

Managed Care (Part I)

The New Era in Health Services
Organization, Financing, and Delivery

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Definition of Managed Care

“A system that integrates the financing and delivery of medical care by means of contracts with selected physicians and hospitals that furnish a comprehensive set of health care services to [a population of] enrolled members, usually for a predetermined monthly premium . . .”

John Iglehart, 1992

Spending by U.S. Businesses for Health Care (% of Business Expense or Profit)

	Percent of Labor Compensation		Percent of Corporate Profits	
	Wages and Salaries	Fringe Benefits	Before Tax	After Tax
1965	2	22	8	14
1970	4	29	20	36
1975	5	29	21	34
1980	6	32	27	47
1985	7	39	51	90
1986	8	41	58	110
1987	7	41	49	90
1988	8	43	48	85
1989	8	45	55	98
1990	9	46	61	108

Ref: Iglehart JK. The American Health Care System: Private Insurance. NEJM 1992;326(25):1715.

Key Features of Managed Care

- Financial incentives for providers (through payment arrangements) to constrain the costs (amounts) of services provided
 - assumption of some financial risk by doctors and hospitals
- Financial incentives for patients to use the providers and facilities contracted with the health plan
- Utilization controls that limit care to “necessary” services

Managed Care Arrangements: Staff-Model HMO

- Providers employed by HMO and practice in common facilities
- Providers (employees) are expected to follow the practices and procedures determined by the employer (HMO)

Managed Care Arrangements: Group-Model HMO

- HMO contracts with a multi-specialty provider group that agrees to provide, on an exclusive basis, all covered services for the enrolled population of the HMO.
- Providers may be either owners or employees of the group.

Managed Care Arrangements: Network-Model HMO

- HMO contracts with two or more provider groups that agree to provide all covered services for the enrolled population of the HMO
- Groups may contract with other HMOs and may care for consumers on a FFS basis
- Providers contract with the group practice

Managed Care Arrangements: IPA-Model HMO

- HMO contracts for the services of individual providers, who practice in their own offices
- HMO may contract directly with the individual providers, or with a legal entity established for the purpose of negotiating with the HMO on behalf of individual providers (also called an IPA)
- Providers may contract with other HMOs and may care for other consumers on a FFS basis

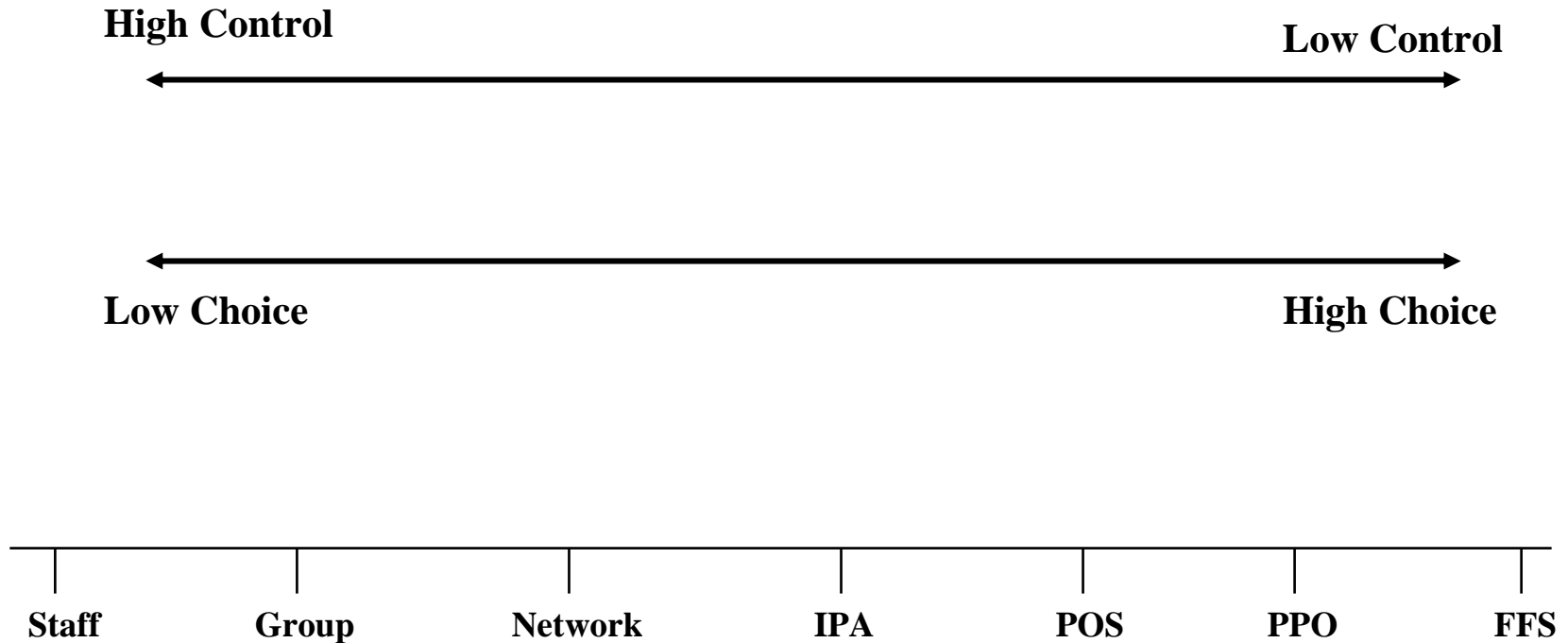
Managed Care Arrangements: Preferred Provider Organization (PPO)

