

RURAL MANAGED CARE: A 20-YEAR ROAD TO SUCCESS

*Here's one HMO that has combined almost all physicians,
most Medicare and Medicaid patients,
and nearly half of the privately insured
in the county – and mixed well with good faith.*

Roger Shenkel, MD

In response to the HMO Act of 1973, physicians in Mesa County, Colorado, founded the Rocky Mountain HMO Inc. in 1974. In the nearly 20 years since its founding, the HMO has evolved into an organization that now successfully manages care for 41 percent of the privately insured, 64 percent of the Medicaid-eligible and 55 percent of the Medicare-eligible in Mesa County.

Virtually all local physicians are involved with the organization, and 85 percent assume financial risk. With an enrollment of more than 50,000, the Rocky Mountain HMO is one of the most viable HMOs in the state and is the fourth largest in Colorado. The physicians in the community remain supportive of the organization and are able to work with the utilization-control mechanisms the HMO has implemented.

Mesa County is in rural western Colorado. Its population of 95,500 clusters

primarily in five small communities and in Grand Junction, a city of 30,500. The nearest urban center, Denver, is 250 miles away. The Mesa County model is worthy of study because it is the offspring of the unlikely combination of

- Tightly managed care
- A rural location
- The inclusion of most physicians
- Successful involvement of Medicare and Medicaid

Somehow, this comprehensive package has worked well for Mesa County. The Medicare and Medicaid components have at times presented problems, but since the inclusion of those programs was acknowledged by the local physicians to be necessary to a comprehensive program of health care delivery, solutions were easier to find. A kind of momentum was built, in which success with each component facilitated inclusion of others.

During the evolution of the Rocky Mountain HMO, the physicians of Mesa

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Dr. Shenkel practices full time in a five-physician group in Grand Junction, Colo. From 1986 to 1992, he served as president of the physician component of Rocky Mountain HMO and oversaw its transition from a passive professional corporation to an active IPA. He is currently on the board of directors of the IPA and has been on the board of the HMO since 1986.

SPEEDBAR

- ▶ Making managed care work in a rural community requires new strategies.
- ▶ Mesa County physicians formulated effective quality-control measures to support their insistence on an inclusive physician panel.
- ▶ The HMO recognized that physician convenience would be an essential ingredient of its success.
- ▶ Using the RBRVS to address reimbursement inequities has helped somewhat.

County and the administrators of the HMO have discovered time and time again that many of the “truisms” of HMO management in large metropolitan areas could not be extrapolated into the rural circumstance.

Involving all providers

In a rural community where all physicians are reasonably busy and large populations are not leaving or entering the community, the ideas of “losing business” or “increasing volume” are neither effective threats nor appealing options for most respected and capable primary care physicians. The prospect of bringing a couple of new partners to town and contracting business away from your child’s Sunday-school teacher (the “competitor”) does not sit well with rural family physicians, general internists or pediatricians.

Likewise, in a small community, the concept of bidding off one consultant against another is intolerable and counterproductive. In the Mesa County medical community of 64 primary care physicians and 82 other specialists, it has been impossible to “contract with the lowest bidder” in the selection of consultants. The primary care physicians who would be responsible for the selection process have personal and professional relationships with all the other specialists that preclude impartial, price-based contracting.

Moreover, many patients have unshakable beliefs about which consultants are capable and caring and which are not. Requiring primary care physicians to forcibly change those relationships would make such patients’ participation unlikely.

The medical community in Mesa County currently has two nongovernmental hospitals. One is a large, MD-based regional medical center, and the other is a smaller DO-based community hospital. In the early 1980s, the hospitals tried to set up a competitive situation—with one hospital’s doctors competing with the other hospital’s doctors. The smaller hospital formed a PHO, but when the larger hospital attempted to organize its medical staff in a similar fashion, its physicians declined. They did not want to fragment the medical community and were not confident that they could share authority equitably with the hospital.

The physician group that had started the HMO almost a decade earlier decided to organize as a separate IPA. Today, 85

percent of the physicians in Mesa County belong to the IPA, 5 percent contract directly with the HMO but remain outside the IPA, and the remaining 10 percent either acquiesce to appropriate fees or are of minimal financial consequence. Now that the majority of local medical insurance business is through the HMO, exclusion of providers on any grounds other than “quality of care” is perceived as restraint of trade.

Quality control

As a responsible consequence of insisting on a community-wide panel, the physicians had to demonstrate a firm commitment to quality control. The IPA has developed a quality review and credentialing process that involves biannual office reviews by two physicians (one being a peer practitioner), close hospital review, a thorough appeal process and a medical practice review committee selected by the IPA, not by the HMO. The HMO contracts for that service from the IPA, but the IPA selects its membership, and the IPA board has final authority over the committee’s decisions.

How well has the IPA monitored its physicians’ quality of care? In the early years, several substandard physicians were eliminated from the panel. This was not achieved without a struggle: Much legal jousting occurred as the substandard physicians tried to refute the charges leveled against them. In the end, however, the quality review process won out.

