

Managed Health Care

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MHA631
Health Insurance

Lecture 2



Objectives

- Understand Managed Health Care and Managed Care Organizations (MCO).
- Explore various Managed Care Models (6 Models).
- Discuss Consumer-directed Health plans.
- Examine accreditation of MCO.

Managed Health Care

- **Managed health care (managed care)** combines healthcare delivery with the financing of services provided.
- The intent was to replace conventional fee-for-service plans with more affordable quality care to healthcare consumers and providers who agreed to certain restrictions (e.g., patients would receive care only from providers who are members of a managed care organization).

Managed Health Care

- Managed health care was developed as a way to provide **affordable, comprehensive, prepaid** healthcare services to **enrollees (or subscribers or policyholders)** (employees and dependents who join a managed care plan; known as *beneficiaries* in private insurance plans).
- Managed care is currently being challenged by the **growth of consumer-directed health plans (CDHPs)**, which define employer contributions and ask employees to be more responsible for healthcare decisions and cost-sharing.

Managed Care Organizations



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Managed Care Organizations

- A **managed care organization (MCO)** is responsible for the health of a group of enrollees and can be a health plan, hospital, physician group, or health system.
- Unlike traditional fee-for-service plans, which reimburse providers for individual healthcare services rendered, managed care is financed according to a method called **capitation**, where providers accept **pre-established payments** for providing healthcare services to enrollees over a period of time (usually one year).
- If the physician provides services that cost less than the capitation amount, there is a **profit** (which the physician keeps). If services provided to subscribers cost more than the capitation amount, the physician **loses money**.

Managed Care Organizations

EXAMPLE: In June, Hillcrest Medical Group received a capitated payment of \$15,000 for the 150 members (enrollees) of the ABC Managed Care Health Plan. The Group spent \$12,500 of the capitated payment on preventive, chronic, and acute healthcare services provided to member patients. The services were provided at the Group's office and local hospital, which included inpatient, outpatient, and emergency department care. (The Group is responsible for paying the enrollees' hospital bills.) In this scenario, healthcare services provided to enrollees cost less than the capitated payment received. The Hillcrest Medical Group, therefore, made a profit of \$2,500. If healthcare services had cost more than the capitated amount of \$15,000, the Group would have experienced a loss.

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Capitated Payment Received (June):

- Total Members (Enrollees): 150
- Total Capitation Payment: \$15,000 (paid upfront by the insurance plan).

Healthcare Costs Incurred:

- Total Spent on Care: \$12,500 (covers all services provided to members)

Profit/Loss Calculation:

Total Revenue (Capitated Payment): \$15,000

Total Expenses (Healthcare Costs): \$12,500

Profit: \$2,500 (\$15,000 – \$12,500)

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Managed Care Organizations

EXAMPLE: In June, Hillcrest Medical Group received a capitated payment of \$15,000 for the 150 members (enrollees) of the ABC Managed Care Health Plan. The Group spent \$18,000 of the capitated payment on preventive, chronic, and acute healthcare services provided to member patients. The services included complex inpatient hospitalizations, emergency department visits, and specialty referrals for high-risk enrollees. (The Group is responsible for paying the enrollees' hospital bills.) In this scenario, healthcare services provided to enrollees cost more than the capitated payment received. The Hillcrest Medical Group, therefore, experienced a loss of \$3,000.

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Managed Care Organizations

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Key Terms

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Primary Care Providers

- Managed care plan enrollees receive care from a **primary care provider** selected from a list of participating providers.
- **The primary care provider (PCP)** is responsible for supervising and coordinating healthcare services for enrollees and approves referrals to specialists and inpatient hospital admissions (except in emergencies).
- The PCP serves as a **gatekeeper** by providing essential healthcare services at the lowest possible cost, avoiding nonessential care, and referring patients to specialists.

Quality Assurance



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Quality Assurance

- Managed care plans that are “federally qualified” and those that must comply with state quality review mandates (laws) are required to establish **quality assurance programs**.
- **A quality assurance program** includes activities that assess the quality of care provided in a healthcare setting.
- The types of quality reviews performed include government oversight, patient satisfaction surveys, data collected from grievance procedures, and reviews conducted by independent organizations.
- **Independent organizations** that perform reviews include accreditation agencies such as the National Committee for Quality Assurance and The Joint Commission.

