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Cancer Carve-Outs

Can They Fulfill the Promise of Managed Care?

by Bettina Kurowski, D.P.A.

Just a few short years ago, managed care began to revolutionize the nation's health care delivery system. The promise of managed care was to reduce cost, improve the quality and outcomes of services, and develop greater efficiencies in a system becoming, according to some, overburdened with bureaucracy and runaway costs.

Within a few years, many of the tenets of managed care became reality, particularly in states such as California, Florida, and Minnesota. Despite concern—and in some cases genuine mistrust within the medical community—health maintenance organizations, managed care organizations, and other health care providers began developing and implementing the innovative programs touted by managed care proponents. Networks of providers were formed. Capitated contracts were signed. High-tech communication systems were created. A new era in health care was born.

THE SYSTEM TODAY

Today, reality has set in. Some in the health care community continue to view managed care as "rationed" care. Others see it as the ideal way to fund prevention and health enhancement programs given the constraints on the current system.

Perhaps the issue having the greatest effect is that the millions of people enrolled in HMOs and other managed care programs in the 1970s and 1980s are beginning to age. What's more, the addition of Medicare risk products and the institution of retiree benefits is further expanding the population that must be covered.

The result? HMOs and other health care provider organizations are faced with the dilemma of determining how to best manage larger segments of enrollees with increasingly complex and costly diseases. In addition, beneficiaries are demanding that the level of care they have come to expect for routine illnesses be expanded to cover even catastrophic diseases, while the payers demand that cost constraints continue.

SPECIALTY NETWORKS, DISEASE MANAGEMENT, AND CARVE-OUTS

Proving the old adage "necessity is the mother of invention," the health care community is meeting the current challenge through the development of innovative health care delivery systems and enhancements to existing ones. The delivery systems are specifically designed to improve services and reduce costs for many of the more costly and complex disease states encountered today.

These systems, some of which have been around for several decades, are known by a variety of names, each with similar goals, yet each with distinct ways of providing services and outcomes. These efforts are known as specialty networks, either Preferred Provider Organizations (PPOs) or Independent Practice Associations (IPAs); disease management; and carve-outs.

Specialty networks. Specialty networks can be either a PPO or an IPA model. According to the American Association of Preferred Provider Organizations' most recent profile on the industry, a PPO is "an organization or subset thereof which has at least one self-developed (or owned) network of providers and has the ability to track utilization and eligible employees for that network or networks."[1]

The majority of PPOs either discount from usual charges or use a maximum benefit schedule based on relative value scales.

IPAs, according to their trade association, The Independent

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Practice Association of America, are loosely formed organizations that negotiate binding contracts, either discounted fee-for-service or capitated, on behalf of physician members.

Payers—insurance companies, HMOs, and large self-insured employer groups—divert their enrollees to the IPAs or network of PPOs they select for plan members. In return they receive discounted fees, claims administration, and other services. IPAs tend to be more prevalent in California, Florida, and other states where managed care is dominant, while PPOs are common throughout the United States. Within the past few years, specialty PPOs and IPAs have begun to break away from their traditional role as a subcontractor to the primary care medical group to negotiate contracts on their own and to take on the risk of providing this service through negotiating capitated contracts.[2]

Disease management. In large part, the term disease management was brought on by the acquisition of pharmacy benefit management firms by major drug manufacturers. This new delivery system claims to better manage enrollee populations with specific diseases such as hypertension, diabetes, and heart disease. Under this type of system there is a concentrated focus on the treatment of a single disease.

Companies that specialize in disease management are cropping up throughout the country and are marketing their services to HMOs and other payers. In addition, many HMOs have developed their own brand of disease management to better serve key segments of their enrollee population.

Disease management does not always involve the full spectrum of care. Often it is merely a drug manufacturer contracting with an HMO to provide a limited program of care to patients with specific disease states such as hypertension or diabetes. Within the past year, cardiology has become a popular model for disease management. Under the disease management model, primary care physicians retain control over individual patients and can refer to the disease management program as needed, or incorporate certain elements of that program directly into their treatment plan.

Carve-Outs. There are many definitions for a carve-out, some quite narrow and some more broad. Traditionally, HMOs and insurance companies define a carve-out as any portion of the benefit plan that is not part of the global service agreement. Payers look at carve-outs as a way to "synthesize" and enhance a health care program, while efficiently managing cost and services, through a variety of sources.

Traditionally, carve-outs have run the gamut from mental health and vision to dental, pharmacy, podiatry, and chiropractic. More than 20 million people currently receive such services from a carve-out. Historically, only mental health carve-outs focused on the treatment of an entire spectrum of illnesses, using a variety of specialists, types of providers, types of treatment, and sites of care. Because they are much simpler to develop and administer, the majority of carve-outs (e.g., podiatry or dental care) offer a limited range of services and sites for a short list of problems. In either case, entire segments of the health care plan's beneficiaries are "carved-out" and placed in separate programs. The primary care physician no longer retains control over that portion of a patient's illness.

