Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

Preparing Your Hospital for Managed Care

Robert T. Clarke

To cite this article: Robert T. Clarke (1995) Preparing Your Hospital for Managed Care, Oncology Issues, 10:2, 28-30, DOI: 10.1080/10463356.1995.11904532

To link to this article: https://doi.org/10.1080/10463356.1995.11904532

Preparing Your Hospital for Managed Care

by Robert T. Clarke

In the days since President Clinton assumed office, health reform is happening all around the country, but not Clinton style. Businesses and managed care plans have seized the initiative so that an intrusive government role seems unlikely, at least for the next several years. The private marketplace will now be guiding the evolution of health care, leaving the traditional role of the hospital in its wake.

According to 1993 health statistics, the majority of the population covered under managed care plans is enrolled in one of the nation's 556 HMOs. These HMOs represent 38.4 million covered lives. HMO plans have increased 2 percent over the past year. However, more significantly, total managed care enrollment for 1993 reached 45.2 million, reflecting a 9.2 percent increase over the previous year. Anticipated continued growth throughout 1994 was predicted to reach 50.2 million covered lives.[1]

Given these inevitable trends, hospitals need to prepare for managed care. In the past hospitals have had a reputation for being stagnant, attempting to preserve the status quo and increase inpatient use while criticizing alternative delivery systems. In today's environment, that's not unlike trying to swim upstream. What the savvy hospital should do is navigate downstream—adapt itself to the managed care environment.

Preparing a hospital for managed care requires a fundamental reassessment of both mission and vision on the part of its governing board, medical staff, management, and employees. "Elevating the health status" of a population will replace "caring for the sick." Being a part of an integrated comprehensive services delivery system will replace a stand-alone mentality.

Gordon Sprenger, chairman-elect of the American Hospital Association, noted in his inaugural address that hospitals have to give up power to become part of larger health care networks. A new relationship must be developed with physicians to give them a significant voice in developing the vision, strategies, and tactics that will affect them in the future. Without such a role, physicians are unlikely to cooperate.

VERTICAL INTEGRATION

When facing integration, a hospital may be wary of becoming *part* of the system when for so long it had been *all* of the system. Integration, however, appears to be inevitable; hospitals face either participation as partners or no participation at all. In its publication, *Vision of the Future*, The Governance Committee identifies four distinguishing attributes of the successful health system of the future: vertical integration, geographic coverage, the ability to manage capitation, and low cost. (The Governance Committee is a division of the Health Care Advisory Board based in Washington, D.C., which conducts custom and secondary research on leading edge health care issues on behalf of its members.)

A vertically integrated system includes not only a provider component consisting of primary care physicians, specialists, clinics, and comprehensive institutional services in all settings, but also the ability to accept risk or capitation. These systems often extend over broad geographic areas, thus positioning themselves to serve multisite employers in many markets under a single contract. The "power of one pen" is critical in managed care contracting.

Vertically integrated systems align hospital and physician incentives. A number of cost reduction advantages then result: Vertically integrated systems use 66 percent less hospital days, 40 percent less high-cost interventions, and 25 percent less specialist visits. The overall result is a 15 to 25 percent reduction in pricing, as reported by the Governance Committee.

Not all hospitals are prepared to make these changes, of course. The question is knowing when to act. The author is reminded of his ill-fated attempt to begin a hospital-sponsored HMO before the physicians were committed to utilization control and before area businesses were ready to take the labor relations risks of limiting their employees' access to providers. The lesson cost $5 million in two years.

Indicators suggest that a market move to managed care is imminent in light of excess hospital capacity, high per-employee health care costs, high inpatient utilization rates, disgruntled primary care physicians, purchaser concentration, and unhappy politicians.

To succeed in managed care, a hospital must know its market. If you find that your market is more than 25 percent penetrated by managed care and you have not started to prepare, it is probably too late.

