

# **The Development of Linked IPAs**

**Grass Roots Development in the Delivery of Health Care by Medical Teams**  
*Creating and Managing a New Health Care System*

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## Preface

The money to pay for medical care resides with the patients. They either pay out-of-pocket or from benefits they earn through work, or through entitlements such as Medicare, Medicaid, or Champus. Insurers are usually the trustees of the benefits and entitlements money. However, in our current system of health care payments, the insurers take ownership of the patient's money before they distribute it to those medical providers who accept assignment of benefits. This process of transfer of ownership of the patient's money to the insurers creates an incentive for the insurers to deny claims and for the patients to ignore the details of the claims and payment processes.

The consequence of this transfer of ownership and abandonment of trusteeship is that each active party in the system is an adversary and the cost of the medical and administrative services are much more that they would be if the transfer of ownership did not happen. As an example, the distribution of the funds that have been paid for health care premiums to insurers is as follows (based on the audited reports we have been getting over the last fifteen years):

	% of Premiums
Insurers	25%
Hospitals	40%
Primary Care Physicians	11%
Specialists	11%
Ancillary	9%
Pharmacy	4%

Within the insurer's 25% are their expenses and profits. The profits have been between 10% and 15% of the gross premiums in the plans with whom we have contracted, but half of that amount has come from the health care funds used to pay the hospitals, physicians and ancillary providers. About a third of the profits are paid back to the physicians as performance bonuses when they have a contract through the IPA that requires insurers to pay bonuses.

Letting the insurers determine the cost of medical and hospital services and then add their expenses and profits has resulted in the highest cost, lowest quality health care in the industrial world.

The report below from the Commonwealth Fund in June of 2010 is the wakeup call for all of us:

<b>Category and Rank</b>	<b>Aus</b>	<b>Can</b>	<b>Ger</b>	<b>Neth</b>	<b>NZ</b>	<b>UK</b>	<b>USA</b>
Overall	3	6	4	1	5	2	7
<b>Quality</b>							
Effective Care	4	7	5	2	1	3	6
Safe Care	2	7	6	3	5	1	4
Coordinated Care	4	5	7	2	1	3	6
Patient Centered	2	5	3	6	1	7	4
<b>Access</b>							
Cost-related Prob	6	3.5	3.5	2	5	1	7
Timeliness	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Health Life	1	2	3	4	5	6	7
<b>Health Expenditures</b>	<b>\$3,350</b>	<b>\$3,895</b>	<b>\$3,588</b>	<b>\$3,837</b>	<b>\$2,454</b>	<b>\$2,292</b>	<b>\$7,290</b>

*Source: Survey by the Commonwealth Fund in June 2010*

Does the new health care law, “**Patient Protection and Affordable Care Act,**” do anything to address the problems that are manifest in our current system? It is not yet clear how it will become affordable and whether all of the patients for whom care must be provided will be protected. It does not change the ownership of premiums from the insurers (the condition that seems to be at the root of the problem) and it does not fix prices for either medical services or for administration and claims. The law does require that the medical loss ratio be 80% for individual plans and 85% for the large group plans which will mean that more is distributed to the health care providers or rebated to the premium payers. I would not bet on there being any rebates

The expectations are that the premiums will double in the next year. We have seen two rounds of 16% increases in the last six months from the major insurers. Some large employer groups have told their employees that the employer will pay the fine rather than provide the health benefits as they are required to do under the Act. The consequence of this new law may create larger numbers of uninsured patients and make less money available for the entitlement plans.

We hope that the future is not as dim as it appears to be. However, we have no intention of letting it negatively impact our member physicians or their patients. We know we can contract with Medicare Advantage Plans that will pay our member physicians more than traditional Medicare through profit-sharing agreements and provide our member patients with greater benefits than they can

get with Medicare and supplemental insurance. We will have to become a certified Accountable Care Organization (ACO) to protect our members from likely reductions in compensation from Medicare.

We can also deal with the commercially insured patients through Cooperatives controlled by the physicians and patients and thus, restore the trusteeship that has been lost in the current system and under the new health care law. Fortunately, Cooperatives are recognized under the new law and insurance policies under which they can operate economically have been exempted from the regulations.

The restoration of trusteeship by physicians and patients can be done in our organization by:

1. Agreeing on the prices between the patients and physicians based on a comprehensive list similar to the current Medicare RBRVS, but without the threat of reduction that hangs over the physicians by lack of long term solutions that depend on Congressional action.
2. Making common-sense written payment agreements between:
  - a. Patients and Physicians
  - b. Patients and Hospitals
  - c. Physicians and Insurers
  - d. Facilities and Insurers
3. Being sure that the agreements with insurers have the least load for administrative services and have provisions to return the profits from the medical and hospital funds to the medical care provider group.
4. Assuring that patients and physicians know all of the costs of health care and thereby dispelling the mystery of the administrative loads and the complexity in paying claims.

The following pages of this book are intended to give the reader comprehensive and practical information that will make caring for patients easier for the providers of health care and better in quality for the patients who seek advice and treatment.



## Introduction

*Buddha* by Karen Armstrong helped me to understand the development of **Linked IPAs**. Metaphorically, I met and decided to "...kill the Buddha." So, I have framed what I have heard and seen of the current health care delivery system and our development, within the ideas of Siddhattha Gotama. I hope what I have written can be used to fix a very broken health care system in which the relief of suffering and stress has been lost in the pursuit of money and fame not only by the providers of medical services but by the administrators and insurers who control them.

Twenty years ago I went to Memphis, Tennessee and to Birmingham, Alabama in an effort to get hospitals in those cities to join a Preferred Provider Network. At the time, I was astounded that those cities were economically depressed, but had two very rich enterprises: medical businesses and pawn shops. Pain and suffering had built the medical businesses and need served by usury had built the pawn shops. It brought to mind a quote from a doctor friend in Houston whose parents had been killed in the Holocaust, "The more I know about human being, the more I like dogs." I decided after this travel experience that I would try to raise the level of compassion in myself. In reading about Gotama, I found the first two steps in the noble eightfold path to enlightenment were where to begin: (1) Right View and (2) Right Intention.

