Managed Care Primer

HealthExec Learning

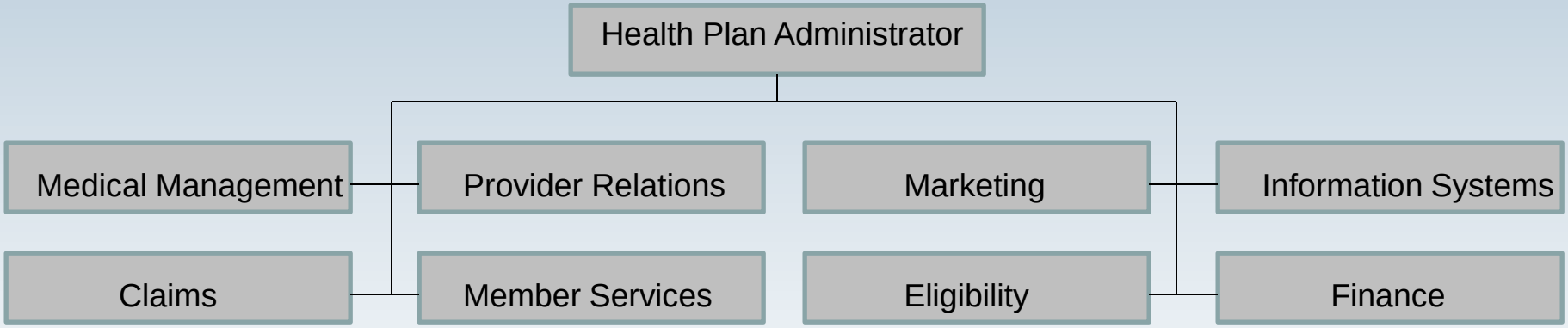
What is Managed Care?

- Managed care includes a variety of approaches in active coordination and arrangement of the provision of health services and coverage of health benefits.
- Types of Managed Care Organizations (***MCOs***) include Health Maintenance Organizations (***HMOs***) and Preferred Provider Organizations (***PPOs***.)
- Managed care usually involves three key things: coordination of the medical care delivered; contractual relationships and organization of the providers giving care; and coverage of benefits tied to managed care rules.

Calculating capitation rates

Capitation based on total pay		
Desired Payment Per Month	$10,000	:Payments
Members to serve each month	952	:Divided by
Capitation Rate	$10.50	:Equals
Capitation based on utilization		
Visits per Member each month	0.25	:Visits
Desired payment per visit	$42.00	:Multiplied by
Capitation Rate	$10.50	:Equals

Health Plans



Note: Health Plans sometimes will contract with third party ***BPO (Business Process Outsourcing)*** organizations to perform various components of applicable functions listed above.

No Surprises Act

The No Surprises Act and accompanying Final Rule, addresses "surprise bills" to consumers typically not covered by insurance, for out-of-network providers that bill at their retail rates instead of the plan's established payment rates (referred to as "balance billing"), often for services that the patient had no control over requesting, such non-participating hospital-based physicians (anesthesiologists, pathologists, etc.) practicing at a participating hospital.

Effective in 2022, the Act prohibits Balance Billing in defined situations and sets forth: methodologies for patient cost-sharing responsibility and provider payment, requirements and limitations of the law's notice and consent exception, and standards for required provider and facility disclosures. The Act also mandates provider data accuracy requirements for plan provider directories.

Selected Key Indicators

Indicator	Calculation	Purpose
Revenue PMPM ($XXX.XX)	Revenue/ Member Months	Measures revenue performance
Medical Loss Ratio (%)	Medical Expenses/Rev.	Measures medical expense performance
Adm Expense Ratio (%)	Administrative Expenses/Rev.	Measures administrative cost performance
Days per 1,000 (XXX)	(Annual Inpatient days/Annualized members)*1,000	Measures inpatient utilization performance (per 1,000 members)

Value Based Payment Models

The following previously discussed models can be incorporated for value based payments:

- ***Pay for Performance –*** P4P incentive payments or withholds involving quality metrics.
- ***Accountable Care Organizations***: ACO care delivery and payment methodologies involve value based approaches.
- ***Medical Homes***: Medical Home care delivery and payment methodologies also typically involve value based approaches.
- ***Bundled Payments***: quality metrics factored into calculation of the bundled payment.
- ***Incentive Based FFS Payments*** – enhanced or reduced FFS payments based upon quality metrics.
- ***Risk Sharing Distributions*** – Shared Savings or Losses, or even full risk distributions based upon quality metrics.

Sample Consumer Driven Plan Design

<table>
<tr><td colspan="2">First Dollar Coverage Preventive Care Benefit</td><td rowspan="2">High Deductible Health Plan Coverage (PPO or HMO)
with percentage coinsurance or copays after deductible is met</td></tr>
<tr><td colspan="2">Deductible (HSA High Deductibles Health Plans must have at least $1,400 / $2,800 deductibles for 2022)</td></tr>
<tr><td>Employer Funded HSA or HRA</td><td>Gap
(that employee must pay out of pocket before deductible is met) or Employee FSA funded</td><td></td></tr>
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