



Nebraska
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**Provider Sponsored Organizations for
Medicare Managed Care
What is Next for Rural Providers?**

Occasional Paper Series
Working Paper 98-1
September 1998

by
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With this document the Nebraska Center for Rural Health Research launches a new series of Occasional Papers. The series will include papers written by Center faculty and staff that comment on current topics of interest to rural health policy makers, researchers and practitioners. The purpose of the series is to disseminate research findings and analysis in a timely and readable manner as widely as possible. We welcome any comments and reactions to any of our publications. The Occasional Paper series is supported by the Center, the University of Nebraska Medical Center, and various funding agencies that are supporting particular projects of the Center.

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Executive Summary

The Balanced Budget Act (BBA) of 1997 established a new type of health plan allowed to contract for Medicare business — the Provider Sponsored Organization (PSO). Rural providers may want to consider forming PSOs for the purpose of seeking Medicare risk payments. Per capita payments (per member per month) have increased in many rural counties as a result of provisions in the BBA. Those increases, when compared to reducing expected revenues in fee-for-service payments, may make managed care an attractive option.

The potential advantages of forming PSOs and contracting directly with the Medicare program include: increased revenues, increases in floor payments for managed care plans, greater opportunity for local control, and potential opportunities to invest in the local health care delivery infrastructure. Disadvantages include: putting a financially fragile delivery system at risk for losses through Medicare business, increased administrative requirements, and the risk of not enrolling a sufficient number of beneficiaries.

Recommendations are made in this paper for rural providers considering pursuing the PSO option.

They include the following:

- having a network of providers to participate in the PSO;
- completing a thorough financial analysis of the PSO business plan;
- developing and implementing a marketing plan;
- developing functional and productive relationships with participating providers;
- completing successful negotiations, both within the PSO (for provider payment) and with specialists and other providers outside the PSO;
- developing and implementing a plan for medical management; and
- implementing an information system that will meet the managerial needs of the new PSO.

This paper is intended to meet the needs of rural community leaders and providers who want to know the right questions to ask and get answers before incorporating as a PSO. Sufficient detail is provided in each section of the paper to introduce the various topics; further investigation would be warranted, and is encouraged for rural organizations getting ready to develop a PSO. The PSO option is not

suitable for all rural communities, but by thinking through what would be needed to develop such an entity rural providers will be better prepared to participate in other health plans that may evolve.

This is the first in a new series of Occasional Papers developed by the Nebraska Center for Rural Health Research. The intent of the series is to disseminate research and analysis to colleagues in rural health in a timely manner. This report was made possible through a grant provided by the Agency for Health Care Policy and Research (#5 U54 HS08610-04).

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Provider Sponsored Organizations for Medicare Managed Care
What is Next for Rural Providers?

Keith J. Mueller, Ph.D.

The initial reaction to a new category of contractors for Medicare risk contracts, Provider Sponsored Organizations (PSOs), was one of optimism that this would become an opportunity to assume the insurance function and thereby increase revenues (Hospitals & Health Networks 1997). Some advocates of this option anticipated “hundreds” of applicants (Managed Medicare & Medicaid News September 22, 1997), however initial estimates have shrunk. For one analyst, quoted in March, 1998, the estimate shrank from “as many as 800” to “I’d be surprised if more than 200 came into being in the first couple of years (Bruce Fried formerly of HCFA, quoted in Hagland 1998).” As of June 1998, the Health Care Financing Administration expects only 25-50 applications in the first year (Managed Care Week June 15, 1998). The once exciting concept of providers forming their own organizations to take on the risk and administrative functions of insurance has been tempered by the reality of the detailed organizing, planning, and financing that must precede contracting. In addition, recent stories about insurance-based health maintenance organizations (HMOs) experiencing financial losses with Medicare products has created apprehension about entering the fray.

This *Occasional Paper* provides an analysis of the decision to form or not form a PSO among rural providers. An initial background section summarizes general arguments for and against moving forward with a PSO. Recommendations are then offered for rural providers interested in the PSO option, or in participating (beyond merely signing contracts) in managed care plans initiated by others.

BACKGROUND

Any move to form PSOs as risk bearing entities will be part of a broader movement by providers to take on the insurance function. In more advanced managed care markets such as Minneapolis, MN providers have already been involved in contracting directly with business interests (Unland 1996). For rural providers, Medicare plans are likely to be their initial foray into direct contracting, as they have not been extensively involved in commercial managed care plans (RUPRI Rural Health Panel 1998). There are two basic reasons for providers to develop their own PSOs; a financial desire to capture dollars currently taken by the insurance “middleman,” and deflecting the desire of insurers to manage the delivery of medical services (e.g., through utilization management protocols).

