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Provider-Sponsored Organizations: Are We Entering the Post-HMO Era?

by Robert E. Hurley, Ph. D., and Debra A. Draper, M.S.H.A.

The rise of managed care over the past decade has been the result of a revolution by purchasers in pursuit of better value for the money they spend on health benefits.[1] These pin-striped revolutionaries have had an enormous impact on the traditional world of health care delivery. In effect, they have displaced health care providers as the most influential party in the nation's health care system and spawned the rise of an entire new industry of managed care companies and related enterprises intent on doing the bidding of buyers. In this new environment, managed care organizations (MCOs) are the instruments of aggressive buyers, not the true purveyors of the revolution. If these organizations fail to provide value and live up to consumers' expectations, they will be replaced with more effective models.

History illustrates that the pace, direction, and intensity of revolutions are difficult to control once they begin. Subsequent events unfold as a result of actions and reactions taken by other parties affected by the upheavals set in motion. Today's major consolidation, restructuring, and reconfiguration among providers illustrate such secondary developments in the managed care revolution. Models and products will continue to change as MCOs look opportunistically for new ways to satisfy purchasers and learn to live with diminishing profit margins.

Perhaps the best contemporary illustration of cascading events in this purchaser revolution is the rise of provider-sponsored organizations (PSOs). PSOs represent efforts by providers to offer new models for contracting and service delivery. All types of cancer providers—hospitals, university cancer centers, oncology carveouts, and physician networks—are forming PSOs through which they negotiate directly with business coalitions and other purchasers of health care services.

Because they offer a distinct opportunity to restore provider control over the delivery of medical services, PSOs may prove to be the ultimate replacement for health maintenance organizations (HMOs). Whether they will be substitutes or complements for MCOs is open to debate.[2] Either way, PSOs may become an integral means by which MCOs devolve many functions and responsibilities back to provider organizations and, in the process, limit their own financial risk and administrative costs.[3]

BEYOND PEACEFUL COEXISTENCE

As providers have come to accept the new realities of the purchaser-driven transformation in health care, they have also recognized that one of the first principles of managed care is "no lives, no leverage." They have realized that as long as MCOs are exclusively positioned to contract with employers for health benefits, the MCOs will control these lives; thus, providers will lack the leverage to negotiate favorable payment and other terms. Providers find this lack of control particularly irksome since they themselves are delivering the care, bearing the malpractice risk, and are likely to be far more permanent in and committed to local markets than the typical MCO. This disadvantaged position has meant having to accept the terms and scope of contracts that MCOs have unilaterally proffered. Not only do plans determine payment rates and schedules, but they also decide what types of functions, such as utilization management, will be retained, shared, or shifted to providers.

But the winds of change have been blowing as various provider organizers have attempted to mount a kind of counterrevolution wherein they develop the legal standing and administrative capacity to initiate direct contracting with employers. Direct contracting with self-insured employers absolves PSOs from having to bear risk; thus, in most states they may avoid falling under the auspices of state insurance regulators.[4] In other instances, MCOs have given life to these entities by offering them opportunities to take on full medical risk through global capitation.[5] While MCOs will retain a sizable percentage of the premium dollar for administrative expenses and profit, in some instances these arrangements may permit delegation of all medical care delivery or utilization management functions to the provider organization.

On a broader level, political

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advocacy and action at the state level have succeeded in enabling many of these new entities to become bearers of risk while not having to meet the same levels of risk reserves as traditional HMOs.[6,7] Although this concept has provoked considerable debate in regulatory circles, it has found growing support in the general HMO backlash that has been sweeping the country, fueled by both provider and consumer discontent. Thus, the PSO as the "un-HMO" version of managed care has a certain intuitive appeal. Providers have also had some success in convincing policy makers that the business risk they bear—or more aptly, the direct financial risk assumed for the health care they deliver—is different from insurance risk, which is borne by those HMOs not rendering services, and thus should be regulated differently.[8]

The pressure to grant providers opportunities to offer alternative managed care products and structures has been strongly supported by major trade associations for both hospitals and physicians. The impact of this support is evidenced by the Balanced Budget Agreement of 1997, which formally recognized the PSO in the sweeping Medicare changes incorporated within the agreement. Though strongly resisted by state regulatory authorities, this new legislation could, when finalized, position the federal government as the licenser of a new wave of PSOs. They would be able to contract with the Medicare program and to compete directly with HMOs and PPOs to enroll beneficiaries in the new Part C program.[9] (See "PSOs and the Medicare Demonstration Project," page 22.) While the actual relationship between state and federal regulatory authorities of these entities continues to be debated, this is the clearest indication yet that a new generation of MCOs may be in the offing.

