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Contracting with an HMO for Medicare Services

by Albert B. Einstein, Jr., M.D., Patricia J. Goldsmith, and David W. Maberry, M.H.A.

Medicare beneficiaries are an extremely important patient population for both community and academic cancer centers: The incidence of cancer within the senior adult population is significantly higher than within the general population. To remain financially viable, a cancer center must develop effective strategies for contracting with HMOs for Medicare services.

The number of Medicare beneficiaries enrolled in a managed care plan has increased by more than 100 percent since 1993. In 1996 an average of 80,000 Medicare beneficiaries enrolled in a Medicare risk HMO product each month. More than five million of the thirty-eight million total Medicare beneficiaries were enrolled in a managed care plan as of May 1, 1997. This unprecedented growth (Tables 1 and 2) in Medicare managed care plans presents cancer centers with new opportunities for targeting their services toward the ever-growing numbers of Medicare beneficiaries.

There are three basic types of Medicare managed care plans: risk, cost, and health care prepayment plans.

- *Medicare risk HMOs.* HCFA pays Medicare risk HMOs a prospective per member/per month premium set at approximately 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. The risk HMO then assumes full financial risk for all Medicare-covered services to Medicare beneficiaries enrolling in the plan. With the exception of an emergency, members of a risk HMO are required to receive all care through the HMO and its contracted providers.
- *Cost plans.* These plans are not at risk for the care provided to enrolled members. The plan is paid a predetermined amount per member/per month based on a total estimated budget. However, any variances between the monthly payments and the budget are reconciled at the end of the year. Beneficiaries enrolled in a cost plan can receive Medicare-covered services outside the plan without restriction.
- *Health care prepayment plans.* These plans are similar to cost plans but do not cover Medicare Part A services (i.e., inpatient hospital care, skilled nursing, hospice, and some home health care).

Currently Medicare risk HMOs dominate the market, representing 280 of the 383 licensed Medicare managed care plans. Approximately 86 percent of the Medicare beneficiaries enrolled in a managed care plan are enrolled in a Medicare risk HMO. This article will focus specifically on the issues related to contracting with a Medicare risk HMO.

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Table 1. Federal Medicare Benefit Payments to HMOs (in billions)

By fiscal year	Payments to HMOs
1996	$17.9
1997	$25.6
2000	$57.1
2002	$72.9
2006	$141.2
2007	$153.0

Source: Congressional Budget Office, 1997.

Table 2. States with Most Medicare Risk HMO Enrollees

State	Number of Enrollees
California	1,354,556
Florida	621,792
Pennsylvania	396,828
New York	314,098
Texas	223,202
Arizona	221,790

Source: Health Care Financing Administration, 1997

BENEFITS FOR SENIORS

Significant financial benefits are available to Medicare beneficiaries who enroll in a Medicare HMO. Although Medicare HMOs can charge beneficiaries a monthly premium, 68 percent of Medicare HMOs do not charge a monthly premium and are referred to as "zero premium plans."

In addition to providing all the services covered by Medicare, most Medicare HMOs offer significant additional benefits at little or no cost to beneficiaries. Routine physicals, eye and ear exams, immunizations, and outpatient drug benefits are included in the basic option package by 70 percent of Medicare HMOs.

Many plans that include outpatient drug benefits—a strong selling point with seniors—have a monthly and annual maximum dollar benefit. However, as

competition in the Medicare HMO market has intensified, some zero premium plans are now offering an unlimited outpatient drug benefit. Of course, beneficiaries in these plans are subject to typical HMO copayments for this benefit and other services.

Another considerable financial benefit accelerating the movement of seniors into HMOs is the rising cost of Medicare supplemental insurance policies. Most Medicare beneficiaries purchase a supplemental or "Medigap" insurance policy, which often costs more than $1,000 per year. However, Medicare risk HMOs cover all the services of traditional Medicare without the significant cost-sharing provisions; thus, Medicare beneficiaries who choose to enroll in a Medicare HMO will no longer need a Medigap policy, resulting in a significant annual health care expense reduction for seniors.