The potential gains from providers taking on the insurance function must be balanced against the resources needed to do so, and the financial risk that would be assumed. While physicians are already engaged in managing the care delivered to their patients, they are not experienced in population based medical management. Even though some health care providers, including hospitals, have developed detailed information systems related to instances of treating patients, they have not developed systems that can be used to manage care over extended periods of time or support the financial management decisions that must be made. Developing such systems will require investing substantial resources. Accepting the risk related to providing insurance will also require resources, related to maintaining minimum reserves. Assuming risk also means there is the possibility of failure — that costs of providing care will exceed revenues from the managed care plan.

The Positives in Forming a PSO

Increased Revenues

A potential for increased revenues, local control and re-investment of earnings in local delivery systems provide incentives for considering formation of a PSO. The decision calculus may be affected by the combination of severe constraints in revenues from fee-for-service and dramatic increases in risk contract payments. In many rural counties, there is reason to believe that Medicare’s risk payment, combined with a competitive premium charged to beneficiaries, would result in higher provider income than Medicare’s direct payment for services rendered.

Over 50 percent of the savings in the Balanced Budget Act (BBA) are achieved through reductions from expected spending in fee-for-service payments (Moon, Gage and Evans 1997), with the largest single share coming from savings in payments to hospitals (30 percent of the five year savings). By the year 2002, the BBA will achieve savings of \$29.6 billion from prospective payment system payments to hospitals, and \$5.3 billion from payments to physicians (Moon, Gage and Evans 1997). While the impact of reducing payment may not seem significant in the aggregate (Guterman 1998), the impact on small rural hospitals and other rural providers could be quite significant. To illustrate, consider that while the payment per discharge in 1995 was \$4,324 for all rural hospitals and \$5,816 for rural hospitals with 300-499 beds, for rural hospitals with fewer than 100 beds it was \$3,657 (Health Care Financing Review, Medicare and Medicaid Supplement, 1997). For the small rural hospitals, particularly those for whom the Medicare share of inpatient revenue exceeds 40 percent (but not 60 percent, the current threshold to be declared Medicare dependent), the reductions in PPS payments threaten an already thin profit margin (for some the profit margin is already negative).

Physician payments are constrained by application of a sustainable growth rate based on changes in the gross domestic product (GDP), not the higher rate of growth in medical inflation. Other payment changes affect the potential revenue of rural providers, including conversion to prospective payment for the following: outpatient services, skilled nursing facilities, and home health. Current payments are reduced for home health, hospice care, durable medical equipment, and oxygen payments.

Increase in the Floor Payment

The reality of payment reductions in fee-for-service can be compared with increases in risk contract payments in many rural counties. In the first year of new payment rates (calendar year 1998), 35 percent of all counties have rates set at the new floor of \$367 per person per month. The floor applies to 34 percent of rural counties adjacent to metropolitan areas and 49 percent of the other rural counties. Approximately 13.8 percent of Medicare beneficiaries live in the counties whose rates are set at the floor (McBride 1997). Differences can be quite dramatic; the lowest rates were increased from \$221 to \$367. For all of the counties at the new floor, the increase exceeded two percent, the minimum increase guaranteed by the BBA. Furthermore, these rates are sure to increase by at least two percent per year, again set in the law. More rural counties will benefit from the implementation of another change from the BBA — blended rates (50 percent national and 50 percent area). The rates are to be phased in, a process that has not begun during the first two years of the BBA because of the necessity to also

achieve budget neutrality (see McBride 1997 for an explanation). By the year 2004, though, nearly 83 percent of all counties are expected to be paid the blended rate, which will have the effect of increasing payment in counties previously below the national average (but above the floor). In short, risk payments will be increasing at rates likely to exceed the rate of change in fee-for-service payments, at least in rural counties.

Local Control

Another reason to consider forming a rural PSO is to maximize local control over the delivery of services. Rural providers, physicians in particular, may have an increasing sense of losing control of patient care to insurance plans that use detailed protocols for utilization management. Choices of referral physicians are influenced by health plan provider panels, which may not include the consultants normally used by rural primary care providers. As the insurer, the PSO would promulgate whatever policies are needed to improve cost effectiveness in delivering services. Rural providers concerned about Medicare beneficiary enrollment into managed care plans that would impose externally derived utilization management protocols and referral physician panels may find the creation of their own managed care plan an attractive alternative.

