



## Managed Care: Concepts and Strategies for Quality Assurance

DR. MICHAEL O. AKINTAYO

Adjunct Professor

General Human Services (Ph.D.), Masters in Administration (M.Sc)

New York City Department of Health and Mental Hygiene, USA.

E-mail: [Akintayomichael@hotmail.com](mailto:Akintayomichael@hotmail.com)

(646)-204-9282

OLUSOLA KARIMU

B.Sc, M.Sc, Doctoral Student

Capella University, Minnesota, USA

E-mail: [olusolakarimu@gmail.com](mailto:olusolakarimu@gmail.com)

Tel: (917)-209-4975

OLUSOLA O.ISOLA

Research Fellow

Institute of African Studies

University of Ibadan, Ibadan, Nigeria.

E-mail: [sola\\_isola@yahoo.com](mailto:sola_isola@yahoo.com)

Tel: +234-(0)802-304-9433

### Abstract:

*To understand the significance of quality assurance in Managed Care, there is need to examine the various relationships, strategies and ethics that exist within its system. Several types of managed care systems have gained popularity in the American health care system. Managed care plans adopt a number of techniques; some are directed at the behavior of physicians while others are directed at subscribers to the plan. Knowledge of the impact of legislative reforms such as HIPPA Act, Medicare and Medicaid on managed care is essential to understand physician-patient relationships. This research is exploratory because it utilizes existing literature and body of knowledge in health care to conclude that it is important to start reducing the risks of inappropriate financial incentives that may threaten the delivery of quality health care, as patient advocates must preserve fundamental duty of physicians.*

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**Keywords:** Medicare, Medicaid, Managed Care, Patient, Physician

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### 1. Introduction

The rising cost of healthcare is an important issue that is confronting the United States today. As a result, the number of employers offering healthcare to employees is declining as they question the value of their health care spending. Industries like Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) employ thousands of people to promote healthier lives through their health plans. However, there is still mistrust among the general population regarding coverage plans on incentives, pricing and benefits to enrollees (Clark, 2006). Briefly stated, Managed Care was established to control rising healthcare costs and Health Maintenance Organizations (HMOs) were the first form of Managed Care Organizations to be established (Mohaghegh, 2007). The purpose of supporting the rise of HMOs originated from the

belief that prepaid medical care, as an alternative to fee-for-service practice, would motivate competitors to produce efficiency in health care delivery and reduce the cost of healthcare expenses (Shi & Singh, 2004).

## 2. Origin of Managed Care

The genesis of managed care can be traced to early 1910 with the development of Western Clinic in Tacoma to deliver medical services to employees and owners of lumber mills in Washington (Mayer & Mayer, 1985). In 1929, health insurance began at Baylor Hospital in Texas to provide teachers and other regular employees with prepaid care. In 1939, the state of California, through its medical societies, created statewide Blue Shield plans which reimbursed for physician services (Starr, 2000). In 1944, New York City launched the Health Insurance Plan (HIP) to provide quality care for its employees. The early 1960s and 1970s witnessed the expansion of the Health Maintenance Organizations (HMOs) and other Managed Care Organizations (MCOs). The growth of managed care in the late 1980s was centered around mergers and acquisitions, resulting in the creation of a single legal body, the development of quality control measures by external bodies like National Committee for Quality Assurance (NCQA) and restructuring in terms of the role of Primary Physicians (PCP) and health plan consolidation (Kongstvedt, 2007).

In the 1990s, the HMOs and other forms of managed care increased and became the standard for employer-sponsored medical coverage and Medicaid programs (Oliva, 2004). Likewise, there was rapid growth in Preferred Provider Organizations' (PPO) participation due to unsatisfying services of health maintenance organizations. Enrollment in the PPO has become an alternative among employers and consumers attempting to promote a medical coverage that is less restrictive, that offer more to providers and lowers the cost of maintaining a health coverage (Hurley, Strunk, & White, 2003).

## 3. Definitions

Randel et al (2001) defined Managed Care as "a continuum of insurance and delivery systems...as those that had capitated or discounted Fee-for-Service (FFS) and/or those that restricted enrollees' choice of providers, while non-managed care plans were FFS indemnity plans" (Randel et al., p.104). Managed Care organizations are established to provide cost control and freedom of choice. Health Maintenance Organizations (HMOs) are organized to deliver comprehensive health services to enrollees through a group of physicians that are controlled and managed by HMO units. Under this coverage, each patient is assigned to a physician (PCP) as the case manager, and the PCP is authorized to refer patients to network specialists for medical procedures (Kongstvedt, 2007).

