

Managed Care: Meeting Employer, Enrollee, and Community Expectations

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Abstract

For a managed care plan to succeed, its employers and enrollees must be as satisfied as its providers and payers. To make managed care a success, healthcare providers and the people they care for must forge new relationships. In managed care, employers and enrollees become the center of the healthcare universe, moving providers from the sickness business to the health and prevention business and making them accountable to their communities for healthcare costs and quality. This article describes how and why a hospital and an independent practice association in Billings, Montana, developed the Yellowstone Community Health Plan, Inc., a not-for-profit, community-based health maintenance organization. YCHP was created to develop functional relationships among stakeholders, to establish provider accountability, and to redesign clinical systems to provide efficacious, cost-effective healthcare.

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Much of managed care today seeks to meet employers' needs. Although providers receive fewer dollars for their services, employers' costs continue to soar. Despite restricted panels, greater cost sharing with employees and other benefit changes, employers premiums continued to rise. As a result, both providers and employers are feeling the consequences.

The Yellowstone Community Health Plan, Inc. (YCHP) sought a way to meet the needs of the many participants in the managed care system. The plan serves the interests of its providers, employers, enrollees, and community. It was designed by Saint Vincent Hospital and Health Center (SVHHC), an affiliate of the Sisters of Charity of Leavenworth, and Montana Associated Physicians, Inc. (MAPI), an in-

dependent practice association (IPA) of approximately 130 physicians.

YCHP is a clinical health maintenance organization (HMO) model that makes its participating providers accountable to the community and its enrollees for the quality and cost of healthcare. YCHP is a collaborative endeavor, capitalizing on the unique skills and interests of physicians, employers, enrollees, and representatives from the community and SVHHC. Managed care as many providers now experience it is based on traditional insurance and financial concepts; YCHP is based on improving health status, managing clinical processes, and allowing community members and providers to make all decisions.

YCHP is a model particularly suited to small urban and rural areas, because the size of these areas allows the health plan to take an active role at a local level. This model is attractive to providers, who have found that treating medicine as a discounted commodity does little to control the cost of care and nothing to improve the patients' health. Currently, most of the U.S. medical system focuses on people who show up for medical care; YCHP focuses on *all* enrollees, whether they show up or not. Wellness and prevention are important. YCHP offers physicians and hospitals the incentive to move from the sickness business to the health business.

How YCHP Evolved

In response to payer pressures in their marketplace during the late 1980s, SVHHC and MAPI formed a physician-hospital organization, the Billings Physician Hospital Alliance, Inc. (BPHA). BPHA was designed to help payers and employers secure discounted provider contracts while helping providers negotiate fair contracts. Although BPHA was simple in design and operation, it did exactly what it was supposed to do. Both payers and providers found it extremely helpful in expediting the creation of preferred provider options for payers and employers. Its greatest contribution, however, was to make BPHA's participating physicians more

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aware of industry trends, many of which negatively affected providers, payers, and employers.

Through the process of negotiating agreements, BPHA discovered that only a small portion of the discounts granted to payers were passed on to employers. In addition, discounts granted may have encouraged overutilization by providers to offset the discounts. The "piece-rate" fee-for-service payment system for providers appeared to encourage utilization and thus hindered the transition from a medical model (focused on sickness and disease) to a health model (focused on wellness and prevention).

Employers found that using restricted provider networks did not appreciably reduce their premium growth rates (ie, utilization was a greater factor than price). The low medical loss ratios for many employers indicated that a disproportionate share of employers' premiums were applied to payer administrative expenses, profits, reserves, and commissions, yet health providers were usually seen as responsible for the high cost of medical care. In addition, deductible and co-insurance structures of many medical benefit packages produced two very common, untoward results. Because of high out-of-pocket levels, people who needed care could not afford it, and those who had reached their maximum out-of-pocket payments overused the system because their cost of doing so was exceedingly low.

Employers were continually cost shifting to employees to assuage the impact of premium increases, which only created greater barriers to care. Employers with employees having preexisting conditions felt trapped and leveraged by payers because they could not shop for competitive premium quotes. Other employers had employees with relatively benign conditions who were locked out of coverage. Employers wanted a greater role in managing the costs of care and their employees' health. Employers' control often consisted of little more than approving monthly premium invoices for payment.