Investment Opportunities

Finally, developing a rural PSO may open options for additional investment in rural health care delivery systems. There are two possibilities for investment. First, in order to develop a successful PSO, the providers will need to invest in information systems, marketing plans, quality assurance systems, and systems to manage the finances for the plan. These investments will increase the value of the provider network in working with other health plans, placing them in a position to offer products in other markets (such as commercial insurance) and/or negotiate more effectively with health plans in those markets. Second, if the PSO is cost-effective, it could realize a gain in net income for rural health as compared to the payments in traditional Medicare. While much of any increase must be re-invested in the plan to benefit beneficiaries, rural PSOs could pay out higher fees to providers and/or invest more in the infrastructure of the PSO.

The Cautionary Warnings about Forming a PSO

Risk

The concept of accepting a risk payment from Medicare obviously means the plan doing so is henceforth *at risk (including the prospects of losing money)* for the costs of the services it provides to those who enroll. The cost of those services will exceed traditional Medicare payments, since for competitive reasons managed care plans will need to offer services beyond those paid for by traditional Medicare. Beneficiaries will not feel any need to change their current enrollment unless there are financial benefits to them, including lower deductibles for currently eligible services (such as lowering the deductible for inpatient hospital care) and coverage for benefits not currently included in Medicare (such as vision care). Consequently, some portion of risk payment, including the increases resulting from changes in the BBA, will be spent for expenses not presently covered by Medicare as well as on management functions associated with managing risk. In short, providers cannot assume that all of the increase represents “profit” to use for increases in provider revenue; the amount that is available will be a function of the cost of an enhanced benefit package and how cost effective a health plan will be.

Increased Administrative Requirements

Rural health providers should not consider using the PSO designation process and offering a Medicare+Choice offer as a lucrative means of paying for “business as usual.” Providers must realize that in forming a PSO they are adding management and insurance functions to their existing patient care responsibilities. These are functions that will require considerable financial investment from the provider members of a PSO, or from external sources. While no group should enter into a PSO venture without confidence of success, they must recognize the risk of losing some or all of the initial investment.

Doing better financially under a PSO arrangement is more than recouping initial investments. A capitated contract (per person enrolled per month) can be profitable for providers, if the following conditions are met:

- at least some significant portion of the persons enrolled do not use services during any given year;
- for those who do seek medical treatment, their care is managed cost-effectively;

- medical services are integrated with other support services to minimize use of expensive modalities; and
- finances are well managed, generating investment income from the monthly premiums.

Meeting these conditions requires:

- effective marketing that reaches beyond any provider's current patient base;
- medical management strategies that constantly improve the quality of practices;
- growth of integrated networks;
- use of case management for persons with chronic illnesses;
- information systems that support care management; and
- financial systems that generate return on investment.

Enrollment Requirements

To meet all of these demands, the PSO will also need to be confident that it will enroll a sufficient number of persons to generate a substantial flow of *net revenue*, which also means being confident that the enrollees will be a cross-section of the population, and not predominantly those who use services (e.g., adverse risk selection).

There are, in sum, reasons to be cautious about launching a PSO, particularly for rural providers. Why particularly for rural providers? There are some obvious reasons:

- rural providers are generally small volume providers, either as small clinical practices (numbers of physicians, not patients per physician) or small institutional providers (small hospitals in particular);
- rural providers are less likely than their larger urban counterparts to already have in place some of the systems appropriate for managed care organizations;
- rural providers are not likely to have large capital reserves; and
- Medicare beneficiaries in rural areas have not been introduced to managed care.

Despite these "handicaps," the PSO option may be attractive, especially given the alternatives.

Summary of Considerations

The decision to develop a PSO is not automatic. At first blush, especially in counties with historically very low AAPCC rates, taking action to receive the new payments is very attractive. Further, the alternative of continuing to accept the declining (in real dollars) fees paid through traditional Medicare is not at all appealing. Only after closer examination are the risks associated with contracting for the risk payment rate apparent. Those risks may be interpreted differently by different rural providers. On a purely philosophical level, some persons and organizations are more comfortable than others with accepting risk. More pragmatically, different providers will be affected differently. For example, while hospitals are the most severely affected providers by the budget savings in the BBA, they may also have the most to lose in a risk contract. If part of managing risk is to reduce use of hospitals for inpatient care, those hospitals not organized to participate in other forms of delivering care could experience net loss of revenues.

