CHAPTER EIGHT

MANAGED CARE FOR EMERGENCY MEDICAL SERVICES

Managed care organizations (MCOs) are making a dramatic change in the way in which emergency medical service agencies operate and receive payment for services. This section is an introduction to some basic concepts of revenue generation and cost recovery within a managed care environment. Revenue generation and cost recovery in managed care environments can be a very complicated and diverse process for emergency medical service agencies, and should be investigated fully by an agency as a means to secure funding. The concepts are constantly changing, so agencies should ensure that they have the most current information when dealing in managed care environments.

BACKGROUND

The principles of managed care are spreading rapidly out of a necessity to create a competitive health care market. The intrinsic factors behind the recent health care reform are rooted in the the basic principles of managed care:

1. moving from a focus on illness to a focus on wellness;
2. shifting from discrete payments for services to for individuals to a pre-paid, population-based payment system; and
3. making quality a strategic initiative.

The focus of these principles is to encourage patients, providers and payees to agree on the best method to achieve cost and quality goals, members' satisfaction and desired profit levels. This is creating an incentive for managed health care organizations to find the most economical and efficient combinations of health care services that can be delivered to their enrolled populations.

WHAT IS MANAGED CARE?

Managed care organizations provide for both the delivery and the financing of health care for their members (enrollees.) These organizations take a variety of forms in how they deliver that care and how they finance services. In addition, MCOs are evolving, with the boundaries between older forms of service delivery becoming blurred and with new forms taking shape. If present trends continue, managed care will become the predominant system for the delivery of health care in the United States. The driving force behind this growth is the belief that health care costs can be controlled by "managing" how health care is delivered. This will mean changing the planning philosophy from "being prepared for anything and everything" to focusing on the most likely occurrences and being prepared to deal with them effectively and efficiently.

Gatekeepers

All managed care organizations build on the foundation of the primary care provider. The term primary care provider generally means a family practitioner, general internist or general pediatrician, however, it can also refer to an obstetrical/gynecological (OB/GYN) physician or a non-physician provider, such as a nurse practitioner, physician's assistant or midwife. This provider has the burden of limiting health care expenditures by limiting access to other providers of health care. Some have used the term "gatekeeper" to describe this func-

tion. Limiting referrals to specialists and decreasing admissions to hospitals are the major means to control access to care. Incentives for primary care providers to comply vary, depending on the type of MCO, and may include bonuses or payment of fees that have been withheld.

Types of Managed Care Plans

Health Maintenance Organization (HMO)

In classic enrollment insurance, the enrollee pays a premium to the health insurer, for which the health insurer contracts to pay for the health care that is delivered. In contrast, HMOs not only contract to pay for the health care of enrollees, but also to deliver the care to them. There are several models of HMOs. The primary differences between each type of HMO are the methods in which the HMO relates to its participating physicians. Payment most often, but not necessarily, takes the form of a "capitation fee." With capitation, the organization receives a monthly, pre-paid, fixed fee for each covered individual or family. For that fee, the HMO agrees to provide the services for which the contract calls. The organization attempts to provide those services to the individual at a cost lower than the fee paid. Thus, the incentives in HMO practices differ markedly from the incentives in fee-for-service practices. In a pre-paid capitation system, the provider profits by delivering less costly and less total services and by minimizing referrals to other providers, since the provider retains more of the pre-paid fee by doing so. In a fee-for-service system, more money can be made by providing more services, and no financial risk accrues to the organizations or to the individual physician by asking others to provide services since classic indemnity insurance will pay for them. The HMO hopes to persuade people to insure with them by offering similar health care services at a lower price, and by controlling those costs by having their providers manage care.

Preferred Provider Organization (PPO)

In preferred provider organizations, the organization contracts to provide health services for a set fee through the use of selected physicians. The physicians agree to the fee structure of the PPO in return for the PPO providing them with patients. These fees are generally lower than the physicians charge their non-PPO patients, but the physicians are willing to accept the discounted rate because the increased volume will maintain or increase their revenue. In addition, physicians in PPOs usually incur no financial risk. Patients in PPOs are allowed to use providers outside the PPO, but must pay extra to do so. Physicians, in order to belong to the PPO, agree to abide by utilization management agreements. Therefore, should participating physicians wish to refer a patient to a specialist, they must first receive permission for the referral, and then refer to a specialist with whom the PPO has an existing agreement. If participating physicians wish to admit a patient to a hospital, prior permission from the PPO must be obtained. Without these authorizations, the PPO will not pay for the service. Unlike HMOs, in PPOs the patient can choose a non-PPO option but must pay extra to do so. The financial burden is placed on the patient rather than on the physician or the organization.

