



*ZdravReform*  
*ЗдравРеформ*

TRIP REPORT NO. RUS-31

**INTRODUCING FAMILY PHYSICIANS  
TO NEW METHODS OF FINANCIAL INCENTIVES:  
DESIGNING AND TESTING  
A MANAGED CARE MODEL**

**Tomsk, Kemerovo, Kaluga, and Tver  
January 8–February 11, 1996**

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# KEMEROVO

## SUMMARY

An extended visit was made to Kemerovo to provide training and technical assistance to representatives of the Territorial Fund, the Kuzbass insurance company, and the proposed pilot site at Tisul. A one-day seminar was conducted covering incentive systems, utilization management, global budgeting and contract development. All elements of contracts were reviewed including conflict resolution, payment terms and methods, use of definitions, authorization procedures, quality assurance and reporting requirements. At the conclusion of the seminar, a series of extended discussions were held over a six day period working with counterparts in the areas of utilization management, patient identification systems, payment methods, business unit development, legislation, administrative management and contract terms and terminology. Draft contracts were reviewed and suggestions made for strengthening them. Igor Sheiman reviewed the status of pilot site development.

A site visit to the Tisul unit was canceled due to poor road conditions. Instead, a meeting was held with Tisul staff that were in Kemerovo for the opening meeting. The delivery system was defined, steps to reduce cost that were completed were described, and the legislative situation was reviewed. The Tisul unit is capitated as the fund holder for all services. A mobile unit covering a range of ambulatory services makes a scheduled rotation through rural communities. Improved monitoring of medical supply usages including medications has been put into place. A Health Insurance Association has been created merging health care and insurance in one organization. Needs were stated including computers, a member assistance protocol and a sample inpatient admission standards from a U.S. HMO which shows admission criteria and length of stay determination methodology.

## BACKGROUND

Three members of the Kemerovo team attended the analyst training workshop in June, 1995 in San Francisco. At that time, team members developed a draft contract during a workshop session. The original SOW for this task had Leavitt reviewing draft contracts. During the TPM held on December 29, 1995, a conference call was held with Kevin Woodard and Igor Sheiman during which revisions were made to the SOW. These changes were for Leavitt to conduct a series of seminars for groups of students to be specified by Nelepina in the areas of medical provider contracts, cost and utilization management and payment schemes. At the last moment a session on global budgeting was added. Kemerovo Oblast has been regarded as a leading site for the development of an HMO model experiment. The purpose of this consultancy was to work on the finer points of managed care product operations with Russian counterparts.

## **OBJECTIVES**

1. Conduct seminars on medical provider contracting, cost and utilization management, and payment schemes.
2. Assess contract development and make recommendations for changes.
3. Assist Russian counterparts in the adaptation of managed care techniques to the Russian context.

## **ACTIVITIES**

Leavitt arrived in Kemerovo on January 10 and attended a meeting during which a schedule was developed and agreed upon. The structure of the RHB Insurance Company was described. On January 11, Leavitt presented a series of seminars (See Annex B for text) covering contracting, utilization management and global budgeting. The entire Kemerovo team was present during most of this session. January 12 and 13 were supposed to have been spent in Tisul, a rural pilot site, reviewing their arrangements. The trip was canceled due to poor road conditions and extreme cold. Instead, the Tisul staff stayed over in Kemerovo City.

The January 12 meeting with the Tisul staff began with a description of the service area, the health care delivery system and the changes that had been made since the San Francisco training. Tisul Rayon has a population of 32,000. Current status was discussed along with proposed changes. The nature of changes in the delivery system was reviewed. Needs were expressed in the following areas: admission standards and length of stay criteria, computers to support a utilization management data base, and a sample protocol from the Contra Costa Health Plan telephone hotline program.

January 13 was a half-day session on utilization management. Areas discussed included the identification of alternative types of care, quality, benefit package design and changing patient flows. A training course in utilization management was discussed -- topics would include prospective, concurrent and retrospective review. The need for less costly modalities such as rehab facilities, home care and community services was discussed.

A very energetic and successful discussion was held on January 15 talking about the detail of a specialty referral and hospital admission control processes. Medical experts on the insurance company staff felt that they had finally received enough information to begin to design their own arrangements. In the afternoon, detailed discussions were held on HMO development techniques including legislative, governance and systems requirements.

Leavitt met with the Territorial Fund payment group on January 16 and provided detail on the various types of payment methodologies. The advantages and disadvantages of each format was discussed. Considerable time was spent on capitation and global budgeting.

On January 17, Leavitt met with the contracts and agreements team to go over concepts of contract

development. Because arrangements in Kemerovo Oblast are not yet firm, specific draft contracts were not available for review. Therefore, the discussion was limited to an in-depth review of each contract element. The contracts and agreements required for an integrated system were defined. In the afternoon, a separate session was held on the development and use of member identification cards.

The final day, January 18, another session was held with the medical experts. They felt that the organization of the delivery system should be a physician rather than an economist function. A target date of sixty days was set for the definition of a pilot site delivery system. A summing up session was held to encourage the Kemerovo team to finalize the definition.

