RECORD, Volume 27, No. 1*

Dallas Spring Meeting
May 30 – June 1, 2001

Session 58PD
Session Title: What's New in Provider and Network Management and Contracting?

Track: Health

Moderator: SUSAN ELIZABETH PANTELY
Panelists: BRIAN G. SMALL
DEWAYNE E. ULLSPERGER
Recorder: SUSAN ELIZABETH PANTELY

Summary: Panelists discuss new developments and strategies related to provider and network management and contracting.

Topics include:
- *Reimbursement approaches and risk-sharing arrangements*
- *Different approaches by provider specialties or disease*
- *The role of care management/coordination*

MS. SUSAN ELIZABETH PANTELY: Since the advent of managed care, we've seen a variety of reimbursement and risk-sharing approaches. We started with discounting, followed by capitation. We then went to different forms of risk sharing, including risk pools, risk sharing, diagnosis-related group (DRG) rates, and case rates. Some of these are gone and some remain. Some of the changes have been responses to try to cut costs, and others have been responses to physician or consumer backlash. We have two panelists that work primarily with risk-sharing and reimbursement strategies. They're going to tell us what they've seen lately. We'll see what has worked and what has not worked, and what's going on in the recent environment.

First, we have Brian Small, an ASA working on his professional development credits for his FSA. He graduated from the University of Iowa. He has been at Blue Cross/Blue Shield of Louisiana since 1990, and he is the vice president of Provider Reimbursement and Audit. We also have Dewayne Ullsperger. Dewayne is a graduate of the University of Nebraska, and he's a partner with Reden & Anders. He consults on a variety of health-care topics. One of his specialties is provider risk-sharing strategies. We're going to start with Brian.

MR. BRIAN G. SMALL: I'm the vice president of Provider Reimbursement and Audit. I spent my first eight years at Blue Cross in the actuarial department doing

the normal things you do there: pricing, small group reserving, and annual statement work. During the last two years, I've transitioned over to the provider side, and now I work with provider contracting to help them analyze contracts and develop strategies. It has been a learning experience. When I stepped in, we were in the midst of a physician recontracting effort. Within the first month, all ten surgeons in Lafayette decided that they weren't going to be in our network, but that's all behind me now. I've got my feet on the ground and we're working on some exciting stuff.

I'd like to tell you a little bit about Blue Cross of Louisiana. We are the largest health insurer in the state. We have 750,000 members; although we're the largest in the state, we're still on the small side for a Blue Plan. We have traditional preferred provider organization (PPO), point of service, and health maintenance organization (HMO) networks. The HMO Networks are a subsidiary of Blue Cross of Louisiana, so you can see we have a lot of networks to worry about. First, I'd like to do a review by provider type. I'd like to share with you the issues that I confront in my job pertaining to these providers. We'll look at the current environment, and then the provider agenda. When they sit down with me, what are the things they want? When I sit down with them, what are the things on my notepad that I want to get across to them?

Let's take a look at trends and what they have been doing. I looked at the Consumer Price Index (CPI) and downloaded Table 1 from the Bureau of Labor Statistics. I looked at one month and compared it to the same month in the following year. From January 1998 to January 1999, hospital services had a trend of 3.8%. That has risen every year, including the latest period, 6.5%. If you look at the variation between inpatient and outpatient, it's probably not surprising that outpatient is higher than inpatient, and physician is less than hospital. If you compare the CPI trends to all items in the index, the health trends are higher. This is one indicator of trends.

Table 2
Contracting Environment
CPI Trends

	Hospital Services	Inpatient	Outpatient	Physician	All Items In Index
1/98-1/99	3.8%	3.4%	4.9%	3.4%	1.7%
1/99-1/00	4.8%	4.1%	6.8%	2.9%	2.7%
1/00-1/01	6.5%	6.1%	7.2%	4.4%	3.7%

Downloaded from Bureau of Labor Statistics, US City Average
http://stats.bls.gov/datahome.htm

You can also look at the Producer Price Index (PPI), which might be an even better indicator because it represents more of the negotiated rate between a payer and a provider. The CPI represents the out-of-pocket expense of the consumer, which probably has a lot of charge trend in it. If you look at the PPI, it's about half that, and for January of 2000 to January of 2001, it was 3.5% for hospital services in general. Another indicator would be Medicare. I think lately, on the physician side, it has been about 5% a year. For hospitals HCFA just released something for fiscal year 2002. It states they are raising reimbursement for inpatient about 2.55%.

Let's look at the hospital-contracting environment. From the hospital side, this is what they're going to tell you. Labor costs are going up. We've all heard about the nursing shortage. At this time, 8,000 nurses are ready to strike in Minnesota, so it's not a good time to be sick up there. Of course, drug costs are going up and hospitals are major purchasers of drugs. They're not getting reimbursed for each drug independent of their per diem or DRG. As drug costs go up, the hospitals are going to have to eat that cost. Of course, technology costs are rising. We are seeing a lot of providers building Positron Emission Tomography (PET) imaging centers. We used to have one in Shreveport that was fine for the entire state for three or four years. Now we have one in Baton Rouge, two in New Orleans, and they're building more. Also, gamma knife technology seems to be a big thing, and these technologies are costly.

Reimbursement is changing for providers. The outpatient perspective payment plan went into effect in August of 2000. I think it could have a huge impact. It might cause providers to do things that they haven't done. They're boning up on their outpatient department charge masters, and they're looking at how they're billing. They're probably going to be able to bill things that they didn't bill before. Skilled nursing facility's (SNF's) prospective payment also came on line recently. The SNF's environment is important to a commercial payer because when you have acute care patients who are getting better but maybe not quite ready to go home, the medical management is going to try to get them into the SNF unit. We've been finding lately that the SNF units have been full because the hospitals aren't staffing them the way they used to staff them. They're certainly not interested in building more of them. So our patients are stuck on the acute side instead of being able to transfer into a SNF because it's not worth the hospital's money to build more SNF units or to staff them. They'd rather keep the patients in the acute bed and get more money. Of course, home health prospective payment really changed the home health care environment and wiped out most of that industry. So reimbursement has changed and affected the hospital environment.

