

Evaluating Managed Care Effectiveness: A Societal Perspective

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EXECUTIVE SUMMARY

Offered to almost everyone that receives employment-based health care benefits, managed care has become the predominant framework for health care plan design. Plan options that emphasize managed care have been added to Medicare and Medicaid programs, making managed care the primary model for health financing and delivery in many parts of the United States.

This analysis provides an overview of the functional components of the managed care system. It discusses the market forces underlying the United States' system for health care financing and delivery and suggests how market forces impact the health care industry. The analysis focuses on societal goals for health care delivery and on managed care's effectiveness in enabling achievement of those goals.

The analysis develops and uses an innovative model developed to summarize the complex interplay among the many stakeholders, or participants, in the health care system. The model provides a framework for analysis of the many relationships among stakeholders. The analysis also highlights current issues in managed care, particularly the barriers that impede collaboration among stakeholders.

1. INTRODUCTION

Managed care has become the predominant structure for employer-based and publicly funded health care benefit plans.

Offered and administered by entities known as Managed Care Organizations (MCOs), managed care plans offer financial incentives for enrolled participants to use health care providers that contract with the MCO. Characterized by such contractual arrangements between insurers and providers, managed care plans range from loosely controlled preferred provider organizations (PPO) to tightly governed health maintenance organizations (HMO). Managed care plans use their contractual relationships and negotiating leverage to lower benefit costs for the purchaser of benefits. In addition, managed care plans, particularly those that are at financial risk for the cost of care—such as HMO plans—attempt to reduce expense by eliminating payment for utilization of unnecessary services, and contracting only with credentialed health care providers and monitoring providers. Managed care also carries an implicit promise of adequate access to needed care.

In less than two decades, managed care concepts have revolutionized the health care financing industry. Prospective payment plans have replaced retrospective reimbursement programs. More than 85% of employer-based health care coverage is provided through a managed care plan.ⁱ In 1998, more than 78 million Americans were enrolled in HMOs.ⁱⁱ Most consumers and providers must follow the provisions of their plan if their services are to be covered by the MCO. As of late 1997, managed care, especially in market areas where it is wide spread, appeared to have slowed the rate of increase in

ⁱ Includes HMOs and PPOs. National Center for Health Statistics. “Employer-Sponsored Health Insurance: State and National Estimates,” Hyattsville, Maryland, 1997.

ⁱⁱ National Center for Health Statistics, 1998.

medical insurance premiums, lowered hospital days and controlled provider costs.ⁱⁱⁱ Since 1997, however, costs have been rising more rapidly again. Quality and access achievements are harder to measure than cost trends.

Federal and state government officials, pressed to reduce Medicare and Medicaid program expenditures, are also promoting managed care strategies along with the employers. Recent estimates project that by 2005, more than 25% of Medicare recipients will be enrolled in an HMO. By 2010, more than 60% of Medicaid recipients will be enrolled in an HMO.^{iv} This trend, however, may be reversing as insurance carriers and managed care plans respond to the termination of Medicare + Choice.

Despite its rapid acceptance, few health care system analysts have taken a close look at managed care's conceptual foundation, its impact on the structural configuration of the delivery system, or tried to anticipate its long-term effect on access, cost and quality. No one knows quite what to expect from managed care and concerns are being raised in many public and private arenas.

While lauded for its cost savings, many professional organizations are concerned about managed care's intrusiveness into the practice of medicine. Consumers are raising concern about managed care plans' restrictions on their choice of provider. Physicians are concerned about their ability to negotiate fees, their autonomy in decision-making and their relationships with patients. These stakeholders, as well as purchasers and policy-makers, are demanding tools and standards with which to evaluate managed care's impact on health care cost, quality and access.

ⁱⁱⁱ David M. Cutler, Louise Sheiner, "Managed Care and the Growth of Medical Expenditures," National Bureau of Economic Research Working Paper No. W6140 Issued in August 1997.

^{iv} (Secondary) "Health and Health Care 2010", The Institute for the Future, Robert Wood Johnson Foundation, 2000.

This analysis provides a model to help explain and evaluate managed care system performance. The model clearly demonstrates that when insurers, purchasers and providers work together to achieve their shared objectives, the managed care system functions effectively.

2. The Emergence and Evolution of Managed Care

Although managed care has been called a revolution in patient care financing, the “revolution” has actually been underway for more than fifty years. Pre-paid employer-based health care coverage dates back to the late 1920s, when Blue Shield and Blue Cross Plans first agreed to reimburse physicians and hospitals for the cost of services provided to Plan members.

The market for health care coverage began to develop in earnest after World War II. Anxious to attract and keep good workers in a tight labor market and stymied by wage controls, employers looked for additional employee benefits they could offer.

Returning servicemen, newly accustomed to having access to health care services, embraced the new form of compensation. Further, increasingly influential labor unions had begun to demand health care coverage. As a result, employer provided health benefits programs became wide spread.

In the 1950s and 1960s, with the economy expanding and employers being unsophisticated buyers of health care coverage, few employers or insurers thought much about health care costs. Insurers paid hospital and physician “charges,” on a reimbursement basis. Hospitals and physicians enjoyed a market without financial rules or restrictions.

In the 1970s, the economy slowed dramatically and employers became alarmed by the share of their employee benefits package devoted to health care coverage. Large manufacturers, particularly

automakers, demanded that insurers begin to provide them with health benefit cost information. Then, armed with data, they demanded better management of health care costs as a means to control overall expenses.

Other employers also began to scrutinize the costs of their health care benefits. Analysts recognized that the prosperity and the policies of the mid-century, including the creation of Medicare and Medicaid, had encouraged costly excess capacity. Federal programs to control expenditures began to restrict new investments in facility construction.

To control costs, insurers developed utilization control programs and began to pay only for “medically necessary” care. Utilization strategies, such as required second opinions prior to surgery and same-day surgery, became popular. Efforts to manage high cost cases, called individual case management programs, became essential.

While the financial impact of the early utilization control measures is debatable, the programs clearly had an impact on the health care financing system, paving the way for managed care. Congress enacted The Health Maintenance Organization Act of 1973 as a cost-containment strategy. The act offered loan guarantees and start up grants to encourage the development of alternative delivery systems. Managed care plans, with utilization controls and preferred provider relationships, became an attractive alternative to indemnity insurance plans for many employers.

In the 1980s the Health Care Financing Administration (HCFA), also under severe pressure to contain cost increases, began a series of changes in Medicare reimbursement policies. HCFA implemented revolutionary payment methods that paid providers prospectively an amount calculated on the basis of their past delivery of specific diagnosis-related services.

