


Managed Care for the Clinician

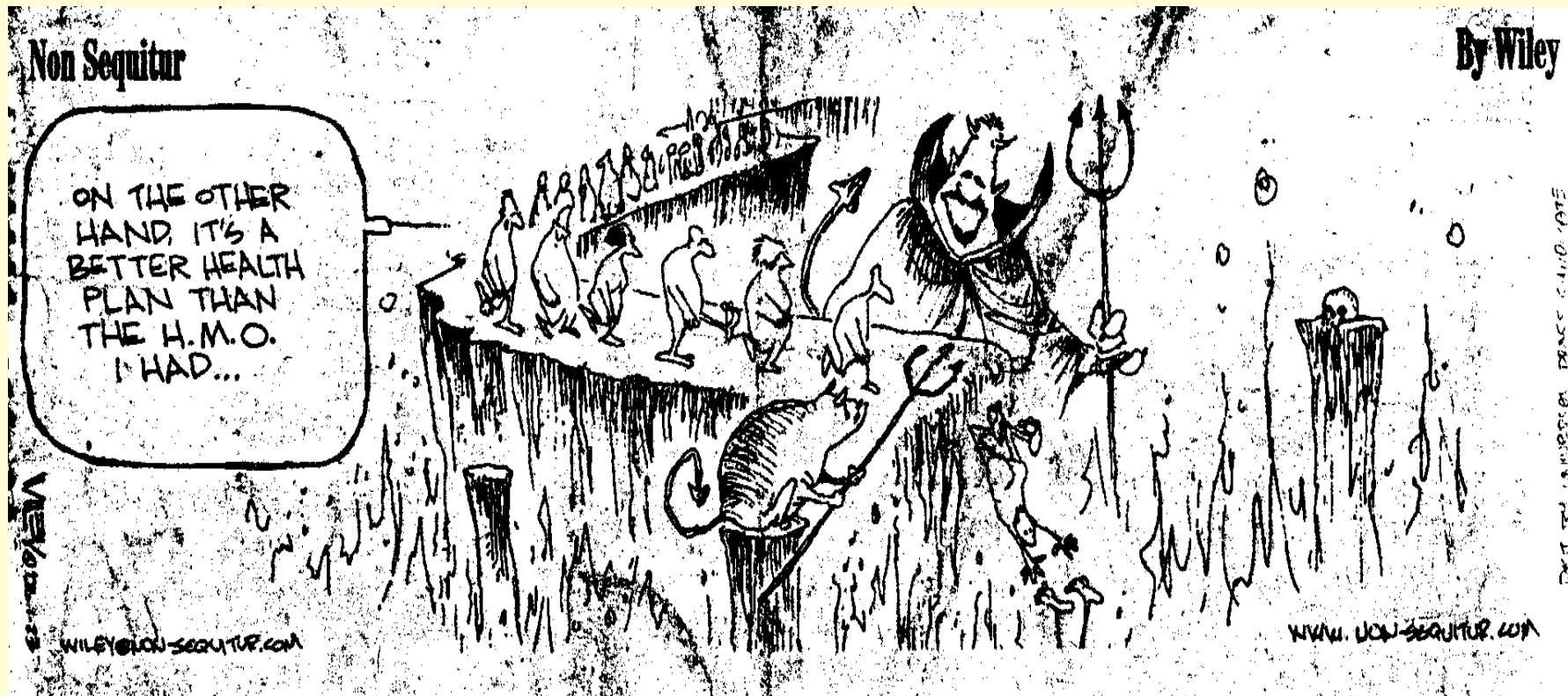
Virginia Keane, M.D.
*University of Maryland School of
Medicine*



Managed Care Definition(AMA)


- “Systems or techniques generally used by third party payers or their agents to affect access to and control payment for health care services.”
 - Notice there is nothing about care in this definition!! Its all about money.
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Some would define it differently