According to the Hospital Association, hospital margins have dropped because of the Balanced Budget Act (BBA). I found this statement on the Hospital Association Web site, so it might be biased. The margins were 6.1% in 1997. They've dropped to 3.2%, but that's probably still better than most health plan's profit margins.

What other features of the environment have I noticed? I think hospitals and health plans are more willing to let unprofitable contracts terminate. The new creed for a hospital administrator is, "No contract is better than a bad contract," which makes sense. Why lose money? We had a recent example in Baton Rouge. A health plan had a hospital contract with the leading provider in town. The provider, Our Lady of

the Lake, has 80% market share. That contract was terminated and now this regional HMO doesn't have a real big hospital in town. That leads to a lot of complications. What we have found is that capacity issues complicate network issues. In Louisiana, you have a lot of towns that have only two hospitals. Maybe there's one big hospital or maybe there are two relatively equal hospitals. You would hope for at least two equal hospitals. When you have one hospital in the network and one hospital not in the network, you have problems when your network hospital is full or at least the emergency room (ER) is diverting patients. Then you have people going out of network and you have to pay higher amounts. You might have just as many people in your non-network hospital as in your network hospital. Then you have all sorts of payment issues, so the capacity issue certainly complicates things.

Another thing on the landscape is medical necessity review organization legislation. This is legislation that came into effect January of 2000, and it allows the patient to appeal a medical necessity decision. There's a three-tier process and they can eventually go to an outside independent review organization. This can cost the health plan quite a bit of money even if their decision is upheld because it costs about $1,200 for that third-level review by the independent review organization. You might be saving $800, which means you have lost money on the deal, even though you got your point across. Do other people have that type of legislation in their states?

There is another thing that we're seeing, and this has probably always gone on. Hospitals are outsourcing service as much as possible. We're just finding that out now. We're seeing cases where lab and imaging services that should be covered in the per diem are actually being billed by a lab or imaging professional provider and we're not catching it. So now we've caught on to that, and we're trying to figure out how to catch that? You have to link the professional claim to the inpatient claim, but the inpatient claim is going to come in months later than the professional claim. You can go to the precertification database and catch it that way if you're doing the precertification, but if some other plan is doing the precertification, then you're probably out of luck.

When the hospitals sit down with me, what do they want? They want simple reimbursement programs. They want to be able to predict what we're going to pay them; preferably they would like to have a discount off charges basis because that's real simple for them and then they can charge whatever they want. They want, of course, higher reimbursement to keep up with inflation. They want reimbursement that matches the cost of doing business with carve-outs for cardiac cases, implants, and prosthetics. I had an e-mail from a hospital that wanted to implant something in someone that was going to cost $6,000, and they wanted a payment above and beyond their contracted per diem rate. I said no, because I don't want to get into that. I believed that they signed a contract, and they should just do it under the contract. You're going to win some and lose some under these things. They sent back an e-mail, and copied the doctor, which said, "Well, we just can't do the surgery." I'm sure it's going to look like we're the heavy, even though they signed a contract saying that they would do the service. That's something that you have to deal with.

From the health plan's perspective, what do we want to do? We want to implement reimbursement programs that insulate the plan from cost shifting. I think there are going to be hospitals that will be hurt by the outpatient prospective payment, and they're going to try to get that money back somehow and probably raise charges. You want to make darn sure that you're not paying on a percent of charges. From the health plan's perspective, we want to increase cooperation with our utilization management efforts. As I said earlier, you have cases where a patient is in the acute setting, and you want to move them to the SNF setting. You get a lot of push back, and there is a lot of conflict.

We want to reward hospitals with a low-cost case mix adjusted cost per case and do a better job of profiling hospitals. We want to identify areas of improvement using benchmarks. As I mentioned, we concentrate on improving the outpatient reimbursement programs. I think there's a lot of interest in outpatient reimbursement now. We have the Ambulatory Payment Classification (APC) methodology that Medicare is using, so it's something that we didn't have before that we can pick up and use to build our outpatient programs.

Let's switch to the physician-contracting environment. Medicare has been raising reimbursement quite generously. The last time we did an analysis, the fee schedule change from 2000 to 2001 was worth 5.1% on the commercial population. Another concern that we're seeing physicians have is that they're objecting to claim-editing software. I think most plans use it, and they should use it. There is some kind of claim-editing software to make sure that people are coding correctly. I think when reimbursement was high, physicians didn't really worry about that because they were happy with the reimbursement. Now that managed care plans have cranked down their reimbursement, we're getting a lot more questions regarding code rearrangement. We find that it's the way Medicare does it. We are getting more questions. I think it goes to show that a fee schedule isn't a fee schedule; it has a lot to do with what's going on with that claim-editing software and the bundling edits. A great deal of money is involved in the claim-editing software.

Physicians are able to do more office surgeries than they used to be able to do. I think that's an evolving trend. They like the idea of doing surgeries in their office rather than going to the hospital. It's more convenient for them and more convenient for the patient. So, what do the physicians want? They want commercial payers to keep up with Medicare fee increases. They would like to be paid for expenses related to office surgeries, which seems to make sense. We would have paid the facility had they done it in the facility, so now they're doing it in the office. Maybe you can pay something to cover the cost. They would also like insurers to disclose the basis for their bundling edits.

What do we want from physicians? I think we want to work to incent physicians to provide treatment in the most appropriate settings. We want to take action on problem providers. I think Blues plans historically have been pretty lax in their network management activities, and I think you need to take action on problem providers, whether it's quality issues or fraud or near fraud issues.

I didn't mention anything about risk-sharing. We have a little bit of risk-sharing activity going on. We don't call it risk sharing; we call it gain sharing, because we

don't want to lose. We recently did away with capitation for almost everybody, except for one group that won't get off capitation. Like everyone else, we're kind of moving away from capitation.

