**Managed Care**

Managed care is a term that is used to describe a health insurance plan or health care system that coordinates the provision, quality and cost of care for its enrolled members. In general, when you enroll in a managed care plan, you select a regular doctor, called a primary care practitioner (PCP). Who will be responsible for coordinating your health care. Your PCP, who refer you to specialists or other health care providers or procedures as necessary. Managed care plans pay the health care providers directly, so enrollees do not have to pay out-of-pocket for covered services or submit claim forms for care received from the plan’s network of doctors. Most managed care plans are certified by the State of New York Department of Health and focus on Preventive health care and provide enrollees with a medical home for themselves and their families. http:www.referencesforbusiness.com/encyclopedia/Gov-Inc/Human-Resources-Management-HRM.html

Manage care organization is also part of HMO. HMO is a managed care organization (MCO) that operates under Article 44 of the public Health law and the insurance law and must be certified by Department of Health. HMO ensures that comprehensive health care services are available to covered individuals. There are several ways to pay for healthcare which includes:

* Medicaid
* Medicaid Managed care
* Managed long-term care
* Family health plus
* Child health plus
* Elderly pharmaceutical insurance coverage
* Healthy NY program

Manage care refers both to programs that coordinate, rationalize, and channel the delivery of care without being risk-based, and it also refers to care managed by organizations that assume full financial risk for the care managed. Manage care also refers, in general, to efforts to coordinate, the use of services to achieve desired access service, and outcomes while controlling costs. The basics of managed care (<http://aspe.hhs.gov/Progsys/Forum/basics.htm>).

Risk-based managed care describes care from organizations that provide or contract to provide health care in broad/ specified areas for a defined population for a fixed, prepaid price (where the managed care organizations (MCOs) are at financial risk to deliver the services for the fixed price) managed care organizations use various strategies to control costs. The basics of managed care (<http://aspe.hhs.gov/Progsys/Forum/basics.htm>)

CHAPTER 2 OF “ Managed Care: Handbook for the Aging Network, “by Robert Kane, Rosalie Kane, Neva Kaye, Robert Mollica, Tish Riley, Paul Saucier, Kimberly Irwin Snow, and Louise Starr. University of Minnesota Ltc Resource Center states that’s: most managed care includes placing care providers at financial risk for all or a substantial part of the costs of care; the incentives from such a situation offer the greatest potential to transform incentives in the care and service system.

In managed care there are levels of risk, these risk are:

* Full risk: accepting all the financial risk for providing services(all the possible, profits as well as the losses)
* Partial risk: accepting a portion of the financial risk of service provision
* No direct-risk: but incentives are present for controlling cost, as in various case-managed primary care arrangements

Improving The Quality of Health Care: who will lead. <http://content-healthaffairs.org/content/20/5/164.full>

**Guidelines for managed care:**

* The physicians and the managed care organization (MCO) should sign a contract requiring mutual honesty in achieving the goal of good patient care.
* The patient should sign an agreement not to hold either the MCO or the physician responsible or liable unless there is a breach of guideline #1
* Patients may come and go to a physician’s office as the physician directs without certification or precertification by an insurance company.
* No employee of an MCO, including the chief executive officer, presidents, and board members, can receive compensation from the MCO that is greater than the median income of the physicians who are supplying the care. Any leftover money in the MCO will not be given as a bonus to any executive but rather, will be refunded to the patients.
* The MCO and the physician should agree that they have no right to each other’s records.

**Barriers to obtaining managed care**

Insufficient insurance coverage has prevented many people with mental illnesses from obtaining needed treatment, and quality care is often hard to find. The health care reform law addresses both these problems. In addition to requiring that individuals obtain insurance coverage, the law. To change these insurance coverage can expanding the number of people who can qualify for the extensive mental health services Medicaid covers, creates several new options for long-term care of people with disabilities, expand Medicaid eligibility, allowing childless adults who are not classified as having a disability to qualify for the program. (<http://www.bazelon.org/Where-We-Stand/Access-to-services/Health-Care-Reform.aspx>) (<http://betterdiabetescare.nih.gov/ISSUESaligningpaymentfixing.htm>)

