A New Model For Managing Care

BY THEODORE N. HARITON, M.D.

In many markets, HMOs have reduced premiums in a quest for market share. Unfortunately, many plans have achieved this by lowering capitation rates. At the same time, again driven by market share, HMOs have created unfunded mandates -- new benefits for members with no corresponding payment increases to physicians. As a result, costs of such items as the new varicella vaccine are passed on to physicians.

In Southern California, the money HMOs have left for medical care has reached such a level that it has become extremely difficult to provide adequate care. Given expert opinion that managed care has wrung out just about all of the excess medical expense possible, there is serious physician concern that HMOs' momentum is spent. To continue to hold down premiums and appease purchasers, health plans may be forced to lower physician payments below a point at which acceptable care can be delivered.

In Southern California and some other mature managed care markets, most HMOs no longer take risk, nor do they provide claims management or any real quality assessment. Because HMOs in many such markets function only as marketing and sales organizations, they have become commodities and are thus vulnerable to replacement.

To survive and feel that we, as physicians, still have pride in our profession, we need to modify the way we practice. Some decisions are those that all businesses must make when having to do more with less. These are the simplest changes, such as reducing expenses by consolidating practices, adjusting staff and making other cost-reduction decisions whose consequences, while perhaps uncomfortable, do not affect the delivery of medical care.

A conclusion we must reach is that we, the physicians, must be responsible for creating managed care solutions that are the most cost-effective, yield the best medical quality and afford the highest physician and patient satisfaction. Our incomes will not be like those in the 1980s, and we must find a method of practice that allows us to control the work we do while maintaining our satisfaction in doing it.

An idea taking shape among some California physicians would eliminate the middleman HMO, replacing it with a physician-owned and controlled medical management company.

The MMC would work with physician colleagues to develop protocols and provide care, but would leave day-to-day medical decisions in the hands of physicians. Specialty capitation and direct contracting would be among its strategic tools.

For many reasons, creation of any such entity would be difficult. It would require up-front capital because traditional payers are removed from the picture; it would subject its organizers to regulatory compliance, and would require them to invest heavily in state-of-the-art information technology. In addition, an MMC would have to avoid the pitfalls that have snakebitten physician-operated HMOs. Logistical questions aside, the idea is worthy of exploration, and I offer this discussion as a starting point.

Ground rules

To achieve high quality medical care and physician satisfaction, we must make some assumptions. The first is that high quality medical care can be defined and that it is reproducible. The second is that physicians want to practice high quality, cost-effective medicine and are willing to continually learn new methods to achieve this goal. The third -- and most important -- is that high quality care is the most cost-effective care. Physicians also want to practice in an environment that is as stress-free as possible. Many doctors think the MMC can help achieve all of these goals.

The MMC manages care and cost by lowering hospital and other medical expenses. It achieves efficiencies by creating clearly defined treatment protocols and preventive care programs. To operate in this manner, the MMC must consider the total cost of medical care -- not the costs of individual components.

Under the current structure of health care financing, each segment of the care-delivery system fights for the biggest share of the medical dollar. This has Balkanized medical care, whittling the promise of managed care down to little more than managed cost.

The key to the MMC's success is in looking at the total cost of care. For instance, an expensive drug that would raise the pharmacy cost -- and thereby lower that unit's profitability -- could lower the overall cost of care for a specific condition. HMOs that still use Cesarean-section rates as a measure of cost-effective medical care are overlooking other factors, such as neonatal intensive care bed-days, that can add significant expense to obstetrical cases. To reap the rewards of lower total medical costs, the MMC must command hospital risk.

Why not just allow people who are trained in business to do that kind of worrying for physicians? In the United States, physician decisions account for between 80 and 90 percent of health care costs. A physician practice management company that may buy your practice

hopes to profit by lowering overhead. Yet PPMs have lowered practice costs, on the whole, only about 5 percent, and with their accumulated debt, they are losing their appeal to investors. In the MMC, all physicians, not just those in primary care, as well as pharmacists and other health professionals, must be in an equity position -- or at least be stakeholders -- for their voices to be heard in the delivery of medical care.

Specialist-capitation model

The gatekeeper system is not always the most cost-effective method of care delivery. In some situations, direct access to specialists is logical and is cheaper in the long run. For example, engaging cardiologists in the primary care of many patients with chronic cardiovascular conditions is an extremely effective method for reducing medical expense for this group while having a direct, positive effect on patients' quality of life.

Specialty capitation is a method the MMC can use to improve quality of care and patient and physician satisfaction. Many physicians are afraid of specialty capitation and should understand that it requires a different mind-set from traditional fee-for-service medicine. For the specialty physician, there are several benefits of capitation: It provides a monthly income on a timely basis, slashes billing costs and office staff time and provides revenue in the month the service was rendered.