Point-of-Service Plans (POS)

Point-of-service plans combine features of classic HMOs with some of the characteristics of patient choice found in PPOs. Similar to the HMO model, the physician is paid through a capitation or other risk based model. Similar to the PPO model, a member of a point-of-service plan can choose to use a non-plan provider by paying extra. Costs are kept down by asking the patient to pay more or by making the provider act as a "gatekeeper," and enforced by placing a financial risk on the provider.

EMERGENCY MEDICAL SERVICES AND MANAGED CARE ORGANIZATIONS

Capitation Versus Fee-For-Service

According to the American Ambulance Association (AAA) in 1998, "capitation will become the dominant form of payment in American health care delivery within the next five years." Emergency medical service agencies, or agencies providing EMS, should understand the concept of capitation and how it could apply.

Advantages and Disadvantages

Capitation occurs when insurers or HMOs pay a fixed amount to a health care organization. This fixed amount is computed per member, per month (PMPM). In other words, if Anytown Emergency Medical Services Department has 23 members within a given HMO, the HMO will pay the organization a fixed amount for each of the 23 members per month. This payment does not change based on the amount of services a health care organization provides. Were all 23 HMO members to use the Anytown EMS Department in one month, there would be no difference in their payment from the HMO, and likewise, were no HMO members to use the department's services in another month, the payment would remain the same.

Under capitated contracts, EMS agencies must strive to provide the amount of care and services medically necessary in the most cost-effective manner. The advantage of capitation for EMS agencies is a stable revenue sources through a guaranteed monthly payment. Agencies who can successfully balance the provision of services with the guaranteed income generated by capitated contracts will find this method of funding beneficial.

The disadvantages for EMS agencies in capitated contracts are the poor predictors for use. In other words, the EMS field is ever-changing, and the services provided are evolving on an almost monthly basis in some areas. Also, community demographics, particularly in suburban areas, are changing at break-neck speed. These factors will all change the response patterns and service delivery of EMS agencies. If agencies are using capitated contracts, the monthly payments will not change until the contract is renewed or renegotiated. This means that the real EMS demands may outpace the anticipated EMS demands, thus making capitation a less effective revenue generator for an agency. In many cases, EMS agencies must negotiate a provision within the agreement on contract to allow for changes to the payment cap to accommodate usage exceeding the anticipated level.

Capitated contracts with managed care organizations involve a great deal of preparation and research on the part of the EMS agency, and the contracting and logistical processes for payments may be very complicated. It is important that EMS agencies adequately prepare for this type of funding alternative and have the resources necessary to make capitation work for their agency.

Preparing for Managed Care Contracting

Managed care contracting must be thoroughly researched and understood by the EMS agency entering into the agreement. The following items may be relevant to an agency's preparation for managed care contracting:

- Who is the agency providing EMS services for? Who else is providing that service within the geographic region?
- What managed care providers cover the majority of the citizens within that service area?
- What is the background on each of these managed care providers? What is their financial status? How do they deal with other EMS agencies? What are the experiences of other EMS agencies working with this managed care provider?
- What form of managed care is involved? How are payments made? Is there a system of fee-for-service or capitation?
- What are the agency's costs for service provision? What are other EMS providers charging?
- How much does the EMS agency need to recover to keep the EMS system operational?
- How long will agreements or contracts with managed care organizations last?
- Are there other EMS agencies that can be partnered with to provide services under a managed care contract?

Doing background research, on both the agency and the managed care provider, is critical for successful contracting with managed care organizations.

EMS Provider Networks

In working with managed care organizations, it may be beneficial to create networks for providing EMS services. In other words, agencies considering managed care contracting may be more successful as a part of a network of EMS providers than acting independently.

There are many forms of networks that ambulance and EMS agencies can form. Each type of network has advantages and disadvantages to both the individual agencies involved and in relation to the managed care organization and contracting process. EMS agencies, when considering managed care contracting as a funding alternative, should also investigate the process of forming networks.

