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# TYPES OF MANAGED CARE ORGANIZATIONS AND INTEGRATED HEALTH CARE DELIVERY SYSTEMS

Eric R. Wagner and Peter R. Kongstvedt

## Study Objectives

- Understand the different types of managed care organizations.
- Understand key differences between managed care organizations.
- Understand the inherent strengths and weaknesses of each model type.
- Understand the basic forms of Integrated Delivery Systems (IDSs) and how they are evolving.
- Understand the major strengths and weakness of each type of IDS, initially, and how they have played out as the markets developed.
- Understand the roles of physicians and hospitals in each type of IDS.

## Discussion Topics

1. Describe the continuum of managed health care plans and key differences for each, using examples of each.
2. Discuss the principle elements of control found in each type of managed care plan. In which plans do those elements appear?
3. Discuss the primary strengths and advantages, and weaknesses and disadvantages, of each type of managed care plan.
4. Discuss in what type of market situations each type of managed care plan might be the preferred model.
5. Describe how a managed care plan of one type might evolve into another type of plan over time.
6. Discuss the key elements of the different types of integrated delivery systems.

7. Describe the conditions under which a managed care plan would desire to contract with an integrated delivery system; describe these conditions for each model type.
8. Describe the conditions under which a managed care plan would actively avoid contracting with an integrated delivery system; describe these conditions for each model type.

## INTRODUCTION

Serious challenges are associated with attempting to describe the types of organizations in a field as dynamic as managed care. The health care system in the United States has been continually evolving and change is the only constant. Nevertheless, distinctions remain between different managed care organizations (MCOs), though many of those distinctions are rooted in the historic classifications that separated different forms of managed care, particularly during its time of rapid growth (see also Chapter 1). Despite the continual blurring of types of health care plans, it is useful to understand the different types of organization even though the pure form may only rarely be observed. It also is worth noting that research done in 1999 suggested that most of the U.S. public, the majority of whom were enrolled in a managed care organization, did not believe that they received their health care coverage through managed care.\*

A decade ago or longer, the various types of MCOs were reasonably distinct. Since then the differences between traditional forms of health insurance and managed care organizations have narrowed to the point where it is very difficult to tell whether an entity is an insurance company or an MCO. In contrast to the situation 20 years ago, when managed care organizations were often referred to as

“alternative delivery systems,” managed care in various forms is now the dominant form of health insurance coverage in the United States, and relatively few people receive their health insurance through the once traditional form of indemnity health insurance coverage. In other words, regardless of organizational type, many of the aspects of managed health care migrated into other forms of coverage and continue to evolve and migrate all the time.

Originally, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and traditional forms of indemnity health insurance were distinct, mutually exclusive products and mechanisms for providing health care coverage. Today, an observer may be hard-pressed to uncover the differences between products that bill themselves as HMOs, PPOs, or managed care overlays to health insurance. The advent of consumer-directed health plans (CDHPs) beginning in the early part of 2000 does provide a greater difference when compared to other types of health plans, however, and these will be discussed later in this chapter as well as in Chapter 20, though even then, many aspects of managed health care are found in such plans.

For other types of health plans (*ie*, non-CDHPs), differences in plan type may be hard to distinguish. For example, many HMOs, which traditionally limit their members to a designated set of participating providers, now allow their members to use nonparticipating providers at a reduced coverage level. Such point-of-service (POS) plans combine HMO-like systems with indemnity systems, allowing individual members to choose which systems they wish to access at

\*According to the 1999 Health Confidence Survey conducted by the Employee Benefit Research Institute, almost two-thirds of the 87% of workers who are covered by managed care think they have never been in a managed care plan. See September 21, 1999, EBRI News Release.

the time they need the medical service. POS rose and fell in popularity as a plan design, however, and is no longer as prevalent as it once was. Similarly, a few PPOs, which historically provided unrestricted access to physicians and other health care providers (albeit at different coverage levels), implemented primary care physician (PCP) case management or gatekeeper systems and even added elements of financial risk to their reimbursement systems. The majority of PPOs did not implement a PCP case management system, but even then often do provide for lower required copayments by members to see a PCP and higher copayments to see a specialty physician, thus encouraging a de facto form of PCP care management. Finally, almost all indemnity insurance (or self-insurance) plans now include utilization management (UM) features and provider networks in their plans that were once found only in HMOs or PPOs, though indemnity insurance is now a quite rare form of coverage.

As a result of these changes, the descriptions of the different types of managed care systems that follow provide only a guideline for determining the form of MCO that is observed. In many cases (or in most cases in some markets), the MCO will be a hybrid of several specific types.

Further confusing this is the existence of integrated health care delivery systems (IDSs)\* that were created by providers in response to managed care. In the never-ending movement to render a taxonomy of MCOs, some of these types of IDSs even require licensure from the state if they accept risk for medical costs (eg, a “limited Knox-Keene” license in California) or from the federal government (eg, a provider-sponsored organization [PSO] contracting with Medicare on a financial risk basis and that does not already have state licensure). IDSs are briefly discussed later in this chapter.

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\*No reason that the *H* doesn’t get use in this acronym other than “IDS” rolls off the tongue better, but IDS is the term commonly used.

Some disagreement exists about whether the term *managed care* accurately describes the new generation of health care delivery and financing mechanisms. Those commentators who object to the term raise questions about what exactly it is that MCOs are managing. These commentators ask: Is the individual patient’s medical care being managed or is the organization simply managing the composition and reimbursement of the provider delivery system?

Observers who favor the term *managed care* believe that managing the provider delivery system can be equivalent in its outcomes to managing the medical care delivered to the patient. In contrast to historical methods of financing health care delivery in the United States, the current generation of financing mechanisms includes far more active management of both the delivery system through which care is provided and the medical care that is actually delivered to individual patients.

Perhaps the strongest reason that many in the industry have for not using the term *managed care* is the negative perceptions now associated with it. As managed care became the dominant model for health coverage in the United States during the 1990s, there was a strong public backlash against the restrictive features that were part of many managed care plans. The backlash, discussed in Chapter 1, may also have been driven to a certain extent by the change in focus as the large, old-line insurance companies entered the managed care market. Their focus shifted more heavily toward cost control and away from the old concepts of health maintenance, preventive care, and managing care by providing it in the most appropriate settings. In addition, many consumers were “forced” into managed care as the new managed care plans became the sole health benefit offering for many employers. American consumers value choice in most of their economic transactions, and health care is no exception.

Many health plans now simply call themselves that: health plans, or in the case of

the larger commercial companies, health insurance plans. Although the term *managed care* may not perfectly describe the current generation of financing and health care management vehicles, it continues to provide a convenient shorthand description for the range of alternatives to be discussed in this book and will therefore continue to be used.