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Quality Assurance

- Plans are required to meet **minimum performance levels** and to show demonstrable and measurable improvement in specified broad clinical areas (e.g., preventive services, acute ambulatory care, chronic care, and hospital care) based on performance improvement projects that each plan identifies.
- The National Committee for Quality Assurance (NCQA) reviews managed care plans and develops **report cards** to allow healthcare consumers to make informed decisions when selecting a plan.
- The **report card** contains data regarding a managed care plan's quality, utilization, customer satisfaction, administrative effectiveness, financial stability, and cost control.

Utilization Management



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Utilization Management

- **Utilization management (or utilization review)** is a method of controlling healthcare costs and quality of care by reviewing the **appropriateness and necessity of care provided** to patients prior to the administration of care (**prospective review**) or after care has been provided (**retrospective review**).
- **Utilization management activities performed by managed care plans include:**
- **Preadmission certification** (PAC, or preadmission review) which is a review for medical necessity of inpatient care prior to the patient's admission.

Utilization Management

- **Preauthorization**, which is a review that grants prior approval for reimbursement of a healthcare service (e.g., elective surgery).
- **Concurrent review**, which is a review for medical necessity of tests and procedures ordered during an inpatient hospitalization.
- **Discharge planning**, which involves arranging appropriate healthcare services for the discharged patient (e.g., home health care).

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Case Management

- **Case management** involves the development of patient care plans for the coordination and provision of care for complicated cases in a cost-effective manner.
- For example, instead of admitting a patient to the hospital, a managed care plan might authorize 24-hour home healthcare services when appropriate.



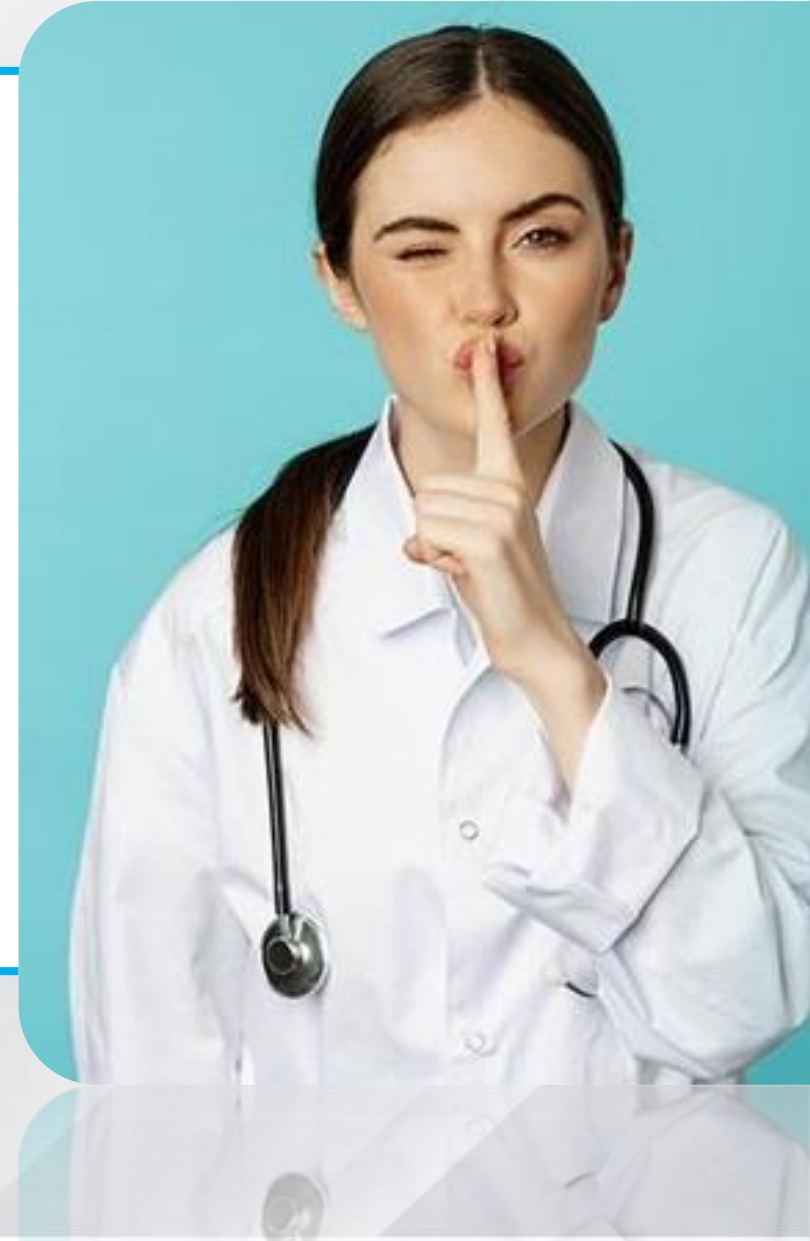
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Second Surgical Opinions

