
HEALTH SERVICE BROKERS

A MONOGRAPH

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EXECUTIVE SUMMARY

PURPOSE

This study was conducted to identify mechanisms used in the private sector to control medical costs which might be suitable for government health care programs, particularly Medicare.

SCOPE

The term “health service broker,” as used in this report, refers to any business that establishes and monitors provider networks, provides utilization management services or secures discounted medical services and supplies. This report provides an overview of methods used by health service brokers to manage health care costs and utilization. This study reports on techniques which brokers employ to ensure their success in each area mentioned above. While this report looked at the overall feasibility of transferring these approaches to government programs, working out the specific mechanics will be left for future studies.

METHODOLOGY

In-person and telephone interviews were conducted with a purposive sample of brokers providing utilization management, targeted discount purchasing and networking services. Discussions were held with the Health Care Financing Administration (HCFA), academicians, representatives of professional organizations, corporations and experts in this field. A total of 51 interviews were conducted.

FINDINGS

- Effective provider networks control network membership, regularly assess utilization of services and remove service intensive providers.
- A variety of approaches coupled with standardized decision trees and other innovations ensure the success of utilization review.
- Targeting specific goods and services for bulk purchase at different levels in the distribution chain can produce savings and maintain patient access.
- Individual case management could improve quality of care, increase efficiency and make better use of benefits for chronically or terminally ill patients.

CONCLUSION

Many private sector mechanisms for controlling health care costs appear to have potential for Medicare, Medicaid and other DHHS programs including those administered by the Public Health Service. Each component should study the mechanisms used by the private sector to determine whether any can or should be adapted to their programs.

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INTRODUCTION

PURPOSE

This study was conducted to identify mechanisms used in the private sector to control medical costs which might be suitable for government health care programs, particularly Medicare.

BACKGROUND

In 1965, health care costs accounted for 6 percent of the gross national product (GNP). According to a recent report issued by the Commerce Department, health spending in 1990 will approach \$661 billion and account for 11.5 percent of the GNP. The Commerce Department also projects that spending on health care in the United States will rise 10-14 percent annually through 1995.

The escalating cost of health care has led third party payers — employers, insurers and the government — to seek new methods to curb these rising costs. In 1983, Medicare implemented the prospective payment system (PPS) to address Part A inpatient costs. Following the adoption of PPS, Medicare undertook a number of policies intended to generate savings for ambulatory care services. These policy actions included a physician-fee freeze, reductions in payments for overpriced procedures, balance billing reform and incentives to encourage physicians to accept assignment. Despite Medicare's efforts to control health care costs, expenditures continue to grow.

As Medicare pursued cost containment measures, health care providers responded by shifting more of their costs to private sector third party payers. Private sector health care costs soared, and employers became disenchanted with traditional health care payment mechanisms and their inability to reduce costs and control utilization. Increasing numbers of employers assumed control of their employees' health plans and became self-insured. The more employers became involved with their health care plans, the more they realized that they lacked the expertise needed to control costs and utilization. New businesses specializing in health care cost containment moved in to fill this vacuum.

To compete with the new companies offering specialized cost containment services, health maintenance organizations (HMOs) and traditional health insurers "unbundled" segments of their existing business and began marketing the individual specialized services to employers. An employer might contract for administrative services from one company, provider networks from a second and utilization management services from a third. This unbundling or "boutiquing" of individual health care cost containment services spawned the health services broker industry.

The essence of the philosophy of health service brokers is a flexible pragmatism and a willingness to try innovative approaches to managing program costs and utilization, while maintaining quality of care and ensuring access to needed services.

Health service brokers range from large national corporations to individuals providing services locally, and represent a wide variety of philosophies and approaches to controlling health care costs and securing health care services. Some of the health service brokers we contacted for this report provided a single health related service, while others provided multiple health services which they boutique or sell as customized packages to employers, third party payers and others, including other health service brokers. Health services brokers attempt to control their clients' health care expenses in a variety of ways. This report focuses on four specific areas where brokers claim to achieve savings and control costs by:

1. establishing networks of doctors, hospitals and other health care specialties whose care is deemed to be cost-efficient, medically competent and appropriate;
2. combining a variety of utilization review (UR) techniques to educate health care providers concerning unnecessary, excessive and inappropriate procedures;
3. targeting certain medical supplies and services for purchase at discounted prices; and,
4. providing individual case management (ICM) for some patients.

SCOPE

The term "health service broker," as used in this report, refers to any business that establishes and monitors provider networks, provides utilization management services or secures discounted medical services and supplies. This report provides an overview of methods used by health service brokers to manage health care costs and utilization. This study reports on techniques which brokers employ to ensure their success in each area mentioned above. While this report looked at the overall feasibility of transferring these approaches to government programs, working out the specific mechanics will be left for future studies.

The Office of Inspector General (OIG), Office of Evaluation and Inspections (OEI) plans to conduct more detailed inspections on some specific approaches used by health service brokers. There are currently studies in the OIG workplan focusing on private sector utilization review, second surgical opinion and Medicaid case management.

METHODOLOGY

In-person and telephone interviews were conducted with a purposive sample of brokers providing utilization management, targeted discount purchasing and networking services. Discussions were held with the Health Care Financing Administration (HCFA), academicians, representatives of professional organizations, corporations and experts in this field. A total of 51 interviews were conducted.