## **FINDINGS**

Leavitt found that Kemerovo was having some problems developing a workable delivery system, particularly in urban areas. The complexities of the existing system and the lack of a widely accepted pricing methodology has made the task much more difficult. Because there was no potential delivery system in place, there were no draft contracts to review. Instead, the time on site was spent providing technical assistance on the development of arrangements and on how to develop effective contracts which will accurately reflect those arrangements.

Kemerovo is ahead in its thinking on many of the detail issues of HMO development. RHB has devoted resources to many areas which will be useful after solution of the delivery system delays. These include information systems, member services and governance. Unfortunately, the delays at the delivery system end combined with the political problems of RHB over use of administrative funds have allowed these other activities to get ahead of the general level of progress of the project. Hopefully, the progress made with the RHB medical experts will enable the delivery system development process to catch up with the rest of the project.

## **RECOMMENDATIONS**

1. Substantial monitoring should be conducted to encourage the RHB to complete the delivery system development process. The RHB medical experts anticipated sending to Leavitt a revised delivery system design and utilization management plan by the end of March.
2. New thinking is needed to solve the problem of urban integrated systems. The Russian pattern of having services split among several specialized inpatient facilities makes it more difficult to define and implement an integrated system. Rural pilot sites are only one form of health care reform. The real challenge will be to develop a system which uses multiple facilities.

3. A simplified pricing system is needed as soon as possible to facilitate the use of multiple facilities. This will require use of procedure codes which clearly define the service provided and a reasonable approximation of what that service should cost. Only then can effective incentive and contract development processes move forward.

# **TOMSK OBLAST**

## **SUMMARY**

A week was spent in Tomsk Oblast to provide training and technical assistance to representatives of polyclinics, hospitals, health care administration and the Tomsk Territorial Fund. After meeting with the polyclinics and health care administration, Leavitt presented a one-day seminar covering incentive systems, utilization management, global budgeting and contract development. A series of meetings were then held to review draft contracts for hospitals, polyclinics and general practitioners.

The contract which received the most attention was the contract form between chief doctors and general practitioners. On the advice of Russian attorneys, it was determined that this agreement had to be an employment contract since general practitioners did not have standing under Russian law to enter into a regular contract. Special provisions were worked out to enable the general practitioners to obtain support services such as nurses, receptionists, finance staff, medical supplies and office space.

The major problem area is anticipated to be how to adequately compensate the newly retraining general practitioners for the additional services they will be providing in comparison with the therapists that are now the initial point of entry into the health care system. Prior experience has indicated that this will be a major area of concern.

## **BACKGROUND**

Three members of the Tomsk team attended Leavitt's analyst training workshop in June, 1995, in San Francisco. At that time, team members developed a draft contract during a workshop session using a rural model. The original SOW remained substantially the same after the December 29, 1995 TPM. The SOW focused on the more complex issues of an urban system. Item B. of the SOW added the key contracts between the payer and the hospitals. The general thinking was that Tomsk was having problems and the purpose of this consultancy was to work with them to solve the problems that they were encountering in their attempt to develop a workable system in an urban area.

## **OBJECTIVES**

1. Conduct seminars on medical provider contracting, cost and utilization management, and payment schemes.
2. Assess contract development, particularly employment agreements, and make recommendations for change.
3. Assist Russian counterparts in the adaptation of managed care techniques to the Russian context.

## ACTIVITIES

Leavitt began his consultancy in Tomsk on January 22. An opening meeting of the Oleinichenko team was held at Polyclinic 10. A number of issues were raised including problems of turning polyclinics into general practices and methods of payment. There had been a number of accomplishments including the development of draft contracts, a curriculum for re-training therapists and the identification of the pilot sites. Some MIS issues were raised and there was a request for Leavitt to review their work. However, there was no follow up and the review never took place. The office sites for the GP's was described and it was indicated that they would be ready by March.

Later on the 22nd, a meeting was held at Municipal Hospital 3 where Leavitt met two of the general practitioners in training. The types of cases that would be assigned to the new GPs was described. 1994 was designated as the base year for comparison purposes. The GPs were given the goal of assuming certain minor surgical procedures and reduction of length of stay.

On January 23rd, a very emotional meeting was held at the Health Care Administration offices. Budgetary issues have presented problems for many delivery sites with substantial shortfalls in funding. Later the team moved to Municipal Hospital 3 again to work with hospital management. Leavitt learned at that time that several key services such as GYN, Maternity, Pediatrics, and Psychiatry are not available at Hospital 3. There are also limitations on the availability of CAT scans (2 per week) at another location. An uncertain legislative status is a problem. Leavitt then attended a meeting at the Tomsk Regional Hospital where the hospital pledged cooperation with the pilot projects.

Leavitt presented his seminar on January 24th covering incentives, utilization management, global budgeting and contracting. A key area, the need to define terms carefully and accurately, was emphasized.

The review of contracts began on the 27th at the offices of the Territorial Fund. A. Ugolnikov set the tone by talking about a four stage process of contract development - strategic, concrete experience, a transformation of GPs to independent status and GPs joining together into associations. Ugolnikov also felt that the legislative base was to unstable at this time to develop final contract forms. The remainder of the day was spent working on general practitioner employment contracts and a contract for the Regional Hospital

January 28th was spent working with the polyclinics to finalize the general practitioner employment contracts.