Federal policies continue to influence managed care's evolution. The 1996 Health Insurance Portability and Accountability Act (HIPAA)^{v,vi} affects managed care by allowing people to move to new group plans without denial due to pre-existing conditions. Passage of the State Children's Health Insurance Plan (CHIP),^{vii} within the Balanced Budget Act of 1997, will also impact managed care's evolution. CHIP increases access to health insurance for low-income children who do not qualify for Medicaid. In many states, CHIP-recipients are offered access to managed care organizations.

The 1997 Balanced Budget Act created options for HCFA to contract with a variety of managed care plans under Medicare Part C or "Medicare + Choice." Many health plans that participated in this opportunity experienced high costs and low reimbursement. Some are now terminating their contracts, particularly in areas where reimbursement has been insufficient for MCOs and providers to break even.^{viii}

Some states have supported demonstration projects to cover the uninsured in managed care, either through state financing as in the TennCare Program, or through tax subsidies and other incentives to encourage small employers to provide benefits. Most of these programs are floundering under an uneven distribution of responsibility. In Tennessee, for example, some of the HMOs are terminating their contracts with TennCare because reimbursement did not adequately cover costs.

^v The HIPAA guarantees health insurance coverage for individuals who change jobs and individuals with pre-existing conditions who would otherwise be ineligible for coverage. Other provisions of the law promote medical savings accounts and encourage the use of electronic medical information exchange.

^{vi} Nichols, L.M., Blumberg, L.J., "A Different Kind of 'New Federalism'?" *The Health Insurance Portability and Accountability Act of 1996*, *Health Affairs* (May/June 1998): 25-42.

^{vii} The SCHIP program, administered by the Health Care Financing Administration, makes funds available only to states that have in place federally approved programs providing health insurance coverage to uninsured children.

Individual state policy initiatives also are impacting managed care's evolution. Concerned about abuses by the insurance industry, states are defining patients' rights through legislative initiatives focusing on grievance procedures and restrictions on doctor-patient communication.^{ix}

As managed care continues to respond to the changing market for health care coverage, new relationships are forming; hospitals are merging to create health networks, physicians are affiliating through joint-ventures with participating hospitals, managed care plans are buying health networks to create integrated delivery systems and employers are joining together and assuming financial risk to create purchasing coalitions. Each step renders the health care system more, or less, effective in its efforts to achieve society's health care objectives. This analysis provides insight into the potential for effective action by the many participants in the health care market place, the "stakeholders" in managed care.

3. THE STAKEHOLDER RELATIONSHIP MODEL

- **Methodology**

There are few models to help structure thoughtful consideration of a system of the scope and diversity of the United States' health care system.^x Nevertheless, the legislative interest surrounding managed care and patients' rights indicates that system evaluation is greatly needed. The model

^{viii} It is estimated that plan withdrawals effects only 1% of the overall beneficiaries as of early 2000. "Medicare + Choice: An Evaluation of the Program," Marilyn Moon, Urban Institute report to the Committee on Commerce, U.S. House of Representatives, August 4, 1999.

^{ix} "Patience for a Bill of Rights," U.S. News and World Report, October 5, 1998.

presented here helps participants in the health care system, “Stakeholders,” to better understand how managed care plans function, how different aspects of quality can be measured, and how various components of accessibility can be evaluated.

Throughout this analysis the term stakeholder is used to represent the many organizations and individuals that buy, sell and use managed care. Stakeholders include insurers, employers, providers, consumers, regulators, and policy makers. While most stakeholders have a direct financial stake in the managed care system, others’ involvement in the health care system is peripheral. Organizations and purchasers that have no direct involvement in managed care are not considered in this analysis.

Although managed care impacts everyone, many people—particularly people who are uninsured, indemnity payers and providers who are not under contract with managed care plans—are not active participants in the system. Stakeholders with a direct involvement considered in this analysis are:

- “U.S. Society” -- the collective public, private, and personal interests of United States citizens.
- “MCOs (Managed Care Organization)/Insurers” -- licensed insurance entities selling or administering fully or partially-insured managed care products. Self-insured employers offering Preferred Provider Organizations (PPOs), Point of Service Plans (POS) and Health Maintenance Organizations (HMOs) share many of the same objectives as risk-bearing MCOs and health insurers.
- “Employers/Purchasers” -- fully insured and self-funded employers who offer managed care products to their employees. This category includes employer coalitions, purchasing groups and government purchasers of managed care (Medicaid and Medicare and other public programs).
- “Consumers/Individual Members” -- enrollees of managed care plans, including subscribers and dependents of subscribers. We refer to members’ use of MCO benefits, not out-of network or uncovered services.
- “Medicaid Eligible and Medicare Beneficiaries” -- individuals enrolled in managed care plans for some part of their Medicaid and/or Medicare benefits. Many of the objectives are similar to other

^x See R. Nauert, “The Quest for Value in Health Care,” *Journal of Health Care Finance* 1996; 22(3) 52-61. Author creates equation for value and models value in relation to quality and cost.

consumers, however, Medicaid and Medicare managed care enrollees often have more complex conditions than the commercial members and greater use of prescription drug benefits.

- “Regulators/Policy Makers” -- private and public agencies that regulate health care financing and delivery.
- “Clinical and Professional Providers” -- independent contractors for care. Examples include independent and group practice primary and/or specialty care physicians or Independent Practice Associations (IPA). If the provider is affiliated with a Physician Hospital Organization (PHO) or through an integrated delivery system, the objectives noted in the Grids refer to his or her clinical practice only. The objectives of physicians in an IPA are represented in this category from the perspective of each individual physician. This category also includes clinical professionals in support of the contracted treatment of health care such as nurses, chiropractors, and mental health professionals. This category does not relate to objectives of providers when treating non-managed care patients.
- “Institutional Providers” -- hospitals, alternative delivery sites such as ambulatory surgical and imaging centers, and inpatient and outpatient facilities within integrated delivery systems. Only the objectives of institutional providers related to managed care patients are included.

This categorization of stakeholders suggests some of the different priorities and objectives circulating within the managed care system. New priorities and changed objectives are constantly emerging as business partnerships are formed and stakeholders modify their alliances and their allegiances. The stakeholder objectives are outlined in grid format, presented later in this section.

- **Modeling Stakeholder Behavior: Assertions and Assumptions**

The model developed for this analysis, called the Stakeholder Relationship Model, creates a framework for evaluating the managed care system’s ability to resolve competing objectives among stakeholders and function effectively. The Stakeholder Relationship Model incorporates the views of

industry leaders--all stakeholders in the health care system.^{xi} Represented by two grids, the model contrasts interactions among stakeholders and enables users to evaluate whether an action will render the managed care system more or less “effective” in achieving society’s health care objectives.