Now there are "Other providers." Three years ago I wouldn't have known what any of the following things were, but now they're really a pain. Comprehensive outpatient rehabilitation facilities, long-term acute care hospitals, PET imaging centers, hospice care, oral surgeons, and Certified Registered Nurse Anesthetists (CRNAs) are all trouble. They all want something and you have to figure out what they do. What makes them different? You need to figure out what makes a long-term acute care hospital special because they charge tremendous amounts of money. Are they really doing anything that a regular hospital couldn't do? My point with these is there's not really a lot of dollar volume, but provider contract analysis and support takes a lot of time.

Conclusion and predictions: Per unit costs are going to continue to rise. I think that the pace from a per unit cost is going to increase a little bit as I think the hospitals are getting to the point where they need more money to survive and they have begun to terminate unprofitable contracts more than they did in the past. I think plans are going to experience cost shifting, either in the form of charge increases or new billing for things that they used to not bill for. I would also make the conclusion that plans aren't ready for outcome-based reimbursement. I wish we could spend the money that we're spending on the Health Insurance Portability and Accountability Act (HIPAA) to work on outcomes-based reimbursement, but it looks like we're going to spend most of our money on HIPAA.

I think we should focus on improved outpatient data, modeling capabilities, implementing Ambulatory Payment Groups (APGs) or Ambulatory Payment Classes (APCs) or some variation. At least model where you are with respect to APC payments; it's not that hard. Watch your outpatient trends. I think that there's going to be large trends in the outpatient area. I think plans have to improve their coding knowledge. Our whole department just went through coding classes because that's really key, and an aspect of reimbursement is knowing what codes you can bill when. We're going to concentrate on finding the most appropriate site of service, and we'll try to get physicians to do more things in the office if it's appropriate. There are a couple of ways of doing that. You can either pay them more money based on the place of treatment, or you can set them up as a quasi-facility. We tried both of them. You could set them up like another provider number, and then make a payment for certain CPT codes when they bill it like that.

MR. DEWAYNE E. ULLSPERGER: I'm going to preface my remarks by saying that I'm trying to cover a few observations of the industry here, but my guess is you're going to have different observations, depending on what market you're in or what markets you've worked in. I'd really appreciate a dialogue during the Q&A session on what folks are seeing out there. It's kind of hard to cover 50 states in about 20 minutes.

I'm going to talk about industry observations. I'll also talk about other trends and new kinds of reimbursement models that are out. Then I want to finish up by talking about a few areas in which I think actuaries can really participate in helping to drive contracting and at least help to anticipate what's going on in the market

and in their trend forecast. Whether you're a health plan or an insurance carrier or part of a consulting firm, I think there's a real opportunity for our profession to make a fairly major contribution in helping to really understand what's going on in the market.

If you look at 1993 through the first part of 1998, we all had a pretty easy time of it. Days per thousand were coming down. It was an era where everybody was worried about managed competition. Trends just collapsed in the commercial marketplace. You had a lot of negative rate decreases in the market. Many employers out there were essentially demanding those rate decreases, and it seemed like the industry was able to do it. You had fairly good profit margins in the managed care world. We all thought we were doing something. Reimbursement levels for physicians' services, as a percent of Medicare, continued to decline. Outpatient, pharmacy, and physician trends seemed to be fairly moderate relative to what they had done in the early part of the 1990s. It seems like that changed in the latter half of 1998. Trends picked up. I don't know if anybody realized that until first or second quarter of 1999, but there was a definite uptake in trend for a lot of commercial plans. There was also a lot of denial going on about that time. It took a long time to recognize both what was happening and then to react to it. It seems like that all converged at a time when providers figured out that they were not making it on these managed care arrangements that they were so willing to participate in over the prior five years. We have demographics, increases in provider reimbursement, and increases in utilization levels, all converging at the same time to drive some pretty high trends in the last couple of years.

If you look at the for-profit hospital systems, their quarterly earnings reports, the press releases that come out, and the 10K filings, you'd see that they're all reporting improved results. The common references in improvement pertain to payer contracts. It seems like what they're saying in a lot of these articles is the consensus is 6-8% improvement in reimbursement levels; however, you hear stories and other articles that may indicate as much as 10-15% improvement. It's likely that the community hospitals are going to follow suit. You have a lot of one-time events occurring in some of your trend lines. You're probably going to see some discrete pop-ups in trend, especially if you have some of these hospitals dominating your network in a fairly small market. The big plans probably don't see this as much, but I think in the smaller plans, you really need to get a handle on what's driving trend, and if you're looking out the back window. You had a 30% increase from a hospital that represented half your business last year. Is that going to continue or is it going to be at a more moderated level? If you had one hospital do that to you, are the rest going to follow next year? So you've really got to keep an eye on what's going on.

Physician reimbursement seems like it has plateaued. In the early 1990s, it was all over the map. There are a lot of markets now, and you're seeing a lot of push back in physician reimbursement levels. You're not going from 140% of Medicare down to 130%, down to 110%, or down to 80% any more (not that too many markets got down to 80%). Once you locked into Medicare, that seemed to be the answer for awhile because Medicare was going up – zero, 1%, or 2% a year. If you weren't paying attention, it started to creep up in 1998 and 1999. It has moved up 5% or 6% over the last couple of years, so even if you tied yourself into a Medicare-based reimbursement schedule or resource-based relative value scale

(RBRVS)-based schedule, you'll still see some trend as long as you're adopting that new schedule every year.
In general, we're seeing a big migration from capitation to shared-risk arrangements, and then from shared-risk arrangements to fee-for-service arrangements. There is a lot of push-back. To a certain extent, the industry did this to itself. We're out there saying, "We know fee-for-service reimbursement was X-dollars PMPM. If you manage it really well, you can get down to 70% of X. We advise you to do that." The providers played in this game and said, "We can manage it better than you are. Hillary is telling us you have 35% margins; we can make it work." They didn't build the infrastructure generally. They'd get their $2.00 PMPM and have a few thousand members on their capitation, but it simply wasn't enough to build the infrastructure and manage these costs effectively. As such, we were putting risk on organizations that simply couldn't be sustained. That's part of the backlash we're seeing right now.