Because many states have not taken full advantage of Medicaid options for adults and may have also restricted children’s access to these services to which they are entitled by failing to provide definitions that enable providers to readily bill for the services they render, patients are been denied services and access to proper and comprehensive treatment plans, procedures and medication management. The new health care reform law passed in 2010, known as the Patient Protection and Affordable Care Act; several other provisions in this law will also help people with mental illnesses, such as prevention programs, improvements to Medicare’s drug benefit, a new insurance plan for long-term community care, reauthorization of the children’s state health insurance program (SCHIP) along with other changes. ([http://www.bazelon.org/Where-Stand /Access-to-Services/Health-care-Reform.aspx](http://www.bazelon.org/Where-Stand%20/Access-to-Services/Health-care-Reform.aspx))

The cultural competence in health care is so off-balanced because of the ability to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’, social, cultural, and linguistic needs. Experts interviewed for this study describe cultural competence both as vehicle to increase access to quality care for all patient populations and as a business strategy to attract new patients and market share. [www.massgeneral.org/healthpolicy/cchc.html](http://www.massgeneral.org/healthpolicy/cchc.html)

A study of factors that prevented patients with newly diagnosed diabetes from seeking medical care found that of seven variables examined, only lack of health insurance correctly predicted those patients who failed to seek medical care for their diabetes. Further, health care utilization appears to decrease out-of-pocket patient costs such as co-pays increase. The economic burden on families can be substantial. Researchers examined the health care costs of families with a child type 1diabetes. They found that most families with a child with type 1 diabetes had health insurance, but incurred out-of-pocket health care costs that were 56 percent higher than those in the control families without diabetes. <http://betterdiabetescare.nih.gov/ISSUESaligningpaymentbarriers.htm>

**Barriers to culturally competent care**

* Lack of diversity in health care’s leadership and workforce.
* Systems of care poorly designed to meet the needs of diverse patient’s populations.
* Poor communication between providers and patients of different racial, ethnic, or cultural backgrounds.

Benefits of cultural competence

The literature review revealed that few studies make the link directly between cultural competence and the elimination of racial/ethnic disparities in health care. Health care experts in government, managed care, academia, and community health care, on the other hand, make a clear connection between cultural competence, quality improvement, and the elimination of racial/ethnic disparities.

**AHRQ agency for healthcare Research and Quality**

* Advancing Excellence in Healthcare: patient safety and quality when health plans share physicians, they may have less incentive to improve care quality.

Measuring a health care plan’s performance is one way to promote competition in the market place and give consumers the information they need to select a plan. Such measurements, however, may not adequately reflect the quality of care received by patients. This is particularly true when hospitals and physicians contract with multiple health plans, creating a degree of overlap that makes performance comparisons difficult. Recently researches looked at the relationships between this degree of overlap in physician networks and health plan performance. When there is a high degree of provider network overlap, for databases were selected to gather for the study. One database included information on physicians and their health plan affiliations for 214 health maintenance organizations. The other three databases included information on health plan characteristics, their performances, and outcomes. The researcher’s constructed two measures of network overlap to determine the effect of a plan’s overlap with other plans on quality performance. The analysis found that plan performance converges as physician network overlap broadens. As a result, the performance for a single, individual plan declined as its network physicians started to contract with other health plans.

**The pros and cons of managed**

* The pros of managed care are since the patient is limited to a specific caregiver the premium is lower. The patient only pays a monthly payment and co-payment. The cons of managed care are that the patients are not allowed to see the doctor of their choice unless the doctor is in their network. The consumer’s perspective, the pros and cons of managed care, the pros from the consumer’s perspective would be only paying monthly payments that are at a fixed rate. The other would be paying a small co-payment every time they see a doctor. The cons of managed care are from a consumers perspective would be only paying monthly payments that is that they cannot see the doctor of their choice. The caregiver has to be affiliated with the managed care organization. The pros would be stability, fewer administrative duties, and better working hours. The cons would be less independence and possibility a decrease in the income. From a caregivers perspective they would rather the patient have traditional insurance. The reason for this because the caregiver is losing money by the patient having managed care. Caregivers get a percentage of the money when they see patient with traditional insurance; then there is also more stability and less working hours for the caregiver with managed care.