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A Road Map FOR Managed Care Success

This report describes 10 practices to help health care providers adjust to the onset of managed care. The intended audience includes all providers of health care services and those who support those providers. But it is particularly addressed to individual physicians, physician groups and hospitals.

Larry Benson likens the advent of managed care to a sand lot baseball game. If 15 kids are vying for 9 spots on the team, some will not be chosen. Likewise in health care today there is overcapacity in all sectors of the provider system. Some providers will not be chosen. The recommendations in this paper, while they won't guarantee success, will improve the odds of survival.

While the selection of 10 ways to cope is somewhat arbitrary, our list provides a sound strategy for dealing with the changes already evident in health care. A health care organization that adopts the 10 practices listed here will be ahead of the game in competing for future health care business. We suggest the readers use our list to verify the completeness of their own planning. Leaders of provider organizations need to ask themselves, "How are we dealing with the issues raised by each of the 10 key methods?"

If you would like a description of how AMX works with its clients in developing and implementing a strategy for success in the new health care environment, please contact Jim Ayers (310) 822-6720.

The 10 Ways

The 10 ways are divided into three groups: strategic planning, operations control and operations effectiveness. No single group is necessarily more important than another. If an organization is just starting to address the challenges of managed care, they should focus on the strategic planning section. If the organization is further along in terms of participating in managed care, the second two sections may be more important.

Each of the 10 methods contains a short description of the current state, what the authors believe the future holds, and how the proposed actions address the challenges of managed care.

Strategic Planning

Strategic issues address the structure of the managed care enterprise, what capital assets are needed or not needed, and the management team to lead the organization. These are important in preparing the organization or group just starting to participate in managed care. They are also important to the organization already in managed care whose performance is below expectations.

1. Provider Integration

Migration to managed care proceeds unevenly from location to location. But where it has progressed to the greatest degree, in states like California and Minnesota, it follows a consistent pattern. That pattern begins with an unstructured environment with many providers and moves to a solidified oligopolistic structure with only a few provider systems.

Because concentration into fewer provider organizations is inevitable, each provider must decide to form horizontal and/or vertical alliances. Horizontal alliances are with those providing similar services -- other primary care physicians, other specialists or hospital chains. Vertical alliances bring most or all medical services into one organization. For example, Kaiser is a vertically integrated provider with a staff of employed physicians and ownership of its own hospitals.

The strategic vision should be accompanied by the plan for financing it.

Returning to our sand lot baseball example, the process of vertical and horizontal consolidation is the "choosing" of the team. Each provider should try to be on someone's team, or on multiple teams. The teams provide single signature contracting with managed care organizations. As the managed care organizations compete among themselves, they will reduce their costs by slashing the administrative cost that goes with maintaining large numbers of contracts. For them negotiating with teams is more efficient.

Alliances offer advantages to providers -- in addition to better chances for survival. Examples include new sources of revenue from referrals within the network, access to better management skills, greater leverage in negotiating with managed care organizations, the ability to recruit both medical and management talent, and perhaps the most important of all, access to capital. The real battle is over control of the insurance premium dollar.

The planning of a provider integration strategy includes the following elements:

- A characterization of managed care penetration in the area. This includes a measure in percentage terms of penetration, who the major "players" are and the structure of managed care providers in the market.
- Competitive assessment. This brutally frank evaluation of position will compare your operation to competitive providers. You need to understand your weaknesses and strengths. In addition, you determine the existence of your competitive advantage.
- Alternative development. Alternatives include the choices available to become more horizontally or vertically integrated.
- Vision. The vision is a model of your role in managed care. Using the alternative you select, it defines your best guess at the organization you'll be, who your customers will be, what their needs are, and how fast you'll evolve to meet those needs.
- Strategic action plan. These are the essential steps to attain your vision. It is reviewed and changed as circumstances change.

The process of defining the initial strategy for integration need not be a lengthy one. Except in the most complex cases, it can be completed in less than a month. The process also serves to educate providers on the managed care environment.

2. Infrastructure Management

Infrastructure management covers all the capital requirements of the provider's

managed care business. Examples are brick and mortar facilities, equipment, supplies, and inventory to serve their patients. But there are too many providers in the health care industry. The authors forecast that up to half the hospitals and over 100,000 physicians will leave the industry. The reduced need for hospital beds and the over-supply of specialty physicians is well documented. The job of managing the coming downsizing is critical.

In addition to facilities, infrastructure management extends to financial assets as well. Examples are capital for expansion, investment in modern systems, and inventory management for supplies and pharmaceuticals, and the estimated $1,000 to $100,000 per physician to build an integrated delivery system. Another challenge is what is referred to in manufacturing as "make or buy" decisions. These decisions revolve around how much vertical integration is really economical. What services, in other words, should be "carved out" to avoid wasteful duplication?