We asked the people we contacted during this study how they control health care expenses, and to identify medical procedures and other services which they found to be good candidates for cost control efforts. We also asked them to provide an estimate of savings they achieved from their methods.

Savings reported by brokers and by clients varied depending on the combination of services provided and the aggressiveness of the broker and client in applying these approaches. We did not attempt to validate estimates of savings, and therefore did not include them in this report.

Qualitative analysis of the interviews was used to identify methods which might be suitable for additional indepth research to determine the feasibility of transferring the approach to government sector health programs. We expect that more detailed studies will offer a more comprehensive analysis and statement of potential savings which can be derived from adopting health service broker techniques.

In addition to collecting service intensity and payment data related to specific procedures, OEI's Statistical Analysis Group (SAG) developed a methodology and obtained HCFA data to determine whether HCFA had the capability to distinguish cost-effective providers from "outlier" providers who bill for substantially more services than their peers. This analysis was refined by examining the data based on physician specialty and by including data on patient hospitalizations as a measure of severity of illness.

In the developmental stage of this study, we talked to academicians and business people knowledgeable in employee health benefits, as well as some health service brokers. Based on these exploratory discussions, we identified two broad areas where health service brokers and employers have concentrated their efforts in an attempt to control rising health care costs:

- provider networks which provide a comprehensive range of services at a discount to their clients, and
- utilization review techniques which assure that appropriate care has been rendered in appropriate settings.

We also discovered that many brokers and employers had refined these techniques and applied them to specifically identified services and patients through targeted purchasing and individual case management.

This report reflects what we learned from brokers and employers who purchase their services. The report is divided into four chapters: provider networks, utilization review techniques, targeted purchasing and individual case management. In each of these four chapters we examine what the private sector is doing and have attempted to identify limitations and obstacles to implementation of these concepts and key elements necessary for success.

CHAPTER 1: Provider Networks

Effective provider networks control membership, regularly assess utilization of services, and remove service intensive providers.

Employers as Purchasers of Comprehensive Health Services

As employers became self-insured and took over control of their health benefit plans, they became aware of the tremendous power they hold as purchasers of health care services. They reasoned that they could apply the same prudent buyer principles they used in their business operations to the purchase of health services. Using health service brokers, they exercised their purchasing power to establish provider networks.

Provider networks operate on the principle of channeling a predictable patient load to physicians and suppliers who practice medicine efficiently. In exchange for an increased patient load, physicians and other providers of medical care and supplies agree to discount the fees they charge for their services. Twenty-one health service brokers interviewed for this report are involved in establishing networks to provide health care services for their clients. The networks encompass preferred provider organizations (PPOs), HMOs, independent practice associations (IPAs) and exclusive provider organizations (EPOs).

- *Health service brokers control membership by screening candidates for their networks; all request malpractice and disciplinary information from candidates.*

Criteria used by health service brokers in selecting providers for their networks vary considerably depending on local conditions. All the brokers we spoke with requested information concerning malpractice claims or disciplinary actions from candidates. By checking for any evidence of malpractice or disciplinary actions, brokers feel they can exclude from their networks providers whose quality of care may be questionable.

Providers requested to join networks must agree to discount the price of their services in return for a potential increase in their patient case load. Institutional providers, such as hospitals and nursing homes, are usually reimbursed on a per diem basis. Individual practitioners, such as physicians, are usually paid using fee schedules. The amount of payment a provider participating in a network can expect to receive is documented in a contract which is periodically renegotiated.

Patients are encouraged to use the network providers through incentives such as lower deductibles and copayments, and discouraged from using “out of network” providers by higher out of pocket expenses. In an EPO, patients pay all of the medical expenses they incur outside of the network.

Most brokers feel that negotiating discounts on fees alone will not produce sufficient savings unless utilization controls are also built into the provider contract. A potential exists for providers in networks to offset discounts for services by increasing the number or intensity of

services they provide to patients. Five brokers said that the networks they established had failed to produce anticipated savings because discounts were offset by increased services. According to one broker, service intensive providers are often those most willing to give the greatest discounts because they know that they will make up the difference by increasing their volume of services.

Some HMO failures, and the inability of some networks to produce real dollar savings, were attributed by some to a network's failure either to exclude service intensive providers or to control their intensity of service. While aberrant providers of this sort may be a small percentage, they can erode or negate any savings expected from the network. Six brokers said that building a good utilization review program to complement the discounted pricing is the key to addressing this problem.

Seven brokers identify potential candidates for their networks by analyzing relevant claims data to determine utilization patterns. They use this information and provider background information to determine whether a physician is a suitable candidate for their network. For institutional providers, they look at the range of services offered, cost reports, utilization data, occupancy rates, staffing ratios, etc. These brokers are confident that these measures enable them to screen out providers with less than perfect credentials, as well as those providers with aberrant utilization patterns.

- *Some brokers build utilization controls into their contracts with providers. Many more use claims data analysis to evaluate provider utilization before renegotiating the provider contract.*

Seven networks require that their members agree to submit to the network's practice protocols and utilization review mechanisms. These agreements are viewed, by brokers, as an effective means to control utilization, ensure quality of patient care and reduce malpractice risk. Practice protocols are usually based on accepted standards of medical practice, research on effectiveness, consultation with experts and consensus of the network members. Post payment analysis is often used as the basis of review prior to renewal of individual member contracts. One employer and thirteen brokers said they use claims data either in validating current contract compliance or to renegotiate contracts at renewal time. Brokers using practice protocols ensure compliance by periodically analyzing individual member practice patterns.