The point just made about rural hospitals raises a closing general consideration. Any rural provider (clinician or institution) should view participation in a PSO as an investment that would earn a return based on the PSO's bottom line, not the direct payment to the provider. Participating in a PSO can be a profitable undertaking, but only if all those in the PSO are committed to success as a PSO. Viewed more globally than the health care providers, a successful PSO could benefit the rural delivery infrastructure and the residents of the community more effectively than individual providers working to maximize their separate financial well being.

RECOMMENDATIONS IF DEVELOPING A PSO

Rural providers considering forming a Provider Sponsored Organization (PSO) will need to proceed deliberately through a logical progression of first balancing the pluses and minuses of risk contracting, and then through planning for a new business. Initially, the providers considering this option will need to be sure they represent a sufficient population base to succeed as an insurance entity. Being in a position to succeed as a PSO requires analysis of financial, medical management, and marketing variables. In addition, a managed care plan requires organizational capacity to handle administrative burdens related to fiscal management, member enrollment and relations, provider relations, quality assurance, negotiations with other providers and systems, and government relations. In the end, establishment of a successful PSO in rural areas *is possible*, but *requires considerable preparation and ongoing intense management*.

Basic Points in the Pluses and Minuses

Before proceeding with the investment of resources (including time and energy) to complete the type of analysis suggested here, rural providers should be able to answer affirmatively the following questions:

- Do I have reason to believe there is a financial benefit to developing a PSO? The answer is yes if the capitation rate seems attractive, or if others are likely to enroll Medicare beneficiaries in managed care plans.
- Do I believe Medicare beneficiaries in this community would be better off if they enrolled in a PSO-sponsored managed care plan? The answer is yes if the PSO can offer a plan that includes benefits beyond basic Medicare for a monthly premium below that charged for supplemental insurance. Another reason the PSO approach may be important is if others are offering managed care plans in the region and the PSO has a value as a locally owned and operated plan that strengthens the local delivery infrastructure.
- Am I supportive of managed care as an approach to delivering services? This is not a question about favoring particular strategies currently used by managed care plans. Instead, it asks if providers support changing their practices, as appropriate, to follow principles of cost-effective medical management. At least some rural providers would argue they already do so, in which

case the answer is yes.

- Am I willing to work collaboratively with other rural providers to offer an insurance product and follow the elements of medical management the PSO may determine are needed? Answering yes to this question requires some sacrifice of autonomy for a collective good. Many providers are already doing this, either as members of an IPA or as members of hospital networks.

The following suggestions take rural providers through the early steps of PSO formation (Clay 1998):

- gather information about the BBA and regulations (a rural perspective is available through the Rural Policy Research Institute web site: www.rupri.org);
- assess how a PSO supports or conflicts with corporate strategies and goals (presented here as a question for each provider); and
- conduct market and organizational readiness (who else will enter, and am I willing to participate in a network response).

Clay's other steps are only appropriate when there is at least a preliminary commitment to proceed. They require a feasibility study, a business plan, application for a license, and an application to be a Medicare+Choice PSO.

Providers contemplating creating a PSO and competing for enrollees into a Medicare+Choice plan must realize they are embarking on a business venture far different from running an individual office, clinic, or even a hospital. They are volunteering to accept the financial risk of providing an array of health care services for a fixed payment over an extended period of time. This will involve being responsible for functions not previously maintained by the providers:

- actuarial assessment;
- capital reserve management;
- claims and payment administration;
- management information systems for administration and patient care functions;
- member enrollment and tracking;
- member relations;

- provider relations; and
- utilization management.

According to the Health Care Advisory Board (1998) that developed the preceding list, a successful PSO will need to develop a capacity for health plan marketing and negotiations with health plan purchasers.