Right view means to see and to understand things as they really are. It means to see things through, to grasp the impermanent and imperfect nature of worldly objects and ideas. It is not an intellectual capacity. It is attained, sustained, and enhanced through all capacities of mind. It begins with the intuitive insight that all beings are subject to suffering and it ends with complete understanding of the true nature of all things. Since our view of the world forms our thoughts and our actions, right view yields right thoughts and right actions.

Right intention refers to the volitional mental energy that controls our actions. Right intention is a *commitment* to ethical and mental self-improvement. There are three types of right intentions: 1. the intention of renunciation, which means resistance to the pull of desire, 2. the intention of good will, meaning resistance to feelings of anger and aversion, and 3. the intention of harmlessness, meaning not to think or act cruelly, violently, or aggressively, and to develop compassion.

The reformation and recreation of the health care and delivery system in the United States requires that every step be taken in the noble eightfold path to enlightenment. We still might fail and what I have written about it might not be helpful, but after you read this essay you will get your own chance to improve it and to "...kill the Buddha."

## **Chapter 1    First Step: Organization of the Physicians into Local Teams**

*In creating Linked IPAs we had to find physicians that other physicians trusted and respected. They had to be as intelligent, articulate, and caring as the best teacher we ever knew. The primary goal of the team was to relieve suffering, so a leader had to be dedicated to that goal and, at the same time, had to have all of the attributes of a good teacher. We have been able to find such physicians.*

Regardless of our experience and knowledge in the administration of IPAs we do not think that we can do the job without the help of physicians like those I have described. Not seeing that is the easy road to the demise of the Local Physician Team or in the current “newspeak” of government Accountable Care Organization (ACO). However, it is the road most often taken by those in power who want to organize a network of physicians to serve the budget of the Health Plan and the pocketbooks of the key investors. Leadership based on models found in business sometimes result in failures in the health care system. Two kinds of failures are when large numbers of people are without insurance and many people lack access to basic health care services.

The clearest evident of the failures of our current health care system is that it cost twice as much as health care purchased in other developed countries and the medical outcomes are not as good as in those countries. Most medical delivery systems run by managers, hired nurses, and medical directors have as their primary—if unavowed—goal the generation of money for elaborate business structures feeding corporate goals and profits for investors. If, however, the main goal of an ACO is the alleviation of suffering, the persons in charge must have an in-depth knowledge of diagnosing and treating sicknesses and injuries. They must have a profound respect for peer relationships and sound economics. The lay organizer who is outside the medical team (the core of the ACO) will be a

peer only in a nominal sense and will not carry the open respect of the medical group.

We have found the physician leaders of Linked IPAs over the last twenty years of working with them in managed care plans, in quality assurance committees and in the direct care of patients.

Hierarchical structures appear to be the intended operational model in which leaders actually direct and perform important roles in health care, but that is the nominal and not the practical structure that is followed. Since the majority of physicians are in a solo practice or in a small partnerships it means there are no standing teams and that the nominal hierarchical structure is without a middle management layer. Consequently, when physicians participate in a large organizational structure as in an IPA they often overlook the role of middle management and run their organization much like they run their practices: Boss to office manager to medical workers. It is therefore a struggle to get a practical structure built around teams because it seems counter-intuitive to the physician leader.

In spite of the possible organizational blind spots, leaders of Linked IPAs have been able to call meetings on short notice and fill the meeting room with physicians coming to hear about something completely new—an opportunity to reform the medical delivery and finance system from the grass roots. Such leaders have been able to bring from fifty to one hundred each of his or her fellow physicians to sign-up and to form the ACOs that comprise Linked IPAs. In order to win over the initial group, they had to follow-up with personal visits to each of the physicians to explain the ACO, the plan for qualification, and the part of each doctor on the medical team. It took about six months to organize and about three years to have an operational team of peers. Based on our past experience and the analysis of what worked and what did not work in forming an ACO, I remained convinced of the pivotal nature of the physician leader's role. Having

no hidden agendas, the past leaders that have spoken the truth, did their best to relieve the suffering of everyone around them and, as good organizers, have built several teams of about 150 physicians each. We have often incorrectly assumed that the primary care physicians would be budget-watchers and gatekeepers in the use of specialty and hospital services. We also erred in assuming that the group of specialists would behave as a group in the care of patients. It took us years to finally realize that it's not money that controls the costs or the quality of care—money is not even a real incentive in patient care. The incentive seems to be pride and fear—pride in what they do and fear that they will make mistakes. Therefore, the system for communicating what is going on everyday with every patient that is referred to a hospital or to a diagnostic facility is the controlling factor. The frequency of patient contact with the primary care physicians and their management of chronic illnesses has also had dramatic impacts on outcomes and costs. When the primary care physicians see patients frequently and monitor their care there are fewer crisis and fewer hospitalizations.

The physician leaders know all of the team members, the roles they play, and how they practice medicine. Furthermore, the team physicians must be reminded constantly that they are in an ACO and not in a traditional practice. The doctors are habituated to referring patients to a very large circle of specialists—as many as fifty--whom they know from their contacts at the hospitals. This number is far too large for a team that serves a small patient population. The reform of the present system must begin with a specific population of patients served by a specific ACO. There can be as many ACOs as needed to serve a whole community and patients can change teams periodically as needed, but open systems and lone wolf physicians and patients will not contribute to any reform, except to bury it.

Linked IPAs is diligent in avoiding contracting with too many specialists and in knowing that the team members must limit their referrals to team members only.

Further, all members of the ACO must get the point—they must take care of their patients as they would take care of members of their own families.

I have known four physicians who put together ACOs with some ease. They all had a clear idea of the nature of an ACO. Each of them called every physician they knew and explained the plan and then gave them a brief span of time in which to respond. He or she told the potential group members that they were his or her first choice for the team but that if they declined, he or she would go to follow-up choices. Each recruited from 50 to 100 physicians in about sixty days and then turned to the ACO management company to build the organization and get it into the market, which we have done.