The Stakeholder Relationship Model is premised on four assertions.

- In an effectively functioning managed care system, all stakeholders of the system will support the diverse needs of the enrolled population.
- In an effectively functioning managed care system, all stakeholders of the system will develop business strategies that do not negatively impact the success of other types of stakeholders.
- In an effectively functioning managed care system, all stakeholders of the system will share information and performance measures, and be held accountable for results.
- In an effectively functioning managed care system, all stakeholders of the system will support the long-term needs of the entire managed care population: managing health and maintaining wellness.

The model also makes several assumptions. The first assumption is that society has achieved consensus that the goals of the health care system are cost control, optimal quality and reasonable access for all. Further, the model requires an assumption that these are the managed care system’s goals as well. These goals are the standard against which stakeholders define their contributions and analysts evaluate the system’s efficiency.

The second assumption is that the system will be effective if all interactions are effective with respect to each other. We know that this is idealistic given that the system is extremely dynamic. One stakeholder’s gain may be another’s loss and constant actions and reactions ensue.

^{xi} See list of Working Group Members, Appendix IV
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Third, and most fundamental, it is assumed that effectiveness can be measured. While attributes of cost, quality and access can be measured, there is no accepted indicator of *overall system* effectiveness. The occurrence of effectiveness is a theoretical state in which all stakeholder interests are maximized with respect to our global goal for health care. This is conceptualized in a diagram provided as Appendix III. The apex of the “pyramid” is the point at which the three sides, cost, quality and access, are optimized.

In addition, the model assumes that there are four forces that work against managed care effectiveness. These four “counter-forces” are natural conditions in the marketplace that may be improving but are nonetheless real.

- Variations in definitions and interpretation of terms hinder cooperation among stakeholders.
- Market influence is not equal among stakeholders—some have more influence than others.
- In the evolving managed care market there are opportunities for (financial) gain that are more attractive than the benefits of cooperation among stakeholders.
- Conflicting objectives among stakeholders lead to sub-optimal compromise; only synergistic objectives will yield an optimal system.

- **An Overview of the Model**

The Stakeholder Relationship Model, represented by two grids, enables systematic analysis of the many activities, objectives and priorities constantly in play among managed care stakeholders. The conceptual model reflects thousands of interactions that occur simultaneously.

Grids A and B identify the global objectives for the system and the specific goals of stakeholders operating within their system. The model is divided into two grids, rather than one, simply to facilitate discussion. The events depicted in the two grids occur simultaneously—presumably at different levels of business activity (one long-term, the other short-term).

Grid B (short term) identifies stakeholders' individual or organizational goals. Grid A (long term) identifies stakeholders' goals from the broader perspective of the system as a whole. For example, from society's perspective, an insurer's objective is to offer reasonable access to medical care for all (Grid A, Line 2, Columns A-C). From the insurance organization's perspective, the objective may be to provide a financially marketable network of acceptable quality that meets standards for geographic access for covered services (Grid B, Line 2, Columns A-C).

Stakeholders' assign different values to their objectives for cost, quality and access. Often, these differences are the product of long-standing traditions. For example, physicians traditionally have placed a stronger emphasis on quality objectives than on cost or even access objectives. The traditional roles of stakeholders, which emphasize their own priorities, create imbalance. The imbalance is visually reflected in the model by the number of objectives under a category, and in the emphasis on each of the objectives.

Emphasis also varies with individual stakeholder's needs. For example, a specialist may relate access to good clinical outcomes and an ability to get the services necessary to achieve those outcomes. The specialist's patient, however, may focus on comfort and treatment convenience. The urgency of a stakeholder's needs may reflect that stakeholder's objectives at a particular point in time.

The model shows that stakeholders act in several ways—sometimes unknowingly and sometimes with intent. Providers, for example, may meet the perceived quality needs of their patients (e.g., thoroughness is better), at a cost that does not meet the needs of the payers (e.g., less expensive is better). Consequently, physicians and HMOs are often in disagreement with one another. Reading across rows gives a sense of a stakeholder's point of view. Reading down the cost, quality and access columns reveals the varying perspective-based objectives of stakeholders.

- **Interpreting the Grids**

Within the rows and the columns of the grids, stakeholders' goals are identified by group perspective. Row 1 describes the societal perspective, using the cost, quality and access components of effectiveness. Optimally, stakeholders assert goals similar to those of society as a whole. In reality, objectives diverge from the balance of the societal view. Reading across the "MCO/Insurer" stakeholder row (Row 2), for example, an insurers' cost goal supports society's aim for a reduced cost medical system (a high-level, "societal" cost goal), and also aims to ensure margins that allow for growth (an operational objective). If the societal goals are realistic, then the gaps between societal values and business objectives in the system can be seen as opportunities for a more effective health care system.

The remaining rows (Rows 2-8) list stakeholder goals and objectives: goals for the system (Grid A) and business (operational) objectives for daily activities (Grid B). Two-tiered goals are used to illustrate the difference between what stakeholders want for the system as a whole (Grid A), and their strategies for their success within the system (Grid B). Stakeholder objectives are presented within the following parameters:

- The societal goals for managed care within the U.S. health care system
- The stakeholders' global goals for the managed care system
- The stakeholders' individual business objectives for achievement within the system

Columns A-C represent the cost, quality and access objectives for each general stakeholder category. Reading down, the objectives of a managed care system are described. Reading across provides the inherent emphasis of each stakeholder category with respect to the three dimensions.

