

Networking

General Decision

Background

Managed care networks are involved with:

- HMOs
- PPOs
- Point-of-service products
- Exclusive provider organizations (EPOs).

These networks have become important to insurers, employers, participants and providers. These networks pick up where utilization review, cost sharing and precertification leave off. To make a managed care network effective, these ingredients are needed:

- Limited access to providers (gatekeeper concept)
- Provider discounts
- Provider risk-sharing

Other ingredients helpful in making the networks successful include:

- Subscriber education
- Centers of excellence (transplant surgery, e.g.)
- Reduction or elimination of mandated benefits
- Outcomes management
- Control of cost shifting
- Operational efficiency
- Improved information
- Better customer service
- Risk management techniques
- Integration of workers' compensation.

Organizing A Managed Care Network

To build a workable managed care network, these factors must be taken into account:

- *Be customer focused.*

- Dogs and the dog food rule still applies.*
- *Get a good mix of providers.*

The primary care giver as well as the specialists must be included; also a good mix of hospitals as well as ancillary service providers (durable medical equipment, home health and therapy service as well as a prescription drug card program). As for the percent of providers, the response will vary by geography. While 5% is too low and 80% is too high, a 25-45% penetration is ideal.

- *The network should be quality.*

Quality will make or break the network. The trick must be to choose the high quality/low-cost providers. An effective evaluation of the physicians will make or break the network. To find the high quality physician, these factors must be examined: community recognition and hospital affiliation. The physician must not only be reviewed for professional credentials, but also for economic credentials -- especially when it comes to high cost services. Similar logic applies to picking hospitals. Getting a 20% discount from a hospital that is already 20% over standard is no gain.

- Carve-out approaches are possible. Examples of carve-outs are these: mental and nervous, prescription drugs, transplants.
- Consumers' access to network.

For the consumer, these questions will be asked:

1. How far do I have to drive to access the network?
2. How long do I have to wait for an appointment?
3. Do I have to deal with a gatekeeper?
4. What happens in an emergency?

Utilization Management

All agree the primary care gatekeeper is critical to a successful network. However, the reader should note the primary care physician must be an asset, not a liability. An interesting thing is going on relative to concurrent review: as treatment guidelines and outcomes management become more important, concurrent reviews become less important. Concurrent review is a form of *punishment* needed for poorer physicians. Also, large case management techniques have grown in significance, relieving some of the need for concurrent reviews.

Risk Transfers

By risk transfers, we mean that the network transfers a fair amount of the financial risk for delivering a service to the network provider. There are three ways of accomplishing this transfer:

- Capitation
- Per Diem
- Withholds.

This use of risk transfer will increase in the years ahead.

Provider Reimbursements

These might be considered in three parts:

- Physician compensation
- Hospital inpatient reimbursements
- Hospital outpatient reimbursements.

Physician Compensation

There are six approaches to physician compensation:

- Fee-for-service
- Discounted fee-for-service
- Negotiated fee schedule
- Fee schedule with a withheld capitation
- Incentive risk payments
- Salary.

Fee-for-service. An ideal specialist, who would be a plus for the network, will usually come in only on the specialist's terms - namely, fee-for-service. The network would prefer to *go along* rather than *exclude*. Also, some physicians consistently charge below the negotiated fee schedule so they are, in effect, fee-for-service.

Discounted fee-for service. The physician will reduce the fee by X%; X% will vary by physician or type of physician. For example, the primary care physician would have a lower discount (or even a negative discount).

Negotiated fee schedule. This fee schedule sets the fees for all services. As with the discounts, the fee schedule may vary by type of physician-one for primary and one for specialists.

Fee schedule with a withhold. This is most commonly found with an HMO. The physician agrees to put some of the fees at risk with a settlement at a future date. The settlement may follow several scenarios:

- Based on the physician's own performance
- Based on performance of the group or subgroup.

Capitation arrangements are often found with primary care services with an IPA-HMO. The capitation rate will often be a function of age and sex of the subscriber. Capitation may also be paid for certain care – allergy, e.g. There may also be a withhold with capitation.

