

Task Force on Managed Care - What We Would Consider in Designing a Managed Care Model for the Capital Region

Introduction

This paper was developed by the Task Force on Managed Care, which was sponsored by the Institute for the Advancement of Health Care Management of the State University of New York at Albany (SUNYA). The Task Force met during 1995 to identify issues and recommendations for a Managed Care Model for New York State's Capital Region (comprising the towns and counties around Albany, New York). The Task Force was comprised of a cross section of the community, including physicians, health provider executives, consumers and advocates for the disabled, regulators, trade organizations, and consultants. Periodic meetings were held to define the scope of this concept paper, to obtain education on managed care issues, and to work through various drafts of materials.

The rapid growth in managed care has historically been driven by cost containment as managed care generally costs less than traditional indemnity coverage. Managed care has provided the focus for much of the health system restructuring effort, using models and concepts already observed and implemented in other areas of the country. Many of the details of any proposed Capital Region managed care model would be shaped by such considerations as the local marketplace dynamics and regulatory constraints at the time of implementation. Details will also likely change rapidly over time. For these reasons, specifics were beyond the scope of this paper. The prime focus was on identifying the major issues and dynamics, as well as a framework for going forward, as outlined below.

I. Environmental Factors (WHY We are Going WHERE We are Going)

- A. Pent Up Pressures for Change (Increasing Complexity, Rapid Innovation)
- B. Fear of What the Future May Bring
- C. Fear of Current Changes and Changing Roles
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II. Evolution / Transition (HOW Will We Get There)

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- B. From Segmented Delivery Model to one Integrated Across the Continuum and Time
- C. From Reactive Model to a Proactive / Planned / Preventive Model
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- A. Achieving a Balance Between Stakeholders (What is Delegated to Whom)
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I. Environmental Factors (WHY We are Going WHERE We are Going)

A. Pent Up Pressures for Change (Increasing Complexity, Rapid Innovation)

1. Rapid Changes in Healthcare technology, delivery and financing systems, quality measures, and consumer expectations have occurred for several decades. The result is an industry which is increasingly complex and difficult to understand. As we can do more, we all expect more. At the same time, demand for health care services is increasing due to our aging population and the fact that we realize that we cannot provide everything to everyone - some form of rationing or queuing is inevitable.

2. Managed Care is a major trend spreading across the country and across payor categories. This market driven concept facilitates change by promising effective care at a lower cost.

3. A two-tiered system of health coverage is likely in our society, which strongly values free choice and resists outside pressure and constraint on this free choice. The marketplace will move toward a basic contract at a standard "commodity" price. Services beyond this package will be funded through added "out-of-pocket" deductibles or coinsurance for those willing and able to pay. This exists today through various optional "riders" and through "point of service" plans.

B. Fear of What the Future May Bring

1. Significant fear paralyzes, while a little fear motivates. Health reform inertia in recent years is due to major fears of what the future will bring, indeed, whether an ultimate solution even exists. Today in New York and the Capital Region, we know that at least some changes will occur, and soon. A major consideration of the Task Force is to define the direction of these changes.

2. Many fear we won't like the future, although we don't know with certainty the details of it. We have been bombarded for years with a vision of tomorrow where Social Security and Medicare are bankrupt. Even without bankruptcy, there will be fewer workers to fund the retirement and health care needs of the aging "Baby Boomers." Universal health coverage, access, and insurance portability is a public policy GOAL. However, domestic and global competition is fueling downsizing and other threats to employment and financial security. This in turn threatens access to needed health care services even for those who have health insurance today.

3. Individual and institutional providers want to provide quality care and want to be paid a fair rate, in a timely manner. They are afraid that insufficient funding will threaten their survival at worst, or adversely affect their ability to provide needed quality services to their patients at best. They also fear that they will be required to provide services without payment.

4. Third-party payors only want to pay for appropriate, cost-effective care. They fear competition with each other, price gouging by providers, and attempts at regulatory micro-management.

5. Consumers want (and will demand) friendly and convenient access to high quality healthcare (at least based on their perception of quality). They are afraid they will not be able to get what they need when they need it due to fiscal incentives to withhold services. Health care is NOT a normal commodity. Individuals faced with illness and survival are not going to "shop around" as they might for other

commodities due to this strong, emotional fear.

C. Fear of Current Changes and Changing Roles

1. Stakeholders are any entities (individual or organizational) which will be affected by the implementation of managed care. The most basic issue and dynamic for each stakeholder is the need to understand and control the healthcare segment for which they are responsible. Roles and responsibilities are changing for most stakeholders.