Stakeholder Relationship Model

Grid A

STAKEHOLDERS' INDICATORS of EFFECTIVENESS of MANAGED CARE SYSTEM GLOBAL OBJECTIVES FOR THE SYSTEM

Stakeholder	Economic Objectives (A)	Quality Objectives (B)	Access Objectives (C)
U.S. Society (1)	<ul style="list-style-type: none"> • Cost-effective medical care for all citizens • Reduction in cost growth for health care services 	<ul style="list-style-type: none"> • Medical care that meets consumers' expectations • Improved health status based on outcomes 	<ul style="list-style-type: none"> • Ability to obtain appropriate medical care when needed with reasonable convenience
MCO/Insurer (2)	<ul style="list-style-type: none"> • Reduced cost medical system 	<ul style="list-style-type: none"> • Medical care that meets customers' expectations 	<ul style="list-style-type: none"> • Offer reasonable geographic access to medical care to meet benefit plan requirements
Employer/ Purchaser (3)	<ul style="list-style-type: none"> • Affordable benefit plans that attract/retain high quality workforce 	<ul style="list-style-type: none"> • Employee satisfaction with medical care and administration managed through MCO 	<ul style="list-style-type: none"> • Geographic provider availability for covered employees • Basic coverage for extraordinary health needs
Individual Member/ Consumer (4)	<ul style="list-style-type: none"> • Costs not a barrier to care 	<ul style="list-style-type: none"> • Positive and satisfying medical encounters and outcomes • Information to make decisions on treatment and providers 	<ul style="list-style-type: none"> • Choice of and ability to change providers • Geographic proximity of providers and services
Medicaid/ Medicare MCO Members (5)	<ul style="list-style-type: none"> • Out of pocket copayments not a barrier to care 	<ul style="list-style-type: none"> • Qualified medical providers and resources • Less apparent discrimination due to need or age 	<ul style="list-style-type: none"> • Increased access and choice than with non-MCO options
Regulators/Policy Makers (6)	<ul style="list-style-type: none"> • Control of expenditures • Advocate financial viability of MCOs and providers • Foster competitive marketplace 	<ul style="list-style-type: none"> • Medical practice consistently meeting minimum quality standards • Improve health status of eligible populations 	<ul style="list-style-type: none"> • Ensure basic services available to eligible populations • Support I/S initiatives to facilitate care delivery
Clinical & Professional Providers (7)	<ul style="list-style-type: none"> • Fair and adequate compensation for services provided 	<ul style="list-style-type: none"> • Physician-driven medical decisions • Favorable medical outcomes 	<ul style="list-style-type: none"> • Unrestricted access to necessary providers and resources
Institutional Providers (8)	<ul style="list-style-type: none"> • Fair and adequate compensation for services provided • Predictable and stable income 	<ul style="list-style-type: none"> • Physician and internal process-driven medical decisions 	<ul style="list-style-type: none"> • Geographic convenience for consumers

Grid B

**STAKEHOLDERS' INDICATORS of EFFECTIVENESS of the MANAGED CARE SYSTEM
SPECIFIC GOALS FOR STAKEHOLDERS OPERATING WITHIN THEIR SYSTEM**

Stakeholder	Economic Objectives (A)	Quality Objectives (B)	Access Objectives (C)
U.S. Society (1)	<ul style="list-style-type: none"> • Cost-effective medical care for all citizens • Reduction in cost growth for health care services 	<ul style="list-style-type: none"> • Medical care that meets consumers' expectations • Improved health status based on outcomes 	<ul style="list-style-type: none"> • Ability to obtain appropriate medical care when needed with reasonable convenience
MCO/Insurer (2)	<ul style="list-style-type: none"> • Income and expense structure that allows MCO to compete and grow • Cost effective network of providers • Incentives to shift risk to entities in control of costs • Risk adjusted premiums to control for moral hazard & adverse selection • Adequate volume of business 	<ul style="list-style-type: none"> • Member satisfaction with medical care and MCO service • Positive outcomes of network providers' service • Care delivery that meets standards • Accreditation of MCO and network providers • Provider satisfaction 	<ul style="list-style-type: none"> • Contract with marketable network of providers • Geographic accessibility to providers for all covered services • Member satisfaction with provider access
Employer/ Purchaser (3)	<ul style="list-style-type: none"> • Highest plan benefits (value) for lowest costs • Financial stability of MCOs • Predictable benefit expenditures for long-term budgeting • Incentives for employees to choose cost-effective plans 	<ul style="list-style-type: none"> • Accreditation of MCO • Ease of administration • Healthy workforce/positive outcomes of medical care • Data to demonstrate performance on cost, access, patient satisfaction and outcomes 	<ul style="list-style-type: none"> • Employee satisfaction with provider access • Timely medical and administrative service—ex: appt times and I.D. card processing and reports
Individual Member/ Consumer (4)	<ul style="list-style-type: none"> • Minimal out of pocket costs • Minimal premium contributions vs. salary 	<ul style="list-style-type: none"> • Networks include reputable and technologically advanced medical providers and resources • Positive and non-burdensome experience with administrative issues ex: appropriate pt. billing • Useful information on personal health maintenance and disease prevention for improved health • Continuity of information flow, ex: complete medical record • Reasonable role in decision making and choices about personal and family care • Satisfactory result in the event of serious illness 	<ul style="list-style-type: none"> • Availability of familiar providers for routine and specialty/chronic care • Comprehensive health benefits • Barrier-free referrals when needed • Timely medical and administrative service ex: appt time, wait on hold, and claims/billing info

Stakeholder	Economic Objectives (A)	Quality Objectives (B)	Access Objectives (C)
Medicaid/ Medicare MCO Members (5)	<ul style="list-style-type: none"> Minimal supplemental costs where applicable 	<ul style="list-style-type: none"> Non-burdensome administration barriers to receiving care Reputable and technologically advanced providers Minimal access barriers Improved coordination of care vs. non-MCO system 	<ul style="list-style-type: none"> Choice of and ability to change providers Non-burdensome administration barriers to receiving care Reputable and technologically advanced providers
Regulators/Policy Makers (6)	<ul style="list-style-type: none"> Medical expenditures reflecting constituent expectations Reduced cost for publicly funded populations 	<ul style="list-style-type: none"> Reasonable satisfaction among constituency Avoid socially/politically controversial business and medical practices, ex: 24 hr. maternity, any willing provider Use data to demonstrate performance on cost, access, patient satisfaction and outcomes Ensure patient rights to information, appeal and choice are upheld Protect patient confidentiality 	<ul style="list-style-type: none"> Ensure reasonable geographic access to necessary medical services Uphold continuity of coverage Ensure patient rights to information, appeal and choice are upheld Protect patient confidentiality
Clinical & Professional Providers (7)	<ul style="list-style-type: none"> Maximum predictable and stable income Patient volume in return for discount and/or assumption of risk Protection from catastrophic costs Appropriately derived compensation, ex: case mix adjusted capitation 	<ul style="list-style-type: none"> Patient satisfaction with medical and office experience Ease of interface with MCO, ex: supportive contracts Integration and flow of info. with other network providers Physician leadership for developing care management practices Reporting/feedback on cost-effectiveness and quality of network providers 	<ul style="list-style-type: none"> Ease of referrals to colleagues Ease of referrals to necessary services for patients (including high tech treatment) Geographic convenience for patients
Institutional Providers (8)	<ul style="list-style-type: none"> Sufficient income to retain competitive market position Patient volume in return for discount and/or assumption of risk Protection from catastrophic costs Appropriately derived payment, ex: additional compensation for teaching facilities 	<ul style="list-style-type: none"> Physician and patient satisfaction with technical resources Integration and flow of info. with other network providers Reporting/feedback on cost-effectiveness and quality of network providers Improved mortality/morbidity outcomes through care management 	<ul style="list-style-type: none"> Ease of referrals to affiliated providers and resources across continuum of care. Ease of referrals to affiliated institutions. Ease of patient and physician access to high tech resources

4. AN ANALYSIS OF BOSTON'S HEALTH CARE MARKET

Few health care markets have changed as dramatically since the advent of managed care as has Boston's. The Stakeholder Relationship Model helps explain the changes that have occurred, and can help stakeholders anticipate future changes in Boston's health care market.