I think the reimbursement levels were unrealistic; – in retrospect you had to wonder what folks were thinking. The reimbursement levels were too low to begin with. You had utilization assumptions that were simply too low. You had folks in Cleveland or Pittsburgh thinking that they could negotiate or live on reimbursement rates or PMPM capitations that were similar to what was being offered in California. I think what they didn't understand is, California really couldn't live on that either. That's part of what we're seeing in the industry right now; there is a huge backlash.

There is still significant capitation. These surviving arrangements were based on sound utilization assumptions to begin with. They didn't expect days per thousand to drop 30% or physician costs to drop 20%. They set realistic utilization expectations to begin with and they set sustainable fee-for-service targets underlying those. In addition, the health plans would continue to have premiums that would support a reasonable fee-for-service equivalent, so in some markets you'll see this pattern of health plans negotiating a contract rate or capitation arrangement that was 20-30% below the market or fee-for-service levels. They immediately would drop their pricing to match that, thinking that it was sustainable. Now you're left with premiums that won't support any realistic expectation of fee-for-service reimbursement levels. There's a huge gap there. The health plans, I think, are absorbing a lot of that gap as they unwind those arrangements. In addition, you had financially sound provider partners. There were many Physican Hospital Organizations (PHOs), and I think many Independent Practice Associations (IPAs) are kind of running on the cash flow. They don't really know what incurred but not reported (IBNR) means. The ones that are surviving do pay attention to it — maybe not as well as the health plans do — but they do have surplus and they have IBNR that can support some of the insurance risk that they're taking.

We're seeing a lot of pressure in addition to the underlying trends that we're seeing. There is pressure to overhaul or change a lot of the managed-care techniques that are out there. They're getting away from the gatekeeper model. They're getting away from a lot of the kind of quarterly utilization review activities that they had been doing before. That's caused by political pressures. There are a lot of legal actions out there and, to a certain extent, there is consumer demand. I also think that once you move a market down to 200 days per thousand from a fee-for-service level of 400 days per thousand, as it was back in the 1980s, the marginal improvement that you can gain in that market doesn't support a lot of the

managed care activities. They have you there. It's too expensive to see every turn on the expense. Part of the problem is, these changes are not consistent with the capitated environment. It's very difficult to go into an organization and say we want to capitate you; here's your X% of premium and, by the way, we're taking off all of the utilization controls our members expect. It just doesn't work.

You had a lot of hospital capitation. The California model that people talk about was generally a physician group that was capitated or an independent practice association (IPA) that was capitated. Generally the scope of physician services is a little broader than what folks in the rest of the country think it is because it includes a facility component for radiology and lab and diagnostic services. There was generally a shared risk fund for inpatient and a lot of the outpatient services, so the physician would get a capitation and participate in gains or losses on this shared risk fund. We did see a few hospital capitations, but most of those are gone. There were a lot of cases where they were sort of combining into one capitation. I don't believe it was theoretically legal, but they did it anyway. Over the past two years, we've seen a lot of these larger systems negotiating some fairly hefty increases in reimbursement. The goal is to get the full fee for service. At the same time, the physician groups don't seem to have the wherewithal to negotiate as good a deal as the hospitals are doing, so the physicians are seeing relatively small capitation increases.

What happens then is, if you had this shared risk pool, and if you have physicians that had a capitation rate that was generally too low, they really relied on that shared risk fund or the gains on that to make a go of it. If you move up your hospital reimbursement, you really can't move your inpatient utilization down too much. You have a whole bunch of new technology showing up in the risk pool. It's shrinking those risk pool gains, so a lot of the profit and much of these physician groups' ability to sustain themselves is going away, because the hospitals are getting the money out of the risk pool. That's not going to work long term, especially when you couple it with Medicare business that's tending to dry up in these markets. You would see physician capitations that were way too high for Medicare, or way too low for commercial. If they had a balanced block of business, they could probably make a go of it. As the Medicare business is starting to dry up, they're losing the profits on the Medicare block. I don't think they really had the necessary ability to manage these independently or look at them separately. They're starting to see all their bottom line shrinking. So you've got a big mix issue there that is going to continue to cause problems if Medicare continues to decline or the enrollment continues to decline.

We're also seeing a lot on negotiations, and this is probably not only occurring in California. I am referring to things like injectables, home infusion, chemotherapy drugs, and all those little Health Care Financing Administration (HCFA) codes you see in the claims data, and really sticking to the guns on material change provisions to protect them from new benefits, new technology, and that sort of thing.

We also seem to be seeing some interest in doing direct contracting with the providers rather than going through the IPA-type model. You'll see a lot of managed care organizations actually bailing out some of these IPAs, so the MCO ends up paying for it twice. They pay the original capitation, and then later, when the IPA is in trouble, they cut a check for a few million dollars to try to keep them

out of the hole. I think there is some growing interest in directly contracting with the providers, and bypassing the IPAs. They also have some of the larger employer organizations out there talking about direct contracting – bypassing the HMOs and going to the IPAs, so you don't know who is going to win out there.

There seems to be a lot of renewed interest in other markets, specifically in looking at the provider network you have and understanding who's efficient and who's not. If you've taken away your utilization management controls, you'll have a lot of fee-for-service reimbursement. One of the few things you can do to really try to hone in on the best network or the best cost level is to go in and look at your provider network and potentially do some downsizing of it. Much of the profiling that is out there is used to try to vary reimbursement rates or withholds and provide some education back to the physicians. We're seeing a lot more counseling with doctors or peer review by committees of doctors. I don't know that a lot of the plans have had the stomach to do it yet, but I've heard that some doctors are being terminated if they can't get their acts together.

We're also seeing a few cases where they say, "We really want you to do these services at this set of facilities, and we don't want you to do them at this set of facilities. If you do them at the preferred list, we'll pay you more." You can't do this with a provider-owned plan because of enrollment issues. So if you're doing your deliveries at a more efficient facility, you can get higher physician reimbursement. This strategy is used to try to help steer that care into a more efficient facility.