The demand for lower costs for complex care is increasing the number of carve-out benefit programs. Some HMOs and insurance carriers not only have developed their own carve-outs, which can be "carved in" to their own integrated benefits, but now market those same carve-outs directly to employers, insurance companies, and other HMOs. Only a few provider companies, such as the Los Angeles-based Salick Health Care, Inc., which specializes in the diagnosis and treatment of cancer and kidney disease, have developed managed care subsidiaries, such as SalickNet, that sell carve-out benefits to HMOs.

CANCER AS A CARVE-OUT BENEFIT

Carve-outs continue to evolve to meet the needs of patients, providers, and payers today. The success carve-outs have had in areas such as mental health and dental services has caused providers to look at the potential benefits they could bring to other disease states as well. The incorporation of managed care into the treatment of chronic diseases such as cancer is particularly promising. Cancer treatment lends itself to a carve-out approach for several reasons:

Cancer is affecting a greater number of people in managed care organizations. As increasing numbers of Americans enter a managed care system via Medicare, their employer, or a retiree plan, managed care organizations are struggling to find ways to service this population. This number is not likely to be reduced any time soon. American Cancer Society (ACS) statistics indicate that if current incidence and mortality rates remain the same, about 40 percent of the population will eventually develop cancer.[3]

Cancer can be expensive to treat and therefore payers are anxious to find ways to cut costs. According to a soon-to-be-published book, written in part by researchers at the National Cancer Institute, cancer costs the nation $41.4 billion annually in direct medical costs.[4] The good

news is that the handful of managed care programs now available are beginning to bring costs in line. For example, a typical autologous bone marrow transplant procedure can require a 40-day hospital stay. Partly to meet the demands of managed care payers, some programs are cutting hospital stays to less than two weeks or are moving entirely to the outpatient setting and thereby are reducing costs by up to 50 percent.

Cancer is an easily definable disease. Many of the new carve-outs are endeavoring to cover diseases with multiple symptoms and indicators such as hypertension. These efforts can lead to conflict among physicians. Carve-outs may even compete over who should retain control of the patient. There is much less doubt as to diagnoses when identifying cancer.

There is a clear beginning and end to treatment. As mentioned, unlike other disease states, cancer is a clearly definable disease. In addition, treatment usually begins upon diagnosis. Likewise, active treatment is discontinued if a patient goes into remission or reaches the end-stages of the disease. Active treatment for other diseases can go on for decades.

Physicians are willing to turn their patients over to a carve-out when cancer is the diagnosis. Many primary care physicians believe they are most qualified to care for patients with diseases such as hypertension or diabetes, especially when the disease is in mild to moderate form. Therefore, it is difficult to persuade physicians to turn over those patients to a carve-out even for a short period of time. Primary care physicians, however, easily recognize the importance of cancer specialists and are willing to have their patients go to another network to receive the best possible care. They recognize that if the patient gets better, which is the ultimate goal for all parties, he or she will return to their care. However, it is important for the network to communicate clearly its policy regarding carve-outs to primary care physicians and to keep them up to date on the status of their patient's treatment.

It can clearly be demonstrated that quality can be improved through consistency of treatment and standardization of protocols. Currently, there are surprising random variations in the treatment patterns for cancer. For instance, the ACS notes that the percentage of women who receive breast-conserving lumpectomies versus mastectomies varies from state-to-state, city-to-city, and even among physicians in the same area. ACS studies show that currently about 25 percent of all breast cancer patients receive lumpectomies. However, these same studies suggest that as many as 50 to 70 percent of patients receiving mastectomies could benefit from lumpectomies. The development of standard protocols could be the first step in creating uniformity in treatment patterns.[5]

Development of standard protocols could be the first step in creating uniformity in treatment patterns.

THE NEED FOR STANDARDIZED PROTOCOLS

To help develop these much needed protocols, SalickNet, a wholly owned subsidiary of Salick Health Care, Inc., recently announced the development of the first group of guidelines in a series.

The process of developing guidelines is extremely labor and resource intensive. When scientific evidence was available, a meta-analysis of the literature was conducted and reviewed by Salick Health Care medical directors throughout the country, as well as by a national panel of independent experts. This process resulted in guidelines for metastatic colon cancer, use of antiemetics, growth factors, site of care for chemotherapy, febrile neutropenia, and TPN.

When the scientific literature was inconclusive, as in the case of bone marrow transplantation for breast cancer, another methodology was used, one first developed by the Rand Corporation. More than a thousand different breast cancer scenarios were ranked for appropriateness of treatment. The resulting opinion ratings formed the basis of the guideline. This technique will be used to develop other transplant guidelines as well.