- **Boston Market Overview**

Known as a health care Mecca, Boston, Massachusetts offers high quality and technologically advanced medical care. Despite the general perception that quality and technology ultimately create efficiency and lower cost, however, Boston's medical costs are among the highest in the country.

During the late 1980s and the 1990s, managed care companies launched a full-scale invasion of the Boston market. At one time there were more than 17 HMOs operating in the metropolitan area—a community of less than two million people. While many of these HMOs are still licensed, there are really only a handful of major players left in this highly competitive market.

The Massachusetts insurance department is the main market regulator, participating in developing standards, reserve requirements and monitoring the business activities of the HMOs. Providers, employers and consumers also play integral roles in shaping Boston's health care in the market. The result is one of the more balanced managed care markets in the United States.

Early on, it appeared that Boston's stakeholders were thriving and the market became a national model of managed care effectiveness. MCOs steadily gained enrollment and employers saw premiums drop when they converted to managed care plans. Providers secured market share and consumers appeared to be well served. Medicaid recipients enrolled in MCOs and regulators watched to assure that plans provided mandated services under their cost projections.

As the industry grew and the stakes increased, stakeholders' objectives began to conflict, creating a tense and unstable marketplace. The Stakeholder Relationship model helps explain why.

Boston Stakeholders' Managed Care Objectives

Stakeholder	Cost	Quality	Access
Providers	<p>Compensation for high infrastructure expenses</p> <p>Win contracts to secure market share</p> <p>Avoid high receivables</p>	<p>Demonstrate superior quality through performance measures</p> <p>Independence in medical decision making</p> <p>Manage risk with care pathways</p>	<p>Link with other providers to create (exclusive) referral networks</p> <p>Offer one stop shopping</p>
MCOs	<p>Low premiums (and low med. loss ratio) to incr. market share</p> <p>Attain economies of scale in mergers/consolidation</p> <p>Shift risk to providers</p>	<p>Demonstrate superior quality through performance measures</p> <p>Control over referrals, authorizations when at risk</p>	<p>Develop competitive niche of providers</p> <p>Edge out competition through consolidation and negotiating leverage</p>
Employers/Purchasers	<p>Keep premiums low/benefits high</p> <p>Offer benefit options</p> <p>Not pay for waste in mergers</p>	<p>High employee satisfaction</p> <p>Include perceived high quality providers and services, esp. hi tech</p>	<p>Meet vast geographical needs, also include prestigious providers</p>
Regulators/ Policy makers	<p>Ensure adequate reserves, especially for not-for-profit organizations</p> <p>Maintain competition-avoid monopolies</p> <p>Ensure Medicaid solvency</p>	<p>Use accreditation to recognize good performers</p> <p>Medicaid quality equal to other managed care</p>	<p>Enforce any willing provider laws</p> <p>Support patient appeals of denials to care</p> <p>Access for uninsured</p>
Consumers	<p>Keep operating costs down</p> <p>Keep personal costs down</p>	<p>Assert patient rights</p> <p>Get a good result in terms of personal health and especially when there is a serious illness</p> <p>Track performance</p>	<p>Maintain loyalty to established providers</p> <p>In the case of routine situations, reduce hassle</p>

In the last decade market influence in Boston has shifted from providers to MCOs to regulators to consumers. During the intense periods of managed care expansion, stakeholder objectives were often in conflict and seldom in synch with the “societal goals” for managed care. There was conflict

between the cost control and data objectives of MCOs, the income objectives of employers and the autonomy objectives of health care providers. Capitation allowed providers some autonomy and ability to control cost, quality and access according to their own specifications.^{xii} However, effectively managing risk became the point of serious contention between the providers and the payers.

Conflicts among providers, MCOs and consumers regarding price, quality and access caused turmoil in the Boston market. MCOs consolidated, enabling them to show financial gains (achieved by increasing membership) and improve their negotiating position with providers. Many MCOs took unprofitable business lines off the market, or limited their sales efforts to certain geographic regions. Providers integrated as well. The two leading systems, Partners and CareGroup, built large provider networks and established the infrastructure to manage risk contracts. Many other providers consolidated and closed down.

Boston's example demonstrates the grids' descriptive functions. In Boston, there continues to be shifting power where one stakeholder group appears to dominate in the market—until others react. In each market, underlying demographic factors will effect the need for stakeholder effectiveness. Stakeholders' objectives will vary, given their sensitivity to market forces, their experiences, and their ability to cooperate with other stakeholders to form alliances.

In Boston, the underlying market factors (high cost structure, educated consumers, high purchaser expectations for quality and the issue of challenging access) keep stakeholders struggling to meet market needs. As a result, the stakeholders are only intermittently effective in providing a balance

^{xii} NCQA holds the MCO accountable for all delegated functions in a capitated arrangement (e.g. delegated authorizations and delegated provider credentialing)

among cost, quality and access. Boston, along with other managed care markets across the country, is working its way toward an effective system.

5. MEASURING MANAGED CARE EFFECTIVENESS

While there are many tools for evaluating aspects of cost, quality, and access, there are no generally accepted indices to measure the effectiveness of the system. Although stakeholders' goals also fall under these three categories, many different perspectives are possible—reflecting the multiple and divergent objectives of stakeholders and the context in which the goal is identified. For example, although cost is often related to the price of the service and method of paying for it, “cost” can also imply financial contingency, or risk. “Quality” refers to both consumer satisfaction and outcome of care. “Access,” refers to both the provider and the consumer’s ability to gain physical access to services as well as their financial ability to utilize services. Other interpretations abound but are generally accepted under the terms cost, quality and access.

Most health system evaluation tools are process indicators or condition-specific outcomes measures. While it appears that no single tool or performance indicator is universally accepted, much effort is being devoted to evaluating these tools and improving their usefulness. Regional and national efforts are underway to create or augment outcomes and performance databases—searchable listings of providers and therapies and their outcomes. Significant progress in this area is likely, as customers

demand better measures and stakeholders respond by developing more sophisticated measurement tools.^{xiii}

A number of independent initiatives are underway to develop standards for quality and establish greater definitional consensus. The National Committee for Quality Assurance (NCQA)^{xiv} developed more than 100 clearly defined health plan quality measures in its Health Plan Employer Data Information Set (HEDIS) reports. In addition, smaller, less encompassing, initiatives are underway to clarify common terms such as “patient visits” and “primary care provider” so that data can be compared across information systems. As managed care has evolved, the breadth of performance measurement needs has grown. A list of performance measurement tools is provided in Appendix II.