- Prior to scheduling elective surgery, managed care plans often require a **second surgical opinion (SSO)**; that is, a second physician is asked to evaluate the necessity of surgery and recommend the most economical, appropriate facility in which to perform the surgery (e.g., outpatient clinic or doctor's office versus inpatient hospitalization).



Gag Clauses



Gag Clauses

- Medicare and many states prohibit managed care contracts from containing gag clauses, which prevent providers from discussing all treatment options with patients, whether or not the plan would provide reimbursement for services.
- Medicare beneficiaries are entitled to advice from their physicians on medically necessary treatment options that may be appropriate for their condition or disease.

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Physician Incentives

- Physician incentives include payments made directly or indirectly to healthcare providers to encourage them to reduce or limit services (e.g., discharge an inpatient from the hospital more quickly) so as to save money for the managed care plan.



Managed Care Models

Managed Care Models

- Managed care originally focused on cost reductions by restricting healthcare access through utilization management and availability of limited benefits. Managed care organizations (MCOs) were created to manage benefits and to develop participating provider networks.
- Managed care can now be categorized according to six models:
 - 1. Exclusive provider organization (EPO).
 - 2. Integrated delivery system (IDS).
 - 3. Health maintenance organization (HMO).
 - 4. Point-of-service plan (POS).
 - 5. Preferred provider organization (PPO).
 - 6. Triple option plan.

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1. Exclusive Provider Organization (EPO)

- An **exclusive provider organization (EPO)** is a managed care plan that provides benefits to subscribers who are required to receive services from network providers.
- A **network provider** is a physician or healthcare facility under contract to the managed care plan.
- Usually, network providers sign **exclusive contracts** with the EPO, which means they cannot contract with other managed care plans. (Network providers are usually reimbursed on a fee-for-service basis.) Subscribers are generally required to coordinate healthcare services through their primary care physician (PCP).

2. Integrated Delivery System (IDS)

- **An integrated delivery system (IDS)** is an organization of affiliated providers' sites (e.g., hospitals, ambulatory surgical centers, or physician groups) that **offer joint healthcare services to subscribers**.
- An integrated delivery system may also be referred to by any of the following names: integrated service network (ISN), vertically integrated plan (VIP), horizontally integrated system, health delivery network, or accountable health plan.

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3. Health Maintenance Organization (HMO)

- A **health maintenance organization (HMO)** is an alternative to traditional group health insurance coverage and provides **comprehensive healthcare services** to voluntarily enrolled members on a **prepaid basis**.
- **HMOs** provide **preventive care services** to promote “wellness” or good health, thus reducing the overall cost of medical care. Annual physical examinations are encouraged for the early detection of health problems.

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3. Health Maintenance Organization (HMO)

- A primary care provider (PCP) assigned to each subscriber is responsible for coordinating healthcare services and referring subscribers to other healthcare providers.
- HMOs often require a **copayment (or copay)**, which is a fee paid by the patient to the provider at the time healthcare services are rendered. Copayments range from \$1 to \$35 per visit, and some services are exempt because coinsurance payments are required instead.

3. Health Maintenance Organization (HMO)

EXAMPLE: Dr. Sanders provided Nancy Jones with evaluation and management (E/M) services at the Center City HMO during an office visit. The contracted E/M service rate is \$64, and Nancy is required to pay a \$10 copayment. She has \$100 annual deductible, which was met earlier this year. She is not required to pay a coinsurance amount.

