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PSOs and the Medicare Demonstration Project: The Crozer-Keystone Model

by Cara Egan

The Balanced Budget Act of 1997 included a provision for the Health Care Financing Administration (HCFA) to establish a demonstration project that would allow provider-sponsored organizations (PSOs) to contract directly with Medicare. The Medicare Choices demonstration project was designed to test one of several Medicare+Choice risk arrangements that HCFA plans to offer Medicare beneficiaries enrolled in traditional fee-for-service medicine. HCFA plans to release its rules for the Medicare+Choice system on June 1, 1998.

The PSO model integrates financing and delivery of care by aligning physicians and hospitals to accept risk for patient care.[1] In a typical arrangement, the PSO accepts capitated payments from Medicare in exchange for services provided, thus essentially eliminating the managed care organization (MCO) as the middleman in health care delivery.

PSOs are attractive to many providers who, resenting the intrusion of MCOs, want to regain control of patient care. By combining payment and delivery of health care, PSOs eliminate the costly redundancies of dual provider/MCO operations, such as billing and administration.[2] The resulting savings can then be shifted to more patient-focused areas. PSOs, however, require vast capital backing and creation of an administrative infrastructure, the costs of which can be prohibitive to smaller networks of providers. As a result, varying degrees of this model have sprung up to allow for joint venturing and risk sharing among providers and MCOs.

The question of how PSOs are to be regulated has been widely debated. The crux of the issue has centered on whether PSOs should be regulated as HMOs, with stricter solvency standards for net worth, or whether a special set of regulations should be created specifically for them.[3] HCFA announced preliminary federal definitions and solvency rules for provider-sponsored organizations on April 1, 1998. PSOs, for the most part, will be held to the same solvency standards as HMOs, with some exceptions. (See "Provider-Sponsored Organizations: Are We Entering the Post-HMO Era?," p. 18.)

Fifty-two sites were selected from the original 354 applicants to submit final proposals. A total of eleven sites were chosen to actually operate as Medicare PSOs. Maturity varies among the final eleven awardees—the more established programs having completed their first year of operation in 1998 and others still in early development stages.

CROZER-KEYSTONE: MEDCARE PLUS

Crozer-Keystone Health System in Media, Pa., a 1,350-bed network of five hospitals, serves a five-county area with a population of more than five million people living in metropolitan Philadelphia and surrounding regions. Selected as a Medicare Choices demonstration site in 1996, Crozer-Keystone launched its PSO product, MedCarePlus, in April 1997, one of the first four demonstrations sites in the country to become operational.

A point-of-service plan, MedCarePlus is at its core a primary care model. There is a special focus on a variety of wellness programs, including health fairs, screening events, health information and education through a twenty-four-hour customer representative hotline, newsletters, and other interventions to involve people in protecting and improving their health status. The plan currently has enrolled more than 3,000 members.

In addition to its primary care approach, the plan is committed to patient access to specialists. The PSO contracts with more than 650 providers, including twenty oncologists. As a matter of policy, MedCarePlus does not restrict patients to their primary care physician for a number of primary diseases, including cancer. Members also pay no penalty premium for choosing providers outside the network.

According to Crozer-Keystone President and Chief Executive Officer Jack McMeekin, direct contracting with Medicare has allowed the PSO network a greater share of and more control over how it spends each health care dollar, an important factor for a system with a serious commitment to its community's health. "We have an opportunity to provide wellness services that in the traditional system no one paid for," McMeekin explained.

The PSO returns responsibility for health care decisions to physicians and their patients. In most PSOs, physicians are directly involved in utilization review, physician credentialing, protocol design, care management, and other administrative processes that have traditionally been controlled by third-party payers. McMeekin believes that transferring more administrative decisions to the provider results in better informed care decisions and less wasted resources, which allow more money to be channeled to wellness programs and actual patient care.

This physician-driven arrangement also saves time and money

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wasted in competing with MCOs for medical management of patients. According to McMeekin, physicians often duplicate processes such as utilization review to defend their treatment decisions against MCO denials. "The PSO frees us from the inevitable stand-off between providers recommending treatment and MCOs fighting to deny it."

