Course Learning Outcomes for Unit II

Upon completion of this unit, students should be able to:

1. Explain licensure, certification, registration, and accreditation of health care professionals and facilities, including the roles of state medical boards, national boards, and accrediting agencies.
2. Discuss the composition of a typical US health care team, and the roles of team members.
3. Explain the various types of medical practice management systems which are available today.
4. Summarize key federal legislation and regulations which impact health care reimbursement and prohibit fraud and abuse in health care.
5. Discuss roles for telemedicine, cybermedicine, and e-Health in today’s medical environment.

Reading Assignment

Chapter 3:
Working in Health Care

Unit Lesson

Managed care in America has become a real “alphabet soup” of acronyms, sometimes hard for students to understand, and definitely hard for patients to understand! In this lecture, we will try to explain the various forms of managed care so that you can make better sense of them as you study, and as you work with them in your career.

In general, managed care can be considered a system for financing, administering, and delivering health care in which all three of those elements are combined in some way. Managed care provides medical services for subscribers in exchange for a premium which is paid. Often that premium is paid partly by the patient, partly by his or her employer.

HMOs

The first type of managed care organization to consider here is the HMO or Health Maintenance Organization. In this managed care design, all health care is delivered and paid for through one organization. HMOs can be set up as Group Model, Staff Model, or Independent Practice Model.

In Group Model, the HMO will contract with independent groups of doctors to provide coordinated care for a large group of patients. A fixed per-member per-month fee for services is agreed upon in advance. The negotiation leading up to that fee can be intense! This is a very common HMO design, and Kaiser-Permanente is an example of one very large Group Model HMO. You may have heard of this very large plan. Some Group Model HMOs have worked very well and can be considered successes. But other Group Model HMOs which formed over the past twenty years were quickly in financial trouble and then closed.

In Staff Model, the HMO actually employs the doctors and other professionals, who provide all care. The employed professionals care solely for the members of the HMO. Commonly, all services are provided at a single location in this model, an HMO hospital or clinic. Patients like the convenience of the Staff Model HMO, but they are often frustrated that they cannot visit doctors who are outside of the staff model group. The HMO typically will not pay for services provided outside its own group of employed doctors, not even partial payment in most cases.
IPA

An Independent Practice Association (IPA) is a model in which independent hospitals, doctors and other providers will contract with the HMO to provide services for members. The providers in the IPA are still free to see other patients who are outside the HMO. The IPA design is quite popular with patients and quite popular with doctors, both of whom feel less restriction and more freedom of choice in this plan. The IPA model seems to be growing in many parts of the US.

PPOs

PPOs are Preferred Provider Organizations in which the managed care plan will contract with a network of doctors and hospitals who provide services for set fees, or on a discount schedule. Patients can choose their own providers, as long as they are within the network. There may be partial coverage for out-of-network services, but there is typically a strong financial incentive for patients to stay in-network.

PHOs

PHOs are Physician Hospital Organizations. Here a group of providers work together in negotiating with the HMOs. The PHO will include doctors, hospitals, nursing homes, pharmacies, even dentists. When all of those providers negotiate together as a group, they have real bargaining power with the HMO, and they may achieve more favorable contract terms.

POS Plans

The POS plan is a managed care design in which patients can visit any provider they choose, and there will be payment, however financial incentives are put in place for the patient to work through a Primary Care Provider and use in-network services. POS plans are also increasingly popular in America. Again there is more choice here than in typical HMO models.

Conclusion

In short, there are many forms of managed care in America. We cannot simply say “managed care” and mean any one specific thing. Hopefully this lecture has provided some insight into the various managed care models which you will see during your work in health care. It can all be quite confusing at times, but you will need a solid understanding of managed care in order to function effectively in the future of US health care.

Suggested Reading

Go the General OneFile database in the CSU Online Library, and search for the following articles. If you have trouble locating the suggested reading, use a combination of keywords from the title, or search by the author.


