Models of Care and Organization of Services

Alina Markova, BA[a,*], Michael Xiong, BA[a], Jenna Lester, BA[a], Nancy J. Burnside, MD[a,b]

KEYWORDS

• Models of care • Dermatology • Physician extenders
• Teledermatology • VAMC • PPO • HMO • Fee-for-service

This article examines the overall organization of services and delivery of health care in the United States. Health maintenance organization (HMO), fee-for-service (FFS), preferred provider organizations (PPOs), and the Veterans Health Administration (VHA) are discussed, with a focus on structure, outcomes, and areas for improvement. An overview of wait times, malpractice, telemedicine, and the growing population of physician extenders in dermatology is also provided.

HMO

An HMO is a type of managed care plan in which a network of designated health care providers (eg, physicians, nurse practitioners [NPs], therapists) is available to enrollees. Under the HMO model, there is a gatekeeper (GA), usually a primary care physician (PCP), whom the patient must first see to obtain a referral to a specialist. By contracting with a specific network of health care providers, and by emphasizing preventive care, HMOs are able to keep costs low. However, this cost cutting may also lead to certain disadvantages, including restricted access to specialists within the HMO network, and lack of coverage for procedures that the HMO may deem unnecessary. Under the Medicare HMO plan (also known as Medicare Advantage), patients are enrolled in traditional Medicare A and B, along with an HMO that offers extra services not covered by Medicare alone, such as prescription drugs, eyeglasses, and dental care.[1–3]

FFS

In an FFS system, health care services are unbundled and paid for separately. The advantage of an FFS model is that patients have the freedom and flexibility to choose any physician and hospital, not just those restricted to a certain network. The trade-off for this autonomy is that patients often have to pay higher copayments and deductibles. A copayment is a set fee, usually in the range of $20 to $40, which patients pay per visit to the physician. The amount of the copayment may differ between physicians in primary care and specialty settings. A deductible differs in that the amount paid is usually a percentage of the total costs for a service. The insurance then covers the remainder of the costs. Depending on variations in insurance policies and treatment plans, patients may be required to pay copayments, deductibles, or both. Physicians under the FFS system receive payment for each type of service rendered, such as an office visit, test, procedure, or other health care services. Because a GA is not required under FFS, patients typically have direct access to specialists. Medicare FFS is also known as traditional Medicare, in which

Funding: None.
Financial disclosures: The authors have nothing to disclose.
[a] Alpert Medical School of Brown University, 222 Richmond Street, Box G-9286, Providence, RI 02912, USA
[b] Department of Dermatology, Providence Veterans Affairs Medical Center, 830 Chalkstone Avenue, Providence, RI 02908, USA
* Corresponding author.
E-mail address: alina_markova@brown.edu

Dermatol Clin 30 (2012) 39–51
doi:10.1016/j.det.2011.09.005

patients are enrolled in Medicare A and B, and pay higher deductibles and premiums to gain access to a wider network of physicians compared with Medicare HMO (**Fig. 1**).[1–3]

PPOs are health care providers that assemble in a network to provide cost-sharing benefits to their subscribers. The network of physicians affiliated with a particular PPO provides care on an FFS basis usually to a group of patients belonging to the same employer group. As a result of this arrangement, the patient receives care from a network of providers at a discounted rate, and the providers have access to an increased pool of patients.[4] PPOs have become increasingly popular as a result of the aversion many people have to the rigidity inherent in an HMO. Compared with HMOs, PPOs have more care options for the subscriber, fewer care restrictions, and less overhead cost for the provider, and more reasonable administrative costs for purchasers.[5] This situation has caused an increase in the number of people who want to be enrolled in a PPO and in turn may create added demand for physicians to affiliate themselves with a PPO.

The Patient Protection and Affordable Care Act has called for significant health insurance reform in the United States. Of relevance to dermatology, the zoster vaccine was included in the first round of preventative services guidelines.[6] This act also included a 10% excise tax on indoor ultraviolet tanning, which took effect on July 1, 2010. This bill restructured payments to Medicare Advantage insurance companies to begin in 2012. These changes will adjust local Medicare spending levels, with bonuses for plans achieving high-quality scores. Such modifications may decrease the availability of Medicare Advantage plans, causing patients to revert to the traditional Medicare plan. Physician payments will be affected variably, depending on the contracted rates of the geographic area compared with those of Medicare.

Although there is a clear trend of improved skin cancer outcomes when diagnosed by dermatologists, and with increasing numbers of dermatologists, the health care outcomes of skin diseases when treated by nondermatologists are not so tangible. In addition to increasing and standardizing the education of skin diseases among nondermatologists, there should be a concurrent movement to educate the public about skin cancer, as well as to increase the number of

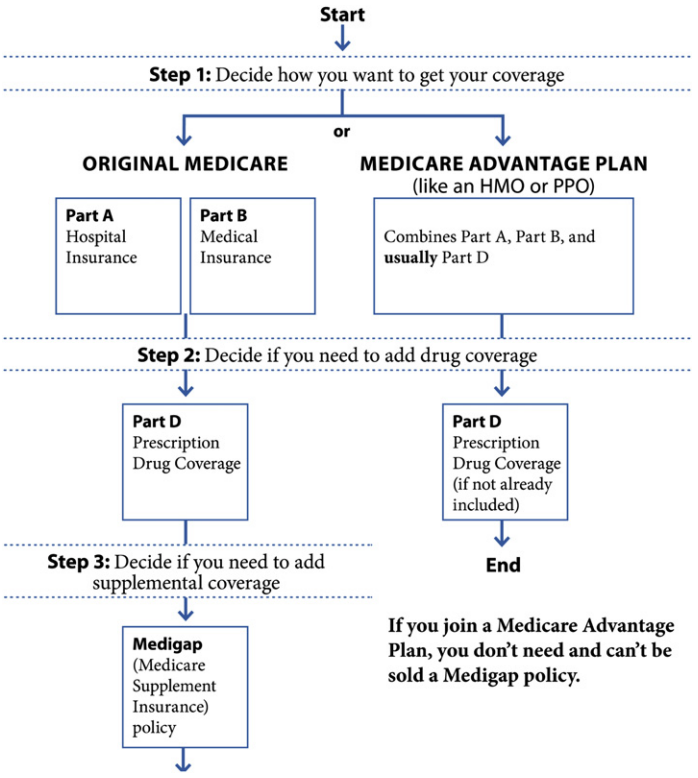

Fig. 1. Medicare coverage choices (*Official Medicare Handbook 2009*). (*From* Centers for Medicare and Medicaid Services. Medicare & You. U.S. Department of Health and Human Services, 2009.)