HOW WILL MANAGED CARE CHANGE EMS?

The prevalence of managed care organizations in the healthcare delivery system will certainly have an impact on the delivery of emergency medical services in the United States. This impact may be felt in a number of ways, including the provision of services, business practices, and funding mechanisms.

EMS agencies should begin to learn more about managed care organizations and their effects on the healthcare delivery system in this country. The role of EMS agencies in this system will likely shift in the coming years, and one of the greatest impacts may be the funding mechanisms for EMS agencies.

Opinions on Managed Care and EMS

A number of associations and organizations are involved in research and education of EMS agencies on the topic of managed care.

The American College of Emergency Physicians makes the following statement concerning managed care and emergency medical services:

"What effect will managed care have on emergency medical services (EMS)? Some large health plans operate or have contracts with private ambulance services, and these plans may encourage their members to use these services rather than 9-1-1. But patients should always be encouraged to use the EMS system for acute medical problems like chest pain, since delays could be a matter of life and death, and private ambulance companies often do not provide advanced life support services. This is also a problem because EMS is an integrated system whose cost-effective operation depends on the participation and financial support of a large population base. America can't afford to destroy a system that has been over 20 years in the making—a vital public service that saves thousands of lives each year—just to increase profits for insurers."

The National Association of Emergency Medical Service Physicians makes the following statement in a 1998 Position Paper entitled "EMS Systems and Manage Care Integration":

"Emergency medical services systems and Managed Care Organizations must cooperate and educate each other in order to effect delivery of reliable, high-quality emergency health care to the entire community. Shared goals are rapid access, medically appropriate care, and operational efficiency. An integrated approach is necessary in order to maintain the integrity of EMS systems. EMS systems serve as a safety net for patients with perceived emergencies. Changes in form and function should be guided by outcome studies that ensure the continued delivery of quality emergency health care services."

CONCLUSION

Contracting with managed care organizations is a viable funding mechanism for EMS agencies. This emerging concept is growing in the field of EMS and will soon be a prevalent form of funding. This method of cost recovery has the potential to be a great benefit to EMS agencies. Unfortunately, the world of managed care organizations, contracting, fee-for-service and capitation is extremely

complex and dynamic. Agencies considering this method must research the managed care organization and its relationships thoroughly. Managed care contracting may also require EMS agencies to hire specialists in managed care, billing and/or capitation. EMS agencies may also need to alter business practices and service delivery. Managed care has the potential to have an impact on all portions of emergency medical service provision. EMS agencies need to be informed and ready to deal with the increased pervasiveness of managed care in the health care delivery system.

RESOURCES

For more information about managed care organizations and emergency medical service agencies:

American Ambulance Association
3800 Auburn Boulevard, Suite C
Sacramento, CA 95821-2132
(916) 483-3827
(916) 482-5473 fax
aaa911@the-aaa.org

Note: Managed Care Guide for the Ambulance Industry, a publication produced by the American Ambulance Association, is a comprehensive guide to working with managed care organizations.

American College of Emergency Physicians
P.O. Box 619911
Dallas, TX 75261-9911
(800) 798-1822
(972) 580-2816fax
www.acep.org

International Association of Fire Chiefs
Emergency Medical Services Section
4025 Fair Ridge Drive
Fairfax, VA 22033-2868
(703) 273-0911
(703) 273-9363 fax
www.iafc.org

Note: The Emergency Medical Services Section of the IAFC is active in monitoring managed care trends in the EMS industry. The IAFC also has a Management Information Center where bibliographies of managed care articles can be obtained.

International Association of Fire Fighters
1750 New York Avenue
Washington, D.C. 20006
(202) 737-8484
(202) 783-4570 fax
www.iaff.org

National Association of Emergency Medical Service Physicians
P.O. Box 15945-281
Lenexa, KS 66285-5945
(800) 228-3677
(913) 541-0156 fax
www.naemsp.org

Note: The NAEMSP has published a position paper on "EMS Systems and Managed Care Integration."

National Highway Traffic Safety Agency
United States Department of Transportation
www.nhtsa.dot.gov

Note: The NHTSA monitors the effects of managed care on EMS systems and has a variety of educational products and publications to assist EMS systems and managers.