Although performance measurement is becoming a more common practice, reporting requirements are not yet standardized and lack comparability. Individual stakeholders are subject to industry and organization specific regulatory forces, such as licensure and accreditation. Performance measures usually reflect those requirements. For example, many managed care organizations report medical loss ratios as performance indicators. This ratio indicates the appropriation of premium dollars toward medical expenses and reflects the organization's interest in managing medical costs. A loss ratio can indicate performance with respect to provider contracting objectives, utilization controls, and disease screening and prevention programs. However, loss ratios are also a management tool that can constrain investment in growth and enhancements in quality.

^{xiii} The July/August 1998 edition of the journal *Health Affairs* (Vol. 17, No. 4) focuses on the evolving managed care market and devotes several papers to the interpretation and measurement of managed care stakeholder performance.

^{xiv} NCQA is the nation's leading HMO accreditation organization. NCQA accredits about half of the nation's 650 HMOs, and those accredited plans represent 75% of all HMO enrollees.

Some industry-wide, baseline performance standards are emerging. However, stakeholders have not yet established generally accepted industry standards. Some organizations, such as the Pacific Business Group on Health, are developing a common set of standards for health plan reporting. NCQA recently made consumer-oriented health plan report cards available on the Internet. Health plan ratings have been available to direct purchasers (employers, unions and government) and health plans. Yet without a generally agreed upon standard for measurement, stakeholders continue to develop and promote information that minimally meets external reporting requirements and that meets internal reporting needs. The increasing experience and sophistication of stakeholders in using these basic measurements, both internal and external, will likely foster further refinement.

6. DISCUSSION

The degree of alignment among stakeholders varies by market area. Geographic market segmentation reflects the differing levels of influence a stakeholder has in specific market areas, as seen in the Boston example. The level of pooled purchasing to improve the affordability and accessibility of employer health plans varies by geographic area.^{xv} Provider integration is also a variable—usually found in high-density medical markets as opposed to areas where providers face little competition.

The economies of scale created through consolidation provide an advantage that smaller stakeholders cannot achieve. The shift of financial risk to providers has encouraged formation of new physician organizations and new relationships with hospitals and insurers to protect their referral

^{xv} S. Long, S. Marquis, “Pooled Purchasing—Who are the Players?” *Health Affairs*, July/August, 1999, 105-111.

relationships, spread financial risk and secure group income. The greater resources of the larger group enable the physicians to hire professional managers, purchase state-of-the-art information systems, and develop group practice protocols.

In Los Angeles several managed care organizations have merged, forming a few companies that represent most of the insured members in the area. The new market organization gives the managed care firms significant influence over other stakeholders. In other market areas employer-purchasing coalitions, such as the Buyers' Health Care Action Group of the Twin Cities, have succeeded in reducing rates while maintaining quality and access for their members. The California Public Employees Retirement System, The Pacific Business Group on Health, The Washington Business Group on Health, and The Federal Employees Health Benefit Plan are examples of groups that have been successful in creating purchasing power by leveraging their numbers of potential enrollees. These powerful entities have also been effective in producing publicly available reports on provider and MCO quality and performance. These databases allow purchasers and consumers to make more informed decisions. The availability of the information may also inspire continuous improvement by the stakeholders being measured.

In addition to stakeholder collaboration, several other forces facilitate managed care effectiveness.

1. Compromise and Maximization

Conflicting objectives raise questions of compromise. Compromise may occur within a single system dimension, such as access. When consumers experience long waits for appointments because their physician's panel is expanded to compensate for decreased margins, patient access expectations are compromised. Conflict between managed care stakeholders often leads to compromises. The definition of managed care effectiveness implies that all stakeholders are satisfied with these compromises. There may

be a point at which one stakeholder compromises others by maximizing its own objectives. To follow the appointment time example, a long wait (access compromise) may worsen the patient's health, thereby increasing the cost of, and decreasing patient satisfaction in treatment (quality). To meet society's health care goals, stakeholders may need to alter or compromise their objectives to support the overall social welfare. Societal goals can be met if the stakeholders are economically or socially inclined to support the objectives of other stakeholders.

2. Synergies Among Stakeholders

While the stakeholder grid (Grid B) reveals conflicts, it also points to a number of similarities in stakeholders' goals. Looking down the column of quality, one sees that patient / member / consumer satisfaction is in every stakeholder row. Similar objectives indicate an effective system, especially when the stakeholders collaborate to achieve goals. There are several national initiatives to develop standard satisfaction survey instruments including the HEDIS Member Satisfaction Survey used by health plans in the accreditation process and by purchasers and consumers in comparing health plan performance.

While there are synergistic strategies among stakeholders, the checks and balances to monitor the system are unstable and biased. Regulators can play a supervisory role but their objectives also need to be monitored. Consumers and employers can watch regulators, but again, their respective needs bias their ability to referee. Collaboration—such as the sharing of risk and responsibility for care—appears to support the balance among cost, quality, and access. However, there is very little monitoring of under-utilization by providers or reinsurance carried by risk-bearing entities in capitation. Ultimately, these synergies may cause a paradigm shift, from the current model of treating illness in individuals to one of maximizing the health and functional well being of populations. Such a system would seek to manage the potential risk factors in healthy individuals as well as bring appropriate treatment to those who are acutely

ill. This is beginning to happen as Medicare and Medicaid enroll recipients in managed care and change the demographic composition of the traditional managed care population. With the complex health needs of these populations and the oversight of government funders, MCOs and providers may soon be held legally accountable for outcomes.

A prime area for synergy, and an area of interest to most stakeholders, is performance measurement. Competition in the marketplace has forced stakeholders to differentiate themselves and develop tools to inform their customers about their strengths. The model of managed care effectiveness implies a concurrent exchange of information among stakeholders. By communicating needs and capabilities, stakeholders can make informed decisions and take advantage of market opportunities.

An effective system of information exchange is appropriate and collaboration leads to a higher level of performance. Yet, voluntary and accurate reporting of performance will only occur when the market demands it. This, in turn, requires stakeholder action. In areas with little market competition, this stakeholder need is not being met.

- **Barriers to Effectiveness**

Several factors impede managed care effectiveness.