- Plan contracts with providers in the community to provide covered services for a discounted fee
- Consumers pay less for services received from preferred providers than those received from other providers

Managed Care Arrangements: Point-of-Service (POS) Option

- May be offered by any model HMO
- Consumer may choose to obtain covered services from providers outside the network, at a higher cost to the consumer
- Like network or IPA plus PPO (hybrid)

Trade-offs in Control of Use vs. Consumer Choice



Players in Managed Care

- Large Employers (purchasers)
- Health Plans (insurers, payors, MCO's = HMO's)
- Providers (physicians, networks, hospitals)
- Patients/consumers

Provider Organizations

- Medical Groups
- IPAs
- Provider Networks
- Hospitals

Financing Health Plans

- Patient/employer premiums to health plan
- Capitation = PMPM pre-payment to health plan
- Health plan contracts with certain physicians, medical groups, networks, hospitals to provide services (selective contracting)
- Health plans may be for profit or not-for-profit

Physician Reimbursement in Managed Care

- FFS (discounted)
- Capitation (pre-payment)
- Bonuses and withholds
- Perverse incentives in FFS vs. capitation

Hospital Reimbursement in Managed Care

- Discounted FFS (per diem)
- Medicare DRG's
- Capitated (less common)

Implications of Different Arrangements

- Different financial incentives for physicians
 - primary care
 - specialists
- Arrangements for referrals vary
- Different levels of control over quality assurance and utilization management

Utilization Management

- ⇒ Gatekeeping
- ⇒ Practice Guidelines
 - Preauthorization
 - Concurrent Review
 - Physician Profiling
 - Education
 - Case-management

Gatekeepers

- Primary care, preventive care
- Manage referral to services
- Manage referral to specialty care
- Protect against overtreatment (overuse)
- Patient/population advocate and financial manager (Jekyll and Hyde?)

Practice Guidelines

- “Systemically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances” (IOM 1990)
- Uniform quality standards
- Developed by Academics
- Used by HMO’s, Insurers, Medical Groups

Managed Care Versus FFS: Utilization Performance

- Lower hospital admission rates in managed care
- Shorter hospital lengths of stay in managed care
- Lower hospital days per enrollee in managed care
- No significant differences in outpatient visit rates
- Lower use of expensive procedures and tests in managed care

Managed Care Versus FFS: Quality of Care

- Higher use of screening tests in managed care
- Little evidence that overall quality of care differences exist
- Probably worse care for patients with mental health problems, the poor, and the elderly with poor physical health

Health Services Quality in Managed Care

- Responsibility for the health of a population (enrolled members)
- Refocus competition to be based on quality
- Potential for underuse as a consequence of financial incentives
- Concerns about access to specialty care

Health Services Quality Issues (cont.)