Clearly, access to and analysis of claims data is critical to the success of a network, whether used in selecting potential providers, or monitoring their behavior after inclusion in the network. Any network that has the means to identify and weed out service-intensive providers before inclusion in the network, and monitor utilization within the network, is well ahead of the game.

The HCFA as Purchaser of Comprehensive Health Services

- *Although beneficiary freedom of choice is protected by law, HCFA is experimenting with demonstration projects to evaluate the feasibility of using provider networks for Medicare.*

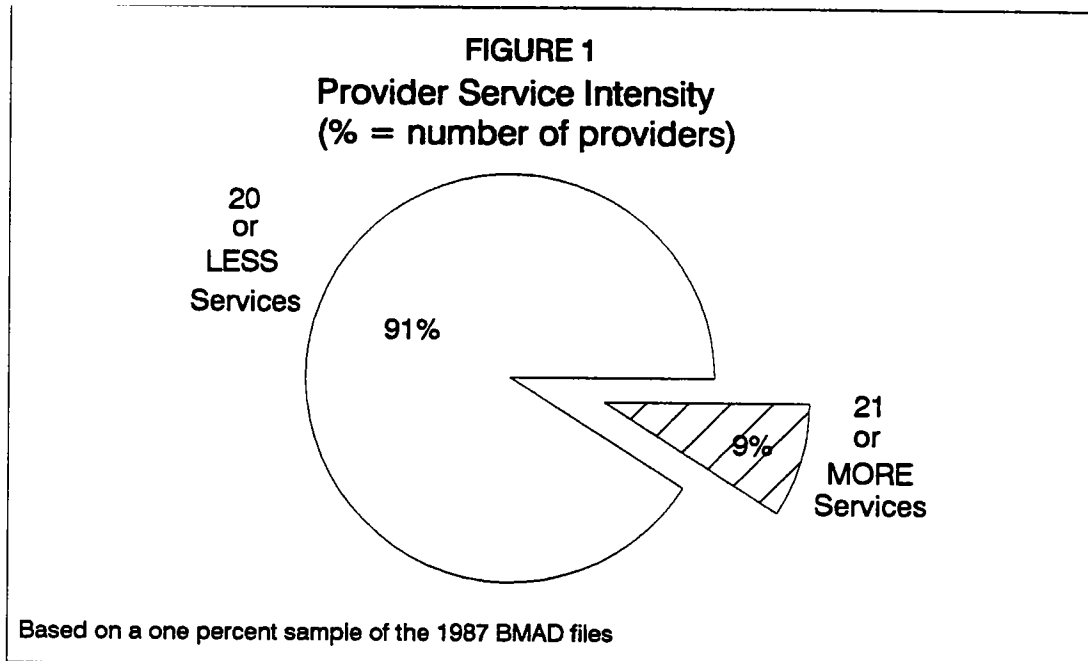
The HCFA has recently undertaken five PPO demonstration projects to evaluate the feasibility of using networks in the Medicare program. The objectives of these demonstration projects are to test the feasibility of this form of service delivery, to determine its attractiveness to beneficiaries and to assess its effectiveness in controlling the volume of services billed to Medicare.

Four PPO projects under study are enrollment models; the fifth is a non-enrollment model. Enrollment models require that beneficiaries elect to participate. Beneficiaries must use network providers or pay a greater share of their health care bill. In the non-enrollment project, beneficiaries do not elect to participate in the PPO network but are enrolled temporarily whenever they use the services of a provider in the PPO network. Unlike the enrollment models, the patient pays no penalty for using a non-network provider.

While HCFA has the authority to conduct demonstration projects to determine the feasibility of using networks to provide comprehensive health services, widespread implementation appears to be prohibited by current Medicare law, which guarantees beneficiaries freedom of choice in selection of medical providers. According to HCFA, the law prohibits Medicare from steering patients to selected providers. The HCFA also feels that current reimbursement mechanisms preclude negotiating with providers for discounts. In HCFA's view, these constraints severely limit their ability to experiment in this area.

- *The HCFA has the capability of identifying service intensive providers through analysis of its own Medicare data bases.*

To determine whether HCFA data could be used to screen providers for a network, we analyzed HCFA's Part B Medicare Annual Data (BMAD) files and hospital admission files for 1987 to see if we could simulate the reviews of claims data that brokers perform when evaluating potential physicians for their networks. Using the 1987 BMAD data, we aggregated the services each beneficiary had received to the physician who last saw the patient. We assumed that the physician last seen by the patient operated as gatekeeper and was responsible for ordering the services that followed. Once we aggregated services, we arrayed the providers according to service intensity. Figure 1 indicates the results of our analysis. It shows that 91 percent of physicians who billed Medicare in 1987 provided, on average, 20 or fewer medical services to their patients. We assumed that physicians billing more than 20 services were outliers and may not be good candidates for a network because of their service intensity.



If Medicare had the ability to influence a patient's choice of physician, patients who chose an outlier physician would have to bear a greater share of the medical costs through increased coinsurance and other incentives. While our assumptions may bias which physicians are identified, similar arrays of data could be done using different assumptions.