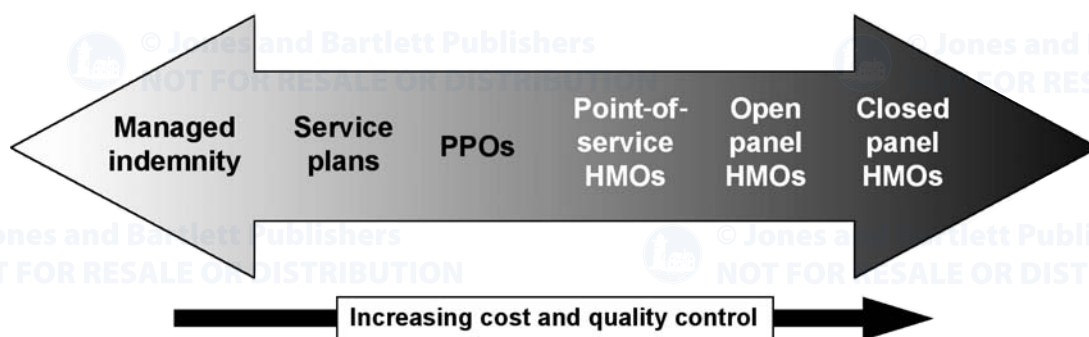
A simplistic but useful concept regarding managed care is the continuum illustrated in Figure 2-1. On one end of the continuum is managed indemnity with simple precertification of elective admissions and large case management of catastrophic cases, superimposed on a traditional indemnity insurance plan. Similar to indemnity is the service plan, which has contractual relationships with providers addressing maximum fee allowances, prohibiting balance billing, and using the same utilization management techniques as managed indemnity (the nearly universal examples of service plans are traditional Blue Cross and Blue Shield plans). Further along the continuum are PPOs, POS, open panel (both direct contract and individual practice association [IPA] type) HMOs, and finally closed panel (group and staff model) HMOs. As you progress from one end of the continuum to the other, you add new and greater elements of control and accountability, you tend to increase both the complexity and the overhead required to operate the plan, and you achieve greater potential control of cost and quality.

CDHPs, which combine a high-deductible insurance policy with a PPO network and a unique pre-tax “up-front” financing mechanism, do not fit neatly on this continuum, however. Because of that, as well as their continued highly rapid evolution, they are described later in the chapter, separate from the more traditional types of managed care plans.

This chapter provides a description of the different types of managed health care organizations and the common acronyms used to represent them. A brief explanation is provided for each type of organization. In addition, this chapter includes descriptions of the basic forms of HMOs—the original types of managed care organizations—and their relationships with physicians.

### TYPES OF MANAGED CARE ORGANIZATIONS

With the clear understanding that there are really no firm distinctions or boundaries between them, what follows is a discussion of the broad types of MCOs. Throughout this book, these types of MCOs may be referred to in such a way as to conform to what follows in this chapter; in other cases, a chapter author might simply throw in the towel and use the term *MCO* or *health plan* to cover the whole array of plan types. But distinctions between types of MCOs are not mere historic relics; there are differences that matter, and the terms themselves still enjoy wide usage (or misuse in some cases).



**Figure 2-1** Continuum of Managed Care



## Indemnity Insurance

Indemnity type of health insurance is simply that: It indemnifies the beneficiary from financial costs associated with health care. Indemnity insurance and service plans were the main type of health plan prior to the advent of managed health care, with notable exceptions as discussed in Chapter 1. Originally, few controls were in place to manage cost, and coverage was only for illness, not for wellness, preventive services (immunizations), or prescription drugs. The insurance company would also determine what the maximum appropriate charge should be for a procedure or professional visit, and that was all that was paid. A provider was then free to bill the beneficiary for anything not paid by the insurance company. In some cases, the insurance company paid the money directly to the beneficiary and the provider needed to then get paid by the beneficiary if it had not already collected its charges.

Rising health care costs hit indemnity insurance hard during the 1980s and early 1990s, and as managed care grew, indemnity insurance shrank. Indemnity insurance is now relatively rare, though not extinct. Where it does exist, it frequently has managed care approaches applied.

## Service Plans

Service plans, the majority of which (though not exclusively so) are Blue Cross and Blue Shield (BCBS) plans, are similar in their basics to indemnity insurance with a very important difference: the existence of a contracted provider network. This contracted network provides for several highly important elements that carry throughout managed care in general:

- The plan contracts directly with providers (physicians, hospitals, and so forth).
- Provider contracts specify that the plan will pay them directly, and they may only bill the patient (member) for coinsurance, copays, or deductibles.

- As long as a member (beneficiary) receives services from a contracted provider, the member is protected from balance billing; that is, a provider cannot bill the patient for charges denied by the plan (see chapter 30).
- The plan has a method of calculating what maximum fee will be paid for all procedures or provider visits as regards professional services.
- The plan has a method for determining appropriate payments to hospitals.

Unmanaged service plans were subject to the same pressures as indemnity insurance in regards to medical costs with the same result. The difference is that the service plan has not disappeared from the landscape to the same degree as indemnity insurance and is often a part of another type of offering. For example, a PPO offered by a Blue Cross Blue Shield plan provides a degree of network coverage even if the member does not go to a PPO-contracted provider.

## Managed Care Applied to Indemnity Insurance and Service Plans

The perceived success of HMOs and other types of managed care organizations in controlling the utilization and cost of health services prompted the development of managed care overlays that could be combined with traditional indemnity insurance, service plan insurance, or indemnity-like self-insurance (the term *indemnity insurance* is used to refer to all three forms of coverage in this context). These managed care overlays are intended to provide cost control for insured plans while retaining the individual's freedom of choice of provider and coverage for out-of-plan services. Though traditional indemnity insurance is now uncommon because of the high cost, it is still worthwhile understanding how these overlays are applied.

The following types of managed care overlays came into existence:

- *General utilization management.* These companies offer a complete menu of

utilization management activities that can be selected by individual employers or insurers. Some offer or can develop panels of participating providers within individual markets and bear strong resemblances to PPOs.

- *Specialty utilization management.* Firms that focus on utilization review for specialty services have become common. Behavioral health (see chapter 13) and dental care are two common types of specialty utilization management overlays.
- *Disease management.* Free-standing disease management companies or an insurer's internal program may focus on specific common and costly diseases (*eg*, diabetes) rather than on utilization more broadly. See Chapter 10 for a detailed discussion on disease management.
- *Catastrophic or large case management.* Some firms have developed to assist employers and insurers with managing catastrophic cases regardless of the specialty involved. This service includes screening to identify cases that will become catastrophic, negotiation of services and reimbursement with providers who can treat the patient's condition, development of a treatment protocol for the patient, and ongoing monitoring of the treatment. See chapter 11 for a detailed discussion of case management.
- *Workers' compensation utilization management.* In response to the rapid increases in the cost of workers' compensation insurance, firms have developed managed care overlays to address what they claim are the unique needs of patients covered under workers' compensation benefits. Workers' compensation insurance is actually property-casualty insurance, not health insurance. Nevertheless, managed care methods may be applied in some cases.

Many indemnity insurance companies have carried these concepts several steps farther along the continuum by transforming

themselves into MCOs through acquisitions of HMOs and other managed care companies. In fact, all of the major indemnity insurance companies that existed at the beginning of the 1990s have either sold their health insurance business lines to other companies or acquired major managed care companies. As noted in Chapter 1, as of 2006 four companies have become the largest MCOs in the country, surpassing the original managed care companies or free-standing HMOs in size and geographic coverage. One of those companies began its life in managed care, one company had its origins in the Blue Cross Blue Shield system of service plans, and two began as indemnity insurers. All four now operate in the same markets and offer similar types of services. At least in the case of these four large commercial companies, it is less an issue of blurring and more an issue of being able to offer almost all types of health plans, with plenty of hybridization.