## **FINDINGS**

Leavitt found that Tomsk had done an effective job in taking on the challenge of an urban pilot project. There are problems, particularly the legislative situation and the shortage of money, but the Oleinichenko Team is attempting to develop pilots which will serve as the basis for eventual coverage of the majority of the Oblast's population.

The Team will have several problems to solve. First, interfacility charges will be essential. Municipal Hospital 3 will have to develop agreements for tertiary care with the Regional Hospital and with another hospital for those secondary services that are not provided internally. The incentive arrangements for the general practitioners will require a solution.

Finally, Tomsk must solve its systems problems. Multiple delivery sites require horizontal communications so that there is effective continuity of care and efficient use of diagnostic and treatment resources. This is an area will require major attention and possibly the use of another Oblast's system for at least an interim period.

## **RECOMMENDATIONS**

1. Continued technical assistance and encouragement should be provided. Some of the finer points of health care reform should be addressed such as enrollment tracking, member services and provider incentive compensation.
2. The system problem will require attention as soon as the general practitioners begin to see patients in their new role. The lack of a system will impact on utilization management, cost containment, financial management and continuity of care. If the Tomsk system is not ready for testing by the end of March, another system should be adopted for at least a one year period.
3. Internal pricing needs to be developed using relatively simple methods for at least an interim period. Current cost accounting methods should be reviewed for ease of implementation and accuracy and, if necessary, modified for immediate use.

# **KALUGA OBLAST**

## **SUMMARY**

A series of seminars for different audiences was conducted by Leavitt over a four day period. Participants included doctors and economists. An opportunity was provided for participants to develop draft contracts. The areas covered in the seminars included contracting, incentive payments, utilization management and global budgeting. Contracting was presented twice, first to the economists and then to the doctors.

Participants also worked on organizational structures for the pilot sites. Various alternatives were explored with emphasis on how current structures will be changed for the World Bank project. A negotiation was held regarding the specific goals of the project.

## **BACKGROUND**

Leavitt was asked to come to Kaluga to provide introductory seminars in the areas of contracting, incentive payments, utilization management and global budgeting. Kaluga is a World Bank site with proposed pilot sites initially in Kaluga City, Maloyaroslavsky and Ferzikovsky. Kaluga Oblast has experienced the same basic problems as other Russian areas: overbedding, use of expensive inpatient services for social service purposes, too many physicians and disincentives to treat patients on an outpatient basis. There are high rates of obstetrical and cardiovascular problems. The World Bank project has targeted the areas of Maternal and Child Health, Delivery System Restructuring and Provider Incentives for Kaluga. The project is looking to move care to the most cost effective setting, make the general practitioners the fundholders and review the incentives for outpatient specialists and the use of clinical statistical groups. In addition, a quality assurance system will be put into place. The purpose of this consultancy was to introduce Russian counterparts to key areas of managed care operations and to work with them to help develop contract forms which will support the desired changes in the health care system.

## **OBJECTIVES**

1. Conduct an introductory seminar on medical provider contracting, cost and utilization management, incentive payments and global budgeting.
2. Assess project development
3. Assist Russian counterparts in the development of contractual forms which fit the needs of the World Bank project and pilot sites.

## **ACTIVITIES**

Leavitt arrived in Kaluga late in the day on January 30 and presented an opening seminar on incentive payments to the doctors. There was a lively discussion on how these concepts would fit into the Kaluga project goals and objectives.

Due to another meeting, only the economists were present for a daylong session on January 31 on contract development and incentive payments. The group developed some sample contracts and included some preliminary efforts at setting incentives.

On February 1, the entire group was present again. The utilization management seminar was presented and the contracts section was repeated. The pilot sites described the changes that they were planning and Leavitt provided comments.

On February 2, the seminar closed with the global budgeting section. The presentation included a section on both top-down and bottom-up techniques. After the participants left, Leavitt and Langenbrunner met with Omelchenko to discuss the goals of the World Bank program.

## **FINDINGS**

Leavitt found a positive attitude among the seminar participants toward the World Bank project. There were lively discussions and some frank realizations that change was very necessary. At the same time, there were expressions of doubt that they could achieve the goals of the project. Part of the doubt comes from the feeling that the goals themselves are overly optimistic. However, a more troubling source of doubt is the sense that there is the strong potential for failure because of aspects of Russian society and the system. Key counterparts indicated that they were concerned about their abilities. They were used to being told what to do and were not confident that it was within their capabilities to carry out the project. There are the vestiges of command and control which prevents individual initiative or innovation.

A key area for change is the substantial modification of the medical economic standards. These standards impact on quality, incentives and cost. Without the development and implementation of new and innovative treatment protocols, many project goals will not be met. There is confusion about whether the current standards are voluntary or not. The reaction, however, is to follow them. This is regarded as the safe option.