A final general point needs reiterating: *Creating a PSO and offering managed plans to Medicare beneficiaries is a viable strategy, if certain assumptions about payment are met, and if rural providers are organized to accept and manage financial risk.* We should also recognize that *providers who consider forming PSOs must not be risk averse; there no guarantees for net gain, but only the prospects for being better off than either continuing to accept fee-for-service payments, or negotiating with other health plans.*

Importance of Having Networks of Providers

One important reality of accepting the risk to insure a group of persons is to know the group will be sufficiently large as to include a high percentage of enrollees who will not need services. Their premiums finance the services provided to users. There are no “magic numbers” as to the number of enrollees needed, but it is certainly higher than any single rural provider, or collection of providers in a single rural community, currently serve. A combination of two facts should make this obvious. First, any effort to offer an insurance product will require an initial capital investment and ongoing expenses related to the insurance function that are not now part of rural provider budgets. These costs will need to be recovered from premiums, requiring substantial enrollment. Second, there are very few Medicare beneficiaries already enrolled in managed care plans, which means a substantial number must be convinced to not only change insurers but also to change the type of insurance they have now. That argument has been a challenge in urban areas where Medicare enrollment is 22.5 percent of beneficiaries in central cities and 12 percent in outlying urban counties. In rural areas where enrollment is currently only 3.1 percent in counties adjacent to metropolitan areas and 0.6 percent in other counties (Medicare Payment Advisory Commission 1998), the challenge is tremendous. Hence, for PSOs to have reasonable prospects, multiple communities will need to be included in a single network to increase the potential number of enrollees.

There have been other reasons to form rural networks, including economies of scale for purchasing supplies, managerial efficiencies, strengthened bargaining positions with insurance plans, and supporting the infrastructure of rural delivery systems (e.g., taking patient call across communities, allowing one hospital to scale back to a limited service facility because of an agreement with another hospital). Therefore, network entities have been formed in many rural areas that could become platforms for PSO formation.

Rural delivery networks continue to form, motivated at least in part by federal programs. The Medicare program now includes provisions for designating “critical access hospitals” that can be eligible for cost-based reimbursement, provided they are part of delivery networks. The federal Office of Rural Health Policy offers grants to support rural delivery networks. Thus, the potential for PSOs, from the perspective of organizations that could consider this option, grows.

Financial Analysis

A thorough financial analysis is needed to answer the critical question: “Will the rural providers in the PSO be better off financially as a result of participating in Medicare+Choice?” All costs associated with administering a managed care plan must be considered, including start up capital, ongoing administrative expenses, and costs of medical services provided. Each of these will be described in turn here. Initially, though, two principles need to be highlighted. First, estimates of the costs will vary considerably. Second, for an increasing number of health plans Medicare is not the only product line converting to some form of managed care. Therefore, some of the fixed costs can be spread across a number of different products.

Capital for start up costs.

Start up costs for a PSO include the following:

- reserves;
- working capital;
- consulting and actuarial fees;
- attorney fees;
- information systems;
- office setup;
- pre-operational staff;
- marketing; and
- first year operating loss (Weissenstein, 1997: 38).

The amount of funds needed will be a function of the market of the PSO (numbers of elderly and dispersion), reserve requirements being met (varies by state unless using the federal solvency standards), and current capacity of the PSO. Estimates in the trade literature begin at approximately \$2.5 million and are as high as \$9 million. Using the list from above, and the estimates provided in the same article, the range is from \$2,425,000 to \$6,000,000. The most expensive items are: reserve requirements (\$1 million to \$3 million), first year loss (\$.5 million to \$1 million), and working capital (\$.4 million to \$1 million). Information systems may be very little (if capacity already exists the cost can be zero) to \$750,000 (Weissenstein 1997: 38).

A critical early decision, then, is how to finance this immediate setup cost. This requires access to capital. There are several options for meeting this need, including:

- securing a financial partner, such as an insurance carrier — the partner would need to be willing to partner without controlling the governance of the PSO (majority must be providers);
- using funds from the provider members themselves — these would need to be dedicated to the PSO and not available for other purposes;
- soliciting contributions to the PSO, including use of grants or contributions from charitable foundations;
- selling shares in the PSO in an open or closed market (for example, shares to the providers, or shares to the community); and/or
- having the providers and others finance the startup costs with no further expectations of direct return on investment; instead relying on payment being more favorable than alternatives to a locally owned PSO Medicare+Choice plan.

The initial capital requirement is a hurdle to overcome, but not a barrier to proceeding.

Developing a financial plan.

A detailed financial plan is a requirement for applying for a Medicare+Choice contract, and is also good business practice. The plan should include an analysis of the market for the M+C product and a cost model showing a net positive margin after a reasonable interval. The market analysis should include the following considerations:

- description of the current Medicare eligible population in the service area, including distribution across age and gender categories, household income, and if available, health status;
- projections for changes in the Medicare population;
- other risk contractors' marketing plans in the service area;
- other providers in the market;
- comparison to payment rates for traditional Medicare in the service area;
- information about the insurance status of Medicare enrollees in the market, in particular supplemental insurance plans they own; and
- assessment of other managed care activity in the market, which could indicate potential for

M+C alternatives.

