Health Maintenance Organization (HMO)

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Agenda

- **Objectives**
- **Topics**
- **Concepts**

Objectives

- **After completing this module, you will be able to learn:**
  - **Define HMO.**
  - **Identify the general characteristics of HMOs.**
  - **Describe the general characteristics of HMOs.**
  - **Differentiate between a closed-panel HMO and an open-panel HMO**
  - **Distinguish among the various HMO models in terms of provider relationships and compensation arrangements**

Topics

C	Health Maintenance Organization (HMO)
1	HMO – General Characteristics
2	Prerequisites for hospitals to participate in network
3	UM Techniques of HMOs
4	Importance of Criteria used to select & evaluate HMOs
5	Comprehensive Set of Healthcare Benefits
6	Types of HMO Models
7	Difference Between Closed & Open Panel HMOs
8	HMO Models

HMO

- **Definition : A healthcare system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area, usually in return for a fixed, prepaid fee.**
- **Requisites To Form a HMO –**

1. To be organized as corporation rather than partnership or other legal entity.

2. HMOs must be licensed in the states in which they are incorporated.

3. HMOs must comply with statutory requirements for HMOs in each state in which they conduct business.

4. Certificate Of Authority (COA) - The license issued by a state to an HMO or insurance company which allows it to conduct business in that state.

HMO – General Characteristics

- **To be federally qualified, an HMO could not exclude pre-existing conditions and had to offer the following services:**
  - **Healthcare delivery in a geographic service area**

    a. Accessibility to healthcare services

    b. An HMO determines the number of primary care and specialty care physicians needed in its provider network in part by examining the size and location of the geographic service area, network adequacy, the medical needs of its members, and employer or other purchaser requirements, including provider education, board certification, and work history.
  - **Both basic and supplemental healthcare services**

    a. Govt. may force HMOs to give certain basic benefits to meet licensing requirements.
  - **Voluntary membership to an enrolled population**

Prerequisites for hospitals to participate in network

- **Typical minimum requirements for a hospital to participate as a network provider :**

  A. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

  B. Verification of the existence of a state license

- **Ways of managing physician utilization by HMO :**

  1. Capitation

  2. Risk Pools

  3. Physician Practice Guidelines

- **Quality Management Techniques of HMOs :**

  Credentialing, Recredentialing and peer review for PCPs and specialists, accreditation standards for hospitals and ancillary services providers, and overall plan accreditation standards.

Utilization management techniques of HMOs

- **Utilization management techniques that most HMOs use for hospital providers include:**