A hospital's market assessment must include an awareness of who the managed care players are, what providers they have committed, and what number of lives they represent. Disease-focused managed care networks are a growing force, such as the Physician Reliance Network created over a year ago by doctors

(continued on page 30)

Robert T. Clarke is President and Chief Executive Officer, Memorial Health System, Springfield, Ill.

with the Texas Oncology Professional Association. Many larger hospitals have full-time staff assigned to monitor these developments.

THE RIGHT STEPS

A number of administrative or operational steps are essential if one is to be prepared for managed care:

- Develop a cost accounting system. Costs cannot be managed until they are known. A cost accounting system that identifies the costs of tests and routine care is essential.

- Initiate a clinical resource management program. One must be able to describe, monitor, and influence the patterns of care. Patterns of care need to be monitored across all sites of care, not just in the inpatient setting. Physician office care, subacute care, home care, and extended care all contribute to the total cost.

- Obtain physician commitment. Do not confuse those physicians who are philosophically ready to participate in resource management with those who actually accomplish it. Profiles should be developed for all physicians and physician groups, and the data shared with them. Physicians do not like being monitored by "outsiders," but most will cooperate when provided meaningful comparative data on their practice patterns.

- Provide education. Thriving in a managed care environment requires new talents. Understanding the intricacies of capitation and its reverse logic is not easy. A hospital's choices are to educate or recruit, and since knowledgeable people are in short supply and expensive, education may be the most cost-effective option.

This is perhaps the most exciting period in the evolution of health care delivery in this century. Hospitals will remain a critically important part of that system. Those who recognize that the hospital is only *one* part will be best positioned to deal with the future.

REFERENCES

[1] Office of the Department of Health & Human Services. *Health, United States, 1993*, compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC), 1994.

CAPITOL COMMENTS

(continued from page 6)

TRENTON

On December 23, 1993, Governor James Florio signed Senate Bill 1631 into law, which took effect in June 1994. This particular piece of legislation is broadly written and applies to all diseases.

ALBANY

New York became the second state with off-label drug legislation when Chapter 853 became effective on January 1, 1991. It applies to cancer drugs only.

RALEIGH

The legislature ratified Senate Bill 622 in July 1993. The bill took effect in October and applies to contracts entered into on or after January 1, 1994. It does not contain language requiring the use of peer-reviewed medical literature.

COLUMBUS

On May 11, 1994, Ohio Governor George Voinovich signed Senate Bill 157 into law. Effective August 10, 1994, the law dictates that no private insurer providing coverage for prescription drugs shall exclude coverage of any such cancer drug on the grounds that the off-label use of the drug has not been approved by the FDA for that indication, provided, however, that the drug is recognized for the treatment of such indication in one of the three compendia or in the medical literature.

OKLAHOMA CITY

On May 26, 1993, Governor David Walters signed into law Senate Bill 106, which included off-label drug language. It took effect on September 1, 1993.

PROVIDENCE

Effective July 12, 1994, Rhode Island law requires coverage of off-label indications of FDA-approved cancer drugs when the off-label use is recognized by one of the three compendia or in peer-reviewed medical literature as safe and effective.

In addition, Governor Bruce Sundlun formally signed S. 2623 into law on October 13, 1994. The law requires health insurers to provide coverage of new cancer therapies still under investigation. The law is limited to Phase III or IV clinical trials that have been approved by the NIH in cooperation with the NCI, CCOPs; the FDA in the form of an IND exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants. The proposed therapy must also have been reviewed and approved by a qualified institutional review board. The new law took effect on January 1, 1995, and sunsets on December 31, 1996.

RICHMOND

Effective July 1, 1994, Virginia law requires coverage of off-label indications of FDA-approved cancer drugs when the off-label use is recognized by one of the three compendia as safe and effective. The law was signed by Governor George Allen on April 6, 1994.

OLYMPIA

The Washington State Commissioner of Insurance, Deborah Senn, recently adopted administrative rules requiring Washington insurers to provide coverage of off-label uses of FDA-approved drugs when the use is recognized in one of the three compendia or in the peer-reviewed medical literature. The language of the rule, which has the force of law, has its roots in the ACCC model legislation. It became effective January 1, 1995.