What made it possible to organize the ACO so rapidly and what does it take to get business for the ACO? If you want to slug it out with the big companies that control the health care funding, including the government, you have to invest big capital, and the ACO can't scrimp on initial investment monies. So, the organizers have invested about \$1.5 million in the development of Linked IPAs. The physicians own the majority of the interest in the business, but recognize that there must be insured business for the ACO, and there must be willingness to move patients to the new ACO's chosen Health Plans.

So, what are the elements necessary for further development of Linked IPAs so that it will be successful in serving an insured patient population?

- (1) Physician leaders who are well-respected, articulate, and caring.
- (2) Member physicians who put the patient first and treat her or him like "family."
- (3) Creation of the right-sized teams.
- (4) Adequate capital for the operation.
- (5) Patience.

## Chapter 2 Contracts With The Medical Practices

We have lead physicians and their peers who understand the ACO organization, want to support it, and are members of selected teams. How did they organize? ***The first step was having enough primary care physicians who were willing to influence their patients to use Health Plans that contracted with the ACO.***

A typical PCP practice will have from 1800 to 2000 patients. Over a period of about three years, it should be possible to convince about 600 of these patients to choose Health Plans that contract with the ACO. It is not possible for the insurers to bring new patients to the practices in any way that does not reduce the quality of care and disrupt the patient/physician relationship. Therefore, the way to get the enrollment numbers needed to profitably use the ACO is for the physician to direct patients to the ACO's contracted health plans. Usually, about 200 of these 600 potential patients will be seniors that choose Medicare Advantage Plans, and 400 will be younger patients who choose commercial Health Plan's through their employers or associations. The ACO needs roughly 20 of these PCPs to have a large enough population to profitably support a specialist team and have a local hospital be cooperative in the pricing and services required.

***Linked IPAs*** has four ACOs that have thirty PCPs each. If the government should change the current insurance system dramatically so that both the Medicare Advantage Plans and employer based plans were reduced in benefits to the usual level, there is still the need to perform under the budget and to earn "performance bonuses" within the changed system. That also requires a team that can provide quality assurance, peer review and care co-ordination.

***The second step was to recruit two specialists in each of a minimum of twelve key categories:***

Cardiology	Diagnostic Radiology	Gastroenterology
General Surgery	Hospitalist	Neurology
Ob/Gyn	Orthopedic Surgery	Ophthalmology
Podiatry	Pulmonology	Urology

Linked IPAs has contracted specialists in each of the categories for each ACO.

Cardiovascular Surgery, Neuro-Surgery, and Oncology are special teams in themselves and are available in only a few hospitals. They form groups of their own and are contracted with by the four ACOs so as to be used more effectively. That organizing principle applies to other types of sub-specialty groups that care for critically ill and chronically ill patients in specialized hospitals.

***Our third step was contracting.*** The first contract between an ACO and a physician that I read was seventy-five pages long, had ten signature pages, and, of course, was written in the strange language of a highly-paid lawyer. Such contracts have changed little in the last forty years, except for the addition of new paragraphs covering the new laws and regulations governing insurance, Medicare and Medicaid. In Texas, about five years ago, the State introduced a standardized "Physician Credentialing Application." It has helped by saving physicians from needing to complete a different form for every insurer with whom they contract. Prior to the use of this application, a physician contracting with insurers might have had to complete twenty different applications. The applications were about twenty pages long and required thirteen additional documents:

- (1) current resume, including work history (no gaps)
- (2) list of continuing medical education credits

- (3) copy of State Medical License
- (4) copy of current DEA certificate
- (5) copy of current DPS certificate
- (6) copy of current liability insurance face sheet
- (7) copy of current liability claims history
- (8) copy of medical board certification or eligibility
- (9) copy of medical school diploma
- (10) copy of residency certificate
- (11) copy of ECFME (if applicable)
- (12) copy of CLIA (if applicable)
- (13) completed and signed W-9 Form

The standardized application is still about twenty pages long and there are still thirteen proof documents, but at least the forms for these documents are now formatted the same. Most physicians now keep a current copy of their completed standardized application and the thirteen proof documents on file so that they can easily respond to new contracts. This process makes the job of our ACOs much easier as they are required to verify each physician's credentials for all of the contracted insurers.

The cost to each insurance company and hospital or their delegated agents to collect the information and to verify the credentials is about \$250 per year for every entity that does it. Sometimes they place this cost on the physician. Linked IPAs bears this cost in our provider contracts. It is a little contribution to reducing administrative costs in health care.

We have found a way to reorganize the contract between the ACO and the individual physician members so as to make it easier to read and to complete. We submitted the contract we wanted to use to each of the insurers that wanted to contract with our ACOs to make sure it contained the wording necessary to comply with current State and Federal laws and regulations. Also, we needed

assurance that it did not conflict with the agreement between **Linked IPAs** and the insurer. After we accomplished that step, we created a declarations page which was the only signature page needed for the provider's contract and contained the basic points of their agreement and the choice of which plans they would accept.

The full agreement was then put into a booklet form, including the required attachments. It is the same for every member. The physician keeps the booklet for his or her file and returns only the signed declarations page, the standardized application, and the thirteen proof documents. Some consultants who advise physicians have suggested that the physicians make changes to parts of the agreement, but it never happens except at the level of the agreement between **Linked IPAs** and the Health Plan.

From the Health Plan's point-of-view a practice with a hundred or more of their plan's members should not spend more than 75% of the premium for hospital and professional services. If more is spent, the Health Plan will consider it a loss and will decide that either the patient population is too sick or that the bad habits of the physician are the cause of the overuse of specialists and hospital services. If the plan cannot solve this problem in a short period of time, about three or four months, then they sometimes terminate the agreement with the practice. The physician is afforded some protection from this action by the ACO, but if the situation is the same with the majority of the ACO member physicians then the plan will terminate the ACO. This is back-end underwriting in a Health Plan that cannot refuse patient members for health reasons, but can cancel their physicians. The consequence of this termination is that the patient might not move to another new provider and will drop the Plan. Or, if the problem is the bad habits of the physician, then moving the patients to a new physician that has a "good" bottom line will accomplish even more for a profit-driven company.

