high quality healthcare services, maximize the quality of healthcare services, and ensure patient satisfaction. Ultimately, universal cost control measures may eliminate differences in the costs of basic services, making quality of healthcare services and patient satisfaction the 2 primary objectives of managed care. Currently, however, all 3 goals are equally important. Most MCOs attempt to achieve these goals through utilization review, risk sharing, quality assurance programs, and outcomes management. Utilization review and quality assurance requirements are determined primarily by the medical director and board of directors of the HMO. It may help the physician to review these representatives, as their individual business philosophies may impact the policies of the HMO.

Utilization Review

Utilization review is extremely important to a participating provider because it directly impacts the practice of medicine. Utilization review, or as it is more recently called, utilization management, is designed to ensure proper use of medical services. Underutilization of services is as dangerous and has a comparable or greater risk of liability than overutilization.

The 4 most common forms of utilization review are preadmission certification, mandatory second opinion, concurrent case review, and retrospective case review. Regardless of the specific method(s), the physician should ensure that the MCO respects the following 4 utilization review guidelines:

1. The MCO focuses attention on participating physicians who consistently show or have the greatest propensity toward excessive utilization.
2. The MCO bases utilization criteria on objective measures. For example, a cardiologist's use of electrocardiogram or stress test monitoring should be based on the practices of other cardiologists with comparable practice profiles, not on the practice patterns of a mix of internal medicine and cardiology physicians.
3. The MCO spells out its utilization and quality management guidelines in detail in the contract or an attachment to the contract. The physician should review these guidelines closely before signing the contract and pay particular attention to the following 3 points. First, determine which medical records must be maintained and made available to the plan. Will the physician be required to serve on utilization review or quality assurance committees? Second, find out how the MCO handles utilization or quality errors. The physician should know how any sanctions are

determined and administered, and what the economic repercussions are to him or her. Third, understand what membership fees will be required, including both initial and annual fees. What services do the fees cover, and will the fees be continued as part of the agreement?

4. When the MCO uses profiling to measure physician performance, the MCO should use valid peer comparisons. Increasingly, MCOs measure the performance of participating physicians against that of their peers to determine if the physician is helping the MCO achieve its objectives. In this circumstance, the physician must know how the MCO defines "peers." Utilization statistics can include varied types of cases, different demographic factors, and other aspects which could lead to invalid peer comparisons.

The physician should also be familiar with the MCO's appeals process regarding utilization and may request a contract provision that allows for termination of the agreement if the utilization review rules change. The appeals process should be spelled out clearly. For example, in the event of a dispute, how quickly must an appeal be filed? Who will hear the appeal (internal or external)? Must the appeal be made within a certain time? Who pays for the cost of the appeals process? (It may be the physician.)

Quality Assurance

Quality assurance has been described as the counterweight to cost reduction and is usually measured in outcomes and/or member satisfaction. A physician contracting with an MCO should be familiar with the quality assurance program. A good program includes a complete plan, a method for credentialing and recredentialing physicians, disclosure of the composition and role of the quality assurance committee, practice guidelines, and educational programs and other informational services for participating physicians.

Plan. The quality assurance plan should include credentialing criteria for physicians and other providers, recredentialing, the composition and effectiveness of the quality assurance committee, practice guidelines, continuous monitoring of quality indicators, educational programs for physicians, compilation of data on physician profiles vs norms, and other relevant subscriber information.

A very important part of the plan is the process MCOs use to handle problems when they occur. Some plans penalize or terminate providers without providing a clear rationale or suggesting guidelines

for altering behavior. Some plans recently instituted reimbursement bonuses for physicians who achieve high cost effectiveness or patient satisfaction ratings.

