Selective Chaos

An internist’s attempt to overcome the absurdity, for providers and patients, of managed care’s selective-contracting system.

by Thomas Bodenheimer

IN 1980 THREE OF US—two general internists and a nurse—started a private primary care medical office in a low-income San Francisco neighborhood. When we began, “managed care” was a policy-wonk expression that meant nothing to our fledgling practice.

As time went on, patients would call saying, “We’re sorry but we have to find a new doctor. Our employer has put us into Universe HMO [a fictitious name], and you are not on the provider list.” We quickly figured out that if we wanted patients, we’d better join Universe HMO. So we joined every health maintenance organization that ventured into the San Francisco market. Our practice grew. Two decades later we consist of three internists, four family practitioners, and a physician assistant.

Over the past twenty years many varieties of managed care have crossed our paths—full-risk capitation, multispecialty independent practice associations (IPAs), a primary care IPA, strict utilization review with preauthorization of prac-
tically everything, and practice profiles that embarrassingly list our average costs per member per month. We have watched as each small, local HMO has been swallowed up by large, national HMOs. We have contracted with one HMO that went bankrupt, and we left one IPA shortly before it went belly-up.

We have been paid capitation and fee-for-service. We have participated in bonus schemes for keeping costs down and bonus incentives for keeping quality up. We haven’t received many bonuses from either of these arrangements because many California IPAs are living on the edge of insolvency, making bonus payments a phantom behavior modifier.

The Bane Of Our Practice

MANAGED CARE SYSTEMS have a peculiar attribute that receives scant attention in the academic literature. That feature is selective contracting: the policy of HMOs and physician groups to contract specialty, ancillary, and hospital services to some service providers and to exclude others. If you are not a health care provider or an HMO enrollee, you might not recognize the importance of selective contracting in the lives of practitioners and patients. As primary care physicians with 60 percent of our patients in HMOs, for us selective contracting is a daily, hourly reality.

Selective contracting is common in managed care throughout the United States. It was created so that managed care plans could negotiate discount prices for physician, ancillary, and hospital services. Let’s say that a managed care plan has enrolled 100,000 people in one city. Physicians and hospitals in that city will accept lower fees to gain access to those 100,000 patients. Providers who do not agree to the discounts do not receive contracts and cannot care for these patients.

To understand the peculiarities of selective contracting in California, it is important to know that HMOs generally contract with physician groups (integrated medical groups or IPAs) rather than contracting directly with physicians, as is done in most states. The physician groups assume risk and are delegated the responsibility for creating a network of providers and for performing utilization review and quality improvement activities.
An Irrational Setup

As our patients increasingly came from HMOs, either through their employers or via Medicare, we became a largely managed care practice. By 1990 we were members of three different IPAs. Let’s call them Sun IPA, Moon IPA, and Star IPA, even though I never thought of them as heavenly bodies. One large California HMO routed its patients to us only through Star IPA. Patients from other large HMOs came to us through either Sun or Moon IPA, depending on which IPA the patient chose. (Patients enrolling in an HMO have to choose both an IPA and a primary care physician, even though most have no idea what an IPA is.) Thus, we would have Universe HMO patients from two IPAs, Galaxy HMO patients from two IPAs, and so on.

Belonging to three IPAs exposed us and our patients to selective contracting at its worst. Each IPA had its own list of specialists to whom we could refer. We might like a urologist in Sun IPA and an orthopedist in Moon IPA, but woe befall us if we sent a Sun patient to a Moon orthopedist. The orthopedist would not be paid, the patient would receive a bill, and the patient’s anger would (rightfully) be directed at us for sending him or her in the wrong direction.

Each of the three IPAs had different clinical laboratories to which we were required to send their patients. Failing to remember which lab belonged to which IPA had similar consequences to those of a faulty specialty referral; such errors often ended up in our paying the lab bill since the mistake was ours. Naturally, each lab had its own requisition form, with differently formulated panels of tests. Most problematic, the Sun IPA labs were located four miles from our office, while our Moon IPA patients could have their blood drawn two floors above us. How many times did we try to explain to patients—often elderly people without transportation—why they had to travel across town for a blood draw when they could get to a perfectly good laboratory with a ten-second elevator ride! There was no easy way to justify the situation, because it was absurd.

No one likes being on night call, especially when the two a.m. phone call starts like this: “Emergency Room speaking. Your patient Eduardo Rojas fell and hurt his arm and we want your authorization to see him.” Okay. That was bad enough. What made my blood boil was having to ask the ER nurse, “Is Mr. Rojas in Sun, Moon, or Star IPA?” I knew that if he was in Sun IPA, he was not supposed to go to...
that particular ER. The nurse, in this instance, didn’t know what an IPA was, and neither did Mr. Rojas. “Does he have his HMO card with him?” I asked (a question that should be an integral and early part of any medical history). Five minutes of bouncy on-hold music later, “He didn’t bring his card,” the nurse replied. “Go ahead and take care of him,” I said. “We’ll sort it out in the morning.”

