North Coast Physician

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MediCal Managed Care

Emily Dalton, M.D.

I thought if I wrote about "Medi-Cal Managed Care" that my readership may run screaming in the opposite direction. But hey, what is life without risk? Anyway, look at this--you're still here. Kudos to you for your determination and tenacity. Here we go:

CAPITATION

In 2013 California decided to change the way Medi-Cal reimburses primary care providers from fee for service to capitation [1,2] . Lots of private insurance Health Maintenance Organizations (HMO's) also reimburse under this model. For those of you lucky enough not to understand capitation, here's the quick and dirty: Traditionally physicians have been paid a set amount for each service rendered: aptly named fee-for service. Under capitation, a physician is assigned a number of patients and gets paid a monthly fee, generally a few dollars per patient per month (PPPM), regardless of whether the patient receives services or not. In theory, this is supposed to motivate physicians to keep their patients healthy, so patients won't come to the doctor often, and in that way the doctor can earn a good income with a reasonable workload. In practice, this can motivate doctors to "cherry pick" healthier patients, and to provide services that require the least amount of effort. In addition, capitation supposes that not going to the doctor promotes good health and I am not sure that makes sense. How are physicians supposed to influence patients to make healthy choices if we don't interact with them frequently? In fact, the whole premise of capitation relies on several very sketchy suppositions.

CAPITATION IS BASED ON ERRONEOUS ASSUMPTIONS

Flawed Assumption Number 1 :

Physicians have control over their patients and can influence their behavior. Ha! I just want to run laughing all the way to the bank over that one. Who in their right mind thinks that a doctor has more influence over a patient's lifestyle choices than culture, hedonism, advertising, habit, addictions, ingrained behavior patterns, finances etc.? It's not like I can lock my patients in the dungeon below my office and force them to eat raw kale while chained to a moving treadmill. (Now there's an idea--is there a HEDIS *(Healthcare Effectiveness Data and Information Set)* measure for that?) The idea that a primary care provider could wave a magic wand over his or her 800 assigned patients and chant "stay healthy" and somehow this could be an effective health strategy is outright delusional. Too many variables are involved over which the doctor has no control. *Capitation cannot be justified with the premise that physicians have substantial control over their patient's lifestyles* .

Flawed Assumption number 2 :

The other assumption, which none of us like to think about, is that *capitation is correcting a problem* . The presupposition goes like this: there is a serious, costly problem that is raising the cost of health care, and at the root of this problem are bad doctors . These corrupt and bad doctors see patients that don't really need to be seen, do unnecessary procedures and make money off their evil actions. Under capitation, these bad doctors are no longer motivated to do these unnecessary encounters and procedures, and subsequently costs will go down. Are any alarm bells going off for you about now? Does it seem reasonable to assume that there is so much corruption in the system that a substantial amount of money can be saved by changing the reimbursement infrastructure for everyone? Are there really so many bad players out there? At any rate, if there are so many bad doctors with questionable practices, isn't it logical that that they could wreak at least as much havoc with their bad behavior under capitation? Or worse? Capitation assumes that doctors will be good and see patients when necessary even though they don't get paid more. For a capitated system to work, doctors have to be really, really good. *Therefore it is illogical to to justify capitation with the bad doctor premise* .

As physicians we can't win. On the one hand we are viewed as unethical, money grubbing, unnecessary-procedure-performing money hungry animals, and on the other we are hard working saintly creatures who will go the extra mile and provide excellent service even when we get paid identically for the bare minimum.*

Flawed Assumption 3 :

Patients who access less medical care are healthier. WRONG, I say. Influencing a patient's lifestyle choices is labor intensive. Can policy makers really believe that less contact with health care providers results in better health? Programs to quit smoking rely heavily on frequent meetings, and intensive therapy. The physicians I know of

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SOMETHING ON YOUR MIND? WANT TO SHARE YOUR THOUGHTS WITH YOUR COLLEAGUES? PLEASE SEND THOSE THOUGHTS FOR PUBLICATION IN THE NORTH COAST PHYSICIAN OR IF YOU'RE INSECURE ABOUT YOUR ABILITY TO WRITE - LET US HELP YOU.

