Research Agenda for Managed Care

Introduction: Research on Health Care Organizations and Markets–The Best and Worst of Times

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The breathtaking pace of change in the way health care is financed and delivered has brought challenges and new activities to all participants in the health care system. Employers are assuming roles as value purchasers; consumers, physicians and other health professionals are finding they must learn new ways to interact with each other; federal and state officials increasingly are using their power as purchasers as well as regulators to assure quality of care for their beneficiaries; hospitals and medical groups are learning how to assume and manage risk. The direction and speed of this transformation also creates—or should create—a similar sea change in the way researchers do their jobs: what questions we ask, how we ask them, how we find answers, and how and to whom we convey the resulting information.

For health services researchers, this could be the best of times. Major experimentation in social programs (Medicare, Medicaid, and public assistance, in particular), coupled with unprecedented levels of change in health care markets, creates a dizzying array of natural experiments crying out for research about what works (or does not work) and why. But if research does not rise to the challenge, this also could be the worst of times. If we miss the wave (or seek out calmer research waters), we may discover we have nothing to say about the issues that matter most to public and private decision makers, consumers, and other potential customers for our work. This challenge is particularly important for government research groups such as the Agency for Health Care Policy and Research (AHCPR). At a time of strained public resources it is more important than ever that public research dollars be used to provide timely and pertinent information that can be used to promote and improve the nation's health (Gaus and Fraser 1996).

AHCPR was created by Congress in 1989 to generate and disseminate information that improves the delivery of health care: to determine what

works best in clinical practice, improve the cost-effective use of health care resources, help consumers make more informed choices, and measure and improve the quality of care. In the last two years, the Agency has expanded its activity in managed care and health care markets. A new Center for Organization and Delivery Studies is conducting and supporting an expanded portfolio of research on managed care and health care markets ("Agency Launches New Center for Organization and Delivery Studies" 1996; Agency for Health Care Policy and Research and Health Affairs 1997). Two recent Requests for Applications (RFAs) are supporting major research initiatives on health care markets and managed care (Agency for Health Care Policy and Research 1995, 1996a), and recent NIH Guide Announcements invite further applications in these areas (Agency for Health Care Policy and Research 1997a,d). Through a new small research grant process, research conferences, research partnerships, and other initiatives, the Agency is also seeking to identify and use new and more pertinent databases and research methods, fund and conduct research in a more timely fashion, and identify new avenues for disseminating findings so that they reach those who need and can act on those findings (Agency for Health Care Policy and Research 1997c; American Association of Health Plans and Agency for Health Care Policy and Research 1997; HMO Research Network 1997; The Severyn Group 1997).

Finally, to make sure that we are asking the right questions and targeting scarce research dollars in ways that will produce the information most needed to improve health care, the Agency is conducting some "market research" of its own: taking every opportunity to talk to the current and potential users of our research findings to enlist their help in identifying priorities for research. As part of this effort, in January 1997 AHCPR brought together a group of physicians, hospital administrators, purchasers, researchers, policy analysts, managed care experts, and others for a two-day expert meeting. As a springboard for discussion, we commissioned four short papers to

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In January 1997, the Agency for Health Care Policy and Research held a two-day meeting of experts to identify central questions for research in four priority areas: health care markets, managed care and access, chronic illness, and long-term care. Four short papers were commissioned to stimulate discussion. This section contains the four articles, and an introductory article, all independently peer-reviewed.

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identify the central research questions for the future in each of four areas: health care markets (Robert Hurley), managed care and access (Nicole Lurie), chronic illness (Ed Wagner), and long-term care (Robert Binstock and William Spector). The ensuing discussion focused on three cross-cutting questions: What are the most critical research questions stemming from changes in health care markets and delivery? What methodological challenges will need to be met for research to answer them? What is the most necessary and compelling role for government in this effort?

Revised versions of these four papers, articles based on independent peer review, follow in this section. While the authors take very different approaches to the subject, some clear common themes emerged in the articles and in discussion on these issues at the January meeting. The following short reflections build on these discussions, as well as on similar recent conversations with other researchers and public and private policymakers.

Emerging Research Areas

1. Studying the Right Things: New Players and Markets. The first and most obvious challenge for research is our need to focus on the primary players in the market, players who have changed dramatically. Past research has focused on hospitals and managed care plans, but we know little about purchasers, who, as Robert Hurley notes, have been the principal drivers of change. Purchasers began by enlisting managed care organizations to hold down prices and in some cases went on to seek greater value rather than simply better price. Some employers and coalitions are now seeking to deal directly with provider-based organizations and to expand the options and powers of consumers in choosing among these organizations. A few "pioneers" also are seeking to explicitly reward health plans and providers who can prove they are providing higher value (Meyer, Rybowski, and Eichler forthcoming 1997), and are working together to encourage high performance among plans and providers serving their enrollees (The Severyn Group 1997). To understand health care markets, we will need answers to some very basic questions about the nature, extent, and impact of these trends among purchasers. We also have only limited knowledge about the other reportedly merging players in this relationship—the provider-based integrated delivery systems (Shortell, Gillies, Anderson, et al. 1996), community care networks (Bazzoli, Stein, Alexander, et al. 1996; Bogue and Hall 1997), and new large physician group practice arrangements (Robinson 1995). Finally, as Robert Binstock and William Spector point out, changes in financing and market structures

are affecting long-term as well as acute care providers and services, but most research on managed care and health care markets has not included the long-term care component.