Incentive risk payments. These are techniques by which additional income may be paid to the provider. These are not the same as withholds; the incentive risk payments are strictly upside.

Salary. This is what one would find with a staff model HMO.

Hospital Inpatient Reimbursement

There are five commonly found types of inhospital reimbursement:

- Full charges
- Per diems
- Per case
- Per DRG
- Fee schedule.

Full Charges. Obviously not a preferred choice but, as with a physician fee-for-service, sometimes needed in order to get a hospital in the network.

Per diem. The hospital is paid \$X per day; it may vary by type of admission (maternity, surgery, e.g.).

Per case. Examples would be \$A for maternity, \$B for cardiology, \$C for transplants, e.g.

Per DRG. Similar to per case but more refined.

Fee schedule. A combination of the above.

Hospital Outpatient Reimbursement

Discounts for outpatient care have lagged behind those for inpatient care.

Information Needs

Critical to the success of a managed care network is the need for good information. The general areas of information are these:

- *Flow between employer and participant.*
(benefits, terms, rates, etc.)
- *Flow between participant and provider.*
(deductibles, copays, etc.)
- *Payer and all others.*
(need to do utilization review, e.g.).

With the rise of managed care, a growing number of hospitals are sponsoring joint medical-data networks. These new systems allow data, voice and image exchanges among hospitals, physicians, pharmacies, labs and managed-care plans within a metropolitan area. Some even extend over an entire state.

- *Employer and payer.*
(what are the savings, problems, e.g.)

Computer transfer of data is critical; paperless and high-tech claims processing is the wave of the future. The success of a managed care network hinges in large part on how well the parties are educated on the terms and goals.

Future Goals

Marketing the Network

Quality outcomes management is the magic work in the years ahead.

Workers' Compensation

Managed care networks will necessarily be bled over into workers' compensation. To accomplish this, the difficulty with chiropractors must be resolved; these are unwelcome in traditional networks and welcomed in workers' compensation networks.

Physician Hospital Organizations

These are popular now, but their future is not certain.

Integrated Networks

Background

These networks (also called *community care networks* or *accountable health plans*) are possibly the next generation of managed care. They possibly are a menace to existing HMOs and PPOs. These networks already have guidelines to conform with those that were established by the Joint Commission on Accreditation of Healthcare Organizations and the American Hospital Association.

Definition of an Integrated Network

Such networks combine delivery and financing, stressing cost and quality through utilization control; but with an additional dimension: fully integrated care. Examples include:

- Primary care for family
- Carve-out mental and substance abuse
- Home care and nursing homes.

The theme of integrated networks is *providers united* but in a local environment. Such networks have these characteristics:

- Emphasis is on community understanding.
- System is more *friendly* to patients.
- Money incentives are provided to avoid poor use of medical system/facilities.

One large provider (a hospital, e.g.) will be the *flagship* entity that owns and controls the other entities. A common controlling entity is the physicians hospital organization (PHO) or the management services organization (MSO) or the integrated provider organization (IPO) or an IPA-HMO. The degree of physician autonomy may vary greatly. In brief, there are many shades and gradations of integrated networks.

Advantages

One large integrated network consists of:

- 24 hospitals
- 33 outpatient clinics
- 16 home health agencies
- 3 HMOs

- 1 PPO.

Here are some of the things that an integrated delivery system can do:

- Elimination of any overlap in clinical services
- Better use of costly equipment (shared MRI, e.g.)
- Centers of excellence for certain procedures
- Common computer software (records, outcomes, protocols)
- Better services to physicians (help in paperwork, better malpractice insurance, sharing risk burden where HMO-capitation is involved, peer support, common employee benefit plans, e.g.)
- Better able to market products/services
- Better able to meet data demands
- Achieve reduced operational costs.

Expectation in the Future

There is every expectation these types of integrated networks will expand in the future. The most likely sponsor of such networks will be the PPO. However, there remains some distrust of each other among the providers. There remain formidable obstacles to the acceptance of the integrated network:

- Physicians refuse to accept primary care and wellness as a core or central health care need.
- Physicians refuse to look to the hospital as the *center of the universe* as is often the case with an integrated network.
- Hospitals, being cash-rich, are reluctant to be yoked with cash-poor entities.
- Hospital managements fail to understand the new health care *game*.
- Managing managed care is an almost impossible task.
- Getting the players to agree on a game plan is no simple task.
- Solving the high-tech computer role in the network is most difficult.
- Getting the providers and the communities to work together is almost impossible.
- Understanding the basic health needs of the community is easier said than done.

