

# Narrow Networks

It's a matter of supply and demand.

BY JON A. HULTMAN, DPM, MBA

My original intent in writing this article was to discuss "narrow networks" and offer a few strategies for approaching payers who employ this particular tactic. Starting out, I did a Google search in an attempt to estimate the supply of podiatric physicians. My question: "How many DPMs are practicing in the USA?" The first listing that appeared was "Podiatrists—Bureau of Labor Statistics" and the second was "Frequently Asked Questions about the Future of Podiatric Medicine." Clicking on the second posting, I found it to be a webpage from Midwestern University. Reading through the FAQs, I came across the following—attributed to me!

It stated, "To quote Jon Hultman, DPM, MBA, 'If you believe that there are too many DPMs, you are neither recognizing the obvious favorable demographics which are poised to increase the future demand for podiatric medical services nor considering the untapped demand that is currently out there.'" This was cited from an article I had written in 1994, causing me to consider what conditions existing in the medical community at that

point in time had prompted me to make such a statement.

In 1994, the expansion of managed care and payment methods such as capitation were relatively "new" to the scene. Similar to today, physicians sought the predictions of experts to help them make decisions about how to adapt to the future, a future

were already "too many DPMs." In 1994, Keith Borglum, CHBC, a physician practice management consultant and a current editorial consultant for *Medical Economics*, stated in *California M.D.'s Business Advisor* that, "50 percent or more of specialists will have inadequate patient volume to maintain a practice." His recommen-

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for which many were predicting an oversupply of physicians. The July 20, 1994 issue of the *Journal of the American Medical Association* actually predicted that by the year 2000, there would be an overall surplus of about 165,000 patient care physicians and that the supply of specialists would outstrip the requirement for them by more than 60 percent!

At that same time, many well-respected podiatric physicians opined that several podiatric medical schools should be closed, declaring that there

dition was, "Figure out how many of your specialty will be needed in your area, and do what is necessary to be one of those who survive." One of the outcomes arising from such dire predictions was cutthroat competition, pitting specialist against specialist, with most doctors signing every ridiculous contract that landed on their desks out of fear that medical practice was about to become a game of musical chairs in which each one wanted to ensure that s/he would be

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seated when the music stopped.

How accurate were these predictions? Fast-forward to a 2010 headline appearing in the same *AMA News* that in 1994 had predicted an oversupply. It read, "Physician shortage projected to soar to more than 91,000 in a decade." The article went on to argue the need for a 15% increase in residency positions to train more doctors. How did the medical practice pundits move from a prediction of future oversupply to one of a dire shortage when no dramatic change had occurred in the either supply of physicians or the demand for physician services throughout the ensuing time period?

Many industries rely on "scientific methods" such as econometrics, regression analysis, and computer simulation models when forecasting future markets for their products and/or services. The problem is that these methods rely on historic data and trends to make predictions. This strategy can be compared to that of a passenger sitting in the back seat of an automobile moving along a highway, who is looking out the rear window and instructing his/her blindfolded driver where to go. As silly as this might sound, experts regularly make bold predictions using a similar method—looking to the past, and many people accept their advice because they see it as being "based on fact." While this method may be helpful when making short-term decisions—especially when change is linear—over the long-term, change is rarely linear. A forecaster needs to look forward, rather than backward, incorporating some common sense and reality checks to any final prediction.

The reality in 1994 was that some capitation plan contracts included as few as two DPMs for populations of 100,000. Access to most other specialists was also artificially restricted by having fewer than were needed—a tactic which created a skewed and artificial sample from which to project any future supply, or demand, for physician services. Given that the actual ratio of DPMs was approximately one per a population of 20,000, one could easily

have made the inaccurate projection of a future oversupply of DPMs. Over the short-term, these restrictive contracts certainly created hard times for many DPMs who practiced in the most competitive markets.

Common sense would have led doctors to predict that these contracts could not possibly last over the long-term. Examining the subsequent results of adhering to this type of contract, we see that, initially, patients covered by the most restrictive ones were happy to have any kind of in-

cause the networks are narrow. This will make them appear more financially attractive over the short-term. It is clear that in the future, doctors must be able to both demonstrate high quality clinical performance through the use of evidence-based medicine and become more efficient; however, this does not change the issue of supply and demand.

We know that the number of DPMs per population has not changed significantly since 1994, while demand for their services has

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surance and were in no position to complain; however, as these plans grew in size, complaints grew—especially from the ranks of baby-boomers who, among other things, did not like to wait for appointments or in medical waiting rooms; patients also wanted to see their own doctors. The rest is history.

Our look at the past serves as a segue back to our current concerns regarding the narrow networks that have surfaced following the implementation of the ACA. There is a new twist this time around. In addition to the similarity that narrow networks artificially constrain access through utilization of population-to-doctor ratios much higher than average, health plans are now also trying to reduce costs by employing paradigms that were nonexistent in the early days of managed care and capitation. These include the use of patient-centered medical homes for six chronic conditions, better coordination of care, and the incorporation of quality and efficiency measures into networks using contracts with doctors who meet standards for both clinical performance and efficiency (with efficiency defined as providing services to plan members for less than the doctor usually charges).

Early cost-savings data for these new plans will be skewed because costs are initially lowered simply be-

increased and will continue to do so based on such realities as the aging population, the growing diabetic population, and the fact that patients who have many of the most costly chronic diseases benefit from increased walking.

Regardless of tactics implemented—such as narrow networks or unnecessarily complex reimbursement policies—doctors should have confidence that demand cannot be artificially suppressed over the long-term. Do we need to worry about developing new strategies to survive with the development of these narrow networks? While we can't predict the future with absolute certainty, I believe that over the long-term, the odds are small that narrow networks can work; this need not be our primary focus. In contrast, the odds are high that evidence-based medicine, clinical quality, and efficiency will become the norm, and these are what we must be preparing for. **PM**



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