Health Policy Report

Executives with White Coats — The Work and World View of Managed-Care Medical Directors

Second of Two Parts

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Part 1 of this article discussed the career paths of managed-care medical directors in both HMOs and provider organizations and described their work in the area of utilization management. In this second part, we resume the description of the work of medical directors.

Quality Improvement

Top-level medical directors spend a substantial proportion of their time on quality improvement. This activity has grown in importance as a result of the rise to prominence of the National Committee for Quality Assurance (NCQA) and its Health Plan Employer Data and Information Set (HEDIS). Many HMOs seek NCQA accreditation and strive to score high on the HEDIS measures of quality.[19] HMOs that delegate quality improvement to IPAs and medical groups can be successful only if these organizations pay attention to the HEDIS measures; thus, the medical directors of IPAs and medical groups must promote quality improvement in the areas measured by HEDIS in order to secure and retain HMO contracts.

Virtually all medical directors agree that preparing for NCQA accreditation and improving HEDIS scores are two of their top priorities. One HMO medical director noted that HMOs and physicians' organizations began paying much more attention to quality improvement after NCQA and employers began demanding data. He lamented, "Every ounce of energy is being diverted to HEDIS; not one ounce of energy is going to any other aspect of quality." Another medical director wondered whether it was worthwhile for a large HMO to spend the millions of dollars required to gain NCQA accreditation.

To achieve NCQA accreditation and improve HEDIS scores, some medical directors at HMOs that contract with individual physicians have introduced clinical score cards for each of their thousands of contracted physicians. For such HEDIS measures as the use of mammograms and Pap smears and the administration of beta-blockers after myocardial infarction, physicians may receive graphs showing their rates of adherence to HEDIS guidelines, their rates for the previous year, the average rate for the HMO, and the HMO's target rate. HMOs using the group-contracting model evaluate the performance of each medical group and IPA with which they have a contract rather than that of individual physicians.

Some medical directors have instituted quality-improvement projects not directly related to NCQA and HEDIS. The medical director of a California IPA, hoping to prevent some strokes, recently issued guidelines for handling symptoms suggestive of a transient ischemic attack. He told us he was motivated by concern for patients, though he realized that reduced costs could be a by-product of his efforts.

A medical director at a large national HMO, who spends 60 percent of his time on quality improvement, analyzed the effect of quality-improvement programs on 92 disorders, using such criteria as the effect on volume and cost of services, variability of practices among clinicians, and attractiveness of the program to the public. He eventually focused the company's quality-improvement efforts on five areas of clinical care: treatment of diabetes, treatment of congestive heart failure, care after myocardial infarction, treatment of depression, and women's and children's health. Because these quality-improvement initiatives cost money, they had to be approved by the organization's executive officers. In some cases, the HMO might be expected to save money as a result of these efforts, but in other cases, it might not. Because patients enrolled in the HMO one year may enroll in a different HMO the next year, the first HMO might incur the costs of preventive care, whereas the second HMO might realize the savings.

Another medical director we interviewed, who was responsible for Medicare enrollees in an HMO, introduced a project to teach primary care physicians how to perform efficient yet meaningful geriatric assessment. This project had substantial initial costs, and the anticipated savings to the HMO were likely to be realized only several years later. The same medical director was responsible for keeping the costs of care for Medicare enrollees below budget, a stressful task not necessarily compatible with his efforts at quality improvement. Though the medical directors we interviewed generally believe that quality and cost reduction go hand in hand, short-term budgetary requirements often belie this belief.

Budgeting

The budgets of managed-care organizations are largely determined by the number of enrollees multiplied by the premium paid for each enrollee. In both HMOs and provider organizations, medical direc-

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tors have major responsibilities for preparing and adhering to budgets.

