Economics of Health and Healthcare
Prof. Deep Mukherjee
Department of Economic Sciences
Indian Institute of Technology - Kanpur
Prof. Angan Sengupta
Department of Management, Amirtha Vishwa Vidyapeetham, Bangalore

Lecture - 33
Managed Care Organizations

Hello everyone. A very popular health care system which comes out of United States is managed care organizations.

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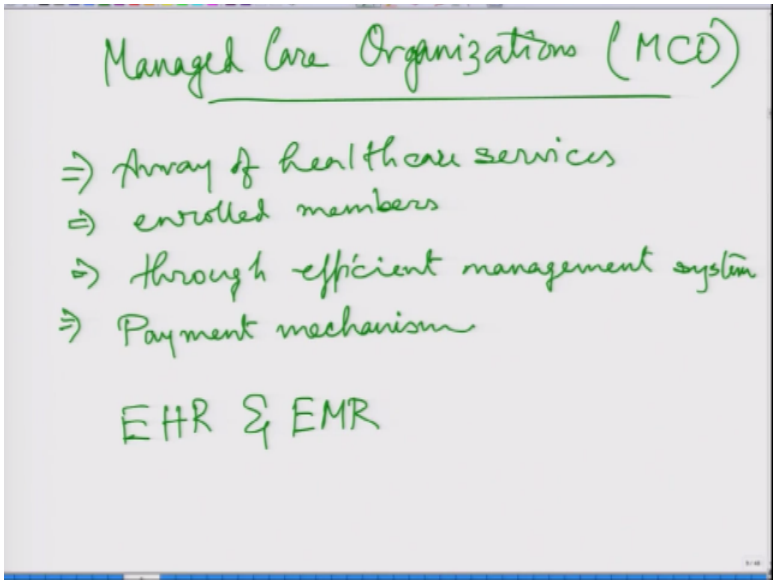

In short, it is MCO. In this lecture or in this session, we will learn about this managed care organizations, we will learn about the underwriters as well as we learn about the reinsurance. So the first part of the session will cover this managed care organizations or MCO. MCO is kind of an array of services; it is an umbrella under which you know it covers all kinds of separate tentacles of this healthcare system.

It has under its domain the hospitals, the clinics, the doctors, the pharmaceuticals, the diagnostic centers, the pathological centers, even the health insurance companies you know. So everything is under a particular system and with this array so I will mention it as an array of healthcare services which is only provided to the enrolled members. So you have to enroll yourself, get a registration card or registration number through efficient management services.

Now in TPA, we have learned that TPA are basically you know supposed to improve the efficiency of management services, reduce the time, reduce the cost, increase awareness flow or information flow. Similarly, the managed care organizations are also intended to make this entire healthcare system or health service delivery points together under the same umbrella where there is lesser information asymmetry, lesser uncertainty.

It is more connected; all the stakeholders are more connected to each other, better data flow and all this so through efficient management system and the fourth is that the payment mechanism. It varies you know from across different kinds of MCOs the payment mechanism varies but at the same time you know these payment mechanisms are also designed in a way so that we are you know again efficiently managing that when we learned about the pricing of our healthcare service delivery.

We also learn that because of the multiple products because of several choices because of the several parts of a healthcare service process, there is ambiguity, it is so complex, so difficult to measure you know convincing pricing mechanism. Hence, if everything is together managed by a particular organization you know these kinds of pricing mechanism are often better taken care of.

So this payment mechanism is also very unique what they try to target in MCOs. So it does not basically change the services, the service providers, the insurance companies, the pathologists, our diagnostic centers provide to the patients, so the service remains same but the management you know the referral, the time, the information flow, everything is smooth and with this introduction of electronic health record, electronic medical record.

In short, they are known as EHR and EMR that is health IT you know introduction of information technology in these healthcare operations. With this EHR and EMR, so now you go to a corporate hospital you will be given a number and taking that number not only in corporate hospitals. Even if you are a registered under a particular scheme you are given a particular number.