Also, Independent Practice Association (IPA) contracts directly with independent physicians, or contract with independent group practitioners or specialists to provide health services. The central focus of IPA is to utilize group practitioners, or specialists effectively in the delivery of health services to enrollees (Kongstvedt, 2003; Randel et al., 2001). Preferred Provider Organizations (PPO) is a network of providers like hospitals, physicians etc., who agree to provide health services to enrollees based on a negotiated fee or at a discount rate. This health service delivery system provides an option for enrollees to use providers outside the network. However, when this happens, enrollees or subscribers will be responsible for the balance incurred on the discounted rate for the services provided (Hurley, et. al. 2004). The strength of a PPO, from patient point of view, is the opportunity for subscribers to choose from variety of physicians at more or less reasonable cost, compared to an indemnity product. From an employer's viewpoint, PPO allows employers to customize insurance plan so that they can

decide to have comprehensive or limited benefits with flexibility to keep costs within a specific range (Hurley, et al., 2004).

#### **4. Managed Care and Physicians**

In managed care, physicians are very important because they make health care delivery possible to enrollees or beneficiaries. Kongsvedt (2007) acknowledged that most Managed Care Organizations divide the role of physician network into Primary Care Physicians (PCPs) and Specialist Care Physicians (SPPs), to emphasize the importance of their roles and responsibilities within the network in delivering quality health care to enrollees. Many primary care physicians are also trained as specialists because they have the potential and expertise to restrict their practices to specific conditions (Kongstvedt, 2007). In managed care, especially in behavioral health management, primary care physicians are the gatekeepers contracted to be the first point of contact for any medical problems. Their primary duty is to act as regular physicians who determine patient's needs and coordinate patient's care with other specialists or medical practitioners. Primary care physicians are known to be caretakers because they are mandated to give approval before they pay a specialist visit or emergency room visit (Sultz & Young, 2006).  
*Credentialing.*

In order for managed care to be successful, there are basic key elements that can be followed. First, it is vital that physicians are properly scrutinized and evaluated based on their medical education background and professional experience. It is not sufficient to employ physicians without carrying proper credentialing, because in the event of legal action against any of the physicians, the plan may be exposed to liability. Recently, many Credentialing Verification Organizations (CVOs) have improved their services to reduce the number of fraudulent credentials being presented to managed care plans (Schaffer, Rollo, & Colt, 1988).  
*Healthcare Integrity and Protection Data Bank (HIPDB)*

The HIPDB was set up to prevent and reduce health care fraud and reporting cases of abuse by physicians with civil judgments. Also, this board was established to document federal or state convictions against healthcare providers and actions against licensing and certification bodies of healthcare providers. This databank must be accessible to the public and organizations, with the desire to maximize the benefits of enrollees (Kongstvedt, 2007).  
*Office Evaluation*

For any HMOs to contract with a physician, an on-site office evaluation is mandated while other requirements of the accreditation bodies must be fulfilled. Most of the times, a physician's office evaluation is supposed to investigate the potential to accept or contract new members and the ability to schedule appointments of patients. To evaluate for efficiency in healthcare delivery, an office evaluation may be done to investigate if office workers are receptive to patients and how the entire office is maintained (Kongstvedt, 2007). It is important to understand that the relationship between managed care and physicians is formal so that a clear understanding is made between them before physicians are contracted. Maintaining a professional relationship between physicians, HMOs and others must be of great significance, in order to keep up with competition among various plans (Kongstvedt,2007).

#### **5. Patient and Physician Relationship**

It is of essence to note that impacts of the growth of managed care can be positive or negative in the eyes of the beholder. It is correct to say that certain areas in managed care have led to mixed benefits between the patient, physicians, and plans. One of the concerns discussed by Emanuel & Dubler (1995: 34) is the failure to provide "reliable assessments of physician competence". Gray

(1997) supported this statement by referring to it as a continued failure, not a new one. Interestingly, in managed care, physicians are obliged to see more patients to keep the practice alive. This means that less time is allocated to each patient for adequate and quality communication with physician. In the past, communication played a crucial role in establishing physician's trustworthiness. Currently, patients do not have enough time to communicate their health issues with their physicians due to the fact that physicians are paid by the number of patients they see in their clinics. This may compromise physician's practice quantitatively in managed care (Gray, 1997).

Another problem identified in the relationship between patients and physicians in managed care has to do with financial incentives. There is the perception that managed care causes physicians to care more for the money than for the care of their patients. This can be done through withholds or financial gains when expensive equipments are not used, or expensive tests are not done. Suffice to note that these financial incentives in managed care distract or prevent physicians from delivering quality care (Armour & Pitt, 2003). However, it is important that regardless of the financial incentives, physicians must ensure that patients are satisfied with the care they are receiving under managed care (Mains, Coustasse and Lykens, 2004).