The asset base and access to capital are important in deciding which partners to join. The golden rule applies: “He who has the gold rules.” Each provider group will have different needs for asset related management functions. What follows is a partial checklist of infrastructure related decisions. Each should decide which are important for their situation.

Start-up capital requirements. For independent providers seeking to band with others, what initial needs exist? Examples include hiring central staff, developing a marketing plan, hiring attorneys to establish a structure and support contracting, and pooling of administrative operations like billing. In a physician setting, we have seen this requirement to be $100,000 per doctor or more.

In-patient and out-patient facilities. These issues include number, location, services provided, and alternatives. An analysis should address the opportunity for consolidation. The feasibility of outside service rather than maintaining an expensive internal resource is a possibility to explore. The process should be supported by the ability to compare internal with external costs. The net result of this effort will be the closing of redundant facilities and perhaps capital expenditures to prepare others to better meet market needs.

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Materials and support function management. Corporate America increasingly relies on outsourcing support functions. All sorts of independent suppliers take on these non-core tasks. Examples include material management and running computers and data processing. Users of these services find outside suppliers perform this work more effectively than someone a company can hire directly. We predict that hospitals and other providers will increasingly rely on outsourcing. Their historical perception of their ability to be "all things to all people" and "we can do anything" will change dramatically in the next four years.

Capital sourcing. Consolidation in health care is already producing organizations of significant size and financial clout. The need for experience with capital markets, banking relationships and other forms of finance will increase at an exponential rate with the coming consolidation. The strategic vision should be accompanied by the plan for financing it. And access to debt alone is insufficient. Equity markets will be required for capital to accomplish the unprecedented resizing and retooling of the health care industry.

Standardization. Concentration in health care will spread "best" practices in facility management. McDonalds brought the concept of standardization to fast food. Aetna, through its Healthways Family Medical Centers, has similar plans for standardized outpatient facilities. Often, starting over from the ground up and deploying facilities and systems based on common best practices is better than overhauling existing disparate inefficient facilities.

In other industries, infrastructure issues might not play as important a role as they do in health care. But two massive movements are and will be going on side by side. One is the massive shedding of existing infrastructure based on now obsolete models of doing business -- they are simply too costly. The other is the emergence of a new model based on the cornerstones of managed care -- capitation, gatekeepers and prevention. Navigating the transition will be a challenging management task.

3. Management Team

Successful managers in the old environment will not necessarily be successful in the new one. The strategic vision should identify the skills needed for the managed care provider organization.

Our assessment is that needed skills and, more importantly, true leadership are in short supply inside the industry. Another important skill on the manage-

ment team will be contracting and negotiations. The managed care organization can be drained financially by missteps in establishing its financial commitments.

A key to success will be recruiting and retaining management and leadership skills. Any plan to enter managed care should include a realistic assessment of existing talent, the market place availability of needed skills, and the feasibility of obtaining those skills. If a sober evaluation indicates that this will be difficult, the plan should change to reflect reality.

Operations Control

The essence of capitated contracts is the shift of financial risk from insurers to providers. Gone are the "cost plus" days for pricing services. The new environment requires new tools to control cost and quality. These tools address contracting risk, best practices for treatment, the costs of such treatment, and feedback to providers in the form of measurement and rewards.

Health care has severely lagged other industries in need and ability to control costs and risk. Those who do it best will survive the transition to managed care.

4. Protocols and Risk Assessment

All providers will more and more be driven to accepting capitated (per member per month) rates for services, rather than fee for service or discounted rates. Conventional wisdom indicates that 70 of all hospital revenue, and some 50-75 of clinician revenue, will be capitated by the end of 1999. Capitation requires new discipline that includes mastery of risk management.

Each managed care provider will have a niche in the supply of health care, and a corresponding piece of the capitated pie. For large organizations like Kaiser, that niche will be broad. For others, like a group of specialists, that niche will be narrower. Definition of the niche for any provider is critical and is part of the strategic planning in item 1 above.

In a capitation environment, however, there is danger of cost shifting from those upstream in the "clinical pathway" to those downstream. So, particularly if you're downstream, definition of the incoming patient's eligibility and diligent monitoring to assure conformance are necessary.

Also in the contracting phase, the risks in different customer groups will vary. Causes of variation include the size of the enrollment, age distribution of patients, and so forth. Understanding and managing this variance can mean the difference in profit and loss. The following paragraphs describe some of the pitfalls in the contracting process.

Define your niche. Protocol coverage is not unlike product definition in an industrial environment. It should follow from the strategic plan and reflect the range of provider capabilities. Too nar-

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row a range of capability may not attract customers, while too broad a capability may bring you into competition with stronger organizations.

Be adaptable. Prepare to modify the "rules" under which you accept patients to meet your customers' needs. Assess the impact on your own costs if a service will have low utilization but is costly to maintain.

