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The Next Shift: Managed Care

Duffy and Farley illustrate an important and by now well-documented truth about medical care: whether, when, and where to deploy medical technology is frequently discretionary. The authors document the dramatic changes in patterns of hospital care between 1981 and 1986 that were fueled by changing financial incentives.

Another major paradigm shift in the organization and delivery of medical care is now underway *(1)*, this time fueled by change from fee-for-service to capitation payment for medical care benefits. This shift is currently being driven by the private sector, but will soon spread to Medicare, Medicaid, and other public sector programs. The changing patterns of care documented in the Duffy paper provide insight into what we can expect.

The trends described by Duffy and Farley were driven largely by a change in the way Medicare paid hospitals. In 1983, the system of payments to hospitals was changed from one based on costs to one based on fixed prices per admission. Each price was determined by the patient's diagnosis. Whereas cost-based reimbursement using Diagnosis Related Groups (DRGs) sends the message "do whatever seems necessary—costs don't matter," DRG-based payment send the opposite message—"If what you do costs more than we'll pay, you eat the difference. But if you can find ways to deliver care for less, you keep the difference." As documented in the paper, patterns of hospital care, which had taken decades to evolve, changed quickly.

The paradigm shift now underway is going to make the change from cost-based reimbursement to DRGs look tame by comparison. Unlike the earlier shift (which was confined entirely to hospitals), the shift from fee-for-service to capitation payment is driving and will continue to drive major structural changes in the health care industry across all sites of service. In order for a capitation payment to work, it must be administered by an organization capable of *managing* a broad range of services, of enrolling a defined population, of accepting responsibility for what happens (or doesn't happen) to *all* of the enrollees, and of managing to generate a profit within a budget (whether or not it's called a profit doesn't matter). In other words, real managed care has finally arrived.

Like DRGs, capitated payment systems will reward those providers who are best able to constrain the costs of medical care. In those local markets where significant choice among plans exists, those plans best able to retain their current enrollees and recruit new ones will be rewarded.

For the past thirty years, our medical care system has been characterized by increasing specialization and fragmentation, and by little attention to efficiency. For the first time on a grand scale this system is being brought under a management umbrella and subjected to strong penalties for inefficiency and strong rewards for efficiency. This development is providing the opportunity to rationalize the way medical care is delivered at the local level within the private sector and without massive and highly centralized regulation. These are objectives that twenty-five years of public sector initiatives have failed to accomplish.

In an unstructured fee-for-service system, intensive micromanagement of medical care (in both public and private sectors) was the only way to control costs. This environment spawned increasingly prescriptive regulation of the scope of insurance benefits, professional fees, institutional budgets, system capacity (implemented through Certificate of Need laws), and even individual procedures (second surgical opinions, rigidly applied protocols, preadmission and concurrent review of hospital care). In contrast, by directly limiting per capita costs, HMOs and other managed care systems hold the potential for drastically reducing the need for such inflexible, often rigidly applied and always contentious techniques. The demise of centrally determined interventions will free managed care plans to innovate at the local level.

By rigidly prescribing which services will or will not be covered, indemnity health insurance covering fee-for-service mechanisms of paying for medical care (which were unbudgeted and unlimited) have locked dysfunctional ways of doing things in place, thereby acting as a powerful deterrent to the development of efficiency-improving innovation. It is only after these modes of payment have been replaced that real progress can be made.

A case in point is the On Lok program in San Francisco. For the past twenty years or so, the innovators responsible for the development of On Lok have demonstrated the power of capitated payment. In exchange for

accepting the budgetary discipline of capitated payment, On Lok has been given the freedom to spend Medicare and Medicaid dollars in innovative ways. They are able to provide many additional services (such as day care, transportation, meals on wheels and visiting nurses) to some of the most frail elderly in their communities for no more than the cost of hospital, nursing home, and physician services in a fee-for-service environment. This model has now spread to other communities.

Does the potential exist for abuse of capitated systems? Of course. But, as we are now seeing, the opportunity for fraud and abuse exists under fee-for-service as well. The problem of fraud and abuse is a very important one, but is more appropriately handled by law enforcement authorities than health policy analysts. Honesty in a world of capitated delivery systems can be encouraged by a combination of the free flow of information and regulation—intended both to level the playing field and to assure access to managed care plans for everyone—and real choice among plans at the local level.

The paradigm shift now taking place may be a necessary prerequisite to much needed and fundamental reform in the way health care in the United States is financed *(2)*. Effective cost containment and real improvements in the efficiency in the organization and delivery of medical care may have to precede any significant efforts to deal with the growing problem of the uninsured. Perhaps only when that has been done will the United States join the club of civilized nations, making medical care a right for all its citizens.

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References

1. Caper, Philip. "Shifting to a New Medical Care Paradigm" *Infocare,* February 1995
2. Caper, Philip. "Managed Competition that Works" JAMA 269:19:2524 May 19, 1993

Medical Care Cost Containment and Quality Assurance

Old Paradigm	New Paradigm
Component Management	**Statistical Process Control**
• Case by case examination and challenge, conducted outside a management framework	• Pattern analysis—broad based monitoring of the processes, costs and outcomes of care
• Micro-management of individual clinical decisions	• Management based on patterns of care across all settings
• Unstructured use of protocols	• Focussed review and management of individual cases, within the context of overall system performance
• "Quality" measures usually focussed on clinical encounter	• "Quality" explicitly includes system performance

Medical Care Financing and Organization

Old Paradigm	New Paradigm
• Unstructured Delivery System	• Integrated System—capable of managing a broad and complex range of services
• Oriented toward individual patients and providers	• Oriented to caring for a defined and enrolled population
• Fee-for-Service, creating incentives to maximize number and prices of services	• Capitated payments from enrollees, creating incentives to minimize numbers and cost of services
• Non-Budgeted	• Defined budget