2. Stakeholder roles are blurring as risks, responsibilities, and knowledge is shared. Regulators are now consumers and third party payors. Consumers are more responsible for coordinating and paying for their own care. Managed care organizations have originated in both third party payor and provider organizations. Taking on these new responsibilities is a challenge, particularly in a competitive environment. On any given moment of any day, stakeholders will need to ask themselves "What hat am I wearing at this moment?," for example:

Stakeholder Role Overlaps	Acts As A Consumer When:	Acts As A Payor When:	Acts As A Provider When:
Consumer	Accessing Services	Paying Deductibles and Co-Insurance	Researching His / Her Own Treatment Options
Managed Care Payor	Purchasing Services from Providers	Paying Providers for Services	Providing Preventive, Diagnostic, Educational, or Treatment Services
Provider	Buying Reinsurance Or Sharing Risk	Operating as a Capitated Entity Accepting Risk	Directly Providing Services

3. Aligning incentives to produce a “win-win” solution is a major challenge. Well-positioned stakeholders are tempted to "make a killing" during times of transition and rapid change. Others fear this position imbalance as a challenge to their ability to control their own destiny. For example, "any willing provider" provisions raise the concern from the provider side that even if they are one of the "chosen" this year, they may not be next year and will look to government to level the playing field. On the other hand, managed care organizations are concerned that these provisions would mandate them to accept high-cost or low-quality providers into their networks.

4. Government regulation will still be needed. Regulations may be obsolete and unnecessary in an efficient and highly competitive marketplace; however, the current marketplace is neither efficient nor competitive. Stakeholders still look to Government to help level the playing field, but somehow avoid over-regulation. This mixture of the old regulatory framework with the new marketplace model will contribute to the confusion of blurring roles. There is also great fear that legislative / regulatory action will be driven by "knee jerk" responses to isolated yet vivid anecdotal quality or access problems which almost certainly will arise during any time of rapid change.

5. Regulatory changes will originate at a federal level. Some form of "block grants" may delegate power and funding down to the state and local level; however, there will be a requirement to conform to

federal initiatives. This will tend to delay meaningful state or local reforms while waiting for federal action.

6. Marketplace redefinition, particularly with the emergence of "new" provider types (e.g. Assisted Living, Subacute, etc.) and shifts in service location (e.g. institutional vs. home care) will cause major rethinking of management approaches to accommodate the new dynamics.

7. Concerns about the timing of Certificate of Need reform, capital access, and the entry of publicly-traded companies relative to the timing of payment reform are significant to institutional providers. There is a great fear that market forces may not be possible with regulatory constraints still in existence in the CON area. At the same time, there is a fear that access to capital will be constrained for current providers. Many fear that opening the New York market to publicly-traded companies (which could resolve the capital access issue) would come at the expense of access constraints to consumers, due to the profit motive.

D. Choice: The Informed Consumer (Who is Aging in Place)

1. Choice in healthcare is desired and demanded by consumers. A range of benefit packages, differentiated by the degree of consumer financial stake / cost participation, will provide one aspect of choice (or perception thereof) to the consumer.

2. Consumers will make choices based on "satisfaction" at an emotional and convenience level (based on their perceptions) rather than "Clinical Quality" which is hard to understand or measure.

3. Consumer needs and expectations change as they age. This is due to increased concerns as people age due to the aging process itself as well as different expectations relative to choice for each generation. Health plan and regulatory oversight designers need to be sensitive to these changing expectations.

II. Evolution / Transition (HOW Will We Get There)

A. From a Regulatory (Guaranteed) Franchise to a Consumer-Driven Market (Risk) Model

1. Increased competition among insurers will cause them to pressure providers to be more cost effective.

2. The least efficient providers (and payors) will be forced by the marketplace to change, realign, or go out of business.

3. Government "Bailouts" will not occur for insurers or providers as they may have previously.

B. From Segmented Delivery Model to one Integrated Across the Continuum and Time

1. Coordinated intervention and prevention will be provided at the earliest point in time and at the least restrictive and costly level. It will be planned over time and coordinated from the perspective of the patient rather than any particular provider.

2. Coordinated chronic care will achieve greater prominence in health care, particularly in educating the consumers and providers as to innovative prevention, management, and treatment interventions.

3. Integration of the entire long term care sector will become increasingly important as our population ages. In the short term, there will be increasing reliance on alternative levels of care (e.g., sub acute, short

term rehabilitation, respite, hospice, assisted living, home care, etc.) as a substitute for long hospital stays.

4. Redefinition of the entire long term care sector will occur as a continuous process. Long term care will shift in focus from what is currently perceived by some as warehousing the elderly to a continuum of service providers which are defined and change with the needs and desires of consumers and payors. These services will tend to be focused on the individual needs of the individual resident.