In addition to and, I guess, complementing the more lax utilization management controls, a lot of plans are looking at DRG or case rate reimbursement. I think the reasoning behind this is that if they've taken away the ability to manage the length of stay, they might as well put it over on the hospital and let them manage it. You have to be kind of careful with that. Some of the relative weights don't necessarily make sense for a commercial population. In addition, they tend to want to tie that to Medicare. Sometimes Medicare reimbursement levels applied to a commercial population don't make a whole lot of sense.

There's also a growing interest in APC reimbursement. With reimbursement such as DRGs and RBRVS, every time HCFA makes a major change in its policy, the commercial market tends to follow. Many plans are starting to look at APC reimbursement. My fear is that hospitals have the advantage over the health plans in this regard because they probably have a better ability to evaluate what the impact of APC reimbursement is than health plans do. When you go in and look at claims data, you see that we haven't historically done a very good job of collecting the CPT codes that are required to administer an APC schedule on the outpatient hospital claims. Many plans will collect only the data that they need to pay the claim, so it makes it very difficult to go back, in retrospect, based on a claim file. I think there will be a fair amount of work to do for a lot of plans to try to understand what's going on. You'll probably see some plans go out with the schedule, and try it out for a while. You're going to have to monitor that and make sure that it's working for you. I think it's also going to be very difficult to administer for some plans that are not set up to pay that. The advantage is that it does improve the proportionate costs that are on a fixed reimbursement schedule. APCs did a good job and lab schedules and radiology schedules did a pretty good job. I think the APCs are more comprehensive, in a list of services that have a fixed

reimbursement rate tied to them. It also reduces your impact when the hospitals change their charge masters. It seems like, in some markets, that's fairly random. They've been ramping them up mid-year, and the health plans did not figure it out until fourth quarter, when it's really too late to make any quick fixes.

We're also seeing a lot of simplification in physician reimbursement and in hospital reimbursement, too. The same health plan will have ten different styles of hospital contracting going on. It is all fee for service, but nothing matches from contract to contract. It's very difficult to administer some of these contracts and when you have a floor of 55% of charges for every particular claim, most systems won't manage that very well. You've got to have somebody go in and manually adjudicate those claims, which is very time consuming.

You also see a phenomenon where health plans will say our fee schedule is X% of Medicare. You go in and look and they have 30 different fee schedules; nobody is on the standard fee schedule that they told you they were on, and it's a mess. They can't even tell you who's on what schedule or how many dollars are coming in on what schedule. I think generally they can tell you who's on it, they can't always tell you how many dollars are flowing through without a whole lot of work.

We're also seeing a lot of plans fixing their relativities. It's common to see fee schedules that haven't been changed in five or six years. With some of the coding changes that are going on, in particular with respect to immunizations lately, you can really end up paying twice for some services simply because of a code change. If it drops off the schedule or a new procedure comes onto the schedule, you can end up paying charges because you don't have a negotiated fee for it.

One of the new things we're seeing is some emphasis on trying to use physician episode case rates or DRG reimbursement for physician services. There are a couple of folks out there that are doing some research in developing these types of programs for people. It's reasonably difficult to administer. You must make sure that things you included in the episode don't creep through and get paid anyway on a fee schedule from a prior arrangement. It does constrict the variance in episode cost, so if you have a lot of variation in how physicians are practicing for particular types of services, at least constrict that variance down. You should be able to manage the trend line a little bit better.

I wanted to discuss one relatively new model; it's probably actually about four or five years old. The reason I bring it up is that I think it does have some applications in other markets or potentially within some of the integrated delivery systems, particularly where you have pods of providers or groups of providers that are in a different kind of intensity scale. If you have an academic institution and a whole bunch of feeder hospitals, I think this type of model might have some application. I think you can use parts of this model in areas where you don't have any physician claims data to look at, to evaluate how efficient some of these providers are given that they might have the same capitation rates, but a different risk profile. You're getting pressured to move up from the folks attracting a higher risk profile. This potentially gives you some rationale to move their reimbursement level up. Of course, you're going to have to take a look at the folks that are attracting a less costly population and make an offsetting adjustment there.

Buyers' Health Care Action Group (BHCAG) started a few years ago. There are some products in the market that are similar. Essentially the care systems bid on a standard population. You bid on a health status of one or a standard risk. The employee contributions are based on these standards; as such, if you have one care system bid $100 for standard population, and another care system bid $80, there would be a $20 difference that might or might not be passed on to the employee. Most of it is in the BHCAG model. They then look at the actual health status of the people enrolling in this population or in each provider organization or care system and make an adjustment to the target or the bid rate based on their actual health status. Intuitively, it seems to make sense. You predict who are going to be the tertiary providers or attract the higher risk population versus those that you wouldn't think would attract the higher risk population and intuitively the spread. When you look at it, it seems to make a fair amount of sense. You'll see a 0.8 to 1.2 is probably a consensus range. The folks that are down at 0.8, probably belong there. The 1.2 folks have cancer care and cardiac surgery. Then they apply a floating fee schedule so that they match this adjusted budget. If you bid $100 and you have a risk factor of say one, your adjusted target is one or 100. If you based your reimbursement on the fee schedule that you had underlying it, and you got 110, then you'd bring a fee schedule down to match 100 so that it's a floating fee schedule.