Balancing the dual role of payer and provider is not always easy, McMeekin conceded. MedCarePlus has established a formal Medicare appeals process patients and their physicians can use to appeal any decision MedCarePlus makes regarding receipt of or payment for services. While PSOs do not obliterate disagreement over treatment decisions, McMeekin contends that the PSO model offers the most equitable, truly "managed" care arrangement.

"Everyone involved in our network understands that to manage care, we have to provide appropriate care in appropriate settings." After that, he said, "physicians and their patients are the only ones to determine the course of treatment."

LICENSING, CAPITAL, AND OTHER HURDLES

Developing a PSO involved a two-year effort during which strict requirements for provider participation, licensing, and equity had to be met. As part of the application process, Crozer-Keystone had to demonstrate to HCFA its ability to address the Medicare managed care system and assure that provider relationships were in place to cover the large Philadelphia market, including its underserved communities.

Demonstration requirements at the time required Crozer-Keystone to seek Pennsylvania state HMO licensure, which would permit the system to structure risk-sharing arrangements with other providers as the PSO expanded. After numerous filings and discussions with the state's Department of Insurance, Crozer-Keystone was awarded an HMO license in February 1997.

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Existing HMO laws in the State of Pennsylvania required Crozer-Keystone to raise $1.5 million in statutory net equity. As the population grows, the equity requirement also will increase. By law, none of the health system's assets other than cash and investments could be counted toward the net statutory equity requirements, including ownership of physician practices, hospitals, and medical equipment. Proposed rules recently published by HCFA offer PSOs some credit for owning the tools for providing health care.

Many PSOs have avoided the bureaucratic hassles of HMO licensing and developed joint ventures with managed care companies in applying for the Medicare Choices demonstration project. Ideally such a partnership would bring together two organizations armed with expertise in their respective areas who could collectively trade on their experience in a provider-led joint venture.

Early in its application process, and prior to its HMO licensing, Crozer-Keystone had in fact approached a major managed care organization with a proposal for a joint venture in the PSO demonstration project. However, the major issue, and one which could not be resolved, was the question of who would be responsible for medical review and utilization. Negotiations failed in the end due to Crozer-Keystone's unwillingness to cede control of patient care.

Instead, Crozer-Keystone currently outsources all functions related to claims processing and adjudication to an independent claims management company. "When we think someone can do a better job for us and our customers, we're better off letting them do it under contract rather than us having to build that capacity," McMeekin explained. However, infrastructure was created to support functions too

central to the mission of the PSO, such as member satisfaction and medical management. "We have to ensure that any dealings with our customers are presented with the patient-focused emphasis our plan has come to stand for," McMeekin said.

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PSOs Elsewhere

"We are differentiating our marketing in a couple of different ways from other health plans. First, we are taking advantage of market research that indicates Medicare beneficiaries are more than twice as likely to join a plan sponsored by a hospital and physician group as to join one sponsored by an insurance company. We are taking advantage of that fact by promoting ourselves as the first in our area sponsored by physicians and hospitals—a claim that other types of payers cannot make. Second, we are working very closely with our physicians, who are helping us market our program. They are sending letters out to their Medicare patients, displaying brochures in their offices, and conducting question/answer sessions with patients. Utilizing our physicians this way has been very helpful in the marketing arena to differentiate our product from other types of payers in Medicare risk."

Joseph T. Calvaruso, chief executive officer, Mount Carmel Health Plan in Columbus, Ohio, went from start-up to product launch of a Medicare demonstration project PSO, MediGold, in just six months.

Sister Norita Cooney, chair of Alegent Health System in Omaha, Nebr., comments on Alegent's joint venture with Mutual of Omaha to form a Medicare HMO.

"Our jointly owned HMO with Mutual of Omaha, which is called Preferred Health Alliance, provides us an opportunity to concentrate on our area of expertise—patient care. We develop care maps with input from Mutual of Omaha. Once the care maps are approved, Alegent is responsible for patient care; we consult with Mutual of Omaha only in exceptional cases.

"Territorial issues do arise. For example, we believe we should have more control over utilization management, with input from our partners. Conversely, while we have no desire to take on marketing responsibilities, we do believe that we have a contribution to make in how services are marketed, especially to rural populations. We are continually working with our HMO partner to find middle ground on these and other issues."