1. Opportunities for Gain

The premium competition in the mid-1990s helped many health plans that offered low price (without regard to quality), to increase market share. Today, new sectors of the health care industry are growing—particularly products devoted to an aging population and products that involve new medical technologies and pharmaceuticals. This growth may again inhibit system effectiveness by reducing the need for collaboration.

2. Conflicts of Interest

One stakeholder's business objectives may conflict with those of other stakeholders and customers' objectives. Hospitals, for example, need to maintain a high inpatient census, yet patients may prefer alternative settings. Payers must keep expenses down, while providers strive to maintain revenues. Many of these conflicts of interest are resolved through compromise and negotiation. For example, a local HMO needs to add providers to the network to increase marketability to employers and certain providers need to contract with the HMO to retain patients. The HMO must provide acceptable reimbursement and administrative support (that costs it money) and the provider must accept the reimbursement and administrative duties (that may create financial risk and loss of some autonomy for the provider).

3. Incremental Reform

Moving to a single payer health care system seems unlikely at this point. We are seeing small changes with more federal control on the industry such as a patient bill of rights (right to appeal, right to sue plan or employer), mental health parity, HIPAA, CHIP, Olmstead, etc. These changes tend to reflect the needs of small populations or interest groups (e.g., CHIP—low income kids, Olmstead—disabled). Other legislative proposals, many of which favor consumer rights, may lead to higher costs industry-wide. With these recent initiatives in evidence, the current state of regulation seems to be only partially (or incrementally) balancing the three aspects of effectiveness—cost, quality and access for all managed care stakeholders.

7. CONCLUSIONS

In this analysis, managed care effectiveness is defined as the optimal combination of stakeholders' objectives for cost, quality, and access with respect to society's goals for health care. The analysis has assumed that effectiveness encompasses all the interactions among all the stakeholders. This global view of effectiveness can be broken down and analyzed systematically to give decision-makers more concrete tools to evaluate their managed care system. This paper presents only a basic perspective on the current managed care system. The following five trends may have a significant impact on system effectiveness.

1. Demographic Change

Examination of current managed care membership reveals a more diverse mix of members than in the early days of managed care. While there are still health plans that primarily seek the employed, under-65 population, many other plans are looking to grow their business in the Medicaid and Medicare markets.

While adding members can strengthen negotiating leverage, the challenges in managing the patients can stretch a plan's abilities. With this changing mix of membership comes the need for broader risk assessment and proactive risk management. Health plans that take on Medicaid and Medicare patients need to invest in care management programs internally or at the provider level and focus on efficient coordination of care along a continuum of services. These plans also need to demonstrate quality to other stakeholders in new ways. Short-term outcome measures, patient satisfaction ratings,

and utilization figures do not necessarily provide a picture of a plan's management of chronically ill members. More appropriate quality measures will be based on the plan's ability to manage, over the long term, the diverse needs of members. Recently, plans have reconsidered—and dropped—Medicare and their Medicaid contracts apparently due to low reimbursements.^{xvi}

2. Changing Employer Funding and Purchasing Practices

The majority of large companies in this country self-insure their health benefits. Many of these companies purchase reinsurance to protect against outlier costs. Self-insured employers are exempt from state regulation by virtue of ERISA. Self-funded employers can provide customized benefit packages for their populations. The financial risk they assume gives employers an incentive to collect and analyze performance data and use the information to purchase high quality health care for their employees. Employers that directly contract with providers can employ best practices from MCOs to negotiate mutually beneficial terms. Direct contracting initiatives can lead to better information exchange between purchasers and providers and provide incentives for long-term investments in health management.

Another topic being discussed among employers that could change these trends is the concept of "defined contribution" health care benefits. At the "extreme" this would put employees with specified dollar amounts provided by their employers out into the individual health insurance market to fend for themselves. There has been little "extreme" action as yet, however, though a number of employers now offer "FLEX" plans that specify how much they will pay and let the employee choose from among a

^{xvi} Felt-Lisk, S. "The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation," Report to the Kaiser Commission on Medicaid and the Uninsured. May 1999.

number of alternative health plans. If a trend toward the extreme evolves, then the relative roles and power of various stakeholders could be affected, and the nature of managed care could change as well.

3. Consolidation among payers and providers

With the mergers, consolidations and increased competition in the health insurance industry, stakeholders find that their former competitors may now be their colleagues, and objectives must be integrated. These factors create incentives for more long-range planning and investments in illness prevention, screening, and patient education.

4. Trends in Performance Measurement

Performance measurement tools are expanding to recognize the inter-relatedness among cost, quality, and access dimensions. Risk adjustment and other tools to normalize data are becoming more widely used and accepted. In addition, advances in information systems capabilities and increased investments in information systems technologies are creating flexibility for more in-depth performance measurement.

5. Regulatory Activity

National and state consumer rights legislation support greater consumer access to information and to appeal processes. The Balanced Budget Act of 1997, intended to reduce Medicare and Medicaid expenditures and eliminate program loopholes, will lower potential revenues for providers. New forms of risk adjustment may bring stakeholders together to perform more accurate budgeting and care management programs. At the same time, consumer protection legislation may have unintended consequences in making the providers, employers and insurers more litigious.

In light of these industry trends, additional analysis using the Stakeholder Relationship Model could be extremely informative. By understanding the underlying incentives and market forces affecting managed care stakeholders, we can look to ways to increase system-wide effectiveness.

Appendix I

Selected Managed Care Terms

Accreditation (JCAHO and NCQA): JCAHO: The Joint Commission on Accreditation of Healthcare Organizations and is the predominant accreditation organization for hospitals and institutional providers. The Joint Commission is a non-profit organization that develops standards and provides review to hospitals, health networks, home health providers, and other health care organizations. JCAHO has developed the ORYX tool to evaluate performance of an organization based on outcomes. NCQA is the National Committee for Quality Assurance and is the predominant accreditation organization for managed care plans. NCQA developed HEDIS (Health Plan Employer Data and Information Set) as a standard tool to assess health plan performance for purchasers and consumers to compare health plans.

Capitation: A prospective payment for a specified set of services, usually calculated per member, per month. Clinical services only may be capitated or clinical plus administrative services as in the case of a mental health carve out. In the case of capitation, the contracted party is at risk for the actual cost of services. “Global” capitation usually refers to contracted risk for the whole spectrum of covered services including inpatient and outpatient care. Physicians and hospitals often partner to take on “full risk.”

Care Management Practices: Programs that attempt to coordinate clinical care in order to improve outcomes and reduce costs. Examples include practice guidelines, critical pathways, case management,

and disease management programs. Care management practices can be initiated by the health plan or by the provider(s).