The completed market analysis should yield estimates of the number of Medicare enrollees who might potentially enroll in the PSO M+C plan. It will also provide data for use in the marketing plan, including target groups (based on population concentration, association with particular supplemental plans or employers, age and gender). ***The network creating the PSO should be prepared to change the definition of the market area as a result of market analysis.*** The analysis may reveal that the numbers of potential enrollees, even after accepting up to three years as an initial period of operating loss, is too small to be confident that an appropriate risk pool will be in the plan. There are no “magic numbers” for this level of confidence, although the minimum enrollment numbers set in the M+C regulations are certainly too low for a sustainable health plan. The principle guiding a judgement about the total number of enrollees is that as a result of a sufficient critical mass, actual experience will approximate the estimated average annual expenditures used to calculate premiums. When numbers are too small, there is a greater likelihood that adverse selection could bankrupt the plan, because risk is spread over too few enrollees. A part of financial planning is to account for at least some adverse selection through reinsurance, but that measure cannot be relied upon to reduce all potential risk.

The financial plan includes an assessment of the competitive market place. Are other HMO plans being marketed in the service area, and if so what are their benefits and premium charges? What are Medicare beneficiaries purchasing in supplemental insurance policies? The answers to these questions provide a parameter to target for the cost of the plan the PSO will offer. A final, perhaps most important, step in financial analysis is to construct the plan to be offered. This involves actuarial calculations of the cost per benefit per member for each benefit to include. Those costs are affected, in turn, by assumptions the PSO management makes about how effectively the organization will be able to manage use of medical care services. For example, utilization of hospital services absent any attempt to manage use might be at a high level now and remain there, perhaps at 1,450 bed days per 1,000 enrolled members; and admission at 250 per 1,000 enrollees, and average length of stay of just under six days. If those numbers were lowered by a PSO to 830 bed days, 170 admissions and five days per stay, the percent of revenues available for other use by the PSO would increase considerably. Assumptions about what the PSO will be able to accomplish in controlling costs include calculations that vary at least once in each direction; more or less savings.

The costs of all benefits need to be calculated, with varying assumptions of utilization. Doing this may lead to a decision not to offer some benefits Medicare does not require. The leading illustration of this point is prescription drugs. Such benefits may be offered, but at varying levels — prescription drug benefits with a monthly maximum benefit is an example. As much detail as possible should be built into these calculations, as the financial success of the PSO is dependent on good judgements in the financial analysis, and the management decisions based on that analysis. The final figures should include an expected monthly claim cost per person, an administrative overhead cost per person, an estimate of the value of the competition's products, and an estimate of the premium needed from enrollees. **If at the end of the financial analysis, the PSO determines pursuing its own M+C contract is unrealistic, members of the PSO should immediately convert the analysis to answering questions about what are good contracts to sign.** Providers should not sign on with plans that have not undertaken careful analysis; patients disappointed by those plans could spread their disenchantment to the providers who participated in them.

Marketing Plan

In addition to market analysis, the PSO must develop a plan for marketing the M+C plan. Marketing begins where the financial plan left off — specifying the benefits to be offered, which are determined based on the competition in the service area. Potential enrollees should be attracted because the benefits are more comprehensive than what they currently have, and are offered at a competitive price to the beneficiary. Along with the definition of benefits, the marketing approach to individual consumers will include policies and procedures concerning emergency services and out-of-area coverage (Prescott 1997).

Marketing strategies include marketing to single enrollees, and marketing to corporate groups (retirees) through corporate benefits officers. The former is currently the most commonly employed strategy, as signing with any particular plan is a decision for the individual beneficiary. However, beneficiaries who currently receive retirement health insurance benefits could be persuaded to enroll in M+C plans if their former employers include that as an option and create incentives for enrollees to select the M+C plans. Employers could be convinced to do so if, as said in the paragraph above, their cost of providing the benefit would be lowered.

Regardless of individual or group approaches, the marketing plan should reflect careful analysis of the following:

- characteristics of the target audience; e.g., they may require more time per sale, may begin with an inadequate understanding of their current coverage, and may be concerned with end-of-life issues;
- interests of the target audience; e.g., related to their educational background including knowledge of health care, their leisure activities, and their mobility;
- communication channels used by the elderly — print, electronic, personal; and
- cost-effectiveness of various communication strategies.