A government public health insurance scheme or any particular scheme you know CGHS, ESIS you have a particular number, enrollment number and with that enrollment number now everything being in the soft copy everything being in the system, so you know your

information is reaching at no time basically across different service provider not only across the service provider when we are sitting in India providing service you know as BPO or KPO, you are providing service to the US healthcare market.

Then based on the same number we are getting, we are accessing the information of the patients who are sitting there. Some doctors are sitting here, some doctors are sitting there in US and then we are trying to connect a network you know. So now again having everybody under the same umbrella, under the same domain of course have helped. Now there are basically two types of MCOs who of course the objective is cost minimization through efficient management practices.

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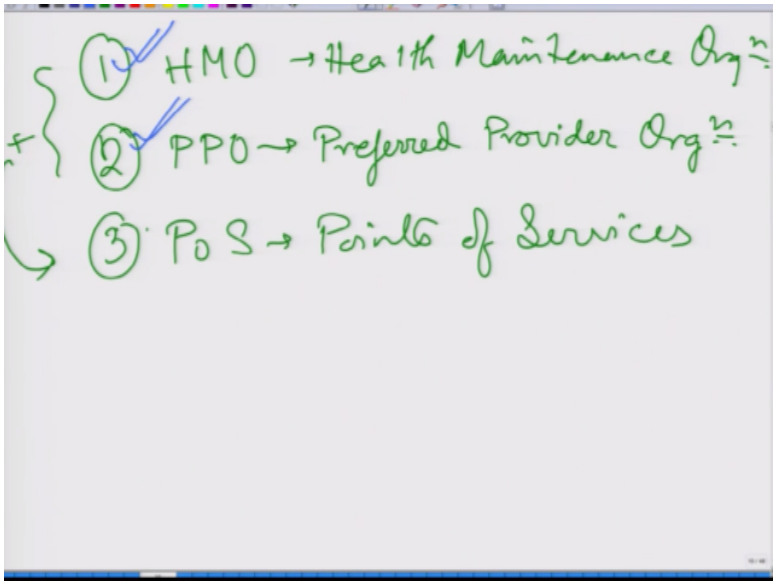

The two MCOs are one the most prominent one is HMO, health maintenance organizations HMO and two is PPO preferred provider organization. So HMO and PPO, there is another one which is said POS points of service which is basically an amalgamation of these two you know some from HMO, some from PPO is featured in points of services. So these are the 3 basic MCO system what we find in USA and the most two prominent one are HMO and PPO.

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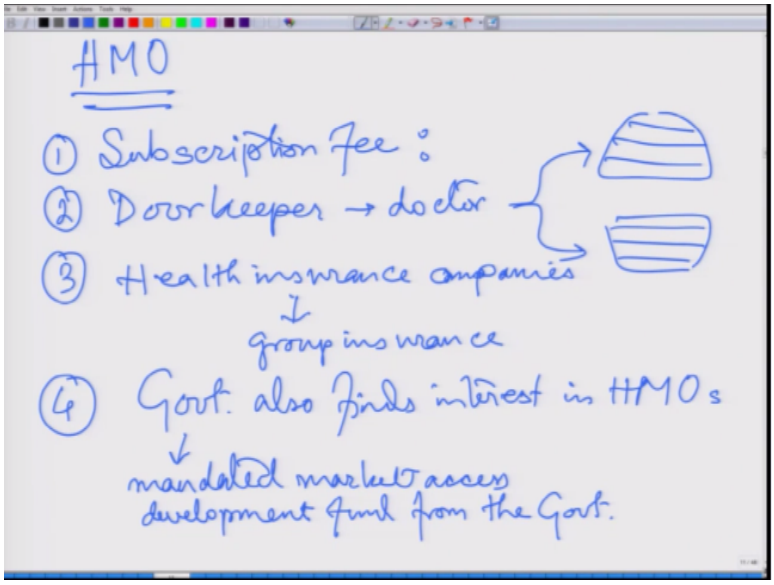

So a registered HMO, so if we are now talking about HMO health maintenance organization that any registered person with an HMO will you know against a subscription fee against the payment of a subscription fee which is often yearly they avail some services you know and they allow the members the HMO members to access the data sorry access the employed providers.

