Evolving Payor Cost Containment Strategies And How to Respond

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Elizabeth A. Spoto, CEO
Spoto & Associates, LLC

Evolution of Managed Care

• Historical Milestones in Managed Care
  – 1929 Baylor started Hospital Pre Payment Plan
  – 1933 Kaiser starts prepaid medical plan for workers
  – HMO Act of 1973
  – Medicare PPS Reimbursement Changes
    • 1983 DRG Reimbursement Inpatient
    • 1995 APC Reimbursement for OPPS
  – 2003 Medicare Drug Improvement and Modernization Act (MMA)
  – 2010 Patient Protection and Affordable Care Act

• Key Characteristics of Managed Care
  – Provider Network
    • Selected using Quality Measures
    • Achieve savings through discounts
  – Formal Utilization Review Processes
    • Pre Cert Procedures
    • Medical Necessity Review
  – Emphasis on Preventive Care
  – Financial incentives for members to encourage efficient use of care

These measures were pioneered by HMOs but now are used by most provider health benefit programs.
Evolution of Managed Care

- **Types of Network Based Managed Care Programs**
  - Indemnity
  - PPO
  - Point of Service
    - In Network – HMO (highest benefit)
    - Out of Network – PPO (lowest benefit)
  - Open Access (no referral needed but no out of network
  - HMO

- **Managed Care Over the Decades**
  1973-1990: HMO’s Acclaimed for Decreasing costs by
  - Managing Hospital Utilization
  - Obtaining Discounts for Rates from Providers
  - Holding Members Accountable for Understanding Financial Responsibility
  1990-2000: Backlash on HMO’s
  - Due to For Profit nature of Companies – many perceived profits more important than care
  - Hassle Factor for Providers and Members
    - Decreased Rates
    - More Paperwork
    - Limited Choices
  - Results: Comprehensive Networks “All in providers” but costs growing faster than GDP or General CPI

2000-2007: Cost Transfer to Members
  - Commercial Plans / Employers Transfer increasing cost to members
    - High Deductible Plans
    - Higher usage fees for improper utilization (ER)
    - Payors increase Utilization management methods to bundle provider payments
    - Government Enters the picture...

- **Evolution of Managed Care — Government Involvement**
  - **Federal - Medicare Advantage (2003)**
    - 2016 MA penetration rate
      - US – 32%
      - GA - 33%
  - **State - Medicaid Managed Care (GA -2006)**
    - Currently 47 of 50 states have a managed Medicaid program
    - Programs set up to curb the growth of entitlement expenditures
### Payor Mix Evolution

<table>
<thead>
<tr>
<th>Payor</th>
<th>% of Business</th>
<th>% of Cost Payment</th>
<th>Contrib Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>25%</td>
<td>160%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Medicare</td>
<td>35%</td>
<td>100%</td>
<td>35.0%</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>0%</td>
<td>0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>25%</td>
<td>85%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
<td>100%</td>
<td>5.0%</td>
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<tr>
<td>Self Pay</td>
<td>10%</td>
<td>20%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Negotiated</td>
<td>30%</td>
<td>30%</td>
<td>90%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>103%</td>
<td>103%</td>
</tr>
</tbody>
</table>

### Evolution of Managed Care

#### GA Premium Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Avg Employee Premium</th>
<th>Employer Contribution</th>
<th>Employee Contribution</th>
<th>Total Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>GA -Single $4,367</td>
<td>$1,203</td>
<td>$5,570</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GA -Family $11,761</td>
<td>$4,448</td>
<td>$16,209</td>
<td></td>
</tr>
<tr>
<td></td>
<td>US -Single $4,598</td>
<td>$1,234</td>
<td>$5,832</td>
<td></td>
</tr>
<tr>
<td></td>
<td>US -Family $12,137</td>
<td>$4,518</td>
<td>$16,655</td>
<td></td>
</tr>
</tbody>
</table>

Does not include amounts for deductible and co-insurance

Source: Kaiser.org

### Evolution of Managed Care

#### Health Care Costs – US Family of Four

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical Costs</th>
<th>Median Household Income</th>
<th>% of Median Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$50,000</td>
<td>$50,000</td>
<td>100%</td>
</tr>
<tr>
<td>2008</td>
<td>$55,000</td>
<td>$55,000</td>
<td>110%</td>
</tr>
<tr>
<td>2011</td>
<td>$60,000</td>
<td>$60,000</td>
<td>120%</td>
</tr>
<tr>
<td>2014</td>
<td>$65,000</td>
<td>$65,000</td>
<td>130%</td>
</tr>
</tbody>
</table>
Evolution of Managed Care – The Financial Crisis

- The 2008 Market Crash and resulting financial crisis dramatically sped up the changes that were slowly evolving.