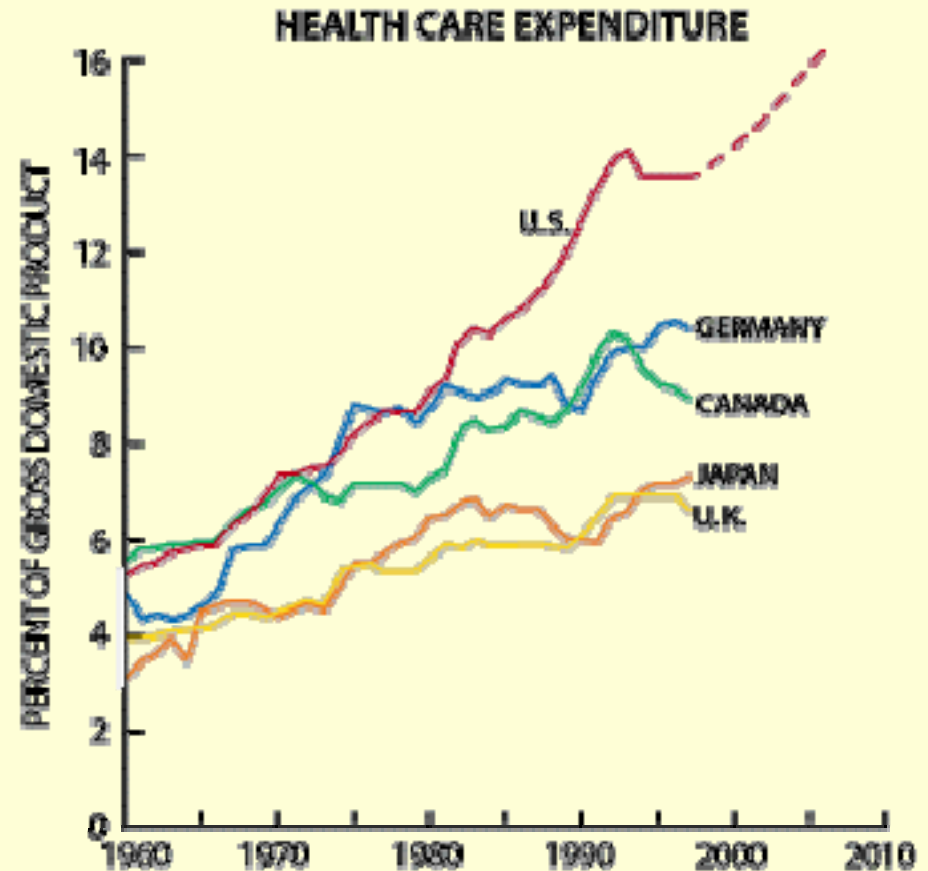


“Managed Care” Is Here To Stay

- It won't always look the same
 - It will evolve to meet the changing needs of the population, the economy and the purchasers of insurance
 - In system with limited resources those resources must be managed. The amount spent on health care can not forever increase: therefore costs **WILL BE** managed!
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How Did We Get Here?


- Health care expenditures have been rising rapidly over the last five decades
- Managed care was seen as a possible solution to these ever rising costs



SOURCE: Organization for Economic Cooperation and Development, *Health Data 1997*. Dashed line shows projections for U.S. made by Shafiq Smith, Mark Freedland, Stephen Hoffer et al., "The Next Ten Years of Health Spending," in *Health Affairs*, Vol. 17, No. 8, pages 128-140; September-October 1998.




Why Have Health Care Costs Risen?