We found that neither severity of illness (measured by hospitalizations) nor specialty accounted for the intensity of services some physicians provide. In the past, physicians providing intensive services to their patients have argued that their patients are sicker and therefore require more medical services. Other physicians argued that their practice specialization accounted for the intensive services their patients received. We analyzed the frequency of services provided to beneficiaries who were hospitalized in 1987. We also analyzed the intensity of services by physician specialty. Physicians who were outliers in our initial analysis were also outliers in their specialty. Patients of outlier physicians did not have a greater incidence of hospitalization than their more conservative counterparts.

While this method of analysis enables targeting of individual physicians, geographical location and other factors should be taken into consideration before excluding a particular provider from a network or penalizing Medicare patients for using them. The purpose of our illustration is to demonstrate that HCFA has data which could enable them to identify service intensive physicians whose participation in a network might be undesirable.

- *Issues for further study*

Studies should be considered on the types of legislative changes that would be needed to permit the establishment of provider networks. Other studies should examine the type of network that would be needed to meet patient needs. Is it better to have national, regional or local networks? Should they include the full spectrum of medical providers, or only primary care physicians? Should government piggyback on already established private sector programs, or control their own networks? Do providers who agree to the largest discounts use more services to offset their discounts?

Regardless of the answers found to these questions, successful networks include the following items:

- a means of identifying and excluding service intensive providers;**
- a method of incorporating practice guidelines into provider contracts;**
- a means of collecting standardized data to monitor network utilization and efficiency;**
- a method for analyzing data to determine network financial condition and individual performance within the network; and**
- a means of influencing patient choice of provider.**

CHAPTER 2: Utilization Review

Brokers, employers and organizations favor a combination of utilization review (UR) techniques for an effective UR program.

Employers as Reviewers of Health Services

Utilization review (UR) is a term that covers a broad spectrum of techniques used, individually or in combination, to examine the use and intensity of services rendered to a patient. Such techniques include, but are not limited to, prospective review, concurrent review, retrospective review and second surgical opinion (SSO). In the last decade, the use of UR cost containment strategies has increased significantly.

The Health Insurance Association of America estimates that about half of all U.S. businesses are using some form of UR . These businesses and health service brokers believe that controlling the use and intensity of services provided to patients is critical to controlling rising health care expenditures. Of the 37 health care brokers we interviewed, 32 offered utilization review or utilization management services. Only one broker did strictly retrospective review and several did strictly prospective reviews. The vast majority employed a combination of strategies.

The scope and focus of UR varies by employer and by broker. Some approaches review all services rendered. The more common approach targets specific procedures, diagnoses, providers or high dollar services for review.

The information resulting from UR is used by brokers for many purposes:

- to identify potential members for inclusion in networks;
- to monitor network provider compliance with agreed-upon practice guidelines;
- to make coverage determinations or payment decisions;
- to identify medically unnecessary or excessive services;
- to preclude certain the kinds of services which have been demonstrated by medical evidence to be ineffective; and,
- to identify patients for individual case management (ICM).

Many brokers and employers use UR services to educate patients about probable outcomes from using certain services and trade-offs associated with using alternate services. Utilization review can result not only in less expensive care, but also in improved quality of care.

- *Prospective review can reduce the number of costly invasive procedures.*

Prospective review is used to ensure a course of treatment which is appropriate, cost effective and of high quality.

Prospective review is not applied to episodes of emergency treatment. The people with whom we spoke generally agreed that prospective review has the greatest impact on controlling health costs, because it can result in the use of a less costly treatment or procedure, the use of a less costly setting or the postponement of a procedure until alternative medical treatments have been tried.

Table 1 lists 21 of the 57 specific items which brokers mentioned as suitable for prospective review. Table 1 contains only those items with Medicare expenditures exceeding \$15 million annually. While the services identified in Table 1 are based on broker experience with prospective review, many have a considerable body of medical research questioning the ability of the service(s) to improve a patient's quality of life. For example, in research conducted by the Rand Corporation on physician behavior for the National Institutes of Health Consensus Development Program, coronary artery bypass surgery was found to be unjustified for 14 percent of their sample, and "equivocal" for another 30 percent.

TABLE 1	
Some Procedures Identified by Brokers as Suitable for Prospective Review	
<i>Procedure Name</i>	
✓ Allergy Shots	
✓ Barium Studies	
✓ Blepharoplasty	
✓ Coronary Artery Bypass Surgery	
✓ Carotid Endarterectomy	
✓ Carpal Tunnel Repair	
✓ Cataract Extraction/Surgery	
✓ Cholecystectomy	
✓ Coronary Angiography	
✓ CT - Scans	
✓ Dilation/Curettage	
✓ Doppler Studies	
✓ EEG, EKG, Holter Monitor	
✓ Hammertoe Operations	
✓ Hemorrhoidectomy	
✓ Hysterectomy	
✓ Laminectomy	
✓ Pacemaker Insertion	
✓ Prostate Surgery/Prostatectomy	
✓ Endoscopic Procedures	
✓ Spinal & Vertebral Surgery	

- *Concurrent review can identify potential cases for ICM.*

Concurrent review occurs during the course of a patient's treatment and requires that approved admissions be recertified at specific intervals. Virtually all the brokers involved in prospective review also conduct concurrent reviews which are primarily used to monitor hospital admissions and other institutional care. Most brokers conduct concurrent reviews over the telephone; some conduct on-site reviews. Many brokers conducting concurrent care reviews use software programs to minimize reviewer subjectivity and to ensure consistency in the decision process.

