Beyond DRGs: Shifting The Risk To Providers

by David B. Swoap

The future of Medicare and the entire health care system will be determined, in large part, by whether diagnosis-related groups (DRGs) lead us from prospective fixed prices to regulatory rate setting and all-payer systems, or whether they will be one step in an evolutionary process of creating incentives for increased efficiencies by appropriately shifting the financial risk from purchaser to provider. Should the former occur, we will end up with a system with little financial risk for providers, but at a cost of locking in current inefficiencies, frustrating new entrepreneurs and innovations, and preventing an overdue market shakedown to weed out wasteful practices.

In order to prevent this development, we must recognize DRGs as an important first step in shifting the financial risk to providers—but only a first step. Although DRGs begin to shift some of the financial risk involved in health care delivery from the federal government to hospitals, they do not extend the risk to other providers in the health care delivery spectrum. The creativity latent at the grassroots level of health care delivery will not be unleashed until we apply economic incentives to all providers of medical care. This policy direction would offer the best hope of achieving our ultimate goal: more services delivered at a reduced unit price.

One clear direction is to encourage the development of comprehensive, organized, competitive, and multiple health care delivery systems, financed by locally negotiated capitated rates. Such a reform would incorporate significant local provider involvement. In order to work, the purchaser, whether government, employer, or individual, must be free to negotiate aggressively and cost-consciously the price of care. And the system must be free from excessive government controls which distort medical behavior according to arbitrary or uniform reimbursement decisions. In a capitated system, the financial risk is shifted from the purchaser to a provider organization responsible for comprehensive health care who, in turn, shares the risk with all providers associated with the organization.

While health maintenance organizations (HMOs) are clearly one remarkably successful demonstration of the vast cost-saving potential of capitated systems, we must avoid trying to reform the health care system through one organizational vehicle. Instead, we must seek to create an environment where constant innovation is possible through all sorts of new hybrids and varieties of delivery systems fashioned by physicians and

David B. Swoap, who served as Under Secretary of the Department of Health and Human Services from 1981 to 1983, is now Secretary of California’s Health and Welfare Agency.
hospitals that may prefer arrangements other than HMOs.

California has received significant publicity for competitive contracting with hospitals, a move which has saved the state $120 million this year without jeopardizing quality care. Yet, just as DRGs must be seen as an interim step toward a more comprehensive competitive reform, California views hospital contracting in a similar fashion. The state is using authority established by the legislature to go beyond hospital contracting and pursue aggressively the development of a variety of capitated health systems to deliver services to Medi-Cal beneficiaries.

California Capitated Models

**County-organized health systems.** As a result of our initial experience in the development of these models, we have learned that one important criterion for success is that a proper balance must be struck in shifting the financial risk from purchaser to provider: there must be enough risk to encourage provider efficiency but not enough to discourage participation or promote underutilization. The parent organization must assume enough risk to offer some protection to its providers but not so much that it jeopardizes its own financial viability.

The state has just completed its first year of contracting with two counties—Santa Barbara and Monterey—to provide the full range of services to all Medicaid (MediCal in California) beneficiaries in their counties. The state is paying approximately 95 percent of what it would have expected to pay under regular fee-for-service. Both counties have established authorities to run the program. Because of the promise of local control, streamlined overhead, and prompt payment, the number of physicians in both counties willing to accept new Medi-Cal patients has increased significantly.

Santa Barbara placed state funds into a “trust account” for each participating primary care physician. The county pays physicians 80 percent of the estimated cost of services per person, based on monthly rates for hospital and specialty services, primary care, and pharmacy. The remaining 20 percent goes into a reserve account. Out of this reserve is deducted administrative overhead, a 2-percent separate risk reserve, and any surplus which at the end of the year will be distributed to the participating primary care physicians. The county has negotiated its own per diem rates with hospitals. For centralized controls, the county assumed all the state’s treatment authorization functions for elective surgery, certain medical equipment, drugs, and many other benefits. The “decentralized” control mechanism is the authorization by primary care physicians of all services that do not come under the county’s control system. One year later, Santa Barbara’s local control experiment is a success. The county will distribute its 3-percent surplus to its primary care physicians. The county,
during its first year, has been able to provide the full range of services to its Medi-Cal beneficiaries with local control and participation from hospitals and physicians at 87 percent of what the state would have paid.

Monterey County, on the other hand, is $3 million in deficit, primarily because the design of the program included little risk for participating providers coupled with overly generous reimbursement incentives, leaving the county with excessive risk. Monterey paid a $3 monthly case management fee to physicians in addition to reimbursing on a fee-for-service basis, and was unable, under the timetable in which it operated, to establish a proper utilization control mechanism. Monterey is now in the midst of changing several of its procedures to increase the provider community’s share of the financial risk involved in this program.

**Primary care case management contracts.** Further variations in balancing the risk between local health care organizations and providers are occurring in California’s primary care case management (PCCM) contracts. Under authority granted by the legislature, the state now is able to contract with primary care providers—internists, general practitioners, obstetricians/gynecologists, pediatricians, family practice physicians, or any primary care clinic, rural health clinic, community clinic, or hospital outpatient clinic holding a valid and current Medi-Cal provider number. The state is paying 95 percent of Medi-Cal rates for contracted services—generally primary care and some specialty services—but not hospital inpatient services. Thus, it is shifting a portion of the risk to these providers, but not to the extent it has in county-organized health systems or HMOs, primarily because it pays separately for hospital services.