C. From Reactive Model to a Proactive / Planned / Preventive Model

1. There is a strong tendency for ALL stakeholders to focus on short term "fire fighting," which makes it hard to plan for the future. For example, the major driving force for all stakeholders at this time is cost containment. There is a danger that much quality and access policy will develop as reactions to some recent cost containment efforts (e.g. minimum stays for maternity), rather than through proactive planning.

2. Successful stakeholders will be those which implement proactive planning. Those with a flexible plan will be better positioned in a rapidly changing marketplace. They are able to anticipate unexpected situations, and be ready to move quickly to take advantage of opportunities.

3. Open Issue: Whose vision will be implemented? Which stakeholder(s) will develop and demonstrate an acceptable longer term vision to all? Who will highlight the value of longer term stability for all concerned? Who will demonstrate and measure the future savings from today's investment? Government has traditionally filled this role of defining the "public good"; however, it tends to proceed too slowly for today's changing marketplace and is a major consumer / payor.

D. From a Static / Stable / Defined Model to a Dynamic / Changing / Flexible Model

1. Innovation will be both allowed and expected. In a market-driven system, this will provide the means of meeting investors' needs. Flexibility and the ability to change rapidly is a success strategy.

III. Major Concerns / Recommendations (How to Overcome Our Major Fears)

A. Achieving a Balance Between Stakeholders (What is Delegated to Whom)

1. Stakeholder wishes will sometimes be at odds. Added control for each stakeholder will come with some loss of some control for another stakeholder. There must be a mechanism to achieve a balance among them.

2. All stakeholders are driven by "politics," whether in the traditional sense or the politics of marketplace influence.

3. Only risk-taking entities will survive, however, risk taking does not guarantee survival. The ability to provide "value" (e.g. cost effective, quality services, etc.) will be the measure of success.

4. Investors and stockholders will want to minimize costs and maximize returns on investment in a market driven system. Consumers are particularly concerned over the challenges to quality and access these incentives will generate.

5. Elected officials and regulators, traditionally protectors of the public good, receive constant requests from all of these constituents to do "something." Without a well-conceived plan and vision, change will

be driven by the press, anecdotes, special interests, and damage control. Given normally slow political time frames, proper change is also likely to be too little, too late.

B. Developing Accurate, Needed Information

- 1. Accurate information is one tool to help provide a balance** between stakeholders. Much controversy is eliminated by accurate information. Informed decisions and solutions to many remaining areas of controversy may become obvious with accurate information.
- 2. Fact-based decision-making places a premium on accurate cost and quality measures** which are credible. Cost effectiveness must be defined and measured.
- 3. The gap between perception and reality is wider in health care** due to the emotional quest for survival and the complexity and lack of understanding of the system (e.g. Is a patient with chronic asthma that is under control healthy or unhealthy?)
- 4. The consumer must be effective** in picking insurance plans and providers which provide quality, cost-effective care, in order to achieve goals by market forces. This can only be achieved through information and knowledge.
- 5. Treatment decisions will make greater use of outcomes data** (e.g., clinical pathways, expected lengths of stay, etc.) These measures will increasingly be used to define the availability and rationing of care.

C. Communicating Needed Information

- 1. All stakeholders will need to be educated** initially and kept well informed on a continuous basis.
- 2. Belief may be more important than understanding** when it comes to utilizing cost and quality measures. Most stakeholders can use these measures if all parties agree they are credible, even if they are unable to calculate or derive these measures personally. This suggests a need for a public relations or marketing focus on the values and validity of these tools to overcome "cookbook medicine" concerns.
- 3. Consumers need to be educated** in their personal responsibilities relative to wellness, and will likely become more knowledgeable, cost conscious, and assertive.

D. Conflict Resolution Processes

- 1. A major cause of conflict is a focus on "either / or", "win / lose" choices** (young / old, healthy / unhealthy, if you win / I must lose). What is needed is to accept that reality is a continuum, that in most real world situations, you can argue both ways, and a balance tends to be both dynamic and somewhere between the extremes.
- 2. The role of the government must change** from that of a regulator ("Tell me what to do.") to one of an educational facilitator ("Inform me and let me decide.")
- 3. An intermediary is needed** to level the playing field between consumers and providers when making appropriate clinical choices. Insurers have traditionally filled this role. With increased competition between insurers, it is likely that government will increasingly fill the role between the consumer and insurer. (Other consumer information tools such as Consumer Reports and HEDIS rely heavily on satisfaction rather than detailed, hard to understand clinical measures.)

4. Malpractice lawsuits will continue to be a means by which the legal profession will define quality; however, it will be negative and will only define "bad" medicine. Physician practice is and has been affected by this pressure. A balance must be achieved by providing positive incentives for "Good" medicine. Some limitations in this area will be in the public interest.