external affairs

Optimal Renal Care

Interview with Ramon Hannah, MD & Joe Carlucci, conducted by Scott Rasgon, MD

Introduction

The formation of Optimal Renal Care (ORC) marks the first "medical services" or "management services" product developed by a Permanente Medical Group (PMG) for the marketplace. The charge to ORC from The Permanente Federation was twofold: first, to assist Kaiser Foundation Health Plan (KFHP) Regions in reducing the cost of renal disease care while improving patient outcome; and second, to develop a product that would be marketable to other health plans. In our first year of operations, ORC has secured contracts with two KFHP Regions (Northwest and Hawaii) and with one non-KFHP health plan.

The ORC model was developed and refined by Southern California Permanente Medical Group (SCPMG) nephrologists and staff. The model reflects SCPMG's experience with the Health Care Financing Administration (HCFA) Capitation Demonstration Project, and the model is anticipated to appeal to HCFA as a potential partial solution to the challenge of end-stage renal disease (ESRD) care, the cost of which rises annually but which produces outcomes inferior to those seen in other industrial nations with better outcomes (eg, Japan and other European countries).

The following is an interview conducted by Scott Rasgon, MD, *The Permanente Journal* External Affairs Editor, with Ramon Hannah, MD, Chief Medical Officer of ORC; and Joe Carlucci, President of ORC.

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What is ORC?

Ramon Hannah, MD: ORC was formed as a Limited Liability Corporation in August 1997 as a joint venture between Fresenius Medical Care North America (FMCNA) and Southern California Permanente Medical Group (SCPMG). Shortly thereafter, SCPMG offered half its interest in ORC to PermCo, which subsequently began offering to the Permanente Medical Groups the opportunity to invest in ORC.

ORC is a disease management organization (DMO) that provides management services for patients with renal disease. "Disease management" (a concept arising from the managed care world) promotes the concept that focusing on individual diseases and their generic management principles is an effective way to increase both the outcome and the cost efficiency of care. Disease management calls for coordination of care across multiple disciplines; involvement of multidisciplinary teams coordinated by a lead physician; programs and staff directed toward managing specific aspects of disease; and development of practice guidelines to achieve efficiency.

Disease management has proven to be highly successful for managing diabetes mellitus, congestive heart failure, asthma, hemophilia, and other conditions, but more real data are needed to evaluate use of this approach with renal disease. A key part of this strategy would be the early identification and management of chronic renal insufficiency, ie, proper attention given at the "pre-ESRD" stage.

Joseph A. Carlucci is the President of Optimal Renal Care, LLC He has been in the dialysis/renal industry for 21 years. He moved into Optimal Renal Care because of a belief that the concept of Renal Disease State Management represents the future for the industry and will result in improved care for patients with ESRD. E-mail: j.carlucci@optimalrenal.com

Ramon Hannah, MD joined the Southern California Permanente Medical Group in 1978 as Director of Critical Care Services at the tertiary care center in Los Angeles. He is currently the Assistant to the Physician Manager of Operations, as well as serving as Founder and Chairman of the Management Board of the National Renal Credentialing Center, and Senior Vice President Medical Affairs of Optimal Renal Care. E-mail: r.hannah@optimalrenal.com

Who is FMCNA?

Joe Carlucci: FMC is the world's largest integrated dialysis services and products company. FMCNA includes all services and products offered in the US, Canada, and Mexico. In North America, FMC owns and operates 770 dialysis centers, treats approximately 56,000 patients annually, and is the leading producer of dialyzers, concentrates, and peritoneal dialysis (PD) supplies and equipment. The company also owns and operates the largest renal laboratories in the world: Life Chem and Spectra.

FMCNA maintains the world's largest patient database, thus enabling reporting of treatment outcomes and chemistry analyses on all its patients. A number of landmark studies have been written from data analysis of this database. FMC has also entered into agreement with the Renal Research Institute at Beth Israel Hospital in New York City to assist the company in research and development.

ORC will work closely with the Renal Research Institute to document and analyze its patient outcomes. ORC's patients will be part of the overall FMC database, as well.

How does Medicare fund dialysis care for patients seen in managed care and fee-for-service practices? What percentage of the Medicare budget is used for ESRD care?

J. Carlucci: Medicare funding for ESRD is changing. In the past, Medicare funded ESRD care through a "cost" program in which Medicare and the insurer shared in the Part A (hospital/facility) and Part B (professional or other practitioner) component, with Medicare assuming up to 80% of the allowed charges. This payment mechanism is being phased out under the Balanced Budget Act of 1997. Patients are now being converted to a "risk" plan, in which Medicare calculates the average costs for Part A and Part B payments on a statewide basis (the so-called average annualized per capita cost, or AAPCC) and gives the managed care plan 95% of that amount annually for the total cost of the patient's care. The managed care organization (MCO) is therefore "at risk" for keeping the cost of care below an average of about $3700 per patient per month (PPPM), equivalent to $44,500 per year nationally.