Evolution of Managed Care – Slowing down of Costs

- Payors are searching for ways to more aggressively manage costs to support their customer’s requests:
  - Governments are looking for ways out of their deficits without raising taxes
  - Employers are done with covering an expenditure that is out of control and not their expertise
    - Large employers are turning to payors and specialty medical management companies for ideas
    - Small employers are leaving the market and new have opportunity to send employees to exchange for small penalty compared to cost
  - Individuals buying insurance are the largest growing segment in the market and, survey after survey shows the greatest factor in determining which plan to choose is cost.

So…what are the strategies that they are using???
Payor Cost Containment Strategies

• Benefit Plan Design
  – Higher co-insurance for ER visits
  – Services provided greater coverage at specified provider
    • Outpatient Lab services -
      – Covered if sent to reference lab
      – Subject to deductible is done at hospital
    • Outpatient Radiology - Separate deductible for outpatient hospital

  - Plan UCR set at percentage of Medicare Level
    - Plan sets UCR level at 125% of Medicare
    - Amounts between hospital contract and UCR goes to patient responsibility
  
  Hospital contract doesn’t cover benefit design so can’t contract around this strategy – this is the new Wild West of Healthcare

Payor Cost Containment Strategies

• Pre-certification/Authorization Steerage
  – Hospital calls to pre-cert outpatient services
  – Payor / third part approves services and then
    • Contacts patients to let them know of less costly options
    • Transfers patients to less costly provider to make appointment
    • Moves pre-cert/auth to other provider

  Examples include
    • High Tech Radiology – MRI, CT, Pet Scans
    • Expanding to other services
      – Nuclear Cardiology
      – Sleep Services

Payor Cost Containment Strategies

• Specialty Network Contracting
  – Payors subcontract to a vendor to manage a network at a fixed cost
    • Lab Services
    • Outpatient Therapy
    • National Quality Center Contracting
  
  Example
    • Blue Cross Open Access – all labs to Lab Corp
    • Wellcare moving to specialty therapy network
    • Peach State – therapy network
• **Narrow Networks**
  - Moving to a narrow network allows a payor to
  - Concentrate their volume with fewer providers
  - Obtain deeper discounts for the volume
  - Who uses narrow networks
    - Historically – large self insured employers in a market
    - Now – payors using them for fully insured business on the health insurance exchange
      - Humana Network
      - Blue Cross “Pathway X” Network

• **Utilization Management as a Weapon**
  - Downgrading Services
    - ER visits (CMO’s)
    - Inpatient Services (from med/surg to sub-acute)
  - Retrospective Audits
    - Delay cash at minimum
    - Selectively deny/downgrade services
    - Deny services originally authorized

• **Provider Payment Policies**
  - Move Policies out of contracts and into provider manuals – where providers can’t contest
  - Mimic Medicare Policies
    - Follow Medicare when it works for Payor
      - 72 hour rule
    - Preventable Adverse Events (PAE)
    - Multiple Procedure discounting
    - Readmission Rules
  - Create Payor’s own spin on Medicare
    - DRG –
      - one-day stay for some cases rather than full DRG
    - Only pay for some adjustment factors
    - Readmissions
Payor Cost Containment Strategies

Feel the Sunshine – Transparency Initiatives

- Payors using claims data to publish average prices per case
  - Make sure they are right
  - Make sure you can explain them
- Quality becoming more of the puzzle
  - Payors publishing quality scores
  - Payors tying rate increases to quality results

Blue Cross Reference Based Benefits Strategy

A detailed review of what is to come… Or

What you can’t do with contracting, you can do through benefit design

Blue Cross Reference Based Pricing Initiative

How is it established?

- Developed by Blue Cross Association using historical claims from all plans (excludes outliers)
- Reference Price utilizes the BCBS Paid (not allowable) PPO claims for all services provided in the episode of care
- Claims set is the same claims used to develop data for Anthem Care Compare
- Reference Price is set by region/area and will be updated annually
- Only surgeons, radiologists and facility fees paid out of reference price (not other fees used to build the reference price)
Payor Cost Containment Strategies

Blue Cross Reference Based Pricing Initiative

How Does Process Work?
- BCBS Association sets actuarially determined price points (60%, 70%, 80%, 90%)
- Employer picks the price point they will cover under their benefit plan
- Website will provide benefit estimate by service location and provider selected
- Quality information displayed are from Blue Distinction program, Web MD, Leapfrog and Optinet/Aim data
- Website will display reference price and show member out of pocket
  - If provider selected is at or below, reference price, plan pays non-co-insurance and deductible
  - Member pays all of cost above reference price
  - All numbers applied towards out-of-pocket maximums