Credentialing Standards. MCOs should specify credentialing standards—a major factor when evaluating MCOs. Physicians should also be aware that these standards often change, and contract provisions should allow renegotiation when such changes occur. MCOs generally consider the following factors important when credentialing physicians:

- Specialty
- Board certification or board eligibility
- Medical school and additional training
- Unrestricted license and valid drug enforcement agency registration
- Continuing medical education accomplishments
- Professional liability history and adequacy of coverage
- National Practitioner Data Bank reports of adverse actions
- History of professional liability lawsuits
- History of involuntary termination at more than one location
- Restrictions placed on the physician's practice by a hospital, managed care organization, licensing agency, or other source
- Active privileges at a hospital participating in the plan
- Physician's community reputation
- Past history of participation in quality reviews, utilization reviews, etc
- Coverage arrangements to insure availability of medical care over 24 hours to patients
- No history of violation of federal or state laws or of standards of ethical conduct. This includes conviction of a felony, or a history of fraud, deceit, or misrepresentation.
- Effect of physician's practice characteristics which may put the managed care plan at increased financial risk. This has become the focus of a growing debate over whether "economic credentialing" (determining a physician's fitness for the plan based on economic factors) has a place in the credentialing process.

During recredentialing, the MCO will usually review utilization data, results of patient satisfaction surveys, quality indicators of care, and physician behavior patterns and how they conform to expectations of the plan.

Composition and Role of Quality Assurance Committee. The quality assurance committee sets the MCO's policies. The physician should ask the following questions: Who are the various members of the committee? What is the physician representation on the committee and who are the panel

members? What are their specialties? The chairperson is particularly important, as he or she has major input into the philosophy and policies of the MCO. A review of his or her background may be insightful.

Practice Guidelines. MCOs expect certain behaviors and standards from providers, and they increasingly use these standards when making decisions about retaining providers. Once the physician knows what standards the MCO will expect, documentation of medical records becomes extremely important.

Many MCO contracts require providers to adhere to certain clinical practice guidelines or approved utilization procedures. If these guidelines are not spelled out in detail, the physician should identify the source of the guidelines. Sources usually include medical specialty societies, commercial sponsors, national organizations such as the Agency for Health Care Policy and Research and the National Institutes of Health, MCO-modified national organization standards, and the MCO itself, as some MCOs have their own standards.

Informational Services. Progressive MCOs provide physicians with the tools needed to monitor their own patient care and conform to desired norms of quality medical care. Availability of the physician's current utilization data as well as utilization norms for the area, for example, may be critical to the success of the physician's practice. Unfortunately, however, many HMOs still provide little utilization information, or they provide the information 12 to 18 months after the fact. Timely utilization information is particularly important for the return of withholds, which can comprise 20% to 25% of the total capitation fee. More information on withholds is found in the following section.

Risk Sharing

MCOs must strive continuously to provide healthcare services at the lowest allowable cost. Risk sharing is one the most important ways HMOs, in particular, attempt to achieve this objective. When HMOs contract with independent physicians, they usually provide fee-for-service or capitated reimbursement.

- *Fee for service.* Many physicians mistakenly assume they are not assuming risk when they opt for reimbursement on a fee-for-service basis. Before signing a fee-for-service agreement, the physician should know what the reimbursement rate will be, how the rates compare with his or her current fee-for-service reimbursement from other insurers, whether there is a withhold from this

fee, and on what basis it will be returned. Withholds—in which the HMO may guarantee the physician a fee of \$20 a month for each subscriber but may withhold \$2 a month against catastrophic loss or overutilization—are common in both fee-for-service and capitation plans. The physician should know if the withhold, which is usually returned at the end of the year if services are not overused, is predicated on the physician's overuse of services or the performance of the MCO as a whole. If the latter, MCO losses can result from external actions out of the physician's control. When evaluating a contract containing a withhold clause, the physician should also find out if the MCO is able to change the withhold amount at its discretion and how the MCO has acted in the past. If the MCO has a consistent pattern of failing to return withholds, evaluate the contract on the assumption that the withhold will not be returned.

Also, physicians should be aware that HMO patients may increase administrative requirements and practice expenses.

Finally, knowing what "services" are covered by the fee will allow the physician to determine the true net value of the fee.