I have five different care systems, A through E, shown on Table 2. I have a claim target that starts out at $100 for A and B. System C is greedy; they took 110. The other two are out to lunch at 90 and 95. Then, they do a quarterly analysis. I don't really think that's administratively all that wise of a thing to do, but they go in quarterly, look at the relative risks, and then adjust the risk status of each of the care systems. These are all ranging from 0.9 to 1.05, depending on the mix of the care systems. Probably a reasonable range is 0.8 to 1.3. That then develops a risk-adjusted claim target. Column C is just simply taking A times B. You look at the actual claims that are coming in over a 12-month period, and you develop an overall care system adjustment factor. Essentially, system A spent $94, and its target was $100. You take 1.064 times 94 to get to 100. If everybody was on the care system's fee schedule for participating in this, then you simply ratchet it up 6.4% and pay the dollars out. Column F shows a relative percentage of folks that are participating in the care system. They may elect children's hospitals that are outside or some nonparticipating services or what have you. Then you make an adjustment so that if the care system needed 6.4%, only 70% are participating. You'd have to increase everybody 9.1% to match that 6.4% on average. This is a way to get the total budget to tie for the total expense to tie to the

TABLE 2
Calculation of Care System Adjustment Factors

Care System	(A) Claim Target PMPM	(B) Relative Risk	(C) Risk-Adjusted Claim Target PMPM (A x B)	(D) Actual Claims PMPM (12 mo avg)	(E) Care System Adjustment Factor (C ÷ D)	(F) Portion of Care System Floating	(G) Resulting Adjustment To Floating Fees [(E-1.0) ÷ F)] + 1.0
System A	$100	1.000	$100.00	$94.00	1.064	70%	1.091
System B	$100	1.050	$105.00	$100.00	1.050	95%	1.053
System C	$110	1.050	$115.50	$118.00	0.979	80%	0.974
System D	$90	0.900	$81.00	$82.00	0.988	75%	0.984
System E	$95	0.900	$85.50	$85.00	1.006	90%	1.007

One of the advantages of this system is it rewards more efficient providers — not necessarily the cheapest ones. If you have a cancer center or you have a cardiology center that is attracting a high-risk population, this provides some rationale for paying them more. The employees, at least in the BHCAG model, pay more for selecting the inefficient provider. If you want the folks in the community that have the best name or do the best advertising or what have you, you can do that if they're more expensive and you don't have to pay for it. This has a little bit of the element of the defined-contribution model and a little bit of the concentric model that we'll talk about next. Another advantage is that it has been relatively stable, at least within the year. If you go from the beginning of the year to the end of the year, you pretty much know what your costs are going to be, and it does provide a lot of cooperation between the providers and the employers. You do hear a lot of conversations about what the care systems are doing to help out the employers.

One of the disadvantages is it takes a lot of time to develop one of these from scratch. It also takes a lot to administer them. You have to have some competition in the market. You can't do this with one provider organization. Doing the bids and that sort of thing is a lot more difficult to do. It hasn't been really tested in the smaller or even the mid-sized market. These are the really large employers within the Twin Cities. I do think that there are some elements of this that could apply to other parts of the country, in particular to some of the large integrated delivery systems.

Another model that we've seen lately is the use of a tiered or concentric provider network. In this model, you are essentially taking your network and splitting it into two or three tiers. If tier one is your most efficient providers, tier two would be the least efficient providers that you may need in the network to attract employers and members. Tier three would be completely out of network, and you could do either

with or without the pure out-of-network. Then you vary the member cost sharing by provider grouping. I've seen some folks try to go a little bit too far with this because they wanted to do it on the Internet. People could look up what their fee would be for a particular office visit, with one provider versus another. I don't see how a member could ever figure it out. I think a better approach or an interim approach is to say we're going to cover you 100% in tier one, 90% in tier two, and 70% in tier three or something like that. It would be more broadly based so you're not trying to get so refined in telling the members how you're differentiating. One of the advantages is that it does foster some competition. It fosters some lawsuits in some cases, too. If it exonerates, some of the providers will say, you're right, we want to get paid more; we're worth 10% more and members have to pay to come in. So it does get the providers to the table to talk about where they fit in the marketplace. The employees pay the additional cost that is somewhat similar to the care system model. The employees are paying more at the time of service. Then the employer cost is reduced, relative to keeping those tier-two providers in at the same benefit level as the tier-one providers. You have to do a little thinking where you position it.

The disadvantage is that it adds one more level of complexity to your membership. You must try to understand their benefit plans. Administratively, it's more complicated. If you get a tier-one provider referring someone to a tier-two provider, or if you have anesthesiologists that are participating in a tier-one facility, you must do a lot of thinking about your network to make sure that you don't accidentally cause your members to get reimbursed or have their benefits adjudicated on a tier-two basis when they try to go to a tier-one facility. There are also issues with Children's Hospitals. If you have the only cancer facility in town in the network and the only cardiac center, you must make sure that you have a reasonable access at each of the tiers within the community. It also requires competing provider organizations. It doesn't work too well in a one-horse town.

I'd like to finish up a little bit here with what I think we can do as actuaries to help steer through some of this. If you go on the employer's side or on the sales side of the business, you'll find sales reps, underwriters, and actuaries in the back room churning out rates. On the provider contracting side, there are contracting folks like sales reps a lot of times. That's it. There is nobody back there saying here's how you should do this. Their goal is to sign a deal. The contract comes up for renewal, they sign it, get it done, and move on to the next one. That probably worked five years ago. Everybody was coming down on the reimbursement rates. Everybody knew what they wanted to do. The complexity of some of these contracts requires a lot more modeling or a lot more thought. When you have a $1,000 per diem, and a $40,000 outlier provision that pays 70% of charges, you can think that your trend is zero, but it won't be. As soon as those charges hit that outlier, and more and more are going to hit it every year, you move to 65% of charges. Eventually if a trend were to continue indefinitely, you're paying 65% of charges. There are a lot of provisions in these contracts that will have minimums, case rates, and these outlier provisions. Many of the hospitals want to fiddle with those. Say you get into a contract, particularly with somebody who has a constant charge ratio of 20-25%, which I saw recently and thought was astounding. If they're in a $90,000 stop-loss on their per diem contract, that's like being in a $40,000 stop-loss for anybody else in the market. If they're ramping up their charges, you've got problems because your trend is going to be a lot higher than what you think it is.

Your provider contracting folks don't always know that. They're saying, Get $1,000 a day, that's great. You've got to look at the fine print on these contracts to make sure that it's really $1,000 a day and not $1,200 going on $1,400 simply because of these outlier arrangements.