Progressively shifting costs to the private sector has long been a Medicare strategy. The Balanced Budget Act of 1997 provided for extending the Medicare secondary-payer period to 30 months; this means that individual insurers or health plans must pay the total cost of care for 30 months after the patient begins dialysis. Actuarial data suggest that the mean annual cost of care for an ESRD patient is between $60,000 and $80,000 per patient per year, versus the mean annual Medicare reimbursement amount, $44,500. Although ESRD patients represent <1% of the Medicare population, their care accounts for >6% of Medicare costs.

What is the relationship between ORC and Permanente physicians?

Dr. Hannah: First, ORC gives Permanente physicians and their Medical Groups additional opportunities to improve treatment outcomes, improve cost structures, and implement new technologies and modalities of dialysis care not available from other vendors.

Second, ORC allows Permanente physicians an opportunity to invest in a business that is poised for the future of ESRD care. HCFA recommends lifting restrictions that currently prevent ESRD patients from joining MCOs such as KFHP. MCOs will either experience more financial problems (as patients move to managed care for the financial benefits of "risk" products) or will turn to DMOs such as ORC for assistance in managing the cost of treating the chronically ill population.

Third, Permanente nephrologists may be given the opportunity to be Medical Directors in Permanente-affiliated dialysis units, which deliver state-of-the-art dialysis care for Permanente patients and others.

But ORC and the Permanente Medical Groups display another very important feature: ORC is but one example of the talents and ingenuity found in KP; and that each KP Region has similar programs and creative processes—unique in the health care sector—for managing patient care. We hope that ORC's success as both an operating business and as an investment will spawn other Permanente Medical Groups to launch other innovative programs.

What is the Medical Groups' relationship with ORC and The Permanente Federation?

Dr. Hannah: Purchase of ORC's services is a decision for KFHP entities to make regionally and for Permanente Medical Groups to make locally. Doing so provides an opportunity to internalize the services of nephrologists (if desired) and to purchase advanced dialysis therapy for patients.

Similarly, the decision to invest—or to decline the opportunity to do so—is an individual decision for each Permanente Medical Group to make.

The Federation charged ORC with helping KP Regions to become more cost-effective in managing ESRD and chronic renal insufficiency. National actuarial data and regional KFHP data clearly show that in every Region studied, costs of ESRD care far exceed amounts reimbursed. In these days of budgetary difficulties and fierce competition in the health care sector, improved cost structures would help everyone.

The other mandate from the Federation was for ORC to help various KP Regions to improve clinical outcomes in renal disease. We believe that the ORC Program will accomplish those goals, too.

How does ORC work?

Dr. Hannah: ORC contracts with its partner, FMCNA, to provide a unique program of dialysis treat-

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ment, the "ORC technologies and modalities." The ability to purchase the most advanced dialysis technology available is attributable to FMCNA having been primarily an equipment manufacturer before the company purchased National Medical Care. FMCNA is part of Fresenius Medical Care AG (FMCAG), a large German company that makes the most biocompatible dialysis membrane in the world and is a leader in dialysis research. The precise clinical benefits of these new forms of technology (eg, single-use dialyzers, blood temperature controls, on-line clearance monitoring, and use of ultrapure dialysate) require a knowledge of dialysis to appreciate.

However, the new modality of daily dialysis—not currently offered by any other dialysis provider—is not difficult to understand. Daily dialysis offers a quantum leap forward in terms of patient well-being, and we look forward to being the first DMO to offer such a treatment modality.

We usually ask FMC to build new dialysis units for each KP Region that contacts with us so that nephrology patient care (ie, office practice) and the ORC multidisciplinary team (ie, social worker, case manager, dietitian, and pharmacist) can together form an integrated nephrology care center. ORC supplies a case-management-centered patient information management system and a financial management system.

Care begins at the pre-ESRD stage, preferably as early as when the serum creatinine level reaches 1.5 mg/dL (132.6 µol/L in men (this level represents a 50% decline in glomerular filtration rate)). Our goals at this stage are to aggressively treat complications that deliver a sick patient to dialysis and to retard—if not prevent—progression of renal insufficiency to ESRD.

ORC supplies a multidisciplinary team that coordinates patient care under supervision of a nephrologist. The pharmacist has proven to be the most valuable team member for pre-ESRD care, the nursing care manager for ESRD care, the dietitian for nutrition care, and the social worker for rehabilitation.

ORC's contracts with FMC and nephrologists are structured so that incentives are aligned and everyone benefits from improved clinical outcomes by sharing in risk pools or quality-based incentives. ORC takes full risk or shares the risk in its capitated contract with a health plan or MCO. Because its reimbursement is no longer limited to Medicare-determined schedules, FMC shares the cost savings that result from keeping patients healthier and so can afford to offer ORC the latest technical advances.

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To whom will ORC be available?

Dr. Hannah: The primary target markets for ORC are the KFHP Regions as well as non-KFHP health plans.

Why would a managed care organization choose ORC for its patients?