- *Capitation.* This is the most common type of HMO payment for primary care physicians.⁵ In a capitation agreement, the independent physician agrees to a set monthly or quarterly fee, and the physician usually receives this fee no matter how many HMO patients visit the office. When considering capitation, the physician should ask several important questions. First, how was the fee determined? This information will enable the physician to compare this income to his or her current per-patient income. Capitation rates are determined by actuarial studies that attempt to project enrollee utilization. The capitation rate is always just slightly above the actuarial assumption, so it does not take much overutilization of services to negate the physician's net income. Second, what services and responsibilities must the physician perform to earn the fee? This will provide insight into what referrals are allowed and who pays for them and will help the physician determine if he or she will be reimbursed for hospital care. Third, can the fee be changed? Fourth, what, if any, stop-loss insurance is available? Stop-loss insurance insures against exorbitant costs incurred when the costs of providing a service far exceed the capitation rate. The physician should determine not only the availability of stop-loss insurance, but the type of plan, the amount and level of coverage, and, importantly, who will pay for the insurance—the physician, the MCO, or both. The point at which stop-loss insurance kicks in is

important (eg, a large IPA may offer insurance at \$50,000 in costs per enrollee whereas a small group may offer it at \$3000 to \$5000), as is the time of payment. The stop-loss insurance should specify when payments are made and should be offered on a per-case rather than a per-physician basis. Perhaps most importantly, stop-loss insurance is only effective in preventing financial loss when it covers liability. If a physician's MCO agreement includes hospital services, substantial loss could occur quickly and rapidly deplete the insurance capacity of the plan. Finally, as with a fee-for-service plan, the physician should determine if the capitation rate includes a withhold. Some plans give the MCO discretion to lower the capitation rate or raise the withhold. Such policies may be intended to force the physician into sharing risk for its internal marketing and administrative programs—both of which are out of the physician's direct control.

It is also essential to understand that since a capitated agreement involves the sharing of financial risk, the risk of catastrophic loss is inversely related to the number of patients involved, the age and health of the overall patient population, and the physician's own utilization rate. If, for example, the MCO provides just 10 or 20 patients, the risk of catastrophic loss is far greater than if the MCO provides hundreds of subscribers, whereby risk is apportioned among a larger number of patients. If the capitation rate is shared with a wide number of other physicians, it may be wise to review their utilization rates to avoid subsidizing physicians with high utilization. Further, "adverse patient selection"—a situation in which the physician sees patients who are older or sicker than those on which the capitation rate was based—will also negatively affect the physician's finances. Participating physicians should also monitor their own efficiency and compare his or her utilization to the norms—especially in the area of primary care visits, specialists visits, ancillary services, lab and radiology tests, etc. Many HMOs will supply utilization norms developed by Milliman & Robertson.

Regardless of the reimbursement method, it is often valuable to project HMO-generated revenue and contrast this with the expected increase in expenses. It can be very helpful to talk to other physicians about their experiences with the HMO. Several state medical associations now provide evaluations of physicians' experiences with local HMOs.

Outcomes Management

Standardized performance indicators are being developed by a number of organizations and will like-

ly consider such factors as the percentage of members who receive immunizations, Papanicolaou smears, mammograms, and other services. Other potential measures include mortality rate after myocardial infarction, low birth weight, incidence of hospitalization of children with asthma, percentage of diabetic patients who receive retinal exams, and the percentage of women who get early prenatal care. In the more distant future, measures such as time required to get an appointment, average waiting time in the office, and patient satisfaction level with the physician's care will likely be used.

Some experts feel that the source of outcomes information will be data from insurance claims. However, this is only one measure of good patient care. To measure quality, risk-adjusted data on mortality and morbidity and information on the patient's quality of health (as measured by days out of work, relapse, etc) are also needed. Clearly, outcomes data need to be standardized before they can provide a consistent measure of patient satisfaction.

Managed Care Marketing

When evaluating an MCO, the physician must also consider the organization's various marketing targets—including the employers and the providers.

Employers. Every community has a mix of large and small corporations and government agencies, and all are MCO targets. The new physician should review the list of employers who contract with the MCO, determine the historical dropout rate of both employers and employees, and determine employee penetration, or the percent of patients at each location that subscribes to the MCO.