The goal of concurrent review is to prevent the use of unnecessary or inappropriate services; thereby reducing costs. Continued stay review determines whether further hospitalization is necessary, identifies other treatment options and evaluates potential discharge planning needs. Concurrent review also plays an important part in identifying cases that might be suitable for ICM.

- *Retrospective review can identify providers with aberrant utilization and procedures vulnerable to manipulation.*

Retrospective review is a multi-faceted approach to UR which occurs after the patient's treatment has been provided. It is used by health service brokers to identify: 1) potential providers for networks; 2) providers who exceed agreed upon treatment norms; 3) service intensive providers; and 4) patients for ICM.

Retrospective review is also used to document for the employer or insurer that the goods and services they paid for were actually received by the patient. It assesses the ability of systems already in place, such as prospective review, to ensure the medical appropriateness of services. It is also used to identify specific services which have a high likelihood of having been upcoded, fragmented or otherwise manipulated to increase reimbursement. Data from retrospective reviews is also used by brokers to renegotiate rates and contracts with providers in their networks.

- *Brokers feel all UR programs benefit from use of standardized software programs which provide more consistent criteria for evaluation.*

A number of brokers have purchased software programs designed to provide more consistent means for determining whether certain medical procedures are warranted. These software programs employ clinically documented standards of care which enable their users to determine whether a proposed medical procedure is necessary and appropriate. The software not only promotes more consistency in the decision process, but also documents the criteria for denial or approval of a medical procedure. If the computer assisted review indicates that a proposed procedure is of questionable value, a second opinion may be scheduled and/or a medical consultant may discuss the proposed procedure with the attending physician before deciding whether to approve the procedure.

Second surgical opinion (SSO) is a UR mechanism that some brokers feel benefits from the use of standardized software. While most brokers felt that SSO was not a very cost effective UR technique, others disagreed and claimed significant SSO savings. Those brokers who claimed success with SSO, used SSO only in selected cases. Some brokers selected procedures which research has shown to be most likely to be inappropriately used. Others selected candidates suitable for SSO by using their standardized prior authorization software. Those brokers who felt that SSO was not a very cost effective UR technique cited extremely high SSO confirmation rates as the main reason for SSO program failure. This may be due to the blanket approach often used, rather than the more focused approach used by those who have had more success. Brokers claiming SSO success also specified who would conduct the

SSO consultation. They felt that directing patients to select providers minimized any conflict of interest and resulted in a more objective SSO.

- *Obstacles to effective UR are resistance by providers and ambivalence by employers/payers regarding enforcement of UR decisions.*

During the course of our interviews, we asked what the major obstacles to cost/utilization management were at this time. Ten brokers told us that there was provider resistance to the system, a lack of physician cooperation, and a need for employers and insurers to enforce their UR decisions. When questioned about what changes were needed to overcome these obstacles, twelve brokers observed that there is a need to work more closely with providers and establish working relationships that decrease adversarial situations.

One way to address these obstacles may be through use of clinical practice protocols or guidelines. The development of practice guidelines is viewed by some brokers and experts as the key to improving the quality of care provided to patients as well as controlling use. Brokers that have developed their own standards of practice claim that most physicians respond well to them and that changes in physician behavior do occur. Physicians who repeatedly fail to abide by clinical practice guidelines are removed from the network.

The HCFA as Reviewer of Health Services

In comparison to the private sector, Medicare's approach to UR primarily has been limited to retrospective reviews. In recent years, HCFA has undertaken several projects designed to broaden their approach to UR.

- *The HCFA's fiscal agents have developed alternative review programs for their private business, but have no incentive to use them for Medicare.*

Many of HCFA's contractors have purchased or developed alternative UR programs similar to those offered by brokers for use in their private business. Several have purchased UR decision software for use in their private business. These contractors rarely extend to their Medicare business the UR programs they have developed or purchased for their private business, because there are no incentives for them to do so. Software which has been purchased or developed by HCFA's fiscal agents is not used for Medicare claims because the authority for making decisions concerning the appropriateness of medical care and procedures lies primarily with Peer Review Organizations (PROs).

- *HCFA's PROs prospectively review a few surgical procedures, but much is left to each PRO's discretion.*

The HCFA currently requires PROs to prospectively review a select number of procedures including coronary artery bypass and cataract surgeries. The PROs have the option of selecting which procedures they will prospectively review. Each PRO has been left to develop its own criteria for use in assessing the medical necessity of the procedures it has selected for prospective review.

The HCFA would like to move toward computerization of the prior authorization process. However, their plans do not call for the establishment of a national system using a uniform decision tree for all PROs. The system HCFA envisions would allow each PRO to establish its own system. According to HCFA, the statute which permits prior authorization of certain Medicare services does not contemplate national standards for PRO decisions. But the statute does not preclude the use of national standards either. Failure to adopt a national uniform approach with documented standards for allowing or disallowing a particular procedure may leave Medicare's prospective review program vulnerable to inconsistent decisions.

