

Competition, Capitation, and Case Management: Barriers to Strategic Reform

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COMPETITION, CAPITATION, AND CASE MANAGEMENT (CC&C) have been the dominant policy themes of the 1980s. These mechanisms were first proposed as a package by the Nixon administration in its 1971 National Health Strategy and have maintained political support within Congress and from a succession of presidents ever since (Reagan 1983; Newman 1972; Enthoven 1980; Nixon 1971). Unfortunately, there have been considerable difficulties translating that support into public policies and programs. For example, in 1986, 4 percent of the nation's Medicaid recipients were enrolled in health maintenance organizations (HMOs) compared to 9 percent of the population as a whole. An additional 3 percent of the Medicaid eligibles were enrolled in partially capitated or medical case management systems. Ninety-three percent of the recipients received care in the traditional fee-for-service system.

The gap between political support for CC&C and programmatic reality is made more puzzling by the general dissatisfaction among government officials with fee for service and the rhetorical appeal of alternative delivery systems. The primary benefits attributed to CC&C are consistent with general preferences within our society for a private market economy. Competition will create a dynamic system of health care providers responding to the needs, pressures, and preferences of consumers. Capitation, as the preeminent fixed price contract, will encourage efficiency. Case management, a sophisticated form of stew-

ardship of the patient, will assure quality of care (Spitz 1979; Newman 1972).

CC&C also will bestow a host of secondary benefits upon the government. Consumer sovereignty would eliminate the need to regulate efficiency or quality of care. This in turn would permit the dismantling of many of the intrusive and costly regulatory agencies required to control the fee-for-service system. In addition, CC&C would enable government to reduce the rate of increase in public health care expenditures, budget more effectively and accurately, transfer the financial liability for public beneficiaries to the private sector, and guarantee access to needed care for clients.

These potential benefits should have provoked government to make wholesale commitments to changing public programs. Yet over the past 15 years, adoption of the CC&C strategy has been minimal. It is tempting to blame the rhetoric for the failure. Too much was promised. Too much was glossed over. Complexity was lost in oversimplification. Balance and perspective were lost in excessive exaggeration.

Blaming rhetoric for oversimplification or exaggeration is akin to blaming a lion for its roar. It is the nature of the beast. Moreover, if there has been a failure, it has not been in the CC&C strategy but in its adoption. Barriers to implementation have arisen within CC&C, which have been treated by the federal government and the states as idiosyncratic or trivial but which, in fact, are systemic and significant. This article examines these barriers in the context of Medicaid, a federal/state health care program for the poor which in 1985 served 22 million people and spent \$37.5 billion (unpublished data from the Health Care Financing Administration).

Medicaid, HMOs, and Case Management

Medicaid's experience with capitation and case management formally begins with the introduction of HMOs. Between 1971 and 1973 there was rapid growth of Medicaid HMOs which was due primarily to California's aggressive pursuit of prepaid health plans. That same policy produced a number of scandals and quashed HMO Medicaid fervor in California and among most of the remaining states (Schneider and Stern 1975; Goldberg 1975). Nationwide HMO enrollment hovered

TABLE 1
Medicaid HMO Enrollment

	1980	1985
ARIZONA	0	175,000
CALIFORNIA	111,383	211,748
COLORADO	2,555	6,054
CONNECTICUT	0	376
WASHINGTON, D.C.	698	117
FLORIDA	0	12,300
HAWAII	4,000	2,892
ILLINOIS	2,000	72,974
MARYLAND	25,355	18,100
MASSACHUSETTS	4,272	4,381
MICHIGAN	59,614	91,038
MINNESOTA	339	831
NEW JERSEY	0	800
NEW HAMPSHIRE	0	383
NEW YORK	33,998	24,200
OHIO	2,363	38,975
OREGON	7,401	19,595
PENNSYLVANIA	2,397	15,327
RHODE ISLAND	150	218
UTAH	4,160	8,762
WASHINGTON	7,600	2,529
WISCONSIN	750	117,388
Total Enrollment	269,035	831,078
Total Eligibles	21,605,000	21,808,000
Enrollment/eligible	1.2%	3.8%

Source: Unpublished 1986 data from the Health Care Financing Administration.

between 1 and 2 percent of the total Medicaid population for most of the 1970s.