### Preferred Provider Organizations

PPOs are entities through which employer health benefit plans and health insurance carriers contract to purchase health care services for covered beneficiaries from a selected network of participating providers. Typically, participating providers in PPOs agree to abide by utilization management and other procedures implemented by the PPO and agree to accept the PPO's reimbursement structure and payment levels. In return, PPOs may limit the size of their participating provider panels and provide incentives for their covered individuals to use participating providers instead of other providers. In contrast to traditional HMO coverage, individuals with PPO coverage are permitted to use non-PPO providers, although higher levels of coinsurance or deductibles routinely apply to services provided by these nonparticipating providers. PPOs can be broad or they can be specialty-only (*eg*, behavioral health, chiropractic, dental).

The key common characteristics of PPOs include the following:

- *Provider network.* PPOs typically establish a network by contracting with selected providers in a community to provide health services for covered individuals. Most PPOs contract directly with hospitals, physicians, and other diagnostic facilities. Providers can be selected to participate on the basis of their cost efficiency, community reputation, and scope of services. Some PPOs assemble massive databases of information about potential providers, including costs by diagnostic category, before they make their contracting decisions. As a practical matter, however, PPOs now rarely deliberately limit the size of their network but rather contract with any provider willing to accept the terms and conditions of the PPO contract (and who meet screening criteria as discussed in Chapter 5).
- *Negotiated payment rates.* Most PPO participation agreements require participating providers to accept the PPO's payments as payment in full for covered services (except for applicable copays, coinsurance, or deductibles). Although negotiating payment rates with physicians and other professional providers may take place, it is more common for the PPO simply to inform the physician of what payment rates will be, which the physician can either agree to and contract with the PPO, or not agree to in which case they do not become a PPO provider. PPOs attempt to negotiate payment rates with hospitals that provide them with a competitive cost advantage relative to charge-based payment systems. These payment rates usually take the form of discounts from charges, fixed fee schedules, all-inclusive per diem rates, or payments based on diagnosis-related groups. Some PPOs have established bundled pricing arrangements for certain services, including normal deliv-

ery, open-heart surgery, and some types of oncology.

- *Utilization management.* Many PPOs implement utilization management programs to control the utilization and cost of health services provided to their covered beneficiaries. In the more sophisticated PPOs, these utilization management programs resemble the programs operated by HMOs.
- *Consumer choice.* Unlike traditional HMOs, PPOs generally allow covered beneficiaries to use non-PPO providers instead of PPO providers when they need health services. Higher levels of beneficiary cost sharing, often in the form of higher copayments, typically are imposed when PPO beneficiaries use non-PPO providers.

PPOs may be owned by many different types of organizations, as illustrated in Table 2-1. Furthermore, a PPO may be operated solely for the benefit of its owner (*eg*, a PPO created by a Blue Cross Blue Shield plan that provides services only to BCBS members), or it may be so-called rental PPO that was formed to offer services to any health plan under an administrative fee agreement (which may be limited to an access fee alone, or may include fees for other activities such as UM, claims repricing, and so forth).

### Exclusive Provider Organizations

Exclusive provider organizations (EPOs) are similar to PPOs in their organization and purpose. Unlike PPOs, however, EPOs limit their beneficiaries to participating providers for any health care services. In other words, beneficiaries covered by an EPO are required to receive all their covered health care services from providers that participate with the EPO. The EPO generally does not cover services received from other providers, although there may be exceptions.

Some EPOs parallel HMOs in that they not only require exclusive use of the EPO provider

**Table 2-1** PPO Ownership Models—2004

Type of Owner	Number of Eligible Employees (millions)	Percentage of Eligible Employees	Number of PPOs
Employer/employer coalition	0.3	0.3	4
HMO	2.4	2.2	60
Hospital	0.3	0.3	6
Hospital alliance	5.0	4.7	55
Independent investor	43.6	40.4	59
Insurance company	51.7	47.9	415
Multiownership	2.0	1.9	34
Physician/hospital joint venture	1.4	1.3	15
Physician/medical group	0.5	0.5	7
Third-party administrator	0.6	0.6	6
Other	0.08	0.1	5
<b>Total</b>	<b>107.9</b>	<b>100%</b>	<b>666</b>

Source: Sanofi-Aventis Managed Care Digest Series. *HMO-PPO/Medicare-Medicaid Digest 2005*. Available at: <http://www.managedcaredigest.com>.

network but also use a gatekeeper approach to authorizing non-primary care services. In these cases, the primary difference between an HMO and an EPO is that the former is regulated under HMO laws and regulations, whereas the latter is regulated under insurance laws and regulations or the Employee Retirement Income Security Act (ERISA; see Chapter 31) in the case of self-funded plans. Most EPOs are actually offered by PPOs, not HMOs.

EPOs usually are implemented by employers whose primary motivation is cost saving. These employers are less concerned about the reaction of their employees to severe restrictions on the choice of health care provider and offer the EPO as a replacement for traditional indemnity health insurance coverage. Because of the severe restrictions on provider choice, only a few large employers have been willing to convert their entire health benefits programs to an EPO format. When EPOs originally surfaced as a form of health coverage, some

observers predicted that they were the wave of the future and would be adopted by many large employers. In reality, some of those who established EPOs have abandoned them in favor of insurance vehicles that offer more choice to beneficiaries. In any case, although the number of PPOs that offer an EPO option to employers has grown, the actual number of individuals enrolled in EPOs has been declining.

### Point-of-Service Plans

POS plans essentially combine an HMO or HMO-like health plan with indemnity (or service plan) coverage for care received outside of the HMO. Once touted as yet another wave of the future, they grew in the mid-1990s only to decline in popularity as their hoped-for cost savings failed to materialize. There are two ways in which POS plans were organized, depending on the vehicle to provide the HMO or HMO-like services.



### Primary Care Preferred Provider Organizations

These types of POS plans are hybrids of more traditional HMO and PPO models, though they are licensed as PPOs.

The following are characteristics of these types of plans:

- Primary care physicians may be reimbursed through capitation payments (*ie*, a fixed payment per member per month) or other performance-based reimbursement methods (see Chapters 6 and 8).
- There may be an amount withheld from physician compensation that is paid contingent upon achievement of utilization or cost targets. Some states restrict the ability of managed care organizations to establish withholds, and they have become less common over time.
- The primary care physician acts as a gatekeeper for referral and institutional medical services.
- The member retains some coverage for services rendered that either are not authorized by the primary care physician or are delivered by nonparticipating providers. Such coverage is typically significantly lower than coverage for authorized services delivered by participating providers is (*eg*, 100% compared to 60%).

### Point-of-Service Health Maintenance Organizations

As POS plans grew, some HMOs recognized that the major impediment to enrolling additional members and expanding market share was the reluctance of individuals to forfeit completely their ability to receive reimbursement for using nonparticipating providers. These individuals consider the possibility that they would need the services of a renowned specialist for a rare (and expensive to treat) disorder and believe that the HMO would not refer them for care or reimburse their expenses. This possibility, no matter how un-

likely, overshadows all the other benefits of HMO coverage in the minds of many individuals. It also precluded most employers from limiting health benefit choice to a single HMO.

A number of HMOs (and insurance carriers with both HMOs and indemnity operations) adopted a solution to this problem: They provide some level of indemnity-type coverage for their members. HMO members covered under these types of benefit plans may decide whether to use HMO benefits or indemnity-style benefits for each instance of care. In other words, the member is allowed to make a coverage choice at the *point of service* when medical care is needed.

The indemnity coverage available under point-of-service options from HMOs typically incorporates high deductibles and coinsurance to encourage members to use HMO services within network instead of out-of-plan services. Members who use the non-HMO benefit portion of the benefit plan may also be subject to utilization review (*eg*, preadmission certification and continued stay review).

