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Too Many Cooks in the Kitchen
(The Unlicensed Practice of Medicine)

by John Ford, CEO Prime Care Managers

Before anyone from the insurance sector reads this paper, you need to know I was an HMO executive for several years operating a successful portfolio of Senior Care Products. Before that I was the corporate benefits managers for a Fortune 500 ERISA plan.

When I was in the HMO industry, we struggled with the best way to progress a cost containment agenda using physicians, or a subset of physicians, to better coordinate care and use measurement tools to benchmark their quality initiatives. In my personal experience we went so far as to employ and brand our own primary care physicians as affiliates to the HMO. In short, we disbanded this strategy due to the operating losses associated by trying to convince our members our HMO doctors were the good guys. Another reason was our lack of appreciation for what was involved in running a successful primary care practice; an immersion into "blue collar" hard work. This boots on the ground experience is what fostered a vision for a better type of partnership.

In my experience, the most acceptable and favorable model for both HMO and physician took place in markets with high levels of physician engagement and a common belief that together we could best achieve the value goal. Yes there were significant differences in our approaches and points of view over medical necessity, utilization standards, delegation of case management, and so on. But in the end, both sides won. Physicians were allowed to keep their dignity and maintain their patient relationships and the HMO was able to grow to market dominance. Lower premiums and happier patients – it was beautiful to watch.

I have watched insurance companies migrate back and fourth with varying attempts at containing costs, some with and some without the cooperation of physicians. Insurance has aggressive tactics, using membership leverage to set fees and force their will and standards of care to the point of practicing medicine. Physicians and health systems then consolidate as a reactionary attempt to bring some balance and control back to their side.

Now, insurance companies are breaking new ground. Perhaps frustrated by attempts, on how to better utilize physicians as partners, they are requesting in depth medical records to "meet HEDIS or better reflect risk scores." Beyond presumed use of the medical record,

insurance companies are compiling more detailed medical histories to upscale their own execution of orders without physician consent or notification. Insurance companies are now transformatively close to calling their members, their patients.

On numerous occasions our physicians have discovered monitors, nurse home visits, specialty referrals, home health orders and prescriptions authorized directly by an insurance company with no communication or correspondence before, during or after the services were rendered. In some instances, the change in care order was life threatening.

I have never in my years of working in the health industry felt more intrusion by insurance intervention in the primary care space than today. There is no doubt in my mind the National Associations of Family Practice and Internal Medicine should be raising it's full attention to this threat to its members. I believe it should not be soft peddled. It is a blatant disregard for the primary care physician's broad role in the continuum of care.

As Secretary Burwell mentions in her outgoing statement ***Building A System That Works: The Future of Health Care*** on December 12, 2016, the PCP is central to the reform agenda. They have realized that "direct" alignment with the PCP and the funding of our efforts, to build coordinated organizations of PCPs, is the optimum business model to reshape the delivery system.

However, amongst insurance companies, I never thought I would see such a blatant disregard for the PCP by insurance companies. In their desperation, they are delegitimizing and bypassing the PCP. For years insurance has preyed upon primary care individuals with deep and disabling fee cuts. To exacerbate the situation, after the cuts, they significantly increased management responsibility with no consideration of reimbursement. Once they depleted our base, they become frustrated by our lack of energy and ability to deliver the infrastructure as care coordinators. How was this ever to be funded, or ever even had a chance to succeed during such lean times?

Contrarily, CMS is funding the PCP ambition with new revenue which puts the PCP directly in charge of community lead care across the country. But Insurance is consolidating, pulling in the tent stakes of collaboration with PCPs. They are moving full steam ahead with a non-community strategy, utilizing their proprietary data, transformed by informatics to generate alternative care plans. These care plans create clinical interventions and work orders to manage care from a corporate office, utilizing a team of field nurses and virtual caregivers. In the process, they are eliminating a more expensive layer of labor costs by

becoming leaner networks without having to compensate the physician.

Make no mistake; this is not just about managing networks with third party utilization review or case management of old. It is now about real clinical care intervention. Insurance is graduating beyond claim data to engaging in real-time clinical chart data, building their corporate database and staffing their own interventional strategies. Coordinating with the patient's PCP is of secondary concern and rapidly becoming a distant burden.

Finally, there is the patient. Let's not forget the patient who is last aware of this looming contradiction to traditional forms of medicine. Patients still believe third party insurance is acting in step with their doctor, the very doctor who is educated and licensed to evaluate complex medical conditions at a relational level. These relationships are a factor of several years of evaluating and personalizing solutions to an individual. Who can argue that when it comes to a person's health, hands-on care is the best care by those who are trained for that purpose?

I am not saying, primary care has evolved it's informatics layer to the fullest or that cultures can change overnight. After all, how could they, when physicians are overwhelmed in a "per click" trance of the everyday diagnosis and treatment. But if insurance would value and promote primary care change, these investments will lead to the best and ultimate care model combining both the art and science of medicine. Insurance companies need to be patient and seek out partnerships of organized and engaged primary care physician groups not vested in bricks and mortar. Real and lasting change comes with engaged physicians, one community at a time, to create a legacy that drives the highest value opportunity in its marketplace. By returning to partnerships with more open dialogue, communication and a common build strategy, I know it can work. I have seen it work.

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