In 1980, 53 HMOs had 269,000 Medicaid enrollees (1.2 percent of the total). Five years later, 54 HMOs had 831,000 enrollees (3.8 percent of the total population) (see table 1). Although a threefold increase, this growth can, in fact, be viewed as disappointing. In relative terms, Medicaid enrollment was well under half the rate of the population at large. Most of the Medicaid activity was concentrated

in five states in the West and industrial Midwest: California, Arizona, Wisconsin, Michigan, and Illinois. More than 70 percent of the enrollment was in six metropolitan regions (Los Angeles, Phoenix, Milwaukee, Madison, Detroit, and Chicago) (unpublished data from the Health Care Financing Administration). The HMO option is not only of apparent limited applicability but one which relied heavily on coercion. Nearly half of the growth in Medicaid enrollment in the 1980s was due to mandatory enrollment in Arizona and Wisconsin (Christianson and Hillman 1986; Riemer 1985). Medicaid clients in those states could only choose among fully capitated systems.

The development of partially capitated or case-managed fee-for-service medical programs has been rapid but still represents an insignificant portion of the Medicaid program. While nonexistent in 1980, by 1986 these variations on capitation and case management had enrolled 671,000 individuals in 19 states. This was 3 percent of the national Medicaid-eligible population. In total, Medicaid has enrolled less than 7 percent of its eligibles in all forms of alternative delivery systems. (We have excluded Texas and Indiana Medicaid programs from this count of enrollees in alternative delivery systems because those states' capitation of their entire Medicaid programs does not and has not produced alternative delivery systems. Similarly, while selective contracting in California and Illinois may be the first step toward public preferred provider organizations, it has not resulted in an alternative system of organized health care. Selective contracting with hospitals, therefore, is not included as an alternative delivery system.)

The reluctance of states to adopt the capitated and case-managed programs is due in part to conflicting signals from the federal government concerning the development of alternative delivery systems. For example, the Omnibus Budget Reconciliation Act of 1981 was expansive in its encouragement of alternative delivery systems. It was followed, however, by a series of congressional acts and amendments that limited the development of HMOs, health insuring organizations, and case management systems. Similarly, the varying ease and then difficulty with which the Health Care Financing Administration (HCFA) and the Office of Management and Budget have approved waiver requests by states over the past five years has effectively acted to discourage states by increasing the uncertainty surrounding the waiver process. Waivers have frequently been an avenue for testing innovations by permitting

a state to limit a new approach to a specific part of the state, a specific population, and a mandatory set of benefits and providers.

In addition, the state bureaucracies are designed to regulate and manage fee for service. There is an emphasis on developing policies based on recipients of care rather than an eligible population. Indeed, state Medicaid agencies' documents and most of the state reports required by HCFA are based on individuals' receiving care and not on the population at risk. This is significant. It distorts policies as well as creating rudimentary problems such as state difficulty in maintaining an accurate monthly roster of an HMO's eligible enrollees. That roster is the HMO's billing mechanism as well as its basis for its major contractual obligation to the state.

The administration of a fee-for-service system is built around the fee-for-service invoice: rapid processing of the invoice, detecting fraudulent or incomplete billings, adjusting reports to reflect the seasonal lag in the submission of invoices, merging the invoice tapes with the client tapes to create utilization and surveillance files. These files allow states to monitor excessive costs and utilization. All of this is based on a detailed itemization of events that have occurred in the recent past.

Capitation, on the other hand, requires that states set rates based on fee-for-service estimates of the costs that will be incurred by a particular population covered by a specific set of services in clearly defined service areas. Unless the states alter their standard operating procedures, the successful transition to capitation not only reduces the validity of the estimates but it eliminates the major source of data that the states have on their Medicaid program.

Medicaid must also operate within legislative biases favoring minimal expenditures on state government. As a result, there are often insufficient funds appropriated for major innovations (resources needed to make changes in staff, information systems, and policies and procedures).

In addition to problems with state government, the slow adoption of capitated and case-managed programs is also due to the resistance or indifference by clients, hospitals, and physicians. Further, existing HMOs are concerned about contracting with state government, accepting enrollment of a "problem" population or being labeled as welfare HMOs.