“Sorry to call you back,” said the nurse cheerfully, forty minutes later. “Which orthopedist should we call for Mr. Rojas’s fractured wrist?” Who knows? I thought, as long as the orthopedist does a good job. “Any will do for now,” I said, and went back to sleep.

The next day our medical assistant made fourteen phone calls regarding Mr. Rojas’s wrist. Eventually, the patient had to see a different orthopedist from the one seen in the ER. Various authorization forms had to be filled out, requesting retroactive permission for out-of-network services.

Hospitalizations were similarly traumatic. If a Moon IPA enrollee was admitted to a Sun IPA hospital, a transfer to the “correct” hospital would have to be arranged. Although our office was in the same building as a hospital contracted with Star and Moon IPAs, we had to drive across town to make hospital visits to our Sun IPA patients.

Pharmacy services, which are usually contracted through HMOs rather than physician groups, also create difficulties. Take the case of Pauline and Louis Donato, an elderly couple with no family support. Both are barely ambulatory as a result of peripheral arterial disease and severe arthritis. Their health plan requires them to make a pharmacy visit each month to pick up their regular medications. Their HMO—a large Medicare managed care plan—recently canceled its contract with the pharmacy two blocks from their home. To obtain their monthly prescriptions from the newly contracted pharmacy, they are forced to ride two buses and walk four painful blocks.

Searching For Sanity

After several years in three IPAs we negotiated with Star IPA to transfer our patients to one of the other IPAs, to simplify our lives. A few years later we began to realize that Moon IPA, to which we had transferred our Star patients and from
which we received the majority of our patients, was becoming financially unstable. We had lived through one HMO bankruptcy and were not excited at the prospect of another insolvency. But the selective-contracting system held a noose around our necks: Moon IPA was unstable but at least permitted us to use the hospital, laboratory, x-ray, and specialists in the building where our office was located. Sun IPA, in contrast, appeared to be a more stable home for our 6,000 HMO patients; however, its contracted labs, x-ray, physical therapy, specialists, emergency room, and hospital were miles away. What should we do?

We opted for Sun IPA and informed Moon IPA that we were leaving, provoking an eerie combination of sweetness (“Stay with us and things will be better”) and anger (“We know your capitation check provides 50 percent of your income and we’re not sending it this month”). We informed the HMOs of our decision and requested that they shift our Moon IPA patients to Sun IPA. Most of the HMOs countered, “The patients belong to the IPA, not to you, so when you leave Moon IPA your patients are assigned to another Moon physician.”

Trying to maintain these patients took a year of laborious work; we contacted thousands of patients, requesting that they call their HMO (not an easy task) to ask that they stay with our medical practice but be transferred from Moon to Sun IPA. Bewildered but loyal, 80 percent of the patients made the switch. Little did they know that they “belonged” to their IPA (which most had never heard of)—not to their physician and certainly not to themselves.

Finally, all of our HMO patients were unified in one IPA. We were blessed with only one x-ray form, one lab requisition, and one set of preauthorization procedures. But this victory came at a steep price. The contracted specialists, hospital, and emergency room were still across town!

Does Anyone Think This Makes Sense?

Let’s pretend that 100 health care consultants are in a room. They are asked to devise a medical care system in which patients are not allowed to go to a good-quality laboratory two floors above their doctor’s office but have to drag themselves four miles across town to get their blood drawn. Every one of those consultants would say, “That’s a ridiculous idea.” Yet in
city after city across this country the architects of managed care—with its selective-contracting feature—have turned that ridiculous idea into reality.

What can be done to fix the dysfunctional selective contracting that permeates American managed care? Fragmentation of services is the principal feature of market pressures that drive managed care contracting. But one model of managed care doesn’t balkanize the delivery system: the traditional group/staff-model HMO. Kaiser Permanente plans and Group Health Cooperative of Puget Sound are examples of this model/solution. Patients enrolled in such systems receive all of their care through one organized entity, and physicians work with their colleagues in a unified system. Integrated group practice has a good record of controlling costs and enhancing quality. Although group/staff-model HMOs have been in existence since long before the market-driven HMO push of the past decade, they have been less popular recently because of patient-perceived limitations of the choice of physicians. Patients do have to select doctors from the medical roster of the group/staff HMO but should be able to choose among integrated care systems on the basis of quality and service. These systems provide all services in a rational and user-friendly fashion, in marked contrast to the current selective-contracting chaos.

Many physicians in the United States contract with several HMOs; many belong to several IPAs. Their reality—dealing with an irrational potpourri of multiple specialty panels, ancillary providers, and hospitals—mirrors the history of our primary care practice. Physicians’ complaints about managed care requirements to pre-authorize medical services are well known. But for our medical practice, authorization problems were dwarfed by the frustrations created by selective contracting.