In sum, it became apparent that all participants were contributing to an expensive *nonsystem* of medical care, whether they were payers, employers, providers, government, or employees. No single group was to blame. SVHHC and MAPI then asked themselves and local employers several questions; Is this the best we can do? Is this nonsystem going to meet my long-term self-interests? Would the current milieu of mistrust among the various participants be conducive to creating a market-driven health system? Could all involved create an affordable system that focused first on its members' health, then on employers' needs, and finally on providers' needs?

The Concept

To make a physician-directed, community-based concept like YCHP a reality, committed, enthusiastic physicians rolled up their sleeves and met weekly for approximately six months. They identified the problems of current medical delivery, which included an honest assessment of the shortcomings in their own practices and styles, and discussed how to structure YCHP to resolve such problems. SVHHC and MAPI believed that without such an undertaking, they would continue to work in an exasperating, duplicative system in which an organization miles away would control their compensation.

SVHHC and MAPI, in conjunction with representatives from employers and the Billings community, created a prepaid health system in which providers designed the system and are accountable for costs and quality of care—ingredients fundamental to their success and community satisfaction. One physician quickly identified why he was not daunted by the challenges of running a health plan in addition to maintaining an extremely busy practice: "The success of managed care should not be judged by the success of physicians and hospitals; it should be judged by the health and financial success of the community and its employers, for it is their resources upon which we as providers make our living."

Aware of the shortcomings in existing healthcare systems, SVHHC and MAPI began to create a system that effectively addressed them. A more responsive approach would include several key components.

First was a return to the family doctor approach, where one physician was thoroughly familiar with a member's health status. This approach was not intended to minimize referrals to specialists but to understand each member's needs and to create access to myriad resources in a community that could address those needs. As opposed to the gatekeeper approach, this approach is typified more by the word *gateway*. A community-based board of directors was formed of representatives from the community, employers, and enrollees; the system's providers were accountable for the cost and quality of care. This allowed the community to participate actively in the health system it was funding. Providers, primarily physicians, were responsible for designing and monitoring the system to deliver health and medical care.

To align constituents' financial incentives, the system adapted the health maintenance approach of a defined premium for employers, capitated payments for almost all providers, and copayments for enrollees to add elements of consumerism. The system's premiums were community rated by class to minimize

the unpropitious effects of medical underwriting for a community, employer, provider, and enrollee. If administrative overhead was minimized and practitioners were actively involved in the care of someone with a chronic condition, the risks associated with that care could be accepted and costs managed. When payers cast off individuals as high risks, that does not mean these individuals do not seek care. It seemed in everyone's interests to ensure that as many individuals as possible had access to healthcare.

A health system that is truly knowledge based needs a clinically oriented information system to measure provider performance against objective standards, match enrollees with the correct providers, identify best practice behavior, profile providers, educate providers and employers, and give notice of required care, to name just a few critical needs. YCHP thus needed an information system to access seemingly unimportant data and transform it through analyses and format into information for providers, employers, and enrollees.

These are the core ingredients of YCHP. Its structure, clinical information system, strategic direction, and moral commitment enable it to address the shortcomings of the current U.S. healthcare system. However, one major caveat applies to almost any endeavor, including this one: Providers and employers must want to do it. Providers and employers must commit to solving problems in a win-win manner. Because SVHHC and MAPI wanted to solve problems, YCHP was created.

The Plan

Through YCHP, local employers purchase prepaid healthcare, which is similar to that available through HMOs. The providers of YCHP provide all care for these prepaid employer groups. Sound actuarial analysis established the amount of risk the providers would assume. The relationship between the community/ employers and YCHP providers was founded on the understanding that if the community gave the entire premium to YCHP's physicians and hospital to manage health and medical care, those providers were accountable for the costs and quality of the care they deliver. Because participating physicians agreed to be accountable to the community, they defined the scope of utilization review, set payment rates, and established clinical practice guidelines. YCHP's participating physicians have been encouraged and challenged to redesign all aspects of the current system.

To create an effective healthcare system, YCHP's participating employers, in conjunction with plan clinicians, assess their employees' current health status

and design systems to improve it. Once health status is assessed, employers and the plan must inventory all the community's resources (traditional and nontraditional, related and unrelated, cooperative and uncooperative) and enlist those people necessary to achieve the goals set for improving employee health. YCHP structure and design facilitates this process.

