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Session 15 PD
Provider Contracting: Current Issues and Trends

Track: Health

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Summary: Panelists discuss current developments affecting health plan contracting with institutional, professional and ancillary providers. What are the trends in financial arrangements sought by providers? Has consolidation changed negotiating strategies? Has technology affected the types of financial arrangements available? How can actuaries assist in the analytical/negotiating process?

MR. DENNIS J. HULET: I'm with Reden & Anders in San Francisco. Also on the panel with me are Dave Axene of Axene Health Partners and Cathy Murphy-Barron of Milliman in the New York office. Cathy has been with Milliman for 14 years, and the majority of that has been in health care. She had a little bit of nonhealth-care work before she joined us in the Milliman practice in Seattle, where we threw her into the health-care arena. She learned a lot quickly and has enjoyed it since then. Dave and I did work together at Milliman for many years. Provider contracting was certainly one of those areas on which we spent a lot of time, and I think he continues to do so in his role with Axene Health Partners. He did have a stint with Ernst & Young between Milliman and starting his own firm. I was at Milliman for 18 years before going to Reden & Anders about four years ago. My entire consulting career has been on the health-care side. I did a little pension work early in my career when I was with an insurance company, but I found that health work is

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Note: The chart(s) referred to in the text can be downloaded at:
http://handouts.soa.org/conted/cearchive/neworleans-june05/015_bk.pdf.

interesting. It seems to be an ever-changing landscape, and I think provider contracting is one of those elements that's ever-changing.

How many in the audience have experience in pricing base/major-type products, which is basic medical with a major wraparound? There are a lot of similarities to some of those early health products and to some of the contracting that we see today, but I think there's so much variety in the contracting that it's difficult to put it in any one particular mold. For my introductory remarks, I want to lay out a few of the issues that I see as part of the landscape for provider contracting.

You've got a number of audiences that you have to be able to address as you think about provider contracting. Usually you're addressing it either from the payer side or the provider side. How many in here have done work for providers in helping them set up contracts with payers? There are only a few hands. That must mean most of you don't work in provider contracting, are just coming to get your feet wet or are doing it from the payer side. How many have been doing it from the payer side? There are a few more hands. When you think about your role in provider contracting, you have to try to put yourself in the shoes of whom you're doing it for and also of the person on the other side of the table. There are people who aren't at the table who are also affected by contracting, and we shouldn't leave them out of the equation.

There are a number of different approaches you can take in thinking about contracting. We won't go into depth on any of them. You have to be able to identify the driving forces that you're trying to deal with in setting up the contracts. Those forces are different in different situations. You need to try to identify up front what issues are being addressed by your contractual relationship and do your best to address them in the form of the contract.

There are many contract terms that are for periods of three to five years. There are a few that are shorter term than that, but overall I think you're better off if you can set up a contractual relationship that is good for all parties over the long term and not something that will give one party or the other a short-term advantage. That causes problems. If you follow the media and what is reported about the contractual contract talks, there are a lot of hard feelings that are introduced because what one party thought the contract meant did not emerge over the long run, and so they're feeling compromised in the position they took.

Data are important. It's difficult to know what the impact of a contract is going to be if you don't have the data to analyze the impact of changing the structure. Many times it requires that you do some estimation since as you change the criteria that are used in the contract, the behavior changes, both for the provider and for the patients. You need to think about that, and the actuarial skills come into play in being able to estimate the impact of some of those changes. Often, expressing that as a range of outcomes is more appropriate than trying to deal with a single number as an outcome.

Also, if we have some time at the end, we can talk about some of the special populations and whether the contracting approaches that are used in those special populations have characteristics that need to be addressed differently as you set up those contracts. Those special populations include Medicare, Medicaid, the uninsured, disease management and other carve-outs. Cathy has been doing some disease management work.

To kick us off I want to share with you a quote out of a book called *Thriving in Capitation*. It so happens that Dave and I were contributing authors to this book, and so I want to quote from myself. I did a chapter that was called "Emerging Models of Capitation." This is what I said at that time, and I still believe it. "The health-care industry, both providers and those involved in financing health-care services and benefits, will continue to search for a better way to reimburse providers for health-care services. A "better way" generally means finding a reimbursement method that improves the correlation between the expected cost of health-care resources used and providing a package of services or benefits and the actual cost of providing those services or benefits.

A major factor that limits our ability to project costs accurately is the variability of the actual cost from person to person, from provide to provider, from area to area and from payer to payer. If the differences between actual costs and expected costs can be minimized, the estimates made and used as a basis of a prospective payment, capitation or other forms will provide less windfall profit from misestimates, and therefore, it'll be a better contract." Those are some of the issues that I think provider contracting hopes to address. Provider contracting hopes to reduce the variability and make it easier for payers or providers to predict that stream of income or expense that they have to deal with in deciding how they're going to form their own future.

MS. CATHERINE M. MURPHY-BARRON: I'm going to talk a little about the current issues in provider contracting. As you know, a lot of old ideas are coming back and looking a little new, and some of them are getting a lot of press. I want to talk about some of those things.

Before I talk about where we are today, I thought it might be a good idea to take a quick look back to see how we got to where we are right now. The 1990s are considered the height of the managed care time period. In large parts of the country the predominant reimbursement method was capitation. The view was that this was how it was going to continue into the future. Then we moved into the late 1990s and 2000, and we had the managed care backlash. Rightly or wrongly, people thought that HMOs were having too much of an impact on how their care was provided and were making decisions that they didn't want made for them. They rebelled against that managed care, and so you saw a movement to preferred provider plans and point-of-service plans and away from HMOs. As a result, there

was a movement away from capitation and back toward the fee-for-service-type environment that we had been in before.

Then you come to today. We're back to having high rate increases on employers' health-care premiums, which, of course, are causing some issues for employers, and we have a tightening of the labor market. We're back to the question, how do we get around that? How do we try to control the costs? We're now revisiting some of the old reimbursement methods that we were using in the managed care environment, looking at them in a different, more thoughtful viewpoint, to try to provide reimbursement that makes sense for all parties.