- Advances in technology
 - Advances in pharmaceuticals
 - Aging population
 - Profit motive
 - Fee for service model drives up costs
 - More services
 - High administrative costs
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Medical Practice in the Fee For Service Environment

- Medical care operated on much the same principal as a trip to Target: you wanted something, you went to the doctor to get it.
 - You often got more than you originally wanted.
 - You often got more than you needed.
 - You sometimes got more than was safe or effective.
 - You didn't really mind because your insurance paid for it, or at least 80%.
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Medical Practice in the Fee For Service Environment

- You could go to a specialist or generalist:
 - no one monitored who you saw.
 - you just called and made an appointment.
 - The doctor billed and the bill was paid by the insurance company, regardless of whether the care was needed. No one questioned the doctors judgment on ordering of procedure, labs, or subsequent visits.
 - What do you think happened to health care utilization? *Pause here to take a wild guess*
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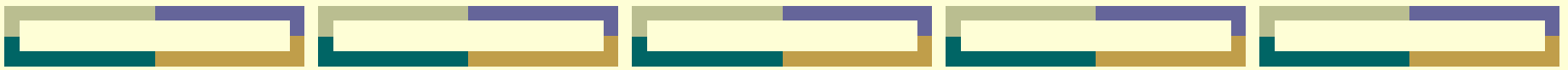
Access to Care

- In FFS(Indemnity) insurance the patient has virtually total freedom of choice of doctors, and control of utilization.
 - Anything the doctor wanted to do he did and billed for, then billed the patient the balance.
 - As long as the doctor got paid the patient retained total access
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Health care utilization in the Fee for service environment

- Utilization went up. *DUHHH!!!!*
 - No incentive to patients to use less
 - No incentive to doctors to order less
 - No incentive to hospitals to limit hospital days
 - SOME OF THIS UTILIZATION WAS FOR THINGS THAT WERE NOT SAFE AND EFFECTIVE (*think tonsillectomies and adenoidectomies!,,*)
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Just How do providers get paid?

- Provider sets the price for a service. Providers are required by law to bill everyone the same amount.
 - After the service the provider completes a billing form. Each insurance company used to have their own form, but now in Maryland all must accept the HCFA(*say hic-fa*)1500. Most doctors have a billing clerk, service or computer program that prepares the HCFA 1500. It has about 2000 data bits including name, address, DOB, SSI number, ICD codes, CPT codes, etc. Get any one digit wrong and the bill will be rejected: sent back to you unpaid!
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Just For Fun!!


- Grab an ICD book and look up a few diagnosis. Try these:
 - Atrial septal defect
 - Ventricular septal defect
 - Cystic fibrosis
 - Asthma
 - Otitis media

Isn't that fun?? Makes prepayment look like a good deal!






How do providers get paid?

- Providers send in the HCFA 1500s, paper or electronic form, with accompanying documentation(a copy of your note.) *You pay for the copies. You also pay for the billing!!*
 - On the first round more than half are sent back unpaid, for one of twenty reasons. You get to refile, sometimes with a written appeal.
 - If the insurance company agrees to pay, they pay what they want. This may also be what you agreed to accept, by contract. You may also have collected a co-pay. If the sum of the co-pay plus the insurance reimbursement is less than you charged, TOO BAD!! You are not generally allowed to “balance bill”, ie bill the patient for the difference.
 - *The trick is to make sure that what they pay plus the co-pay covers your cost and provides you with a living wage.*
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Quality of Care

- Outside of scientific efficacy and effectiveness studies no one really scrutinized quality of care
 - Patients decided on quality and voted with their feet: I don't like this doctor, or what she did, or the outcome, or the décor in the office...: Ill see this other doctor instead.
 - There was no consideration of health status and quality of care on a population basis
 - There was no attention to population based disease management.
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Who was paying for all this maybe not so great care?

