Cost Containment: The True Quest of Managed Care

Virginia Keane, MD
University of Maryland School of Medicine

Why We Have Managed care in the First Place

- Remember from module one, the cost of health care in the US is rising at an alarming rate, is about 15% of the GDP!!
- Health care costs are so high that many employers are no longer offering health insurance, or the employee portion of the cost is so high that people decline the benefit. The government safety net covers the elderly(Medicare, for the over 65 crowd(oh yeah and those with renal failure, boy they must have had a good lobbyist, huh?)), and the very poor(Medicaid). About 30% of Americans do not have health insurance.
- Something had to be done about the cost: Managed Care was the answer.
- *new answers are emerging, like health care spending accounts, but right now they account for a very small percentage of health care expenditures so we won't go into them in depth.*

What does *cost* mean?

- Cost is what it actually costs to provide a service. Total cost includes
  - Direct Cost: the cost of the service or item
  - Indirect cost: some portion of the facility overhead
  - *This is why an aspirin costs $12.00 in the hospital.*
- Charge is what you get charged for the service. It includes the direct and indirect costs and a profit margin.
- Reimbursement is what the provider actually gets paid by the insurer.
- The patient may bear some out of pocket expense depending on his plan, i.e., a co pay, or 20% of usual and customary.
- Most insurances, including Medicare, either forbid or put a cap on “balance billing”, which is the practice of billing the patient for the difference between charge and collections from co-pays and reimbursements.

What is Cost Effective Care?

- Care that undergoes a general economic analysis where the outcome of care is sufficiently beneficial, or less expensive i.e.: it is more cost effective to have a primary care doc diagnose and treat otitis media than to have an ENT doc do the same
- Care that is subjected to a strict economic analysis, comparing the cost of a given intervention to that of a specific outcome: i.e. at $900.00 per vial, with hospital days as the primary outcome, it is not cost effective to give all infants born at less than 32 weeks RSV prophylaxis, but at $600.00 per vial it becomes cost effective and we will cover it as a benefit.

How the Naïve Thought Managed Care Would Control Costs

- Managed care was going to keep costs down by keeping the population healthier. It would provide medical preventive care at regular intervals,and be so wonderful that everyone would be clamoring at the doors for health education. Of course we would all be compliant with ever bit of advice we were given.
- Managed care would offer lifestyle enhancing, health promoting creative innovations, like health club memberships, incentives to lose weight, air conditioners, smoking cessation classes and medicines for parents.
- Managed care would offer early disease detection: everyone would get mammograms and colonoscopy, no one would have horrible, hard to treat late stage disease.

How the Naïve Thought Managed Care Would Control Costs

- Managed care would improve access to primary care, so people with acute illness, like pneumonia and cellulitis, could be treated early and avoid hospitalization, and people with chronic illness, like asthma, diabetes, COPD and CHF would get regular care, the latest and greatest cost effective treatments, and avoid hospitalization.
- Capitation would negate the need to bill, eliminating a huge contributor to health care costs(about 10% of the charge is to cover the cost of billing and collection).
- Managed care organizations would work with primary care providers to teach them to manage care efficiently: the partnership would benefit everyone.

The Real Tools of Cost Containment

- Prepaid Care
- Managed care
- Preventive Health Care
- Provider Contracting
- Risk Sharing

Prepaid Care

- Prospective payment to doctors or integrated health systems saves money by eliminating the need for billing, claim review, payment, and decreases accounting complexity. This eliminates cost.(*too bad ceo salaries eat up the savings!)*
- Prepaid care shifts the risk to the entity that has already been paid. If the cost of care exceeds the collected dollars tough on the provider! The insurance company is protected. The patient is protected. The provider eats the cost.

Managed Care

- Two major areas
  - Controlling access to care
  - Manage utilization of services.
- The smart CEO/Medical director analyzes his costs and tries to decrease the big ticket items. About 40% of all health care costs are in-patient costs, so inpatient care is the often the target of care management efforts.

Enter the Gatekeeper!

- Most MCOs use the primary care provider as a gatekeeper: they control the access door to specialists, hospital care, medication, durable medical equipment. and diagnostic testing. In many systems the gatekeeper has a financial incentive to limit access: some of the capitation may be withheld, and only paid if the doctors overall utilization is at or below a predetermined level, or the doc may get a bonus if they have low utilization.