As we're talking about current issues and trends, I want to talk about some of the reimbursement methods that are getting a lot of press right now. Dave is going to deal with hospital contracting. I'm going to focus on reimbursing physicians and doctors. Some of the methods that are getting a lot of press are things like reimbursing physicians for e-mail consultations, which hadn't been done much prior to this; pay-for-performance, which is a big buzzword right now; some fee incentive methods; and episode-based global fees. We still have all the other methods that we've had all along, including capitation and fee-for-service, but there are some buzzwords out there right now.

Nowadays most of us are computer-literate. I registered for this meeting on my computer. I booked my airline reservation and even checked in for my flight without ever leaving my desk in my office. Most of us know how to use a computer. If you have a simple question for your doctor, most people would prefer to shoot off an e-mail to the doctor and get an answer back. Up until now, doctors (not all, but some) have been somewhat reluctant to communicate by e-mail. When surveyed, doctors said that while they wouldn't mind doing it but would prefer to get paid for it because they see it as adding more to their workload without getting reimbursed for it. They feel that they are not getting paid enough, anyway, at the moment.

The payers are also starting to realize that there's potential here to limit other claims. If you have patients who can get their issues addressed via the Internet, you're paying a smaller fee than if you have to pay for the office visit that would probably happen if the patient couldn't get it resolved by e-mail.

For the physicians and the patients involved, e-mail is also useful for monitoring chronic conditions. If you have somebody with diabetes or in any of your typical disease-management-type populations, the doctor wants to know how the patient is doing over a period of time. A lot of that communication can take place via e-mail, and you have what you need to monitor the patient. Also, of course, you have ready-made documentation. The doctor has ready-made documentation to put in the file, and he or she doesn't have to spend extra time writing up notes for the patient file, and, of course, it's often more legible than the usual physician's writing.

Just as an aside, if any doctors are in the room and you're thinking of doing this, you have to set up strict guidelines about how you deal with communications by e-mail. Be strict about what things you will deal with by e-mail. For example, you might be using it only to monitor chronic conditions or for prescription drug refills. It should never be used for urgent conditions because the patient should immediately go to the doctor and get the condition taken care of, as opposed to waiting for the doctor two days to reply to an e-mail. There has to be strict guidelines as to how long you're going to wait to reply to e-mail, say 24 or 48 hours. Whatever it is you set up, the guidelines have to be there. The patients have to know all these guidelines and the expectations. Of course, privacy is another big issue.

The other big buzzword right now is pay-for-performance. In its current form today, it's generally an add-on to fee-for-service. The doctors are paid a bonus for meeting quality-of-care criteria. In the general press right now when you talk about pay-for-performance, you're usually talking about quality performance. It doesn't have to be that way, but that's generally what they're talking about when they talk about it in the press. Pay-for-performance came from a desire to control costs by improving quality. It's done by aligning the incentives with improved outcomes. The incentives have to be significant because you want a lot of doctors to participate. You want it to be significant enough that the doctors will change behavior to whatever it is you're trying to incent.

Currently there are just a few comprehensive pay-for-performance programs that have been established, but a lot of payers are considering it or talking about it as a thing they have to do because there has been a lot of talk about it. The jury is still out as to whether it's controlling the costs, and we have to wait and see how that pans out because of measuring quality and all the other issues associated with it. The general thinking is that this is encouraging quality care and it's the right thing to do, so therefore it deserves consideration. Even the Centers for Medicare & Medicaid Services (CMS) is getting in on the act. It just started its demonstration project and is paying out 5 percent of annual performance targets as bonuses on top of its fee-for-service payments. It's definitely not a methodology that's not going to go anywhere.

The issue with the pay-for-performance is, How do you define quality and how do you measure it? In the types of programs currently out there, some of the things that they're using as measures are preventive care measures such as pediatric immunizations and mammograms and giving providers bonuses depending on how much they're prescribing these things and how many of their patients are getting them. They're also using things such as appointment access, complaints and turnover rates. They use the practice guidelines; some of the simple programs that are out there right now are just a matter of whether the doctor is conforming to the guidelines. If the doctor is prescribing a treatment, does that treatment align itself with the guidelines that the payer set up? If yes, the doctor is eligible for the bonus. If no, the doctor is not. It can be that simple. Health Plan Employer Data

and Information Set (HEDIS) measures are sometimes used because they are published, fairly standard and measurable. They're easy to use as a measurement. Member satisfaction surveys are sometimes used. The issue with these programs is that quality is subjective. You have to be clear about how it's defined. It has to be something that the doctor is able to quantify and also on which the doctor is able to have an impact. Because you're bonusing him for an action, he has to be able to get to that action.

As I said, the pay-for-performance doesn't have to be quality, even though that's often what we're talking about. Some of the other things that could be used are utilization or cost targets. For example, emergency room (ER) visits per patient per year or administrative targets, such as the level of health-care technology, are sometimes used. However, in today's environment we're usually talking about quality.

There are some key considerations if you're setting up this type of program. I've already addressed some of them. The targets, measures and processes that you're using have to be carefully chosen. They have to be definable and measurable. The targets are critical. Avoid having too many targets because then you reduce the incentives. Time and effort are involved on the physician's part to meet these targets. If you have too many of them, the physician doesn't have enough time or ability to meet them and therefore might not try to meet any of them.

The patient population is another consideration. The provider has to have enough contact with the patients to be able to affect the outcome. Also, the population has to be large enough so that your answer is statistically significant. That's important. As Dennis said earlier, data are important. Both the payer and the physician have to have timely and accurate data, and so a significant investment in information technology could be required to make this work. As I said, incentives have to be significant enough to have change become effective.