Provider fee (contracted E/M service rate)	\$64
Patient copayment	– \$10
Insurance payment	\$54

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4. Point-of-Service Plan (POS)

- To create **flexibility** in managed care plans, some HMOs and preferred provider organizations have implemented a point-of-service plan (POS), under which patients have **freedom to use the managed panel of providers or to self-refer to non-managed care providers**.
- If the enrollee chooses to receive all medical care from the managed network of healthcare providers, or obtains an authorization from the POS primary care physician for specialty care outside the managed care network, he pays only the regular copayment or a small charge for the visit.
- If the enrollee sees a non-managed care panel specialist without a referral from the primary care physician, this is known as a **self-referral**. The enrollee will have greater out-of-pocket expenses.

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5. Preferred Provider Organization (PPO)

- A **preferred provider organization (PPO)** is a network of physicians and hospitals that have joined together to contract with insurance companies, employers, or other organizations to provide health care to subscribers for a **discounted fee**. PPOs do not routinely establish contracts for laboratory or pharmacy services, but they do offer reduced-rate contracts with specific hospitals.
- Most PPOs are **open-ended plans** allowing patients to use non-PPO providers in exchange for larger out-of-pocket expenses. Premiums, deductibles, and copayments are usually higher than those paid for HMOs, but lower than regular fee-for-service plans.

6. Triple Option Plan

- A **triple option plan** (*offered either by a single insurance plan or as a joint venture among two or more insurance payers*) provides subscribers or employees with a choice of **HMO, PPO, or traditional health insurance plans**.
- It is also called a **cafeteria plan (or flexible benefit plan)** because of the **different benefit plans** and extra coverage options provided through the insurer or third-party administrator.

Consumer-directed Health Plans

Consumer-directed Health Plans

- **Consumer-directed health plans (CDHPs)** include many choices that provide individuals with an incentive to control the costs of health benefits and health care. Individuals have **greater freedom** in spending healthcare dollars, up to a designated amount, and receive full coverage for in-network preventive care.
- In return, individuals assume significantly **higher cost-sharing expenses** after the designated amount has been expended. (The catastrophic limit is usually higher than those common in other plans.)

Consumer-directed Health Plans

- CDHPs have become a **popular alternative** to the increased costs of traditional health insurance premiums and the limitations associated with managed care plans.
- CDHPs usually provide **Internet-based support** so individuals:
 1. track healthcare expenses,
 2. improve their health by viewing useful information and learning about preventive services,
 3. obtain information about provider quality, and
 4. receive notification about provider group-rate pricing.

Accreditation of Managed Care Organizations

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Accreditation of Managed Care Organizations

- Accreditation is a voluntary process that a healthcare facility or organization (e.g., hospital or managed care plan) undergoes to demonstrate that it has met standards beyond those required by law.
- The [National Committee for Quality Assurance \(NCQA\)](#) of Washington, DC evaluates managed care organizations.
- [NCQA](#) is a private, not-for-profit organization that assesses the quality of managed care plans in the United States and releases the data to the public for consideration when selecting a managed care plan.

Key Takeaways

1. The financing of America's healthcare system has changed the way healthcare services are organized and delivered, as evidenced by a movement from traditional fee-for-service systems to managed care networks.
2. A managed care organization (MCO) is responsible for the health of its enrollees, which serves as a health plan or contracts with a hospital, physician group, or health system.
3. Most managed care financing is achieved through a method called capitation, and enrollees are assigned to or select a primary care provider who serves as the patient's gatekeeper.

Key Takeaways

4. Federal legislation mandated that MCOs participate in quality assurance programs and other activities, including utilization management, case management, requirements for second surgical opinions, non-use of gag clauses in MCO contracts, and disclosure of any physician incentives.
5. Managed care is categorized according to six models: exclusive provider organizations, integrated delivery systems, health maintenance organizations, point-of-service plans, preferred provider organizations, and triple option plans.
6. Consumer-directed health plans (CDHPs) provide incentives for controlling healthcare expenses and give individuals an alternative to traditional health insurance and managed care coverage.



Thank You