Managed care is changing our health care delivery system as radically as the computer chip has changed telecommunications. Health care professionals and organizations that do not understand managed care's implications will not be prepared for the future. For example, one implication of managed care is payment capitation, which is the transfer of financial risk from the insurer to the provider. As a result, health care providers, including occupational therapy professionals, need to be better managers of scarce resources by recognizing the cost implications among various alternative procedures while still delivering quality care. Under managed care with capitation, occupational therapists will need to learn to provide services within the parameters of a fixed budget, requiring reengineering of the therapies and processes of care and a considerable reduction in the procedures and modalities for any given treatment or therapy. As a result, patients will be required to do more for themselves, and occupational therapists will have to become better patient educators and motivators. Additionally, managed care will require changes in professional curriculums, emphasis through continuing education, and assimilation of better cost information to practitioners to facilitate decision making. Implications of managed care other than payment capitation are assigning to enrollees a gatekeeper who is responsible for limiting access to costly specialty services, practicing utilization review to audit usage patterns and provide constructive recommendations to reduce costs and improve service quality, and forming networks and associations among medical providers for developing economies of scale and providing an integrated continuum of health care services to enrollees.

The era of a health care delivery system using cost-based reimbursement has come to a close. With this end has begun the era of utilization review, payment capitation, and substitution of less costly delivery settings and providers for the acute care hospital and physician specialists. The public and private sector's concern for cost control is the engine of change in this new era.

In the private sector, large corporations have watched their costs for employee health benefits escalate at near double-digit annual inflation rates. Many firms have responded by reducing benefits or offering employees innovative plans that were quickly designed by insurers to answer the demands for affordable health care. The outcome has been a movement away from the traditional indemnity plan to managed care arrangements (e.g., health maintenance organizations [HMOs], independent practice associations [IPAs], preferred provider organizations [PPOs]) (Kongstvedt, 1989).

In the public sector, health care inflation has been
more rapid than in the private sector. Local communities have experienced out-of-control cost increases through county clinic and hospital operations, states through Medicaid programs, and the federal government through Medicare and state subsidies for indigent care. As a result, health care delivery systems have reorganized at the local level, and both the states and the federal government have embraced prospective reimbursement. Additionally, many states have requested federal waivers through the Department of Health and Human Services to implement innovative forms of health care delivery.

Added to the concern over the magnitude of health care cost inflation is Congress's desire to balance the budget by 2002. With a current inflation rate of more than 9% for Medicaid and Medicare, costs must be controlled, reduced, or both for this goal to become a reality. According to Bellamy (1995), "Congress must come up with one trillion dollars in savings over the next seven years to balance the budget without touching Social Security, interest payments on the national debt, or defense" (pp.1-2). To reduce the health care inflation rate, Congress is currently considering proposals that would reduce payments to hospitals and physicians, increase the premiums paid by Medicare beneficiaries, grant states greater discretion over Medicaid, and encourage enrollment in private sector managed care plans. Ultimately, total control over Medicare and Medicaid administration could be relinquished to the private sector, with the states and federal government simply acting as conduits for health care expenditures.

Principles and Concepts Behind Managed Care

There are numerous explanations for the high inflation rate for health care costs. Commonly cited causes, but definitely not exhaustive, include the following:

- Cost recovery to develop new technologies and pharmaceuticals
- The practice of defensive medicine to reduce the risk of malpractice suits
- Excessive administrative costs
- Redundancy of extremely costly resources due to competition between neighboring facilities
- The proliferation of unnecessary medical procedures
- A surplus of highly skilled specialists
- Overspecialization

Our current health care system is believed by many to be somewhat effective, but not necessarily efficient. Many believe the answer to better control of health care costs is managed medical care. Several acceptable definitions of managed care exist, including the following:

- "Any measure that, from the perspective of the purchaser of health care, favorably affects the price of services, the site at which services are received, or their utilization." (Hastings, Drasner, Michaels, & Rosenberg, 1990, p. 1).
- "A comprehensive approach to healthcare delivery that encompasses planning and coordinating care, educating patients and providers, monitoring the quality of care, and controlling costs." (Lepler, 1995, p. 1)
- "A generic term that has evolved over the past few years to encompass a variety of forms of prepaid and managed fee-for-service health care." (MacLaren, 1994, p. 10)

Common to these definitions are the themes of financial controls, primary care physicians (gatekeepers), limited access to specialists, limited access to hospital beds, and prepayment of care. The objective of the managed care system is to inject economic considerations into the medical decision-making process and remove the physician as the single source for determining which medical services are rendered.