Another item that I want to talk about is fee incentive. This is similar to pay-for-performance. You want a doctor to do something, so you pay the doctor to do it. It's as simple as that. Again, it's a bonus over and above the underlying reimbursement. However the doctor is currently being paid, this is a bonus over and above that. For instance, if you want to increase the use of your disease management program, you pay the physician for every individual that the physician refers to your disease management program, assuming, of course, that the patient fits the criteria for your disease management program.

As another example, let's say you want to encourage your primary care physicians (PCPs) to follow appropriate referral tracking or to do follow-up with the individual after the individual has been referred to a specialist. You might pay the physician a fee for doing that, say filling out the documentation or making contact and following up on the patient after the patient has gone to visit the specialist. In a capitation environment, as you know, encounter data can often be somewhat unreliable

because payment is not based on giving up the encounter data, so you might pay a small fee for every record that the physician submits to encourage timely reporting of data.

Episode-based global fees is another item that's getting a lot of talk at the moment. It's like case rate, but it's not based on a single event. It's based on an episode of care. You have a starting point, and all the care from that starting point until a certain period of time, across the entire continuum of care, is paid for based on one capitation rate (or fee rate, if you want to call it that). It focuses on that particular event. You get paid for all the services of that particular event. The physician is at risk for anything that happens over that period of time. The episode can be characterized in one of three ways. It can be a chronic episode of a disease over a period of time, such as diabetes over a year. It can be an acute self-limited condition, like a myocardial infarction with six months of follow-up care. It can be a single procedure with follow-up, like a nonsurgical revascularization with one year of follow-up.

For episode-based global fees to be effective, to have them work from the physician's point of view as well as the payer's point of view, the episode has to be identified appropriately and has to be risk-adjusted somehow based on clinical factors. You can't have the physician favoring one class of patients over another class of patients purely for economic reasons. That's not what you want to have happen; that's the whole point of risk adjustment. The episode should include any clinical complications that high-quality care could prevent or fix. That encourages the doctor to give high-quality care for the set fee. You also have to have realistic upper bounds. If something unexpected or catastrophic happens during the episode, you don't want to penalize the doctor for something that the doctor has no control over. This kind of fee payment aligns with a lot of the current disease management programs.

Capitation is on the list even though it's not new; it's revisiting the old capitation. While we moved away from it aggressively during the managed care backlash, it has not gone away. It is a realistic way of trying to control costs and is something that you need to think about as a payer, but it's not exactly the same capitation as the old days. Both sides, both payers and physicians, who were burned before are leery of capitation. The physicians know now the risks involved and are careful about what risks they will accept and for what services they'll accept risks. It's perhaps a more thoughtful process now than it was in the past. Sometimes what you'll see is while the predominant payment method is fee-for-service, you might have certain services that are carved out and paid for on a capitation basis. So while physician services are paid fee-for-service, you might see the radiology or lab carved out, and that's paid separately on a flat capitation rate.

There is also some talk about contact capitation. This works in a specialist environment. Say an individual is referred to a specialist. The first time the specialist meets with that patient is the beginning of the contact period. During that

period, be it six months or 12 months, the physician is responsible for all the care for that individual over that period of time. The physician's first contact with the patient is the beginning of the period and the beginning of the time that the physician starts to manage the care, so to speak. Capitation hasn't gone away. It will be there because it is an effective methodology.

I wanted to touch on one last thing. CMS is changing the way that it's paying for certain drugs that are usually administered in the doctor's office. These include cancer drugs and immunosuppressives, but they also include a lot of the biotechnology drugs, which are expensive with high trends. Many carriers are now paying 106 percent of average sales price. The sales price is net of discounts and rebates. The issue with these drugs is that they're traditionally part of the medical benefit because they're administered in the doctor's office, there was mark-up on the part of the doctors when they were billing because they're billed on HCPCS codes, and that mark-up was the income to the doctor. Now with the new Medicare payment methodology, a lot of that mark-up is gone. Because it includes a lot of these expensive drugs, a lot of payers like you are looking at this class of drugs carefully. You'll see a lot of pushback between the physicians and yourselves about how to pay for them in a way that makes sense.

MR. DAVID V. AXENE: My remarks today are going to focus on a survey of hospital contracting best practices on which I had the privilege of working within the past year. Looking around the audience, many of you participated in it, so some of it's old news to you. But there were some interesting results that emerged from this study, and what I'm going to do is talk about some of the key findings from that study.

Essentially, a client asked us to survey as many health plans as we could in the country to find out how they go about hospital contracting (not how much they contracted for, but how they went around to do the contracting). What approaches did they use? What information did they share? The client was pretty proud of its own process, but in the search for the perfect process it wanted to do a best practices survey to find out how others were doing it to see if there was anything new and innovative that it could learn. It proved to be interesting for the client, and hopefully it will be interesting to you.

In talking about provider contracting, I want to share with you a word picture of how I look at some of these things. Some of you may have heard this before. At the far right part of the spectrum, think of something called financial self-interest (FSI). That's a good thing. Each one of us has financial self-interest. If you had to pay for your own airplane ticket to come to this meeting, and your company wasn't going to reimburse you, many of you would have found the cheapest flight possible because it was in your FSI to save money. At the other end, I call it "G" for "greed." In the middle, there's something I call the "G-line." The G-line is where you hop over from FSI into greed. This is where we meet the story.

It appears that in provider contracting, too many people are operating on the greed side of that line. Doctors think the health plans aren't paying enough. It's not a FSI issue because how did they respond? With 35 percent to 40 percent rate increases. The health plans are sometimes operating on the other side of that line because while they have exorbitant profits, significant bonuses to executives and so on, they're trying to pay less and less when it comes to the providers. Then we have the patients, who are sick and tired of their high deductibles and whatever, because they feel they deserve to be on the other side of that G-line and have complete health care at no cost. If you think about provider contracting from this simple word picture where one side is FSI and one side is greed, where are you in that process? I think it helps you sift out where you should be. Should you be on the good side of the G-line, or should you be on the bad side of the G-line? As we went through the survey, we found wide variations in positioning on that line as people went out to contract with hospitals.