Furthermore, financial incentives are given based on accessibility. This means that physicians receive incentives when they see their patients, and are more likely to see their patients in an emergency (Armour & Pitt, 2003). However, the negative aspect implies that physicians see many patients and do not have enough time to spend with their patients. Contrarily, the Council on Ethical and Judicial Affairs (CEJA, 1995) emphasized trust as one of the key elements of relationship between a patient and a physician. Sometimes, some doctors spend adequate time with their patients to make them feel important and willing to return for their medical appointments. When a physician demonstrates that patients' needs come first, it establishes trust and dedication in the relationship (CEJA, 1995).

Similarly, some employers prefer to change their healthcare plans in order to reduce cost. When this happens it becomes a problem whereby consumers have to change providers periodically. Situations like this often make consumers to lose the dignities of patient-physician relationship, which is continuity of care (Emanuel & Dublar, 1995). In addition, utilization review management is seen as another obstacle in managed care because of its ability to limit the costs on every patient. However, utilization review nurses are knowledgeable about the cases they review, and recommend appropriate specialists whenever necessary (Kongsvedt, 2007). This often results in the best care available to patients and whenever there is a conflict in which utilization management is implemented, it is always brought to the attention of physicians. This is important because the success of utilization management depends so much on physicians to adequately represent their patients in making the best decision (Gray, 1997).

The relationship between patients and physicians is improving because of the establishment and implementation of the HIPAA Act. It places important value on the relationship in the sense that patients can be assured that sensitive information regarding their health released to physicians will not be shared or released out unless they are informed by the proper authority (Randel, et. al., 2001). Emanuel (1995) summed up the relationship between the patient and the physician as the bedrock of success in health profession and enumerated some key issues that pose threats to the relationship. Some of such issues include, but not limited to the length of stay of the patient, which may abruptly end relationship with a private physician. Others include specialty referrals, access to care, financial arrangements, and tests requested (Emanuel, 1995).

Furthermore, in order to have continuity of patient and physician relationship in managed care, it is important to preserve trust. This is crucial because over the years trust on the part of patients has been observed to be fundamental in therapeutic relationships (Bradford, 1997). The ability of patient to accept medical advice and services is based on the trust in the physician, and on ethical standards of the profession which place greater value on physicians to put “patient’s interest above self-interest” (Bradford 1997; p.1). Paradoxically, one can posit that managed care can still function in such manners that promote patients’ trust through monitoring, auditing, and accountability, rather than trusting the physician’s self-determination (Bradford, 1997).

Summarily, history has shown that there have been critics that felt that trustworthiness in doctors has been diminished and is still diminishing. As a result, they argue that there is an erosion of trust in fee-for-service care under managed care. One of the reasons for this is the conflict of interests that occur due to inappropriate services rendered to patients so that physicians can make enough money (Rodwin, 1993). In addition, there is the attitude of patients not to trust physicians lately, due to reduction in physicians’ power and autonomy. Therefore, patients make every effort to seek second opinions because of the awareness that cost containment is the essence of managed care organizations (Gray, 1991). In order to improve trustworthiness of care in managed care, it is essential that managed care develop effective ethical standards, enhance mission-oriented nonprofit organizations, increased physician autonomy and provide solutions that include strategic monitoring, evaluation and public disclosure of success of managed care plan (Bradford, 1997).

## **6. Cost Containment Strategies**

Cost containment strategies in managed care have failed to control medical cost without affecting or jeopardizing the quality of care (Mohaghegh, 2007). Researchers have conducted studies on cost containment and quality of care, and there is no conclusive evidence on how quality of care is affected by cost containment strategies. Many researchers believe that managed care focuses more on the input of care, in terms of man power, capital and tools as compared to output-patient care (Mohaghegh, 2007; Shi, 2004).

The purpose of Managed Care Organizations is to provide health care to enrollees and at the same time, include measures to control and maintain costs. Therefore, managed care includes elements that may successfully work for or against what it stands for. These elements are, but not limited to “cost containment, accountability for quality and cost, measurement of health outcomes and quality care, health promotion and disease prevention programs, management of resource consumption, consumer education programs, and continuing quality improvement initiatives” (Shi, 2004). Managed Care Organizations have been scrutinized based on how these elements or components affect care delivery. Also, managed care is scrutinized regarding the restrictions on the ability of consumers to choose physicians and hospitals, as well as the ability to provide quality care.