This is old news to most physicians and accepted practice with some Health Plans. ACOs that are completely independent from the Health Plans and from the hospitals stand the best chance of avoiding the cancellations and fixing the problems. A reformed health care system must eliminate this practice and perhaps should do this by judging the physician within his or her team and based on patient outcomes and not only the bottom line. Sometimes patient populations are really unhealthy and the premium does not match the real costs. There is currently enough fat in the non-professional portions of the Medicare Advantage Health Plan premiums to offset most of the projected losses until real solutions are worked out. Under the new health care law the plans will have to pay 80% to 85% for the medical and hospital services or rebate to the patients. This means that the ACO should be able to more easily increase provider reimbursement and performance bonuses.

The addendum contains a sample "provider agreement" like I have been discussing above. There is no point in breaking this narrative to go into detail about each clause in that template agreement. I will say that in reading it and understanding it you gain some respect for the highly paid lawyers who are trying to describe the duties and responsibilities of the Health Plans, the physicians and their ACO organizations.



## **Chapter 3 Organization of the Physicians within the ACO**

This could be easy, or we may have deluded ourselves into thinking that we are fine because we have contracts with individual physicians and have made a roster for each hospital with each position covered by our hand-picked medical teams. We will not know what we have done until the really sick patients show up in the utilization reports and the physicians are sitting around the table with the Utilization Management (UM) nurses trying to figure out who did or did not do what was needed for the patients. We think we have picked the right hospitalists, and if the patients actually see them before the hospital's usual coverage system has put them into someone's care who is not on our team, we may be able to save the patient, the budget, and then create a real team. We have some extensive experience with having done this well in the past taking care of patients from Selectcare, Cigna, and Blue Cross, but a new start with a new HMO has to develop enough activity to check the teams again.

We could get lucky. Our teams from the past may, as I suggested in Chapter One, do their work without interference from the case managers who have been assigned by the hospital's accountants to maximize income and limit losses. The natural teams will be there when the patient is sent to the hospital and not too late, like on the next day. They will make the right decisions about what is wrong with the patient very quickly and will only admit a patient whose condition requires hospitalization. They absolutely will not admit a patient to the hospital unless there is no other alternative because of the risk of disease and injury in any hospital setting.

Our hospitalists have good relationships with the ER doctors. They have all of their consultants on the spot within hours, no delays until the next-day for Cardiology, Neurology, Gastroenterology, Orthopedics, etc. They try not to admit

patients to ICU who will not survive. They observe people and improve the diagnosis of the patient's problems. When they do admit a patient, they keep him or her until the problems are resolved and the hospitalization is no longer required. They prefer the Skilled Nursing Facility (SNF) in most cases, instead of the Long Term Acute Care facility (LTAC). They do not have a financial interest in the hospital, the SNF, or the LTAC. They plan the discharge of the patient and get them back to their PCP as soon as possible.

The key to the team having good outcomes is attention to detail and a profound respect for everyone who is helping the patient. The work is about suffering and mitigation of suffering in others. It is not a performance seeking an award. Teams engrave their trophies in still water and smile when they see that the water is quiet again.

The team physicians of Linked IPAs that we have known through observation of their work have had an extraordinary sense of responsibility in the care of their patients. We do not say this as if to worship professionalism, but we mean ordinary people do not care for other people with the same intensity and intimacy that these physicians have cared for their patients. This is a primary characteristic of someone who means to relieve suffering. Outside motivations in caring for patients, like money and fame, are bad character traits. The physicians who are "all about the money" or "all about recognition" should not be on any teams. They destroy the team and everyone on the team knows it as soon as you try to include them.

An insight into the right understanding of the practice of medicine has been written by Dr. Nassir Ghaemi, MD, who had this to say about himself and his peers:

"We doctors are not gods. Nor should we wish to be. The concept of medical godhead reflects a mistaken notion of medicine, in my view; I call it Galenic,

because it stems from the medical theory of Galen, which has seeped into our profession and our culture after two millennia of wide acceptance. This is the view that nature causes disease, and that the doctor fights nature to cure the disease. The doctor provides the cure: only a step is left to godhead.

The other view, long lost but deeply correct, I think, is the Hippocratic view of medicine: The idea here is that nature heals disease, as well as causes it, and the role of the doctor is to help nature in the healing process. The doctor is the not the central hero, but the handmaiden to nature. This does not mean that cure does not occur, but it occurs less than we think, and nature deserves the credit, not any human being. There is no room for doctor as god, and our purposes are more humble: to cure sometimes, to heal often, to console always.

Medicine is a complex affair; we frequently do not do justice to what our patients suffer and what they need. Pretending to know more than we do only makes matters worse. But being honest about what we do *not* know is not a sign of weakness....”

You can find the kinds of physicians that understand the nature of their practice and they can become a team. It has to be done if the ACO is to serve the needs of patients and operate within a budget dictated by government and business.



## **Chapter 4 Contracting with the insurance Companies**

Most of the major insurance companies that provide health insurance coverage through employer sponsored plans or through contracts with Medicare and Medicaid contract directly with individual practices for provision of medical services for their policyholders. They construct either "Preferred Provider Plans," or "HMO Plans" and very few "open access indemnity plans." They expect to spend 75% of their premiums on hospital and medical services (now raised to 85% by the new law), 15% on their overhead (reduced to 10% now), and 10% for their shareholders (reduced to 5% now) or for dividends for their policyholders if they are a mutual company. Many times they fail to reach their budget goals, but in the last five years under the Medicare and Medicaid Plans, they have been able to match the targeted percentages in each category. Under the new law they will have reduce marketing and sales costs and profits to reach their 85% medical loss ratio. Reducing or holding the line on payments to the health care providers will not give them more profits, but will lower the prices to the government and to the patients.