This survey was administered telephonically. We didn't visit people to look in their eyes to see if they were telling the truth. We just asked them a set of questions. It was a structured survey; we asked the same questions to everybody who participated. It took probably 45 minutes for the fast ones and an hour-and-a-half for the slow ones to get through the questions. We looked at things such as organization and people. What kind of people did they have working on the contracting side? How were they organized? To whom did they report? We even asked the silly question, "Do you have actuaries in that operational department?"

To set a perspective here, how many of you who claim to be actuaries work exclusively with provider contracting at your employer? Look around the room. You'll only see a handful, maybe two or three. What this suggests is that in this room, most of you are doing other things than exclusive provider work, or you're probably doing provider work in your spare time as you're doing all of your pricing or incurred-but-not-reported (IBNR) issues or whatever else it is that you're working on. It was interesting to find how these different organizations were structured.

FROM THE FLOOR: Did you do it also by size of the organization?

MR. AXENE: These were all large health plans. I think the smallest of them was a major Blue Cross BlueShield plan. We chose to go with fairly substantial organizations. There were some regional health plans, but most of them were substantial plans.

We looked at reimbursement methodologies. What kind of methodologies were they using for inpatient hospital care? What kind of methodologies were they using for outpatient? Again, we were focusing on hospital contracting. We did not get into the physician side at all. We got into some things about negotiation tactics. In other words, how do they treat their friendly hospital? What information is shared? What

do they compare? How do they look at what the hospitals claim they did versus what they did?

In doing the survey, interviewing everybody and trying to summarize the results, we came up with what I call best practices. How did I define a best practice? Yes, there was an element of, "Wow! I never thought of that," or "I've never seen that done that way before." There's some of that in defining a best practice, but, frankly, we were trying to identify the best or ideal practice for which everybody should strive. In some cases, we found dueling best practices, because there seemed to be two strong sets of opinions as to which was the right way to do that, but generally we found a clear, dominant best practice in each of these areas.

In looking at how the actual contracting department was structured in terms of organization and people, we found a couple of major approaches. The first was an integrated model, where actuaries were housed within the departments responsible for contracting. So the two of you who raised your hands who are actuaries working exclusively on that, are you housed within the department, or are you housed within the actuarial department? One is in the actuarial department; one is in the provider department. It turned out that we concluded that the ideal model for this was to have the actuaries housed within the actual department that is responsible for the contracting. The actuaries can rub shoulders, on a day-in and day-out basis, with the people responsible for doing the contracting.

Now behind that ideal structure there were some obstinate chief actuaries. These obstinate chief actuaries said, "I will never let my actuaries work for the chief medical officer or somebody else. The ideal structure is that we'll let these actuaries work totally on provider contracting issues because it takes relatively unique information and knowledge to work on those issues. However, we're not going to let go of the strings that control them. We're going to force them to report up through the chief actuary." The good news is that if they're truly operating closely with the contracting department, it's hard to tell the difference. The bad news is that the strings were so strong that they weren't able to function because the department always viewed them as outsiders. When we interviewed other people within these departments, they said, "Yes, the actuaries are here working with us, but they aren't us." They weren't integrating and keeping the actuaries involved on all the issues. That was a controversy there, and we concluded, using our subjective skills, that the best practice was to put the actuaries within the department.

Another best practice on the structure was that if both the contracting leadership and the care management staff leadership reported to the same individual, there always seemed to be a better-performing department. If you have a chief medical officer who's responsible for all the care management staff, if they are making decisions without understanding the cost for those decisions, sometimes they would choose the wrong answer. They would assume something was cheaper (not that cost was the answer of why they would do it) when, in fact, it wasn't, and, frankly, the contractors weren't out there trying to make it cheaper. They were two

separate silos not talking to each other. All the organizations that did not have that integrated process had serious problems in the results of their contracting. The integrated model, where provider contracting and care management acted as a team, both reporting to the chief medical officer or that kind of individual, had the best performance.

In terms of staffing, the organizations that had the most successful or best-operating organization had both dedicated actuarial and information technology (IT) resources within the contracting department. It turned out that IT is one thing where there are always too many things to do and not enough access to the people who can do that. Departments that relied on centralized, nondelegated IT resources had a horrible time getting all their stuff done. If they had dedicated local resources that were accessing the big mainframe and other types of things, they were able to accomplish a lot more. When there were dedicated actuarial people focused just on contracting issues, they were able to accomplish even that much more beyond that. The idea of actuarial and IT resources dedicated within the contracting department was a sign of a high degree of functionality.

The assignment of duties was an interesting issue. Do we have people doing just hospital contracting and people doing just provider contracting with physicians, or do we have the same people working on both sides of the house by specific region? In looking at the performance of these organizations, those plans using the holistic approach of having the same people working as a team by region within an organization's larger network, where they were responsible for both the hospital and the professional side, had far higher performance, both in terms of profitability and in terms of effectiveness in their ability to contract with people. A best practice here is to think of a holistic approach rather than a dedicated, distinct, hospital-separate-from-physician approach. You can have separate people focusing on the separate issues, but have them work together so that they understand the unique needs of that particular region. That was an important finding.

As far as incentives were concerned, many of the organizations had incentives for their contracting staff. Usually the incentive was, do your job or you're fired. That's the exit-door incentive. If you don't do your job, you're out of there. But the ones who performed the best had their staff incentivized significantly, some as high as 30 percent to 50 percent of base compensation, to achieve certain specific goals in terms of contracting. Some of those who had those types of incentive arrangements turned out also to have some of the better contracting arrangements with the more dynamic relationships with the providers. Both short-term and long-term incentives were better because most of these incentives asked, How well did the renewal go? It was not just a matter of hitting them hard up front. It was also an issue of how well the renewal went.

