BASICS OF MANAGED CARE

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WHY PARTICIPATE IN MANAGED CARE?

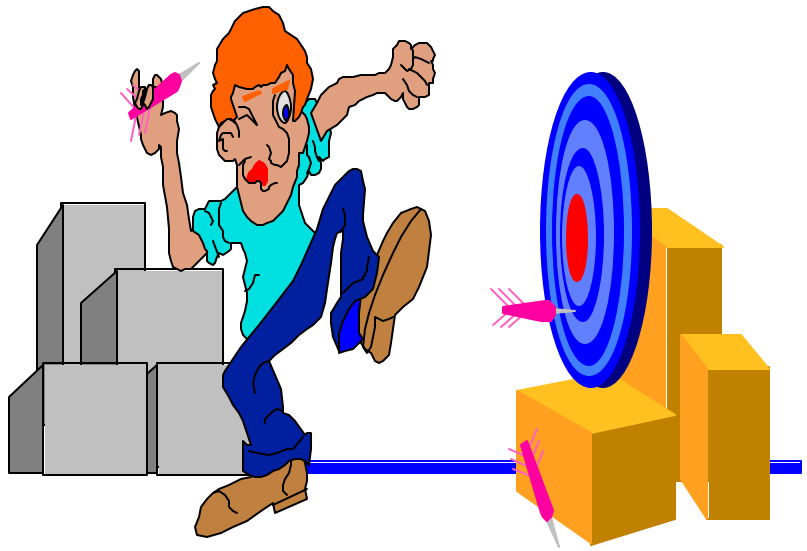
- Enhance the quality, accessibility, coordination, and continuity of care for HIV-infected individuals enrolled in managed care plans
- Ensure your agency's ability to access HIV-infected populations enrolled in managed care plans so your agency can offer them grant-funded prevention and psychosocial services
- Improve your agency's likelihood of financial survival
- Diversify your agency's client and income base
- Influence the governance and policy making process within managed care plans
- Adopt sound business practices used by managed care plans to improve your agency's products and more efficiently use scarce resources

MANAGED CARE ELEMENTS

- ***Combines*** **financing and delivery systems**
- **Patients are *enrolled* in a managed care plan with a defined *benefits* package**
- **Patients usually select or are assigned a *primary care provider* (PCP)**
- **PCPs act as a *gatekeeper* who determines access to specialists, hospital care, and other services**
- **Payment is typically paid on a *prospective, capitated* basis, but fee-for-service payments may be made for some services**

Some MCO goals...

- Clearly define patient populations, modify their care seeking behavior, & predict their care use & costs
- Identify high risk & high cost patients
- Identify & minimize financial risk
- Maximize profitability
- Organize systems of care that achieve these goals



MCO FUNCTIONS

- MARKETING
- MEMBERSHIP ACCOUNTING
  - group billing, contracts, enrollment, and PCP assignment
- NETWORK OPERATIONS
  - provider credentialing and contracts
- MEMBERSHIP SERVICES
  - education and grievances
- CLAIMS ADMINISTRATION
- MIS
- FINANCE
  - Budget projections and capitation rates
- UTILIZATION MANAGEMENT & QUALITY ASSURANCE

HMO MODELS

- ***Staff:*** **Physicians are HMO employees**
- ***Group:*** **Physicians are members of a single or multi-specialty group practice that contracts with the HMO**
- ***IPA:*** **Either the physician contracts directly with the HMO or through a physician corporation**
- ***Network:*** **The HMO contracts with group practices, IPA-physician corporations, and/or with individual physicians**