### Health Maintenance Organizations

HMOs are organized health care systems that are responsible for both the financing and the delivery of a broad range of comprehensive health services to an enrolled population. The original definition of an HMO also included the aspect of financing health care for a prepaid fixed fee (hence the term *prepaid health plan*), but that portion of the definition is no longer absolute, although it is still common.

In many ways, an HMO can be viewed as a combination of a health insurer and a health care delivery management system. Whereas traditional health care insurance companies are responsible for reimbursing covered individuals for the cost of their health care, HMOs are responsible for providing or coordinating health care services to their covered members through affiliated providers who are reimbursed under various methods (see Chapters 6 and 7).

As a result of their responsibility for providing covered health services to their members, HMOs must ensure that their members have access to covered health care services. In addition, HMOs generally are responsible for ensuring the quality and appropriateness of the health services they provide to their members.

### **Health Maintenance Organization Models**

The commonly recognized models of HMOs are staff, group, network, independent (or individual) practice association (IPA), and direct contract. An additional model is the open access plan, which has characteristics of an HMO and a PPO. The major differences among these models pertain to the relationship between the HMO and its participating physicians. At one time, individual HMOs could be neatly categorized into a single model type for descriptive purposes. Currently, many (if not most) HMOs have different relationships with different groups of physicians. As a result, many HMOs cannot easily be classified as a single model type, although such plans are occasionally referred to as mixed models. The HMO model type descriptions now may be more appropriately used to describe an HMO's relationship with certain segments of its physicians.

The following paragraphs provide brief descriptions of the five traditional HMO model types, followed by a brief description of the open access model.

#### **Staff Model**

In a staff model HMO, the physicians who serve the HMO's covered beneficiaries are employed by the HMO. These physicians typically are paid on a salary basis and may also receive bonus or incentive payments that are based on their performance and productivity. Staff model HMOs must employ physicians in all the most common specialties to provide for the health care needs of their members. These HMOs often contract with selected subspecialists in the community for infrequently needed health services.

Staff model HMOs may also be known as closed panel HMOs because most participating physicians are employees of the HMO, and community physicians are unable to participate. There have been many well-known examples of staff model HMOs in the past, but most of them have since shed the physician components. Examples included Harvard-Pilgrim Health Plan (the physicians became an independent medical group that is no longer exclusive to Harvard-Pilgrim), Group Health Association of Washington, DC (no longer in existence), FHP (no longer in existence), and others. In most cases, these plans "spun off" the physician component as a private medical group, though initially subsidized by the HMO parent. The track records of these suddenly free-standing groups were not always good, and some of them are now gone. Those staff model HMOs that still exist are incorporating other types of physician relationships into their delivery system. And although insurance companies that dabbled in the creation of staff model systems (*eg*, Aetna's Healthways) have abandoned them, some integrated delivery systems still use a staff model approach (for example, in the Twin Cities).

Physicians in staff model HMOs usually practice in one or more centralized ambulatory care facilities. These facilities, which often resemble outpatient clinics, contain physician offices and ancillary support facilities (*eg*, laboratory and radiology) to support the health care needs of the HMO's beneficiaries. Staff model HMOs usually contract with hospitals and other inpatient facilities in the community to provide nonphysician services for their members.

Staff model HMOs have a theoretical advantage relative to other HMO models in managing health care delivery because they have a greater degree of control over the practice patterns of their physicians. As a result, it can be easier for staff model HMOs to manage and control the utilization of health services. They also offer the convenience of one-stop shopping for their members be-

cause the HMO's facilities tend to be full service (*ie*, they have laboratory, radiology, and other departments).

Offsetting this advantage are several disadvantages for staff model HMOs. First, staff model HMOs are usually more costly to develop and implement because of the small membership and the large fixed salary expenses the HMO must incur for staff physicians and support staff. Second, staff model HMOs provide a limited choice of participating physicians from which potential HMO members may select. Many potential members are reluctant to change from their current physician and find the idea of a clinic setting uncomfortable. Third, many staff model HMOs experienced productivity problems with their staff physicians, which raised their costs for providing care. For example, the former Group Health Association in Washington, DC was forced to sell itself to Humana and convert to a group model plan partially because of physician productivity concerns; eventually, Humana in turn sold its entire DC plan to Kaiser (a group model plan, not a staff model). Finally, it is expensive for staff model HMOs to expand their services into new areas because of the need to construct new ambulatory care facilities. These disadvantages have led to steadily eroding presence in the market to the point where they are only present in a few locations in the country.

#### **Group Model**

In pure group model HMOs, the HMO contracts with a multispecialty physician group practice to provide all physician services to the HMO's members. The physicians in the group practice are employed by the group practice and not by the HMO. In some cases, these physicians may be allowed to see both HMO patients and other patients, although their primary function may be to treat HMO members.

Physicians in a group practice share facilities, equipment, medical records, and support staff. The group may contract with the HMO on an all-inclusive capitation basis to

provide physician services to HMO members. Alternatively, the group may contract on a cost basis to provide its services, in which case it shares attributes of a staff model described earlier.

There are two broad categories of group model HMOs as described in the following subsections.

*Captive Group.* In the captive group model, the physician group practice exists solely to provide services to the HMO's beneficiaries. In most cases, the HMO formed the group practice to serve its members and recruited physicians and now provides administrative services to the group. The most prominent example of this type of HMO is the Kaiser Foundation Health Plan, where the Permanente Medical Groups provide all physician services for Kaiser's members. The Kaiser Foundation Health Plan, as the licensed HMO, is responsible for marketing the benefit plans, enrolling members, collecting premium payments, and performing other HMO functions. The Permanente Medical Groups are responsible for rendering physician services to Kaiser's members under an exclusive contractual relationship with Kaiser. Kaiser is sometimes mistakenly thought to be a staff model HMO because of the close relationship between it and the Permanente Medical Groups. Although not the only example, Kaiser is clearly the most robust, particularly in California.

*Independent Group.* In the independent group model HMO, the HMO contracts with an existing, independent, multispecialty physician group to provide physician services to its members. In some cases, the independent physician group is the sponsor or owner of the HMO. An example of the independent group model HMO is Geisinger Health Plan of Danville, Pennsylvania. The Geisinger Clinic, which is a large, multispecialty physician group practice, is the independent group associated with the Geisinger Health Plan (though the health plan also contracts with

independent physicians to ensure adequate coverage of its entire service area).

Typically, the physician group in an independent group model HMO continues to provide services to non-HMO patients while it participates in the HMO. Although the group may have an exclusive relationship with the HMO, this relationship usually does not prevent the group from engaging in non-HMO business. These types of group models may or may not also contract with other, independent physicians in the community to broaden the network for marketing reasons.

**Common Features of Group Models.** Both types of group model HMOs may also be referred to as closed panel HMOs because physicians must be members of the group practice to participate in the HMO; as a result, the HMO is considered closed to physicians who are not part of the group. This may not necessarily be the case if the HMO also contracts with community physicians, though that is most likely to occur when the medical group does not cover all parts of the service area.

Both types of group model HMOs share the advantages of staff model HMOs of making it somewhat easier to conduct utilization management because of the integration of physician practices and of providing broad services at its facilities. In addition, group practice HMOs may have lower capital needs than staff model HMOs do because the HMO itself does not have to support the large fixed salary costs associated with staff physicians. Related to that, group model HMOs often report very low administrative costs because some of the activities of the HMO (*eg*, care management) are done by the medical group and not the HMO and are therefore considered part of the medical expense, not an administrative expense.

