

Findings Brief

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Selective Contracting for Tertiary Care Services by Managed Care Plans:

Price of Services Overshadows Quality When it Comes to Selecting Hospitals

The current predominance of managed care in the U.S. health care system means that most insured patients now receive tertiary care services — such as coronary artery bypass graft surgery (CABG) and neonatal infant care (NICU) — on the basis of contracts negotiated between managed care organizations (MCOs) and hospitals that deliver such services. A key issue that emerges in this environment is how managed care enrollees can be assured that their tertiary-care contracts have been negotiated on the basis of quality, rather than on the basis of price or cost factors alone. To better understand this issue, a team of researchers led by Jack Hadley, Ph.D., of Georgetown Institute for Health Care Policy and Research (IHCPR), and including Darrell Gaskin, Ph.D., also of the IHCPR, Kevin Schulman, M.D., of the Georgetown University Medical Center, and Jose Escarce, M.D., Ph.D., of RAND, have examined the processes employed by MCOs during contract negotiations with tertiary care hospitals. The researchers discovered that as the amount of managed care and/or hospital competition in a metropolitan statistical area increases, the importance of the price of services as a factor in the selection of providers also increases relative to the importance of the quality of services. The researchers concluded that while the actual contracting processes vary widely across markets, in general, the price of a service matters more in highly competitive markets, and the quality of the service is relatively less important.

The value of examining contracting for tertiary care services — technically defined as specialty services provided by a subset of hospitals (Schulman et al., 1997) — lies in the fact that the contracting process serves as a readily accessible component of managed care cost-control measures — measures whose value many believe must be weighed against an MCO's commitment to providing quality care. According to Schulman, the two fundamental questions asked by the team when deciding to look solely at tertiary care were “how do we evaluate health plans, and how do we gain a better understanding of what we, as consumers and potential patients, are buying when we sign up for a certain policy?” Since 85 percent of health care costs are spent on services, including specialty services, which are utilized by only 15 percent of all consumers, looking at tertiary care

meant the researchers were delving into an area of health care that many people will never encounter, but which is critical to understand for those who do end up needing significant acute or chronic treatment.

Researchers Examine the Contracting Process

Throughout their study, the researchers focused on the following: 1) how do MCOs choose which hospitals they contract with for tertiary care services; 2) how do the characteristics of the MCO structure of a particular health care market and characteristics of the hospital market affect the contracting process; and 3) what effect does the contract have on how plan enrollees are channeled toward a hospital to receive tertiary care? The first two issues were studied through surveys of MCO and hospital administrators, which were structured to collect national data on trends and variations in the contracting process. To gain deeper insight into how community factors affect the process, the team held in-person interviews with MCO medical directors and contracting officers, as well as with managed care contracting administrators within hospitals in three different markets, varying by managed care penetration, managed care enrollment, number of hospitals and hospital beds, and primary and non-primary physicians.

When it came to analyzing the data culled from the national survey, the researchers hypothesized that MCOs contract with hospitals in order to secure high-quality care at the lowest price for their enrollees. They specifically examined the following four variables for their impact on that decision: 1) price charged by the hospital, 2) quality of care (either observed through hospital outcomes data or as perceived by the plan), 3) geographic convenience of the hospital to MCO enrollees, and 4) MCO market penetration. While these four variables do not account for the multitude of factors that may affect the final contract award, they do offer substantial insight into the issues that are most pertinent to MCO administrators.

Importance of Price Increases with Level of Managed Care Penetration

Based on the data analyses as well as the case study portion of the study, the researchers came to several conclusions. First, similar

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processes for contracting CABG and NICU services were evident across the surveyed MCOs, which suggested that the study's findings could be used to evaluate how other tertiary care services are delivered.

In terms of competition — both from the MCO side and the hospital side — market penetration tended to have the greatest effect on whether price or quality were a higher priority in awarding the final contract. Related to this is the finding that as the level of HMO market competition increased, so did the proportion of HMOs that reported being actively involved in the care process through monitoring both length of stay and pre- and post-stay costs. As would be expected, when taking the competition aspect out of the equation and holding quality and geographic convenience constant, hospitals that charged higher prices to the MCO for either CABG or NICU were *less* likely to be awarded a contract by an HMO. Conversely, when price and geographic convenience were held constant, the higher the quality measure, the *more* likely a contract would be awarded. Additionally, MCOs became less likely to award a contract to a hospital as the geographic distance between the hospital and enrollees grew, quality and cost remaining constant.

By using the case studies as a guide for how to interpret the data analyses, the researchers concluded that quality is a meaningful factor in the contracting process. But as competition increases among both MCOs and hospitals, price will overshadow quality in importance. The significance of these findings lies in the fact that once quality is sacrificed for the sake of competitive prices, consumers might be paying less but also receiving less, ultimately undermining the cost-effectiveness goals on which the delivery system is based.

As evidenced by the researchers' third research focus on the question of how contracts affect the numbers of plan enrollees channeled to a particular hospital, the issue of tertiary care contracting is crucial not only to consumers but to hospitals as well. For hospitals, the growth in managed care has meant that contracting with MCOs is necessary for fiscal survival. In many areas, if a hospital is not enrolled in MCO panels, it will not see the volume of patients it needs to treat in order to

meet its costs. The researchers also discovered, however, that having a contract does not guarantee that a health plan will channel its patients to a given hospital.

The Quantity Illusion

Optimally, Schulman says, plans that place a premium on quality would purchase services "correctly" and serve as "advocates for patients, using their market share leverage to secure an efficient arrangement for delivering quality care." But instead, he says, what we may be experiencing with the increase in managed care penetration and competition in the health care market is "quantity illusion" — a term used frequently by Mark Pauly, Ph.D., an economist and professor with the Wharton School at the University of Pennsylvania, to describe the phenomenon of consumers being required to pay less for important services, but also receiving less in return.

Understanding the Effects on Patients

The findings of this study imply that by understanding something as removed from the day-to-day delivery of health care as the contracting process, individuals and employers can become better informed when it comes to choosing a health plan. And if information on MCO-hospital contracts can be distilled to the individual consumer, stakeholders on all sides of the issue could benefit. According to Schulman, "when people buy insurance, they are buying catastrophic care. Everything else they receive is really pre-paid financing. So consumers pay for insurance because they desire coverage in the event of an unexpected need for expensive care. Therefore, by looking at how an insurer decides which hospital(s) will provide that care and measuring the objective process and quantifying outcomes of care, we can understand the importance an MCO places on quality care."

Considering that the role of tertiary care delivery within the "black box" of managed care had not been widely studied before this research began in 1994, there are many issues left to grapple with, including how to inform consumers so that they can differentiate between buying into a plan and buying actual services. For now, this study sheds new light on an important, yet not well-understood, layer of the managed care delivery system. ■

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Also see Schulman M.D., Kevin, L.E. Rubenstein, D. Seils, M. Harris, J. Hadley, Ph.D., J. Escarce, MD, Ph.D., Quality Assessment in Contracting for Tertiary Care Services in HMOs: A Case Study of Three Markets, in the The Joint Commission Journal on Quality Improvement, 2/97, Vol. 23, No. 2.