The IPA’s system balances the skepticism of the HMO management with the insistence of the medical community for proof beyond a doubt of quality defects. There would seem to be no solution in the small community situation that would *fully* satisfy both parties as well as consumers. However, the IPA’s review system now makes it impossible for a substandard practitioner to enter this community and survive financially.

Given the need to use most practitioners, the objective of the review process has shifted to improving the quality of all practitioners’ care. Constructive feedback and re-review of practices after that feedback, coupled with the practitioners’ desire to be up to par, have improved office medical records and, presumably, the overall quality of care. Physicians with deficiencies are asked (and paid) to be one of two physicians reviewing exemplary practitioners.

This tool has been most effective in quelling discontent among physicians receiving poor reviews.

Management strategies

The management team and the board of the HMO have been firm but at the same time very patient with the tedious and slow evolution of the physician component. They have consistently espoused the "community" emphasis, and that, together with an all-inclusive panel of providers, has given them a distinct marketing advantage.

At the same time, they have consistently applied pressure for close adherence to the gatekeeper concept and have insisted on correcting unnecessary expenses. They have been pro-physician as long as the physicians have been responsible in their quality-of-care and cost-containment efforts.

The HMO has directed its major cost-saving efforts towards ancillary services rather than physician fees. By contracting with one chain of pharmacies, the HMO was able to reduce medication costs significantly. To reduce respiratory therapy costs, the HMO purchased its own equipment. It established its own home-health agency to ensure quality, reduce costs and maximize utilization of home health care. In the case of high-cost clinical items that lack less expensive alternatives, such as MRI scans, the HMO asked the appropriate IPA physicians to document necessity and save money where prudent. The key to success in all these actions is that the HMO has involved the practicing physicians in decisions regarding cost containment rather than making its decisions according to financial data alone.

The HMO has also found many ways to reduce its physicians' hassle factor:

- The HMO collects all copayments rather than forcing physicians to do it and supports a fee-for-service-less-withhold system that avoids capitation
- The HMO was willing to contract with a local lab and allow physicians' staff to draw

blood even though a national chain offered a better bottom line.

- Precertification, when indicated, is accomplished with a local phone call to a familiar voice.

- Eligibility certification, if the card system fails, is also only a local call away.

- The HMO provides free on-site training for office staff whenever it's needed.

The hassle-factor transition has been interesting. In 1974, the hassle involved in dealing with an HMO seemed overwhelming to physicians unused to the concepts of gatekeeping, preauthorization and quality control, while

Amazing, but true...

- This HMO pays the doctor's fee *and* collects the copayment.
- The Medicare fee schedule and the Medicaid fee schedule are the same as the private fee schedule.
- If you spend extra time with a patient, you tell the HMO and they pay you.
- Family physicians can do lab work on Medicare patients.
- If you see a patient in your office after hours, you get paid more for the effort.
- When you find a mistake in a hospital bill, you get half of the savings to the HMO.
- Every doctor in town sees Medicaid patients.
- Most of the doctors in town still smile at each other.



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in 1993, the local system seems preferable to Medicaid, Medicare and several private managed care plans.

Physician reimbursement inequities

Addressing reimbursement inequities has been the most disruptive activity in the organizational history of this noncompetitive model. A physician reimbursement committee selected by the IPA recommends fee levels and adjustments, although even token increases of nonprocedural services have sometimes been met with major

SPEEDBAR

► The HMO's initial negative incentive system was not effective in improving utilization and cost controls.

► The new system rewards cost-effective doctors from a \$900,000 incentive pool.

opposition. Disclosure of reimbursement numbers to all members has prompted acceptance of some modifications. Medicare adjustments are monitored and adopted when appropriate.

Most recently, the RBRVS fee relationships were applied to the total pool of funds available for physician fees, and a revenue-neutral conversion factor was developed. Fees under that level are being increased and fees over that level are being frozen until a balance is achieved that the physicians can live with.

Cost containment and utilization control

The obvious disadvantage of involving most providers is the difficulty of ensuring cost containment and utilization control. How do you convince an HMO that you



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are taking these issues seriously? Part of the Rocky Mountain HMO's willingness to maintain the larger provider panel was based on an unwritten commitment from its physicians to improve their utilization and cost controls. Industry dogma holds that every prepaid plan needs an incentive system to promote cost-effective care, and that doctors should be paid more if they save the system money and less if they are expensive. This dogma did not work well

in Mesa County.

Initially the system enacted an increased withhold for the most expensive 5 percent of the primary care physicians. That system failed for several reasons:

- It was difficult to validate numbers.
- Close review often yielded legitimate reasons for doctors' high expenses.
- Reviewers realized that they would not want to take care of the difficult patients on the reviewed doctors' panels.

For subspecialists, a system was implemented that cost them some withhold money if the primary care physicians who used them had high overall costs. That system proved ineffective and disruptive; it was dropped.

Early on, the HMO also tried to impose a positive incentive: if there was a surplus, only primary care physicians shared in it, and more "cost-effective" primary care physicians got a larger portion of the surplus. This posed no problem because there was never a surplus—until 1985, a year when hospital costs were well below projections. That year, when large checks went out to the primary care physicians with the lowest cost data, the resultant uproar among the other specialists almost destroyed the entire organization. Joining in the uproar were several physicians who felt that their accepting any part of the surplus was immoral, regardless of how much of their withholds they had lost in the previous years.

