Editorial Column

Getting at the Management of Care Within Managed Care

The importance of assessing the overall value derived through managed care was a major theme in Stephen Shortell's editorial in the December 1997 issue of *Health Services Research.* In this issue of *HSR,* Nelson, McHorney, Manning, and their colleagues augment our understanding of the role and impact of prepaid managed care plans on the cost side of the "value" equation. Like many researchers before them, the authors of this study correctly note the inability of their research to identify what it is about managed care per se—what policies, practices, and protocols—are most influential in generating observed cost-savings. In this editorial, I would like to summarize what we have learned from existing research, the important questions that remain, and perhaps some important and largely untapped opportunities to address these and other unresolved questions about managed care.

What have we learned about the differences between healthcare delivery under managed care plans relative to "unmanaged" indemnity insurance? Based on reviews of recent empirical literature, Miller and Luft (1994,1997) generally conclude that HMO enrollees have lower utilization of costly health services, similar or more physician visits, more preventive care, and mixed differences in satisfaction and health outcome when compared to individuals covered by traditional indemnity insurance plans.

Nelson, McHorney, Manning, et al. in this issue of *Health Services Research* add to this body of knowledge by specifically focusing on elderly patients with multiple chronic conditions. Study of this patient population is important since, as the authors note, "older people afflicted by chronic medical problems can benefit from good care or be harmed by its lack" (p. 770). Growing interest in expanding HMO enrollment under Medicare further heightens the need to understand the care received by elderly patients with chronic conditions through managed care systems.

The Nelson study examined 1,681 elderly patients with chronic conditions from the Medical Outcomes Study (a four-year prospective data collection effort that obtained health services utilization and outcomes data

in the mid-1980s for about 20,000 enrollees of HMOs and traditional indemnity plans in selected geographic areas). They found, after adjustment for differences in multiple patient characteristics, that patients with chronic medical conditions who were covered by prepaid health plans had fewer hospitalizations than their counterparts covered by indemnity health plans. Outpatient visits, on the other hand, were slightly higher for HMO patients but this difference was not statistically significant. Clearly, coupling these findings with an understanding of the potential differences in health outcomes for this patient population is vitally important given the burden of illness faced by the patients with chronic conditions.

Another point of consistency across the current study and those reported elsewhere is the understanding that research has not revealed the contents of the "black box" of managed care. Specifically, what features of managed care—precertification of health services and other utilization review, physician panel selection approaches, provider reimbursement methods—are effective in creating cost savings? Miller and Luft (1997) define the situation well when they state that "we are beyond the point of wondering if any HMO plans 'work' . . . and need to know why some HMO plans 'work' " (p. 19).

This is especially important since unfettered, unmanaged indemnity coverage is becoming more of a distant memory than a reality. As noted by many others, health plans—including those that continue to pay on a fee-for-service basis—are adopting utilization management techniques to control health services utilization so that they remain price competitive in the marketplace. Diversification of insurance products has also occurred with Preferred Provider Organizations, Point-of-Service plans, and HMOs with POS options, all of which join together certain features of indemnity insurance with other features of traditional HMOs.

For many reasons, it has been difficult to obtain information on care management practices from health plans. Such information may be considered proprietary by health plans given the highly competitive nature of health insurance markets. In addition, health provider panels associated with given health plans are vast and highly variable. Health plans may be employing a menu of care management practices, with one set of practices applied to certain groups of health providers and a different set to others based on the terms of provider contracts and reimbursement. Knowing what policies and practices a health plan generally uses is not very useful if we do not know the providers to whom they are applied.

Market developments in managed care, however, may provide new and unparalleled opportunities to assess the impact of care management

practices on cost savings. Physician medical groups are increasingly assuming the clinical and financial management responsibilities as they take on capitated payment arrangements (Gold, Hurley, Lake, et al. 1995; Goldfield, Berman, Collins, et al. 1992; Hillman, Welch, and Pauly 1992; Robinson and Casalino 1996; Wholey and Burns 1993). This is especially true in the high HMO market share communities of California, Minnesota, Oregon, and Washington. As this contracting approach becomes more common and comes to represent a significant portion of a physician's practice, providers will undoubtedly adopt specific care management approaches so that they can live within their fixed per member per month payments.

Specifically, one would expect physician medical groups or their affiliated health systems, management service organizations, physician-hospital organizations, or practice management companies to develop and implement protocols to manage high-cost services; clinical guidelines for the care of patients with particular diseases; demand management programs to influence patient health-seeking behaviors; clinical information systems to capture data on utilization, costs, and outcomes; provider profiling and feedback mechanisms to provide detailed data on utilization and costs by physician; and total quality management approaches.

There is a pressing need for health services researchers to develop and undertake high-quality qualitative and quantitative research to understand what happens within the "black box" of care management. Case studies to identify the types and intensities of care management techniques applied by provider organizations are an essential starting point. We also need to develop and test survey instruments and protocols to capture these dimensions on a larger scale in order to facilitate empirical analysis. Identifying patients to which provider care management techniques are applied is likely to be more tractable than trying to identify and link health plan practices to providers and ultimately to patient populations. At a minimum, if we can ascertain the share of a medical group's patients covered through capitated arrangements, we can examine the types of care management approaches the practice develops and the relationship between this and aggregated outcome, utilization, costs, and quality of care data.

Some early research has already begun along these lines. Conrad, Wickizer, Maynard, et al. in the August 1996 issue of *Health Services Research* provided a preliminary look into the black box of managed care, focusing on a small group of hospitals and their affiliated physicians. Kralewski, Wingert, Knutson, et al. (1996) provided insights on how capitation affects the organizational structure and processes of medical groups in Minnesota. These studies

provide a foundation on which we can build more broad-based studies in the future.

Another interesting aspect of recent market development in managed care is that the capitation of health providers brings us back to the original conceptualization of managed care in the United States. As noted by Smillie (1991) and Ellwood and Lundberg (1996), the health maintenance movement was originally based on health providers assuming the fiscal and clinical responsibility for a defined population of enrollees. Why the evolution of managed care in the United States moved away from this framework initially—with health plans assuming fiscal responsibilities—and now is moving back to this original concept represents an important area of study. Specifically, an assessment of the key political, organizational, economic, and social factors that led to this somewhat circuitous development path would be valuable.

Overall, Ellwood and Lundberg (1996) appropriately speak of managed care as a "work in progress," one that will continue to present challenges but reveal new opportunities to health services researchers in the years to come.

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