Communication is still largely vertical. Successful implementation of reforms will require horizontal communication. It makes things more complex, but horizontal communication is the engine that powers changes in the way health care services are provided. Horizontal communications also reduce the role of central authorities and foster the feeling that providers can do what they feel is best for the patient, not just what a committee has determined as the lowest common denominator in advance.

## RECOMMENDATIONS

1. Monitoring and technical assistance should continue on a regular basis. The Russian counterpart staff should have the capability to access consulting assistance whenever they encounter an impediment to progress.
2. Assistance and feedback should be provided in the development of an effective communication system which will enhance the ability of providers to most effectively manage specific cases.
3. Each of the major subject areas of this seminar should be explored in much greater depth with a longer presentation followed up with an extensive period of technical assistance during which the generic concepts presented are adapted to the individual circumstances and dynamics of each rayon.
4. A workable system of procedure codes and pricing must be established prior to the implementation of any system of provider incentives.

## **TVER OBLAST**

### **SUMMARY**

A day long seminar covering contracting, incentive payments, utilization management and global budgeting was conducted by Leavitt for approximately 75 attendees. Reviews of proposed contract arrangements were then conducted for several sites including Tver Hospital and Polyclinic #1, Kuvshinova Rayon and Vishney Volovhuk Rayon. Several contracts will be ready for further review when Leavitt returns on March 11.

A proposed administrative contract for information services was discussed. The team mentioned several areas which should be included in the final document such as provider reporting requirements, standardized reports available, patient privacy requirements and monitoring of capitations. A draft contract will be developed for review on March 11.

### **BACKGROUND**

Leavitt was asked to come to Tver to provide introductions to the areas of contracting, incentives, utilization management and global budgeting. Tver is a World Bank site with a number of proposed pilot sites located in both Tver City and two outlying rayons, Kuvshinovo and Vishney Volochek. Tver Oblast has experienced the same basic problems as other Russian areas -- overbedding, use of expensive inpatient services for social service purposes, too many physicians and disincentives to treat patients on an out patient basis. There are high rates of obstetrical and cardiovascular problems. The World Bank project has targeted the areas of Maternal and Child Health, Cardiovascular Disease, and the development of a Family Medicine Program. The Bank is looking at the development of new methods of compensating providers which will base payments on services rendered or risks shared rather than input levels. In addition, they are looking at developing professional responsibility rather than enforcement and to enhance quality of care. The purpose of this consultancy was to introduce Russian counterparts to key areas of managed care operations and to work with them to help develop forms which will support the desired changes in the health care system.

### **OBJECTIVES**

1. Conduct an introductory seminar on medical provider contracting, cost and utilization management, and global budgeting.
2. Assess contract development and make recommendations for changes.
3. Assist Russian counterparts in the adaptation of managed care techniques to the Russian context.

## **ACTIVITIES**

Leavitt arrived in Tver on February 5 and attended a meeting with key officials to describe the program that would be presented the following day, identify audio-visual equipment needs and discuss any areas that the local authorities wanted to have covered.

On February 6 Leavitt held a day long seminar covering contracting, incentives, utilization management and global budgeting. Approximately 75 Russian counterparts were in attendance representing all elements of the World Bank project.

On February 7, the team met with the outlying rayons, Kuvshinova and Vishney Volochuk. As problems were identified, solutions were proposed. For example, when the counterparts raised the issues of current Oblast rules and regulations, a waiver was proposed and developed which would exempt the pilot sites from these rules and regulations for the duration of the pilot project.

The same activity was continued on the following day, this time with Hospital #1 and Hospital #6. The facilities were described, plans for the pilot projects were outlined and goals identified. Revisions were proposed and will be incorporated in revised draft agreement which will be ready for review on March 11.

February 9 was spent with the management information system staff reviewing the elements of what an agreement between the information center, the health committee and the Territorial Fund. Items discussed included the methods of data collection, input format and frequency, report generation, products and destinations. Data exchange between provider groups or rayons would be outside the information center. Roman Zelkovitch of Kemerovo Oblast would be involved in the project. A planned visit with Children's Hospital was not held due to lack of time

## **FINDINGS**

Leavitt found a positive attitude among the majority of the Russian counterparts toward the World Bank project. A variety of pilot sites is planned which should enable the Oblast to experience the full range of problems that will occur when the remainder of the Oblast is converted to reformed health care systems.. Attendance at the seminar was the best of the four Oblasts Leavitt visited. The six year project period and substantial funding through the World Bank loan should enhance significantly the chances for success.

At the same time, a number of warning signs should alert the project team to potential problems that must be overcome. There continue to be substantial remnants of the command and control type of thinking. Even though the management of health care has been decentralized to the Oblast level, key managers still have a tendency to think that they are under the old system. Medical Economic Standards are still referred to as if they are part of a system of enforcement. This is particularly true in the outlying rayons where the changes in attitude have been slower to take hold. Leavitt also found examples of questioning the need for contracts. Contracts are agreements between

independent parties. The prevailing system had been for the central authority to tell everyone what to do. This does not allow for any individual initiative or innovation. The question is also raised as to whether the mindset is present to have a successful introduction of incentives for providers.