The current incentive system is a positive rather than a negative one, with different treatment of primary care physicians and subspecialists. The HMO sets aside about \$900,000 annually to be used by the physician group for this purpose. For lack of an alternative formula that is acceptable to both the primary care physicians and subspecialists, the HMO currently splits this fund between the two groups based on their previous years' fees.

Individual primary care physicians are allocated their portion of the pool according to a formula that is based 40 percent on office review, 40 percent on practice pattern financial data and 20 percent on patient satisfaction as determined by surveys. A physician who is good and expensive can still be rewarded, but not as well as a physician who is good and cost-effective. Quarterly payments are accompanied by the physician's own utilization data—and

SPEEDBAR

► Open disclosure of all physicians' cost data has been an effective cost-containment tool.

► The HMO has kept cost increases well below national averages since adopting the positive incentive system.

Percentage cost increases, 1990 to 1992

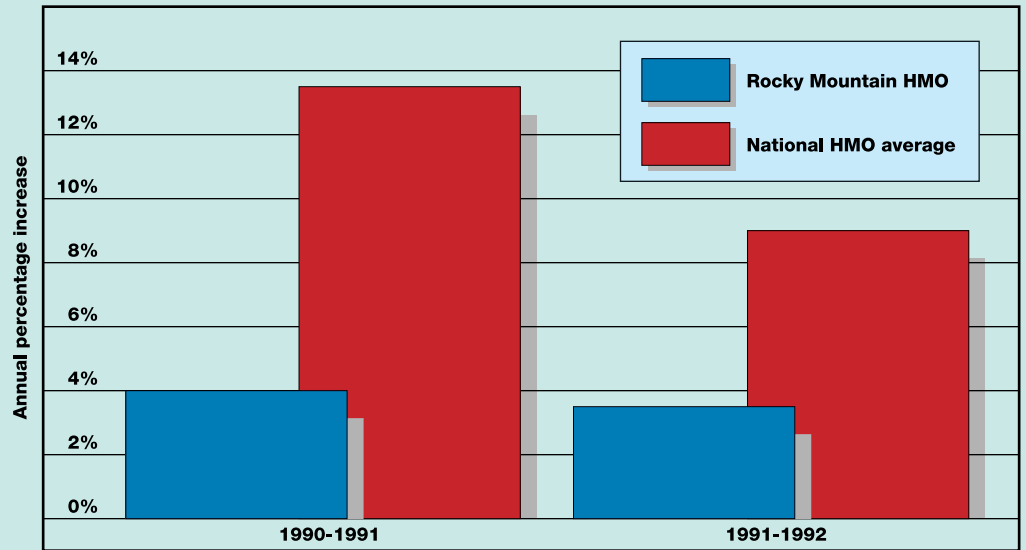


Figure 1: A comparison of cost increases for the years 1990 to 1992 indicates that Rocky Mountain HMO did better than the average HMO in controlling increases, even though it covers a substantial portion of the population of Mesa County, including the majority of patients insured by Medicare and Medicaid.

the utilization data of all other primary care physicians for comparison.

The system for other specialists is still being formulated, since they cannot agree to any system that anyone else has devised, yet have not been able to develop an incentive plan of their own. Faced with being forced to leave their funding in the incentive pool, they have devised a temporary system whereby 30 percent is paid out based on practice review, 30 percent is paid based on practice pattern data and 15 percent is based on patient surveys. Twenty-five percent is used to pay secondary care physicians for participating in educational meetings devoted to analyzing discrepancies in practice data between them and their peers and for devising cost-saving practice tools for the program.

With one to 10 physicians in any given field and with many of them having subspecialty interest areas, it has been impossible to devise utilization data that the physicians feel is credible enough to use as a basis for payment of a positive incentive. Data is currently being developed to compare practice patterns within each specialty. The physicians involved are paid generously to sit down together and analyze that data to identify any quality or cost issues and act on them if appropriate.

Another effective tool for cost con-

tainment has been the open disclosure to all doctors of every other doctor's cost data and comparative rankings. Few doctors are pleased to be more costly than their peers. Consultants are affected by their knowledge that the primary care physicians who refer to them know how much each charges for the services, tests and therapies they order—and that primary care physicians prefer cost-effective providers when quality of care is not an issue.

How well is it working?

The positive incentive program was instituted in 1991, and 1992 was the best financial year in the HMO's 20-year history. Cost per member increased 3.9 percent from 1990 to 1991, and only 2.9 percent from 1991 to 1992. Nationally, HMO plan costs per employee rose 13.5 percent in 1991 and 8.8 percent in 1992 (See Figure 1).

The Mesa County model of health care distribution has shown that a noncompetitive managed care system can be used in a rural setting to administer both private and governmental health programs in a responsible, cost-effective manner. This program has preserved a favorable environment for the delivery of quality health care and avoided the disruption of continuity of care inherent in competitive models. **FPM**