While this list is long, the states with sizeable HMO enrollment are proof that these barriers are surmountable. Perhaps more powerful

constraints are the persistent and growing concerns by public officials that government's capacity to operationalize the CC&C strategy is inadequate, and that public movement into these areas—even at a pace comparable to the private sector—is too perilous. In the end, the failure of CC&C will result from these perceived risks and operational sticking points, and not from start-up problems associated with administration or provider and client resistance. Why? What has happened?

Competition

There is an assumption among proponents of a competitive solution that poorly administered low-quality provider groups and health plans will be driven out of the market, that consumer sovereignty will effectively control the seller's behavior, and that the visible hand of government will be replaced by the invisible hand of the market. There is a further assumption that given this self-regulatory dynamic, once government arranges for public beneficiaries to be enrolled in capitated plans, government has not only limited its fiscal liability but has transferred all of its responsibility for the clients to the plans. If there is a problem, the plan is at risk, not government. The magic of the market place has made access, cost, and quality the concern of the HMO alone. Reliance on the market has freed government from the need to regulate or monitor providers.

The operational reality is that the market can be indecipherable to most consumers and that when the "market" responds that response is likely to be sluggish. For example, quality of care is of critical importance to most health care consumers. Government, however, has been unable to define quality of care adequately or evaluate it, let alone disseminate quality-of-care information to consumers in a credible, accessible, and sustained fashion or counteract aggressive advertising by "poor quality" HMOs (Health Care Financing Administration 1986). Further, even when plans are identified by the media as inefficient, exploitive, or of low quality, regardless of the veracity of the charges, those HMOs can persist for months or years.

For example, the press coverage of International Medical Centers for its Medicare contracts in Florida or HealthPower for its Medicaid contracts in Ohio was, at best, a strong public indictment of both HMOs (*Cleveland Plain Dealer* 1985a, 1985b). Yet both survived as

a tribute to the credibility of the press and the tough competitive presence of government as a prudent purchaser.

What the federal government and a few uninitiated and inexperienced states fail to recognize is that HMOs require as much if not more review than the fee-for-service system—not in terms of government as the regulator but government as a purchaser of care.

The issue is contract compliance. When fixed price contracts are negotiated in any other market, they typically include both product specifications and methods for confirming that the specifications are met upon delivery. Neither demand implies that the purchaser is unreasonable or intrusive nor that the supplier is unethical or incompetent.

Contract enforcement and compliance was a central problem in one of the largest competitive demonstrations to date: the Arizona Health Care Cost Containment System. In 1982 this program established a competitive bidding process among 17 capitated plans caring for all of the indigent recipients in the state. During the first few years it became clear that the market could be used to set prices but that very little else followed automatically. Serious problems surfaced in the performance of the fiscal intermediary and the HMOs, problems that should have been anticipated but were assumed away by the rhetoric of the market. As two scholarly observers of the Arizona experience have noted:

While the competitive bidding process may prove useful in establishing reimbursement rates for providers of indigent care, they require that the resulting contracts be effectively executed. This draws state governments into contract monitoring and enforcement activities that have many similarities to more traditional regulatory activities and are subject to similar biases. The complexity of these activities and the factors that influence them have not been fully appreciated by advocates of competitive contracting (Christianson and Hillman 1986).

Government has also constrained itself by casting the major options in the health care market as either competition or regulation. Since regulation and contract enforcement are similar, to enforce a contract has inexplicably become an anticompetitive act. Nonetheless, the uncritical acceptance of the self-regulating market and the nonintrusive role of government courts disaster (Spitz 1985).

In order to develop a more practical approach to competition we

need to take a more critical look at the two mechanisms which make competition work in the new world of alternative delivery systems: capitation and case management. Both mechanisms have economic and political appeal. Capitation is a fixed fee paid to a provider at prearranged intervals for the health care services for an individual. By limiting the available resources, capitation places providers at risk and encourages more efficient styles of practice.

Case management allegedly maximizes the use of those limited resources. Case management typically entails a physician accepting responsibility for providing and supervising all of a patient's care. The patient, in turn, is formally "locked into" his physician (Spitz and Ostby 1987). The physician case manager guarantees access to care and quality of care—the two critical aspects of health care which might be adversely affected by capitation. Theoretically, capitation and case management have the trappings of "self-regulation." In reality, they are fraught with operational difficulties.