In terms of reimbursement methodologies and administrations, the issue of using a model contract turned out to be a clear best practice. What I mean by model contract is that you have a contract that you don't change. Almost everybody had a

model contract, but we ended up with some people using that contract only 5 percent of the time, with 95 percent getting changes or modifications, all the way down to those who truly used the model contract and had variations less than 5 percent of the time. The key is to administratively be able to manage and administer the contract once it's signed, and that requires few exceptions. If your contract requires too many exceptions, you have a lousy contract, so get new lawyers. However, if you have a good contract with a good reimbursement approach, exceptions can be truly maintained to a significantly small amount. Sometimes we want to be everything to everybody, but flexibility costs a lot of money. There were several examples where by going to a standardized contract and using it, they were able to cut their costs by more than 40 percent in terms of the administration of that contract.

Let's talk about operational issues when changing methods. It was interesting because several of the players had changed their contracting methodology. Some were going from per diems to diagnostic-related groups (DRGs), and some were going from DRGs to per diems. Some were changing it for the heck of it. As you change provider reimbursement methods, what is a good way of making a change? The client that hired me to do this study was about to change it and wanted to find out the best way to do that change. It turned out that the best practice in terms of changing the method is to make sure, first of all, that you can process it before you change to that methodology. Many of the organizations will change it and then say, "Okay, IT department, let's make sure that we can do it." If you can process that methodology from the beginning, that is the right way to do that.

Another important part of that was what I call the "just-do-it" methodology. In other words, it's better to tick off everybody over as short a period of time as possible than it is to incrementally tick them all off over a longer period. It turns out that hospitals and physicians have a short memory. They always hate you. What they do remember is how long they hated you. So if you make it a shorter, more painful period, you'll get over it faster, and you'll get back to normal operations. There was a great example where a company decided to completely change it. One company used a three-year model, where it decided to continually tick off everybody over a three-year period of time. Another one decided to ram it through in six months. Although it had a bunch of temporary people come in to help with the process, the six-month company had far better results, both financially and in terms of contracting ability, than the three-year deal, doing almost the same process with almost the same outcome.

The best practice in terms of term of contract is three years or longer. Nobody in his right mind would want a one-year contract, because as soon as you finish negotiating, you've got to start all over again for next year. The best practice was three years or longer, with a strong tendency toward ever-green contracts with annual adjusters that are built into the contract, sort of like a self-propagating contract that automatically adjusts every year.

In terms of inpatient care, it turned out that all-payer (AP) DRG was almost uniformly the best-practice methodology for external payment. There were some that used CMS DRGs, but the AP DRGs seemed to be the one that everybody gravitated to that was using DRG payments. All except one of the health plans studied was either on APs or going to APs. It turned out that AP was the one for external analysis, but all patient refined (APR)-DRGs and refined diagnosis-related groups (RDRGs), which is the DRG system that has the acuity/severity score built into it, were the best practice for internal analysis. My big question was, Why don't you use it for both? I'm a fan of APRs and Rs because it has this automatic severity thing in it, and it's helpful to show the customers what the severity was so that they can better understand what's going on. The answer thrown in my face was that they can't process them as quickly and as efficiently as they would like. They go with the APs because it's easier to run them through the system. It became an issue of administrative simplicity. I don't buy it, but that was the overwhelming choice for process.

In terms of outpatient, other than the predominant number who just chose to pay it on percent of charges, the people who were trying to do the best on outpatient were making use of ambulatory patient classification (APC) or a related APC outpatient methodology. One plan in particular developed a structured fee schedule arrangement for all outpatient hospital events. It is the most sophisticated thing that I've ever seen. I'm sure that some day at a future SOA meeting there will be actuaries talking about it. It is nice to see that somebody took the time to do the homework to create a fee schedule that works for hospital outpatient. I'm assuming that other organizations are going to pick up on this. It's an APC, basically a UB-92 line-item coding process, that they use, and it's sophisticated.

The best practice in terms of adjudicating hospital claims was that over 95 percent fully adjudicated without human intervention. Take a look in your organizations and figure out how many of your hospital claims are touched by human hands before they go out the door. If 95 percent or more are not touched by human hands, you are at best practice. I have not seen as many as I studied here that were achieving that level. In other words, there were several here that were above 98 percent fully adjudicated without any human intervention, which is important if you want to keep the administrative side down.

The part on negotiating tactics was interesting. I try to be a nice guy. I try to follow the Golden Rule and all those other wonderful things, but I haven't seen that done often in hospital contracting. It's usually "let's stick it to them" or "let's react to them sticking it to us." But I'm proud to say I've now met two health plans that have a phenomenal collaboration style that is mandated by their health plans. I didn't believe it when I first heard this, so I probed a little further. I followed up after the survey and visited these people. Yes, they are breathing human beings—some nice people—with a successful hospital contracting methodology. They have a mandated approach not to be antagonistic. It's an overall customer-service approach within their health plans; they have agreed to have a collaborative

approach. In fact, one of the plans has gone so far that a significant part of your raise every year is evidence that you were collaborative in what you did. It has got a higher weight on the provider-contracting people, and so they're getting better raises by being collaborative. Since they switched gears on this a few years ago, the health plan is making more money today. Their hospital contracting process is the most efficient thing I've ever seen because they're agreeing to things without having a lot of bloodied attacks. It was pleasant to finally see that in practice.

In terms of benefit plan design issues, the best practice is to build in a tiered network capability. Most people feel that tiered networks are going to happen; it's a given. They want to make sure as they update their contracts that they can automatically handle that.

Hospital systems were bothering most everybody, but the divide-and-conquer strategy seemed to be the best practice. In other words, if HCA comes to town and there are a bunch of HCA hospitals, treat them individually, not as one big glob. The health plans were holding on to the divide-and-conquer strategy because they felt that was the best strategy. As far as recontracting, I talked about "just do it." Keep the recontracting process to less than a 12- to 18-month process. If you can do a six-month process, that's great.