Finally, the communication process under health care reform requires both vertical and horizontal channels to be active. The information system development staff needs to have this requirement emphasized so that the resulting system will serve more than the needs of the central authorities. This will increase the complexity of the development task, but it is an essential component of a managed care program.

## **RECOMMENDATIONS**

1. Monitoring and technical assistance should continue on a regular basis. The Russian counterpart staff should have the capability to access consulting assistance whenever they encounter an impediment to progress.
2. The proposed management information design should be modified to as to make the outputs useful for operations as well as for monitoring. The development staff should be provided with examples of managed care systems from other countries to illustrate the types of reports and user needs they must accommodate.
3. Each of the major subject areas of this seminar should be explored in much greater depth with a longer presentation followed up with an extensive period of technical assistance during which the generic concepts presented are adapted to the individual circumstances and dynamics of each rayon.
4. Integrated systems will require both internal and external pricing so that services can be monitored on both a frequency and a cost basis. These pricing system, along with a companion procedure coding system, should be simple at first, allowing for acceptance of the concept prior to the development of a complex cost finding and allocation system. This will also support a much more effective incentive payment system.

## **ANNEX A**

### **PERSONS CONTACTED**

#### **PEOPLE CONTACTED - KEMEROVO**

##### **RHB "Kuzbass" Insurance Co., Kemerovo**

Tamara I. Slobodyanik, Medical Director  
Sergei Golubev, Medical Expert  
Asya Vershinina, Financial Expert  
Natalia Melechova, Director Planning  
Marina Andreeva, Quality Expert, Planning Department  
Svetlana V. Polykova, Reviewer  
Elena Kurakina, Programmer  
Natalya Nelepina, Head, RHB  
Juri Gasanov, Head, Administrative Management Group  
Konstantin Shipachov, Head, Contracting  
Nadia Klemova, RHB Branch Director, Tisul

##### **Territorial Fund**

Mikhail Okunev, Medical Expert  
Svetlana Babarikina, Head, Payment Group

##### **Tisul Unit**

Anna Petrenko, Chief Physician, Health Unit  
Tamara Kosova, Deputy Chief Physician, Health Unit

##### **Information Center**

Roman Zelchovitch, Director

##### **U.S. Agency for International Development**

Susan Cheney, COTR/Moscow  
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### **Tomsk Oblast**

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L. Petrova, Chief Doctor, Polyclinic 1  
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### **U.S. Agency for International Development**

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## **PEOPLE CONTACTED - KALUGA OBLAST**

### **Kaluga Oblast**

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V. Kundyukov, Head, Healthcare Department, Kaluga  
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S. Voronin, Head, Treatment Section, Oblast Health Department  
V. Sumarokov, Head Doctor, Emergency Hospital  
N. Malyarov, Head Doctor, Hospital #5  
V. Sokolova, Deputy Head Doctor, Hospital #5  
Dokuchayev, Deputy Economist, Hospital #5  
I. Aksyutenkov, Head Doctor, Ferzikovo Rayon  
T. Prokutova, Economist, Ferzikovo Rayon  
E. Entov, Director, Maloyaroslavets Branch  
T. Delnova, Economist, Maloyaroslavets Branch  
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T. Luznetskaya, Deputy in Economy, Emergency Hospital  
A. Vlasov, Head Doctor, Ochyabrskaya Hospital Polyclinic  
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Alyeshin, Deputy Director, Oblast Health Department  
N. Azarova, Head, Planning Section, Oblast Health Department  
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## **PEOPLE CONTACTED - TVER OBLAST**

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A. Zlobin, Director, Territorial Fund  
B. Moghilevsky, Head, Tver Health Committee  
A.M. Molokayev, Consultant  
A. Sinenko, Chief Physician, Hospital and Polyclinic #1  
T. Kozlova, Deputy on Economics, Hospital and Polyclinic #1  
Y. Korniyevski, Chief Physician, Central Rayon Hospital and Polyclinic  
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## **ANNEX B**

### **TEXT FOR OVERHEAD SLIDES TO BE TRANSLATED INTO RUSSIAN**

#### **SLIDE 1**

CONTRACTING

THE STRUCTURE OF MANAGED CARE ORGANIZATIONS

HENRY LEAVITT

E. PETRICH AND ASSOCIATES, INC.

SAN LUIS OBISPO, CA USA

#### **SLIDE 2**

This will be a box chart which we will translate during the session.

#### **SLIDE 3**

CONTRACTS IN MANAGED CARE - WHY?