Capitation

Capitation seems to be a very simple process. A payer simply sets or negotiates a rate that a provider is willing to accept. Once the contract is signed, the capitation rate should no longer be an issue. The mechanics of setting and applying the rate, however, turn out to be very complicated (Gruenberg, Wallack, and Tompkins 1987). Indeed, there are three unresolved but related problems which can distort and at times pervert the financial incentives that capitation was intended to produce.

Rate-setting Standards. Since 1971, Medicare and Medicaid have developed rates based on the fee-for-service experience of a population similar to the HMO enrolled population. (These populations are matched by age, sex, residential area, welfare category, institutional status, and health benefits [U.S. Code of Federal Regulations, Title 42; Kunkel and Powell 1981].) These matched rates are called the "adjusted average per capita costs" or AAPCC. The rationale for the AAPCC is that any new delivery system would have to be less expensive than fee for service to justify a change in public programs. Therefore, government must determine what an individual would have cost had they remained in fee for service and then what minimum level of

efficiency must be attained by the new delivery system. In general, the federal government pays 95 percent of the AAPCC for Medicare beneficiaries and states 90 to 95 percent of the AAPCC for Medicaid clients (Kunkel and Powell 1981; U.S. Code of Federal Regulations, Title 42, Subchapter C, Subpart 417.588 (a)–(c); (2)–(4)).

HMOs experience 10 to 40 percent lower hospitalization than fee for service (Luft 1978). A rate set at 95 percent of fee for service offers considerable opportunity for an HMO to generate net revenues. Initially, that opportunity could be construed as a bonus payment to capitated plans, a reward for bringing their plans into production and participating in a government program.

All of this raises several questions. How long should government continue to pay a bonus to the plan? When is the fee-for-service rate too high? For example, if the hospital days per 1,000 in a city are twice the national average, should the capitation rate reflect an enormous and (on the surface) inappropriately high hospitalization rate or should the rates be based on a more moderate fee-for-service system? For example, the inpatient hospital days per 1,000 in the Northeast are nearly 30 percent greater than in the West. The HMO hospital days per 1,000 in New York, however, are only 6 percent greater than in California. Should HMO rates in New York be based on comparable HMO utilization rates elsewhere in the country or on the fee-for-service experience in New York?

When is the AAPCC too low? A public program like Medicaid may offer a very limited fee-for-service benefit package and derive enormous discounts from providers. HMO rates based on this experience then would be artificially low. Further, by contracting with the state in that situation, an HMO could open itself to considerable financial liability (who is financially responsible for the enrollees, after they exhaust their formal hospital coverage?) and to poor business relations with hospitals and physicians, upon whom they also rely for their nongovernment enrollees.

Should the AAPCC be used if fee-for-service dominance in the market is altered? In Detroit, one-fourth of Medicaid clients (approximately 95,000 individuals) are enrolled in HMOs (unpublished Health Care Financing Administration data). This level of HMO enrollment would affect the continued usefulness of fee for service as the payment standard of performance—particularly if you suspect even minor levels of adverse selection. In Madison, Milwaukee, and Phoenix,

there are only capitated systems for Medicaid clients. Clearly, in these three instances fee for service is not only inappropriate, it is nonexistent. When this occurs, what is the appropriate standard? Nongovernment fee-for-service experience? Negotiated rates? HMO costs? At this point the question is still being framed. It is highly probable, however, that whatever the solution it will incorporate some absolute standards of appropriateness, adjustments which recognize variations in the cost of uncontrollable factors (such as a less healthy population or higher wages) but which ignore variations due to expensive and noneffective styles of practice (such as those identified in the small-area variations literature).

Predictive Quality of Capitation Models. Even if the appropriate rate-setting standard is selected, we cannot adjust that standard so that it accurately projects an individual's need for and use of health resources. If that adjustment is not made, a capitated plan can be unjustly rewarded or punished simply because its enrollees' health status was different from that anticipated. When the AAPCC was first employed, it was assumed that adjusting the fee-for-service population by demographic characteristics (age, sex, residential area, etc.) was sufficient. However, the AAPCC explains only 1 percent of the variation of an individual's expenses over a forthcoming year (Ash et al. 1986; Thomas, Lichtenstein, Wyszewianski and Berki 1983). When prior year's utilization of health services are included in the predictive rate-setting models, this figure increases from 2 to 13 percent of the variance explained (depending upon how prior use is measured) (Welch 1985); that is, 87 percent or more of the variation in future costs incurred by an individual is either subject totally to chance, undetected by current rate-setting models, or requires information that is not generally collected and/or is too expensive to collect (e.g., the results of complete annual physicals on every individual in a given population).