One key budgetary decision involves the relative percentage of the organization's income that will be spent on medical services (the so-called medical loss ratio) as opposed to that spent on administrative costs. Some chief medical officers of HMOs consider themselves advocates for greater spending on medical services. Chief medical officers often propose to the organization's executive officers how the medical-services portion of the budget should be spent. Final decisions are generally made by the executive officers rather than by the medical directors, though the decision may be reached through consensus.

Some medical directors complain that although they are responsible for budgets, many key budgetary decisions are made in other parts of the organization. Perhaps the single largest budgetary item is the capitation payment or schedule of fees paid to hospitals and physicians (or in the group-contracting model, the capitation payment to medical groups and IPAs). These rates are often set by the organization's contracting department and chief financial officer and are not under the control of the chief medical officer.

Preparing the budget is easier than adhering to it. Medical directors report periodically to their organizations' executive officers whether monthly expenditures are exceeding the budget, and if so, why. Budgetary pressures can be intense. Alan R. Zwerner explained in an interview, "On the one hand, purchasers want to pay you less. On the other hand, there is a never-ending battle against pharmacy cost increases, new technologies, an aging population, demanding baby boomers, and the managed-care backlash."

Budgets may be decentralized in large organizations, with regional leaders given latitude in making decisions about expenditures as long as they do not exceed their budgets. Medical directors view the move toward managed care as prompted by the recognition that physicians must learn to provide medical care within a budget.

Creating and Maintaining the Network

HMOs rely on networks of physicians, hospitals, pharmacies, providers of ancillary services, and home care agencies to provide services to their enrollees. A major function of medical directors is to help create and maintain these networks, especially the physician component. For example, Aetna U.S. Healthcare, which usually contracts with individual physicians rather than with medical groups or IPAs, has regional medical directors who are responsible for the network of physicians in the assigned region.

One of the network medical directors reported that he spends 50 percent of his time visiting primary care offices, 20 percent visiting specialists, and 30 percent performing administrative work, including checking credentials and solving problems for the 750 physicians in his network. When the HMO was smaller, the medical director could visit each primary care office annually; now he concentrates on visiting large practices, "problem physicians," and specialists who provide a high volume of services. During these visits, the medical director explains the way the HMO pays physicians and discusses the utilization, quality, and patient-satisfaction scores received by the physicians.

Medical directors generally have the authority to terminate contracts with physicians, medical groups, or IPAs. They claim that contracts with physicians are rarely terminated, and almost never for reasons of cost. In a study by Bindman et al., about 20 percent of primary care physicians interviewed in California reported that they had had a contract with at least one health plan that had not been renewed, but the reasons for the termination were not explored in the study.[20]

Evaluating Physicians' Performance

Many primary care physicians periodically receive data (profiles or score cards) on their practice patterns from the managed-care organizations of which they are members. Profiles may include data on costs (both the total cost per enrolled patient per month and the cost of referrals to specialists), quality (e.g., the percentage of eligible women screened with the use of mammography or PAP smears and the percentage of patients with diabetes who undergo annual eye examinations), and patient satisfaction. The accuracy of these profiles has become a controversial issue in managed care.[21]

Chief medical officers are heavily involved in deciding which practice patterns to include in the profiles. As HEDIS measures have grown in importance, a number of medical directors have discontinued cost profiles (which may not include adequate adjustment for risk) and have upgraded measures of quality and patient satisfaction, whereas others continue to use cost data, in addition to data on quality and patient satisfaction.

Reviewing profiles for thousands of physicians in a network is an impossible job. The medical directors of individual-contracting HMOs focus on physicians with very high or very low costs or low scores on measures of quality and patient satisfaction. The medical directors of group-contracting HMOs review the profiles of IPAs and medical groups. In both models, outliers may be counseled, penalized financially, or possibly removed from the network. The medical director of Harvard Vanguard Medical Associates studies profiles indicating the quality of care at the group's clinical sites and determines how to make improvements at sites where the quality is deficient. A Health Net regional medical director studies the cost and quality profiles of the IPAs and medical groups in the region and focuses utilization management on groups with rising numbers of hospital days per 1000 enrollees or other specific measures of high cost or low quality.