IN FEE FOR SERVICE SECTOR

NO RULES

1. NO COORDINATION BETWEEN PHYSICIANS AND HOSPITALS
  1. PAYMENT DETERMINED BY OUTSIDE PARTY
  2. NO CONTROL OVER VOLUME OF SPECIFIC SERVICES

#### **SLIDE 4**

IN MANAGED CARE SECTOR

1. STRUCTURED RELATIONSHIPS
2. MANY PAYMENTS DETERMINED INTERNALLY
3. SERVICES PROVIDED SUBJECT TO RULES
4. INCENTIVE ARRANGEMENTS

#### **SLIDE 5**

1. CONTRACTS DEFINE RELATIONSHIPS

## 2. SET PAYMENT LEVELS

## **SLIDE 6**

### WHY DO WE USE CONTRACTS

1. MAKE WORK ASSIGNMENTS
2. DEFINE RELATIONSHIPS
3. SET UP COMPENSATION ARRANGEMENTS
4. AVOID MINOR DISPUTES AND SET UP WAY TO SOLVE MAJOR DISPUTES
5. DEFINE LENGTH OF RELATIONSHIP

## **SLIDE 7**

### GETTING READY FOR CONTRACTING

1. IDENTIFY WHERE WE NEED CONTRACTS
2. WHO SHOULD BE INVOLVED
  - PRIME CONTRACTS
  - SUB-CONTRACTS
  - EMPLOYMENT CONTRACTS
  - CONSULTANT CONTRACTS

## **SLIDE 8**

1. WHAT DO WE WANT TO ACCOMPLISH?
  - DEFINE RELATIONSHIPS
  - SET UP COMPENSATION
  - ARRANGE FOR SERVICES
  - DECIDE WHAT SERVICES ARE NEEDED
  - IDENTIFY THE PARTIES

## **SLIDE 9**

### WHAT IS NEEDED TO MAKE A CONTRACT?

1. TWO OR MORE PARTIES
2. STATEMENT OF FACTS
3. TERMS
  - DEFINITIONS
  - WHAT SERVICES ARE INVOLVED
  - GENERAL COMPENSATION TERMS
  - COMPLIANCE WITH LAWS AND RULES

## **SLIDE 10**

1. ASSIGNMENTS OF RESPONSIBILITY
2. REPRESENTATIONS
  - PHYSICIANS ARE LICENSED
  - PHYSICIANS AVAILABLE 24 HOURS PER DAY
  - HOSPITAL HAS FOLLOWING SERVICES
  - POLYCLINIC WILL MAINTAIN MEDICAL RECORDS

## **SLIDE 11**

1. TERM AND TERMINATION
  - EFFECTIVE DATE
  - ENDING DATE
  - RENEWAL REQUIREMENTS
  - EARLY TERMINATION PROCESS
  - WHAT HAPPENS TO PATIENTS?

## **SLIDE 12**

1. COMPENSATION
2. GENERAL TERMS AND CONDITIONS

## **SLIDE 13**

### REFERRAL CONTROL PROCESS

1. PATIENT PRESENTS TO PRIMARY CARE PHYSICIAN
2. PRIMARY CARE PHYSICIAN WANTS TO MAKE REFERRAL
3. PRIMARY CARE PHYSICIAN REVIEW PRACTICE STANDARDS TO SEE IF REFERRAL IS PERMISSIBLE
4. IF PERMISSIBLE, ISSUES APPROVED REFERRAL DOCUMENT
5. IF NOT PERMISSIBLE, AS MEDICAL DIRECTOR FOR SPECIAL PERMISSION. MAY OR MAY NOT BE GRANTED
6. SPECIALIST MAY NOT SEE PATIENT WITHOUT PROPER DOCUMENT
7. SPECIALIST REPORTS BACK TO PRIMARY CARE PHYSICIAN IN WRITING
8. SPECIALIST GETS PAID.

**SLIDE 14**

EXHIBITS

- A. COMPENSATION ARRANGEMENTS
- B. SERVICES COVERED
- C. PHYSICIANS AND HOSPITALS INVOLVED
- D. REFERRAL REQUIREMENTS
- E. UTILIZATION REVIEW RULES

**SLIDE 15**

LET US DEVELOP A CONTRACT TOGETHER

1. PURPOSE - COUNTERPARTS WISH TO LEARN ABOUT CONTRACTS
2. PARTIES - COUNTERPARTS AND CONSULTANT
3. DEFINITIONS - HAVE UNDERSTANDING ABOUT MEANING OF KEY TERMS

**SLIDE 16**

1. REPRESENTATIONS
  - CONSULTANT KNOW SOMETHING ABOUT CONTRACTS
  - HAS STARTED MANY HMOs
  - HAS BEEN IN MANAGED CARE 18 YEARS

**SLIDE 17**

- COUNTERPARTS WISH TO LEARN SOMETHING ABOUT CONTRACTS
- NEED TO USE CONTRACTS TO HELP REFORM HEALTHCARE IN RUSSIA
- ARE MOTIVATED TO LEARN ABOUT CONTRACTS

**SLIDE 18**

1. BEGINNING AND ENDING DATES
2. DISPUTE RESOLUTION
3. COMPENSATION
4. GENERAL TERMS
5. WHO HAS THE AUTHORITY TO SIGN THIS CONTRACT?