A related research challenge is the need to focus on the most critical differences and relationships among these market players. This is a difficult task at a time of rapid change when even venture capitalists and other investors are having difficulty distinguishing between early strong trends and trendy false starts. At a minimum, however, it seems critical that we supplement our study of mergers with studies of other kinds of measures of corporate growth and market dominance (see, for example, Robinson 1996; Fuchs 1997) and look at variables such as the locus of ownership (national vs. local) as well as the more traditional distinctions between for-profit and not-for-profit institutions. (See special issue of *Health Affairs* 1997.)

2. Research At (and Among) the Right Levels: Defining the Units of Analysis. A second challenge for future research is to identify the most useful units or levels of analysis and to know when it is time to change the focus. A generation of very important research has concentrated on differences in incentives, performance, and outcomes between managed care and indemnity plans. But it is time to move on, to look at new levels and new connections.

First, we need to focus on more micro-level elements within managed care. Managed care in some form is becoming the most common mode of health care delivery, and differences among arrangements that fly under that name are now often greater than differences between managed care and indemnity arrangements (which themselves have adopted many of the features originally associated with managed care). As Ed Wagner points out, it is now critical that we begin to understand the impact of particular managed care features and arrangements. As a corollary, researchers increasingly need to understand and explain differences at the provider level of individual hospitals, clinics, and physician groups, because that is the level at which these variations in incentives and care models may well play out. As noted earlier, some of the more sophisticated purchasers appear to be seeking information on quality and value at the provider rather than the plan level, and consumers also are increasingly recognizing that the financial and other incentives of providers may have an impact on quality. Responding to this purchaser demand will be a significant challenge, because provider units may relate to several health plans, each with distinct data systems.

A second and even greater challenge will be to examine how the different levels—individual physician, group practice, integrated health system—influence each other. To meet this challenge one must confront measurement issues involving appropriate linking and aggregation of data at each level.

Finally, even as we move our focus down to smaller provider-based units, we also may want to think about broadening our focus in other ways, to look at the continuum of care, and at the structures and models that maximize care coordination and clinical integration. This continuum also may include activities outside the traditional medical care system. Because of new financial incentives and the growing focus on outcomes as a measure of quality, some plans and providers will need to broaden their attention from sick care to prevention and wellness. (Some plans and providers, of course, have taken this approach for many years.) Full implementation of this wellness orientation, in turn, requires collaboration and coordination with social services and public health. Research on the dynamics and successes of some of these collaborative models will be very useful.

3. Identifying the Critical Variables: Moving Beyond Money. A third challenge is to broaden our disciplinary horizons when positing hypotheses about differences in behavior and outcome among health plans, providers, and others in the market. Most managed care research has been structured around the premise that financial incentives influence behavior. While research findings indicates that this hypothesis has some merit (Hillman, Pauly, and Kerstein 1989; Hellinger 1996), it is also clear that such explanations fail to account for many significant variations. In particular, the work of Shortell, Gillies, Anderson, et al. (1996) indicates that factors such as organizational culture and leadership can have a powerful impact on behavior and outcomes, but many questions about these nonfinancial incentives remain. Further research on understanding the determinants of organizational behavior and processes of organizational change could be very helpful. For example: Do provider-based models (such as integrated delivery systems) have different clinical cultures and priorities than insurance-based models? Are motivations and ethics different in for-profit vs. not-for-profit systems? Many observers suspect that being publicly traded may be a more powerful organizational influence than for-profit status: Does the research bear this out? How do some of the newer "virtual" organizations achieve the organizational capacity to meet their needs? How can organizational culture be changed to meet new market demands? What happens after two organizations with very different organizational cultures merge or become partners? To what extent and in what ways do changes on the demand side (value-based purchasing efforts by employers, use of report cards, involvement of patient advocacy groups, accreditation activities, etc.) affect the incentives and behavior of plans and providers?

4. Impact of Policy Changes: The "So What?" Questions. A fourth imperative for research is to relate events and trends in public and private financing and delivery of health care to outcomes such as access, cost, and quality.

This is not a new question, but the speed and simultaneity of changes in the marketplace raise both the stakes and the hurdles to finding answers. At the micro level, it is important to know the effect of adjustments in financing and delivery of services. Do cost-sharing requirements (particularly under some of the newer point-of-service arrangements) engender more selective decision making by consumers or delays in obtaining necessary care? Do changes in the composition of primary care teams (and other changes in the division of labor among professions) increase or decrease patient-provider communication and patient satisfaction? Does removal of a primary care gatekeeper increase unnecessary utilization and/or costs? The multiplicity of market-induced natural experiments provides an obvious opportunity to study such questions and to conduct intervention research in health plans and provider groups, although the difficulty of identifying a control group in the current environment of change presents formidable challenges.

