A Study Guide to Essentials of Managed Health Care

Fourth Edition

Peter R. Kongstvedt

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CHAPTER 1

An Overview of Managed Care

CHAPTER STUDY REVIEW

1. The first managed care system can be traced back to 1910 and the Western Clinic, which many cite as the first example of an HMO. One of the first health insurance plans was implemented at Baylor Hospital in Houston, Texas, in 1929. Despite the AMA's 1932 declaration of a strong stance against prepaid group practices, managed care plans continued to gain popularity. With the increase in commonality of managed care plans came increased legislative involvement. A major boost to the HMO movement was the 1973 federal HMO act. Two other major pieces of legislation affecting the managed care field were 1996's Health Insurance Portability and Accountability Act and 1997's Balanced Budget Act. Today, multistate managed care firms dominate the market, reflecting a trend toward consolidation. Most Americans with health care coverage are covered by some form of managed care plan.
2. Three areas of innovation in managed care are:
   - The collaboration of physicians and hospitals to form PHOs
   - The development of carve-outs
   - Advances made possible by computer technology
3. Managed care has matured considerably since its modest beginnings. Three aspects of the maturation of managed care are:
   - ***HMO and PPO growth***: HMOs and PPOs have grown exponentially as employers have come to rely on managed care at the expense of once traditional indemnity insurance plans. Medicare and Medicaid programs have contracted increasingly with HMOs.
   - ***External oversight activities***: In 1991, the National Committee for Quality Assurance (NCQA) began to accredit HMOs. Today, many employers look favorably upon, sometimes even demand, NCQA accreditation.

- ***Shift in focus of cost management efforts***: Inpatient hospital utilization is still scrutinized, but more notice is being taken of ambulatory services.

4. There are three main aspects of the restructuring that has taken place in managed care.
   - ***Blurred distinctions among plans***: The managed care environment is becoming increasing complicated as organizations become hybridized.
   - ***Increased role of primary care physicians***: PCPs assume responsibility for the allocation of resources and have begun to rise above specialists and hospitals in their importance to managed care organizations.
   - ***Consolidation among plans and providers***: Large, multistate care organizations account for the vast majority of national enrollment and there is no end in sight to the current trend toward mergers.
5. There are several key issues that will affect the future of managed care. Five of the most important issues are:
   - ***Public versus private sector issues***: There has been a recent worsening of the public-private relationship for two major reasons—employees' resentment of having limited or no access to traditional indemnity programs and high cost sharing, and concern over whether managed care companies deny claims inappropriately and are otherwise overly restrictive. The government may play a greater role in managed care through increased legislation.
   - ***Quality***: Some quality issues that will affect the future of HMOs include whether they will focus on maximum value rather than minimum cost, how well chronically ill patients will fare under capitated arrangements, and the role that primary care physicians will play in the care of chronically ill patients.
   - ***Coverage and new technologies***: Currently, there is no procedure for deciding when a procedure is no longer considered investigational or experimental. This issue will become increasingly important with the fast pace of technology and the concurrent advances in medical treatment.
   - ***Funding for the uninsured***: Managed care creates a more price-competitive environment, which reduces the financial capability of providers to care for the uninsured.
   - ***Graduate medical education***: Typically, the cost of continued medical education has been addressed by higher fee-for-service costs. It remains to be seen how funding for graduate medical education will be handled in the future.

CHAPTER 2

Types of Managed Care Organizations

CHAPTER STUDY REVIEW

1. There are many types of managed care plans. Each was designed to fulfill a specific set of needs, and each has inherent strengths and weaknesses.
2. Managed care and indemnity insurance was developed to provide both cost control and freedom of choice. There are four types of managed care overlays—general utilization management, specialty utilization management, catastrophic or large-case management, and workers' compensation utilization management.
3. PPOs typically create a provider network for covered individuals by contracting directly with hospitals, physicians, and diagnostic facilities. Unlike HMOs, PPOs allow members to use non-PPO providers, but apply higher coinsurance rates or deductibles for out-of-network services. Many PPOs have utilization management programs.
4. EPOs have an organization and purpose similar to that of PPOs. Members may use participating providers for all health care services, but the plan generally does not reimburse patients for services received outside of the network. Some EPOs use primary care physicians to act as gatekeepers.
5. POS plans are hybrids of traditional HMO and PPO plans.
   - ***Primary care PPOs***: Primary care physicians act as gatekeepers for referrals and institutional services. Patients have some coverage for services not authorized by the primary care physician or delivered out of network, but coverage is usually significantly lower than for in-network providers.
   - ***POS HMOs***: These provide some level of indemnity-type coverage for members, who can choose which plan to use for each instance of care.
6. HMOs are organized health care systems responsible for financing and delivering a range of comprehensive health services. Some

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HMOs use prepaid fixed fees and all must ensure that members have access to covered services. The differences among HMO plans pertain to relationships between the plans and participating physicians.