- *The Medicare program conducts concurrent review on certain Part A services, but without computer assisted guidelines.*

Medicare conducts "concurrent" reviews on some skilled nursing home stays, rehabilitation services, home health visits and other Part A services as part of their claims processing. Information, in the form of treatment plans and, in some cases, physician certification as to the need for continued care, is provided on the claims submitted by providers. Decisions on whether to continue coverage of a benefit, and for how long, is determined by examining the information submitted along with the claims. The Medicare process can be described as less aggressive compared to some private sector approaches which are conducted on site or over the telephone, and less "objective" compared to the use of computer assisted guidelines used by brokers to reduce the subjectivity of UR decisions.

- *The HCFA is experimenting with alternative approaches to retrospective review.*

The HCFA is currently sponsoring some demonstration projects involving retrospective review. In one project, a health service broker has been subcontracted to conduct utilization reviews. The purpose of this project is to determine if the use of private sector contractors would improve Medicare UR efforts. This project has generated some complaints from the provider community but appears not to have had an effect on patient satisfaction with the Medicare Program. The savings from the use of an independent UR firm appear to be significant. In another demonstration project, a Medicare carrier has been developing screens which will enable them to match diagnosis with treatment. Early results indicate the screens have been successful in identifying aberrant practices where the care and services given to a patient are not indicated given the diagnosis.

These experiments indicate a recognition on the part of HCFA that its current UR activities are not yielding the expected results in terms of cost avoidance and savings. Some people with whom we spoke felt that HCFA has permitted their contractors too much latitude in their approaches to UR and that many of HCFA's contractors did not effectively use their UR data to correct problems in the Medicare system. One broker we spoke to felt that there may be a conflict of interest on the part of carriers, and a reluctance by PROs to challenge peers, when it comes to dealing with utilization issues.

- *Issues for further study*

Studies should be conducted to determine the effectiveness of UR activities already in place in government programs. New approaches to UR should be explored. Would national, standardized software facilitate a more consistent approach to decision-making? Should independent subcontractors be used for UR activities? Should Medicare's fiscal contractors, many of whom own prior authorization software, screen cases so that only unresolved cases are forwarded to the PRO? Should SSO be performed by a designated group of independent subcontractors, rather than left to a physician of the patient's choice?

Whatever techniques, or combination of techniques, are used, an effective UR program should:

- provide a review trail so that the process can be duplicated by an independent third party;
- provide some method for documenting the process and assuring consistent, uniform decisions; and
- produce reliable, uniform data to assess individual contractor performance, and to accurately track cost savings and effectiveness.

CHAPTER 3: Targeted Purchasing

Targeted purchasing in the private sector has developed beyond the purchase of prescription medicines and durable medical equipment.

Employers as Purchasers of Targeted Medical Services and Supplies

Volume discounts, “bulk” purchasing and competitive bidding for supplies and services are variations of the purchasing principle used by health service brokers to establish networks. As with networks, volume discounts are negotiated for specific medical goods and services in return for directing patients to contract providers.

- *Targeted purchasing now includes a wide variety of costly medical services, such as coronary artery bypass grafts (CABG), intraocular lens implants, home intravenous therapy and diagnostic imaging.*

While the concept of securing certain medical items and goods at discount is not new, many of the medical supplies and services being pursued by brokers are innovative. These targeted discounts are frequently negotiated for very specific services or episodes of treatment. Thus they differ from, and are independent of, the discounts derived from a comprehensive network of providers. The brokers we spoke with believe this area has developed beyond the purchase of medical supplies, equipment and drugs to include a wide variety of costly medical and surgical services.

Eighteen of the health service brokers we spoke with are involved in targeted purchasing. Table 2 lists some of the items they believe can be targeted for purchase at a discount. The services listed in Table 2 are high cost services mentioned by more than one broker. Certain surgical procedures, such as coronary artery bypass and cataract surgery, also were mentioned as items suitable for targeted purchase. These and other surgical procedures were not shown in Table 2 because HCFA has recognized that alternative procurement and reimbursement methods are suitable for some high cost surgical procedures.

Equally as imaginative as the items and procedures being targeted by brokers for discount purchase are the unconventional applications of the methods being used to

TABLE 2

Some Items Identified by Brokers as Suitable for Targeted Purchasing

Diagnostic Imaging

- ✓ Durable Medical Equipment
- ✓ Home Fetal Monitoring
- ✓ Home Health Services and Supplies
- ✓ Home Intravenous Therapy
- ✓ Medi-vans/Ambulances and Supplies
- ✓ Orthotic/Prosthetic Devices
- ✓ Prescription Drugs
- ✓ Rehabilitative Therapies
- ✓ Respiratory Care
- ✓ Skilled Nursing

secure them. Negotiated package rates with “centers of excellence” (hospitals, ambulatory surgical centers and certain physician offices for specific surgical procedures) can, according to brokers and others we interviewed, improve the quality of patient care and produce savings.

Discounts negotiated with manufacturers and wholesalers rather than retail providers are another promising area. One broker negotiates rebates from pharmaceutical manufacturers and does not attempt to secure discounts from dispensers. Patients purchase their prescriptions wherever they choose. Billing for reimbursement also remains unchanged. The patient’s insurer records the quantity and amount paid for each drug and periodically notifies the drug manufacturer of each drug quantity reimbursed. The manufacturer repays the broker a pre-negotiated amount. This approach appears to be the least intrusive and least disruptive method for securing drugs at discount. While used primarily for prescription drugs, it appears that this method may also have possible application to other areas such as durable medical equipment and parenteral and enteral feedings.