- *Employers.* Many MCOs reimburse on a capitated rate based on age assumptions, and the capitation rate may be based on a young, healthy population. If, however, the MCO changes its marketing strategy and begins selling to employers with large numbers of retirees to achieve higher Medicare participation, the capitation rate should reflect this change in strategy.
- *Dropout rate.* The dropout rate can signify employer and/or patient dissatisfaction with the plan. Dropout, or disenrollment, information is provided by the local insurance commission, the HMO itself, the local medical society, and other local physicians.
- *Employee penetration.* Employee penetration is a key factor, because it will help the physician determine if a particular MCO will help increase, prevent erosion of, or even lessen his or her patient base. The physician, for example, may ask: "What is the average rate of penetration by the HMO among employers offering the pro-

gram?" With new HMOs, a 6% to 8% penetration may be quite good, depending on how many other insurance plans the employer offers. If several other options are offered, a 5% penetration is good. The rate of penetration after the first year can also offer insight into patient acceptance. The physician may also ask for the total HMO enrollment and projected enrollment for the following year. If the projected increase is significant, the physician should request information to support the projection. This research is especially important when the HMO's marketing staff promises a major increase in patients "in the future."

MCOs may market their programs through internal sales forces or independent brokers. While the internal sales force theoretically offers a staff totally dedicated to the product, it can raise administrative expenses. Outside brokers, usually less of a drain on administrative expenses, are sometimes reimbursed only when business has been generated. These agents often serve other clients, however, and their ability to devote time to the MCO may be compromised.

The physician should also find out what services are offered to the employers, as they can vary significantly from one employer to another. The most important types of services offered by MCOs include: inpatient responsibilities, outpatient responsibilities, elective procedures, preventive services, ancillary services such as ambulance service or house calls, and medical rehabilitation services.

The physician should also clearly define exclusions from coverage. Does the promise of services specifically exclude cosmetic services, experimental services, services associated with preexisting conditions (if the fee does not cover them), and/or non-medically necessary services?

Providers. Many states require HMOs to provide a list of participating providers, and when evaluating a managed care contract, the physician should review this list. This can help the physician determine if the MCO contracts with any willing provider, or if it contracts only with "preferred providers" and limits the number or geographical distribution of providers. This list can also reveal any emphasis toward primary care physicians, which may presage significant restrictions and cancellations of agreements with specialists.

The physician may also wish to review a list of providers who have terminated their relationships with the MCO, and vice versa. The physician can obtain information about provider satisfaction by talking directly to participating physicians as well as the state or county medical society.

Managed care organizations often establish their

own physician/patient ratios, and these ratios can impact style of practice. For example, managed care organizations may prefer to deal with a limited number of physicians who meet their utilization standards. The effect of this on the physician's practice is to increase the percent of all their patients who are subscribers at that MCO. This, in turn, makes the physician (or practice) more dependent on the MCO.

Exclusivity

Many MCOs request or demand that physicians sign contracts prohibiting them from contracting with other MCOs. This would be advantageous, especially for physicians who are new to an area, if the physician were assured a significant increase in patients. In mature markets, exclusivity can enhance a physician's practice if the HMO has achieved significant market penetration. However, MCOs rarely guarantee specific numbers of new patients, and it is very difficult to guarantee significant patient expansion in areas with heavy managed care penetration. As a result, the physician should study exclusivity clauses carefully. When discussing exclusivity agreements with an MCO, the physician may also request exclusivity. The more the MCO limits its contracts with like specialists in the area, the greater the advantage for the contracting physician.

The Role of Federal Qualification

Federal law requires certain employers to offer a Federally qualified HMO as an option. Federal qualification mandates standards of benefits, payments, and availability of services and allows HMOs to accept Medicare patients. It is anticipated that new legislation will increase the value of Federal qualification for HMOs.

A Federally qualified plan may or may not offer advantages over other plans. Federal qualification requires higher capitalization than many states require and increases the likelihood that a participating physician will be paid in the event of MCO bankruptcy. When evaluating a non-Federally qualified plan, the physician should review the corporate liability status and the availability of stop-loss insurance, which should be available from the plan.

Number of Plans to Join

In today's environment, it is no longer a question of whether a physician should accept MCO patients. In many parts of the country, where managed care is prevalent, the question is not only which managed care plans to join, but how many. When making this determination, there are 3 factors to consider. First,

what are the physician's overall practice objectives, and how well does MCO involvement meet these objectives? For example, how busy does the physician want to be? How much risk should be accepted? Is the physician willing to computerize and develop new office systems? Second, there are dangers in becoming overly dependent on one MCO. If the healthcare environment permits, a physician may wish to avoid depending on one MCO for more than 20% of their patients, because the more leverage an MCO has on a practice, the more vulnerable that practice is to changes in MCO marketing or reimbursement strategies. An HMO that loses several accounts may cost dependent providers a large part of their patient base. Finally, involvement with multiple MCOs to protect against overdependence on one risks saddling a practice with an unworkable number of different rules and systems.