Contracting with individual practices is the safe way for insurance companies to limit the fees they will pay to physicians and to retain any of the surpluses they might accumulate. The companies fix fees by using Medicare approved rates as a basis, paying some percentage more or less than the Medicare rate. The range is from 80% of Medicare for diagnostic and surgical specialties to as much as 125% of Medicare for primary care. I have seen higher percentages offered through contracting networks controlled by the insurers, but they usually have a withhold clause of 20% and seldom, if ever, pay the withholds to the practices.

The large employer plans and the Medicare and Medicaid Plans cannot exclude individual patient members, but can limit coverage through higher deductibles and coinsurance. If these deductibles and coinsurance amounts are high

enough they can transfer bad debt to the practices too. However, generally, the insurance companies manage the financial risk by terminating physicians who have high risk patients or who are not taking part in the “utilization management” program of the company.

My conclusion is that having an individual contract between an insurance company and medical practice is just a stupid thing for a physician to do. Most of the physicians have known that for years and have formed Associations to do the contracting. It has worked to the advantage of the physicians in some cases and not in others. When the Association is very large, and connected to a hospital system or inspired by a medical association, it looks very much like a union to the insurance companies and to the Federal Trade Commission. Since big insurance seems to be connected at the hip with big government the “union looking” Associations have had many days in court for “de facto” price fixing and have lost and been told that they can only play the game if they are “at risk” with the insurance company so that the fees paid to the providers vary as utilization rises and falls.

The bitter pill in this scenario is that large Associations do not operate well as teams. To work well they would have to be broken up into in small groups that would exclude many of the member physicians from particular plans. In the large group mode they get their fees whacked, their withholds retained, and their administrative costs increased.

So, what will actually work? The answer is a physician team serving a specific patient population that is no greater than the team can actually manage at one or two hospitals. Linked IPAs’ physicians have decided that this is the kind of ACO they want, and have made contracts with insurance companies that are fair to both parties.

There is a temptation for physicians who form an ACO to want to be the capital stock insurance company and have it all. This has been done by many group medical practices already, but seldom, if ever, by an ACO. The capital requirements of operating even a modest Health Plan are astronomical. As an example, the ACO could have 20 PCPs and each of them could have 500 Medicare Patients to put into their own plan. That would mean 10,000 Medicare patients for the ACO. The premium in 2009 for 10,000 such patients from Medicare was \$120,000,000 per year. The reserve for that premium volume is \$30,000,000. The development cost for a Health Plan is \$2,000,000 and the minimum capital and surplus is \$2,000,000. That means you need at least \$34,000,000 to get into the game in a meaningful way and if you miss your targeted budget by more than 2% you may become impaired and you will need to ask Congress to bail you out, which they will never do because they are committed to Wall Street and the Banks, and modestly to the U.S. auto makers.

The better strategy is for the well organized medical team to contract to share the profits with the insurance company. It should be a well capitalized insurance company and should be willing and able to manage your financial risk because they need the ACO's help to make a profit for their shareholders or to make a dividend for their policyholders.

The numbers and percentages I am using are not peculiar to the health insurance business, but are typical of other types of casualty insurance. The target margins for marketing, sales, administration and profits are from 25% to 40% of the premiums. That means that the contract must call for full disclosure of all of the income and expenses in detail at every level. Individual physicians almost never get to see that detail and most Associations of physicians, large and small, don't get to look at the 15% to 20% that is taken from the top and called administration and marketing expenses. You can get that detail when you are working with public companies and you have a good accountant working for

the ACO. If you write a good contract and you deal with insurance company managers who respect the contracts they sign you can always get the details.

## Chapter 5 Enrollment of Patients

Such mistrust and nonsense surrounds the enrollments of patients into Medicare Advantage Plans that it is a wonder it happens at all. In spite of the benefits being far greater for patients enrolled in these plans than in their having Medicare alone or Medicare and a Medi-gap Policy, the Center for Medicare and Medicaid Services (CMS) restricts the time and the opportunities for patients to enroll and they scare away both the physicians and agents from telling eligible patients about the plans. The open enrollment periods for most patients is from November 15<sup>th</sup> through December 31<sup>st</sup>. This may change in 2011 to an even more restrictive time frame, perhaps beginning in October and ending on November 30<sup>th</sup>. Both times are three months less than the past rules allowed. The exceptions are for people who are just becoming eligible for Medicare, those who are in special needs programs, and those who are also eligible for Medicaid. Ninety percent of the eligible population has only the open enrollment periods to make a change to an MA Plan.

A simple comparison between Medicare Advantage with prescription drug coverage and Medicare with a supplemental drug and Medi-gap coverage is as follows:

	Medicare Advantage w/ Drugs	Medicare	Medicare Drugs	Medi-gap
Premium	\$0	\$ 96.40	\$26.50	\$275.00
Hospital Part A deductible	\$450	\$1,068		\$0
Part B deductible	\$0	\$ 135		
Part B Coinsurance	none	20%		\$0
Annual Deductible Drugs	\$0		\$ 295	
Coinsurance Drugs	none		25%	
Copay Drugs	\$0 - \$58			
Gap Coverage Drugs	Generic		none	

This is not a complete comparison, but if more were written in the chart then Medicare and the stand alone drug plans and the Medicare plus Prescription Drugs plus the Medi-gap would look even more expensive. What is being protected in not promoting the Medicare Advantage Plans more fairly is the private insurance industry that sells Prescription Drug Plans and Medi-gap plans. Also, Medicare Advantage Plans are mostly HMO plans and the freedom to choose any doctor or hospital that accepts Medicare is restricted in HMO plans to their contracted networks. That supposed benefit is entirely false in practice. Patients use a few physicians and these physicians are on staff at two or three hospitals and HMOs use the level of care they need and go outside of their networks to get it. Freedom to choose any physician in the Medicare system is merely an advertising gimmick used by many insurance companies who are trying to sell policies and sometimes by political pundits and politicians who oppose a universal health care system.