Some health plans, as they're doing changes, have what they call the "early adopter" bonus payment system, which is paying the provider more money if they buy in early. When you're changing the methodology, it's always helpful to say that somebody else already signed the contract. They get all those people that have already signed the contract by having an early adopter, or early signer, bonus. It's like going into some of these health clubs where "if you sign up today, you'll get this discount." They say that if you sign up to the contract "today," they'll give you an extra 1 percent, 2 percent or 3 percent reimbursement. The plans using early adopter programs are happy with that.

The data sharing was interesting. The best practice here, which is by a health plan in the Pacific Northwest, uses standardized renewal packages. I had never seen this approach. For every hospital, the information is gathered in a systematic way. The report is identical by hospital, and it's a standardized renewal package. This was clearly a best practice. What you have is that they're going to treat each one of these on a standard approach, with none of this arbitrariness. The idea of open sharing of information with the hospitals was also a best practice, not "I'll show you mine when you show me yours." It was open sharing, and, with a collaborative style, that's helpful. Some health plans had a target of trying to get an x percent savings through effective contracting. I'm not talking about x percent savings by discounting, but x percent savings through effective contracting. Effective contracting was defined as having streamlined renewals and satisfied providers, so that we can avoid focusing so much effort on those troublesome areas. Some of those goals were as high as 2 percent of revenue that they were saving through effective contracting.

One company in particular, and several were trying to emulate it, was using what's called a "contracting checkbook." At the beginning of the year, senior management sits down and says, "We can increase our health-care expenditures to y dollars." Then they basically build up a checkbook. If at the end of the year the hospital dollars were less than y dollars, they won, because they saved money. If they were more, they lost, because they spent more money. Using this on an ongoing basis to monitor the hospital contracting process was extremely effective. They also tied incentives to the staff working on their own personal part of that checkbook, which was an interesting process.

In summary, we see a movement toward more collaborative contracting. If you're in a health plan today that is not using the collaborative approach, watch out, because there are a lot of people moving to the collaborative approach. There's more two-way disclosure of results of the contracting process, meaning good communication with the providers. There's improved monitoring of the results, either using the checkbook or an actual report showing that process and how it impacts trend. There's greater use of actuaries for the medical economic analysis than I had expected to see. There was a significant integration with product pricing. In the past, we had the contracting people out there doing their own thing and the actuaries trying to guess where the prices are going, but now the best practice is integrating that so that everybody is talking to everybody and, as a result, hopefully getting better answers.

MR. HULET: I appreciate the comments that both Cathy and Dave have made. Dave's comments about hospital contracting brought to mind the work that I've done over the past couple of years with hospital systems that are trying to get their contracting acts together. They are concerned about their ability to react appropriately to the contract terms presented to them by health plans. Dave mentioned the divide-and-conquer strategy that many of the health plans want to use. Well, there are hospital systems that are using the reverse strategy and saying, "We'll get more power in the marketplace and therefore be able to dictate what happens in those contracting discussions." They are sensitive to the public view of what the hospitals are doing. In many cases, they're working in a governmental environment, where the government is looking over the hospital's shoulder and particularly trying to determine the impact of the contracts that those hospitals sign with the payers and what impact that then has on the uninsured or the underinsured.

California has had some particular legislation passed to force the hospitals into more disclosure so that some of the discounts that are given through the contracting process to health plans can get to those individuals who don't have any relationship with an insurance company or a health plan. We're likely to see more of that as the voice of the uninsured becomes a more noticeable force to the politicians. They want to react to those people whom they think are going to go vote. If the way health plans contract with providers becomes an issue that will get them votes if they act on it, they will do so. Some of you may have heard or read

about the contracting that was done for a particular plan, the California Public Employees' Retirement System (CalPERS) in California. That's the large public employees' plan. For one of its products, it excluded a large number of hospitals from the network. That was done in an effort to lower trends, save costs and improve the outcomes for the CalPERS benefit program, but there was a lot of political fallout because the hospitals that were left out did not particularly care for that. There are a lot of questions about what will be the eventual fallout. One of the legislative proposals was that a hospital system could no longer contract as a hospital system, and therefore the health plan divide-and-conquer approach would be imposed by government.

Another aspect of contracting that comes up is that when you set up a contract, how do you define the terms? What's in and what's out? We've seen a number of disease management companies struggle with a definition. They were able to get the health plan to agree to the carve-out, and now we're a couple of years down the road and so it's time to measure results, but there are divergent opinions as to what the contract definitions mean when you apply them to the data that have been collected over the contract period. So in your contracting, you need to pay close attention to what definitions are used. Do you and the party with whom you're negotiating have the same understanding of those definitions? If not, you're probably going to spend a lot of unnecessary time at the back end in trying to decide what the settlement should be.

Another area where you get into that struggle in terms is with stop-loss provisions that are often attached to hospital contracts. The terminology of contracts will often impose some kind of a limit on the chargemaster increases that a hospital can impose. When you get to the back end of the contract, somebody has to make a determination as to what has happened with those chargemaster increases versus what was allowed by contract. That's a difficult proposition, primarily because the chargemaster includes so many items, and that is not detail that's normally collected as part of a claims payment system. As a payer, you have little ability to get in there and determine exactly what the hospital did in their chargemaster over a two- or three-year period. If you've got contract terms like that, you need to think about it up front. How are you going to monitor that? One way you can do that perhaps is to put in some key types of patient DRGs or APR-DRGs, whatever it may be, track the charges that go with that particular kind of a patient and use that as a proxy for determining what that increase has been.

There are a lot of aspects to contracts, and one of the suggestions that has been made by the Health Practice Council is that we need to have a more in-depth session on provider contracting. They are wondering about the level of interest in this group in particular, since you were inclined to come to a session about provider contracting, to have an all-day seminar on this issue. If that kind of a session would be attractive to you, can we see by the show of hands?