Group model HMOs have several disadvantages in common with staff model HMOs. Like staff model HMOs, group model HMOs provide a limited choice of participating physicians from which potential HMO members can select. The limited physician panel can be a disadvantage in marketing the

HMO. The limited number of office locations for the participating medical groups may also restrict the geographic accessibility of physicians for the HMO's members. The lack of accessibility can make it difficult for the HMO to market its coverage to a wide geographic area. Finally, certain group practices may be perceived by some potential HMO members as offering an undesirable clinic setting. Offsetting this disadvantage may be the perception of high quality associated with many of the physician group practices that are affiliated with HMOs. These disadvantages become less of a problem if the medical group(s) are quite large as is the case with Kaiser Permanente in California.

### Network Model

In network model HMOs, the HMO contracts with more than one group practice to provide physician services to the HMO's members. These group practices may be broad-based, multispecialty groups, in which case the HMO resembles the group practice model described earlier. An example of this type of HMO is Health Insurance Plan (HIP) of Greater New York,\* which contracts with many multispecialty physician group practices in the New York area. Network models also predominate in California where there are a number of existing large medical groups, unlike most other parts of the country where groups tend to be smaller.

Alternatively, the HMO may contract with several small groups of primary care physicians (*ie*, family practice, internal medicine, pediatrics, and obstetrics/gynecology), in which case the HMO can be classified as a primary care network model. In the primary care network model, the HMO contracts with several groups consisting of 7 to 15 primary care physicians representing the specialties of family practice and/or internal medicine, pediatrics, and obstetrics/gynecology to provide

\*In 2006, HIP merged with Group Health Inc., a non-Blue Cross Blue Shield service plan, thus hybridizing the model to a significant degree.



physician services to its members. The HMO may compensate these groups on an all-inclusive physician capitation basis or on a partial capitation basis, but rarely on a fee-for-service basis (see Chapter 6). The group is responsible for providing all physician services to the HMO's members assigned to the group and may refer to other physicians as necessary. In the case of all-inclusive physician capitation, the group is financially responsible for reimbursing other physicians for any referrals it makes. In some cases, the HMO may negotiate participation arrangements with specialist physicians to make it easier for its primary care groups to manage their referrals.

In contrast to the staff and group model HMOs described previously, network models may be either closed or open panel plans. If the network model HMO is a closed panel plan, it will only contract with a limited number of existing group practices. If it is an open panel plan, participation in the group practices will be open to any physician who meets the HMO's and group's credentials criteria. In some cases, network model HMOs will assist independent primary care physicians with the formation of primary care groups for the sole purpose of participating in the HMO's network.

Network model HMOs address many of the disadvantages associated with staff and group model HMOs. In particular, the broader physician participation that is usually identified with network model HMOs helps overcome the marketing disadvantage associated with the closed panel staff and group model plans. Nevertheless, network model HMOs usually have more limited physician participation than either Independent Practice Association (IPA) model or direct contract model plans do if for no other reason than the fact that there are simply not that many large medical groups.

#### **Independent (or Individual) Practice Association Model**

Independent (or individual) practice association (IPA) model HMOs contract with an association of physicians—the IPA—to provide physician services to their members. The

physicians are members of the IPA, which is a separate legal entity, but they remain independent practitioners and retain their separate offices and identities. IPA physicians continue to see their non-HMO patients and maintain their own offices, medical records, and support staff. IPA model HMOs are open panel plans because participation is open to all community physicians who meet the HMO's and IPA's selection criteria.

Generally, IPAs attempt to recruit physicians from all specialties to participate in their plans. Broad participation of physicians allows the IPA to provide all necessary physician services through participating physicians and minimizes the need for IPA physicians to refer HMO members to nonparticipating physicians to obtain services. In addition, broad physician participation can help make the IPA model HMO more attractive to potential HMO members.

IPA model HMOs usually follow one of two different methods of establishing relationships with their IPAs. In the first method, the HMO contracts with an IPA that has been independently established by community physicians. These types of IPAs often have contracts with more than one HMO on a nonexclusive basis. In the second method, the HMO works with community physicians to create an IPA and to recruit physicians to participate in it. The HMO's contract with these types of IPAs is usually on an exclusive basis because of the HMO's leading role in forming the IPA.

IPAs may be formed as large community-wide entities where physicians can participate without regard to the hospital with which they are affiliated. Alternatively, IPAs may be hospital-based and formed so that only physicians from one or two hospitals are eligible to participate in the IPA.

Most, though not all HMOs, compensate their IPAs on an all-inclusive physician capitation basis to provide services to the HMO's members. The IPA then compensates its participating physicians on either a fee-for-service basis or a combination of fee-for-service and capitation. In the fee-for-service variation,

IPAs pay all their participating physicians on the basis of a fee schedule, and the IPA withholds a portion of each payment for incentive and risk-sharing purposes.

Under the primary care capitation approach, IPAs pay their participating primary care physicians on a capitation basis and pay their specialist physicians on the basis of a fee schedule. The IPA may withhold a portion of both the capitation and fee-for-service payments for risk-sharing and incentive purposes.

IPA model HMOs overcome the disadvantages associated with staff, group, and network model HMOs. They require less capital to establish and operate. In addition, they can provide a broad choice of participating physicians who practice in their private offices. As a result, IPA model HMOs offer marketing advantages in comparison to the staff and group model plans.

There are two major disadvantages of IPA model HMOs from the HMO's perspective. First, the development of an IPA creates an organized forum for physicians to negotiate as a group with the HMO. The organized forum of an IPA can help its physician members achieve some of the negotiating benefits of belonging to a group practice. Unlike the situation with a group practice, however, individual members of an IPA retain their ability to negotiate and contract directly with managed care plans. Because of their acceptance of combined risk through capitation payments, IPAs are generally immune from antitrust restrictions on group activities by physicians as long as they do not prevent or prohibit their member physicians from participating directly with an HMO.

Second, the process of utilization management can be more difficult in an IPA model HMO than it is in staff and group model plans because physicians remain individual practitioners with little sense of being a part of the HMO. As a result, IPA model HMOs may devote more administrative resources to managing inpatient and outpatient utilization than their staff and group model counterparts do. Notwithstanding this historical dis-

advantage, many IPA model HMOs have overcome the challenge and succeeded in managing utilization at least as well as their closed panel counterparts.

### Direct Contract Model

As the name implies, direct contract model HMOs contract directly with individual physicians to provide physician services to their members. With the exception of their direct contractual relationship with participating physicians, direct contract model HMOs are similar to IPA model plans. Direct contracting is the most common type of HMO model.

It is also common for this type of model also to be referred to as an IPA, despite the lack of the legal entity of an IPA. It is not the intent of this chapter, or this book, to proselytize purity of terminology. If individuals wish to refer to this as an IPA, that's their business. But the reader should be aware of the differences because the presence or absence of an actual IPA has an effect on the HMO and its management needs.

Direct contract model HMOs attempt to recruit broad panels of community physicians to provide physician services as participating providers. These HMOs usually recruit both primary care and specialist physicians and typically use a primary care case management approach (also known as a gatekeeper system).