Patients who do not choose a Medicare Advantage Plan with Prescription Drugs will pay from \$4,000 to \$6,000 more a year for medical care in premiums, deductibles, and coinsurance. If you are old and don't get sick or hurt you may avoid the expense, but not for long. You are what is called a temporarily able-bodied person, a TAB. You have only avoided, for the moment, the first noble truth, "The world is full of suffering and stress." Of course, insurance is all about taking the gamble away and giving someone else the risk or "stress." Most of the people who discover what I am saying will want to save the \$4,000 to \$6,000 per year in a stress free way and still remain a TAB.

Only 10% to 15% of people who are eligible for the Medicare Advantage Plans have enrolled in them so far. In 2003 Congress increased the reimbursement to these types of plans so that the underwriting risk associated with them was greatly reduced. Congress did that in two ways: they increased the rate and they based the reimbursement on the morbidity of the population being served. There has been a hue and cry by some congressmen that this was done to line the

pockets of the insurance industry. That has happened, but the alternative was to line the pockets of the insurance industry that was not in the Medicare Advantage business and to deny patients needed coverage, to give them extra expenses, and to transfer more bad debt to physicians from noncollectable coinsurance and deductibles.

I have no expectation that the present and future Congresses and Administrations will do much to change the way people are insured or not insured, nor the reimbursement for medical services under Medicare or Medicare Advantage Plans, except to bring the fees closer to parity. They are paralyzed by their relationships to big financial institutions whether they are failures or successes. Everybody is in every game and they protect the activities that make them money; and they beg to transfer the activities that lose money to big bother. So far, all the big bothers all over the world support those transfers because they are the owner class or are owned by that class.

Since this chapter is about enrolling patients, you may think that I have gone mad and diverted my attention to the nonsense in Medicare and the madness of government. But, you cannot do enrollments or anything of much value unless you understand the world like it really is; The Right View, Number 1 in the eight-fold path to enlightenment.

I've called this Chapter, "Enrollment of Patients" because that is what we should be doing if we want the health care delivery system and the payment system to work even moderately well. What usually happens is that sales agents who are not known to the patients nor to the physicians sell a host of different policies to people they track down through every way they can imagine. They run through their family contacts first, then a few close friends, then the people at church, or at the clubs. Sometimes, the companies they represent send them lead cards gotten through print advertising. Regardless of the way contacts are made, the productivity is, on the average, very low; about one sale a day for those agents

who actually make a living selling insurance. This is bad news for the health care system because the patients and the agents must discover whether the patient's physician is with a particular plan that has the best benefits for the patient and the best commission for the agent and is available when the parties meet. The probability of all of that happening at once is very low, so what really happens is that sales aren't made, patients get plans that have the best commissions, patients get good plans but have to change doctors, patients get bad plans because that is where their doctor has a contract, or patients pay \$4,000 to \$6,000 more each year and say to themselves, "We are Americans, we deserve this nonsense. Our employers paid their representatives to do this for us."

Now, as you would expect, these agents have to have a license, have to have professional liability insurance, must be appointed by each company they represent, must have completed continuing education each year to keep their licenses. Yet, if they sell Medicare Advantage Plans, they must take added examinations, must be retrained on each plan each year, may not contact potential enrollees through door to door sales, nor by mass calling, nor by means that is not a direct referral from someone both parties know or is in the form of a written request from the potential enrollees that could have come as a response from mass advertising or attendance at an advertised meeting or from literature displayed in the physician's office. Physicians are prohibited from selling the Plans in their offices and from sharing patient information with either the companies or the agents. However, physicians can tell patients they have contracted with a plan and also tell patients how to reach an agent or get permission from the patient to have the agent contact them by phone. Physicians have little or no motivation to help in marketing in any way.

Since agents can sell all other types of insurance, including Medi-gap, without this long list of contact rules, it is easy to see why productivity could be low for this product. Thousands of agents are in every city, yet not many are willing to go through this extra nonsense to get a better deal for seniors and their

physicians. So, I think that the usual agency system is not the best way to enroll people in these kinds of Health Plans or any kind of reformed health care system.

All of this is a problem because we have an employer driven and government mismanaged non-health care system that a large percentage of the people cannot use even if they wanted to use it. All that ever happens when I think about this mess is the Ricky Nelson song lyric plays in my head over and again, "You can't please everyone, you just have to please yourself. " Consequently, I am driven to solutions that are limited to natural networks and voluntary associations.

About five years ago I met Henry Ospitia, a Columbian man from Florida who was a business consultant and Spanish language radio show host. He decided to get into the Medicare Advantage Sales business. He took one look at the insurance mess and said, "The people from top to bottom in this business don't know shit about what they are doing." Then he set up a system to prove that he knew what to do to enroll patients in a Medicare Advantage Plan. It was not a secret. It was not complicated. It was nothing like the way insurance agency systems work. Here is what he did:

1. He picked a market that he understood well and specific people to call – Hispanics.
2. He bought a computerized phone system with predictive dialers and a very good database management system (Other Agents and Companies did this too in the first years of Medicare Advantage Plans).
3. He hired people who were bilingual to talk to everyone who answered the phone. He trained these people in how to talk to people on a personal level and establish a trusting relationship with them.
4. He invited people to come to meetings where he gave them information that was valuable to their lives other than just the insurance products.

5. He then told the people who were eligible for Medicare about the benefits of just one Medicare Advantage Plan that he sold.
6. Normally agents sell 20 enrollments a month. Henry alone sold 150 the first month.
7. Henry then started training more people to do what he did. He paid them a salary. He gave them six appointments a day from his meetings and calls. Each salesperson produced 80-100 sales a month.
8. In less than a year Henry was responsible for more than 50% of the sales of the company he chose to represent. Now he does it for three companies in exclusive markets, however he can no longer use his calling systems. He has to do it through personal referrals from his existing client base.

Henry pleased himself. In 2009, when CMS changed the rules about calling people at random, he changed his company away from the Medicare products to products for patients in associations who get medical benefits from doctors and pharmacies for reduced cash prices. His associations are growing at a rate of two hundred members a week. They may pass a new law or regulation next year so that Henry and people who remember Ricky Nelson can't please themselves.