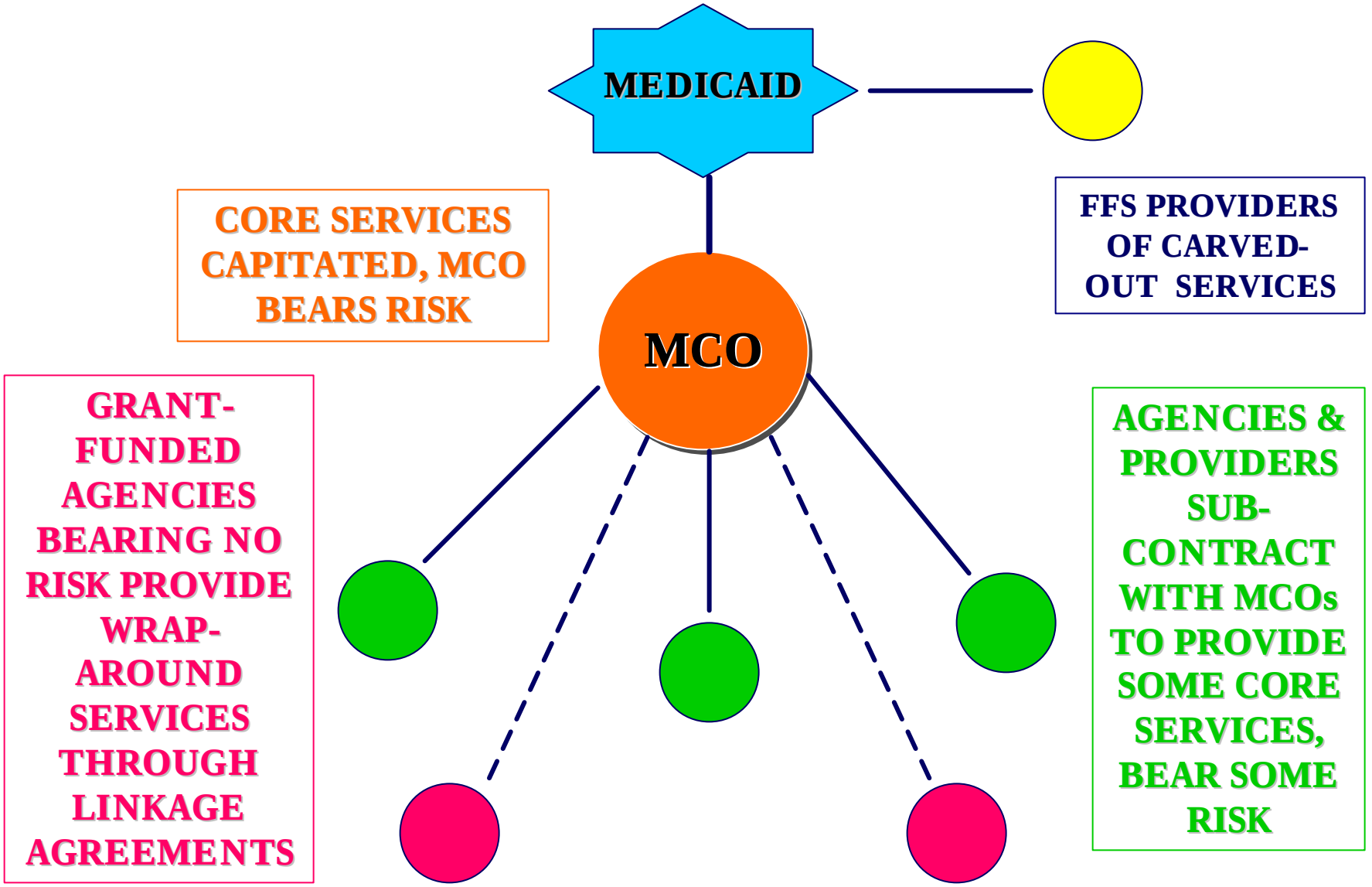
OTHER MANAGED CARE MODELS

- ***Point of Service (POS):*** **HMO offers members the option to receive services from non-MCO providers at a reduced rate of coverage**
- ***Preferred Provider Organization (PPO):*** **A system that contracts with providers at discounted fees; members may seek care from non-participating providers, but at higher co-pays or deductibles**
- ***Integrated Service Network (ISN):*** **A collaboration of either PCP (horizontal) or primary, specialty, and inpatient providers (vertical) for managed care purposes**
- ***Physician Hospital Organization (PHO):*** **legal entity between hospital and physicians to contract with MCOs**

PLAN SELECTION CRITERIA

- Established provider network
- Geographic coverage
- Sufficient capacity & accessible services
- Acceptable marketing, enrollment, grievance, & disenrollment procedures
- Established quality assurance program
- Fiscal solvency
- Established administrative & governance structure
- Meets State managed care licensure criteria

FINANCING & DELIVERY OF HIV SERVICES IN A MEDICAID MANAGED CARE ENVIRONMENT



WHAT IS CAPITATION?