J. Carlucci: In today's difficult, price-conscious, competitive marketplace, an MCO should ask for better outcomes, improved member satisfaction, and lower costs of care. ORC is prepared to guarantee a 5% reduction in current costs from the managed care organization's historical cost basis. We are confident that, coupled with our unique technology and modalities, our multidisciplinary care management program can permit us to realize substantial cost savings over time. Similarly, our unique contracting arrangement with FMC and the dialysis units as well as the team approach to care will result in greater member satisfaction. Experience in Southern California (and in particular, a favorable Standardized Mortality Rate of 0.78 for 1997) suggests that our faith in achieving improved clinical outcomes is well founded.

What are the advantages of using a multidisciplinary approach to patient care?

Dr. Hannah: The most obvious advantage is that the care coordinator or care manager can serve as a liaison within our complex health care delivery system. Obtaining appointments in our system can be daunting, especially to chronically ill patients. Many of these patients have comorbid conditions such as diabetes, cardiovascular disease, and malnutrition. Their care across the multiple medical disciplines therefore requires careful coordination—and such coordination obviates the need for duplication of services and prevents unanticipated side effects of therapy (a major problem seen in this group of patients). Having a care manager, dietitian, social worker, and pharmacist all helping the nephrologist care for patients makes the nephrologist far more efficient.

Using one person (ie, the care coordinator or care manager) as a point of entry into our health plan, coordinating all care, and communicating any problems to all the practitioners represents a major improvement in health care delivery that is difficult to achieve in fee-for-service medicine.

What standards of care are you trying to accomplish, and how do they compare with national standards?

Dr. Hannah: ORC assembled an international committee of experts in ESRD care to serve as ORC's Quality Standards Committee. Physicians from Italy, France, Canada, and the US were chosen for their

achievements in improving clinical outcomes, often by using different modalities of dialysis care. Experts in patient rehabilitation and dialysis nursing care were also added. In our first meeting, held in September 1998, we defined standards of care as well as practice guidelines for approaching cardiovascular disease in patients who have chronic renal insufficiency and ESRD.

We also defined a dietary approach to renal disease; proper timing of access placement and initiation of dialysis; and proper amount of dialysis to deliver. In addition, we agreed that new modalities of dialysis (specifically, daily dialysis) were essential for the success of our patients and of our organization.

In late October, we developed standards for COPD and dialysis and approved our quality assurance program. The standards we have developed exceed any nationally developed guidelines from either the government or from the renal care community and are the highest in the nation.

How do you know you can reach these high standards, and how will ORC ensure that these goals are reached?

Dr. Hannah: ORC had a number of Permanente nephrologists at the recent Quality Standards meeting in Washington, DC. In this and other forums, Permanente nephrologists have been very excited to finally have the greater ability to improve dialysis care for their patients—an opportunity they would never have had before ORC came into existence. Their enthusiasm and endorsement of the ORC program is our best guarantee of reaching our goals.

We have a vigorous Quality Assurance Program that ensures patient standards are met through an organized process of care that defines just how we will operate as a total team focused on a single objective—better outcomes for our patients. All providers have financial incentives to meet these standards; failure to do so results in financial penalties. The capitated payment system, which permits us to invest in programs and personnel to improve patient care, also removes many of the barriers to improve patient care that exist in the fee-for-service world. Given the financial rewards as well as a new opportunity to do the best possible for patients—two additional incentives—why would a provider not want to meet such standards?

Our success comes down to a wager: We wager that looking at the longitudinal costs of care, investing in programs and people to make patients better will result in healthier patients at time of dialysis, keep patients healthy during the dialysis years, and enable patients to receive transplantation. A healthy patient consumes fewer resources, particularly hospital bed days. Patients' well-being translates into operational success for ORC.

How does ORC generate income?

J. Carlucci: To date, ORC has signed three contracts on a capitated (ie, case rate) basis and is paid a fixed sum each month per ESRD patient. In addition, the payer reimburses ORC on a fee-for-service basis for the pre-ESRD patient population enrolled in the program.

ORC has also signed contracts with commercial underwriters to mitigate outlier costs or to purchase stop-loss insurance.

ORC generates income in two distinct ways. The first is by operating an effective, high-quality ESRD care program which produces cost savings by improving the health of ESRD patients, thus ensuring that they subsequently require fewer resources. At the end of the operating year, total cost of care is subtracted from total income derived from capitated payments; the surplus is divided (according to a preset formula) by ORC. After costs have fallen below the Medicare AAPCC (revenue to health plan from Medicare, using a capitated formula), cost savings are passed on to the health plan.

Income is generated also by providing pre-ESRD services such as availability of a multidisciplinary team and various patient education programs, for which ORC charges a per-patient-per-month (PPPM) fee.

Health plans have a difficult time determining the actual annual cost of care for an ESRD patient. Within the KP system, the number seems to be between $55,000 and $65,000 PPPY; other health plans have reported expenses as high as $70,000 PPPY. Because ORC contractually guarantees a 5% reduction in costs, the program is appealing on the basis of quality as well as cost reduction.

How can I learn more about ORC?

Dr. Hannah: Call the corporate office in Danvers, Massachusetts at 888-999-1413, or the SCPMG/Optimal Renal Care Office of Medical Affairs at 626-685-3499; we will be happy to discuss ORC with you.

If you are interested in ORC as an investment, please call the national PermCo office @ 510-987-4578. ❖

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