

Managed Care Effectiveness

Introduction

This topic is more difficult than would first be surmised because there are:

1. Numerous interested parties

- Society (as a whole)
- MCO (managed care organization)
- Plan Sponsor (normally the employer)
- Covered Persons
- CMS (Centers for Medicare and Medicare Series)
- Regulators (federal and state including policy makers)
- Providers.

2. Numerous goals

- Profit or loss
- Quality of service
- Availability.

With each interested party having a disparate stake in the goals, what is presented to us is a very complex multidimensional continuum.

Discussion

Society

Profit-Loss. Society wishes managed care to be cost-effective, cost-containing and tend toward a lowering of overall costs for all societal members.

Quality of Service. The provided care should meet the expectations of the plan sponsors and the covered persons and tend toward outcome-measured improved health.

Availability. Health care should be available as appropriate, as needed and with reasonable ease.

Plan Sponsor

Profit-Loss. The plan sponsor wishes for a plan with affordable benefits, which will attract and retain a high-quality workforce. Plan sponsors will always grant the best benefits for the lowest price. Further, the plan sponsor will want the MCO to be financially stable and provide benefits at predictable prices for budgeting purposes. Also, the employer wishes for there to be incentives for the participants to elect cost-effective options.

Quality of Service. The plan sponsor wishes for employees to be satisfied with the benefits provided through the MCO as regards quality of services. The plan sponsor would expect the MCO to be accredited; the administration to be relatively easy and simple; the medical care to have positive outcomes; and data to demonstrate that quality medical care is indeed being achieved. The plan sponsor wishes to find high quality providers in the network and for the plan to embrace the best of high-tech administration.

Availability. The plan sponsor wishes as broad a range as possible of geography, providers and benefits with as little impediments as possible for the participants such as wait and travel time, red tape, etc.

MCO

Profit-Loss. The MCO must have sufficient profits to compete and grow; its networks must be cost-efficient; incentives must be built in to aid cost-containment; antiselection and fraud must be controlled; there must be an adequate flow of new business; the risk must be shifted to the MCO.

Quality of Service. The covered persons and physicians must both have satisfaction with the quality of care; quality is measured by outcomes and delivery; accreditation of both the MCO and the providers is essential. Referrals must be controlled.

Availability. There must be reasonable access by geography, network providers and range of options and services. The providers must have a competitive position; engage in consolidation and negotiation.

Covered Persons

Profit-Loss. The covered person wants the requisite contributions and out-of-pocket charges to be low; the costs should be stable and benefit options are desirable. Of great importance to the covered person is that there should be no blockage to quality or quantity of care.

Quality of Service. Covered persons want favorable medical encounters and outcomes; also a requisite is information to make provider and treatment choices. Factors critical to the quality of service include the following:

- Good networks

- Efficient administration
- Useful information and data
- Well managed medical rewards
- Covered persons involved in decisions
- Ability to handle the outliers.

Availability. Geographic convenience and the ability to change providers easily is important. Also important would be access to specialists for chronic diseases, benefits of a comprehensive nature (e.g., well-patient care), minimum of administrative impediments and choice of plan options and costs.

Centers for Medicare and Medicaid Services

Profit-Loss. CMS prefers arrangements where there are minimal contributions from covered persons; also that any such contributions not be an impediment to care.

Quality of Service. Since the covered persons are similar in age, sex, etc., the issue of discrimination is minimal. Use of both in- and out-of-network care must be anticipated; access between the in- and out-of-networks must be with minimal barriers.

Administration must not adversely affect quality of service.

Availability. Ideally, there should be increased availability with managed care. CMS wishes the following.

- Free choice of providers
- Easy administration
- Quality providers.

Regulators

Profit-Loss. Constituents should be reasonably satisfied with their medical expenditures. There should be a reduced cost for the publicly-funded populations. The medical costs should be controlled; marketplace competitiveness should be fostered; usually, regulators are supporters of MCOs.

Quality of Services. The services must improve the health status of the eligible populations and the medical standards should meet minimum standards. Certain socially objectionable medical practices should be avoided (drive-through maternity. e.g.). Data to measure outcomes, satisfaction, cost, access, etc., should be developed. Patients must have the right of appeal, right to choose, etc.

Availability. Basic service must be available to the eligible populations. Such issues as geographic reasonableness; continuity of coverage; and patient rights to data, appeal, choice must be honored.

Providers

Profit-Loss. The provider should be fairly and adequately paid so that such provider has a reasonable and stable income. The provider must be competitive.

Provider-assumed risk is acceptable but the risk should bring added patients and/or income; the provider should be protected against catastrophic risks. Teaching facilities should be paid at a higher rate.

Quality of Service. The medical decisions should be made by physicians with the expectation of favorable medical outcomes. There must be a satisfactory provider-patient relationship with the MCO, other providers with physician leadership with the MCO and other providers with physician leadership in management-of-care practices.

Availability. Unrestricted access to the necessary providers and resources is necessary; there should also be geographic conveniences. Referrals should be handled smoothly.

Assessing Performance

There is a plethora of means by which the effectiveness of an MCO in meeting its goals may be measured:

1. HEDIS (Health Plan Employer Data Information Set)
2. NCQA (National Committee Quality Assurance) Accreditation
3. Foundation for Accountability
4. JCAHO (Joint Committee of American Hospital Organization) Accreditation
5. CAHPS (Consumer Assessment of Health Plans Study)
6. Clinical Guidelines
7. American Accreditation Health Care Commission
8. Physician Accreditation (AMA, e.g.)
9. Miscellaneous Survey and Studies
 - Utilization review
 - Indices of quality of care (satisfaction, commuting and waiting, out-of-pocket, etc.)
 - Provider profiling
 - Financial-related statistics.