- **A reimbursement method for health and associated services in which a provider is paid a fixed amount**
  - **Payment is usually monthly for each member served**
  - **Payments occurs without regard to the actual number or services provided to the member**
- **Capitation is a:**
  - **Means for payment for expected services**
  - **Budgeting tool**
  - **Management tool**
  - **Cost control tool**

CAPITATION VERSUS FFS

ELEMENT	CAPITATION	FEE FOR SERVICE
CONCEPT	Payment of a fixed amount per patient usually monthly; services are expenses against revenue	Fee (revenue) for each service provided
FUNDING	Based on the number of enrollees, not the number of services	Based on the number of service units provided, not related to the number of patients
INCENTIVE	Control utilization and provide fewer and/or less costly services; provide early detection and treatment to lower total cost of care	Provide more services or charge more per service; sick patients require more services and generate more revenue

MONTHLY CAPITATION

$$\frac{\text{Utilization} \times \text{Cost}}{12 \text{ months} \times 1{,}000 \text{ members}} = \text{PMPM}$$

Utilization = number of units of service for each benefit for 1,000 members

Cost = average cost per unit of service

PMPM = per member per month capitation payment

ASSUMPTIONS UNDERLYING CAPITATION RATE SETTING

- Covered and excluded services are clearly defined
- The average utilization rate per service is known or can be accurately projected
- If the average utilization rate varies by population group, their rates are known or can be projected
- The cost per service is known and is unlikely to vary during the contract period
- Administrative costs are accurately defined (*i.e.*, there are no hidden costs) and adjustment can made in the PMPM for those costs
- Can additional revenue (*i.e.*, grant income) be used to supplement the PMPM
- Discounts may be taken for “efficiency”

HIV RISK ADJUSTERS

- Age and gender
- Source of insurance (i.e., can risk be spread across several payers)
- Spectrum of HIV disease (i.e., HIV asymptomatic, symptomatic, AIDS)
- Surrogate clinical markers (i.e., CD4 count, viral load)
- Other clinical co-morbidities (i.e., other chronic diseases, substance abuse, mental illness, tuberculosis)
- Psycho-social co-morbidities (i.e., poverty, homelessness)

CHALLENGES TO SETTING HIV CAPITATION RATES

- It is difficult to identify the claims of HIV+ recipients
- Historical service utilization data may be:
  - unavailable for all planned services,
  - based on a small number of patients,
  - heavily influenced by high or low cost users,
  - unable to account for “case-mix,”
  - untimely
- Historical data on service costs may be:
  - based on inefficiently operated programs,
  - offset by other grant funding streams,
  - or reflect cross-subsidization of programs
- “Carved out” services (e.g., drugs and diagnostics) may influence medical management in unplanned ways

HIV CAPITATION RATE SETTING

(Continued)

- Time allocated for clinical encounters may be insufficient as the complexity of medical management increases
- Historical per capita utilization rates may not predict future service use
- Demand for services may exceed anticipated levels
- Due to lack of person-based data, the combination of services used may not be clear
- Combinations of services used may change
- Costs may change as efficiencies are introduced, through negotiation, or as large market forces prevail

ADVERSE SELECTION

Attracting members who are sicker than the general population

- **This results in higher than budgeted expenses for the plan**
- **MCOs may avoid enrolling individuals who are sicker than the "average" patient**
- **Some MCOs may avoid enrolling HIV-infected individuals because of their relatively high treatment cost**

UTILIZATION MANAGEMENT

- Prior or pre-authorization (e.g., expensive or commonly over-used services)
  - Medical necessity, contracted facility, cost-effectiveness)
- Referrals
  - Part of gate-keeper function of PCP
- Concurrent reviews
  - Is the ongoing service too long and can other services be substituted?
- Formularies
  - Open versus closed formularies, generics, cheapest delivery system
- Claims review
  - Appropriateness review
- Provider selection and profiling