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who promote healthy eating and nutrition spend countless hours with their patients, educating and motivating them. They host seminars, provide cookbooks, set up interactive websites, and perform frequent consultations. None of them do this on a $2 per member per month stipend. Most take cash and work to some degree outside the standard medical establishment. Do you think Dean Ornish M.D. met with president Clinton just once or twice? I don't know this for a fact, but I imagine the transformation from a fast-food eating, dessert -loving pudgy atherosclerotic former president to the vegetable loving skinny vegan you see today took more than 3$ PPPM.

Capitation cannot be justified on the premise that less medical care results in better health.

Flawed Assumption Number 4:

Physicians are good, moral professionals who will continue to see patients and provide excellent care even though we get paid exactly the same if we put in the bare minimum of effort. While I like to think that most doctors are good, moral people, the key word here is people . Most of us go to work for the paycheck: Is there something wrong with that? Many of us also do volunteer work, but when we go to our jobs we expect to paid for our work. That's the agreed upon social contract.

Besides, why are we the only ones in the game who are expected to uphold moral and ethical standards to our personal detriment? The insurance industry is full of lying, cheating, double-talking extortionists who think nothing of holding your very life hostage in return for profit. I'll take a transaction with a drug dealer any day of the week over trying to deal with one of the major insurance companies.

Capitation cannot be justified by claiming that physicians are good, reliable workhorses who will always do right by their patients regardless of the financial incentives.

California Capitates Medi-Cal

While the fee for service system has problems, capitation also has flaws that are equal and opposite in nature. I find it puzzling that the State of California was determined to convert MediCal to a managed care system, but they did. In 2013 the State handed over the administration of Medi-Cal to a variety of county-based managed care organizations. Most of these pay based on a capitation system.

In the northern counties we have been experiencing crazy layering upon crazy. Here's what happened. The Department of Health Care Services (DHCS) knew implementation of such a drastic change could be fraught with problems. Would capitation grossly underpay the clinics compared to fee for service? Would it pay more? No one really knew for sure. Additionally there was a roadblock on the path to capitation. The Federal government has 2 HUGE, vitally important programs that help pay for Medicaid visits--the system of Federally Qualified Health Centers (FQHC), and the Rural Health Clinic (RHC) program. These organizations are paid on a payment-per-encounter basis or "all inclusive rate". Fully capitating Medical could leave federal money on the table, so the DHCS decided on a hybrid approach. After clinics received their capitated rate, they would also be allowed to bill a "Code 18 wrap around" fee so that they would be sure to collect the maximum allowed by whichever federal program they participated in.

Capitation starts to sink the small, independently owned rural health clinics

I think that the State must have thought that capitation would dramatically underpay clinics, because many rural health clinics were advised to bill an additional $35-45 fee for each patient seen. The problem is, no one knew what the right amount to collect ought to be, and the whole new system would have to run for 12-24 months before anyone would know for sure what the right amount would be. It was utter chaos for awhile. Some clinics missed the memo about the Code 18 money, and went grossly underpaid. Others may have estimated correctly and come out even. I believe the majority of rural health clinics overestimated the code 18 amount and got overpaid, but were not billed for 1,2, or even 3 years. By then, the amount owed was staggering, and many had so much debt that they shuttered their doors and could not continue operating. As one of the office managers I spoke with said : "They were supposed to make us whole, not put us in the hole". This problem played a role in the closure of three of our local rural health clinics-- Humboldt Medical Group, Olkin and Jones and Redwood Family Practice, and continues to cause significant hardship for many of the remaining rural health clinics in the area. Bill Finerfrock, executive director for the national association of rural health clinics said that Washington State had a similar problem that resulted in the closure of many of their rural health clinics. In fact, his organization had been lobbying the Centers for Medicare & Medicaid Services (CMS) for rules to better protect rural health clinics. I spoke with Gail Nickerson, president of the California Association of Rural Health clinics who bemoaned the fact that reimbursement is no longer based on a cost basis. The original idea was to pay clinics based on their costs, not to bankrupt them with debts. How far things have come. I was not able to get a comment from Partnership about this issue-no one would return my calls.