In our practice, our capitated Ob-Gyn contract allows us to make all medical decisions concerning the conditions for which a patient is referred. We go to the payer only to get hospital authorizations when booking surgery, and for authorizations for referrals for gynecologic subspecialty care, such as infertility or some gynecologic oncology cases.

We can do this because we are comfortable being at risk and understand the cost-convenience tradeoff. For instance, our lab work is sent to a capitated lab. If we perform a urinalysis or a pregnancy test in the office, we are not compensated for it. But if convenience counts for something, then it may be cheaper in some situations for us to do these simple procedures ourselves. We can obtain instant results and finish a patient's treatment during the same visit, rather than have to make the patient return for care. This improves satisfaction for all: our patients, who appreciate the convenience; our physicians, who like the ease of practice; and our office staff, which is rewarded with less paperwork and hassle.

When capitated physicians are allowed to care for patients as they would under fee-for-service practice -- that is, to treat cases in their sum without having to seek approval for each procedure -- they save time while increasing their own satisfaction. Ease of practice is a bonus that should not be overlooked.

From the MMC perspective, specialty care capitation has many advantages, not the least of which is cost predictability. Other advantages include ease of data collection, increased patient satisfaction and specialist participation in developing treatment protocols, which results in clearer delineations of medical care responsibility.

Not all are alike

There must be an element of fairness when dealing with providers, whether they are specialists or primary care physicians. To that end, contracts should be designed so that compensation is equitable relative to the amount of work done.

For instance, if a primary care physician is at risk for specialty costs, then that physician will want to keep referrals to a minimum. But if specialty care is not included in primary care capitation, the gatekeeper will refer everything. The capitation rates for primary care physicians should reflect these motivating factors.

For specialists, these considerations will differ with each discipline. Specialists want control over utilization. They want specific guidelines, and will be willing to work with the MMC to develop them. By giving specialists a sense of entitlement, we have better hope of coordinating care and managing total medical costs, not just components of care.

The key to evaluating different specialty groups is to divide them into distinct categories, which can be the basis for negotiating contracts or helping groups reach quality targets, among other uses.

One category may consist of services that have little patient contact and no effect on hospital utilization. This category includes laboratory and pathology. In contracting with this group, quality and cost would be paramount considerations.

Another category includes services with a great deal of patient contact and little or no effect on hospital utilization. This category includes imaging and dermatology. In this group, patient relations are as important as quality and accessibility. In specialties with high patient contact (such as imaging), a bonus system based on patient satisfaction would be appropriate.

A third category incorporates disciplines that have a great deal of patient contact but no patient control. Anesthesia is a good example. They, along with other hospital-based physicians, usually operate within a closed system. With this group, quality and patient satisfaction are major considerations.

A final category encompasses those specialties that have a great deal of patient contact and a direct effect on hospital utilization. This would include urology, general surgery, obstetrics and gynecology, orthopedics and cardiology. This group has a significant effect on the total cost of care, and for this reason, members of this category must feel that they are partners as well as providers.

To establish this partnership, these groups require the ability to provide comprehensive treatment to patients for their specific conditions without having to seek third-party approval at each turn or send the patient back for separate referrals for each procedure. These physicians should be able to decide the number of visits, diagnostic services and treatment needed, and to maintain the ability to schedule surgery as required. This autonomy directly affects patient satisfaction.

All for one, and one for all

These guidelines give the MMC a basis for engaging both primary care physicians and specialists, as all physician providers should be considered partners in this endeavor. To manage care in a truly positive sense, the expertise of all physicians is required. Each specialty, meanwhile, needs to define itself and mold its role relative to the group so that cost-effective, quality-driven methods of delivering health care are defined.

The MMC will have to find methods of working with capital markets to finance such projects. Through direct contracting and by excluding the HMO from the system, a greater share of the premium dollar can be reallocated from administration to medical care.

The predominant business-guided model of managed care, the HMO, is poised to implode. I believe that the MMC is the only sustainable model for lowering health care costs. Physicians must accept that in the past, medical care was too expensive and there was a good deal of waste. The MMC can build a system for care that actually reduces costs without destroying quality of care and thereby provides long-term return on investment. To survive in this new world will require a difficult shift in thinking, but we physicians must find a way if we are to ensure high quality care while salvaging respect for ourselves and our profession.

Theodore N. Hariton, M.D., is in private practice in Tarzana, Calif. He founded Keystone South Valley Independent Practice Association, now a division of Lakeside Health Services, and was a founder of the Doctors Co., a medical malpractice insurer.