- Largely private: mostly employers, who provided health insurance as a work benefit
 - 1965, with the onset of Medicare(federal insurance for the elderly and disabled) and Medicaid(federal and state funded insurance for the indigent) the government became a major payer.
 - BUT: Ultimately it is workers who pay: salary is restrained to provide health insurance, and taxes pay for the government programs.
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Something has to give

- So, we are paying more and more
 - There's no end in sight for the increases
 - No one knows what we are getting for our money
 - Something had to change
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Penetration of managed care

- Managed care was not new:
 - Late 19th century the logging industry, where there was a high risk of injury, implemented a prepaid medical system.
 - 1929: Rural Oklahoma sees the birth of a prepaid farmers cooperative health plan: they built a hospital too!
 - 1932: Committee on Costs of Medical Care recommended linking group practice and prepayment plans
 - Other leaders:
 - 1937: Group Health Association, Washington DC
 - 1942: Kaiser Permanente
 - 1947: Group Health Cooperative, Seattle, Health Insurance Plan of Greater New York
 - 1957: group health Plan, Minneapolis
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Changes in the 1970s

- HMO act of 1973 allowed managed medical care plans to increase in number, enroll more patients through federal grants and loans
 - Business got behind this model
 - So did government
 - It was hoped that managed care would control costs(added bonus: we wouldn't need a national health plan!)
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Widespread Penetration of Managed Care

- California and the Minneapolis- St. Paul led the way(early adopters)
 - Now about 80% of private insurance is some sort of managed care
 - Medicare: had managed care hiccup in the 1990s: HMO enrollment was voluntary,and many seniors jumped at the chance, because HMOs covered drug costs while FFS Medicare did not. However, the HMOs had miscalculated: they couldn't afford the pharmacy costs , and most dropped out of the Medicare market.
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Managed Care in the Public Sector

- In the 1990s the federal government offered states the opportunity to convert Medicaid to managed care. Most states have done this. Maryland's Medicaid managed care program is called Health Choice
 - With the passage of the Medicare pharmacy program managed care companies are again entering the Medicare market.
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Basic Components of Managed Care

- Insurance company contracts with payers to provide (pay for) a fixed set of health care services for a fixed rate per person
 - Insurance company contracts with selected healthcare providers to provide a range of services for an agreed upon price, including drugs and equipment, using explicit standards.
 - Utilization is monitored and controlled, quality is monitored and improved.
 - Financial incentives encourage participants to use in-network (ie contracted, and therefore probably less expensive) services.
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Risk and Lives

- The entity that agrees to provide care for a fixed fee is taking a risk: Insurance companies love to pass this risk on to others, but often get stuck with it
 - If you have risk, the way to protect yourself is to increase the number of people (known in the trade as lives) you control. More lives means more dollars and more power! And if you select carefully, it means more likelihood that you will have well people, who don't cost very much!!. *(More profit for you, and maybe a bonus if you are a CEO)*
 - For example, if an insurance company covers 90% of all the inhabitants of a city, all of the doctors will have to contract with that company even if it pays very poorly!
 - If you are a practice that accepts a fixed rate per patient contract you want to maximize the number of patients you have, because in general this increases the number of well patients (who don't come in very often)
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Contracting and Consolidation

- If you are contracting with an insurance company you have more negotiating power if you provided more services or a significant market share of one service
 - Hospital “A”, which provides traditional inpatient services may not be able to compete with hospital “B” that has 17 clinics, an outpatient surgi-center, home nursing and a durable medical equipment company.
 - A two physician practice may not be able to compete with a 100 physician, 20 location multi-specialty group practice
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Managed Care Glossary


Learn to talk the talk!

- Managed care has its own language
 - Familiarity with this language will make lots of things easier:
 - Day to day patient care
 - Contracting
 - Fighting with HMO clerks on the phone
 - Commiserating with colleagues at cocktail parties.
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Managed Care Glossary


Managed care Models

- **Staff model:**HMO employs the providers, usually owns the facilities. Providers are salaried.
 - **Group Model:** HMO contracts with a group, group exclusively provides care to that HMO's clients.
 - **Preferred Provider Organization(PPO):**Managed care plan contracts with a provider group to provide care to a group of patients for a discounted rate. If patients use the PPO providers they pay less out of pocket. If they go outside of this network they pay more. Patients can generally see specialists without a referral, but with high out of pocket costs (co-pays)
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Managed Care Glossary

