

## The Role of the Managed Care Industry

Based on a presentation by Sidney C. Smith, Jr., MD

### *Presentation Summary*

In the recent past, cost was the main factor that drove managed care companies. Currently, large employers and the media are putting pressure on managed care organizations (MCOs) for quality. Increasingly, such factors as National Committee for Quality Assurance approval and meeting Health Plan Employer Data and Information Set (HEDIS) ratings are viewed as important requisites for MCOs. The

American Heart Association has begun an initiative with MCOs to identify opportunities for comprehensive delivery of healthcare services that include risk reduction strategies for patients with cardiovascular disease. These meetings have opened the lines of communication and generated ideas for innovations. Cardiologists can become part of the process and, hopefully, patients will benefit from these new systems.

**T**he need for risk reduction strategies for patients with CHD and risk factors has been well established. However, such strategies require funding, and thus far, managed care has been reluctant to provide such funding. In 1995, the American Heart Association (AHA) undertook a major initiative to address lack of reimbursement by managed care for preventive services. The first step was initiated at a meeting the AHA committee convened in Dallas with representatives from 10 major managed care groups.

"The atmosphere of the meeting was very productive," said Dr. Smith. "We asked representatives from the MCOs what barriers made it difficult to fund risk reduction therapies. We told them it was not cost effective to pay large amounts of money for procedures such as stent placement, yet not be willing to

pay for 1 hour of patient counseling for smoking cessation when the reduction in mortality is greater than 40% after smoking cessation," he elaborated.

The representatives from the managed care organizations (MCOs) explained that in the late 1980s and early 1990s, cost was the major competing factor. More recently, the pressure for cost has reached a plateau and now the push toward demonstrating quality is increasing.

### **The Push Toward Quality**

The pressure for quality is growing because employers want the managed care company they choose to be accredited by the National Committee for Quality Assurance (NCQA) and to meet Health Plan Employer Data and Information Set (HEDIS) ratings. The NCQA, originally founded in 1979 as an offshoot of two managed care groups,

became an independent organization by 1990 with a 20-member board and its own funding. NCQA developed accreditation standards and participated in the HEDIS ratings.

Now the NCQA is an independent body involved in evaluating managed care programs. HEDIS criteria are used in the decision to choose an MCO by 59% of the large firms that employ more than 10,000 people. Most large firms stipulate that an MCO have NCQA accreditation.

The managed care group representatives who met with the AHA in Dallas explained that if the AHA committee could influence HEDIS and the NCQA accreditation process, they would be able to facilitate a change in the managed care industry.

A recent article in *Barron's* [March 4, 1996] evaluated 216 health maintenance organizations (HMOs). Of these, 25% were deemed either substandard or placed in a provisional category because they were unable to meet HEDIS standards or were not NCQA accredited.

New criteria will be incorporated into the HEDIS standards over the next 2 years; eight out of 24 will be cardiovascular-related test measures. HEDIS has gone from having only one cardiovascular measure to eight, along with two reporting measures. These measures include the number of individuals in the plan who smoke and quit, prevention of stroke with atrial fibrillation, cholesterol management in patients hospitalized with CHD, treatment for heart attacks, control of blood pressure, and use of beta-blocker therapy.

If a physician wants to become involved in contracting for managed care, it would be wise to think about joining a program that can demonstrate it will meet the HEDIS standards, Dr. Smith said. Programs are now being measured by whether they can meet HEDIS requirements.

### **Innovative Plans**

Although the majority of large HMOs have had surplus cash for the past few

years, these companies have been reluctant to provide prevention services and education. However, more recently they have begun to consider innovative plans. Some MCOs are providing grants to academic centers to look at healthcare delivery strategies and to develop systems of delivery. The AHA is also discussing the feasibility of partnerships between the biopharmaceutical industry and managed care for funding studies on how to implement these techniques.

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— Sidney C. Smith, Jr., MD

"We have gotten to the point where science can make a difference, but now we need the ability to deliver this science to patient care. In physics, one definition of work is: the exertion of force over a distance. If we think of science as the force, we haven't done our work unless we take it the distance to the bedside," commented Dr. Smith.

"One of the reasons managed care organizations are on the move," he continued, "is that they are now under pressure to show evidence of preventive care. Not only from large employers, but also by reporters who are concerned by the failure of managed care groups to provide preventive care. Prevention is becoming one of the main criteria used to rate MCOs."

As market demand for quality grows, managed care will respond. The more the public can influence the market, the more they can begin to get the products they want. That is the goal of the AHA

managed care initiative, explained Dr. Smith.

Recently, *Consumer Reports* [August 1996] listed 10 plans that refuse to share their HEDIS data. This is a strong sign that HEDIS and other criteria with an emphasis on prevention are going to be increasingly brought to the public's attention. Those plans that are out of compliance may also be out of business, because patients, as well as employers, are increasingly beginning to regard HEDIS as a rating system.

Other trends will also affect the provision of risk reduction strategies. One such trend is hospital mergers, which have increased dramatically over the past few years. In 1994 alone, there were 674 hospital mergers. By way of example one system in San Diego has grown from one hospital to include six hospitals, three clinics, and four skilled nursing/convalescent facilities, with an annual budget of \$1.4 billion.

#### **Comprehensive Services, Multidisciplinary Efforts**

Healthcare delivery systems have moved well beyond the doctor's office, Dr. Smith emphasized. Comprehensive risk reduction therapy will require complete healthcare delivery systems structured for patients seen in clinics who are subsequently hospitalized, perhaps transferred for surgery, and then sent to a convalescent center.

Programs built to provide comprehensive care are going to be the ones that obtain contracts, predicted Dr. Smith. Such programs will integrate care using multidisciplinary teams of nurses, cardiologists, cardiac surgeons, internists, and family practitioners. The rewards will be contracts and business in managed care.

"In the AHA's discussions with managed care, their representatives seem very interested in seeing such strategies implemented," Dr. Smith told the audience.

These strategies will ultimately benefit MCOs. For example, successful cholesterol management can achieve one third reduction in hospitalization, one third reduction in revascularization, and a significant improvement in patient outcomes.

Dr. Smith urged cardiologists to become involved in setting up comprehensive clinics for CHD risk using not just the science demonstrated in recent studies, but also the talents of nurses, physicians, and other healthcare providers.

"Physicians who are beginning to look beyond the current controversies may find opportunities to improve prevention through managed care. The beneficiaries of these opportunities will be our patients," he concluded.