**SLIDE 19**

MONITORING CONTRACT PERFORMANCE

TYPES OF PERFORMANCE TO BE MEASURED

1. COST
2. UTILIZATION OF SERVICES
3. PATIENT DEMAND
4. PATIENT RISK MANAGEMENT
5. EXPECTED VS. ACTUAL COST

***THIS SECTION IS FOR THE INCENTIVE COMPENSATION SECTION. I AM CONTINUING THE NUMBERING SEQUENTIALLY FOR MY CONVENIENCE IN MATCHING MY ENGLISH TEXT TO THE TRANSLATED SLIDES.***

**SLIDE 20**

INCENTIVE PROGRAMS FOR PROVIDERS

POSITIVE MODIFICATION OF HEALTH CARE  
PROVIDER BEHAVIOR

HENRY LEAVITT  
E. PETRICH AND ASSOCIATES, INC.  
SAN LUIS OBISPO, CA USA

**SLIDE 21**

GENERAL COMMENTS ON INCENTIVES

1. NO SINGLE CORRECT TYPE OF INCENTIVE
  - ADJUST TO LOCAL CONDITIONS
  - BE FLEXIBLE
2. REWARD ONLY THOSE THAT CONTROL OR IMPACT ON SPECIFIC RISKS
3. USE QUANTITATIVE METHODS TO MEASURE
4. CAN VARY WITH DEGREE OF SUCCESS
5. INCENTIVES SHOULD BE EARNED BY ACTIONS

**SLIDE 22**

TYPES OF ORGANIZATIONS THAT CAN USE  
INCENTIVES UNDER MANAGED CARE

1. POLYCLINICS
2. HOSPITALS
3. INTEGRATED DELIVERY SYSTEMS
4. ANCILLARY SERVICE PROVIDERS
5. INSURANCE COMPANIES

**SLIDE 23**

HEALTH CARE INCENTIVE METHODS

6. RISK INCENTIVE POOLS
7. UTILIZATION GOALS
8. RISK CORRIDORS
9. REFERRAL CONTROLS
10. LESS INTENSIVE/RESTRICTIVE CARE SETTINGS
11. PATIENT SATISFACTION MEASURES
12. PRODUCTIVITY MEASURES

**SLIDE 24**

TYPES OF INCENTIVE POOLS IN  
MANAGED CARE ORGANIZATIONS

1. PRIMARY CARE PHYSICIANS
2. SPECIALIST PHYSICIANS
3. HOSPITAL FUNDS
4. ANCILLARY SERVICES

**SLIDE 25**

DEFINITION OF INCENTIVES

COMPENSATION ABOVE REGULAR SALARY

- BONUSES
- PROFIT SHARING
- UNSPENT FUNDS IN BUDGET CATEGORIES
- DISTRIBUTION FROM RISK POOLS
- RESULTS OF IMPROVED PRODUCTIVITY

**SLIDE 26**

PHYSICIAN INCENTIVES

PRIMARY CARE PHYSICIANS

1. HOSPITAL
  - ADMISSIONS
  - LENGTH OF STAY
  - OUTPATIENT VS. INPATIENT
2. OFFICE VISITS
  - USE OF ALTERNATIVE STAFF
  - ALTERNATIVE CARE SETTINGS
  - NEW REIMBURSEMENT METHODS
  - SPECIALIST REFERRALS

**SLIDE 27**

PRIMARY CARE PHYSICIAN POOL

1. WHAT SERVICES ARE INCLUDED
2. PAYMENT OPTION USED
3. WHAT PROVIDERS PARTICIPATE IN THE INCENTIVE PROGRAM
4. WHAT PRIORITIES ARE USED TO CARRY OUT THE DISTRIBUTION

**SLIDE 28**

SPECIALIST PHYSICIAN POOL

1. WHAT SERVICES ARE INCLUDED
2. USE OF ALTERNATIVE TREATMENTS
3. USE OF SUBACUTE FACILITIES
4. IMPROVED CASE MANAGEMENT
5. LINKAGE OF MEDICAL RECORDS WITH PRIMARY CARE PHYSICIANS
6. USE OF OFFICE SURGICAL PROCEDURES
7. PAYMENT OPTIONS
8. PRIMARY CARE PHYSICIAN SHARE OF SPECIALIST INCENTIVE POOL
9. DISTRIBUTION PRIORITIES

## **SLIDE 29**

### WITHHOLD CALCULATION

FEE = 4000

WITHHOLD PERCENT = 20

PAID NOW = 3200

IF BUDGET IS ON TARGET = PAID 800 AT END OF YEAR

IF BUDGET IS MORE THAN RESULT = PAID 800 AT END OF YEAR PLUS A SHARE OF ANY EXCESS FUNDS LEFT OVER

IF BUDGET IS INADEQUATE = WITHHOLD MONEY IS USED TO SATISFY UNBUDGETED FOR CLAIMS. ANY MONEY LEFT OVER IS DISTRIBUTED ON A PROPORTIONAL BASIS USING THE AMOUNT EACH PHYSICIAN HAS AT RISK.