PSO marketers must adhere to requirements set forth by HCFA, governing such practices as enrollment, disenrollment, involvement of providers in marketing, and discriminatory advertising designed to attract certain groups and/or exclude others. Execution of the marketing plan will require under-

standing that marketing a M+C plan is not the same as selling vacuum cleaners; it requires far more attention to meeting personal needs of potential enrollees. The value of the plan should be what people purchase, so the benefits are critical to marketing. There should be a reason to choose the PSO product over others. Finally, once the elderly are enrolled, marketing continues for the purpose of retaining those persons in the plan.

Provider Relations

PSOs will need to establish rules of governance that specify how provider members are involved in decisions concerning benefits to offer, quality assurance plans to adopt, payment schedules for providers, and external contracts to be signed. Some important decisions concerning individual practitioners need to be made by the PSO before a M+C contract can be signed:

- who will be invited to participate in the PSO (perhaps not all providers in the service area);
- how providers will be credentialed to participate in the managed care plans the PSO chooses to offer — in-house credentialing versus purchased service;
- application of any requirements for board certification, an especially important issue in many rural areas where there may be older physicians who have not “bothered” with board certification;
- rules for “deselection” from PSO provider panels;
- use (or not) of economic profiling;
- application (or not) of federal rules concerning self-referrals (so-called Stark rules); and
- how liability will be shared among PSO members.

Many of these questions can be addressed by health care delivery networks before forming PSOs for the purposes of offering managed care plans. They are issues that are dealt with in physician manuals used by Independent Practice Associations (IPAs), physician agreements also developed by IPAs, and network bylaws written by hospitals and physicians (and sometimes other entities such as mental health providers, public health providers, and long term care providers).

PSOs need to maintain the interests and involvement of member providers. The medical director for the M+C plan can take a lead role in this activity, but will need support from a number of others. A variety of services can be used to maintain the active involvement of providers:

- continuous education sessions for health care professionals;
- career development for administrators of the network and of member institutional providers;
- committee activities related to governance of the PSO; and

- servicing practices and institutions through purchasing agreements, discounts on necessary products and services, and organizational development.

These are only suggestions for initial and continuous activities related to provider relations. The key point being made here is to be sure this function is included in plans for the PSO.

Negotiations

There are three sets of negotiations important to the PSO as a M+C product is developed and marketed. First, there are internal negotiations needed to secure the providers needed by the PSO. Second, the PSO will need to negotiate with providers outside its own network for services it cannot provide such as transplantation and other highly specialized services (this is especially true in the case of rural PSOs). Third, the PSO may choose to negotiate with providers in other service areas for out-of-network care. This may be especially likely in areas where a large portion of enrollees migrate to a different area for entire seasons (e.g., from the upper midwest to the sun belt). In any of those negotiations, a set of common contract issues needs to be addressed:

- fees and charges;
- timeliness of payment;
- term of the contract;
- settlement of grievances;
- assurances of business;
- responsibility for sharing information; and
- other rights and responsibilities.

Physicians will be especially concerned with any contract provisions related to medical management, the next general topic discussed in this paper. Hospitals will pay special attention to decision authority for continued inpatient stays and financial liability related to stays that exceed standard lengths. Issues for all providers in the network include how payment is determined, and how membership in the network is determined. On the latter point, there will be concern about admitting natural competitors to the network for the PSO, who may then have access to information that can be used when competing for other products. The final internal contract will need to address access to information issues for that purpose, as well as to protect patient confidentiality.

Medical Management

Medical management must be effective for a PSO to deliver cost-effective care for any extended time. The patient benefit of managed care is to have a health care delivery system that pays heed to maintaining health, not just treating illness and injury. While this may seem to be an obvious point, it has not been the driving force behind what has been labeled “managed care” in recent years. Instead, managed care has become equated with reducing expenses by any means, including arbitrary (at least in the perception of consumers) decisions to reduce utilization by denying payment for certain services. Such actions are the *negative* in managed care; medical management strategies properly implemented are actually the *positive* in managed care.

An early step in medical management is to focus on utilization of services. For cost savings purposes, but also for quality of health, the emphasis is on reducing inpatient days in the hospital. For Medicare populations, as illustrated in the discussion of financial analysis, the potential for savings is quite significant. There are two elements to this strategy — preventing unnecessary hospitalizations, and reducing the length of stay for those who are hospitalized. In the context of medical management, neither emphasis requires less care, but instead, different modalities of care. Once again, the importance of having integrated networks participate as PSOs becomes obvious; alternative care strategies are best executed by providers who are themselves members of the PSOs, and the financial gain from better use of the capitated premium dollar can be distributed across all providers. This component of medical management requires specification of responsibilities in demand management — the roles for triage nurses, physicians, hospitals, community based services, and long term care (including rehabilitation and home health). The tools of conventional case management would be used.