Like IPA model plans, direct contract model HMOs compensate their physicians on either a fee-for-service basis or a primary care capitation basis. Primary care capitation historically was more commonly used by direct contract model HMOs because it helps limit the financial risk assumed by the HMO.\* Unlike IPA model HMOs, direct con-

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\*As is noted in Chapter 6, many health plans have moved away from primary care capitation in recent years. Although there are several reasons for this change, one of the most compelling reasons has been the need to get accurate encounter reporting from physicians for quality measurement purposes; fee-for-service reimbursement facilitates such reporting.

tract model HMOs retain most of the financial risk for providing physician services; IPA model plans transfer this risk to their IPAs.

Direct contract model HMOs have most of the same advantages as IPA model HMOs. In addition, direct model HMOs eliminate the potential of a physician bargaining unit by contracting directly with individual physicians. This contracting model reduces the possibility of mass termination of physician participation agreements.

Direct contract model HMOs have several disadvantages. First, the HMO may assume additional financial risk for physician services relative to an IPA model HMO, as noted earlier. This additional risk exposure can be expensive if primary care physicians generate excessive referrals to specialist physicians.

Second, it can be more difficult and time-consuming for a direct contract model HMO to recruit physicians and manage the network because it lacks the physician leadership inherent in an IPA model plan. It is more difficult for nonphysicians to recruit physicians, as several direct contract model HMOs discovered in their attempts to expand into new markets. This disadvantage is now primarily of historical interest only because there is little or no new HMO market expansion anymore.

Finally, utilization management may be more difficult in direct contract model HMOs because all contact with physicians is on an individual basis and there may be little incentive for physicians to participate in the utilization management programs.

#### **Mixed Model**

As the term describes, many HMOs or MCOs are actually mixes of different model types. It is far more common for closed panel types of MCOs to add open panel components to their health plan than the reverse, but there are examples of large open panel HMOs adding a staff model component through a contract with an IDS, for example.

#### **Open Access HMO**

The oxymoronic term *open access HMO* is an HMO that does not use a PCP or “gatekeeper”

approach to managing access and utilization. In other words, though licensed as an HMO, there is no requirement at all to go through a PCP to access a specialist. It is common for the copayment to be different (*ie*, lower to see a PCP, higher to see a specialist), and there may be other mild economic incentives to use PCPs preferentially, but it is not required.

In this regard, they bear some resemblance to PPOs, except that a PPO may not differentiate copayment or co-insurance based on specialty type, though many certainly do. Open access plans may also put the physicians at some level of financial risk for medical costs, as discussed in Chapter 6. Last, these types of plans reportedly depend heavily on their ability to create meaningful physician practice profiles to allow medical managers to focus on problem areas (see Chapter 16).

Open access HMOs are not as common as PCP-based HMOs. Many were created and then failed in the 1970s and 1980s. However, new ones appeared in the late 1990s and appear to be reasonably successful. It is fair to say that the environment that physicians practice in at the present is substantially different from that of 1980, but it is not clear if that is the reason these new open access plans appear to be succeeding. Nevertheless, by the early-2000s, most HMOs that were going to become open access had done so.

#### **Self-Insured and Experience-Rated Health Maintenance Organizations**

Historically, HMOs offered community-rated premiums to all employers and individuals who enrolled for HMO coverage. The federal HMO Act (no longer in force) originally mandated community rating for all HMOs that decided to pursue federal qualification. Many states had similar requirements.

Community rating was eventually expanded to include rating by class, where premium rates for an individual employer group could be adjusted prospectively on the basis

of demographic characteristics that were associated with utilization differences. Such characteristics often included the age and sex distributions of the employer's workforce and the standard industrial classification of the employer.

Although community rating by class provided HMOs with some flexibility to offer more attractive rates to selected employer groups, many employers continued to believe that their group-specific experience would be better than the rates offered by HMOs. Some HMOs developed self-insured or experience-rated options in response to the needs expressed by these employers.

Under a typical self-insured benefit option, an HMO receives a fixed monthly payment to cover administrative services (and profit) and variable payments that are based on the actual or incurred expenses made by the HMO for health services. There is usually a settlement process at the end of a specified period, during which a final payment is calculated (either to the HMO by the employer or to the employer by the HMO). Variations in the payment arrangement exist and are similar in structure to the different forms of self-funded insurance programs.

Under experience-rated benefit options, an HMO receives monthly premium payments much as it would under traditional premium-based plans. There typically is a settlement process where the employer is credited with some portion (or all) of the actual utilization and cost of its group to arrive at a final premium rate. Refunds or additional payments are then calculated and made to the appropriate party.

The HMO regulations of some states preclude HMOs from offering self-insured or experience-rated benefit plans. HMOs avoid these prohibitions by incorporating related corporate entities that use the HMO's negotiated provider agreements, management systems, utilization protocols, and personnel to service the self-insured line of business.

Rating methodologies are discussed in Chapter 25.

## CONSUMER-DIRECTED HEALTH PLANS

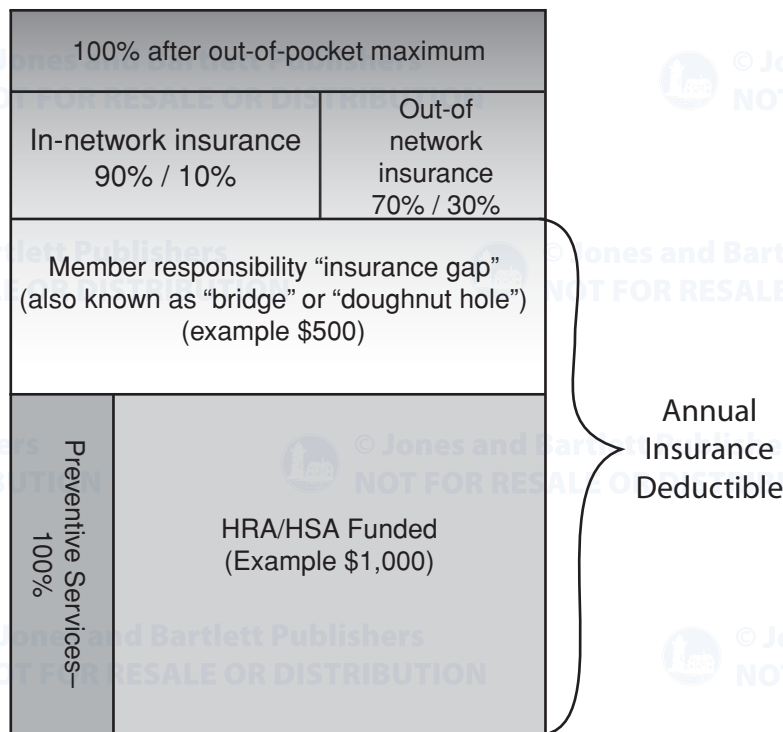
CDHPs combine a high-deductible insurance plan with some form of pre-tax savings account. They are often associated with a PPO network as well. At its most basic, health care costs are paid first from the pre-tax account and when that is exhausted, any additional costs up to the deductible are paid out-of-pocket by the member (this gap is sometimes referred to as a bridge or, less charitably, as a doughnut hole). Preventive services are usually covered outside of this system, however. The definition of preventive services is not uniform among plan sponsors. Any funds left over in the savings account may roll over to be used in following years as needed.

