Medical Management (Cost Control) Trends
Topics

- Definition
- Trends vs. cycles
- Options
- Influencers
- Limits
Medical Management Cost Control Defined for This Presentation

- **Benefit limits**
  - Cost sharing (CDHC, high deductible plans, tiered co-pays)
  - Other coverage limitations/exclusions

- **Utilization management**
  - Medical necessity & contractual compliance review - prior auth (PA), inpatient concurrent review (ICR), drug utilization review (DUR)

- **Condition management**
  - Case management (high cost, catastrophic, etc)
  - DM, population management

- **Network management**
  - PFP
  - Tiered, specialty and “closed” networks
  - Risk transfer (case rates, capitation, “shared” risk)
  - Quality*** (medical errors, etcs)
Trends vs. Cycles

- Trends in cost control practices often are cyclical due to:
  - Demand (need) for savings
  - Program cost
  - Popularity
  - Politics
  - Sex appeal (such as having sparkles, being highly technical, producing lots of reports, has only positive impacts, costs a lot or maybe is a new cost)

- Some interventions produce one time savings but fail to alter underlying trends (for example, lower provider fee schedule)
Health Plan Premium Growth Compared To Other Indicators 1998-2003

WHY?

The Bottom Line UK Version

KFF/HRET, 9/2003
Increased Cost Sharing

- CDHC (High Deductible Plans-
  HSAs – “Consumerism”)
  - Growth from 2000 – 2004 – 100% per
    year (1,176,000)\(^1\)
  - Wal-Mart, GM\(^2\), DaimlerChrysler\(^3\)
  - 5.2% of total premium in 2005
  - 7 to 15% lower utilization

\(^1\)Forrester \(^2\)DaimlerChrysler \(^3\)Atlantic Information Service
The Story

- Specific utilization management (UM) processes, if done aggressively, can reduce claims cost
  - Sherwood Report for BCBS Association
  - Professional experience

- The trend is increasing number of Health Plans adopting the UM processes that reduce claims cost and performing these aggressively
## What is an Active and Aggressive UM Process

<table>
<thead>
<tr>
<th>Process</th>
<th>Payment Denials$^1$ as % of Cases Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Review</td>
<td>&gt; 5 %</td>
</tr>
<tr>
<td>Precertification</td>
<td>&gt; 5 to 10 %</td>
</tr>
<tr>
<td>Medical Necessity Review</td>
<td>Criteria/Guidelines used for most reviews</td>
</tr>
<tr>
<td>Steerage</td>
<td>Varies</td>
</tr>
</tbody>
</table>

$^1$ Denials may include true avoidance of services
<table>
<thead>
<tr>
<th>Services</th>
<th>Process</th>
<th>Cost Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Network Management, Provider Contracting</td>
<td>30% reduction</td>
</tr>
<tr>
<td>Inpatient Hosp</td>
<td>PA &amp; ICR</td>
<td>10% reduction</td>
</tr>
<tr>
<td>Outpatient Procedures (OP Surgeries)</td>
<td>Prior Authorization</td>
<td>5% reduction</td>
</tr>
<tr>
<td>High Cost Outpatient Diagnostic Tests</td>
<td>Prior Authorization</td>
<td>5% reduction</td>
</tr>
<tr>
<td>Drugs</td>
<td>Drug Utilization Review</td>
<td>15% reduction</td>
</tr>
<tr>
<td>Chronic Disease</td>
<td>Disease Management &amp; Ambulatory Case Management</td>
<td>? 1% reduction</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>30% to 50% reduction</td>
</tr>
</tbody>
</table>
### Claims Cost Management What Doesn’t Work

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Process</th>
<th>Cost Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Ambulatory Case Management</td>
<td>0% reduction</td>
</tr>
<tr>
<td>All</td>
<td>Predictive modeling for future high cost individuals</td>
<td>0% reduction</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>0% reduction</td>
</tr>
</tbody>
</table>
### Inpatient Admission Review

#### Typical Results

<table>
<thead>
<tr>
<th>% of Admits Reviewed</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Admits Reviewed That Are Denied/ Diverted</td>
<td>5%</td>
</tr>
<tr>
<td>% of Denials Overturned on Appeal</td>
<td>9%</td>
</tr>
<tr>
<td>% of Admits Deferred Until Later</td>
<td>25%</td>
</tr>
<tr>
<td>Net Reduction</td>
<td>Reduction in Admissions</td>
</tr>
</tbody>
</table>
An aggressive inpatient concurrent review program may downgrade an additional 10% of acute hospital days to a lower level of care (e.g., observation, skilled or subacute)
WHAT ABOUT THE REST?