What they do if I pay the subscription fee? I can avail the group of healthcare providers who are registered or impaneled under the HMO but in HMO one thing is little you know unique that or what is characteristics of an HMO is I cannot actually select my own practitioner so what happens there is always a doorkeeper who is a doctor of course who is a doctor and I need to approach my doorkeeper doctor and he or she will suggest me which way my you know treatment will go.

So then there are several impaneled doctors right and she can or he can refer me that based on my health problems they can refer me that which will be those impaneled doctors I can consult with. So after subscription fee, I can access those doctors and then I do not have to make any payment to them. After I make a subscription fee, I go to those doctors, I avail any diagnostic system these are free.

You know even a sort of insurance if it is a part of insurance because you have made a payment already, you know these are free and after a certain while maybe that depends maybe you will be charged but that depends. So over here this health insurance companies

because they get the money from us, these HMOs are not health insurance companies, they just collect the money as a subscription fee.

And then they connect the health insurance companies to ensure these patients. Yes, they connect these health insurance companies. Now what these health insurance companies do? They are now getting a group insurance because an HMO has a pool of patients or a pool of even if they are not patient right every I can go register myself under HMO even if I am not ill right that is the funda.

So the health insurance companies now will be allured because there is a group insurance you know and it is kind of a mix of population, so there is no cherry picking either. So therefore the government also finds interest in HMO and what they do interest in HMO and they find that HMOs are really doing a good job towards the society.

And so what HMO gets from government is one they have a mandated market access and number two they receive a development fund from the government and then the information share of course because the data that HMOs have they share it with the government and government can use them the data for the research or to improve their you know database. So this is all about HMO.

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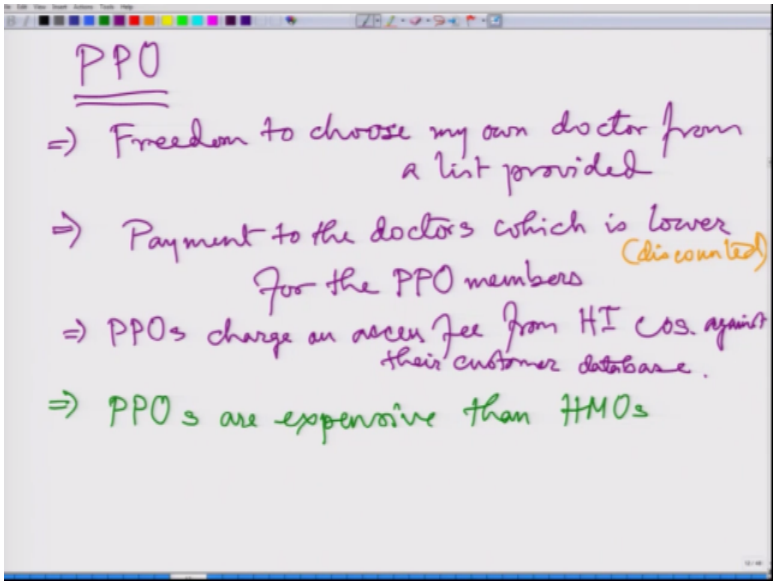

When we talk about PPO which is preferred provider organization PPO, the name suggests that as in HMO I have to always go through a doorkeeper, in PPO I can directly you know once I register with a PPO I have a list of doctors and I can choose my doctor based on the

proximity based on the ratings in the internet, Google it and then find okay this is the best doctor so I will go to him or her.

So they can choose it and then the doctor of course have to be under this PPO mechanism. So here I have a freedom to choose my own doctor from a list provided yeah provided by the PPO. Over here the subscription fee is low but how the payment mechanism works is that I still need to make a payment to the doctors which is lower for the PPO members, lower means discounted.

For the PPO members, this rate is discounted. So the PPO members enjoy a discounted rate so because they have already been big because we have paid some amount of money to avail this you know we can see in terms of if you are aware of this Club Mahindra they have a group of hotels, they provide services, the transportation services you know several other services in terms of a vacation.