Further arguments have generated from the financial incentives to physicians, to low utilization and the number of tests needed by patients for physicians to control costs (Mohaghegh, 2007). It is obvious that MCOs are interested in reducing medical costs and will attempt to encourage physicians to try every means to reduce costs. For example, when physicians embark on preventive screenings, MCOs will reimburse as long as it is established that it will reduce costs. The flip side of this argument is that it may force patients to change plans if they are not pleased and the costs may not be recovered by the MCOs. In addition, reducing costs through preventive screening and treatment may affect the quality of health (Ullmann, 2003).

*Utilization Management*

Mohagheh (2007) enumerated three most popular cost containment strategies by Managed Care Organizations (MCOs). They are utilization management, case management, and financial incentives provided to physicians. Utilization Management is a process that allows case review to determine the appropriate services, with cost-effective methods of care delivery. Spector (2004) indicated that utilization review or management is a precaution against inappropriate medical care. Also, it allows physicians and other providers to review and manage patient care from professional perspectives that emphasize medical necessity, quality of care, decision-making, and length of hospital stay. Paradoxically, utilization management can also be used to reimburse physicians for deliverable services. Under utilization management, physicians are seen as gatekeepers or plan administrators who authorize services and make decisions regarding patient's care and discharge plan (Spector, 2004).

#### *Disease and Case Management*

Mays (2004) suggested that under disease and case management, case managers have the responsibility of improving care and reducing costs of chronic diseases through their decisions. They oversee patient care plan so that they can prevent redundancy in providing care and encouraging self-management. Despite the assumption that disease and case management reduces or saves costs, one study has shown little evidence of cost saving, but if it is desired that a case should be left for a long term then it may increase cost savings (Mays, 2004).

#### *Fees-for-Service*

It must be said that programs established as financial incentives to physicians based on the quality of care they provide have also been used to limit healthcare costs. Recently, managed care via fees-for-service encouraged physicians to contain cost by prescribing generic medicines with the implication of lowering costs. In addition, some plans may "offer physicians a portion of the money that is saved from using generic medicines versus brand name prescriptions" (Mohagheh, 2007:310).

### **7. Managed Care and Reimbursement**

Kongstvedt (2007) claimed that MCOs, HMOs and PPOs use risk-based reimbursement to pay physicians especially, PCPs. Many of the managed care have forms of incentives like capitation, fee-for-service, and pay-for-performance for their physicians.

#### *Capitation*

Kongstvedt (2003:106) defined capitation as "prepayment for services on a per member per month basis". This means that the primary care provider receives a specific amount for each enrollee regardless of whether services are utilized or not on monthly basis. For example, according to HMO agreement, any healthcare provider that agree to join the network must sign a capitation agreement. This agreement covers most of the procedures that the primary care provider provides. Also, capitation rates may depend on variables like age, gender, current health status, location, and practice type (Kongstvedt, 2003).

Another element of capitation is a withholding system which involves withholding of a percentage of the primary care physician's reimbursement each month. Through this method, the primary physician receives payment each month in the amount of the capitation rate without the withheld amount. At the end of the year, if there is money left to cover cost overruns, the money is returned to the primary care physician (Kongstvedt, 2003). Therefore, for capitation to become successful PCP must make sure that patient's admission is totally avoided by making sure that patients are healthy through preventive care. Trespacz (1999) suggested that enrollees or plan

beneficiaries must understand their diseases and collaborate with physicians/gatekeepers to manage their health effectively and efficiently, so that they can be healthy.

Furthermore, the scope of covered services is another aspect of capitation. This explains what must be covered by primary care services, so as to estimate the costs of primary care. Kongsvedt (2007:118) suggested that the most powerful reason for an HMO to capitate providers is that “capitation puts the providers at some level of risk or incentive for medical expenses and utilization. Capitation eliminates the fee-for-services incentives to over utilize and bring the financial incentives of the capitated provider in line with the financial incentives of the HMO”. Regardless of the perceptions of capitation among the general population, the most important is how it affects patient care. Physicians are paid regardless of the number of patients they see per month, and as a result some of them may spend more time rescheduling appointments and delaying care for patients especially those who are HMO subscribers (Kongstvedt, 2007).

#### *Carve-Outs*

Kongsvedt (2007) referred to carve-outs as capitation system which allows specific services delivered by the primary care physicians to be taken out of the capitation payment. For example, immunization, mental health services and dental care not paid under capitation but reimbursed on a fee schedule and are a part of most capitation programs.

#### *Risk/Withholds/Bonus*

It is obvious that every capitation program has risks for either services or finance. A service risk occurs when the patient care physician has increased program visits and finds it difficult to sell their services to others for additional visits. This indicates that the more capitation visits the PCP has, the less the PCP is paid per visit (Kongsvedt, 2007). Therefore, if providers do not control utilization, they will put themselves at risk.

