PRINCIPLES AND PRACTICES OF MANAGED CARE

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MANAGED CARE

A system of health insurance characterized by a *network* of contracted providers providing health services to a *defined* population for a *fixed payment.*

MANAGED CARE

Managed care places special emphasis on the appropriate use of ambulatory and inpatient settings, evidence-based decision making, cost-effective diagnosis and treatment, population-based planning, and health promotion and disease prevention.

PAYER GOALS

- Employers and government want to pay a prospective, predictable amount for health care and they want to assure the lowest possible price, best quality, and broadest access for employees or lives.

RISK

Risk in Health Insurance:

- Financial risk is an unexpected unfavorable financial outcome
- Insurance companies accept a risk in exchange for a premium
- Problems come when the event costs more than expected and/or there are more events than expected.

RISK CONT.

- In the event that costs exceed expectations and/or more events occur than predicted, insurance companies:

  - Hold money in reserve to cover the variation of outcomes
  - Keep track of financial results on an incurred basis not on a paid basis
  - Increase enrollment to spread risk over a larger population

RISK CONT.

- Purchase reinsurance
- Reduce variation in the cost of units of service by contracting
- Avoid adverse selection by providing benefit coverage similar to other health plans in the market

SUCCESS FACTORS FOR QUALITY HEALTH PLANS

- Build a strong physician – health plan partnership
- Provide health plan expertise to support physician practice
- Provide physicians with quality and cost data
- Maintain a local orientation as health care delivery is local

- Berenson and Coughlin
The Commonwealth Fund
March 2011

PAYMENT MODELS

Fee-for-Service (FFS): provider reimbursement in which the provider is paid retrospectively according to the number and type of services performed

- FFS encourages utilization of services and lacks incentives to be efficient and keep people healthy

PAYMENT MODELS

FFS, contd

- Managed care plans mitigate expense of FFS with cost and clinical control measures such as utilization and clinical management, quality assurance, provider contracting, and utilization of provider networks

More care isn't necessarily better care.
In many cases more care is bad care

PAYMENT MODELS CONT.

Global Capitation/Full Risk: a per person payment made to a health care provider to deliver health services to a defined population over a set period of time

- The provider receives a negotiated prospective monthly payment per member based on the expected cost of providing the specified services

PAYMENT MODELS

Global Capitation, cont

- Payment varies to reflect the total number of members covered and, typically, characteristics of the members such as age and sex; but payment does not vary based on the actual services provided to each member

- Administrative functions vary between plan and provider

PAYMENT MODELS CONT.

Professional Only Capitation/Partial Capitation:

- Similar to global capitation but only for professional services or specified services
- 1990s, ICM services were capitated but other mental health services were fee-for-service
- Medicare Community Nursing Organization Pilot: nurse case managers receive capitated payments for medical case management, all other services are fee-for-service

PAYMENT MODELS CONT.

Single Specialty Capitation: plan contracts with a single facility or organization to provide specialty services

- specialty facility receive prospective payment for providing services
- e.g., laboratory services, radiology, physical therapy

PAYMENT MODELS CONT.

Case Rates:

- Bundled payment (case rate): a single payment for all services related to a treatment or condition, possibly spanning multiple providers and settings
  - e.g., a single payment for coronary artery bypass graft surgery including all care related to the procedure; single payment for all services related to prenatal care through delivery

- Diagnosis Related Group (DRG): Hospital reimbursement classification system that groups patients according to principal diagnosis, surgical procedure, age, presence or absence of significant comorbidities or complications, and other relevant criteria.

PAYMENT MODELS CONT.
Mental Health Programs

- Value Options (TX): Partial Risk – Managed care plan pays providers prospectively for a subset of services, such as case management or crisis services, with other services reimbursed on a FFS. The plan may be at risk for costs or gains that exceed a pre-determined cost.

- Block Grant (KS): Place a limit on the total revenue that a provider will receive in a given year. The provider claims against the grant retrospectively and justifies the amount for quality control purposes. The provider will not be paid for expenses in excess of the grant, but there is a reconciliation process that protects providers that may have experienced unexpected volumes.

PAYMENT MODELS CONT.
Incentives/Pay for Performance

- Physician/Hospital Pay for Performance: financial incentives for positive clinical outcomes, patient safety, efficiency, and structural indicators such as the investment and use of health information technology

  - incentives are funded through withholding a portion of current payments, adding new money to existing payments, or sharing savings that accrue through reductions in expenditures

PAYMENT MODELS CONT.
Self Directed Care

- Self Directed Care (TX): $4,000/year to individual for purchase goods & services, with up to $7,000/year available for individuals who need high levels of service
  - Individuals make their own clinical purchases (individual and/or group therapy, psychiatrist, medication management etc…)
  - Individuals make non-traditional purchases (health/fitness, transportation, communication/pc, clothing/furniture…)
  - Funded by Medicaid, General Revenue, and Local Funds

DATA

Managed Care is about
data, data, data

MANAGED CARE IS

- Managed care relies on a large population for accurate data
- Small number of consumers use most of health care resources
- Implement strategies to address what we learn from data
  - Disease management programs
    - Diabetes, COPD, High-Risk Pregnancy, Serious Illness
  - Complex Case Management
  - Point of Care: reducing hospitalization usage

SUMMARY

- Managed care is about access, price, and quality.
- Different payment models are the means by which plans achieve these goals.

THANK YOU.

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