- ***Staff model***: In this model, physicians who serve beneficiaries are employed by the HMO and are typically paid on a salary basis. These plans include physicians in common specialties to provide for members' various needs. Physicians out of network cannot participate in these plans, which provide limited choice for patients.
- ***Group model***: In this model, the plan contracts with a multispecialty physician group practice and physicians are employed by the practice, not the HMO. These groups may be either captive or independent. This plan also provides a limited choice of participating physicians.
- ***Network model***: In this model, the plan contracts with more than one physician group. These may be broad-based multispecialty groups or small groups, each representing different specialties. The group is responsible for providing all health care services for patients and physicians can refer to other physicians as necessary. These groups may be either closed or open panel.
- ***IPA model***: In this model, the plan contracts with associations of physicians to provide services for members. This open-panel plan includes a broad range of physicians from various specialties. IPAs create organized forums for physicians to negotiate as a group with HMOs.
- ***Direct contract model***: In this model, similar to the IPA model, the plan contracts directly with individual physicians. The plan recruits broad panels of community physicians, both primary care and specialists, to participate as plan providers.
- ***Open access HMOs***: This model does not require a primary care service physician or gatekeeper. There may be a financial incentive for patients to see primary care physicians for referrals, but this is not required.
- ***Self-insured***: In this model, the HMO receives a fixed monthly payment to cover administrative services and variable payments based on actual expenses made by the HMO for health services. There is often a settlement process at the end of specified periods in which a final payment is calculated.
- ***Experience related***: In this model, the HMO receives monthly premium payments. There is often a settlement process in which the employer is credited with some or all of the actual utilization and cost of its group to reach a final premium rate. Refunds are calculated and made to the appropriate party.

CHAPTER 3

Integrated Health Care Delivery Systems

CHAPTER STUDY REVIEW

1. An IDS is created when more than one type of provider comes together in a legal structure to manage health care. The goal of an IDS is to improve efficiency in managing health care delivery.
2. There are three basic structures of an IDS:
   - Systems in which only physicians are integrated
   - Systems in which physicians are integrated with facilities
   - Systems that include insurance functions

Moving from the first to the third structure, the degree of integration and potential ability to operate in a managed care environment, the complexity of formation and operation, the required capital investment, and the surrounding political difficulties increase.

3. There are many IDS types; each has its own advantages and disadvantages.
   - ***IPA***: An IPA is a legal entity comprised of independent physicians who contract with the IPA primarily to have it contract with one or more HMOs. IPAs offer a broad choice of physicians and require less capital to start than some other IDSs. However, IPAs can be unwieldy because they comprise a large body of physicians with little in common. They are also unable to leverage resources, achieve economies of scale, or significantly change behavior.
   - ***PPMC***: PPMCs comprise physicians only, without the involvement of a hospital. These groups can be either for-profit, comprehensive PPMCs, or specialty PPMCs. Regardless of type, their sole purpose is to manage physicians' practices. However, PPMCs do not have a good track record, creating an atmosphere of distrust.
   - ***GPWW***: A GPWW does not require the participation of a hospital and is often formed as a means for physicians to organize

without hospital support. GPWWs are owned and governed by member physicians and have the legal ability to negotiate and commit on behalf of all members. These groups lack a significant ability to manage practice behavior and they must continually seek out new sources of capital, information systems, and management expertise.

- ***Consolidated medical groups***: These groups are formed when physicians combine resources to become a true medical group practice. These groups operate independently of hospitals and are able to achieve substantial economies of scale, influence physician behavior, and have the leverage to negotiate. Unfortunately, these groups often face uncontrolled overhead and have poor utilization patterns.
- ***PHO***: PHOs allow a hospital and its physicians to negotiate with third-party payers; this type of IDS can be either open or closed. A drawback of the PHO model is that it is often structured loosely and fails to actually improve contracting ability.
- ***MSO***: MSOs offer both a vehicle for negotiating with MCOs and additional services to support physicians' practices. These groups bind physicians closer to hospitals and can bring economies of scale and professional management to physicians' office services. However, physicians can challenge allegiances with relative ease and these groups have limited ability to enact change.
- ***Foundations***: This model can be formed when a hospital creates a not-for-profit foundation and purchases physicians' practices, then places them within the foundation. Foundations are governed by boards not dominated by either the hospital or physicians. The foundation model provides a high level of structural integration and can satisfy legal constraints that prohibit hospitals from purchasing services or employing physicians. Unfortunately, there exists in the foundation model a built-in potential for conflicts between hospitals and physician groups, and foundations must continually prove that they provide a benefit for the community to retain non-for-profit status.
- ***Staff models***: Staff model IDSs employ physicians directly, either by purchasing their practices or hiring them. Physicians are salaried and can enjoy incentive programs, but management sometimes treats physicians like other staff, which can cause resentment among physicians. Physicians may also have little motivation to be productive in this model.
- ***Physician ownership models***: Physicians hold a significant portion, if not all, ownership in this type of model. Because of this, they have a vested interest in the system's success. Drawbacks to

this system include the high level of resources required to build and operate it, and the high buy-in cost for new physicians.

