BEWARE THE MEDICAL COST MANAGEMENT ZOMBIES

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EXL Digital Intelligence center

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It’s no wonder why most healthcare plans are in a state of shock. For years, they’ve functioned in a service-based environment, managing a predictable number of members using same platforms that they’ve used for decades.

All of a sudden, they take on 20 million new, previously uninsured members, have to move providers from a service-based to a value-based reimbursement model, and are attempting to manage it all on legacy systems that simply weren’t designed to do anything they need them to do now – resulting in losses of hundreds of millions of dollars. Replacing the system is not only a billion-dollar proposition, but potentially disruptive to an environment that’s already less-than-stable, at best.

This creates a financial horror story that isn’t limited to commercial or managed care plan providers. Pharmacy, disability and workers’ compensation plans are also being bled dry.

To find a way to rein in expenses using the systems and assets they already have, organization leaders are turning to medical cost management programs to stop the bleeding. However, many quickly discover that all self-proclaimed cost management experts aren’t always what they seem. The industry is now overrun by zombies: consultants awakened from the dead by an escalating market need.

These consultants aren’t interested in eating people, but can drain budgets without ever relieving the organizations’ pains. Their approaches are typically either too clinically focused, or too business focused – not both, for the organization as a whole. In the end, clients are typically left with a large paper document outlining useless next steps, with no plausible means of execution. As a result, very little, or nothing changes.

To achieve the desired results, risk-bearing entities for managed care, disability, workers’ compensation and long-term care need an integrated approach to medical cost management—one employing a combination of analytics, technology, and living, breathing healthcare professionals to put the program in motion.

This paper discusses the elements of an integrated cost management program, why it works for any line of business where health outcomes matter, and how to choose the right partner to maximize results.

How Medical Cost Management Solutions Remedy the Underlying Cause of Pain

The overarching goal of comprehensive medical cost management is simple: identify areas where changes can reduce the cost of claims, improve processes and increase efficiencies.

“Healthcare plan leadership not only can see why their costs have continued to rise, but review specific strategies for cost reduction.”
To drive better outcomes, the engagement should involve:

- Analyzing the current state to identify opportunities to reduce excess cost. This analysis includes mining data from claims, studying provider and hospital patterns, as well as evaluating site-of-care orders for drug administration, surgeries and patient observation. In addition, it’s critical to also review a plan’s current member management process.

- Identifying and segmenting physicians, specialists and hospitals associated with higher-than-average claim costs. These targets could include individuals and organizations associated with excessive testing, high admission rates, non-generic prescribing habits or other behaviors that add to the overall cost of care.

- Pinpointing manual or inefficient processes that could benefit from robotics automation or some other streamlining measure.

Data gathering and analysis are followed by the creation of a detailed implementation plan, prioritizing actions that bring the greatest, quickest returns. Healthcare plan leadership not only can see why their costs have continued to rise, but review specific strategies for cost reduction.

Of course, the implementation plan has little value if the organization doesn’t have the personnel to execute it—and most don’t. So, it’s critical to partner with a provider who has an expansive, geographically dispersed team of skilled clinicians and analysts to augment the existing staff and take the plan through completion. The best strategic partner can combine business and clinical insights—enabled by analytics—to complement its clients’ strengths.

In some cases, that means deploying RNs for physician or patient outreach, hospital visits or other tactics. For others, it’s re-engineering internal processes. Once the initial outcomes are reached, specific performance management tools, provider appointment trackers, feedback mechanisms, and roadmaps can be transitioned to the internal organization to ensure ongoing progress.

The idea is to identify all the areas where the plan has opportunity for improvement, and apply best practices, technology and outreach to rapidly achieve these targeted savings at the lowest cost possible to the plan.

**The Best Candidates for Medical Cost Management Programs**

Although any organization could potentially benefit from a comprehensive program, companies that fall short of national benchmarks have the greatest need—and the most to gain.

Good candidates for medical cost management include:

- Healthcare payers with medical cost spend greater than 85%.
- Healthcare payers with commercial inpatient admissions greater than the benchmark set by the Health Care Cost Institute of 54 admissions per 1,000 members.
- Healthcare payers with Medicare Advantage plans with Star ratings of 4.0 or below.
• Disability and workers’ compensation plans with median allocated loss adjustment expense above 10%.
• Any health-related plan not consistently hitting their target profit levels.

Treating the Most Common Cost Drains

Although a number of factors can negatively impact plan costs, these are some of the most common offenders:

“More is Better” Provider Mentalities

Healthcare reform not only added 20 million people to the insurance ecosystem, but fundamentally shifted a traditionally service-based system of care to value-based. Yet, some providers and specialists continue trying to maintain the status quo.

If a patient presents with certain symptoms, the provider might order multiple tests simultaneously, instead of starting with one that could potentially diagnose the condition on its own. Or, they may refer a patient to a specialist who takes an additional X-ray or MRI. All of these factors drive up costs without positively impacting the quality of patient care.