To secure fundamental change, YCHP providers are designing a system that delivers thorough care for a reasonable price when and where the patient needs it by the correct provider (ie, primary care physician, specialist, physician assistant, or nurse practitioner). A system that takes the correct actions clinically will find that the cost of care falls into place as it did for YCHP. That is the cornerstone of this plan's vision and mission. Contrast YCHP with the traditional insurance company or HMO approach that requires precertification by a nonpeer, pricing on claims history, cost shifting through high deductibles and coinsurance and medical underwriting, and offers very limited prevention and wellness programs. These policies achieve economic objectives but create barriers to medical care.

Provider Accountability to the Community

YCHP's participating physicians are charged with the design and direction of care, and the community representatives, employers, and enrollees on the YCHP's board of directors are charged with the governing the plan. The board is responsible for ensuring that community, employer, enrollee, and provider objectives are achieved within the plan's structure. They have a delicate assignment—balance the needs and expectations of the community, employers, and enrollees with provider expectations.

To be truly accountable, YCHP providers must meet employer and enrollee expectations. As an example of this accountability, the chief administrative officer of one of the region's largest law firms, who is a YCHP enrollee and board member, recently surveyed her employees and their spouses after one year with the plan. The survey indicated some dissatisfaction in three areas: inconsistent application of SVHHC's copayment collection policy; poor service at one network pharmacy; and inadequate primary care service from the plan's obstetricians/gynecologists, who were primary care physicians for enrollees as well as specialists for the plan. This information was brought to the plan, and the first two issues were resolved. The obstetricians/gynecologists could evaluate their role as primary care physicians and decide if they wanted to continue providing such service. Providers seldom get this kind of information and feedback.

Community representation in the plan is also critical because the plan's policy must be part of a community system—that is, health and medical care are only two aspects of a community's well-being. They are inextricably linked to housing, nutrition/food, education, policing, aging, and so on. Current U.S. policy treats each of these as unique systems; however, a community's needs and problems are interrelated and should be perceived and addressed as such. Current medical policies and practices address patient issues, not population issues, but effective health policy requires a system-wide perspective. Representatives on the health plan's board of directors must maintain a true system-wide perspective on behalf of their community.

Coordinated Care Means New Relationships

When SVHHC and MAPI began searching for alternatives to current "managed financing" initiatives and thinking, resources were not being used in the community's best interests because each provider had his/her own agenda and interests. Consumers had lists of providers at their fingertips, with no guidance on how to use them. As a result, care was not well managed or well coordinated. For example, one of YCHP's first enrollees had been seeing five different mental health providers on a weekly basis for more than three years for the same problem. Another early enrollee saw two unrelated orthopedic surgeons and a chiropractor in a 2-week span for the same complaint.

To coordinate care, YCHP's pioneering physicians quickly recognized that they must change their relationships with their peers, with SVHHC, and with allied healthcare professionals. They realized that their success in truly coordinating care would depend largely on their ability to redefine relationships. As one psychiatrist lamented, "I wish my physician colleagues would keep in mind I was a physician before I was a psychiatrist." In Billings, mental health providers are not well integrated with the medical community. Many primary care physicians routinely see patients for psychosocial issues, which is reflected by the fact that of YCHP's five most commonly pre-

scribed drugs, three are antidepressants. If primary care physicians and mental health providers could integrate their care, these patients' outcomes would benefit.

When health policy is initiated at state and national levels, it is difficult for local providers to build effective working relationships, because the focus then seems to be on how each individual provider gets his or her perceived fair share of cash from the system. For example, could effective working relationships be established among chiropractors, podiatrists, and orthopedic surgeons, midwives and obstetricians, physician assistants and family practice physicians, primary care and specialty physicians, through health policy formulated at the state or national level? There is not much incentive for providers to work together when mandates come from distant agencies, yet providers *must* work together to use resources wisely and continuously improve enrollee outcomes. Such teamwork can only be done locally. Financially driven policy and incentives will not change relationships; they will merely change positioning and posturing for available cash in the system. YCHP is realigning relationships to make the community and its members—not its providers—the center of the healthcare universe.

Sister Joanne Lappetito wrote that, "building networks, developing new relations, reducing duplicative services, and introducing economic efficiencies are but the means to an end. The end is the enhanced health status of the community."¹ Ultimately, managed care is not about money. It is about improving health and medical care.

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... REFERENCES ...

1. Lappetito, J. The motives behind collaboration. *Health Progress* 1975;9:50-51.