- ***PSO***: PSOs are cooperative ventures of group providers who control financial arrangements and health service delivery and activity is focused on the Medicare community. The need for reserves in this model has been greatly underestimated and PSOs often do not have managerial or systems capabilities to administer the plans.

4. Virtual integration is a system under independent parties come together to behave like an IDS under managed care, yet retain their own identities and missions.
5. Four key legal issues facing an IDS are *private inurement, fraud and abuse*, *antitrust actions*, and *licensure provisions*.

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CHAPTER 4

Elements of the Management Control and Governance Structure

CHAPTER STUDY REVIEW

1. A managed care organization's board of directors is responsible for the governance functions of the MCO. These functions include:
   - Final approval of corporate bylaws
   - General oversight of profitability or reserve status
   - Oversight and approval of significant fiscal events
   - Responsibility to protect shareholders' interest (in for-profit plans)
   - Review of reports and document signing
   - Setting and approving policy
   - Oversight of the quality management program
   - Hiring the CEO and reviewing his/her performance (in free-standing plans)
2. There are seven key management positions on the board of directors of a managed care organization. These members must act in the best interests of the organization or they could face liability issues.
   - executive director/chief operating officer
   - medical director
   - finance director
   - marketing director
   - operations director
   - director of information systems
   - corporate compliance officer
3. There are seven committees crucial to the successful operation of MCOs.
   - QM committee
   - Credentialing committee

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- Medical advisory committee
- Utilization review committee
- Pharmacy and therapeutics committee
- Medical grievance review committee
- Corporate compliance committee

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CHAPTER 5

Examining Common Assertions about Managed Care

CHAPTER STUDY REVIEW

1. There are many theories behind the widespread adoption of managed care. Some feel that it has been a response to the crisis of rising health care costs. Others believe that it is a result of problems with the quality of health care including underuse, overuse, misuse, and geographic variation.
2. Much of the political debate surrounding managed care has revolved around claims concerning the treatment of particular individuals' cases. Conversely, when consumers are asked directly about the quality of their personal health care, most express satisfaction.
3. Many common myths surround the issue of managed care. For each of these myths, there is either evidence that proves them false, or a lack of evidence to substantiate them.
   - ***Myth***: The growth of managed care health systems has restricted choice.
   - ***Myth***: Members enrolled in managed care plans received lower quality services than did those with traditional indemnity coverage.
   - ***Myth***: Doctors' decisions on necessary treatment often are overruled by plans' utilization review personnel.
   - ***Myth***: Physicians who participate in health plans are exposed to a greater number of medical malpractice claims because they are limited in the services they can perform.
   - ***Myth***: Managed care plans do not provide coverage for the necessary duration of hospital stays.
   - ***Myth***: Managed care plans avoid enrolling sick patients and achieve high quality and positive outcomes by enrolling healthier members.

- ***Myth***: Managed care enrollees have more difficulty gaining access to specialty care than do patients with indemnity coverage.
- ***Myth***: Women enrolled in managed care plans do not have adequate access to obstetrical and gynecological care.
- ***Myth***: Health plans cause low levels of enrollment in clinical trials.
- ***Myth***: Forced to see too many patients, physicians are spending less time with those patients.
- ***Myth***: Health plans use "gag rules" to keep physicians from discussing with patients certain available treatment options.
- ***Myth***: To generate large profits, managed care plans sacrifice quality of care.
- ***Myth***: Hospitals are losing money because of increased enrollment in health plans.
- ***Myth***: The increase in managed care has caused a decrease in physician profits.

4. There is a proliferation of evidence showing that managed care has helped lower health care costs and make health care more widely available.
5. Before the advent of managed care, few in the health care industry were subject to measures of quality. With the growth in managed care enrollment, most aspects of the health care delivery system are now subject to rigorous quality assessment measures.

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CHAPTER 6

Primary Care in Managed Health Care Plans

CHAPTER STUDY REVIEW

1. The PCP plays a key role in the managed health care delivery system. The PCP is often the first point of contact for the patient. Acting as a gatekeeper, many PCPs refer patients to specialists when necessary.
2. Most health care systems consider three specialties primary care: *family practice*, *internal medicine*, and *pediatrics*. In some rural or underserved areas, *general practitioners* are also considered primary care physicians.
3. In creating a provider network, MCOs must take into consideration a variety of factors, including access needs and geographic requirements, needs of plan members, and variety of practitioners.
4. When developing a network, open-panel MCOs are likely to have to deal with a variety of contracting situations. Such situations include:
   - ***Individual physicians***: This is the most common category in open-panel MCOs. Individual physicians contract directly with the health plan.
   - ***Medical groups***: In this situation, small groups operate as cohesive units to contract MCOs.
   - ***IPAs***: Independent practice associations are the original form of the open-panel plan. IPAs are legal entities that contract with physicians, then act as a negotiating body between the physicians and the MCO.
   - ***IDS***: An independent delivery system can be hospital-based or physician only.
   - ***FPP***: Family practice plans are organized around teaching programs and are usually found at university hospitals.

   Each situation has relative advantages and disadvantages.
5. MCOs credential physicians to ensure a level of quality and acceptability among their physicians and to protect themselves from