HOW PSOS CAN DEMONSTRATE SUPERIORITY OVER MCOS

Many PSOs have a hospital or hospital system as a core component due in part to the fact that such entities are leading the way in delivery system consolidation and integration in local communities. They also tend to have the deepest pockets with which to finance PSO development and to produce the capital to meet reserve and solvency requirements. But they may also have the most to lose in an aggressively managed care environment that unrelentingly reduces inpatient service use.

The challenge for those PSOs that hospitals develop and finance is to essentially rise above their inpatient roots. Hospitals or hospital systems need to create new resource allocation strategies to devise a true continuum of care and to redeploy resources to non-inpatient service sites. They also have to face the inevitable consequences of rightsizing supply with demand. As hospitals begin to operate under capitated contracts, they face difficult challenges in undertaking the "make or buy" logic that prepayment forces on producers.

To be successful, providers must demonstrate their superiority to MCOs in care management, customer service, and provider relationships. Forming a PSO means providers must take on new responsibilities they have never had to assume in the past. The following list includes those areas that will require significant investment and development.

Information technologies/smart managed care.
Many observers believe that managed care can be made much more consumer friendly and far less intrusive for providers if communication and information technologies are effectively applied. PSOs will be challenged to acquire the capital needed to design and develop more sophisticated care management systems and techniques. The need for resources is likely to lead many PSOs into joint ventures with MCOs.

Self-care and an emphasis on informed consumers.
Efforts to make consumers more knowledgeable and provide them with timely, useful information are proceeding on many fronts in the managed care revolution. PSOs will need to embrace this trend, even if it means changing who delivers services and where services are provided. Although some providers may be skeptical about how well consumers can be informed, this is a powerful development that providers would be unwise to resist.

Continuum of care orientation.
Assuming risk for all the health care needs of an enrolled person is for most providers a new experience that requires a far broader perspective than many have displayed in the past. A key incentive of capitated care is to provide the most clinically appropriate care in the most economically appropriate site. As the anchors and bankers of many PSOs, hospitals will struggle the most with the implications of this new orientation.

"Productification" of medical services.
PSOs will be expected to continue the movement toward experimenting with new ways to purchase, package, and provide medical services. Clearly, there is interest in continuing to standardize medical practice to the extent possible and to gather more and better data to evaluate those providers doing a better job in the "production" process. PSOs will not be able to avoid the need to reengineer and redesign care delivery. In fact, given their clinical expertise, they will be expected to do a better job than MCOs have done in the past.

For providers—both hospitals and physicians—the PSO represents a potential opportunity to recapture control over the terms of their work, and perhaps even more importantly, their destinies. Hospitals and physicians could, in effect, eliminate the middleman and recapture those resources not going toward direct patient care. Of course, more money could flow to the providers for the work they are doing. Perhaps even more significantly, as more providers realize that managed care is purchaser driven and not a passing fancy, PSOs are seen as a way for providers to accept the inevitable and to pursue efforts to reconfigure themselves—not merely to react to MCO pressures and initiatives.

WHO ELSE COULD BENEFIT?