There are two basic forms of CDHPs: commercial CDHPs that use Health Reimbursement Accounts (HRAs) and plans associated with Health Savings Accounts (HSAs). HSAs were created as part of the Medicare Modernization Act and are a more rigid form of CDHP in how they are constructed, with guidance provided by the Treasury Department (because the HSA is funded with pre-tax dollars), including such definitions as what constitutes preventive care. Commercial CDHPs and their associated HRAs are also subject to Treasury Department regulation, but that applies only to the HRA itself, while the plan design is otherwise more flexible, subject to state insurance regulations or, in the case of self-funded business under ERISA (see Chapter 31), the Labor Department. As a practical matter, the differences are not especially important to understanding the basics of CDHPs for purposes of this overview.

An example of a simplistic schematic of a CDHP is illustrated in Figure 2-2.

CDHPs are not considered managed health care plans by some who consider them as more akin to simpler indemnity-type insurance plans from the past. This is because of the presence of a high-deductible health insurance policy as the primary product, with





**Figure 2–2** Example of Basic Construct of a CDHP

new benefits in the form of preventive services combined with new pre-tax funding mechanisms for at least a portion of the costs. Furthermore, one of the primary tenets behind CDHPs is that the consumer has become shielded by traditional managed care plans as to how much health really costs; in other words, consumers have come to believe that an office visit really only costs \$10 or that a sophisticated diagnostic test only costs \$20. The CDHP is therefore constructed to make cost a factor in consumer decision making through the use of both the pre-tax fund and the bridge, with the CDHP providing information to consumers to help them make decisions based on cost and quality of services. Because consumerism and aspects of CDHPs are discussed in greater detail in Chapter 20, the method of providing that information will not be discussed here.

CDHPs have not entirely shed all aspects of managed health care, however. Most are associated with a PPO to provide the value of the negotiated discount to the consumer. From the provider viewpoint, this is a mixed blessing at best because providers may find that it is difficult to collect all of the money owed to them when they must bill the member directly. Integrating the functions of the HRAs or HSAs through debit cards, and even finding ways of providing a credit facility so as to improve the provider's ability to collect what it is due, is a major focus of effort at the time of publication and is discussed further in Chapter 20.

Simply integrating with an existing PPO is the most common but not the only aspect of managed care that CDHPs retain. Integration of medical management into the new plan designs remains an evolving aspect as well, particularly with CDHPs offered by the larger

and more established companies. Disease management (DM; see Chapter 10) and case management (CM; see Chapter 11) are most frequently applied because a small proportion of the population accounts for a disproportionately high percentage of medical costs. In those cases, medical costs can quickly move past the pre-tax fund and the bridge and trigger the high-deductible insurance, where focus on managing chronic disease is exactly the same as it is for any other type of managed health care plan. Having said that, how a CDHP applies DM in the early stages of a chronic disease, when costs are still applicable to the pre-tax fund and the bridge, is still evolving.

### **INTEGRATED HEALTH CARE DELIVERY SYSTEMS\***

There are myriad types of IDSs, and some of the more common forms are discussed briefly in this chapter. At the very least, an IDS represents providers coming together in some type of legal structure for purposes of managing health care and contracting with health plans such as HMOs, PPOs, or health insurance companies. The IPA as discussed earlier is an IDS, and some IDSs combine different types of providers as well. The common denominator, however, is the physician; many types of organizations can exist in health care for purposes of managing health care and contracting with health plans that do not involve physicians (*eg*, a multifacility hospital system with affiliated ancillary services), but unless there is a significant physician component (specifically, physicians other than the paid hospital staff), it would not be considered an IDS.

\*Portions of this section were adapted from Chapter 4: "Integrated Health Care Delivery Systems," by Peter R. Kongstvedt, David W. Plocher, and Jean Stanford. *The Managed Health Care Handbook*, 4th ed. New York, NY: Aspen Publishers, 2000.

Although neither this chapter nor this book focus on creating and operating an IDS, it is worthwhile to have at least a passing acquaintance with them. The most common IDSs are briefly described as follows.

### **Independent Practice Association**

IPAs have been discussed earlier and that discussion will not be repeated here.

### **Physician Practice Management Companies**

Physician practice management companies (PPMCs) arrived on the integration scene in the mid-1990s. PPMCs may in some ways be viewed as variants in management services organizations, but unlike the MSO, PPMCs are physician only. In other words, there is no involvement by the hospital. PPMCs were usually publicly traded companies as well, placing great pressure on the need to report positive earnings.

Most major PPMCs have failed—either going through bankruptcy or exiting the business altogether, though a few do remain in existence. Several reasons contributed to their failure. One common problem was decreased productivity because the PPMCs purchased physician practices only to find that once the physician had "cashed out" his or her practice, there was no longer sufficient incentive for the physician to be highly productive. PPMCs also found that there was in fact little profit margin to be had in practices in which the primary cost was for compensation, despite small improvements in practice overhead costs as a result of economies of scale. Last, many PPMCs entered into full-risk capitation arrangements with HMOs and found themselves unable to manage them profitably. Since the failures of the late 1990s, there has been little PPMC activity other than some specialty PPMCs that are part of an approach to highly specialized care management (*eg*, pediatric intensive care).

### Group Practice Without Walls

The group practice without walls (GPWW), also known as the clinic without walls, is a step toward greater integration of physician services. The GPWW does not require the participation of a hospital and, indeed, is often formed as a vehicle for physicians to organize without being dependent on a hospital for services or support. In some cases, GPWW formation has occurred to leverage negotiating strength not only with MCOs but with hospitals as well.

The GPWW is composed of private practice physicians who agree to aggregate their practices into a single legal entity, but the physicians continue to practice medicine in their independent locations. In other words, the physicians appear to be independent from the view of their patients, but from the view of a contracting entity (usually an MCO) they are a single group. This is differentiated from the for-profit, physician-only MSOs described later by two salient features: first, the GPWW is owned solely by the member physicians and not by any outside investors, and second, the GPWW is a legal merging of all assets of the physicians' practices rather than the acquisition of only the tangible assets (as is often the case in an MSO).

To be considered a medical group, the physicians must have their personal income affected by the performance of the group as a whole. Although an IPA will place a defined portion of a physician's income at risk (that portion related to the managed care contract held by the IPA), the group's income from any source has an effect on the physician's income and on profit sharing in the group; that being said, it is common in this model for an individual physician's income to be affected most by individual productivity.

The GPWW is owned by the member physicians, and governance is by the physicians. The GPWW may contract with an outside organization to provide business support services. Office support services are generally provided through the group, although as

a practical matter the practicing physicians may notice little difference in what they are used to receiving.

The GPWW model continues to exist in markets with a sufficient amount of full-risk capitation or other strongly managed health care. Full-risk capitation may still represent a significant amount of revenue in such markets, but even when capitation is for the direct services only, the GPWW can potentially achieve enhanced revenues through pay-for-performance programs which will be discussed further in Chapter 8. Outside of such markets, however, the GPWW model is much less common.

### Physician-Hospital Organizations

The physician-hospital organization (PHO) is an entity that, at a minimum, allows a hospital and its physicians to negotiate with third-party payers. PHOs may do little more than provide for such a negotiating vehicle, although this could raise the risk of antitrust. PHOs may actively manage the relationship between the providers and MCOs, or they may provide more services, to the point where they may more aptly be considered MSOs (see discussion later).

PHOs often formed as a reaction to market forces from managed care. PHOs are considered the easiest type of vertically integrated system to develop (although they are not actually that easy, at least if done well). They also are a vehicle to provide some integration while preserving the independence and autonomy of the physicians.