They plan the vacation all this, so similarly these HMOs and PPOs are also kind of you pay a subscription fee and then for Club Mahindra is basically a kind of a HMO in terms of tourism industry but under same thing at the same time this HMO and PPO works towards the reduction of cost but if we compare between the HMO and PPO the cost is higher for PPO as compared to HMOs.

So PPOs are expensive than HMOs because in HMO you are not paying anything literally after you know get that registration card with HMOs so but in PPO every time you go for a treatment you need to pay and it is increasing if you have to go for a multiple times and for every service delivery you have to pay. So what happens is that the rest of the money the doctors get from the PPOs and PPOs pay the doctors out of what, the PPO members have paid as a registration fee, so that is how it works you know.

So but eventually PPO themselves earn money from by charging an access fee to the insurance company and also little bit from us or from the patients and why they charge them the access fee because you know what they get from us is lower as compared to HMOs, so they have to make some money and also they may have a nexus with the doctors.

But again because HMO gives kind of a free access to the healthcare organizations and they come for the group insurance. Here also the HMOs give access to the health insurance organizations to get a group insurance, here also is the same thing but PPOs charge the access fee for the database of the population of course for their customers from this health insurance company.

So I will keep it like PPOs charge an access fee from health insurance companies against their customer database yes and the services you know now points of services are basically the amalgamation of you know a combination of HMOs and PPOs like they charge, they do not have a subscription fee as such, so under POS we also need to pay the doctor again a discounted fee.

But at the same time in POS they have you know the gatekeeper or doorkeeper or gatekeeper doctor through which I can get access to the various other doctors anyways.

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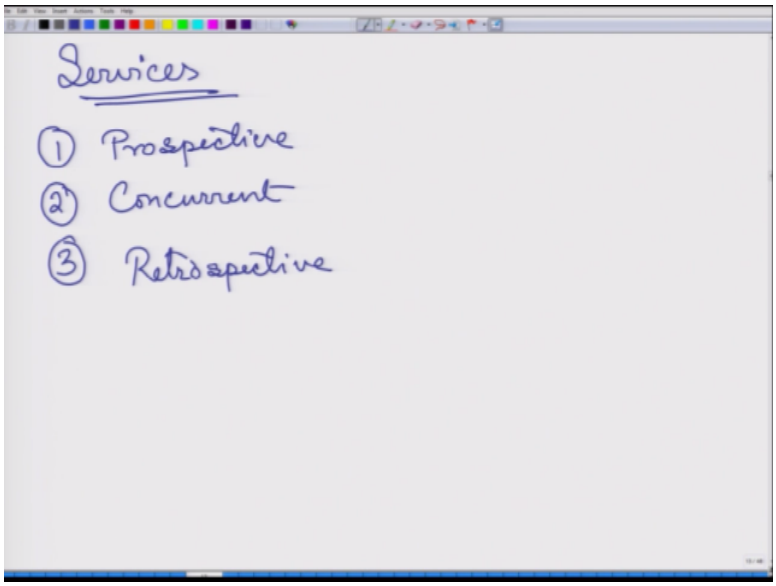

The services what I get from these managed care organizations are number 1 is prospective services, number 2 concurrent services, number 3 retrospective services. Now what is prospective, concurrent and retrospective?

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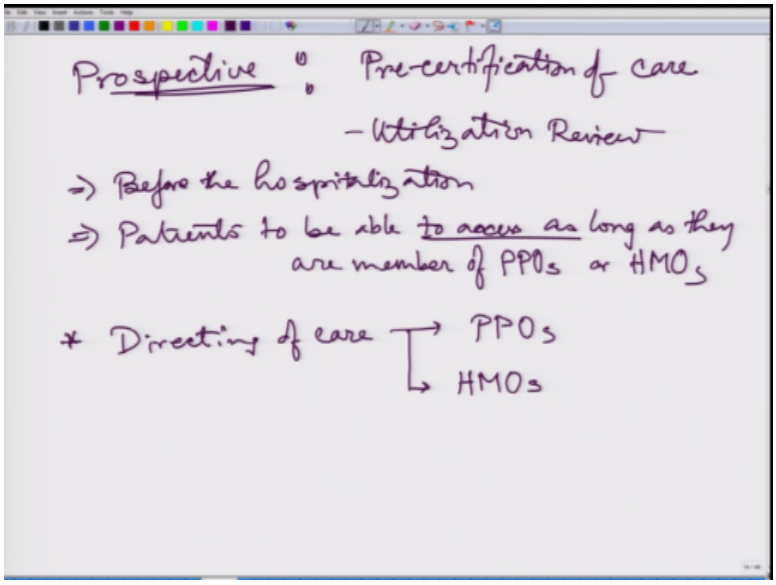