OPPORTUNITIES FOR CANCER CENTERS

Medicare HMOs present cancer centers with opportunities for increased patient volume, higher revenue, and improved cancer care.

- *Potential for increasing patient volume.* Medicare HMOs typically have very tight provider networks. Thus, the Medicare beneficiaries enrolled in an HMO are steered to a limited number of contracted providers.
- *Prospect of maximized reimbursement.* Medicare HMOs typically reimburse their contracted hospitals based on a per diem payment methodology for inpatient services and flat rates for many outpatient services. Per diem rates are typically lower than the Medicare inpatient payment system, and a cancer program may initially experience reductions in reimbursement. With effective cost and utilization management, coupled with an ability to effectively negotiate and financially model proposed per diems and flat rates, a cancer program administrator can maximize the program's reimbursement levels.

Cancer centers that contract with a Medicare HMO on a capitated basis can achieve reimbursement levels greater than standard Medicare. The decision to accept financial risk for defined services must be carefully evaluated. Accepting risk entitles a cancer center to the rewards of its efforts to reduce costs and unnecessary use of resources.

- *Opportunity to improve care and treatment.* Through disease management, cancer centers can improve cancer care by eliminating much of the uncoordinated treatment, unnecessary testing, and the resulting patient dissatisfaction.

To realize these opportunities, a cancer center must be competitive by tightly managing its costs and utilization of resources. A strong in-house case management function will assist in managing a patient population reimbursed on a fixed payment methodology. At the Moffitt Cancer Center and Research Institute, three R.N. case managers oversee the treatment plans for all patients, coordinating treatment schedules and ensuring the appropriate utilization of drugs and other resources.

Managing the utilization of pharmaceuticals is crucial to financial success under a Medicare HMO contract. Under a traditional per diem contract, the managed care plan pays the hospital a fixed amount per day of inpatient confinement. This fixed payment does not change, irrespective of resource utilization. For the H. Lee Moffitt Cancer Center and Research Institute, this per diem often did not cover the direct cost of very expensive drugs such as Taxol or GCSF, let alone the cost of providing inpatient care.

The Center has addressed this issue by developing an inpatient per diem "pass through" where the HMO reimburses the hospital for the cost of some of these high-cost drugs. The Center's vice president of managed care and business development and contract negotiator worked with the HMO to develop and price a list of high-cost drugs for which the HMO pays the per diem in addition to a percentage of the charges to cover the cost of the drugs in question.

Effective cost management also requires that cancer center goals and incentives be aligned with the goals and incentives of physicians, who control the vast majority of expenditures in a cancer center. Practice guidelines and clinical pathways are effective tools in managing oncology patients. However, the cancer center's medical staff must be involved in all aspects of the development of practice guidelines and clinical pathways for them to be successful.

Medicare HMOs spend a good deal of money to enroll each Medicare beneficiary and strive to keep enrollment turnover as low as possible. Medicare HMOs expect excellent customer service from all of their contracted providers. Monitoring patient satisfaction and maintaining high ratings is an important competitive advantage. A cancer center with a reputation for high quality and excellent customer service gains leverage in negotiations with Medicare HMOs. Likewise, a cancer center that can demonstrate its value to the HMO network and differentiate itself from other providers in the network by focusing on its clinical expertise in oncology, multidisciplinary approach, and preventive services stands an improved chance for success.

CONTRACTUAL ISSUES: LOOK BEFORE YOU LEAP

Before contracting with a Medicare HMO, a cancer center administrator should determine if any services will be "carved out" to an exclusive provider network. Most HMOs have an exclusive contract with one of the national clinical laboratories and require their contracted hospitals to send outpatient pathology to the contracted lab. In addition to pathology, HMOs often carve out other outpatient services such as mental health and diagnostic radiology. An administrator should investigate which service lines, if any, will be excluded or carved out from the contract and whether such exclusions will raise quality and logistic issues. Many Medicare beneficiaries who enroll in a Medicare HMO are unaware that they are now required to receive certain services from a provider other than at the cancer center at which they have been receiving treatment. This fragmentation can raise quality of care issues. For example, patients may be faced with additional travel, which can be problematical for elderly cancer patients who are weak from the disease and treatment.