By definition, a PHO requires the participation of a hospital and at least some portion of the admitting physicians. In the mid-1990s, PHOs were formed primarily as a defense mechanism to deal with an increase in managed care contracting activity. Even then, it was not uncommon for the same physicians who join the PHO already to be under contract with one or more managed care plans. Since then, fewer PHOs were created, though existing ones continue to operate.

In its weakest form, the PHO is considered a messenger model. This means that the PHO analyzes the terms and conditions offered by an MCO and transmits its analysis and the contract to each physician, who then decides on an individual basis whether to participate.

In its simplest and more common version, the participating physicians and the hospital develop model contract terms and reimbursement levels and use those terms to negotiate with MCOs. The PHO usually has a limited amount of time to negotiate the contract successfully (eg, 90 days). If that time limit passes, then the participating physicians are free to contract directly with the MCO; if the PHO successfully reaches an agreement with the MCO, then the physicians agree to be bound by those terms. The contract is still between the physician and the MCO and between the hospital and the MCO. In some cases, the contract between the physicians and the MCO is relatively brief and may reference a contract between the PHO and the MCO.

The reader should note that the “PO” portion of a PHO may be a different model entirely. As an example, a GPWW or an IPA could represent the physician portion of the PHO, although most commonly the physicians remain independent and contract individually with the PHO.

One final note concerning PHOs and other types of physician organizations: the Federal Trade Commission (FTC) has toughened its scrutiny of such organizations during the last few years. Physician organizations that are not paid on a capitation basis, and that do not accept substantial financial risk through some other mechanism, now find it much more difficult to operate within the FTC’s antitrust safety zone. Although it is beyond the scope of this introductory chapter, those interested in physician organizations are urged to consult with competent antitrust counsel during the formation and operational stages.\*

\*Interested readers may also want to review the full FTC’s opinion in the *Matter of North Texas Specialty Physicians* and other resources on this recent case.

### Management Services Organizations

An MSO represents the evolution of the PHO into an entity that provides more services to the physicians. Not only does the MSO provide a vehicle for negotiating with MCOs, but it also provides additional services to support the physicians’ practices. The physician, however, usually remains an independent private practitioner. The MSO is based around one or more hospitals.

In its simplest form, the MSO operates as a service bureau, providing basic practice support services to member physicians. These services include such activities as billing and collection, administrative support in certain areas, electronic data interchange (such as electronic billing), and other services. Recently, existing MSOs are being considered as excellent vehicles to provide the electronic backbone for the electronic medical record and other forms of electronic connectivity (see Chapter 17).

The physician can remain an independent practitioner, under no legal obligation to use the services of the hospital on an exclusive basis. The MSO must receive compensation from the physician at fair market value, or the hospital and physician could incur legal problems. The MSO should, through economies of scale as well as good management, be able to provide those services at a reasonable rate.

An MSO may also be considerably broader in scope. In addition to providing all the services described earlier, the MSO may actually purchase many of the assets of the physician’s practice; for example, the MSO may purchase the physician’s office space or office equipment (at fair market value). The MSO can employ the office support staff of the physician as well. MSOs can further incorporate functions such as quality management, utilization management (UM), provider relations, member services, and even claims processing in those markets where there is significant full-risk capitation. This form of MSO is usually constructed as a unique business entity, separate from a PHO.



The MSO does not always have direct contracts with health plans for two reasons: many plans insist on having the provider be the contracting agent, and many states will not allow health plans (especially HMOs) to have contracts with any entity that does not have the power to bind the provider. The physician may remain an independent private practitioner under no contractual obligation to use the hospital on an exclusive basis.

### Foundation Model

A foundation model IDS is one in which a hospital creates a not-for-profit foundation and actually purchases physicians' practices (both tangible and intangible assets) and puts those practices into the foundation. This model usually occurs when, for some legal reason (*eg*, the hospital is a not-for-profit entity that cannot own a for-profit subsidiary, or there is a state law against the corporate practice of medicine), the hospital cannot employ the physicians directly or use hospital funds to purchase the practices directly. It must be noted that to qualify for and maintain its not-for-profit status, the foundation must prove that it provides substantial community benefit.

A second form of foundation model does not involve a hospital. In that model, the foundation is an entity that exists on its own and contracts for services with a medical group and a hospital. On a historical note, in the early days of HMOs many open panel types of plans that were not formed as IPAs were formed as foundations; the foundation held the HMO license and contracted with one or more IPAs and hospitals for services.

The foundation itself is governed by a board that is not dominated by either the hospital or the physicians (in fact, physicians may represent no more than 20% of the board) and includes lay members. The foundation owns and manages the practices, but the physicians become members of a medical group that, in turn, has an exclusive contract for services with the foundation; in

other words, the foundation is the only source of revenue to the medical group. The physicians have contracts with the medical group that are long term and contain non-compete clauses.

Although the physicians are in an independent group, and the foundation is also independent from the hospital, the relationship in fact is close among all members of the triad. The medical group, however, retains a significant measure of autonomy regarding its own business affairs, and the foundation has no control over certain aspects, such as individual physician compensation.

### Provider-Sponsored Organization

*Provider-sponsored organization (PSO)* is a term used to describe a cooperative venture of a group of providers who control an integrated provider system engaged in *both* delivery and financing of health care services. PSOs were part of the federal Balanced Budget Act of 1997 and were created so as to allow provider organizations to contract directly with Medicare on an at-risk basis for all medical services, bypassing existing Medicare HMOs (called Medicare+Choice at that time, and Medicare Advantage now) entirely. Though PSO activity was focused on the Medicare population, it could theoretically have expanded to include commercial and Medicaid initiatives as well. As a grand experiment, however, it failed miserably.

Providers found to their detriment that taking on full risk for the health care costs of the elderly involved more than taking the money and providing the services. In other words, "cutting out the middleman" in the form of bypassing experienced Medicare HMOs was a fast route to deep financial losses. Medical costs were made up of more than the services delivered by members of the PSO; considerable expense was also associated with care delivered by non-PSO providers, medical technology costs, and so forth. Furthermore, many PSOs tried to maintain existing fee-for-service reimbursement or otherwise failed to spread the financial risk sufficiently.

Last, PSOs found it difficult in many cases to practice the type of care management that was required to keep costs under control because the providers themselves rebelled at such constraints.

The failure of so many PSOs when they were first introduced meant that they essentially disappeared from the managed care landscape. Medicare still has provisions for how PSOs may accept risk for Medicare members, and it is possible that there may be a cautious reappearance of them, particularly in light of the new acuity-based premium payment being implemented (see Chapter 26).

### CONCLUSION

Managed care is on a continuum, with a number of plan types offering an array of features that vary in their abilities to balance access to care, cost, quality control, benefit design, and flexibility, and the rise

and, evolution of integrated health care delivery systems has paralleled the industry. During the last two decades, managed care has gone from being a relatively small part of the health care system synonymous with “alternative delivery system” to being a mainstream manner in which employer-insured individuals obtain their care. Managed care organizations will continue to evolve, with features from one type of plan appearing in others and new features continually being developed. As consolidation in the marketplace continues, it will blur the lines further. The recent appearance of new designs such as consumer-directed health plans makes taxonomy an even greater challenge than it was before. And although there is no one single definition of the term *managed care* that has endured in the past or will survive into the future, the basic tenets of managed health care will continue to evolve in pace with market demands and requirements.