Procedures Covered?
- Inpatient
  - Laparoscopic gastric bypass
  - Hip replacement
  - Hysterectomy
  - Laminectomy
- Outpatient Procedures
  - Knee arthroscopy / repairs
  - Hernia repairs
  - Endoscopies/Colonoscopies
  - Other
- Outpatient Diagnostics
  - MRI / CT
  - Lab procedures in certain regions

Reference Coverage Levels

<table>
<thead>
<tr>
<th>Reference Price Level</th>
<th>Reference Price</th>
<th>Provider Rate</th>
<th>Payment Example</th>
</tr>
</thead>
</table>
| 50% $500             | 40%             | 1,400 Hospital Contracted Rate with Payor
| 60% $800             | 50%             | 680 80% of Reference Price @ 60% |
| 70% $1,000           | 40%             | 620 80% Co-insurance of Net Price @ 60% |
| 80% $2,500           | 20%             | 170 20% Co-insurance of Net Price @ 60% |
| 90% $3,000           | 10%             | 270 Entire amount over Ref Price |

Assumptions: Plan pays 80/20, chooses 60% reference level and patient has met deductible
- All numbers are hypothetical for illustration purposes only
Payor Cost Containment
Strategies

Blue Cross Reference Based Pricing Initiative
How will providers know if member has reference based benefits?
• No information will be on member ID card
• Precertification – info should be on 271 transaction report saying “Reference based benefits apply. Additional patient liability may apply.”

Payor Cost Containment
Strategies

Blue Cross Reference Based Pricing Initiative
Who is the product designed for and who has purchased this in Georgia?
• This product is only available for self funded plans
• Kroger is using this on a trial basis
• The State Health Benefit Plan has NOT selected this option for 2014

Employer Cost Containment Strategies

• Employers are Bypassing Networks Group & Pension Administrators TPA and ELAP Services
  Warehouse Home Furnishings Distributors, Inc is an ERISA plan using Group and Pension Administrators as their TPA
  – The TPA does NOT utilize a hospital network only a physician network through PHCS
  – GPA has a business associates Agreement with ELAP. Under this agreement ELAP
    • Reviews all hospital claims
    • Compares hospital claims to AHD Medicare Cost report information
    • Requires hospital claims to justify charges above Medicare reimbursement by range of 12-20%
    • Returns to GPA for pay claims
    • Has legal appeals based on accuracy of hospital Medicare reimbursement vs services rendered
    • Offers free legal support to members who are pursued by hospitals to collect amounts owed by members below hospital charges and ELAP determined reimbursement rates

http://www.elapservices.com
How Does a Hospital respond to these growing cost containment strategies?

- Explain your position to employers:
  - Loose the mumbo jumbo
  - Quality is about being treated like a person
  - Demonstrating efficiency and coordinated care scores big points
  - Transparency is closely linked to value perception – i.e. chargemaster/pricing headlines
  - Tiered networks are just fine

Contracting Strategies

- Contract for all of your entities at the same time on the same paper if possible
- Price your services according to how hard they are to steer
- Review Payor Policies and Procedures-trend to leave detail out of contract
  - Tie to current Medicare
  - Spell out details
- Make sure any payor quote of your promise is correct and demand due process to review data and fix changes
- Consider Direct Employer Contracting if makes sense
Provider Response to Payor Cost Containment Strategies

Hospital Pricing
- Historically, pricing is set up to maximize cost reports
- Itemized to a level of detail that is overwhelming (itemized statements)
- Hard to explain the $8 aspirin
- Rationalize your pricing
  - Could your bed day be undervalued? Yes
  - Can you support your charges compared to the growing retail market
    - Radiology
    - Lab – retail cost
- Medicare will be the default on what is fair if you can't explain otherwise
- Transparency is perceived as a strong value in today's world

Provider Response to Payor Cost Containment Strategies

Quality
- Employers/community residents do not know how to measure quality so they measure:
  - Neat & clean
  - Hi Tech looking
  - Communicate & Coordinate
- Quality Ratings are in their infancy so you need to perform and educate your community
  - TJC Scores
  - Leapfrog Scores
  - Hospital Compare
  - Other items such as Patient Centered Medical Homes
- If you don’t tell your story, others will interpret your story for you

Evolution of Managed Care – PPACA / Provider Response

Rural Providers must integrate their local market and do what they do well
- Work with POP’s through employment / join ventures to foster better care coordination
- Ensure pricing reasonable and can be explained in your market
- Ensure quality scores of major services at or above market averages
- Protect reimbursement and rights in contracts to extent possible
Questions