Referral Networks

Primary Care Physician

Primary care physicians coordinate referrals through the care coordinator once the end-line specialist is identified. Early consultation with the end-line specialist is required. Transfer of information is coordinated through the care coordinator. The primary care physician must be willing to take patients back from the end-line specialist when treatment is completed.

Referrals

These are the essentials:

- Toll-free telephone
- Care coordinator
- End-line specialist.
- Further studies or emergency care
- Transfer needed information.

Network Specialists

Must meet standards as regards regulating, credentialing, practice outcomes, etc. Also, such specialists must agree to terms of network. There must be a method by which such physicians are evaluated and disciplined.

Developing the Referral Network

Specialties

- Cardiovascular/cardiac surgery
- Oncology/hematology
- Neurology
- Orthopedics
- Obstetrics/gynecology
- Pediatrics.

Flagship Specialty Physicians

The *flagship* specialty physicians select additional physicians as needed to complete the network. During this process, the *flagship* physician communicates the program's mission and focus to each of the selected physician team members.

Evaluating the Referral Network

Patient Point of View

It allows the patient to maintain an established relationship with the primary care physician; patients trust their primary care physicians; most patients trust the judgment of their primary care physicians regarding specialty referral. It assures each employee smooth and easy access to specialists on a local or regional basis who have achieved a level of

excellence both clinically and economically. Primary care physicians are willing to change referral patterns if the specialty physician is humane and respected.

Primary Physician Point of View

Primary care physicians like the concept because their thoughts, ideas and judgments are respected; difficult patients are transferred to specialty care; they understand that it decreases medical costs and they have direct physician input with the specialist.

Payers Point of View

Payers like the concept because they understand how a superfluous intermediary physician can use a considerable amount of the medical dollar; they understand how income is generated by the superfluous intermediary physician; they receive specialists' performance reports; they accept the physician evaluation, direct referral concept and lower medical bills.

Marketing a Managed Care Network

To market the network successfully, the critical criteria as to what constitutes a good network must be considered. These criteria are:

Board certification. A substantial number of board-certified physicians must be enrolled and the spread by number of specialties must be broad. Also, credentialing must be checked.

Hospital affiliation. To have a network consisting of physicians without hospital admitting privileges would be a marketing disaster.

Utilization patterns. Judgment by the physician as to appropriateness of care is vital. Ideally the network should be made up of prudent, careful, and low utilization providers.

Geographic spread. The geographic spread is essential. Having participants drive over 30 minutes to see a network physician is a major drawback to the network.

Physician turnover. Pruning by the network management is essential to maintain standards; too much turnover, however, is a negative.

Post-implementation reviews. Follow-up audits and reviews are needed to keep the network up to par.

Miscellaneous. All pertinent information on the providers should be given to the prospects; network directories must be kept current; primary care physicians must make provisions for backup care (when they are away, e.g.); care must be given to screening foreign-trained physicians; network must do due diligence on physicians; network must not allow the quality of care to suffer.

Evaluating Networks

Typically, the four primary variables of interest are these:

Variable (per 1,000 Population*)	Mean	Standard Deviation
Admissions	95	8
Hospital days	480	90
Average Stay (Days/Admissions)	5	-
Office Visits	3590	532

*Under age 65

These figures were based upon a small sample of United States hospitals and physicians and are to be accepted as illustrative only. Question: why is the variance so great when physicians claim that human biology is universal? Answer: the practice of medicine varies widely by geography.

- Are some medical practices in a community not appropriate? *Yes.*
- Are some medical procedures in a community not appropriate? *Yes*

One of the goals of managed care should be to make a level playing field of procedures and practices thereby elevating the overall quality of care.

Before quantifying network effectiveness, certain terms need to be understood or at least defined:

Effectiveness. This is the ability to deliver quality care at lower than market prices over an extended period of time.