FROM THE FLOOR: There was one two years ago in Salt Lake City.

MR. HULET: Are there particular issues that you would like to see addressed in that kind of a seminar?

MR. BRIAN G. SMALL: I have a question for the panel with regard to hospital contracting. We have one camp within the plan that likes the idea of per diems because it feels that encourages the medical management staff on the hospitals to get the patients out in a timely basis. Another camp would like to contract on a DRG basis because then medical management doesn't have to fool with that, and it's less antagonistic in hospitals on the risk for the length of stay. On the other hand, if the length of stay goes up, eventually that's going to impact the hospitals, and they're going to want more money. Do you have any thoughts on which is better? Have plans seen the length of stay go way up when they went to a DRG?

MR. AXENE: The survey did say that most everybody was moving away from per diems to a DRG process. I struggle with that because I believe that there's so much that can be done to shorten length of stay. I think that the best answer, as far as I'm concerned, is a little bit of both. Several years ago, we developed a methodology that uses DRG case rate adjustments for a specified length of stay, with per diem outliers after that. That keeps the medical management people in business because it still saves money by shortening length of stay, but what happens is that there is a fair payment for everybody up front, which is the case rate. The typical shorter payment might be for three days of stay, let's say. The problem is that if you use Medicare DRGs, it's based upon the geometric mean length of stay, which is about twice too long, and so there's a serious issue. You have to regauge or recalibrate them.

I think that the best answer depends upon the unique characteristics of the health plan. If you don't have a case management department or a care management department, and if you're planning to get rid of the ones that you do have, obviously you don't want a per diem. Hospitals are so obstinate today that usually you want to give them something that they want through the collaborative style, and they would prefer some type of DRG. Now, they can agree to a DRG without understanding it, and so you can refine that DRG to do better. I will probably come down on the side of a tweaked DRG payment structure as the ideal way to go. It's painful for me to say that because I've been quoted earlier as saying that it should be a per diem.

MR. HULET: I think the hospitals themselves are torn because they'll see a DRG contract and realize that they can do pretty well under that contract if they do some things to improve the efficiency of the care during the stay. As soon as they've done that, the health plan is going to want to put downward pressure on what that increase is going to be, because they see that the hospital is making a lot of money. It seems to fluctuate from period to period, which one the hospital prefers and which one the health plan prefers. It goes back to Dave's moving line—which side are you falling on? Are you trying to be more collaborative, or are you looking

out for your best interest? At this point in time, the money to be made is in the per diem or the money to be made is in the DRG payment.

MR. PETER BURT DAGGETT: I have a question for Catherine and the entire group. You talked about the episode-based contracting initiatives on the physician's side, but for a lot of the episodes, specifically the ones you talked about, a large majority of the costs are in the other areas of health care or in inpatient hospital and length of stay, lab and X-ray. Do you want to talk about any methods to put into the physician's hand, either goals or risk, for managing those other pieces of health care around that same episode of care? At the end of the day, that physician is the center of the world. Have you seen anything like that?

MS. MURPHY-BARRON: The theoretical idea behind the episode of care is to have the care across the whole continuum, including all the services, and to have the physician be at risk for that. Putting that into practice is a little harder, and so I haven't seen much of it in practice yet. There's a lot of thought about how to do that, but so far I haven't seen a good way to do it.

MR. HULET: That gets to the definitional issue again. How do you determine what's in and what's out so that you can measure it? Since there is overlap among physician specialties, it does sometimes cause problems in identifying who should be part of that episode and where you make the payment. Where do you impose the penalty if somebody seems to get overly aggressive in doing tests and things like that?

MR. AXENE: The only place I've seen it effectively implemented is in outpatient surgicenters, where you have physician-owned surgicenters. They're willing to take all the money in one lump sum until the government starts chasing them for their safe-harbor provisions.

MR. GEOFFREY C. SANDLER: When you're talking about hospital contracting, you referred to a collaborative approach, which I think is a great idea. In the New York marketplace, like most things in New York, there's a lot of antagonism on just about everything. Did you get a sense from the health plans to whom you talked that when they embraced a collaborative approach, they traded away a lot, in terms of the best contracting deal that they could have had? Did it cost them a lot to do that? What do they think was the payback?

MR. AXENE: That was one of the questions that I asked. Sometimes "collaborative" is associated with the word "wimp," and I think that wimps sometimes don't get the good deals. I asked them specifically about that, and they presented some information to show that their contracting perspective had improved with a collaborative style. In one of the particular programs on the collaborative style, it tried as a health plan to turn over a new leaf and to become the nice guy because it had been the bad guy with employers. It had been the bad guy as an employer. It had been the bad guy as a provider contractor. It had been a bad guy with the

government. It was trying to turn over a corporate new leaf, and so this overall process was one where the place it was improving from had been so bad that it was easier than normal to show an improvement. But think of a contracting situation where you start the contracting process on June 1 and by the first of August, everybody is signed up. It renews all of its contracts in less than two months.

MR. SANDLER: Doesn't that mean that you left money on the table?

MR. AXENE: I don't know. The profits are higher than they've ever been, and the contracts are competitive. I asked silly questions like, What percent discount are you getting? Knowing some information in particular about that particular market, it had better discounts than I thought were achievable. I know that it sounds counterintuitive.

MR. JIM TOOLE: This question has to do with collaboration and quality. I'm going to draw a little bit outside of the box on my property and casualty (P&C) experience. Within hospitals today, there are a number of systems breakdowns. It has been estimated that there are between 50,000 and 80,000 medical errors a year, leading to deaths and longer care periods, which increase costs significantly, a vast majority of which do not lead to any sort of tort or lawsuit, yet the carriers have to eat the cost. What steps are being taken with the payers to manage, much like the worker's comp and risk management who go through plants to make sure that steps are being properly addressed to minimize risk, that issue in our providers?