Review capitation contracts. Commitment to these business deals should be preceded by a formal risk review. The review should cover the viability of the managed care organization, limits to cost exposure based on historic and predicted utilization of contract groups, dispute settlement, and obligations to accept patients.

Charges set by providers will no longer form the base for prices for any health care service. The most efficient provider will negotiate a price based on their drastically reduced cost structure. Those who can't make money at that price will leave the business. Part of the negotiations will focus on "gray" areas, some of which are described above. These introduce flexibility and "customization" into contracting and will make the difference between profitable and unprofitable relationships.

5. Utilization Measurement

While item 4 above addresses steps to take before services are delivered, retrospective utilization measurement "closes the loop" with measurement after the services are delivered. For any diagnosis, providers should capture information on actual services delivered. These should be compared with industry benchmarks available from a number of services.

This will seem, particularly to some physicians, as an intrusion on their "right" to clinical autonomy. But the reality of managed care is that such information, including the outcomes of treatment, is invaluable for refining optimal medical practices and controlling costs. As provider concentration increases, the authors expect to see the quality of medical care improve from the sharing of information on best practices.

The existence of systems of information sharing should be viewed as a necessary competitive weapon in bidding for managed care contracts. They not only assure managed care organizations of the existence of financial controls but also demonstrate a commitment to improving health care service. A provider simply cannot manage an organization without a state-of-the-art computer-based information system.

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Risk and capitation are the same. Risk is shifted from the insurer to the provider through the mechanism of utilization. Successful management of any organization means managing risk. How would any provider, hospital or physician, conduct prospective, concurrent and retrospective utilization (risk management) without an information system? A pad of paper and a ten key calculator? Highly unlikely.

6. Activity Based Costing

Historically, revenue has been variable based on more procedures and more visits and more bed-days. Managed care and particularly capitation implies that revenue is fixed - ten thousand patients capitated at $30 per member per month is $300,000 of fixed revenue. Therefore, the only way to control profitability is to control costs.

Activity based costing ties hand in hand with utilization review. While utilization review addresses medical outcome, activity based costing addresses the cost structure of that utilization and therefore the provider's financial outcome. In a capitated environment, both are needed for effective control of operations.

Most organizations create budgets around departments or other organization units. This practice is largely based on the notion that department managers are in the best position to set and track budgets. What passes for cost management becomes a collection of these department budgets, based on "full time equivalents" (FTEs). Over time the budgets bare little resemblance to the actual work in the department.

But patients will receive care from several departments for a single condition. And they have little interest in the provider's internal organization. They want service for their medical condition. Activity based costing takes their point of view.

In activity based costing, costs are tracked by "cost drivers." These could be the principal DRGs treated, for example. Collecting costs this way shows what different treatments cost. This is valuable information to set pricing, improve treatment processes, and compare inside with outside costs.

We see activity based costing playing a major role in pricing capitation contracts, deciding whether to "make or buy" a service, and as information for negotiating risk reduction clauses with managed care organizations.

7. Compensation and Rewards

How the provider organization recognizes and compensates its members will determine their behavior. Alignment of rewards and recognition with the elements of utilization, cost, risk, quality of service, and customer service goals will be a major area of innovation in managed care.

The challenges of redesigning compensation programs will be especially challenging in a capitation environment. Fee for service or discounted fee for service

methods are relatively straight forward. Capitation compensation should balance the following factors:

- Quality of outcomes. Does the provider practice good medicine?
- Patient satisfaction. Does the provider meet patient expectations-both medical and non-medical?
- Productivity measures. Is the provider efficient as well as effective?
- Cost of services provided. Are the costs of services as tracked with utilization measures within reason?
- "Fit" within the group practice. Does the provider contribute to the group?
- Group profits from capitated business.
- How much money do we have to compensate our providers?

The move from fee for service to capitation will produce a number of compensation methods. Provider organizations will have many options to control traditional variables like salary, bonus, profit sharing, and other incentives to reward their people. The design of such programs will affect employee behavior and the ability to attract talent to the organization. If compensation remains a relic of production fee-for-service practice while the market paradigm switches to cost control, the organization can be guaranteed failure.

Operations Effectiveness

Lowering the cost of delivering an acceptable level of outcomes is and will increasingly be a determinant of success. The authors believe providers must reduce the capitated cost per covered life by at least 20 percent in three years. All this must be done without upsetting customers-both the patients and the payers. What follows are three tools for operating effectiveness to achieve the balance between cost, customer service, and patient outcomes.

8. Reengineering

This has been a popular movement in American industry where it is linked with sweeping improvements to business processes. The reengineering approach implies "radical" and fundamental changes to the way products and services are delivered. Reengineering seeks leaps in cost or lead time improvements of 50 percent or more. This contrasts with smaller, incremental approaches such as CQI and TQM that may "tinker" with process improvement, only bringing gains in the 5-10 percent range.