OTHER RISK PROTECTION STRATEGIES

- **Stop Loss / Reinsurance**
  - Establishes an upper limit on annual health care costs for an individual member
  - Aggregate stop loss sets an upper limit for members
  - Managed care plans usually purchase reinsurance
  - Providers can negotiate stop loss with the plan
- **Risk Corridors**
  - Establishes a “ceiling” and “floor” of risk
  - Loss greater than the predetermined amount is reimbursed (e.g., 10% over costs)
  - Profit greater than the predetermined ceiling is returned to the plan

APPROACHES TO MANAGING HIV-INFECTED RECIPIENTS IN A MEDICAID MANAGED CARE SYSTEM

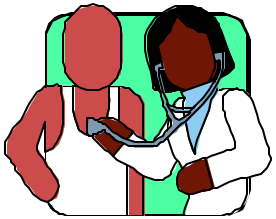
- "Mainstream" recipients
- Carve-out recipients into fee-for-service
  - Carve-out HIV-related services
  - Enhance capitation rates
- "Mixed" approach based on assistance category

ORGANIZING HIV SERVICES IN MANAGED CARE SETTINGS

- ✓ **Training & experience of clinical staff & their willingness to treat HIV-infected patients**
- ✓ **Ability to rapidly disseminate new therapeutic approaches & provide on-going training**
- ✓ **Contractual relationships with HIV specialists & social support programs**
- ✓ **Up-to-date quality assurance programs**
- ✓ **Attitudes of other patients treated in same settings & communities in which services are provided**
- ✓ **Adequacy of capitation rate setting system to cover current & anticipate future HIV costs**
- ✓ **Confidentiality, disclosure, & privacy**
- ✓ **Case finding & outreach**

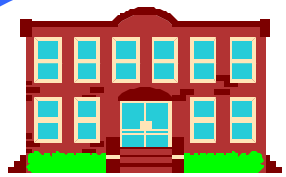
IDEAL HIV NETWORK

LABORATORY

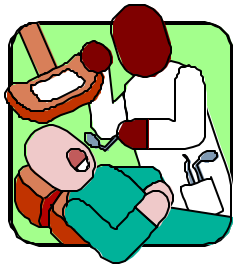


SPECIALTY CARE

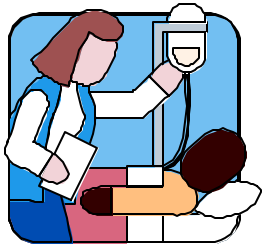
HOSPITAL



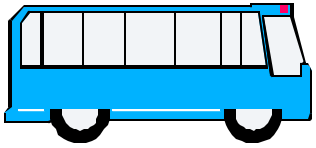
PRIMARY CARE



DENTAL



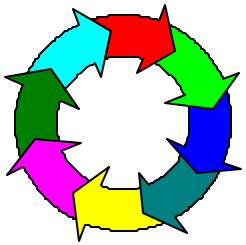
HOME HEALTH



ANCILLARY

PHARMACY

WRAP-AROUND



NETWORK STANDARDS

- Availability of HIV-experienced PCPs and specialists
  - Standing referrals to specialists
  - HIV-experienced clinician should be gate-keeper
- Role of HIV-experienced clinician in developing and implementing care plan
  - Use of multi-disciplinary teams
  - Identifying HIV-experienced person to be responsible for care coordination
  - Continuity standards for referrals
- Adequacy of network capacity to assure delivery of covered benefits (e.g., panel sizes)
- Accessibility standards
  - Travel time, appointment scheduling time, visit wait time, 24 hour coverage by a "real person," geographic coverage, culturally acceptable services and providers
- Fiscal solvency

MEMBER RIGHTS & RESPONSIBILITIES

- Enrollment (marketing & assignment)
- Member Handbook & Membership Department
- Primary care provider (PCP) assignment
- Benefits package
- Availability, accessibility, & continuity
- Grievance procedures
- Confidentiality & disclosure
- Member satisfaction
- Disenrollment