MR. AXENE: Unfortunately, my perspective is that there isn't a lot being done other than some isolated efforts in choosing hospitals' four-tiered networks, which have much better performance on medical errors. The Institute of Medicine had a wonderful study that showed that. There are many hospitals instituting initiatives, and to the extent that those hospitals implementing initiatives to reduce medical error can demonstrate reduced medical error, they get Brownie points in the contracting process, and sometimes they get into the best tier in a tiered-networking program because of that. But I think the general industry as a whole isn't paying attention to that.

MR. TOOLE: So why aren't we pushing that?

MR. AXENE: We should be, and I think the astute people are pushing that. But there are other things catching people's attention. The idea of loss prevention that is common in casualty is a foreign concept through most of traditional health care. I've spent most of my life working in managed health care, and in some of the managed care industry it's a common area because we use the illustration of loss prevention on the casualty side, but unfortunately that is not a topic of keen interest. How to get the bigger profit margin is a topic of keen interest, but that other one is sort of tangential, and I don't see a lot of activity on that, unfortunately.

MR. HULET: There's also a question of how proactive a medical management staff or health plan can be on the admissions to a hospital. Often the information they get is after the fact, and so they have their contractual terms to make payment. There are some health plans that have a proactive management staff who are at the hospital on a daily basis checking up on their patients. Those types of programs are going to have a much better chance of catching something that's going wrong than those plans that just wait to get the claim in.

FROM THE FLOOR: Looking at case management is looking at tactical situations. Strategically, you want to look at systems that are in place to prevent the problems from even occurring.

MR. HULET: There are hospital systems that are investing a lot in their information technology so that they can have information on what the right hand is doing that's damaging the left hand and so forth, but I think we're a long way from saying the industry is on top of it. We, as actuaries, should do our part in trying to encourage those with whom we work, whether they be the providers or the health plans, to invest in technology that can help them do that, because the injury to patients that add more dollars to our system is just tremendous. We had a discussion about some of those issues in the session prior to this on the national health-care expenditures. As they try to identify what the long-term trend in medical cost is likely to be as compared to the gross domestic product (GDP), the question comes about, What is in our system right now that we will be able to get rid of? Some of those things they claim we'll be able to minimize over the next 75 years, and that's great news, but should it take us 75 years, or should we be able to do it in the next five to 10 years? That's a struggle that we all will see, regardless of who our employer is, because if it doesn't affect us directly as a health plan, it affects us as a purchaser of health care in our premium rates.

MR. VINCENT HERR: David, you mentioned third parties without contractual relationship to the provider or the carrier, including the uninsured. I assume that you're also talking about smaller insurance companies that don't have the contracting clout to receive the type of discounts that larger carriers are negotiating. In the last month, there was a front-page *Wall Street Journal* article on hospital contracting. It mentioned that one of the perhaps odd consequences of this type of pricing structure is that sometimes hospitals use the bills for uninsured and other parties reflecting higher gross pricing to enlarge the value of whatever charity services they might be providing and perhaps the resulting tax benefits of that or other incidental community benefits they might receive from showing those kinds of contributions. What kind of increasing influence do you expect to see from third parties, such as other insurance companies, or maybe where they're aligned with uninsured interests, in reflecting more average or realistic, if you will, charges on hospital bills that don't have a relationship to large carrier contracts? What kind of trend do you see going in that direction, and are those going to be significant?

MR. AXENE: First of all, I think most everybody has some kind of a contract. There are small carriers that don't, and I think that the ease by which you can get a discount is often worth at least negotiating at time of claim to try and get a discount. I don't see the noncontracting entities as being a material part of the health-care system, because they can't afford to stay in business without some kind of a discount. I heard a recent argument that the reason that health costs are so high is that the health plans have negotiated such deep discounts that they have to make it up on the uninsured. I thought that was an interesting concept. I thought that most of the uninsured don't have to pay for their bills, under the Hill-Burton Act, and so the reason the rest of us have to pay so much is to make up for the uninsureds.

MR. HULET: It has been interesting to look at hospital results in different markets. When you look at what portion of their average cost is covered by Medicaid, Medicare or private payers, it varies from one marketplace to another. There are some marketplaces where the hospitals do well with Medicare reimbursement. There are other marketplaces where they don't come close to covering their costs. Since the hospitals have to keep enough revenue coming in to cover their ongoing costs and hopefully make a little bit of return on their dollar, they have to try to balance the equation. They can't do much about what they get out of Medicare and Medicaid, and those are large payers for many hospitals. So they have to look to the private market. As Dave says, you're not going to get many dollars from the uninsureds. They have to balance that with what they're charging for health plans.

If you're a health plan, I'd encourage you to look at your data and try to assess the relative payments you make as compared to what Medicare and Medicaid pay. If it appears that you're carrying the load because of how it's priced in your marketplace, you become proactive in a political arena to try to get increased reimbursement through those government programs so that you in your private sector business don't have to pay as much to those hospitals. Ultimately the hospital has to look at it as a closed equation. They have revenue coming in from a number of sources, and they have to somehow balance that to cover their expenses. Since the only place that the balloon can expand when it's pushed by those government entities is in the private sector, I'd encourage you to look in that area if you haven't done so because there may be some things, particularly on Medicaid, where you can get some movement of the local government in those payments.

MR. WILLIAM JU: This question is for Dave. You mentioned that when the staffs were paid more incentives or higher bonuses, that resulted in better contracting. Do you have any details to elaborate on what kind of extra things they did that resulted in the better contracting?

MR. AXENE: Once the staff was financially motivated to do a better job, they did a better job. In other words, the incentive had to be big enough, first of all, for them to change their behavior. The kinds of things that they were doing included being

more aggressive in negotiating and being more thorough in their preparation. It was an all-around quality improvement of what they did. Each of these organizations had set some criteria as to where they had been performing so they could measure improvement from their previous state, but there was no specific action that they were doing, other than doing their job better.