What is Managed Care?

The term "managed care" has been roaming the halls of hospitals and healthcare organizations since the 1970s when employers, large non-profit organizations, and the federal government were encouraged to begin offering a form of "pre-paid" insurance to patients. This offering, known as managed care, is an approach to healthcare insurance that integrates the financing of health care and health delivery to keep costs to consumers at the lowest price possible while providing high-quality, patient centric care.

Many managed care plans will include:

1. Utilization management—processes that determine medical necessity for treatment and services;
2. Quality management—administration of policies and processes that minimize or completely harm while optimizing patient care and outcomes;
3. An extremely limited network of providers (physicians and organizations such as hospitals, imaging centers, pharmacies, and laboratories) who are each credentialed and contracted;
4. Financial incentives for the patient to use network providers; and
5. Some level of financial incentives or risk-sharing by the provider for the care provided.

Health Maintenance Organization (HMO)

The types of managed care insurance or benefit management approaches have evolved almost as much as managed care holistically. At its incept, managed care was synonymous with a health maintenance organization (HMO) process. The traditional HMO framework allows enrollees to select a primary care provider (PCP) to serve as the patient's gatekeeper for all necessary services and must provide referrals for the patient to be seen by a specialist or to receive imaging or laboratory studies. The PCP is expected to manage and oversee the care so that only necessary and appropriate care and services are provided according to available evidence or consistent with standardized care pathways. In an HMO, only network providers are available to the patient, so specialists, hospitals, pharmacies, imaging centers, and laboratories are preselected and credentialed and contracted by the HMO. In the case of an HMO with a gatekeeper model, coverage will only be available for care and services authorized by their PCP.

Less traditional HMOs have appeared where the PCP does not serve as the gatekeeper, and the patient may refer themselves to a specialist. However, for the service to be covered and paid for by the managed care plan, the patient is still limited to only receiving care and service from in-network providers. However, some managed care plans may include benefits that could allow an enrollee to obtain services and treatment from out-of-network providers. The utilization and quality management programs in HMOs voluminous data related to the care and services authorized and provided by the PCP and other providers. This data is communicated to the PCP and other network providers regularly as the financial incentives revolve around compliance with the managed care plan's utilization and quality programs' targets. For the patients, the financial incentive is that they receive insurance coverage only for services that occur within the network unless out-of-network benefits are authorized.

Preferred Provider Organization (PPO)

Not all managed care occurs via an HMO plan. Due to the patient's desire to have more providers' choices than would be available either in the gatekeeper or non-gatekeeper HMO. This is largely due to provider's complaints about the loss of autonomy in HMO arrangements. As a result, the preferred provider organization (PPO) has emerged. In this managed care approach, the insurance company recruits a network of providers in a given geographic region, including both PCPs and sub-specialists along with a set of hospitals, pharmacies, imaging centers, and laboratories who all agree to take a discounted rate in exchange for the opportunity to be listed as in-network and possibly be selected by a relatively large group of patients as their chief provider. The providers are held to utilization and quality targets and will bear some level of financial risk for the population of patients they serve based on performance. Patients have more autonomy around care decisions related to selecting subspecialty providers than in the HMO. However, they are still limited to receiving care from in-network providers. The network, however, is likely more extensive than the network available in the HMO setting.

Point of Service

Patients are becoming advocates for their own healthcare and are demanding more choices in health delivery. Therefore, a point of service (POS) managed care arrangement has materialized, which may appeal to more discretionary income patients. In a POS plan, the patient may use this managed care plan like a PPO to limit their choices to only in-network providers, which maximizes their coverage. However, in a POS, patients may choose to see a provider outside of the network, but to do so, they will incur more cost-sharing. Thus, the patient may see nearly any provider they choose, either in-network or out-of-network. Still, if they stay within the PPO

network, they pay the least, but they will share a higher portion of the care cost and pay more if they go outside the network.

The Financial Picture

Managed care reimbursement methodologies and financial arrangements vary widely and occur along a continuum from retrospective fee-for-service payments (providers are reimbursed based on the actual costs incurred after services are rendered) to prospective fee-for-service payments (Medicare payment is made based on a predetermined, fixed amount), and capitation (predictable, set fees to cover the cost of all or some of the health care services for a specific patient over a certain period of time). There are numerous variants that strike a balance between the level of retrospective payment (paid after service is delivered, i.e., fee for service) and prospective payment (paid before the service, i.e., capitation or prepayment.

So what?

If you have a managed care plan, you belong to a health insurance plan that contracts with healthcare providers and medical facilities to provide care at a reduced cost. Its main purpose is to better serve you by focusing on prevention and care management, which helps produce better patient outcomes and healthier lives. As a bonus, managed care helps control costs so can keep more of what you've earned… your M.O.N.E.Y.

Future Topics

Suggestions for a future *All Things Healthcare* topic? Contact me at services@fluiditywriting.com or https://www.fluiditywriting.com/contact.