We're seeing a lot of plans as a result of somebody placed into more of an underwriting position in the contracting area. It is similar to what Zion is doing. It's a great idea. I think actuaries can really do a good job for the organization. We've got the ability to pull data; the ability to really understand what's going on. We must kind of model this out and understand what the impact is on trend. I think it's incumbent upon us as actuaries to take the lead in that area and develop some kind of an underwriting function within the organization that keeps an eye on these contracts and helps the folks think about what alternatives might be in the structure and the terms of the contracts. This is especially true if you're trying to untangle a bunch of capitation arrangements or risk-sharing arrangements. There's nobody better than one of the actuaries to go in and look at what the impact of that ought to be. They can look at prior fee-for-service experience and other actuarial models to try to estimate things like, if you had to move it off of a certain cap level and you wanted to pay X% of Medicare, what does that mean to your underlying cost structure? They can also look at outpatient hospital arrangements. There is APC contracting and looking at charges. There are a lot of things that fall through a hospital contract that end up in the little line that says, "All else at 65% of charges." Really look at the hospital's cost-to-charge ratio. Is it really losing money? I hear a lot of people talking about the hospitals being in bad shape, but some of these guys are doing pretty well, and they're still asking for 50% increases on their reimbursement levels because they're saying all the hospitals are losing money. They're not telling you they aren't losing money.

We can also look at the whole benefit redesign. Does the network make sense? Are they really inefficient or not? Are you correct in your assessment of tier one versus tier two in a concentric network model? We can do what ifs. Say a hospital wants a 30% increase, and you don't want to give it to them, so you terminate it. What happens? Does it move to another hospital that is 50% higher in reimbursement? What happens if we part ways? Also, who is this contract more important to — the health plan or the hospital? Who is going to be damaged the most or hurt the most if this contract goes away?

Trend evaluation: You'd be surprised at how many actuaries do not talk to the provider contracting folks. They look out the back window and say, "We had a trend of X% last year. People are going to get older, so we're going to make that X + 1% this year." That's it. They're not having conversations with the provider contracting folks and they're not talking to marketing. They're not talking to the senior management in the organization; they're just staring out the back window. You really have to look at what's driving your trend. Is it one-time events? Can you expect this to continue? Are you going to have other hospitals follow suit in this regard? We're really getting a handle on where your trend line is going to be and what do you need a price on?

FROM THE FLOOR: I was intrigued by the last few comments that Dewayne made because, in our plan with Blue Cross & Blue Shield in Rhode Island, our contracting folks have some analytical folks in there and they can do the kind of work that

you're suggesting be done. We also are very heavily involved with them. The problem with the people in the contracting area is they have different marching orders. They're more focused on trying to get the contract signed and moving on to the next one, as you mentioned. The issue that I have is trying to define and get agreement on roles and responsibilities for the various aspects of contracting—from the development of the strategy through the evaluation and the what ifs to the actual negotiating strategy and our ultimate goals. To some extent, it's a matter of getting our goals aligned (ours being the plans, the contracting folks, the actuaries in the various other areas), but that's easier said than done. I'm looking for some ways to spark an interest in all parties working together. I have no problem in having the analytical people, who are skilled in the contracting area, do the analysis and then having a statistician review their work. But this assumes that the analytical people in the contracting area are working under the proper motivation, but they're not. How do you work that through?

MR. SMALL: We have that struggle as well. Theoretically, in my position, I set the reimbursement. The contracting people supposedly go out and do the contracting. I say, "Here's what you're going to sell; go sell it." Of course, I must sell it to them, and they often want to get the thing signed. However, they're not as motivated as I'd like them to be about getting the best deal and really pushing it. We've had a lot of arguments, We've talked about this exact thing. I guess the structure in our plan is that the finance people do have control of the reimbursement level, but there's still somewhat of a lack of motivation from the contracting department. Maybe they should be incented. Some health plans do incent their contracting department to get better deals and to somehow get them to share in some kind of savings they get, because I'm looking for answers to get them on board. I think a lot of it is understanding. You have to sell the contracting department the idea that this is fair and hopefully that's what your analytical people should do in the provider contracting area. Then it's provider contracting's job to say to the provider—this is fair; our competitors are doing it. Be prepared for the provider's arguments.

MR. ULLSPERGER: We have seen some plans, too. They have somebody setting their budget every year. They'll actually come up with a model, and it doesn't have to be the fanciest one. We have ten hospitals in our network. I have another 20% going out or whatever saying, "Here's what we've budgeted for increases overall. It's almost like an employer's book of business review on what applied to hospitals." We need X% out of contracting this year," and set the objective and having a talk with marketing and actuarial and provider contracting to say, "Marketing: Can you sell this increase in the market?" Get an agreement around the table and say, if Marketing can't sell it, we need to make some adjustments to the target. Provider contracting can't sell it, we're going to have to make some adjustments in marketing. You must get those folks to talk back and forth, so they understand that they impact each other in the process.

MR. SMALL: We set the budget this year and that helped so much because the contractor said, "Oh, yes, we're over budget. We don't want to go over budget." Get everybody around the table and say, "Here's the budgeted amount we're going to put in for hospital increases. We can't go any higher than that." This conversation really gets them on board.

FROM THE FLOOR: I'd like to state three questions and then get your input on each of them. My first question relates to APC implementation. With it being recently introduced, when do you realistically think that the private payer population will implement APC contracting methodologies? The second question relates to the term of the contract. When you're contracting with providers, what is your preferred term of the contract? Is it two years, or three years? And if it's a multiple-year contract, what do you like to tie that to? What I mean is, if you're increasing rates from year one to year two, do you tie it to CPI or do you try to lock them into a fixed fee schedule for two or three years? The third question relates to the last two areas that we talked about — the BHCAG pricing models and the tiered networks. One of the things that seemed to be missing from that was any type of accountability for the quality of the care delivered. It seemed to be all focused on what the price was. Will quality ever be integrated into provider reimbursement? Do you see that happening with your specific plans or elsewhere? It seems like there has been talk about this for multiple years, but we never see any results.