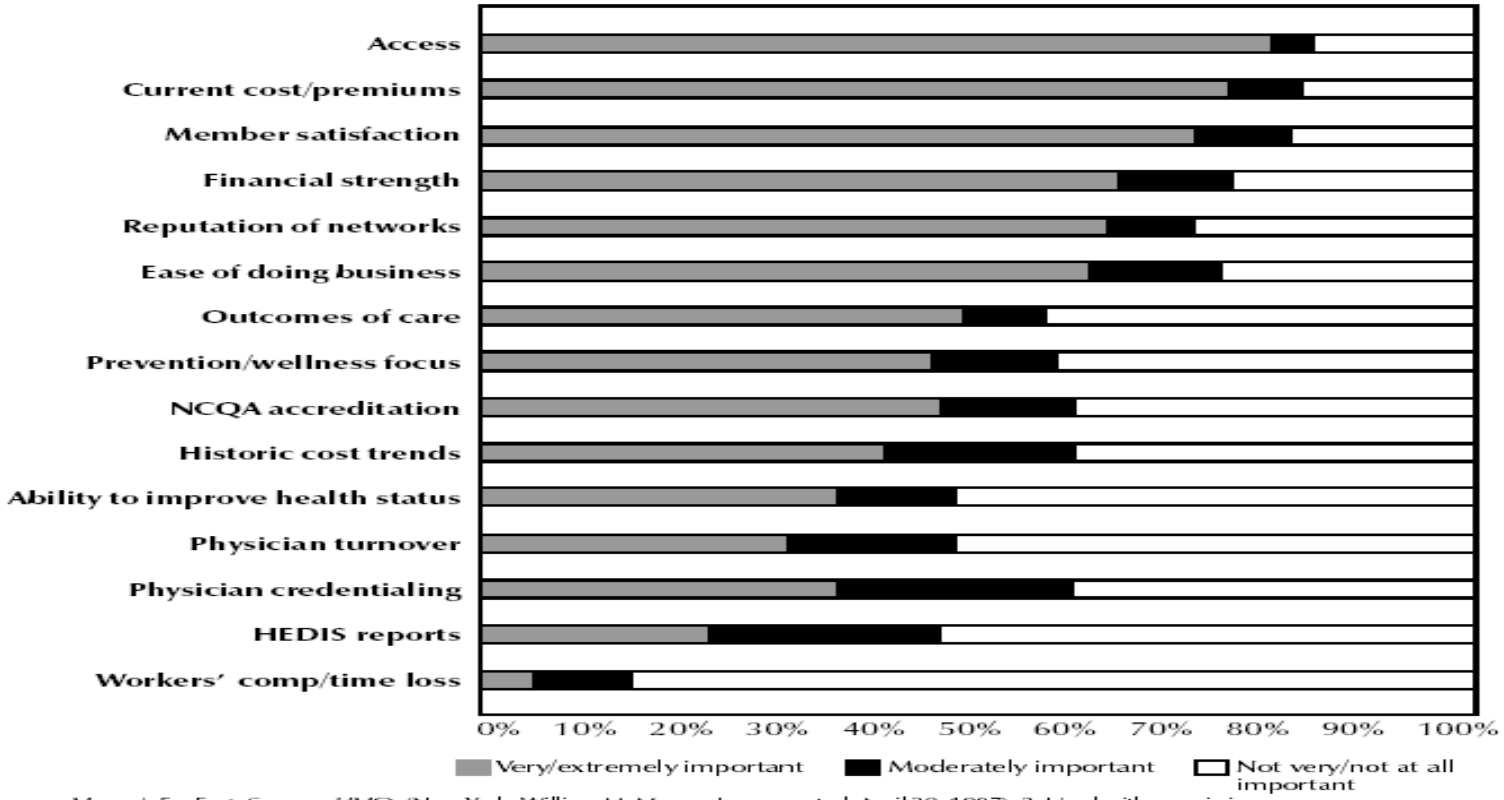
1. **inpatient utilization review**
2. **concurrent and retrospective reviews of admissions**
3. **precertification for inpatient hospitalization**
4. **discharge planning**
5. **case management**

- **Pre-certification- Also known as preadmission certification, preadmission review, and precert .The process of obtaining authorization from a health plan.**

Importance of Criteria used to select & evaluate HMOs

Figure 3A-1. Importance of Criteria Used to Select and Evaluate HMOs.

Respondents were asked to rate the importance of various criteria in selecting and evaluating HMOs, using a scale of 1 (not at all important/not used) to 5 (extremely important). Access/geographic coverage is the highest rated, with 86% of respondents rating it extremely or very important.



Source: *Mercer's Fax Facts Surveys: HMOs* (New York: William M. Mercer, Incorporated, April 30, 1997): 3. Used with permission.

Comprehensive Set of Healthcare Benefits

- **By offering a comprehensive set of healthcare benefits to its members, an HMO ensures that its members obtain quality, cost-effective, and appropriate medical care.**
- **Ways that an HMO provides comprehensive care include -**

1. coordinating care across a variety of benefits

2. emphasizing preventive care by covering many preventive services either in full or with a small copayment

3. offering its members access to wellness programs

Types of HMO Models

- **Closed-panel HMO - An HMO whose physicians are either HMO employees or belong to a group of physicians that contract with the HMO.**
- **Closed access - A provision which specifies that plan members must obtain medical services only from network providers through a primary care physician to receive benefits.**
- **Open-panel HMO - An HMO in which any physician who meets the HMO's standards of care may contract with the HMO as a provider. These physicians typically operate out of their own offices and see other patients as well as HMO members.**
- **Open access - A provision that specifies that plan members may self-refer to a specialist, either in network or out-of-network, at full benefit or at a reduced benefit, without first obtaining a referral from a primary care provider.**

Difference Between Closed & Open Panel HMOs

Figure 3B-1. Closed-Panel HMOs and Open-Panel HMOs.