Sometimes, the degree of community involvement in MCO plans provides a good guide to sensible physician involvement. If 30% of the community is enrolled in MCO plans, the physician may wish to have at least 30% of his or her patients as MCO patients. Further, the physician may wish to balance risk by seeking an equal number of HMO and PPO agreements.

The physician should remember that, for each MCO agreement signed, the accompanying administrative responsibilities may increase exponentially since each MCO may have 3 or 4 separate agreements with various subscriber groups. The physician's administrative staff must be prepared to track financial data for each plan every month, including

charges, copayments, capitations, and accounts receivable; develop a system to stay abreast of changes in each plan's rules and guidelines; and track patient statistics for each plan every month, including number of visits and panel size (which indicates the plan's growth or lack thereof).

Conclusion

Managed care involvement is an essential component of most medical practices, whether the practices are large or small. For the new physician evaluating a practice position, it is important to understand the role of managed care contracting and the intent of managed care policies. With this knowledge, the new physician can maximize the chances for a successful career.

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CME QUESTIONS: TEST #059901

Johns Hopkins University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. Johns Hopkins University School of Medicine designates this continuing medical education activity for 1.0 credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association. This CME activity was planned and produced in accordance with the ACME Essentials and Standards for Commercial Support.

Instructions

After reading the article "A New Physician's Guide to Evaluating Managed Care Opportunities," select the best answer to each of the following questions. In order to receive 1 CME credit, at least 7 of the 10 answers must be correct. Estimated time for this activity is 1 hour. CME credits are distributed on a yearly basis.

1. In evaluating a managed care network panel, the new physician should *not* look at

- a) who the providers are
- b) how the providers are paid
- c) the ratio of physicians to patient population
- d) the number of providers in the panel

2. If financially possible, a physician should attempt to maintain what ratio of patients to health plans?

- a) less than 10% of all patients from one managed care organization
- b) less than 20% of all patients from one managed care organization
- c) more than 20% of all patients from one managed care organization
- d) more than 40% of all patients from one managed care organization

3. The provider should be able to report the following financial data for each contracted managed care plan *except*:

- a) charges
- b) copayment information
- c) accounts receivable information
- d) size of the plan's enrollment

4. Recent healthcare trends include all but one of the following for preferred provider organizations (PPOs).

- a) declining numbers of PPOs in rural areas
- b) extensive conversions of PPOs into HMOs
- c) adopting many of the cost cutting features associated with HMOs
- d) rising trend of reimbursement toward the fee-for-service modality

5. A good quality assurance plan includes all the features below *except*:

- a) a method of credentialing physicians
- b) composition and role of the quality assurance committee
- c) practice guidelines
- d) compensation information

6. Recredentialing of physicians usually does not include

- a) utilization data
- b) patient satisfaction surveys
- c) physician behavior patterns and their conformity to the plan's objective
- d) prior involvement in managed care

(CME QUESTIONS CONTINUED ON FOLLOWING PAGE)

CME TEST FORM

AJMC Test #059901

A New Physician's Guide
to Evaluating Managed
Care Opportunities

(Test valid through
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Is the information presented useful in your practice?

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If so, which?

Do you find the information presented in these articles to be fair, objective, and balanced?

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yes no

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In your opinion, were the authors biased in their discussion of any commercial product or service?

yes no

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(CME QUESTIONS CONTINUED FROM PREVIOUS PAGE)

7. Capitation agreements involve financial risk. A physician should study which aspects of a capitation agreement?

- a) what services must be provided
- b) how the capitation rate was calculated
- c) is stop-loss insurance available
- d) all of the above

8. The degree of risk inherent in capitation is increased as the number of patients included in the agreement grows.

- a) true
- b) false

9. Adverse patient selection refers to

- a) assignment of patients with other plans
- b) assignment of patients who are sicker than average for the plan
- c) assignment of patients who are geographically remote from the practice
- d) all of the above

10. Stop-loss insurance is often recommended

- a) for fee-for-service patients
- b) for patients who choose other physicians
- c) on a case-specific basis
- d) all of the above