The prospective services are those which talk about first the pre-certification of a particular case that whether you know a particular case will get insurance or not, it is a kind of utilization review. So I will keep it like of care for a particular case and it is done by the utilization review. This utilization review is done before the patient is accessing the healthcare system that is the hospital or something or the treatment process before the treatment process starts.

So the utilization review is like my background checking, my experience rating or something like that. So the utilization review starts before the hospitalization or starting of the medical care and patients to be able to access as long as they are member of PPOs or HMOs, access the healthcare yeah, so that it is also under pre-certification or utilization review.

It is also checked that for how long the patient has been under this particular scheme, how long they can avail the treatment, what are the facilities they have availed and you know and all this. So this is the prospective you know before the treatment starts and then you know there will be one personnel attached for a particular case who will look at the direction of the care, so directing of care.

So which way it will good like say a particular gatekeeper or particular doctor who suggests that okay you go to this particular doctor or you go to that particular doctor and then the referral starts working, you go to diagnostic, you go for this checkup, you go for some other doctor. So you know this entire networking is required to be managed well, so the entire process flow of their treatment.

And this is generally done by a designated person for a particular case. So this directing of the care starts just when the prospective services starts you know so that after that based on this pre certification or the utilization review the doctors decide that in which way this treatment process will move. The next is that there is a difference in case of direction of care, one is it is like for PPOs and the other is for HMOs.

So how it works for PPOs are very different than how it works for HMOs. We have learned that right. PPOs, the patients choose their own preferred doctors. In HMOs, it is generally referred or recommended.

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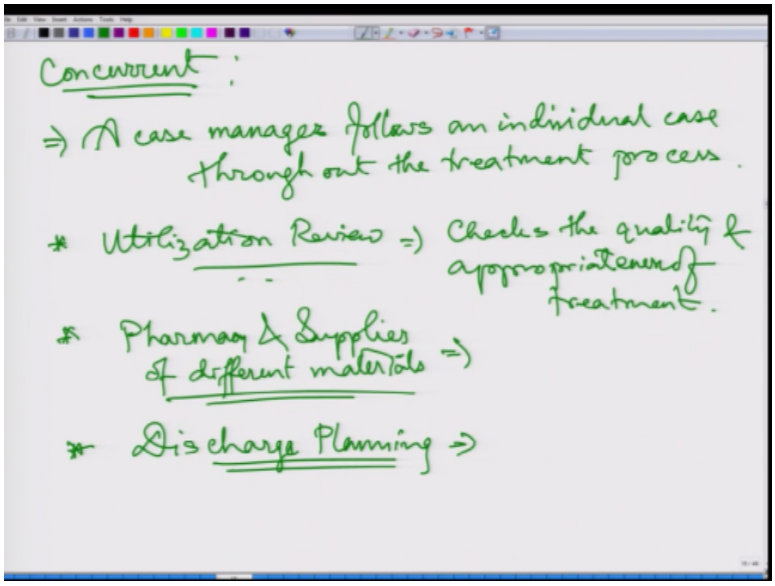

In case of concurrent as the name suggests, in case of concurrent it is like a case manager that particular manager you know a case manager will look at the case follows an individual case throughout the treatment process yeah. So and now the treatment has started, so once the treatment has started after this utilization review you know and the pre-certification, the case manager takes up and then takes the case up and then look what has been recommended and how is it being followed.

And then the first thing again under a concurrent mechanism of MCO is utilization review that checks the appropriateness and the quality of the care, appropriateness of the treatment yes. The next thing is pharmacy and supply materials and supply of different materials you know mostly pharmacists. So this means that what has been recommended, what kind of medications have been recommended, which kind of apparatus have been recommended.