A Nasty Corollary

- Every time a patient connects with the health care system they generate cost.
- In prepaid systems, the gatekeeper has an incentive to keep the patient away, especially if capitations are low, demanding that the PCP/ gatekeeper take on too many patients in order to run an office and make a living.
- This may backfire, as delays in diagnosis may increase overall cost.
- Most Doctors do not have the actuarial experience to balance these factors. This is one reason why so many physician groups met financial ruin in the early days of capitation.

Controlling Access to Care: Methods

- Requiring referrals for specialist care: sometimes the PCP can take care of the problem. Sometimes the PCP wont refer for other reasons.Sometimes the process is so arduous the patient will just forego care! This saves money!
- Requiring preauthorization before specialty care can be obtained.: this allows the MCO to determine if the service is medically necessary. They use published guidelines(though these might not be readily available to doctors) to determine if a service is medically necessary(so do not fear, the nurse, or clerk, on the phone denying your request has not made a decision, they have merely followed an algorhythym, based on the information you provided. Often if you provide better information they will approve your request.   If it is not medically necessary, it will be denied. This saves money. Sometimes.

Controlling Access to Care: Another way it can backfire

- A few years ago United health Care, one of the country's biggest MCOs decided to stop requiring preauthorization of referrals. They determined they were spending more on the process than they were saving on denials! Apparently doctors had learned to refer only when medically necessary.

Controlling Access to Care: Methods

- Pharmacy costs: don't add costly new drugs to your formulary, or require "step therapy", where you use less expensive alternatives, prove they are ineffective for a particular patient, then can request special permission to use an expensive drug (think claritin/zyrtec)
- Durable Medical Equipment: limit the benefit (sorry, we don't cover hearing aids), or require arduous documentation of medical necessity
- Limit ancillary services: severe restriction of rehab services (PT, OT, Speech) and mental health services, regardless of medical necessity, is a great way to restrict cost. Most people don't need these services, and a small number of dissatisfied patients will hardly be noticed!

Managing Utilization of Care

- This can apply to any service, but is most often applied to inpatient care, as it is the costliest, and therefore the place you get the most for your cost control buck. They goal is to "help" physicians minimize the use of costly care like MRIs, and hospital days, if the same outcome can be achieved with less expense. There are several methods(gosh darn all these lists!)
  - Preauthorization
  - Concurrent review with use of DRGs or ORGs
  - Case management
  - Retrospective review

Precertification

- For non emergent admissions, the reason for admission is reviewed to see if it meets criteria for medical necessity.
- Unbeknownst to most doctors there are books, containing the opinions of expert panels and the supporting medical evidence, that document when hospitalization, and procedures are medically necessary.
- These books are licensed by MCOs, and some large providers(hospital systems) and used to determine medical necessity.

Precertification

- FOR instance: hernia repair on an otherwise normal two year old does not require an inpatient stay. Do not attempt to ask for an overnight. However, if that patient has chronic lung disease, or a tracheostomy, you may get it through.
- If elective admissions are not preauthorized, and the MCO contract with the hospital says they only pay if its preauthorized, the hospital <u>will not</u> get paid. If the hospital is not paid the doctor is not paid. OOPS!
- Some MCOs are available 24/7/365. For these, even emergent admissions must be pre-authorized. If not, they will audit retrospectively, and if the admit is not deemed medically necessary you <u>will not</u> be paid. Days not paid are called denied days. Too many denied days and you are off the medical staff!!!

Utilization Review: Concurrent Review

- You’ve seen this: A strange women with a fancy scarf introduces herself as a nurse from Maryland Physician Care and she wants to know what the plan is for Baby Sparrow. Just how long do you plan to keep him to see if he gets his chirp back? You think” Isn’t this a Hippa violation?” No, it isn’t. She represents the patient’s insurance company, and she is there to be sure you discharge the patient in a timely fashion. HOW DOES SHE KNOW WHAT IS TIMELY ?

Use of DRGs and ORGs

- She uses her handy dandy Milliman and Roberts! What is that?
- Another secret book, known only to MCOs and a few large heath care providers. It establishes OPTIMAL RECOVERY GUIDELINES for diagnosis requiring inpatient care. Hospital stays within the length of these guidelines are just how long insurers are willing to pay without proof that additional days were medically(NOT SOCIALLY!) necessary.
- DRGs(diagnosis related groups) basically do the same for the Medicare population. Other insurers often adopt Medicare policy. The difference is, if hospitals are paid on a case basis for a DRG diagnosis(say DKA) and they get the patient out SOONER than the DRG guidelines, the hospital gets to keep the change! How is that for incentive!