The large amount of unexplained variation is problematic only if there are reasons to suspect that healthier or sicker patients will exhibit a bias in the selection of a plan or if a provider can affect that choice. This biased distribution is referred to as either adverse or positive selection. While some studies have shown that healthier patients prefer fee for service and others prefer HMOs, few have shown that selection bias does not exist (Luft 1981).

Selection bias wreaks havoc with predictive models and, therefore, with the rates. The success of a capitated program need not turn on

its ability to predict an individual's costs. After all, the stochastic nature of health events precludes accurate predictions of the future costs of individuals. Indeed, the rate-setting models perform much better when predicting the average costs for large groups of randomly selected individuals. At this level, average prediction errors tend to be on the order of 1 to 2 percent. Once biased selection is introduced, however, average prediction errors for *groups* range from 6 to 100 percent even when prior utilization is incorporated into the model (Ash et al. 1986).

Given the existence of selection bias, how does it work and how does it affect public programs? From the patient's perspective two processes appear to affect choice. First, if an individual does not have a preexisting physician relationship (i.e., he is healthy or recently moved into a community) he is more likely to accept the less costly but more restrictive environment of a capitated plan. Those with physician relationships tend to maintain those relationships and not leave their doctor for an HMO. On the other hand, if the patient has anticipated costs that are very high and cannot get adequate coverage in the indemnity market, he may also opt for the all-inclusive coverage that many capitated plans offer. This adverse selection of HMOs by the costly patients is less likely to occur in Medicare and Medicaid than in the private sector. It is unlikely in Medicare because of the highly developed market of supplemental insurance for the elderly (Link, Long, and Settle 1980). In Medicaid, there are very few costs incurred by the poor and the Medicaid coverage is always available.

From the providers' perspective it is always in their interest to encourage enrollment of healthier patients and disenrollment of the sick. This may take the form of an HMO setting up enrollment booths only in suburban shopping malls for Medicare patients (Luft 1983) (thus biasing enrollment to ambulatory, moderately wealthy elderly individuals with weak preexisting physician relationships), to encouraging high-cost patients to disenroll by being unresponsive, having them queue up for services, or suggesting to them that the HMO cannot supply them with appropriate care.

A recent study of 35,933 cases of Medicaid aid to families with dependent children (AFDC) found strong evidence of selective enrollment and disenrollment: 89.5 percent of those families who did not have a previous physician contact for three months prior to the enrollment

period under study joined an HMO, whereas only 7 percent of the recipients with preexisting physician relationships joined an HMO. Of those that enrolled in HMOs, however, the sickest members seem to have been systematically purged from the HMO rolls; the 1,052 families that disenrolled from HMOs had postdisenrollment hospitalization rates that were nearly twice the average fee-for-service recipient (Des Harnais 1985).

This kind of experience has been incorporated into models of HMO performance. Simulations by Tom McGuire and Randall Ellis suggest that if an HMO has low, moderate, or high positive selection (i.e., their enrollees are 10 percent, 20 percent, and 30 percent less expensive than the average patient in an AAPCC cell), then depending upon their market penetration, the HMO breaks even at 65 to 90 percent of the AAPCC—well below the current rates set at 90 to 95 percent of the AAPCC (Ellis and McGuire 1986).

The incentives facing an HMO vis à vis the individual patient are very different from those facing an individual physician who participates in several HMOs and individual practice associations (IPAs) and maintains a fee-for-service practice as well. In this instance, the physician will play an important role in the patient's choice of delivery system. For example, he might encourage a family with two healthy teenage children to join the IPA while other patients who the physician knows need bypass surgery or are obese, hypertensive, and diabetic might be encouraged to stay in fee for service. There is anecdotal information from Florida that this occurred when potential Medicare enrollees were directed into or away from capitated plans after their physicians first completed a detailed physical examination (and billed Medicare accordingly) (personal communication from Kathy Langwell, Mathematica). Indeed, between one-fourth and one-half of the Medicare enrollees in four of Florida's largest competitive medical plans received physician services (presumably physicals) from their HMO physician one month prior to their enrollment (U.S. General Accounting Office 1986, 70–72). Those services were paid by Medicare on a fee-for-service basis.