Closed-Panel HMOs	Open-Panel HMOs
■ Providers must be HMO employees or be affiliated with a group that has a contract with an HMO to join the HMO network.	■ Providers contract independently and may be selected to join the HMO network as long as they meet HMO qualification standards.
■ Providers operate out of HMO facilities or those operated by the group practice that contracts with an HMO.	■ Providers operate out of their own offices.
■ Providers generally see only HMO members.	■ Providers see both HMO members and non-members.
■ Members select a PCP from the HMO network.	■ Members select a PCP from the HMO network.
■ Members obtain referrals from the PCP because services are covered only if specialists are also in the HMO network.	■ Members in a few cases may self-refer to specialists inside or outside the network without going through the PCP first (out-of-network services may have reduced benefits, however).

HMO Models

Model	Description
IPA Model	Contract is with one or more associations of physicians in independent practice who agree to provide medical services to plan Members.
	Often contract with several parties, including individual PCPs, specialists, and multi-specialty groups.
	The IPA's member physicians become part of the HMO's provider network. Member physicians, who agree to adhere to the IPA/HMO contractual requirements, remain independent practitioners who manage their own offices and medical records and usually see other patients besides HMO members.
Variation	Direct Contract Model HMO - *the HMO contracts directly with individual* physicians who provide medical services to HMO members. Unlike the IPA model HMO, in a direct contract model, there is no IPA or other legal entity that represents and negotiates contracts for a large number of physicians.
Structure	Could be Closed or Open panel
Compensation	Usually Discount FFS (Specialists)or capitation(PCPs)

HMO Models - Continue

Model	Description
Staff Model	The contractual arrangement between the physicians and the HMO is an exclusive one because physicians cannot participate in the HMO unless they become HMO employees.
	Participating physicians provide medical services only to HMO members. The HMO must therefore employ enough PCPs and specialists to meet the needs of its members.
	A staff model HMO may also contract separately with sub-specialists who may occasionally receive referrals from PCPs.
	Most physicians practice in ambulatory care facilities (ACF)
	The risk of providing medical care to HMO members rests primarily with the HMO.
Structure	Closed panel
Compensation	Salary
Disadvantage	A staff model HMO is usually more time-consuming and expensive to establish and maintain because of the capital costs needed to build facilities and because of the large fixed expense of physician salaries. Adding medical services or expanding to new service areas is also capital intensive, thus limiting a staff model HMO's competitive ability in a changing health plan market.

HMO Models - Continue

Model	Description
Group Model	Contracts with a multi-specialty group of physicians who are employees of the group practice.
	The group practice may be formed as a corporation, partnership, professional association, or other legal entity.
	The physicians in the group practice generally share office space, support staff, medical records, and medical equipment at a common medical center or clinic.
	Physicians are employees of the group practice, in which they may also have an equity (ownership) interest.)
	Captive Group Model or Independent Group Model
Structure	Could be Closed panel or Open panel
Compensation	Negotiated capitation rate to the group practice, which in turn compensates physicians in the group practice. The group practice determines physician salaries and accompanying incentive payments according to a physician's performance, area of expertise, and the amount of administrative work he or she must perform.
Disadvantage	May be limited by the geographic location of the group practice. May also have differing quality in the variety of facilities offered by its group practice. Limited member access in captive group model

HMO Models - Continue

Model	Description
Network Model	HMO contracts with more than one group practice of physicians or specialty groups. (multiple group practices)
	A network model HMO is in effect an extension of a group model HMO in that the network model HMO contracts with multiple group practices, rather than one group practice.
	An HMO establishes a network model to provide a wide range of physician services in a geographic service area
Structure	Could be Closed panel or Open panel
Compensation	usually compensate group practices on a capitation basis.

Questions?

Thank You!