What do you think of these Milliman and Roberts Guidelines?

- Diagnosis : Meningitis, Cryptococcal
- Day one: admit, diagnosis implement treatment
- Day two:continue amphotericin
- Day 3:neuro symptoms improved, renal function fine, continue amphotericin
- Day 4: patient alert, tolerating diet, afebrile. Discharge with home nursing, house calls and out patient Lumbar Punctures to monitor.
- Length of stay: 3 days

- Diagnosis: sepsis, neonatal, confirmed by +blood culture
- Day one: Admit to Level II nursery(not NICU) Sepsis workup, start IV antibiotics
- Day 2: blood cx +, continue antibiotics
- Day 3:temp stable, transfer to full term nursery(level 1)
- Day 4:Place PIC line, discharge to home (is this safe?) wih home nursing visits to give antibiotics
- Length of stay: 3 days.

Those Pesky Milliman and Roberts Guidelines

- Yes, they are extreme! Remember, they are OPTIMAL: everything has to go perfectly for them to really be applicable.
- With concurrent review(daily MCO nurse review of the progress) of your EXCELLENT notes documenting WHY each day is medically necessary additional days are approved in a real time fashion.
- If only retrospective review is done, the additional days will probably be denied, appealed, then some will eventually be covered.
- Other, more liberal systems, are available, but most MCOs use Milliman and Roberts!.
- I don't <u>know</u> why they don't give the doctors the guidelines, at least on a case by case basis. Wouldn't it be nice to know what the optimal standard is?

Case Management

- In inpatient settings also known as discharge management, can be provided by MCO staff or hospital staff.
- Goal is, get the patient out as soon as possible by making sure we have made conditions as optimal as possible. Get that spacer! Set up that home nursing! Talk with that PCP! DISCHARGE!
- Out patient case management tries to assure that patients have everything they need, and are compliant with care, in order to prevent hospitalizations.

Retrospective Review

- Retrospective review is the process of reading the patient chart after the patient is discharged, and deciding THEN if the the care was medically necessary.
- If care deemed medically unnecessary, it is not paid for.
- This is a great way for MCOs to keep patients happy without spending a dime. Of course, it doesn't make hospitals or doctors very happy. Sometimes the providers don't renew their contracts(remember when University cancelled the contract with United Health Care? It was because of a 30% collection rate!!)
- Retrospective review is also used to trend care, compare doctors, institutions, and make decisions about what to put in next year's contract!

Enough With the In-patient Stuff!!

- So now you get the picture: MCOs are intent on cutting cost and they mostly do it by targeting in-patient care
- They still have a few out-patient tricks up their sleeve.

Preventive Care

- Health promotion and screening for early diagnosis are done MUCH better under managed care than in the indemnity, FFS system. (*After all, the FFS system worked on behalf of docs and hospitals if patients were sick!!)*
- These services include prenatal care, immunizations, mammograms, cholesterol screen, blood pressure checks. Most ultimately save money(I don't think there's any data to show cholesterol screening saves money)
- Having high percentages of patients receive these services wins you points in the Quality reviews(module 2, remember!) which may win the MCO more contracts. Contracts =lives, lives=dollars! Money makes the world go around, the world go around, the world go around!!(didn't you see Cabaret?) Save it or get it, it makes the same clinking sound!

Provider Contracting: the heart of the matter

- MCOS make contracts with hospitals, doctors, pharmacies, ancillary service providers, DME companies, case management companies, labs, integrated health systems etc, etc, etc
- They specify the services to be provided and what they will pay.
- They like to make as few contracts as possible, so big groups and integrated systems have an advantage.
- Naturally they try to pay as little as possible
- There is room for negotiation on some items
- Remember, providers are forbidden by law from sharing info on charges. If you do this you may be criminally charged with price fixing. This means they know what everybody else in town is charging, and what they are getting , but you don't. Who said life is fair?

Maryland's Monkey Wrench

- In most places MCO's save lots of money by negotiating hospital rates. In Maryland this is not possible. WHY?
- Maryland has a HCFA waiver that creates an all payer system for hospitals. Basically a state commission sets hospital rates for various bed types using very complex formulas that take into account un-reimbursed care. Rates vary by hospital, and are NON NEGOTIABLE. All insurers must agree to pay the rates. This system assures that the insured patients cover the cost of hospital care for the uninsured, so we do not have a "dumping" problem in Maryland . Hospitals become the care source of last resort for the uninsured. Yes, this **is** very expensive, and Maryland is moving to address it by expanding the system of community health centers. In the meantime hospital rates are fixed, so mcos negotiate other things, like length of stay, rates for ambulatory services, who does case management, etc, etc, etc… (didn't you see the King and I ??)