At the macro level, it is critical that we examine the cumulative impact of changes in public and private programs on access to care, particularly for the more than 40 million people who are now uninsured. As one participant in January's expert meeting pointed out, for example, simultaneous changes in Medicaid, welfare, and immigration policy may be creating a witching hour for access to health care by poor and near-poor children. Some of these market-level changes may also be having a profound effect on individuals with private insurance. As plans and providers merge, form new organizations, win and lose contracts, acquire and sell physician group practices, how does all of this activity affect continuity of care for the enrolled population? Public and private policymakers will need data on these issues as quickly as possible.

In particular, research is needed on the impact of market changes and alternative financing and delivery arrangements on people with chronic care needs. As Ed Wagner points out, managed care has the potential to be especially beneficial to individuals with chronic care needs, but research has yet to offer proof that this promise has been realized. Participants at AHCPR's January meeting, and their counterparts in other meetings convened by the Agency (Agency for Health Care Policy and Research 1996b, 1997b) have expressed concern that some of the financing incentives and delivery arrangements that appear to work for individuals with conditions requiring acute care may not work for individuals with chronic care needs. In either event, there clearly is a need for research identifying which managed care features or models of care are more likely to be linked with favorable outcomes for individuals with chronic conditions, and in particular for individuals with multiple chronic conditions.

As a related issue, there appears to be a growing recognition of the need to measure impact at the community level. Public and private purchasers are each in their own way trying to reduce costs and increase the quality of services for their own groups of employees and enrollees, but it is not clear when or if these efforts result in community-wide improvements or just in new forms of cost shifting or risk shifting. An important question for research is the consequence of particular market configurations on public goods, and in particular the identification of mechanisms that have worked to provide these goods—access to health care for the poor, clinical training, the conduct of clinical research, and the provision of certain high-cost services such as trauma care, for example—even in these changing markets. The growth of strong employer purchasing groups, and a few more ambitious public-private purchasing coalitions provides a particularly good opportunity to examine some hypotheses about the community-wide impact of these efforts.

Conceptual and Methodological Challenges

Answering these four types of policy questions will require rethinking and debate on central concepts and approved scientific method, concerted effort in measurement development, and mechanisms to bridge proprietary interests and create uniformities in data.

1. Rethinking How We Conceptualize, Classify, and Study Managed Care and Health Care Markets. Probably the greatest challenge to research on managed care is the fact that market realities have evolved far more quickly than has our ability as researchers to conceptualize and classify them. As a result, it is not clear how to isolate and measure those features of the complex new health care organizations that are likely to be most important to use of services, customer satisfaction, health status, or costs. The old alphabet soup configurations of HMOs, IPAs, PHOs, and so on no longer do the job, but no generally accepted alternative framework has emerged. To address this issue, AHCPR has been leading and encouraging the development of new conceptual frameworks for analyzing the configuration, operation, and impact of emerging health organizations and markets (see "Agency Launches New Center for Organization and Delivery Studies" 1996; Conrad 1997; Bazzoli, Shortell, Dubbs, et al. 1997).

A related issue is the need to align our definitions of respectable research methods to the questions at hand. Researchers sometimes have a tendency to start with the database and then analyze whatever questions the data can answer. While this approach yields greater efficiency for individual researchers, the aggregate result may be that we as a nation produce lots of

research answering yesterday's questions and little research answering today's and tomorrow's. Funders of research have an obligation to make sure that the realities of the peer review process do not exacerbate this problem. But funders cannot do the job alone. Researchers also need to take some new risks and close some old data files. In particular, it must be recognized that for certain kinds of questions the most appropriate methodology may be the use of rigorous qualitative research drawing on well-executed comparative case studies, or of a combination of qualitative and quantitative methods.

2. Developing New Measures. A second cross-cutting need to support research and policy on managed care and health care markets is the development of new measures to adequately answer the "so what?" questions. Without further work in the area of risk assessment and adjustment, for example, public and private purchasers will find it very difficult to compare quality among plans or providers, and will also find it difficult to create a payment system that provides appropriate incentives to plans and providers who take care of people with chronic care needs. Similar problems arise in each of the substantive research areas: to study access, as Nicole Lurie points out, we need better measures of underutilization and cultural competence. To evaluate long-term care quality, Robert Binstock and William Spector note, we need better measures of quality of life and health status.

3. Building Research Bridges. A final cross-cutting methodological issue concerns the need to provide the infrastructure and mechanisms needed for research on common questions, even as individual stakeholders pursue their individual data collection on proprietary questions. For example, experts at this and other meetings have indicated that national leadership would be helpful in the creation of encounter data and information system linkages and uniformities, and in the creation of a market-level area resource file. Many have also suggested the need for a neutral convening body to try to pull together multi-site intervention research and other health services research in ways that protect but still transcend the appropriate proprietary and competitive market interests of those involved.

Conclusion

The pace of change does not appear to be slowing, and a new generation of health services research will need to evolve just as rapidly if researchers are to address important issues. The stakes (and risks) have never been higher. We hope the four articles presented here will stimulate discussion among *HSR* readers about ways in which research can rise to the challenge and will foster further dialogue with AHCPR and others about how we can be most helpful as partners in this process.

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