Our discussion of adverse selection has focused on the distribution of patients. What is occurring, however, is more likely to be the product of a threefold effect: more healthy patients are being cared for by more efficient providers (the less efficient ones presumably would be forced out by the capitated plans themselves) in more efficient

delivery systems. All of which would create AAPCC reimbursement rates based on the sicker patients being treated by less efficient providers in a less efficient delivery system. Such an outcome is not improbable and points again to the need to redefine the standards and models employed for rate setting.

The Meaning of Risk. Conventional wisdom states that capitation imposes uniform risks and incentives. What this wisdom fails to recognize is that capitation consists of two different kinds of risks: the insurance risk or the risk of an medical event occurring; and the performance risk or the risk imposed upon the medical providers to respond efficiently and effectively once the medical event occurs. Further, the appropriateness, effectiveness, and impact of capitation appears to vary from agent to agent. We are still unsure as to how and why capitation affects different groups of intermediaries or providers. For example, what does it mean when the federal government capitates the state of Arizona for its Medicaid population? When the state of California capitates Contra Costa County for the medically indigent? When a proprietary HMO, public hospital, outpatient department, physician group or individual physician is capitated? Each level of capitation not only raises different issues concerning the allocation of health resources but different medical and ethical problems. At state or county levels failure to live within a capitated rate may, as it frequently has in the past, result in a supplemental appropriation (Spitz and Hereford 1986). In a capitated outpatient department, the capitation rate may be a secondary consideration to teaching and the flow of patients into inpatient settings. In both of these instances, the impact of capitation is muted either by an ability of the capitated agent to "buy" its way out of a limited budget or because other goals are being met which offset losses incurred under the capitated arrangement.

When a small group of physicians or an individual physician is capitated, however, it is not possible to diminish the impact on medical practice. Capitation can place the physician in an adversarial and pernicious relation with his patient not because the physician is at risk to perform inefficiently but because he has effectively become a small insurance company. This is a role the physician may not completely understand. In all likelihood he is not prepared financially to assume an underwriting risk and fails to understand how that risk increases as the size of the enrolled population decreases. Once physicians

begin to appreciate the potential losses they might bear, however, then each fully capitated patient becomes a financial time bomb raising a series of ethical and economic questions: What does capitation mean if the cost of the most efficient care still exceeds capitation revenues? How is the physician to care for his remaining enrolled patients if they need services? Will this arrangement place the physician in the disturbing position of denying needed care to one or two patients so that others may be cared for adequately? Can a system be designed that encourages efficiency but eliminates incentives for a competent and ethical physician to harm his patient?

The meaning of risk also changes when a physician participates in several different delivery systems. As the number of delivery systems proliferates and as physicians attempt to keep their patients by participating in as many plans as possible, then the number of patients per plan will decline and the ability to track the impact of any one system on a physician's practice becomes difficult. Further, a distinction needs to be made between a stochastic event—the luck of the draw—and physician behavior. For example, if 30 patients are enrolled with a primary care physician under the ABC IPA plan and none of those patients require care during the year, the low utilization is clearly not due to the physician's efficient practice.

A related issue turns on the physician's decision to change his behavior. Is there a minimal number of patients or financial return that triggers a change in a physician's practice patterns? What kind of changes do they precipitate? And how does a physician reconcile different and conflicting incentives when he participates in more than one plan?

There is a range of responses to these questions. Certainly, if the physician is fully at risk for all services and costs incurred by a specific patient, then that patient is handled with great care and attention. On the other hand, if the physician is assigned patients and placed at minimal risk, changes in his medical practice may not occur. For example, in Detroit in 1985, 78,150 Medicaid recipients selected or were assigned to 1,144 physician case managers. These physicians were responsible for providing or approving all care received by their patients. The physicians were reimbursed on a fee-for-service basis and also received \$3 per month per patient as a case-management fee. The median number of recipients per physician was 20. Eighty-two percent of the physicians had 100 or fewer patients (Michigan

Department of Social Services 1986). Is it reasonable to expect that a physician with an active patient panel of 1,500 to 2,000 individuals will change his behavior for 20 patients from whom he receives a \$60 monthly case-management fee? For 100 patients from whom he receives a \$300 monthly fee?