Paying Physicians

The job descriptions of most medical directors are not limited to overseeing clinical activities. Especially at higher levels of the organization, medical directors also participate in formulating corporate strategy. One link between these two components is the method of compensating physicians. Medical directors, along with corporate financial officers, decide whether primary care physicians and specialists will be paid on the basis of capitation, by fee-for-service mechanisms, with bonus incentives tied to cost or quality profiles, or by a combination of these payment methods. In group-contracting HMOs, the medical directors help decide how IPAs and medical groups are paid; payment might involve capitation based entirely on a percentage of the premium received by the HMO or might include rewards for low cost scores and high quality scores. The medical directors of medical groups and IPAs help decide how the physicians in their organizations should be paid, a process that is often highly contentious. As a medical director of a physicians' group said recently in an interview, "We have three systems of compensation: the one we used last year, the one we are using this year, and the one we will use next year."

Working with Customers and Regulators

Chief medical officers and regional medical directors often act as spokespeople for their HMOs. They may spend up to a third of their time in this activity, marketing the health plan to large employers, speaking with the press, and interacting with regulatory bodies such as the Health Care Financing Administration, state agencies, and the NCQA.

Putting out Fires

All organizations have crises, and managed care is no exception. Malpractice suits, major financial losses requiring cutbacks in services, and bankruptcies of medical groups under contract periodically make substantial and unpredictable demands on medical directors' time.

Policy Decisions

Medical directors may initiate or respond to discussions about policy in their organizations. Should the requirement that primary care physicians authorize referrals to specialists be eliminated in favor of giving patients direct access to specialists? Should hospitalized patients be cared for by hospitalist physicians? Should the health plan cover prescriptions for sildenafil (Viagra) or contraceptive pills? Are programs for the management of chronic diseases worthwhile, and if so, should they be developed in house or contracted to other companies?

HOW ARE MEDICAL DIRECTORS PAID?

In 1997–1998, chief medical officers in managed care, on average, earned $203,000.[22] Almost all the medical directors we interviewed were paid a salary plus a performance bonus. The specific criteria for calculating bonuses varied, but most bonuses had two parts: one part was based on the overall financial performance of the organization; the other was based on the medical director's achievement of specific objectives set by the supervising executive. The medical directors we interviewed reported that their bonuses were not directly tied to measures of utilization such as the number of medical procedures denied or the number of hospital days per 1000 enrollees. In the case of a medical director responsible for achieving accreditation from the NCQA, the bonus was tied to achieving that goal. Bonuses received by medical directors who were responsible for quality improvement were often related to an improvement in HEDIS scores.

The company's overall financial performance accounted for 30 percent of a typical bonus, and the medical director's performance in relation to specific objectives accounted for 70 percent. Meeting target objectives might lead to a bonus that approximated 20 percent of the medical director's salary; exceeding the objectives could result in a bonus amounting to 50 percent of the salary. All the medical directors we interviewed downplayed the influence of the performance bonus on their decision making and stated that they never denied appropriate medical services on the basis of their own or the organization's financial interests. The general view was that if they denied a needed service, the denial would do harm to the organization in the form of a lawsuit, bad publicity, or both.

Medical directors argue that few medical services are actually denied in managed care. However, 87 percent of the physicians surveyed in 1999 by the Kaiser Family Foundation and Harvard School of Public Health stated that their patients had been denied some type of service by a health plan in the previous two years.[23]

TWO VIEWS OF MEDICAL DIRECTORS

Many physicians view medical directors, especially medical directors of HMOs, as doing little more than micromanaging care — making clinical decisions about patients whom they have never examined and assisting corporate executives in controlling costs at the expense of patients. According to this view, medical directors have abandoned their white coats in favor of suits. Medical directors themselves hold quite a different view. They believe they can improve the quality of care for entire populations of patients while restraining the use of unnecessary, costly, and possibly harmful services. For them, the distinction between the suit and the white coat is negligible.