Managed care Models

- **POS: Point of Service:** Mixed model that allows the patient to operate like they are in an HMO or have FFS, as long as they use in network services. For instance: they choose a Primary care provider, they can see in network specialists for the least if they have a pcp referral, a little more without a referral, and out of network specialists will be quite expensive, but partially covered.
 - **IPA:Independent Practice Association:** HMO contracts with group of providers who may also contract with other insurers. This is the model most University of Maryland practices use: we contract with lots of different managed care companies. The benefit: you are beholden to no one payer, and don't risk all your business if they pull out. The disadvantage: every payer has their own rules, and you have to learn them all!!
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Managed Care Glossary: provider groups

- **Provider:** any person or organization that delivers health care service of any kind
 - **Group Practice:** Uni or multispecialty flavors!!
 - **Integrated Delivery system:** soup to nuts service. Occurs most commonly when a hospital buys up practices, ancillary services, equipment companies, etc. Enhances contracting power.
 - **PHO: Physician hospital organization:** Hospital and docs join forces to enhance contracting ability
 - **MSO: Management services organization:** Legal/administrative entity that can handle things like credentialing, billing, contracting and payroll for health care providers.
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Managed Care Glossary: services

- Primary care: General/ basic care focusing on preventive care, common illness care and chronic disease care
 - Secondary Care: care provided by specialists and community hospitals
 - Tertiary Care: Care requiring high levels of specialty and technology, usually at hospitals/facilities that are large and sophisticated.
 - Quaternary Care: The most specialized care: transplants, ICU care, cutting edge therapies.
 - *Generally payers want services to be provided in the lowest level possible, to avoid unnecessary costs*
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Managed Care Glossary

Financial terms.

- **FFS: Fee for service.** You provide. We pay on a service by service basis
 - **Capitation:** A fixed amount pre paid per member for a given time period.
 - **PMPM: per member per month:** the most common capitation scheme.
 - **Commercial insurance:** same as private insurance. Can be FFS or managed care. Distinguished from public insurance, Medicaid and Medicare.
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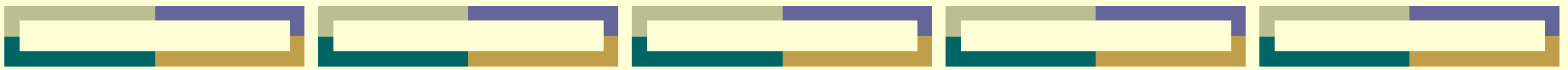
Managed Care Glossary: Financial Terms

- Co-Pays: the amount the patient pays out of pocket
 - RBRVS: Resource based Relative value scale: a classification system developed in the 1980s that is used to calculate the value of a service based on the skill and training it took to provide. It was supposed to help create parity of primary care doctors with procedure driven specialties by assigning value to the decision making and care management services. *It doesn't really work.*
 - DRGS: Diagnosis Related Groups: a classification for inpatient diagnosis used to pay hospitals a per case amount instead of paying for specific treatment and length of stay. Medicare uses DRGS. If hospitals can keep costs below the DRG amount, they get to keep the CASH *and compete for additional prizes!*
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Managed Care Glossary Benefits

- **Benefit package:** what your insurance pays for.
 - **EOB:Explanation of Benefits:** that report you get that tells you what the insurance paid for
 - **COB: Coordination of Benefits:** if you have more than one payment source the process that makes sure the provider doesn't get paid more than once.
 - **Mandated Benefits:** services that state pr federal law requires insurers to pay for .
Insurance companies hate these!!
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Want to learn more? visit these web sites!

- Tufts managed health care
Institute: www.tmci.org
 - American academy of Pediatrics:
www.AAP.org
 - Medical group management Association
www.mgma.com
 - National Association of managed Care
Physicians: www.namcp.com
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