Rural Health Policy Briefs

What is Managed Care

The American health system is going through a transformation. Increased emphasis is being placed on market based strategies as a means to reform the system. Typically, this means managed care. Even within the federal system, managed care is being targeted as the new engine to drive (and reform) the American health care system. Medicaid waivers, for states to develop Medicaid managed care plans, are being issued and Congress will address the issue of Medicare risk contracts through reform of the Adjusted Average Per Capita Cost (AAPCC) rates.

The growing interest in managed care, network development, and alternative health system models is closely linked to the need for institutional and system survival. A recent national survey of rural hospital CEOs found 47 percent were affiliated with another hospital or health system and of those affiliated, 77 percent indicated they did so for further managed care opportunities. The same survey found 54 percent of these CEOs saying that if they did not network with another hospital/system their survivability would be in question.

Nationally, a common form of managed care, the health maintenance organization (HMO), is continuing to grow in number and membership. HMOs grew from 545 in 1993 to 591 as of March, 1995. The number of people enrolled in HMOs likewise increased: 45.2 million, 1993; 51.5 million, 1994; and 58.2 million, 1995. Another managed care arrangement is the Preferred Provider Organization (PPO). At the end of 1995, an additional 91 million Americans received care through PPOs.

Managed Care Fundamentals

Managed care is a rather generic phrase covering a spectrum of models. The essence of managed care is to integrate the delivery and financing of care into one system. It involves some form of prepaid or managed fee-for-service health care where the incentives, for both providers and patients, are significantly different than traditional fee-for-service reimbursement. To influence market decisions and control costs, providers are asked to deliver services at a prepaid level generally through a form of capitation in which the provider has a set dollar amount to deliver care per member per month (referred to as a PMPM) or the fee schedule has been negotiated at a discounted dollar rate. Typically, providers affiliated with a managed care plan assume some level of financial risk. Under a capitated system, if a physician treats the patient at a dollar amount above the prepaid amount, the physician experiences a financial penalty. For patients, incentives are set to influence decisions to use an affiliated provider of a managed care plan; consequently, if they go outside the plan's providers they can be penalized with significantly higher copayments and deductibles or even disallowed from using the plan again. Managed care also relies heavily on utilization review and quality assurance programs to control costs and to measure and enhance the quality of services. Hospital reimbursement, under managed care, is commonly done on a predetermined, negotiated basis, often as a per diem.
Contrasting a fee-for-service system with a managed care system reveals certain philosophical differences. In a sense, fee-for-service systems encourage greater utilization of services because greater revenues are related to a greater number of services provided. Conversely, managed care systems emphasize cost control because a greater utilization of services entails a reduction in revenue. In other words, under managed care each service can be perceived as an expense or a cost as opposed to additional revenue. Funding under fee-for-service is based on the number of services provided; funding under managed care is based on the number of enrollees served—not the number of services provided. Managed care systems typically offer more comprehensive packages of benefits. Primary care and preventive services are emphasized. The philosophy of managed care underscores the need for prevention, wellness, and primary care as a means to control expenditures and maintain quality.

**Managed Care Models**

Managed care can be better understood by examining a variety of models. As managed care continues to evolve, the clear definition of each model blurs as they adopt features from other models. Market oriented reform maximizes the need for organizations, (e.g. managed care entities, business groups, and provider networks) to be flexible in their arrangements and the design and structure of those arrangements. For example, some HMOs may offer a staff model plan and an independent practice association (IPA) plan. Some health systems/networks offer a choice among HMO, preferred provider organization (PPO), and point-of-service (POS) options. Systems deal with capitated providers and fee-for-service providers simultaneously. Managed care, like health care in general, is in a state of transition and flux, again.

A common model is the health maintenance organization. Physician payments in HMOs tend to be through a capitated method; however, discounted fee schedules can also be used. The staff model HMO employs salaried physicians to provide services. Staff model plans usually contract with selected subspecialists and with hospitals. The group model HMO contracts with a physician group to provide services to subscribers. The physicians are not employees of the HMO. Under some group plans, physicians see only HMO members; under other plans they can see both enrolled members and non-members. Thus, under some arrangements the group can be in an exclusive contract with the HMO; in other cases a group can have multiple arrangements with different plans. Both staff and group models have the advantage of directing the health market to a selected number of physicians (thus controlling "out-shopping" to other providers) and overseeing most services on an in-house basis. A network model HMO means multiple group practices and/or IPA and/or individual practitioners are linked together under the umbrella of a plan. Physicians can maintain greater levels of autonomy and consumers may have greater options. Individual physicians can participate in an Independent Practice Association (IPA) model in which the HMO contracts directly with individual physicians or a physician corporation. These physicians are members of the IPA but can retain their individual practices, offices, and medical records. They treat HMO patients and non-HMO patients. While IPA plans have grown rapidly in number, they have also been criticized for offering less efficiency in both utilization review and administrative costs. A final HMO model is the point-of-service (POS) option. Members have greater latitude to use providers outside the HMO, albeit with significantly higher copayment amounts and an established deductible.
Preferred Provider Organizations (PPO) represent another managed care model. Under this model, an employer or an insurance company may contract with providers such as hospitals and physicians for services to enrolled members. Providers are generally paid on a fixed fee schedule and often a negotiated discount fee is established. While enrollees have the freedom to use providers outside the PPO, they have financial incentives to use a participating provider, i.e., deductibles and copayments can be significantly higher if non-participating providers are selected.

Exclusive Provider Organizations (EPO), a relatively new entry in the managed care market, offer characteristics similar to HMOs and PPOs. Some managed care experts view the EPO model to be a PPO/HMO hybrid. As in many HMO models, members are required to use the providers in the plan. Services obtained outside the plan are generally not covered. Cost control mechanisms tend to be forceful enough to create premiums that are lower than PPOs. Like PPOs, EPOs offer less financing risk to providers than HMOs and resemble PPOs in administration. Many employers offer in their plans both PPO and EPO options.

References:


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