A more advanced approach to medical management, and the one effective M+C plans should strive to achieve, is disease management. This strategy requires the following steps:

- health appraisals of enrollees to identify those with chronic conditions and those at risk for developing chronic conditions;
- developing a long term plan for treating those with chronic conditions;
- coordinating care across a number of different providers; and
- monitoring the health of the individual person.

This approach to health care delivery requires considerable initial investment, but the potential for return is substantial. The health plan will realize cost savings because chronic conditions are monitored and controlled, resulting in much less treatment of exacerbations (e.g., hospitalizations, outpatient services). The enrollee has the most to gain, as there will be a substantial improvement in quality of life. That gain, in turn, translates into gain for the plan through patient satisfaction.

The combination of a general plan for all enrollees, use of demand management to control use of the most expensive medical services, and disease management to monitor chronic illness would build an effective medical management strategy for the M+C plan sponsored by a PSO. While a great deal of attention would initially be given to financial and marketing analysis, a PSO should not embark on creating and offering a M+C plan without a well conceived strategy for medical management. The strategy must include more than meeting requirements of Medicare for accreditation and implementing demand management and utilization review. The optimal medical management plan focuses on quality of care for individual enrollees, recognizing the relationship between quality and effectiveness of the plan.

Information Systems

A network-level information system is an essential ingredient to make any health plan effective. The initial step for many rural PSOs will be to choose an appropriate and affordable approach to information networking to support the development and ongoing operations of the PSO. Although the use of information networks is relatively common place in urban-based plans, the approach to creating a network-level information system in rural areas is less obvious due to the vastly different geographic, organizational and resource conditions under which information networks must be developed. In choosing a system a rural PSO will need to address the following key questions:

- What information networking approaches and technologies are available?
- How do we identify our network-level information needs? and
- What questions and selection criteria do we use in selecting a system that fits our particular needs?

As the development process proceeds it will be necessary to complete an analysis of available data sources and reports, and the computing environment of PSO member organizations and business partners.

In implementing the network information system the PSO should seek to provide information and communication services that support:

- basic organizational functions including financial planning and management, clinical services and linkages to clearinghouse information services and health professions education programs; and
- PSO board, committee and staff involvement in the day-to-day operation and planning, development and evaluation of PSO products and services.

The following system applications in particular should be facilitated by the rural PSO's network information system (Kelly 1998):

- claims payment and encounter tracking;

- utilization management to support preadmission/referral authorization, concurrent review, and case management;
- case-mix and cost-accounting systems;
- quality and outcome reporting;
- market data base, including current demographic data; and
- provider data base, including information on credentials, location and hours of operation.

Eventually, additional planning and investment will be needed to expand the system's capability to produce data that measures outcomes of care and can relate those outcomes to variables under control of the health plan.

Although the development of a rural PSO network information system clearly is a technology initiative, the process of choosing, acquiring and implementing a system is as much an organizational development initiative as it is an effort to achieve technology enhancement. Core values concerning ownership and control of data, member autonomy, security and potential revenue from information services will need to be addressed openly and effectively along with highly technical discussions concerning server, transmission and user interface issues. Consequently, the system development package should include both technological and organizational development elements to help ensure success.

SUMMARY COMMENTS

This paper presented overviews of important considerations for any group of rural providers thinking about embarking on a path toward offering a locally owned M+C product. A considerable volume of literature is building about each of the topics discussed in this section, and rural PSOs are encouraged to become well versed in each. The reason is simple, success depends on acumen. A recent quote of Mickey Herbert, the co-CEO of Physicians Health Services in Trumbull, Conn. should be heeded: “I think there are a lot of organizations ready to rush into Medicare managed care. Some of it is hubris. Some of it is seduction. There is a lot of naivete out there — a feeling that you can start an HMO with an accountant and a couple of bookkeepers. But this is a tough business and you better not think about getting into it unless you are damn good (Wehrwein 1998).” Some organizations will enter this field — the first application to HCFA for waiver from state requirements was filed by S. Joseph Healthcare System in Albuquerque, New Mexico in June, 1998. Others will surely follow; hopefully considering the topics described above.

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