One employer, with plants in four communities across the country, uses a mail-order pharmacy for prescriptions, contracts for discounted durable medical equipment, has a single-source contract for mammograms and is exploring the competitive bid approach for dental care, vision care, chiropractic services, podiatry and home health care.

This employer, and in fact all of the employers and brokers negotiating discounts for targeted services, felt that a detailed analysis of service needs and market conditions was essential before entering negotiations or letting out a request for competitive bids. They also felt that while a large-scale, national approach may be appropriate for some services and some markets, the same approach may not be suitable for others.

The HCFA as Purchaser of Targeted Medical Services and Supplies

- *Although Medicare law does not permit HCFA to engage in targeted purchasing of medical equipment and supplies, HCFA has begun exploring “centers of excellence” in a demonstration project involving CABG.*

There is currently no provision in the Medicare law which would permit HCFA to engage in competitive bidding or in negotiation for specific medical services and supplies. Medicare would need a legislative change to implement selective purchasing of services and supplies. Repercussions from excluded providers and suppliers is likely.

Despite no specific legislative authority to implement targeted purchasing, HCFA does have the authority to conduct demonstration projects to study the feasibility of securing some services in ways which were not contemplated when Medicare legislation was enacted. One such demonstration project, currently being undertaken by HCFA, involves the use of “centers of excellence” to provide some surgical procedures. The project is just getting underway with selection of providers still in process.

- *Issues for further study*

There appears to be a need to explore what types of legislative changes would be required to enable government programs to engage in targeted purchasing. Studies should also explore the following questions: What types of services would be suitable for targeted purchasing? Where in the distribution chain is it most advantageous to target purchases, e.g., at the manufacturer, distributor or retail level?

Regardless of which services are targeted or how savings are achieved, a targeted purchasing approach should:

- incorporate utilization controls to detect and avoid increased use that might negate discount savings; and,
- produce reliable data which can be used to assess cost effectiveness and to negotiate future discounts.

CHAPTER 4: Individual Case Management

Brokers believe ICM improves quality of care, increases efficiency and makes better use of benefits for patients with catastrophic or terminal diagnoses or with chronic conditions.

Private Sector Case Management

Individual case management is a process of directing patients, identified through other forms of UR, into more cost-effective modes of treatment. It is typically used for catastrophic, long term or high dollar medical cases. It may be an integrated component of a UR program or a stand-alone component. Like other UR programs, its goal is to ensure appropriate, quality care and promote cost control.

Table 3 identifies some of the areas brokers find suitable for ICM. The list was limited to costly conditions mentioned by more than one employer or broker. The conditions listed are also those in which a coordinated approach would provide significantly better care to the patient than the piecemeal approach which sometimes results under traditional coverage.

Individual case management is often referred to as “care management” because it coordinates the mix and level of patient care throughout the entire course of treatment. Coordination of services may include home health care services, outpatient treatment or rehabilitation and the procurement of durable medical equipment or supplies. These services and supplies may be delivered by networks or by suppliers under special contract. The ICM services may include some health benefits not usually covered under the health plan (such as certain forms of home-based care), but deemed more cost effective in these special cases.

Twenty-seven of the brokers and all of the employers we interviewed have some involvement in ICM. They felt ICM was valuable because in today’s environment catastrophic cases constitute a disproportionate share of health care expenditures. Brokers believe that the earlier the introduction of a patient to ICM, the greater the control over the use of efficient and cost effective services.

TABLE 3

Some Conditions Identified by Brokers as Suitable for Individual Case Management

- ✓ AIDS
- ✓ Pediatric Care
- ✓ Multiple Trauma
- ✓ Chronic Illnesses
- ✓ Premature Birth/Neonates
- ✓ Stroke
- ✓ Heart or Neurological Problems
- ✓ Severe Burns
- ✓ Transplants
- ✓ Cancer
- ✓ Substance Abuse

In its best form, ICM is a collaborative process to coordinate a plan of care. Typically, the case manager or health care consultant assigned to a patient develops, in conjunction with the patient, family, and health care providers, a treatment plan and alternatives which cover both the hospitalization and any post-hospital care that may be required. The case manager assists the patient in making informed decisions about treatment alternatives and then functions as a liaison between the patient, doctors, and insurer. This facilitates the development of a treatment plan that not only is appropriate and cost effective, but also one that meets with the approval of the patient.

- *Candidates for ICM are identified through utilization review techniques or through a patient advocate.*

Two strategies are used by brokers and employers to identify suitable candidates for ICM. The proactive approach is broker initiated, the reactive is patient initiated. The proactive strategy flags suitable candidates for ICM during prospective or concurrent utilization review. Candidates for ICM may be identified by diagnosis, procedure, cost or intensity of care. One broker told us that the proactive strategy enables them to identify 20-30 potential cases a week for their clients.