There are four principles that apply in this process. First, an enrollee in most managed care plans is assigned a primary care physician (PCP). The PCP is responsible for determining what care is appropriate and whether a referral to a specialist is warranted. Enrollees are normally not allowed to seek services through other physicians before consulting with their PCP first. This triage mechanism results in the substitution of less costly care for self-referred specialty care and avoids the occurrence of unnecessary procedures. Serving in a role similar to that of the PCP is the case manager. Case managers take on enrollees who either have extensive medical problems or are expected to receive care over an extended period. Their responsibility is to determine whether the care rendered an enrollee is appropriate for both economic and quality assurance purposes.

Second, managed care plans use utilization review. This evaluation is conducted by health care administrators and other professionals to determine resource usage patterns in patient care. The objective of this process is to provide cost control, promote quality of care, and guarantee enrollee satisfaction (Taylor & Taylor, 1994). Unsatisfactory findings determined during utilization review are brought to the attention of the appropriate authority for corrective actions.

Third, managed care plans involve the formation of networks and associations between medical providers along the continuum of care from acute to long term. Examples
include HMOs, IPAs, PPOs, and physician hospital organizations. Common to such organizations are contractual agreements that determine payment for health care services rendered. Ownership and control differences exist in such organizations, with some combining financing, administration, and service delivery into one entity and others operating through a loose network of numerous contracting, but independent, entities. Occupational therapists could be associated with managed care organizations as either an employee of a contractually affiliated, free-standing clinic, a self-employed person who works as an independent contractor, or as an employee of the managed care organization itself.

Fourth, managed care involves **capitated reimbursement**. This concept refers to a prospectively determined payment system based on some level of activity. Examples of activity levels include amounts measured as per diem, per enrollee, per procedure, and per admission. Thus, capitation based on the number of plan enrollees would result in a set amount of reimbursement each month that would fluctuate only as the size of the enrollment population changes. The objective is to limit the financial risk to the managed care organization by transferring it to the health care provider. As a result, the provider can influence profitability only through controlling costs because revenues are fixed at a predetermined amount.

**Implications for Health Care Professionals**

The organization and delivery of health care services under managed care will focus on cost control to improve profitability. Whenever possible, services will be delivered on an outpatient basis and use less costly medical professionals. By the year 2000, it is estimated that 65% of health care will be provided outside of hospitals, and 69% of nurses currently employed within hospitals will be working elsewhere (MacLaren, 1994). This shift to outpatient service delivery will result in a considerably lower hospital inpatient census, and many hospitals will be forced to scale down, merge with others, or close.

More will be expected from health care professionals as hospital operations are streamlined, nursing and allied health staff numbers are reduced, and patients are discharged more quickly (Lepler, 1995). Throughout this evolutionary change, consumers will demand quality services, resulting in an increased emphasis on quality assurance by both providers and managed care plans. Additionally, providers will strive to reduce utilization rates through offering health promotion programs that will target the most costly diseases, such as AIDS; lung, breast, colon, and prostate cancer; cardiovascular disease; and diabetes (MacLaren, 1994). Thus, knowledge of quality assurance and health promotion will increase health care professionals' (including occupational therapy practitioners) competitive edge in the managed care environment of health care delivery.

New opportunities will be available for those allied health professionals who are multiskilled and can provide multiple services more cost-effectively than several specialists. There will be expanded opportunities for physician assistants and nurse practitioners whose physician extender services are less costly than the services of a physician. There is also the possible use of multidisciplinary allied health professionals who can replace highly specialized personnel in certain settings. For example, occupational therapists with comprehensive training in the rehabilitative sciences can substitute in performing certain services traditionally the responsibility of physical therapists. Additionally, allied health professionals will fill new positions in case management, utilization review, quality assurance, and programs that emphasize disease prevention (MacLaren, 1994).

The days of the entrepreneurial physical therapist and occupational therapist who operates his or her own professional practice are coming to a close. The future dictates the necessity of being a part of a large, comprehensive health care services entity, one with the capability of successfully competing and providing a spectrum of services cost-effectively. There will still be ample opportunities for allied health professionals to secure employment in a managed care environment. What will change is the location of the job site and setting. The hospital will no longer be the dominant employer. Most employment sites will be located in the less acute segments of the health care continuum.

**Conclusion**

Health care is currently in a state of disequilibrium, moving from traditional fee-for-service medicine with the acute care hospital at the center to managed care with payment capitation and an increase in the number and nature of services offered through outpatient ambulatory facilities. Accompanying these changes are the new, evolving roles of health care organizations and professionals. Those organizations and professionals who do not understand the implications of managed care will not be prepared for the future. Most specifically, changes created by managed care include a massive shift in the delivery of services through outpatient sites as opposed to the acute care hospital; across-the-board staff reductions, including medical, nursing, and allied health personnel; an increased focus on health care outcomes; the substitution of less costly personnel for physicians and other...
highly compensated persons; and greater use of information that allows for cost control. Those who understand the implications and who make the necessary changes and adjustments will be well positioned to succeed in this new era.

References