Medical directors share the following set of beliefs, many of which are grounded in well-known findings from studies of health services. First, there is great

geographic variation in the practice patterns of physicians, and some practice patterns are better than others. In the area of acute care, particularly among specialists, there is a strong tendency to provide unnecessary diagnostic and treatment services. Managed care should eliminate or at least reduce this variation, especially by curbing overtreatment, and should strive for the highest standards of practice. In the words of a medical director of a West Coast HMO, "My job is rationalizing health care from a cottage industry with too much variation, bringing discipline and systems to providers of care."

Second, there is no fundamental conflict between the needs of patients in managed-care organizations and the financial concerns of the organizations, because high-quality care generally costs less than low-quality care.

Third, in the areas of preventive care and management of chronic diseases, undertreatment is common, and physicians should be encouraged to improve their practices. Over time, better care in these areas saves money.

Fourth, if physicians are made aware of how their practices compare with those of their peers, care can be improved. It is therefore important to provide physicians with data on utilization and quality measures.

Fifth, health care in the United States costs too much, and the gap between the demand for services on the part of individuals and the fiscal resources of society is growing. Patients should receive only the services they actually need, not any service they demand. If no effort is made to achieve a balance between individuals' interests and those of society, a crisis will ensue. Managed-care medical directors believe they can promote this balance.

Sixth, managed-care organizations — whether for profit or not for profit — operate within fixed budgets, and conflicts over how money should be spent are inevitable. Medical directors act as advocates for patients, arguing that as much of the budget as possible should benefit patients rather than stockholders, executives, pharmaceutical companies, highly paid specialists, or other recipients of managed-care dollars.

Finally, medical directors have a broad perspective on medical care in America, rather than the narrower perspective based on individual encounters with patients. As the medical director of a large IPA put it, "I wield the biggest stethoscope in America."

In contrast with medical directors' beliefs about their role, the mass media, the public, and many practicing physicians blame them for what they see as the evils of commercial managed care. This view has been expressed by Linda Peeno, formerly a medical director of an HMO:

> I started this new career full of enthusiasm and plans for being part of positive changes in health care. But what I found was that the pressure was always there: Deny as much care as possible in order to cut costs. . . . We were removed from the bedside of patients, distanced from their pain, anxiety, fear, confusion. . . . We no longer looked them in the eye, touched their skin, heard their complaints. . . . Our job was to manage care, and simply put, that meant we had to keep the costs of care as low as possible.[24]

In her 1996 testimony before the House Subcommittee on Health and Environment, Dr. Peeno stated, "I wish to begin by making a public confession. In the spring of 1987, as a physician [medical director], I caused the death of a man [by denying a heart transplant]. . . . I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was 'rewarded' for this."[14]

CONCLUSIONS

How can two such diametrically opposed views of the work of medical directors persist? Definitive data are not available to answer this question. Inappropriate denial of care may be most likely in HMOs, medical groups, and IPAs that are new and small and that therefore lack both concern about their brand name and organizational decision-making processes and structures that make the denial of care a collective enterprise.

The two opposing views reflect inherent conflicts in the role of medical directors — between the desires of patients and physicians, on the one hand, and the financial profit or survival of the organization, on the other, and between the unlimited demands of individual patients and the limited resources of society. In an effort to resolve these conflicts, medical directors have developed an ideology centered on the belief that high-quality care is less expensive than care of lower quality. However, they also realize that, at least in the short term, this is not necessarily true.

There is as yet no consensus on the part of the medical community or the general public about how to balance the interests of individual patients with the need for cost containment. Until such a consensus is reached, medical directors, who are charged with the politically taboo task of rationing care, may continue to be unpopular with many patients and physicians.

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