- Predictive modeling (for identification of high cost cases)
- Case management/Care coordination
- Population & Disease management
Predictive Modeling

- Used to identify individuals to receive interventions
  - SOA study shows R2 (0.1 to 0.23) too low to accurately perform this task
  - Survey info (health risk assessments) being added to predictive models to improve effectiveness – to date no evidence showing improved results
Case Management/Care Coordination

What do we know?

- Probably effective only in very loosely managed indemnity programs, in most managed care programs unlikely to reduce costs beyond that achieved by UM
- At best, offers very small overall cost reduction
- Should be viewed as quality improvement function
- All reported cost savings are “soft” and are losing credibility
Population & Disease Management

What do we know?

- Does not include Service carve outs – at core, most of these are UM programs and should be evaluated as such
- Demand management – cost savings doubtful outside of staff model settings
- Disease or condition management programs
  - Popular, although now being critically scrutinized
  - Original contracts with DM vendors have flawed methodologies for calculating savings
  - Little but growing credible support for true cost savings
  - May be a replacement for non-effective UM programs
Why Traditional Disease Management Doesn’t Reduce Costs in US or Western Europe

- Treating elevated cholesterol to prevent heart attacks, strokes and cardiac death example; (US population based)
- For every avoided heart attack or stroke, about 100 people must receive a full years treatment with cholesterol lowering drug
- For every avoided cardiac death 500 people must receive a full years treatment with cholesterol lowering drug
Cost Regression Due to Natural History of Disease

- Diabetes
- CHD
- CHF

% Costs:
- Peak Cost
- 18 Months Later
Figure M-1
Medicare Diabetes Average Claim Cost

Example of Regression to the Mean

Quarters

Q1 - Q5 Cost Decrease of 82%

Pre Implementation**
P O S - Q 5: $3,322

Post Implementation***
Q 1 - Q 5: $3,342

Q 1 - Q 5: $3,261

Q 13 - Q 16: $2,804

Q 1 - Q 5: $2,322

Q 1 - Q 4: $3,842

Q 5 - Q 8: $1,125

Q 9 - Q 12: $3,222

Q 13 - Q 16: $2,804
Health Plan Use of UM Processes

- Facts do not match perceptions or public statements
- Active and aggressive “Managed Care” processes as defined here actually have steadily increased over the past 10 years
# Prevalence of Active and Effective UM Processes

<table>
<thead>
<tr>
<th>Process</th>
<th>Estimated % of Plans Using Process and Judged Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Review</td>
<td>60 to 75 %</td>
</tr>
<tr>
<td>Precertification</td>
<td>5 to 10 %</td>
</tr>
<tr>
<td>Medical Necessity Review</td>
<td>50%</td>
</tr>
<tr>
<td>Steerage</td>
<td>5 %</td>
</tr>
</tbody>
</table>
## Health Plan Use of Aggressive UM Processes (Mirkin Index)

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>1994</th>
<th>1999</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>Rare</td>
<td>Few</td>
<td>Almost All*</td>
</tr>
<tr>
<td>Blues</td>
<td>None?</td>
<td>Few</td>
<td>Most</td>
</tr>
<tr>
<td>Regional for Profit</td>
<td>Few</td>
<td>Most</td>
<td>Half to Most</td>
</tr>
<tr>
<td>Regional not for Profit</td>
<td>None?</td>
<td>Few</td>
<td>Half to Most</td>
</tr>
</tbody>
</table>
Dave’s Expert Opinions

- **Utilization Management**
  - Payment denial is primary tool
  - Is “sentinel” effect still real – probably not

- **Case Management/Care Coordination**
  - In our experience there is no good evidence these reduce costs

- **Other medical management functions/tools**
  - Unlikely to have any stand alone value to control costs - IT solutions are just coming to market, they may have value by reinforcing adherence to clinical guidelines and protocols or reducing the cost per review for UM
Questions?