Managed Care

Purpose of Managed Care

Managed care aims to replace traditional fee-for-service plans and reimburse providers to make healthcare services more affordable.

Managed Care Organizations (MCOs) assume accountability for reimbursement of healthcare services for groups that are typically called enrollees, policyholders, subscribers, members, or beneficiaries. An MCO can be a hospital, healthcare provider group or health plan provider.

Patients with managed care insurance coverage are required to receive services from a pre-established list of service providers called Primary Care Providers (PCPs). Primary care providers coordinate healthcare services for their patients, including approving referrals to specialists and hospital admissions. This PCP approval role is also referred to as the gatekeeper role, with the ultimate goal of providing quality healthcare services at the lowest possible cost.

Managing cost is an important part of the primary care provider’s role as the gatekeeper. If they are able to successfully reduce costs by limiting or eliminating unnecessary healthcare services, the primary care provider receives a payment from managed care, which is called a physician incentive.

Managed Care Models

Managed care was developed to manage benefits by limiting the utilization of healthcare services and reducing cost. There are six managed care models:

- **EPO**
  An Exclusive Provider Organization (EPO) provides benefits to enrollees or members who are required to receive healthcare services from in-network providers. A network provider is a healthcare professional or provider group under contract with a managed care plan.
| **IDS** | An **Integrated Delivery System (IDS)** is an affiliated provider group that offers combined services to enrollees or members. Affiliated groups may include hospitals, surgical centers, or physician groups. |
| **HMO** | A **Health Maintenance Organization (HMO)** provides comprehensive healthcare services to enrollees or members who voluntarily opt for them. HMOs focus on wellness and preventive care, which can reduce the overall cost of medical care for patients. An HMO can be based on one of the five models:  
  - Direct Contract Model: Local physicians deliver services.  
  - Group Model: Providers, who are members of an independent multispecialty practice group, deliver services.  
  - Individual Practice Association: Physicians, who have an independent office practice, deliver services.  
  - Network Model: Two or more multispecialty practice groups deliver services.  
  - Staff Model: Physicians employed by an HMO deliver services. |
| **POS** | The **Point-Of-Service model (POS)** provides enrollees or members with the option to use a managed care panel of providers or to self-refer services from out-of-network providers. |
| **PPO** | A **Preferred Provider Organization (PPO)** is a network of physicians and hospitals that have jointly contracted with an organization to provide healthcare services to enrollees or members. Patients can use out-of-network providers; however, they will typically need to pay more for those services. |
| **Triple Option Plan** | A **triple option plan** provides enrollees or members with the option of an HMO, PPO, or traditional health insurance plan. |