- Health plan, medical group and physician level
- Health outcomes and patient satisfaction
- Concern for care for vulnerable populations
 - Elderly
 - Chronic Disease
 - non-English speakers
 - Lower SES

National Standards for Evaluating Health Plans

- The Health Plan Employer Data and Information Set (HEDIS)
- Developed by the National Committee for Quality Assurance (NCQA)
- Consumer Assessment of Health Plans (CAHPS)
- Coalition of purchasers, consumers and labor representatives, health plans, measurement experts

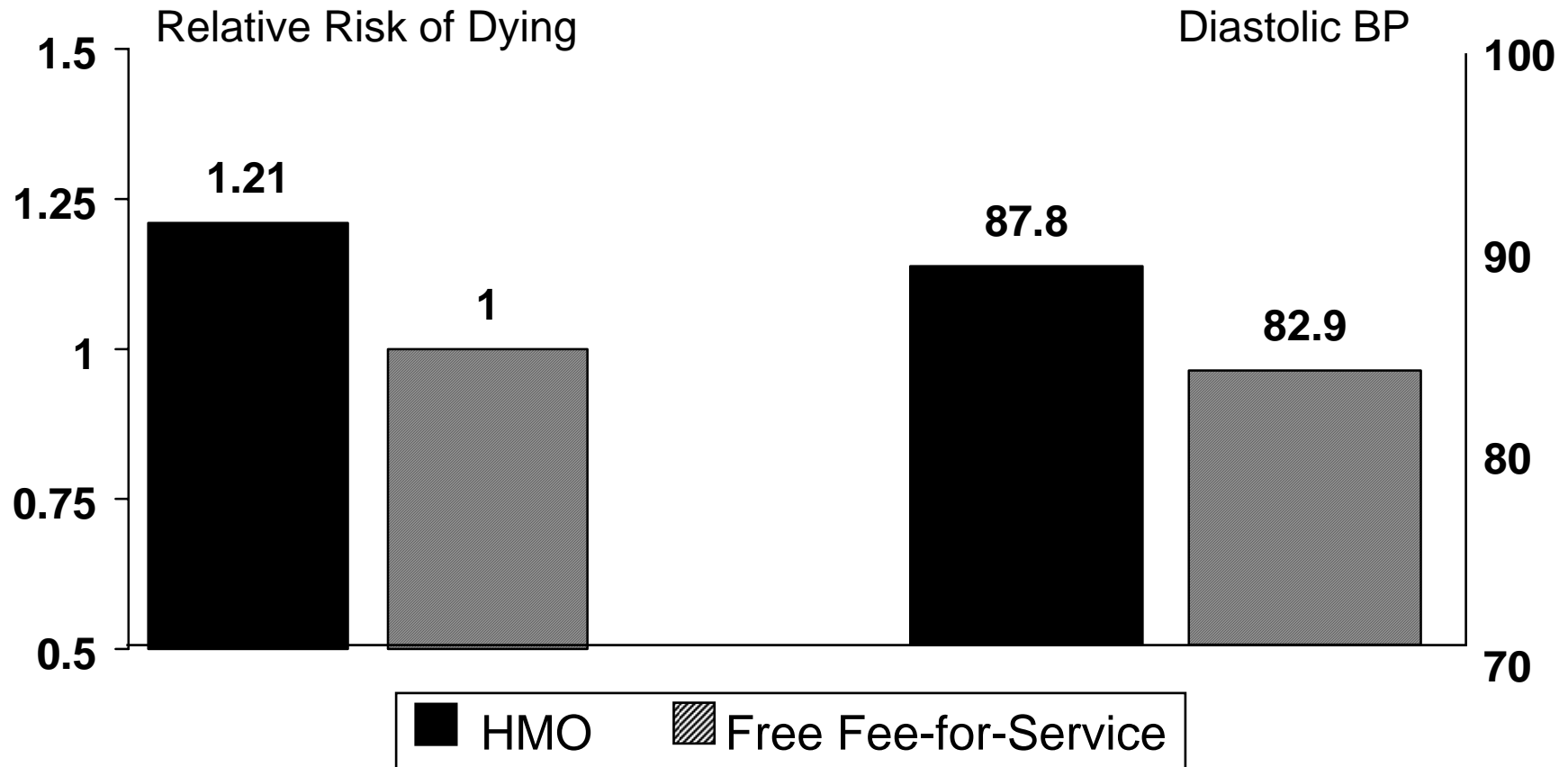
Summary: Managed Care, 2006

- Rapidly increasing proportion of population in managed care (esp. California)
- Medicare and Medicaid managed care growing
- A multitude of evolving contractual arrangements
- Many different methods for controlling utilization
- Limited standards for assessing quality

Implications for Health Policy

- How far can you cut costs without compromising quality?
- Managed care for the chronically ill, elderly, and the poor, prone to underuse
- Is there a managed care backlash and what are the alternatives?

Poor, High Risk HMO Patients Fared Poorly in the RAND Experiment



Source: RAND Health Insurance Experiment, Ware, J. Lancet 1986; 1:1017.