Providers are just one group that can benefit from PSOs. The rise of the PSO concept affords modest promise for buyers, consumers, and even MCOs as well. Buyers may find that stimulating the development of these types of models can promote innovation by and competition with other forms of managed care. In some markets (such as Minneapolis)

buyers have concluded that excessive consolidation among MCOs undermines their ability to buy what they want.[10] Unleashing a new wave of market participants, including those eager to build membership, may offer buyers additional contracting alternatives and potentially add downward pressure on prices—precisely at the time that HMO premiums are creeping up again.[11]

Consumers likewise could benefit from more competition, especially provider-engendered competition, which may mean more inclusive networks and perhaps more choices.[12] A major frustration for consumers of changing plans and reconfigured provider networks is the loss in continuity of patient/physician relationships. If PSOs can deliver on their assertions that they will be physician governed and physician sensitive, they may be able to succeed in creating a more patient-friendly environment that preserves some features of the physician/patient relationship that HMOs are alleged to have jeopardized. They may also be able to devise new compensation systems and other care delivery arrangements that put to rest concerns about skimping on care or imposition of conscience or gag clauses.

Even MCOs can gain from the rise of the PSO, especially if they avail themselves of the opportunities to contract with them in so-called "downstream risk" arrangements. Such contracting allows MCOs to fix their financial liabilities for medical care at the very time that their medical loss ratios have been rising and shareholders have become increasingly restive. Global capitation contracts also enable MCOs to reduce their administrative costs by off-loading administrative functions onto PSOs. In turn, this may reduce the tensions and friction between plans and providers that have ensued as a result of the provider perception that MCOs are engaging in micromanagement.

Despite the apparent benefits that PSOs may represent, there are ample reasons to view the counterrevolution with some skepticism. A major concern lies with the motivation of providers to use these vehicles to simply circle the wagons to fend off the intensifying attacks of MCOs on their way of life. Not only would such a motive undermine the intent to engage in authentic reform, but it certainly would also engender doubt among buyers unwilling to accept what they see as hollow promises from PSOs. Purchasers may see these forays as ostensibly keeping dollars out of the hands of MCOs, but practically putting them in the pockets of providers. For all the criticisms being leveled at MCOs, buyers believe that they have succeeded in dramatically slowing the rate of premium increases, and they will not willingly accept a reversal of this development.

Competing directly with MCOs does not guarantee success.

Competing directly with MCOs does not guarantee success. Many PSOs will be undercapitalized, and as start-up enterprises they will need to build infrastructures to perform basic care management, customer service, and administrative activities.[13] The alternative is to buy such services from other third-party administrators. How will PSOs demonstrate their superiority—beyond the slogans of provider control or physician governance—to well-established HMOs? For example, how does an organization such as United Airlines, which is ostensibly different from other airline carriers because it is employee owned, differentiate itself in a fiercely competitive industry? The task is daunting, particularly because purchasers are extracting increased performance data to hold MCOs accountable for the well-being of their employees.

Will fully integrated organizations such as regional health care systems or comprehensive multispecialty group practices succeed over the long term? The answer remains unclear. Growing numbers of niche providers encompassing specialty networks, disease management programs and systems, and carve-out products and options pose very serious threats to organizations that own all or most of their capacity and are reluctant to outsource substantial components of the delivery system. Many large MCOs that own provider capacity are divesting themselves of it, or enabling their once-captive providers to diversify their revenue streams, to avoid the financial drag of having to fully support a complete delivery system. Additionally, technological development, excess subspecialty capacity, and new forms of organizing care may provide attractive "buy" alternatives to the full service, capitated system.[14]

POLICY AND PRACTICAL QUESTIONS

Until recently, regulation of PSOs was the prerogative of state legislators and insurance commissioners. Today, with Congress including PSOs as an option for Medicare beneficiaries, the question of how PSOs should be regulated and by whom has moved to the national level.[15] Much of the debate has centered on whether PSOs are qualitatively different from commercial MCOs, and if so, whether PSOs should have a special set of regulations created specifically for them. Whether PSOs have an advantage over HMOs in the market could depend on answers to this key question.

HCFA has begun to address many of these questions in proposed solvency standards for PSOs published April 1, 1998. For the most part, it appears that HCFA will hold PSOs to the same $1.5 million

net worth requirement as HMOs. Proposed rules for enrollment also appear to favor PSOs, which must enroll a minimum of 1,500 members (500 in nonurban areas), compared to 5,000 members for HMOs.

Tangible health care delivery assets may be counted toward the minimum solvency requirements. In such a move, HCFA appears to be favoring hospital-backed PSOs over physician-led networks, which are less likely to own these types of assets.[16] In addition, 10 to 20 percent of intangible assets, such as provider networks and contracts, may be counted toward the net worth requirements.