MR. SMALL: Those are great questions. I don't see us doing APCs; we're kind of piggybacking on them and improving our fee schedules. I do know several people doing APCs. I think there may be more interest in waiting and going with an APG model because, with an APG model, there's more packaging. I think the more packaging there is the better it would be. In fact, I've heard some predictions that Medicare will eventually go to APGs because they're not going to get the savings out of APCs.

MR. ULLSPERGER: I think as far as APC implementation is concerned, there is a lot of interest. I don't know if anybody signed a contract yet. I have seen some provider-owned plans use that as part of the contracting strategy. However, when you have an arm's-length relationship between the hospital and the health plan, it's a lot easier to move into something that's kind of uncharted territory. That is because there is general agreement that, if you really blew it, you can fix it later, I think it will be a couple of years before these become more mainstream. You do have to get the hospitals to buy into it, and they don't seem to be in the mood to do anything lately that's going to restrict their cost.

As far as the term of the contract, the preferences you have are per diem; there are no outliers and no increases, but that's not very realistic. You see a lot of different options out there. Some folks will look at a medical CPI and some folks will use suburban CPI for all services. Some folks will say it's X% for the next two or three years. You often see a two- or three-year contract. Part of the problem with that is if you really became aggressive, and this contract comes up for renewal in three years and you don't remember that, you must accommodate what could be a fairly sizable increase in the fourth year into your pricing. You see a lot of plans that forget that. Then they're surprised in the fourth year. In the Twin Cities, everybody is a quality provider, so you don't really have to worry about that. I think they do worry though. It's really a separate function. The employers are certainly worried about quality. It doesn't necessarily show up in the reimbursement model directly, but it is a pretty good group of providers. The quality providers also tend to be relatively cost effective in the market. That's not the case in every market. We have a lot more leeway. in the Twin Cities with respect to quality than you might have in other markets. Some talk about quality access and build that into their position bonus structure. It seems like it's generally lip service that you're

paying to this. It's a minimal amount of money. Everybody gets it, unless they've really behaved poorly. They put it in there so they can say they have it. There are not a lot of people who do it, so I think you're right. I think the Society or the American Academy of Actuaries might be putting together a group of people that will look into quality. How are the actuaries going to participate in the discussion and help change that? You're right; it's not in there. On the concentric model approach, quality is presumed in the model. We're assuming that you're doing all you should be doing up front as far as quality care issues, and this is kind of a subset of that group of providers.

MR. SMALL: I like to have an indefinite contract period. We've been fairly successful in not having termination dates in our contracts because, if possible, you don't want to have the same argument every year. As a result, you just try to make them indefinite. I would say it's disappointing, and I think, in my role I should be doing something with quality. However, I'm not sure we're paying claims yet. I don't see it happening in the next couple of years, but I would hope they would come around. I don't see it on my radar screen yet.

MS. JOAN P. OGDEN: After 16 years of working with both providers and payers in provider reimbursement mechanisms, I admit to a very jaundiced view. I have an observation not a question. You have a group of highly educated people who are highly motivated to make sure there are no dollars removed from their wallets. Regardless of how the reimbursement mechanism is established, a significant percentage of them, in my experience, will find a way around the mechanism. A recent example: a hospital on DRG reimbursement discharged patients two days before the end of their stay, and admitted them under rehab DRG for the last two days and managed to make two DRG reimbursements on each stay. Unless you are busy looking for anomalies in your claims processing, you'll just pay it.

MR. DAN LEVIN: I have a question for Brian. You said that when it comes to negotiating contracts, in general, the hospitals prefer percentage off charges because they can charge as much as they want, whereas the health plans obviously prefer to have accountability. You also said that for Louisiana Blue right now, there's really no more capitation. Is everything in your state now just a percentage off charges for you or is there something in-between?

MR. SMALL: No, we don't pay much of a percentage off charges, and we have a lot of effort going into the outpatient side. We are really digging into what we are paying on charges because we're not exactly sure how much we're paying on charges on outpatient services so we're going through a modeling process on outpatient to see what's falling off the fee schedule. Then we're going to try to see what we can put back on the fee schedule. For the most part, we're either on per diems or DRGs or fee schedules. What we don't have a fee for would fall into the percentage charge line. That's really where we want to focus, to make sure we get off the percentage charges. The first thing any of the providers will say is give me percent of charges, we're not going to do that. They really don't have any alternatives. They don't like our methodology, but the only methodology that they offer is percent of charges.

MR. LEVIN: So it's mostly situations like 100% of RBRVS?

MR. SMALL: On the physician's side, we have something like that and you would also have hospital contracts. We have our own home-grown fee schedules.

MR. THOMAS L. HANDLEY: We see the shift away from capitation, particularly in the physician community. What we are looking at is how can we keep the physician involved and interested in using efficient methods of treatment. You both mentioned a little bit about some of the shared risk. Brian, I think you called it *shared gain*. What are some of the things that plans are doing on a shared-risk basis? Are they using withholds or is stop-loss involved? Can you comment?

MR. SMALL: The deals that we're talking about would focus on prescription drugs, We have a multi-specialty group; if they improve their generic usage and improve the utilization, they would get some of that savings and something similar on the inpatient side. That's the simple deal that we're looking at.

MR. ULLSPERGER: Yes, I think we're seeing a lot of withholds with the physician networks. You're seeing some bonuses or incentive programs to get folks accustomed to using the facilities that you want them to go to because you have a better deal in ambulatory surgery centers instead of outpatient hospital facilities or what have you. There are some approaches out there. They are all over the map in terms of how they work. It's a lot harder to do some of this in an open access model versus a gatekeeper model, so if you've taken away the gatekeepers approach, you don't have as much to tie back to. You have to do it on a network-wide basis or market-wide basis. It's a lot harder to drill down to that PCP and really understand what's going on. If you go from gatekeeper to open access, you have a harder time in setting a particular provider, with the exception of some of these steerage components or various bonuses like that.