The reactive strategy relies on the patient to voluntarily contact a “patient advocate” or adviser, employed by the broker or the employer, for assistance on coordinating the health plan benefits for a high-cost episode of care. The patient advocate or patient “hotline” also functions as an integral part of some brokers’ UR programs by providing patients with information on alternative medical treatments. In some programs, this system is also used to assist terminally ill patients in making decisions and arranging for the medical care they will need at the end of their life.

- *Obstacles to ICM include insufficient patient and provider education, and honest disagreement over treatment alternatives.*

Most ICM programs being conducted by brokers are voluntary, in that patients are not required to use the identified alternatives. We often heard that patient participation rates of such voluntary programs are extremely low, and that educating patients and physicians concerning availability of ICM and its benefits is a key obstacle which needs to be overcome for a successful ICM program. Many brokers, employers and experts believe patients want and appreciate help in assuring that they get the best medical care possible, and that good care will not ruin them or their family financially. Nevertheless, some of the employers we spoke with offered these management services strictly on a voluntary, patient-initiated basis, lest they appear too intrusive.

Another ICM obstacle is honest disagreement over treatment alternatives. National practice guidelines, outcome assessment research and changes in reimbursement incentives were mentioned by many of the people we interviewed as elements that would play a key role in the future of ICM. Practice guidelines and outcome assessment were considered to be key developments that would enable ICM to resolve disagreements over treatment alternatives in the best interest of the patient.

The HCFA as Individual Case Manager

- *The HCFA is capable of identifying service intensive patients, using the resources currently available, but lacks the authority to direct such patients into ICM.*

The HCFA does not routinely conduct any ICM for Medicare beneficiaries because current Medicare law prohibits steering patients to select providers. The nearest form of “individual case management” in the Medicare program is a provision which enables patients diagnosed as terminally ill, or their representatives, to elect hospice care in lieu of more costly care under the regular Part A benefit.

The HCFA staff, with whom we spoke, felt that ICM in the Medicare program might not be as effective as in the private sector, because of the differences in the diagnoses associated with Medicare patients compared to those covered by private insurance. The HCFA also felt that the current provisions of the statute clearly define what is covered and not covered by Medicare and that the statute may not be flexible enough to allow Medicare to use the most cost effective means for securing ICM services. Some of the brokers with whom we spoke also indicated that the Medicare population is unique, and that some of the techniques and methods used by the private sector might not be as effective for the Medicare program.

We learned in our discussions with HCFA that one PRO (Nebraska) is conducting a ICM pilot study. According to HCFA, this project is focusing on high cost diagnoses. The obstacles encountered thus far in this demonstration project are:

- inability to target beneficiaries suitable for ICM,
- inability to target patients before hospital admissions,
- difficulty in approaching patients to encourage use of ICM,
- inability to document savings.

Identification of suitable patients for managed care, as early as possible, appears to be the key to successful ICM. We examined HCFA BMAD files to determine if Medicare carriers had the ability to identify patients who might be suitable for ICM based on intensity of medical services. In analyzing the BMAD sample, we found that about one percent of Medicare patients receive more than 51 medical services annually. We believe that the data being maintained by the carriers can be used to identify patients receiving a high volume of medical services. Two questions must be asked with regard to these patients: 1) Are they suitable candidates for ICM? And 2) Is the care they are receiving appropriate?

- *The HCFA believes that patient advocate services would be best provided by outside organizations.*

In our discussions with HCFA, we outlined the “patient advocate” or “patient hotline” approach used by some employers and brokers. Many companies use patient hotlines to determine patient interest in ICM, and to direct patients into specialized networks or to targeted purchasing arrangements. The people we spoke to in HCFA agree that long term efforts are needed in this area. However, they felt that a patient advocate approach to UR might be viewed as “too soft of a service” for Medicare to provide if it were voluntary, or as “big brother” interfering in the practice of medicine if it were mandated. The HCFA feels that advocate services might be better provided by outside organizations representing the elderly and disabled.

- *Issues for further study*

There appears to be sufficient potential for researching the feasibility of ICM for Medicare and other federal health care programs, in light of the special populations these Federal programs serve. What kinds of criteria will best identify potential candidates? Who should perform the review for potential candidates, and how can this be done most efficiently? Who should be responsible for managing the treatment of identified patients? How can appropriate patients be encouraged to choose the ICM approach? How could a patient advocate function within a government program?

Any ICM program should:

- emphasize a collaborative approach among patients, physicians and payers;
- use common, written guidelines or protocols;
- include a procedure for resolving honest disagreement over treatment alternatives; and,
- gather reliable data for tracking participation rates and cost effectiveness of the program.

CONCLUSION

The intent of this report was to stimulate discussion as to whether any of the approaches used in the private sector for controlling medical costs might be relevant to the public sector. The purpose was not to endorse any one method or practice. Before any such undertaking, additional studies are needed which will provide more indepth information on each method.

Some of the methods used by brokers may be more readily adapted to public sector programs than others. The DHHS will need to give careful consideration to the legislative obstacles and administrative impairments which currently prevent the transfer of these private sector cost control mechanisms to the public sector. The DHHS' success in integrating these kinds of programs depends on whether the necessary legislative changes can be made.

Overall, many private sector mechanisms for controlling health care costs appear to have potential for Medicare, Medicaid and other DHHS programs including those administered by the Public Health Service. Each component should study the mechanisms used by the private sector to determine whether any can or should be adapted to their programs.

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