In the long lost past when these Medicare Plus-Choice Plans (as they were first called by CMS) began, some physicians and Health Plans got together and the physicians just told their patients they were only going to have that plan if they were a Medicare patient. (Kelsey-Seybold Clinic in Houston formed their on HMO MA-PD Plan in 2008 and they use this tactic now.) Then, if the patient wanted that physician's care and advice, he or she could join the blessed plan. It was and still is a very effective enrollment method. Usually, the HMO didn't use agents, but enrolled patients using salaried staff. When the numbers of physicians were few, and there was a risk-sharing agreement between the plan and the physician, the programs worked okay, but as the ambitions of the Health Plans and the physicians grew the numbers of physicians listed for the plans

became huge and the costs grew both administratively and medically. The bigger the network the looser the controls on administrative, hospital and diagnostic costs.

The plans tried to solve this utilization control problem by more automation and more detailed reporting of encounters between patients and medical and hospital providers. The doctors that moved their patients wholesale into a particular plan found that instead of making a profit they were paying the Health Plan for hospital and specialist costs beyond any network or facility they personally would have approved. All of this was before the 2003 rate increases and the change in reimbursement based on morbidity, but the experience among physicians was widespread and negative. Now, it is almost impossible to get one of those physicians to move all of his or her patients to a particular plan and take the risk of paying for the care.

What has changed besides the CMS payment amounts and methods is the risk bearing. It has been spread among more physicians, financed by the Health Plans and budgeted over longer time frames with stronger reserves set aside for potentially large claims. Also, it is not done unless there is a whole team of physicians working for a particular patient population and the patient's services can be kept within the team. I'm sure someone will show me another model, but that is the only one I've seen that works.

The point of this essay is about caring for patients and to do so means that resources must match the tasks. What I am going to suggest is something like E.B. White and William Strunk, Jr. advised in the Elements of Style, "avoid needless words." I think we should avoid needless help in the delivery of health care, in the enrollment of patients, and in the use of equipment and facilities, and, finally, in the system of government and regulation. As Henry has discovered; it is communication between the people who actually know how bodies and minds

work and the patients who are trying to learn for their own sake about the causes of their suffering and stress that sets up all of the member enrollments.

Let us assume that we taught a person how to read and to understand contracts between physicians and insurance companies, just as those contracts are presently being offered. Further, let us teach that same person “right speech” and “right actions” in the relationships with physicians and insurance company representatives and patients. Then, let us teach that person how to be a great operator of Electronic Medical Records systems, Medical Billing and Appointment Systems, and Internet Communications. They would be so good they could teach it to the physician’s staff. Finally, we would teach that person the Medicare Advantage Plans and the Commercial Insurance Plans and connect them to the licensed representatives of selected companies that the physician wanted to have under contract. Then, this carefully selected and fully trained person would become the consultant for ten physician’s offices. He or she would spend ½ day a week in each office and would handle all of the contracts with insurance companies, all of the contacts with their provider relations and sales representatives, all of the training for the EMR, Medical Billing, and Internet Communications system. The physician would commit to guarantee payment to the consultant of one tenth of the consultant’s salary per month, but whatever the consultant earned from the ACO administrative fees would be credited against the guaranteed payment. In about twelve months, if the physician were committed to having patients in the contracted plans the cost to the physician for the consultant would be Zero dollars.

This system could result in about 100 patient enrollments per year per physician’s office, or 1,000 enrollments linked to the consultant’s services and influence. That number is consistent with Henry’s production of 80 per month by his sales representatives. It has the advantage of also being better for the patient care and more likely to lead to a better plan for the patient. The

assumption is that the consultant will lead the physician to contract with the best plans for both the physician and his or her patients.



## **Chapter 6 Home Visits with Each of the Patients**

Suppose that you get people enrolled in plans that are economically good for the patients and good for the physicians. Further, suppose that the people in your organization get to know the patients well and that you all really do want to relieve suffering and stress. You can't do that through the mail or by phone. You can't sit quietly at your computer and crank out memos to members with full color pamphlets that have generalizations about the most common chronic diseases. That will not help anyone except yourself. It is unlikely the physicians will go meet patients at their homes, even though there are some exceptions to that. It is likely the majority of patients will make an appointment with their PCP, get a comprehensive examination, and get the advice and care they seek. This will not establish the kind of relationship needed to relieve suffering and stress compared to a personal visit to the patient's home. This is especially true for those who don't go to the doctor and, in our experience, that is about 20% of the patients.

I might not have considered a home visit by a nurse very important had we not contracted with XLHealth for our ACOs in Texas. They are a special needs program that was assigned 15,000 Medicare patients who had one or more of the following chronic diseases; Diabetes, COPD, Heart Disease, or End Stage Renal Disease. Their program was to see if frequent contact with these patients and close attention to their care and instructions would make a difference in the cost of their care and their medical outcomes. It did have a dramatic impact in both reducing costs and improving outcomes. Since CMS changed the way Plans were reimbursed to a morbidity model, after the study XLHealth decided to form an HMO, called, Care Improvement Plus, and to become a Special Needs Medicare Advantage Plan. They contracted with our ACOs for physician services and in October of 2006 they began contracting with agents to enroll patients into their new plan.

They had a list of 15,000 patients from their pilot project to convert to their Medicare Advantage Plan. I had the opportunity to go with three agents on sixty of these patient conversion visits. These patients were all very happy to have seen a nurse in their home several times over the prior year and still they had gone to doctor's offices routinely for examinations and treatments. The agents actually signed up more people for the new Special Needs Plan than were on the list of XLHealth. The spouse or another family member would also join, as soon as they realized they could get the same care as their family member had been getting under the pilot program. It seemed to me that the nurse's home visit and the attention of the company to the patient's particular problem was more important than their relationship to their primary care doctors. They were willing to join even if their doctor was not listed in the directory of the Plan.

XLHealth was so confident of their own medical delivery system that they did not pay much attention to which doctor the patient consulted. They still have an open panel approach to their delivery system, but they have now outgrown their ability to see every patient at home several times a year. They are becoming an insurance company instead of a medial care provider. However, the start for them showed that personal contact with the patient in the home does something positive that no other kind of contact can do. I think it relieves suffering and stress and loneliness and makes people well.