Because shifts in health care are so radical, reengineering is not only the appropriate philosophy for improvement, it is the only one that will achieve the necessary results. In many cases, reengineering and new information systems are linked. But reengineering projects fail for lack of dealing with other factors like evaluation of the need for doing a task, the organization structure to do work, or the need for technology in performing the work (other than information systems).

Reengineering is particularly appropriate for the mature business. Those just starting into managed care may not have developed the mature processes that need changes. They have the advantage of starting from scratch. But the larger organization may have many non-productive processes or practices that must be exorcised.

An effective reengineering program will have the following elements:

- It must be broad, encompassing processes that run across several departments.
- There should be competent process engineers able to identify value and non-value added tasks.
- It should include soft-side issues like organization values, measurements, rewards, and skills.
- It should tackle the difficult issue of organizational structure and the roles of people in it. Many improvements are possible through lowered overhead.
- Information technology can support improved processes. The next item describes these. But we caution clients that information technology should not be the "centerpiece" of the effort.

The initiatives above are good opportunities for starting a reengineering pro-

gram. For example, consolidating facilities is an excellent time to rethink business processes. Moving to a new facility creates a supportive climate for change. Now that the integrated system is formed by contract or asset merger, how does one actually integrate the care processes? Reengineering is one of those "no option" measures. Survivors will master the process of making continued major changes to existing processes.

9. Information Management

The technology used in information systems continues to fuel rapid evolution of these systems in all industries. In health care, larger organizations will experience increased management complexity, making ready access to information even more important. Information technology will find roles in quality/utilization improvement, the clinical/financial interface, community networks, cost accounting (including activity based costing), managed care contract administration, and electronic data interchange.

Lower costs for personal computers have made them ubiquitous in many organizations. In contrast to just a few years ago, basic computer "literacy" is now expected of those entering the professional workforce. This presents an opportunity to use these systems "proactively." Proactive systems use the computer to cut out manual administrative work shortening processes and reducing

An example in the managed care environment is eligibility checking. A swipe of a card could avoid the 3-4 percent overdelivery of services due to lapsed eligibility. Not having to make phone calls or manually update records would save dollars for many providers.

The plan for information systems is closely related to other measures listed here. These include infrastructure management, all the management control measures, and reengineering. In fact, the needs in these areas will, and should, drive the information system plan. Keep in mind, however, information technology is an enabling technology. Solely superimposing information systems on existing, generally inefficient health care processes will not achieve the dramatic improvements in outcomes.

10. Service Quality Assurance

No provider organization, even with excellent health care practitioners and low cost delivery, will survive if customer-patients are unhappy with service. Examples include long delays for appointments, not being able to call and get through, and queues in the facility.

To maintain a high standard of customer service, providers need to actively manage resources at points of contact with customers.

Examples include:

- Reception areas to avoid check-in waits.
- Phone answering so calls are picked up in a reasonable time.
- Appointment capacity for providers so patients don't wait for routine service
- Claims processing departments to provide prompt resolution.
- Waits for ancillary services like laboratories, pharmacies, and x-ray.
- Listening to Muzak, for 30 minutes while waiting for the procedure authorization.

While the techniques for managing these interfaces are used extensively in other industries, many health care providers fall down in delivering satisfactory service. Often, the budgeting process is to blame; not enough service providers are available for the workload.

Well managed service delivery will have the following elements:

- Standards for service at customer interface points. Examples are physical appointments scheduled in 30 days or three rings to pick up a phone. These will be a product of local competitive conditions, the kind of customer you are trying to attract, and what is medically appropriate.
- Workload measures at the point of contact. To budget, providers need to know the volume of work. This is a function of incoming volume and the time it takes to serve each customer.
- Provider service models. The model translates workload into the number of providers needed. For example, a telephone appointment center will probably need more receptionists on a Monday morning than a Friday afternoon. This is because workload patterns change by day of week and time of day.

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- Service measures. For points of entry there should be measures of accessibility or customer service. These should be both real time so immediate action can be taken and retrospective to monitor recurring problem areas and trends.
- Contingency plans. When the workload exceeds the available resource, alternative measures should go into effect. Airlines, for example, bring office staff automatically onto reservation lines when those lines fill up.

These elements of customer service management will help avoid many of the day to day conflicts around decisions related to budgets, replacement workers, and access to temporary staff. They protect customers from poor service and raise renewal rates of customers assuring the prosperity of the organization.

Conclusion

The purpose of this discussion has been to both educate and challenge management of provider organizations. It contains specific methods to improve the way health care is delivered in this country. Many of these are difficult to implement, but that makes them no less urgent in an era of upheaval.