One element of many capitation programs is withholds. Withholds are a certain percentage that is withheld from the Primary Care Patients (PCP). This withhold is used at the end of the year to cover cost overruns and if there is no cost overruns a withhold is returned to the PCP (Alguire, 2003). Withholds serve as an incentive to PCP to control expenses and utilization. Also, there are other financial incentives in many capitation programs that provide bonuses to PCPs who meet specific criteria (Kongsvedt, 2007).

#### *Risk Pools*

Risk pools are a part of capitation programs where PCPs are for referral services. Risk pools can be created for specialty care, hospitals, and ancillary services. The risk pools are used to reconcile payment of the costs incurred by PCP. Excess funds remaining in the PCP's risk pools at the end of a defined period are disbursed to the PCP (Kongstvedt, 2007).

#### *Pay-For-Performance*

Pay-for-Performance (PFP) involves payment for quality in healthcare delivery. It is a performance-based payment that links physicians to number of initiatives leading to quality service (Wechsler, 2006). The aim of PFP is to apply payment incentives to improve healthcare delivery across United States. This method encourages physicians, private and government hospitals, and health agencies to meet specific standards in the delivery of quality care in order to have financial rewards as well as positive public images. According to Wechsler (2006:30), the idea is to shift from the paradigm that “pays the same rate to all health professionals, no matter the quality of care delivered. Current fee-for-service arrangements often reward inefficient providers that deliver excess care.” It is a means by which providers' performances are measured

based on quality and efficiency. For example, some Physician Group Practice who are under Medicare provider pay incentives to doctors who implement case management that leads to reduction in disease complications, less hospitalization and high quality care (Wechsler, 2006).

A capitation program is designed to control expenses and utilization. Capitation programs at best should address scope of services, payment, carve-outs, withholds, bonuses, and risk pools. Most of the capitation programs have risks that many physicians find unacceptable. For a PCP to be successful they must be skilled in maintaining adequate treatment and cost effectiveness (Denning, 1997).

In addition, there should be government intervention to regulate activities of managed care organizations, so that the health care industry does not become a monopoly serving the interests of providers. The Health Insurance Portability and Accountability Act (HIPPA) represent a major federal government intervention in health care industry, which regulates the private health insurance market (Kongstvedt, 2007).

### **8. Managed Care and HIPPA Act**

The purpose of Health Insurance Portability and Accountability (HIPPA) is to regulate health insurance. States are allowed to share regulatory power with federal agencies that have regulatory authority over private health insurance coverage and group health plans (Kongstvedt, 2007). HIPPA act provides an opportunity for the congress to improve health insurance coverage for workers by ensuring that workers have access to coverage through continuity. Title I and II of the Act make provision for states to protect subscribers from discrimination by MCOs because of pre-existing conditions and subject consumers to minimum standards of accessibility (Kongstvedt, 2003). From the consumer's perspective, HIPPA Act is beneficial because employers are becoming more aware of the potential impact of the Act on company operations, as every health plan must comply with the law (Watson Wyatt, 2003).

The implication of the Act is that every employer in the United States, through their health plan must comply with the HIPPA policies and failure to comply carries civil, criminal, and financial penalties. On the other hand, employers are more concerned about their relationship with employees who may not trust their compliance with HIPPA Act (Watson Wyatt, 2003). Furthermore, the HIPPA stipulates that all health care plans and organizations should maintain strict privacy and security of data of their subscribers. HIPPA requires electronic data to be secured and confidential so as to improve care data systems. It places demands on both the consumer and the provider in federal regulations to make sure that employers educate their employees on HIPPA laws and how to comply with them. On the other hand, it sets guidelines that protect against waste and fraud on both sides (Kongstvedt, 2007).

### **9. Conclusion**

It is true that managed care organizations provide incentives to physicians to limit their provision of care. However, it is important to know that patient welfare must remain paramount at all times. Therefore, professionals and the society must now act to ensure that managed care techniques must be implemented in a way that protects patients and the integrity of patient-physician relationship (JAMA, 1995). Also, the foundation of patient-physician relationship is the trust that patient's welfare will always be considered as priority and physicians will always serve the needs of their patients. Without trust on the part of patients to believe that physicians are committed to protecting their well being, it would be difficult for physicians to provide quality health care. Additionally, it must be known that while some cost containments can be used to eliminate waste and inefficiency, they can also be used to limit the availability of tests or



procedures that may save lives. It is important for any managed care plan to disclose any incentives that will limit care to patients on enrollment periodically and financial incentives must be based on quality of care.

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