Network. This is any arrangement (PPO, HMO, HPO, EPO, POS, etc.). Network is also a network of networks.

Degree of Management. The extent on the continuum to which the patient's choices are limited with high for staff-HMO to low for traditional indemnity plan.

New Managed Care Networking

Here are some examples:

- *Employer-to Employer*
Examples are coalitions and purchasing cooperatives.
Vendors are usually helpful.
- *Providers and Payers*
An example would be a PHO and an insurer.

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- *Drug Makers and Rx Card Plans*
An example would be the ABC Drug Company and its Rx card plan. Many of the major Rx manufacturers also have Rx plans.
- *Managed Care Plans and Small Insurers*
While the big insurers have gotten into managed care by owning networks, the smaller insurers are competing by renting networks.
- *Academia and Provider Networks*
This joint effort aims at quality assessment, and larger issues than can comfortably be handled by the usual players.

Rural Networking Problems

Big inroads with managed care have been made in urban areas.

Problems with Getting Managed Care into Rural Areas

- *Payment.* Rural practitioners are reimbursed at rates lower for identical procedures than urban practitioners.
- *Lack of technology.* Many rural hospitals do not have the technology that urban facilities possess.
- *Geography.* Long traveling distances and poor roads create access difficulties to facilities and providers.
- *Demographics.* While one quarter of the total U. S. population live in areas considered rural, one third of those residents are elderly.
- *Physicians shortage.* Only a small percent of the nation's active doctors work in rural areas and many of those physicians are nearing retirement age.
- *Lack of insurance.* The percent of uninsured rural is higher than uninsured urban persons.
- *Decrease in patient admissions.* The number of inpatient admissions in rural hospitals is decreasing.
- *Loss of patients.* When rural hospitals refer their patients to metropolitan facilities, they risk losing those patients permanently.
- *Loss of nurses/staff.* Health care professionals continuously migrate to urban areas in search of higher pay.
- *Federal funding.* Fewer health service dollars are spent on rural residents per capital.
- *Illness.* Because they are, in general, older than urban residents, rural residents are more likely to suffer from chronic disease conditions.

Response to the Problems

The following solutions should be considered:

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- Encourage people to obtain care locally.
- Help rural physicians with their added demands (on-call, 7 days per week care, e.g.)
- Incorporate physician extender services into a provider network.
- Use telecommunication devices to enhance technology.
- Implement programs to assist rural communities in the recruitment of local physicians.
- Provide patients with a better awareness of what rural managed care offers.
- Assist the small community in restructuring the services they provide.

Specialty Networks

In General

These networks use centers of excellence. They are specialty-oriented and usually physician-created; they involve highly structured protocols; they use a global fee; they provide discounts of 20-40% below *market*. The physicians who participate therein must deliver on costs, outcomes and client satisfaction.

One large national heart surgery network has been established. The network has some 35 hospital/surgery teams in place. Surgeries include all invasive heart surgeries.

A major obstacle to the network is that global fee involves hospital cooperation; such cooperation is difficult because by *playing ball* with the network and producing the global fee advantages, the hospital must *gore the oxen* of the other non-network surgeons.

Another major obstacle was the anti-trust law. This was hurdled when the Department of Justice and the Federal Trade Commission held the network was in the *safety zone* of physicians' joint ventures. The networks gained the *safety zone* by agreeing to limiting heart surgeon membership to 20% of the area heart surgeons. Other anti-trust-related network rules include: physicians work for bundled fees thereby putting them at risk; network physicians may take out-of-network clients.

Some of the operational rules followed by the network to achieve success are these:

- Maintain high standards, experienced and scientific types of personnel
- Deal only with high volume and high quality physicians (150 procedures annually with less than a 5% mortality rate)
- Require a serious *ante* of high (\$60,000) dues and fees
- Set forth strict protocols of practice
- Conduct disciplined audits and utilization reviews

- Capture all significant data.

The procedures are also subjected to strict outcomes criteria such as:

- Patient satisfaction
- Return to work measure
- Mortality rates.