Given all of this, there are only two facts about capitation that we can state with certainty. First, it is a fixed periodic fee received by a provider for most or all of a patient's care. Second, most capitated systems have strong incentives to reduce costs. The methods for reducing costs are not inherent in capitation. They may be harmful or beneficial to the patients. Because of this, capitation for public programs might be viewed by the patients solely as a reduction in benefits: a simple mechanism for limiting the funds available to public beneficiaries.

It is in this context that case management plays a critical role. Capitation limits resources. Case management maximizes the use of those resources. Case management transforms capitation from a punitive measure (i.e., one which reduces benefits) to an expanded benefit by reducing costs while increasing access and increasing quality of care (*Missouri Medicaid Bulletin* 1983, 5; Massachusetts Department of Public Welfare 1982, 5; New York State Department of Social Services 1985, 30). All of the policy goals that the federal government and states have been unable to achieve become attainable by transferring patients to capitated programs that are case managed. Case management has become the philosopher's stone of cost containment.

Case Management

Case management is an interesting term. While its derivation is rooted in a number of professional disciplines (social work, mental health, geriatrics, and primary care [Austin 1983; Perlman et al. 1985; Overholt and Berguin 1983; Anderson 1975; Dennis and Goodrich 1963]), the term itself does not surface at the federal level until the late 1960s. The need for "case management" was not viewed as a means for controlling clients or improving the efficiency of providers but rather helping clients overcome federal bureaucracy and maximizing their access to federal funds (Rehr 1985). The rapid growth of human services during the 1960s and early 1970s greatly increased availability

of services but not necessarily access to those services. As James Intagliata (1981) notes, this occurred because:

public funding was provided primarily through narrow categorical channels, [so that] the network of services that emerged was highly complex, fragmented, duplicative, and uncoordinated. Countless individual programs have been developed to provide extremely specialized services or to serve narrowly defined target groups. While these factors interfere with service accessibility for all potential users, the barriers are particularly burdensome for those persons whose complex problems necessitate that they engage multiple, disconnected programs in order to get the assistance they need.

Case management was first introduced in Congress in the Allied Services Act of 1972. This resolution proposed that social service programs should be consolidated, offering a full range of services while increasing access to care. The resolution never passed but the idea, intent, and perceived need for the program persisted. Three years later, the Community Mental Health Centers legislation of 1975 (P.L. 94-63) was passed (Turner, TenHoor, and TenHoor 1978). Again, legislation was designed to develop a community support program which coordinated benefits and *maximized* access to clients.

The nature of case management as a federal policy did not change until passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981. Under this legislation state Medicaid programs could receive federal waivers which allowed them to "implement a case-management system . . . which restricts the provider from or through whom a recipient can obtain primary care (U.S. Code of Federal Regulations, Title 42, Section 431.55 (c))." Federal requirements prohibited case management from "substantially impair[ing] access to services of adequate quality" and required "that a specific person or agency be responsible for locating, coordinating or monitoring Medicaid services on behalf of a recipient (U.S. Code of Federal Regulations, Title 42, Section 431.55 (c) (1) and (2))." In addition, states would have to demonstrate that case management was "cost effective (U.S. Code of Federal Regulations, Title 42, Section 431.55 (b) (1))."

Cost effectiveness was a thread woven into OBRA. It not only affected primary-care case management but was a part of case management in the Medicaid home- or community-based waivers; the lock-in provisions of recipients who overutilize Medicaid services; the lock-out

of providers who abuse Medicaid; the design of competitive arrangements for Medicaid; and the restriction of beneficiaries to selected "cost-effective" providers. Case management had formally made the public policy transition; it would not only coordinate benefits but would be "cost-effective" without "substantially impair[ing] access to services of adequate quality."

Four years after the passage of OBRA, the Consolidated Omnibus Budget Reconciliation Act (COBRA) (P.L. 99-272) of 1985 deemed case management so successful that states could elect to provide case management as an optional service in the Medicaid program without seeking federal waivers. Several aspects of this newly created benefit are puzzling if not bizarre. First, case management is undefined. The legislation describes case management as assisting recipients to "gain access to needed medical, social, educational and other services (P.L. 99-272, Section 9508 (g) (2))." States, however, are unable to decipher what this law means. According to a National Governors' Association survey of Medicaid directors, state administrators could not clearly identify the content and limits of this new benefit:

Case management lacks a precise conceptual or operational definition. In the absence of a definition, case management typically describes a range of activities that can vary from routine, minimally professional referral services, to primary nursing, to comprehensive care plan development, oversight and monitoring (Luehrs 1986).