Risk Sharing

- Another way MCO's save money is by shifting risk to providers. They do this through prospective payment. Lets say you have 1,000 patients from a certain MCO, and your capitation rate is $12.00 per member per month. This means you have 144,000 of income from the MCO. You also have 1,000 FFS patients,who make an average of 3.2 visits per year. You collect an average of 45.00 per visit, for a total of 144,000. Office overhead is 168,000, and you take home a salary of 120,000.

Risk Sharing

- Now, suppose your contract withholds 20% of your MCO payment, and only returns it to you if the total cost of care for those 1,000 patients is less than 1,000 per patient per year. There's a school bus accident in your community and 13 of your patients are hospitalized, two in intensive care. Your average cost per patient for the year is 1,243.00 You don't get your withhold back. You are short $28,000,which the MCO will use to offset extra hospital costs. Your choices?
- Take a 28,000 salary cut this year
- See more ffs patients to make up the difference(does this mean you see fewer mco patients, or do you work harder? Where do those extra visits come from?)
- This is peanuts. The real money is saved when MCOs risk share with hospitals over inpatient costs. Hospitals work very hard then to keep costs down, meaning they keep charges down.

A Dirty Secret: a cost saving method you wont find in the books

- Delaying Payment: All insurers seem to use this trick: delay payment. The longer the money stays in their pocket the longer they can invest it, or at least show it to their shareholders and bankers as cash on hand. SO, if they have 90 days to pay they pay on day 89. Anything not preauthorized is automatically denied and sent back to you thirty days later. You have to write an appeal, which they then have 90 days to decide on.
- Providers, and governments, are catching on to this trick, and including measures to limit it in contracts, but its still happens.

One You wont Find in the Books: Cost Shifting

- So MCOs need data to pass their HEDIS audit. They used to send an auditor to you office to review charts. She took up space, but she did her work as efficiently as possible. NOW they just ask you to send photocopies of records. YOU have to provide the staff to pull the charts, copy the records, and you pay the postage. Suddenly their cost of business has turned into your cost of business. They will not pay you for records. You will have to wait til next year to see if you can renegotiate your contract.

Another one you wont find in the Books: Cherry Picking

- MCOS are notorious for recruiting HEALTHY patients. They contract with employers, who usually employ healthy people. People who are sick, or have a sick family member, know it will be harder to get care in an MCO, so they pick an indemnity plan if they have a choice. This is called cherry picking: selecting well people to cover to keep your costs down. The age of cherry picking is coming to an end, as more and more of us are enrolled in mcos, and we get older and older, but in the few markets left to conquer,and the Medicare population, this practice will continue.

OH No! Not Another One!

- Changing the Rules: Now you don’t need a referral, now you do. Now this drug is covered, now it isn't. Now we pay for spacers, now we don’t. Now we pay for Denvers, now we don’t. If we pay you FFS and we stop paying for some CPT code, there’s a good chance you wont notice, and that’s good for us. I’m sure you can think of other examples from your residency experience.

Disease Management: Throughout the Spectrum, Regardless of Geography

- Disease Management involves identifying a guideline or best practice for a disease(usually a common, chronic illness, like asthma, diabetes, or CHF) and working to bring all your providers on line with the newest, best practices. It speeds up adoption of new practices.
- Case managers usually work with patients to educate them about their disease and its management, enhance compliance, and make sure they have medications and equipment necessary to optimize outcomes.
- Some MCOs have had excellent results decreasing cost and improving health though use of disease management programs.

Cost Containment: the Patient's Point of View

- Why patients should appreciate cost containment efforts
  - Ultimately it will keep their premiums lower, and help keep them insured.
  - Many cost containment efforts also result in improved health outcomes
  - Emphasis on preventive care may prolong life and enhance function.
  - Adherence to clinical guidelines, and enhanced health education may enhance life and health.
- Why patients resent cost containment efforts
  - When you are sick and they are making it hard to get care it is demoralizing.
  - Every time the doctor gets a denial the patient gets a notice, and fears a bill
  - I've been on the medication for six months. How come its suddenly not covered.
  - I don't want to change doctors, but my PCP is no longer participating in my insurance plan. What do I do?

Last Slide!!

- So you are a provider, but you are also a patient.

- What’s your point of view on cost containment?