A downside thought is this: why is a national consortium necessary as opposed to a local center of excellence? Another is that the quality measures are yet ill-defined and community standards vary widely.

Conclusion: The specialty network appears promising but is not yet proven as it is too new. If it does work, expect the concept to be applied to other big-ticket surgeries. The underlying theory of such networks is that both the cost and quality are goals. To accomplish this, only the best surgical groups and hospitals are invited to establish a network (to cover a geographic area) devoted to both cost and excellence.

Network Uncredentialed Provider

The Practice. Managed care organizations are either accepting providers with partial credentials or with no credentials at all. This is being done because of (a) time constraints, (b) business reasons, (c) no other providers are available, or (d) high popularity of such providers so it is foolish for the network to not force the discount.

The Problem. Using uncredentialed providers opens up the network to a huge liability because of its act of steering patients to such providers. The burden of such provider's malpractice falls on the network. This is what is legally known as assumed negligence.

The Solution. The cleanest and best solution to the credentialing challenge is for the network to require credentialing on all providers. There are some useful modifications, however.

Modification Number 1. Let the uncredentialed provider be in the network with a forced discount

Modification Number 2. Let the uncredentialed provider be in the network with forced discount but without steerage; i.e., there are no network-created incentives to use such provider.

Modification Number 3. If the uncredentialed provider is in the network at the request of a client, let such client give the network a hold harmless to protect the network from malpractice liability. The network might give written notices of disclaimer for uncredentialed providers.

Selection Criteria

The sponsors of the network agreed upon these criteria:

- Ability to deliver quality care
- Reasonable geographic positioning
- Willingness to enter into a long term relationship with network sponsors.

The sponsors would usually be the *heavy hitters* (Blue Cross, the Big Five Insurers, e.g.). Such sponsors must be able to integrate care, quality, improvement and outcomes assessment.

Advantages of Such Networks

- With special procedure providers, care quality improvement and quality assessment become obtainable.

- Consumer will be provided more and better information upon which informed decisions may be made.
- More orderly and rational handling of medical techniques with less competition among providers will result.
- By increasing volume and specialization, unit costs will be reduced.

Popularity of Specialty Networks

Package prices for hospital and physician services that became common for cardiac and transplant surgery in recent years now are expanding across a wide range of other expensive specialties and are winning acceptance from PPOs, payers and providers.

Among the procedures and services for which case rates now are, or soon will be, available with major organizations are joint replacement, birth deliveries, physical therapy, behavioral health, cancer treatment, hernia repair, lithotripsy and hemorrhoidectomy.

Leased Networks

Background

Many managed care organizations utilize access or lease agreements with leased networks that provide warranties by the leased network that (a) the leased networks have *state-of-the-art* credentialing criteria and credentialing procedures; (b) the leased network has the ability to monitor the satisfaction of the credentialing criteria by providers; (c) the leased network recredentials biannually; and (d) the leased network will maintain these capabilities throughout the term of the access agreements.

Regulatory Authorities

Self-governing organizations include the American Accreditation Program, Inc. (AAPI) and the National Committee for Quality Assurance (NCQA) that have established criteria and standards for the delegation of credentialing to a network leased by a managed care organization.

Performing Due Diligence

These are needed steps in doing such due diligence.

- Do the leased network have credentialing and recredentialing criteria up to regulatory standards?
- Are there investigative procedures in place?
- Is there good written documentation?
- Are providers covered by professional liability with a rated carrier? Is it verifiable?
- Are providers adequately profiled?

Access To Care Problems

Access to care. (Small town A has no dermatologists) must be contrasted with access to financing (person B has a medical problem with no plan of coverage).

Rationing. Regardless of the access problem and its solutions, rationing must be recognized as a necessity; there are not enough dollars for all persons to have all the quality care they need or want; hence rationing is necessary.

The concept that people need to be *informed* buyers of health care like they would if buying a stove is nonsense; there is no emotion with a stove; there is with one's health.

The staggering cost of *end of life* care must be factored in; a 25% savings in this area could be drastic in the overall health care model.

The *employer-based financing* might be questioned as no longer being the most efficient. The mobility of the workers, the ability of the employer to change or drop benefits are marked weaknesses.