Rural Health clinics represent an ideal public-private partnership that allowed physicians a balance of aid and autonomy; support with independence. It's wrong that small independent rural health clinics are dropping like flies with little notice or outcry. Join me in a moment to mourn this loss.

"MediCal", Continued Next Page

"MediCal", Continued ....

A Hybrid System with a mix of capitation, fee for service and all inclusive payments is confusing

At any rate, I don't see how a system can reap the purported benefits of capitation in a hybrid system. Physicians are getting so many mixed messages from such a variety of contradicting programs that we are ready to tear our hair out. My HMO patients are fully capitated and we get paid the same whether we talk on the phone, do an office encounter, or converse in an email. In order to be reimbursed for my patients on regular private insurance, they must come in for an office visit. Our MediCal patients are in the twilight zone--we get paid capitation fee whether we see them or not, but then we get paid some more if we do an office visit. I'm not sure this mish mash makes any sense at all, and if all this chaos is supposed to motivate my behavior in some way that has been lost on me. All this makes me want to do is come to a dizzied halt and cover my ears.

*(The policy wonks did think of this, and their woefully inadequate solution to to keep us motivated is through quality bonuses--but that is another topic altogether--see "QIP...or is it?", North Coast Physician, January 2017)

1. Medi-Cal Managed Care: An Overview and Key issues. Margaret Tater, Julia Paradise, and Rachel Garfield, The Kaiser Commission on Medicaid and the Uninsured March 2016

2. On the Frontier: Medi-Cal Brings Managed Care to California's Counties, California Healthcare Foundation, March 2015.

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increased resistance.

Recently, isolated strains of C. auris have shown resistance to the three major classes of antifungal drugs currently approved by the FDA. This resistance has not been seen in any other Candida species. C. auris has proven difficult to identify using standard clinical lab practices and can easily be misidentified. According to reports from the CDC, five of the original seven cases were either misidentified as C. haemulonii or limited to an identity of Candida spp. and current diagnostic biochemically-based tests are unable to differentiate. The CDC recommends specialized molecular testing to identify C. auris such as D1-D2 region sequencing of 28s rDNA and MALDI-TOF (3) (4). The CDC has also requested local health labs who suspect possible C. auris to send samples to regional labs for identification and broth microdilution suscep-tibility.

West Regional ARLN Lab News
Antibiotic Resistance Lab Network (ARLN)
Washington State Department of Health Public Health Laboratories
Volume 1 Issue 2 March/April 2017

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1. "Morbidity and Mortality Weekly Report (MMWR)." Centers for Disease Control and Prevention. Centers for Disease Control and Preven-tion, 10 Nov. 2016. Web. 24 Mar 2017.
2. "Fungal Diseases." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 16 Mar. 2017. Web. 24 Mar 2017.
3. Kathuria, S., P. K. Singh, C. Sharma, A. Prakash, A. Masih, A. Kumar, J. F. Meis, and A. Chowdhary. "Multidrug-Resistant Candida Auris Misidenti-fied as Candida Haemu-lonii: Characterization by Matrix-Assisted Laser Desorption Ionization-Time of Flight Mass Spec-trometry and DNA Sequencing and Its Antifun-gal Susceptibility Profile Variability by Vitek 2, CLSI Broth Microdilution, and Etest Method." Journal of Clinical Microbiology.U.S. National Library of Medicine, June 2015. Web. 26 Mar 2017.
4. "Fungal Diseases." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 24 June 2016. Web. 25 Mar 2017.

https://www.cdc.gov/fungal/diseases/candidiasis/candida-auris.html 3-31-2017

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