HMO: Health Maintenance Organization. HMOs are generally the most restrictive form of managed care, usually requiring members to select a primary care provider and use only contracted, “in-network” providers. Non-network providers are usually only covered in emergency situations or if the care cannot be provided by a provider that is part of the network.

Integrated Delivery Systems: Providers, often including hospitals and physicians, combined to create a legal entity for the purpose of contracting with managed care organizations. The clinical services provided by the IDS usually include inpatient and outpatient care and can therefore handle care under “full capitation.”

In-Network/Out-of-Network: Providers who sign a contract to provide services to the health plan (at an agreed upon level of reimbursement) are considered part of the plan’s network (“in-network”). Physicians are usually credentialed before they are marketed as part of the network. Providers who have not signed a contract or have not yet been credentialed are considered out-of-network.

Primary Care Physician (PCP): PCPs, sometimes called a “gatekeeper,” are physicians who agree to coordinate care for a patient. The PCP is often required to authorize referrals for specialty care for HMO and POS patients. PCPs are usually board certified in internal medicine (IM), pediatrics

(PEDS), general practice (GP) or family practice (FP). Obstetricians and gynecologists (OB/GYNs) are sometimes allowed to practice as PCPs.

Point-of-Service (POS): POS plans are a moderately restrictive form of managed care. The members are usually required to select a primary care provider. If specialty referrals are approved by the primary care provider, reimbursement is usually at a higher level than if care is not approved. Out of network care is usually covered at a lower level of reimbursement than approved, in-network care.

Preferred Provider Organization (PPO): PPOs are generally the least restrictive form of managed care, allowing patients to select “in-network” providers at a high level of reimbursement, or non-contracted “out-of network” providers for a lower level of reimbursement. Referrals for specialty services from a primary care physician are usually not required.

Appendix II

Examples of Stakeholder Performance Measurements

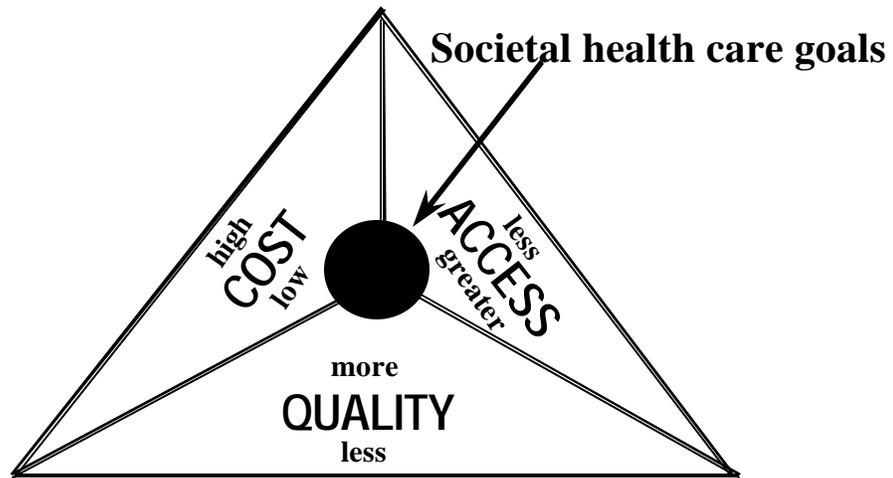
<u>Source</u>	<u>Measurement/Tools</u>	<u>Uses</u>	<u>Limitations for internal use</u>	<u>Limitations for external use</u>
MCO/ Insurer	Health Plan Employer Data and Information Set	Necessary for accreditation; useful in benchmarking; widely accepted as a reasonable measure	Measures focus on outcomes rather than processes -HMO oriented (hard to collect out of network data)	Unclear how other stakeholders should interpret HEDIS; Population based and process oriented
	Foundation for Accountability	Patient centered measures	Measures are provider-patient outcomes-oriented	Still new, not broadly used, closed-panel oriented
	NCQA Accreditation	Health plan legitimacy and compliance with standard criteria	Expensive preparation for accreditation review; post –review report of limited use for health plan improvement	Needs broad benchmarking Does not provide a continual evaluation; accreditation. Needs periodic review
	American Accreditation Healthcare Commission	Modification of NCQA/HEDIS/ FACCT for POS and PPO products	Still in development	
	Utilization Reports, Experience		Must be detailed by product	Not adjusted for risk, acuity, timing, etc.
Employer/ Purchaser	Health Benefits Expense	Indicator of budget vs. actual	Subject to market dynamics	Need industry-specific benchmarking
	CAHPS Consumer Assessment of Health Plans Study	Standard survey of enrollee experience with health plans	Training required on how to administer survey Still in development and evaluation phase.	Value of tool in assisting consumer plan selection not yet determined Study completion in yr. 2000
	Employee Satisfaction	Indicator of consumer perceptions	May be biased by sample and/or format	Internally developed surveys not comparable to external benchmarks
Individual Consumer/Member	Satisfaction surveys, Out of pocket costs; Waiting time Commuting distance	Indicators of satisfaction	Extenuating circumstances may apply Surveys may not represent current population	Thresholds vary Not adjusted for reporting biases

Appendix II Continued

Examples of Stakeholder Performance Measurements

<u>Source</u>	<u>Measurement/Tools</u>	<u>Uses</u>	<u>Limitations for internal use</u>	<u>Limitations for external use</u>
Regulatory/Policy Makers	Aggregate public health mortality and morbidity	Outcomes measures	Geographic variations diminish impact of generalizations	Not specific enough for local action
Clinical Providers	Net income Internally generated performance reports	Benchmarking against colleagues or industry standards	Confidentiality cannot be assured	Industry standards have not been agreed upon
	AMA accreditation	Will include outcomes component		
	Patient visits	Productivity	Not acuity adjusted	Unclear acceptable standard that applies to all providers
	Compliance w/clinical guidelines	Adherence to generally accepted standards of practice	Compliance not easily enforceable, not acuity adjusted.	Unclear indicators of clinical capability
	Provider profiling	Comparisons among peers	Confidentiality, potential for misinterpretation	Comparability, risk adjustment, potential for misinterpretation
Institutional Providers	Financial ratios, margins	Evaluate financial performance	Poor indicators of quality and/or cost	
	JCAHO Accreditation	Evaluate compliance and infrastructure relative to standards	Focus on performance measurement in early stages	Most MCO networks require JCAHO accreditation therefore most have it

The Frontier of “Managed Care Effectiveness”



MCE = the optimal balance of stakeholder interests for cost, quality and access where each stakeholder optimizes objectives w/o compromising the success of other stakeholders.

Appendix IV

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