PCCM physicians are at risk only for those services for which they are under contract. They are, however, also acting as a Medi-Cal field office in approving all other services, including hospital procedures. The state will pay for any authorized inpatient services although it hopes to prevent excessive risk by offering an incentive: if the organization saves more than what MediCal would pay for similar services for a similar case-mix in that particular geographical setting, it will split the difference with the contractor. The state offers a risk limit of $10,000, which means that for a reduction in its capitated rate, a PCCM contractor will be protected from costs which exceed $10,000 on any enrollee over the period of a year.

The purpose, as in county-organized health systems, is to help encourage more physicians and community groups to become experienced with the building blocks of capitated systems little by little: to place more control and, simultaneously, an ever larger portion of the risk in the hands of local physicians and clinics—giving them the chance to control the financial, as well as the clinical, aspects of medicine. The state currently has thirty-two proposals for PCCM contracts. The applicants represent a mix.
of physicians’ groups, hospitals’ outpatient departments, teaching institutions, and community clinics.

It will be instructive to identify which configurations of risk shifting and risk sharing offer the best opportunity for shrinking unit costs without promoting underutilization of needed services. The state signed its first PCCM contract with San Ysidro Health Center, a comprehensive nonprofit clinic in San Diego County, which is paid at a capitated rate for its physician, pharmacy, pathology, and radiology services. Most of its services are provided by inhouse, salaried staff; outside specialists are paid on a fee-for-service basis by the contractor. All noncapitated services are paid on a fee-for-service basis by the state.

Procare, Inc., our second PCCM contractor, is a San Diego for-profit corporation with stockholders which is subcontracting with a pediatrician, two family care practitioners, a general practitioner, an ophthalmologist, a pharmacy, and a laboratory, and is paying each a predetermined capitated rate. These subcontractors are willing to provide services at a rate lower than fee-for-service in order to lock in volume and to find opportunities to establish themselves early in what most providers anticipate will be a comprehensive movement in California toward capitated health systems. However, Procare, Inc., is sharing a portion of the risk with these providers: if the patient requires services these providers don’t normally deliver, the parent organization absorbs the cost.

At the same time that the Procare, Inc., contract becomes effective in December 1984, a similar PCCM plan will become operational with a physician who operates three clinics in Long Beach. Other contracts are expected to follow at the rate of about one per month in 1985. Enrollment projections for the first year of operation range from 2,000 to 30,000 beneficiaries per plan. In each of these plans, we are observing unique configurations of risk-balancing between parent organization and providers, and of subcontracting on fee-for-service and capitated bases. All these contracts, along with county-organized systems, are stimulating a new view of health care delivery at the grassroots level. Physician groups desiring PCCM contracts are discovering that it takes more than professional camaraderie to assure efficient delivery; in order to make the system work, they must take actions such as appointing a medical director to make the tough medical decisions based on financial considerations, establishing monitoring systems to control utilization and, in general, concerning themselves with the kinds of financial considerations often foreign to them.

Another advantage of these contracts is that they provide physicians an opportunity to practice medicine in accordance with the latest scientific knowledge, and not just supplying services determined by artificial reimbursement policies, a distinction John Wennberg cogently makes in his article, “Dealing with Medical Practice Variations: A Proposal For Action,” in the Summer 1984 Health Affairs.
Conclusion

The United States will soon be at a crossroads. In pursuing its plans for solving the Medicare crisis, the administration will lay the groundwork for future American medicine.

Given the developments we have seen so far in California, it is clear that with the proper amount of flexibility and incentives, local health care providers, hospital administrators, and entrepreneurs are becoming the architects of a number of health care delivery models, many of which are still in the experimental stage, but some of which already appear successful. To move now toward a nationally determined, rate-setting approach to solving Medicare's problems would have the tragic effect of snuffing out all the latent creativity just beginning to surface with a combination of local control and innovative reimbursement structures. Indeed, the kinds of reforms occurring in California could not take place under a regulatory, fixed-price mechanism.

If DRGs develop from a laudatory initial step toward prospective payment to increasing government control through rate setting and all-payers systems, we will have locked in inefficiencies and have lost the potential for dramatic creative reform. In so doing, we would keep the current cost-based system, but capped, which is an appealing prospect to many providers because it augurs little risk and little change.

It will, however, take profound change to solve the financial crises on the horizon in health care, and few dramatic achievements in this world are accomplished without risk. By accepting some risk for themselves, providers can assure that we depart from government's failed approaches of the past in making arbitrary cuts in benefits, reimbursement, and eligibility, and, instead, in a rational and comprehensive fashion, moderate the unit price of care. The cost of health care must be constrained, not by national controls on fragmented portions of the health care system, but by locally negotiated capitated rates with organized systems which provide comprehensive care to all our people, with risks properly and proportionately shared. This will create incentives for payer, patient, and provider alike to control cost and improve quality.