And whether it is being you know excess is being brought or you know there is a shortage or if there is an anomaly whether you know during the process if there is any shortage or if something was required the previous day and it has not been there. So this pharmacy and other supplies you know the other commodities management is also done by this case manager and then the third is discharge planning.

So once this treatment is at the last stage and you know the patient is supposed to be discharged then you know the discharge planning starts and then they will give the patient a discharge summary over where it will be written that what the patient is supposed to do, what kind of medications they are supposed to follow, before preparing the discharge summary they will look that what had been recommended.

Everything had been followed during their 5 days, 7 days, 1 day, 3 days stay under the treatment process and whether you know the patient is okay to be discharged because everything cannot be done by if in the case of a surgery the surgeon cannot do in case of a particular treatment process where a senior doctor is doing, senior consultant is doing it is not always possible to you know follow that by that senior consultant.

So it is then this case manager speech in and you know do a fantastic job with their medical knowledge.

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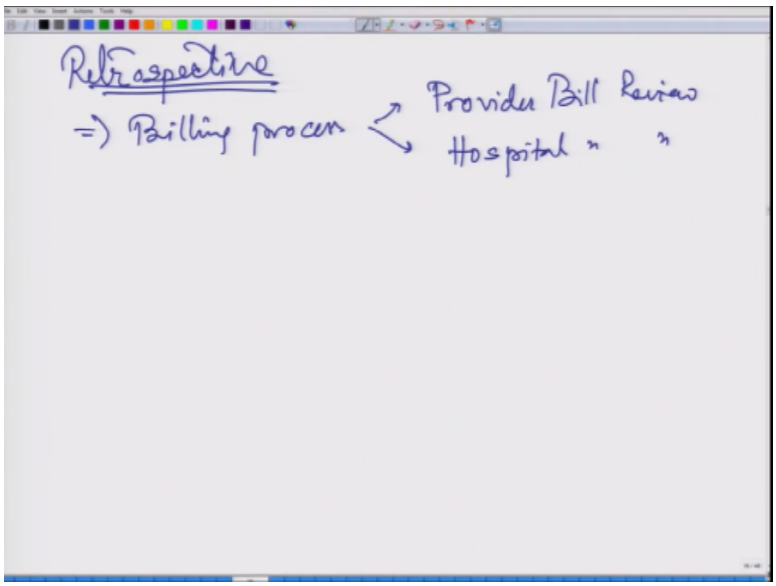

And then the final one is retrospective. In retrospective, it is basically where the billing process starts and in billing process we generally have two parts, one is provider bill review and another one is hospital bill review. Provider bill review is generally you know generally the services rendered by the diagnostics centers, by the pharmaceuticals, if the physiotherapists are coming from outside.

So these are the external services you know which had been provided by the healthcare provider if not directly by the hospital you know, so that is the provider bill review, if that is provided by the hospital because in MCOs all these components are separate but are connected together. So the hospital can be a separate entity and these you know these diagnostic centers they are separate.

You know they may not be under hospital, so their bill will be separate, hospital bill will be separate and the combined bill will be prepared. So the provider bill review are those reviews, their bills like say diagnostic center, pharmaceuticals and all these things where a hospital bill review are generally by the hospitals you know the salary or the consultant remuneration.

And if they decide to mention that how much for this you know customary fees, the worker's compensation and all this you know and how much are paid for the rooms, for a particular service provided, a customary service provided, so all these are done under this hospital bill review. So therefore when we do this retrospective service, we are generally you know looking at this billing because billing is the most you know common error under billing in a hospital scenario.

The most common errors which appear is under billing, there can be you know the miscalculations causing losses to the hospital finally in every way or causing losses to the patients. If it is causing losses to the patient, the patient will you know give a bad reputation or will carry a bad reputation about the hospital and then they will never come back or will give a very bad feedback.

So the hospital is finally at the receiving end, so the and the billing errors are not really intended for and that is where this retrospective operations are done, retrospective services are done by that you know case manager under an MCO, HMO or PPO. Thank you.