Clearly, if case management is any of an unspecified range of activities, then it is not a system of care but a process. Further, it appears to be a process without substance. Of the 18 state Medicaid programs with physician case-management programs (employed either on a fee-for-service or partial capitation basis), all require that the primary care physician provide or approve all physician services, and inpatient and outpatient services. All require that a patient receive prior approval from his case manager before seeing another physician for a nonemergency referral. Fourteen states require 24-hour coverage by the primary care physicians (Spitz and Ostby 1987).

These restrictions increase the physician's information about his patient, improve continuity of care, and specify a point of responsibility. But what is the physician responsible for doing differently now that he is a case manager as opposed to a primary care physician? On this

point the states are mostly mute. Nine states do not have any clinical definition as to what is meant by case management. Nine additional states require that the clinical standards used to test, screen, and treat Medicaid children in the fee-for-service system (the Early Periodic Screening, Testing, and Diagnosis Program) be applied to a case-management program. This does not necessarily change the expectations placed on the physician from those that applied when he was solely a primary care physician. Only three states (Massachusetts, New Jersey, and South Carolina) have more extensive clinical requirements of their case managers. These states, however, represent 6,300 individuals of the more than 671,000 clients enrolled in these case-managed systems (Spitz and Ostby 1987). Thus, more than a half-million individuals are assigned to physicians who do not know how they are to alter their clinical practice now that they have been designated case managers by the state.

If the physicians cannot determine what the substance of a Medicaid case-management program is, then the states cannot determine when case management occurs and when it does not. That information would be unnecessary if there were a uniform community standard of care practiced by physicians and acceptable to the state; strong interaction among primary care physicians and between primary care physicians and specialists; and self-policing by the community's physicians. Those conditions may hold in some areas, but in major urban areas there are such wide variations in training, skills, and interaction among doctors that any assumption of a community standard is whimsical. And it is in the major urban areas that most public clients in case-managed systems reside.

It should be stressed that even if case management were nonexistent, we should expect that the patient lock-in alone would reduce expenditures. Restricting a patient to one physician who provides or approves all of the patient's care will inevitably reduce self-referrals and the use of multiple sources for primary and specialty care. Outpatient department and emergency room use should decline. All of this would occur without changing the physician's behavior. A point of access would be guaranteed but general access reduced. In other words, this is a gatekeeper arrangement—not a management one—in which a rather formidable gate has been constructed. The gate apparently works. The gatekeeper's actual or preferred response, however, is simply being ignored.

In this instance, ignorance is political bliss. The rhetoric proposes that case management reduces costs, improves quality, and improves access. The accomplishment of one goal—the reduction of costs—in the absence of conflicting evidence of a reduction in access or quality of care can be “proof” that access and quality of care have been increased. As a result, a process without substance is credited with resolving the central problems of our health care system.

Conclusion

The CC&C dilemma is not intractable. We’ve raised a number of problems but solutions exist for each one. Contract enforcement and compliance are not foreign elements in the market or government. If there is a desire to monitor health care contracts, techniques developed in a number of Medicaid programs with long-standing HMO programs offer a starting point. If adverse selection around high-cost cases creates critical problems for capitated programs, then states can separate those cases from the population at large and design treatment modalities and reimbursement schemes that are appropriate for costly patients. If case management needs to be clinically defined it may be possible to develop a model protocol around a small number of frequent or very costly conditions that a primary care physician normally encounters. If limitations on health care expenditures are inevitable and if capitation becomes a dominant payment mechanism, then the medical and ethical implications of these financial constraints must be made explicit. To ignore financial limitations or render them innocuous through the unstated magic of case management places an unfair burden on physicians. Government and providers have an obligation to plan for an era of reduced resources, to target reductions, and to prohibit or encourage some forms of risk and efficient forms of practice. If this is not done, we expose ourselves to random or unpalatable reductions.

These proposals may or may not work. Their usefulness is an empirical question. Solutions, however, will not be forthcoming if we remain captive to a rhetoric that denies the existence of problems, and presupposes operational mechanisms which are simply illusory. Under this scenario the failure of CC&C as public policy becomes a failure of government with little understanding of what occurred or why.

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