A summary of the Nurse Home Visit Program is:

I. Goals

A. Get in front of the hospitalizations with every patient

1. Determine who is at risk
2. What the risk is
3. What the PCP and consultants have done so far
4. What the PCPs and Consultants want to do
5. How we can use our medical and administrative capacities to assist the PCPs and Consultants

- B. Contact every patient in their home to get baseline information from them about their own health and their family support systems and do a comprehensive physical examination.
  - 1. Get the information we gather back to the PCPs and Consultants and the Health Plan in a pure form with as much relevant medical data and professional analysis as possible to assure that all coding of medical history is completed and up to date. The completed medical record and encounter data will be sent electronically to the Health Plan and the PCP and consultants. Anyone unable to receive the data electronically will get it in a standard printed format
  - 2. Connect the PCP's staff to this project for positive feedback and support
  - 3. Eliminate the social and economic barriers that are discovered and may negatively impact the health outcomes.

## II. Structure and Process

- A. Use the Nurse as a field contact with both Patients and PCPs and Consultants
- B. Support the Nurse with the Medical Director in the field and in the Clinic office to get expert guidance on the patient care and the proper analysis of the data gathered from patients and physicians.

## III. Form (see the attachment for the comprehensive form used in the field)

We have only used NPs in this program while other programs, such as the one done by XLHealth, have employed both RNs and LVNs in home visits. In our case, the Health Plans wanted a higher level of care and they wanted to be able to use the diagnostic information gathered by the NPs in their reports.

We provide the Nurses with MEDICs software to gather the patient examination and demographic information and we use the OpenEMR systems (Certified in 2011) to transmit that information to the physicians and insurers. Both systems

are HIPPA compliant and details about them are in the supporting document section of this book .

## Chapter 7 Delivery of Health Care Services

In the countries where access to medical and hospital services is easy the population is healthier and lives longer. Since we Americans are not yet among those countries that have easy access we rank low in the first world in health and longevity. That is a bitter pill for a proud people. However, the problem is about the whole population and not about the population of those who are fully insured. The group of physicians you reach out to may or may not be willing to serve those people in their community who are uninsured. In fact, they are often not willing to serve people who are insured by Medicaid. It seems to be more about class prejudice than money though it may also be that the Medicaid program is sometimes very difficult to use in terms of eligibility and payment. Of the 520 physicians in our ACOs we have about 350 who are willing to take Medicaid and far less who will take the uninsured on any terms other than cash up front for full billed charges – about twice or three times as much as they get from the insurers. Some physicians I know have always been open to everyone regardless of their ability to pay. Some patients who can't pay are difficult to serve and physicians get discouraged, but that's all about humility and humility is difficult to maintain by either physicians or patients.

The problem in the delivery of health care services for a new organization is the establishment of relationships between the physicians on the newly formed teams and the patients' desire to seek care and advice from the these teams. The relationship building begins with the home visit program I talked about in the last chapter because it gives the patient a sense of trust in people and specific directions about physician contacts. When all of the patients are contacted they will see the physicians an average of five times a year if they are over 65 and less times if they are younger. Five times may not be enough judging by what happens in Japan and in some countries in Europe, but it is the best average I've seen in this country.

There is some risk in getting medical care that patients will be hurt rather than helped. That risk is greater if the patient receives invasive procedures or is hospitalized. The statistics on this are appalling and reporting of them is avoided as much as possible in the press. However physicians and medical researchers have reported it in detail.

Gary Null *PhD*, Carolyn Dean *MD ND*, Martin Feldman *MD*, Debora Rasio *MD*, and Dorothy Smith *PhD* had this to say in an essay about the American medical system:

“A definitive review and close reading of medical peer-review journals, and government health statistics shows that American medicine frequently causes more harm than good. The number of people having in-hospital, adverse drug reactions (ADR) to prescribed medicine is 2.2 million. Dr. Richard Besser, of the CDC , in 1995, said the number of unnecessary antibiotics prescribed annually for viral infections was 20 million. Dr. Besser, in 2003, now refers to tens of millions of unnecessary antibiotics. The number of unnecessary medical and surgical procedures performed annually is 7.5 million. The number of people exposed to unnecessary hospitalization annually is 8.9 million. The total number of iatrogenic [induced inadvertently by a physician or surgeon or by medical treatment or diagnostic procedures] deaths is 783,936.

The 2001 heart disease annual death rate is 699,697; the annual cancer death rate is 553,251. It is evident that *the American medical system is the leading cause of death and injury in the United States.*”

## Chapter 8 Reporting Health Care Encounters

I actually object to this idea of reporting health care encounters as if I were a libertarian patient and the record were an infringement upon my liberty. It is, but I am resigned to cooperate with other people who regard this activity as a necessity. I am even somewhat humbled by the importance of the patient records kept by Dr. Paul Farmer in Haiti in so far as it has distinguished his work and helped relieve the suffering of others. The run-of-the-mill practice of encounter reporting in order to be paid by an insurance company I find to be corrupting. You cannot codify diagnosis and treatments without reducing the information you have discovered. Further, when you make the report the basis of payment, greed or sloth will influence what is recorded. The record will be corrupted and the greater the numbers of these reports the more corrupt the collection will become. A simple test is to ask a doctor who needs to see the medical record of a patient, if the encounter reports submitted to the insurance companies for claims will do. He or she should just laugh.

If you disconnect the compensation from the reporting, as in Dr. Farmer's case, you could get something of value to an epidemiologist. That is exactly what must be done in the ACO, the real medical records recorded in a real medical records system. While codification makes the record easier to sort and compare, it does not improve it. I don't have an alternative to my objection, I just want to know how inadequate the analysis is regardless of the coding. I recently watched a physician demonstrate his new Electronic Medical Records and Billing system. He had replaced one that had cost him \$40,000 with this new one that was just as costly, but enabled him to know exactly which diagnosis and procedure codes were going to be paid by the insurers at the highest rates. He could use a pick list to improve his presentation of the patient's problems and his services. That is what I mean by a corrupting system.