These proposed regulations will set off another round of questions in the PSO debate. Policy makers have a number of concerns to address when considering whether special rules apply to PSOs, including:

- Are these entities qualitatively different from commercial MCOs? If so, what are the regulatory implications?
- Should entry barriers be lowered to foster new, innovative models of managed care sponsored by now-awakened providers?
- Does the fact that these providers render services directly and do not merely contract for or arrange them represent a different type of risk-bearing?
- Should PSOs be able to meet reserve requirements by pledging some of their fixed assets (e.g., building, property) in lieu of having to raise substantial amounts of cash to deposit with regulators?
- Will PSOs perhaps require less consumer protection because they are provider governed and physician/patient relationships are more likely to be preserved?
- What are the competitive implications of allowing PSOs preferential status relative to the HMOs they might displace—does this mean the proverbial playing field is no longer level?

Of course, separate regulations for PSOs do not mean they would be treated less stringently than HMOs, which are regulated differently than traditional health insurers.[17] Even so, HMOs are no doubt uncomfortable with the prospect of competition with PSOs, which may offer more value for the money.

From the practical standpoint, purchasers who instigated the managed care revolution have their own concerns, including:

- Will PSOs satisfy or frustrate their aims for more value for the money they spend? Will PSOs contribute to lower costs with a decline in outcomes, or better outcomes at comparable costs to what MCOs are currently achieving?
- Can PSOs lead to more long-term stability and continuity in relationships between providers and employees/patients?
- Will PSOs devise more unobtrusive ways to manage care, ways that reduce friction and promote greater satisfaction for both providers and consumers? PSOs could do both, but there is no guarantee they will.

PSOs can be seen as an opportunity for providers and MCOs to achieve new and more balanced levels of cooperation and collaboration.

The provider-sponsored organization appears to be a significant addition to the evolving managed care marketplace. PSOs can be seen as an opportunity for providers and MCOs to achieve new and more balanced levels of cooperation and collaboration. Or they may be viewed as an alternative to established MCOs that buyers may be willing to embrace if they perceive PSOs as promoting more competition and potentially superior products. The jury is still out on what is still an emerging trend. But given the current backlash against managed care and the resiliency and tenacity of the medical profession, it would be ill-advised to underestimate the importance of this development.

REFERENCES

[1]Hurley R. The purchaser-driven reformation in health care alternative approaches to leveling our cathedrals. *Frontiers of Health Services Management* 9(4):5-35, 1992.

[2]Barnett A. Who needs the middleman? *Business and Health* (Supplement: *The State of Health Care in America*) 34-38, 1997.

[3]Slomski A. Who needs HMOs? *Medical Economics* May 12: 200-215, 1997.

[4]Hirshfeld E. Assuring the solvency of provider-sponsored organizations. *Health Affairs* 15(3):28-30, 1996.

[5]Kelly M. State insurance regulation of provider-sponsored organizations. *Healthcare Financial Management* 51(7):44-46, 1997.

[6]ibid.

[7]Hudson T. The great debate. Resolved, PSOs are going to be regulated. The question is, will they get what they want? *Hospitals & Health Networks* 70(2):26-29, 1996.

[8]Robert Wood Johnson Foundation. Regulating provider-sponsored organizations: 1997 federal budget provisions may change dynamics. *State Initiatives in Health Care Reform* 24, November 1997.

[9]ibid.

[10]Slomski A. 1997.

[11]Hudson T. 1996.

[12]O'Hare P. Medicare and Medicaid risk contracting opportunities for PSOs. *Healthcare Financial Management* 51(7):35-36. 1997.

[13]Physician Payment Review Commission. *PPRC Annual Report to Congress*. Washington, D.C.:1997.

[14]ibid.

[15]Calvaruso J. Operation start-up. *Hospitals & Health Networks* 71(23):34, 1997.

[16]PSO solvency falls short of expectation: Upfront funding just fraction of total cost. *News and Strategies for Managed Medicare & Medicaid* 4(9):1, 1998.

[17]Calvaruso J. 1997.