Patients treated at a cancer center are often more costly to treat than the patient population typically cared for at a general community

Partnering with Physicians

The H. Lee Moffitt Cancer Center and Research Institute, in Tampa, Fla., has created a model physician-directed oncology network based on the principles of disease management. The network is a partnership between the academic and community physicians and the Moffitt Cancer Center itself.

A physician-directed oncology network is an opportunity for health care providers to maintain or regain some control in the managed care market by accepting the financial risks and potential rewards of managing oncology care for a defined population. Through disease management, a network of providers can more effectively and efficiently coordinate the continuum of cancer care for a defined population. The network is based upon the principle that outcomes will be improved and costs will be minimized if clinical care is managed by clinicians and incentives for cost control are extended to each individual network participant.

The H. Lee Moffitt Cancer Center and Research Institute's network willingly shares risk with the insurers to return control of patient care to the physician and restore quality to the managed care equation. In this model, the network contracts to provide specified oncology services for a fixed payment and assumes the responsibility for providing care according to its own clinical guidelines and quality standards. For the network and the providers to be financially successful, the network's members must agree to function in a care management system.

Broad guidelines of care based on disease site, stage, and clinical pathology are defined and agreed upon by the providers. Using provider-defined guidelines and pathways, case managers review and approve treatment plans. When exceptions to the guidelines need to be made, medical directors discuss these with the prescribing physician to better understand and pass judgment on the particular situation and recommendations. Information systems track compliance with guidelines and link cost information with clinical outcomes. Participating physicians must have clinical outcomes as well as cost, utilization, and patient satisfaction information comparing their practices with their aggregated peers in this model. Compensation formulas give physicians incentive regarding utilization, quality outcomes, and patient satisfaction.

The network is attractive to insurers because it provides one-stop shopping for all cancer services in a broad geographic area. A single contract for all cancer-related services with defined parameters for sharing risk and reward can be executed with one entity. The network is positioned to combine the best of both academic and community medicine, which is the foundation for a very marketable product.

hospital. A cancer center does not have the ability to spread the financial risk of treating high-cost oncology patients across a broader patient population that includes some lower-cost non-oncology patients. The full service hospital has access to these patients and can price its per diem at a lower amount because it will get a mix of high- and low-intensity admissions. All cancer patients who are admitted to a cancer center are generally high utilizers of resources and therefore more costly. As such, the cancer center must set its per diem accordingly.

In addition to changes in reimbursement, Medicare HMOs present cancer centers with several other operational issues. Virtually all services provided to a Medicare beneficiary enrolled in an HMO must be authorized by his or her primary care physician and/or the HMO, as is the case with most managed care plans. Having the administrative infrastructure in place will facilitate effective and efficient compliance with these requirements.

Adverse selection can be a concern for both Medicare HMOs and cancer centers. Medicare HMOs are paid the same per capita premium, regardless of the health status of each enrolled beneficiary. For this reason Medicare HMOs may be apprehensive about enrolling a sicker-than-average population. Some Medicare HMOs have expressed concern that they will receive adverse selection and attract many of the seriously ill oncology patients if they add a cancer center to their provider panels. Similarly, administrators may share this same concern if their centers are contracting with Medicare HMOs on a capitated basis. Although the H. Lee Moffitt Cancer Center and Research Institute has not found this concern to be valid, administrators should be aware of it as they pursue Medicare HMO contracts.

The "pod" system of creating provider networks is another challenge that cancer centers may face in contracting with Medicare HMOs. Basically, the HMO narrows its commercial network by de-selecting certain providers and assigning Medicare numbers to a "pod" of providers that are financially at risk for all the care that is required by those members. In Florida, some Medicare HMOs are using a pod system in which they contract only with full service hospitals and the physicians who practice at those hospitals. This strategy obviously excludes specialty hospitals such as cancer centers.

Without question, Medicare HMOs will transform the way cancer care is delivered and paid for. The senior population has always been a valuable patient base for cancer centers. Cancer center administrators will have to develop strategies for dealing effectively with this rapidly growing market force. Failure to do so will inevitably result in significant decreases in a cancer center's patient population and the associated revenues.