All of these guidelines—both evidence- and opinion-based—are used in SalickNet's product, which is already on the market and purchased by many HMOs and other managed care entities.

The knowledge developed through guidelines allows physicians and patients to focus on treatment options with the greatest potential to improve outcomes. It also helps to guard against over- and under-use and can ensure some consistency in the application of costly and high-risk procedures.

Equally important, the guidelines also give payers something they need—data to help them track the clinical pathway of treatment and measure outcomes or results of treatment.

A key part of any guideline system is the profiling of outcomes. SalickNet includes measures related to short- and long-term mortality, morbidity, patient and referring physician satisfaction, quality of life, overall effectiveness, and availability of services. Profiling of outcomes will provide a broad-based outcomes measurement system in cancer for large populations.

THE ROLE OF CASE MANAGERS

Working closely to support the development of outcomes measurement systems are case managers. Case management is a collaborative process that promotes quality care for the individual and cost-effective results or outcomes for the health care coverage provider.

Case management is particularly

important for developing treatment plans and managing care for patients with complex and potentially costly diseases such as cancer. Typically, case managers working with a carve-out will assess the program's protocols and the full spectrum of cancer care services available to the patient, both inside and outside the existing system. Then, acting as both an advocate for the patient and the program, they will assess the patients' needs and determine what resources are appropriate for that particular patient. More importantly, the case manager will determine if outcome goals are being met. If not, new treatment pathways can be developed in conjunction with the medical team, case manager, and the patient.

Equally important to payers, the inclusion of case managers in a carve-out allows for the development of detailed reports showing expenses, results, projected outcomes and their costs, and other options. Many payers have indicated that such knowledge helps in justifying the inclusion of high-quality programs for cancer care in benefit plans.

HOW TO IDENTIFY A GOOD CARVE-OUT

Although there is no doubt that many of the new carve-outs have already demonstrated their potential to save money and improve services, there is concern that some carve-outs will just add another layer of bureaucracy to the nation's health care delivery system. Some say new systems mean new paperwork and procedures and more training for employees. In addition, many established HMOs already offer existing networks, usually through PPOs, treatment services for cancer and other disease states. Such doubts make it difficult for HMO executives and benefit managers to determine what is and is not appropriate for a carve-out service.

Based on the history of existing carve-outs and the knowledge gained from recently formed models, several criteria for what makes a good carve-out stand out. Key questions to be asked include:

1) Will the carve-out reduce costs, contain costs, or at least make the cost of treating a specific disease state predictable?

2) Will the carve-out improve the quality of care, and as importantly, the quality of life for the patient?

3) Will the carve-out enhance the overall benefit plan and create a synergy among the overall benefit? For example, in the case of cancer carve-outs, does it offer elements not previously offered through the benefit design, such as research protocols, outpatient services, nutritional counseling, and cosmetic counseling?

4) Can the carve-out demonstrate its value through data? Can it show that patients live longer or have an enhanced quality of life with the new benefit design? Although strict cost comparisons are obviously important, with cancer it is also imperative to demonstrate value in ways other than mortality.

5) Will it be possible to efficiently, with minimum time and effort, integrate the carve-out into the existing benefit structure?

The future for managed care organizations in general and cancer carve-outs in particular appears promising

THE FUTURE OF CARVE-OUTS

The future for managed care organizations in general and cancer carve-outs in particular appears promising—with or without government mandated health care reform. According to the Group Health Association of America, the number of HMO enrollees has increased from six million in 1976 to more than forty-five million today, close to an eight-fold growth in less than two decades.[6]

Many new and existing HMOs are expanding to cover rural and far flung geographic areas where few major managed care organizations had a presence in the past. The growth potential for carve-outs is particularly positive with regard to these new managed care organizations. They must have the services provided by carve-outs to compete with the larger and more established HMOs. Despite the fact that many major HMOs have their own network of providers for certain disease states, there is still an opportunity for separate carve-outs to make an inroad.

Community cancer centers and regional comprehensive cancer centers will play a vital partnership role in the growth of carve-outs. Such centers will be sought out by new cancer carve-outs to help them expand their networks, which in turn will help ensure that such potentially cost-saving and beneficial plans are available to a broad cross section of health plan enrollees, not just those in major urban areas. In addition, to offer cost-efficient programs, new services will need to associate themselves with respected, established community cancer centers.

As carve-outs mature and begin to substantiate claims of better service and lower costs, HMOs and other payers will study the results and determine if there are potential benefits for their organization. Ultimately the result of these partnerships, if the promise of managed care continues, will be lower cost for payers, and most importantly, more clearly defined goals and better outcomes for a larger population of people. ■

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