## **SLIDE 30**

### HOSPITAL INCENTIVES

1. REDUCE INTERNAL COSTS
2. USE ALTERNATIVE SETTINGS FOR LONGER STAYS
3. EXPERIMENT WITH HOME CARE
4. INCREASE EQUIPMENT TO LOWER LENGTH OF STAY
5. IMPROVE MEDICAL RECORDS SYSTEM
6. REVIEW PRACTICE PROTOCOLS CONSTANTLY

## **SLIDE 31**

### HOSPITAL POOL

1. WHAT SERVICES ARE INCLUDED
2. WHO SHARES IN INCENTIVE POOL
3. TYPES OF COMPENSATION - PER DIEM, CAPITATION, CASE
4. DISTRIBUTION PRIORITY

**SLIDE 32**

**CALCULATION OF INCENTIVE ADJUSTMENTS  
TO COMPENSATION**

1. SHOULD BE SIMPLE
2. SHOULD BE MEASURABLE
3. SHOULD BE OBJECTIVE
4. TOTAL REVENUE SHOULD BE ADJUSTED BY:
  - A. COST PER UNIT OF SERVICE
  - B. PERFORMANCE - RATE OF USE PER 1000 PATIENTS
  - C. INDIRECT COSTS

**SLIDE 33**

**CAPITATION DEVELOPMENT PROCESS**

TYPE OF SERVICE	COST PER UNIT	RATE OF USE	CAPITATION
HOSPITAL	\$1000	500 DAYS/1000	\$41.67
PRIMARY CARE			
BASIC VISIT	30	2100/1000	5.25
INTENSIVE VISIT	99	200/1000	1.65

**SLIDE 34**

**IMPACT OF MIX OF SERVICES ON CAPITATION**

ASSUMPTION = 2300 TOTAL VISITS PER 1000 PATIENTS

2100 PRIMARY CARE AND 200 SPECIALIST = \$6.90

1800 PRIMARY CARE AND 500 SPECIALIST =

$$1800 \times 30 = \$4.50$$

$$500 \times 99 = 4.13$$

TOTAL PHYSICIAN OFFICE VISIT CAPITATION = \$8.63

## ANNEX C

### UTILIZATION MANAGEMENT PRESENTATION

#### Two primary elements of the total cost of care

Unit Cost

Number of units used

- Number of each type of unit
- Shifts within types of units

#### Who controls utilization?

Physicians

Hospitals

Patients

UM Departments

#### Physicians

Manage utilization by control of access to and volume of services used

How?

- Specialist referrals by primary care physicians
- Inpatient admissions
- Use of prescription medicines
- Diagnostic tests

Time Frame

- Mainly prospective and concurrent

Methods

- Protocols
- Professional judgments
- Incentives
- Substitutions
- Chart reviews
- Patient Exams

## **Hospitals**

### How?

- Internal staff
- DRG/Case Management Staff
- Make lower cost services available such as out patient surgery
- Profile physicians

### Time Frame

- Prospective, concurrent and retrospective

### Methods

- Chart reviews by RNs
- Protocols - LOS Studies
- Internal cost studies - restructure of operations

## **Patients**

### How?

- Select cost effective providers
- Avoid use of unnecessary services
- Personal behavior

### Time Frame

- Prospective
- Point of service

### Methods

- Copayments
- Health Education
- Selection differentials

## **Utilization Management Departments**

### How?

- Admission control standards
- Existing patient review
- Retrospective studies
  - = Patient specific
  - = Type of case specific
  - = Admitting physician specific

### Time Frame

- Prospective, concurrent and retrospective

## Methods

- Nurse reviewers
- Physician appeals panels
- Grievances
- Studies
- Provider training

## **ANNEX D**

### **GLOBAL BUDGETING PRESENTATION**

**Definition: Setting a budget based on per capita cost vs. line items**

#### **Budgeting for Integrated Organizations**

Methods

1. History
2. Actuarial
3. Time Study

#### **Flexible budgeting**

Use targets with contingency funding

- Marginal variations should not impact on cost
- Develop reserves to use for unforeseen events
- Track trends over a 2-3 year period

#### **To respond to a “top down” allocation of funds**

#### **Steps to develop a global budget response**

1. Define the enterprise
2. Identify revenue streams
3. Categorize costs
4. Determine size of enterprise
5. Estimate volumes of activity
6. Develop internal budget
7. Monitor initial budget for accuracy of cost estimates and volume
8. Revise as often as necessary

#### **Prices should reflect at least the marginal cost of providing the service**

Marginal cost used when using up excess capacity which would go the waste otherwise

**Fully allocated pricing - Price includes variable cost and a distribution of the appropriate portion of fixed and semi-variable costs.**

**Negotiation should be based on experience and data.**

**Managing under a global budget**

1. Maintain information needs on a systematic and regular basis - establish management accounting reporting system, integrate with budget for each subunit
2. Get performance reports based on each area of budget responsibility
3. Emphasize procedure costing to improve accuracy of future budgets
4. Link cost with outcomes - will be rough at first
5. Define data necessary to define interfacility payments. Take two or three years to get final product. Need to develop effective UM and incentive systems.
6. Keep track of costs by demographic categories, less emphasis on disease categories
7. Need procedure coding system used consistently, base on labor cost.
8. Performance budgeting - budget vs. actual
9. Monitor shifts in patterns of patients among providers - eventually leads to optimization of costs and revenue.

## **ANNEX E**

### **SCOPE OF WORK**

**NOTE: Items A and B were modified at the Team Planning Meeting (TPM)  
held on 29 December 1995 in Bethesda, MD.**