Chronic ER Overuse

Even though existing reforms sought to reduce the number of people using emergency rooms as their primary care surrogate, ERs are still packed with very non-emergency-need patients.

According to a research brief issued by the New England Healthcare Institute, the overuse of emergency rooms is responsible for up to $38 billion in wasteful spending in the United States every year. The Institute estimated that avoidable visits to emergency rooms range as high as 56% of all visits.1 The problem is pervasive.

In many cases, the primary care provider is the catalyst. If a patient calls a physician’s office after hours, or with a symptom that could have either a critical or routine cause like abdominal pain, he or she is typically directed to “call 911 or go to the nearest emergency room” for treatment.

In a study of emergency department use by patients with medical insurance, the California HealthCare Foundation found that 46% of the problems could have been handled by a primary care physician, but two-thirds of the patients said they’d been unable to get care outside of the emergency room.2 Many simply couldn’t get a timely appointment with their primary care physician or specialist, so off to the ER they went.

In other cases, the ER itself is the catalyst, by waving co-pays for those patients who can’t afford to pay them. This makes the ER visit less expensive than a visit to see a primary care physician, so the patient may choose to continue taking the lower-cost route to care.

Unnecessary Hospital Admissions

Many of these ER visits result in unnecessary hospital admissions, another contributor to the increasing cost of care. The benchmark for hospital admissions is 5.4% of the plan population per year, with a goal of no more than 54 annual hospital stays for every 1,000 members. Considering the fact that each unnecessary admission
Reality Check: A Medical Cost Management Case Study

Of course, concepts are one thing. The real proof comes from practical application of medical cost management in the real world. This is one health plan provider’s story.

**THE SUBJECT:** A small, 190,000-member regional health plan provider located in the Northeastern United States.

**PROBLEM:** The organization was losing money year-after-year, and had to find a way to stop the bleeding.

The Comprehensive Cost Management Solution plan of attack:

1. **IDENTIFY THE PROBLEMS**

   After conducting an in-depth claims analysis, EXL identified the following areas of concern:
   - Hospitalization rates topped 69 per 1,000 members annually, sending inpatient claims costs soaring.
   - J-code costs were far above national benchmarks.
   - There were significant discrepancies in medication costs, even when the drug came from the same manufacturer.
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2. **PINPOINT THE CAUSE OF THE PROBLEMS/AREAS OF OPPORTUNITY**

   The team then analyzed hospital patterns and provider patterns to identify areas of waste, including:
   - Unnecessary admittances.
   - Site-of-care issues: drugs infused in a hospital that could be administered at a doctor’s office or through home health care.
   - Drug cost discrepancies.
   - The prescribing physicians associated with excess spend were identified, with this list segmented by practice type, size and location.
   - Drugs with cost discrepancies, and their manufacturers, were identified.

3. **DEVELOP AND EXECUTE A TARGETED IMPLEMENTATION PLAN**

   Using the collected data, an implementation plan was created, prioritizing the areas where proposed changes could bring the greatest returns. This execution included an aggressive provider engagement strategy, with a team of RNs physically visiting targeted physicians to drive behavioral change. These skilled clinical professions excel at working with providers, and explaining how they can increase their own incomes by shifting mindsets—and actions—to align with a value-based payment model. Providers were highly receptive and willing to make changes because the team brought actual metrics, and the conversation centered on behavioral changes that benefit the provider, the member, as well as the plan.

   In addition, the team reviewed drug contracts and worked with the internal staff to recommend renegotiating these, ensuring pricing equity.

4. **MEASURE RESULTS**

   Within 30 days, the plan started seeing a reduction of claim costs from the targeted physicians. Although the execution process is ongoing at the time of this paper’s publication, initial results indicate the plan is expected to reduce 2.8% of admits versus full baseline overall; and 6.4% reduction versus baseline excluding maternity and all planned admits. Just as important, it now has the tools and processes for more effective population management in place.
This list includes just a fraction of the issues that could negatively impact plans. High administrative costs, as well as ineffective population management are also common issues among health plans, workers compensation and disability plans alike.

The key is identifying the budget zappers and devising a comprehensive solution to bring about behavioral and operational change.

Beyond the Basics: Pulling Every Lever Possible to Decrease Risk and Reduce Cost

As complex as the world of healthcare has become, it follows that there’s no one panacea; no single change that will trigger a transformation. So, it’s critical for plan leaders to partner with a provider that has the capacity to pull all of the levers, providing a broad scope of interoperable services beyond the initial medical cost management engagement.

• These should include:
• Platform expertise
• Clinical cost management
• Data scrubbing and analysis

comes with an average $10,000 pricetag, it’s easy to see how even a relatively small reduction in admissions can have a big impact on annual cost.

Misdiagnosis
As patient loads increase, the time doctors spend with each patient shrinks proportionally. Speedy consults increase the likelihood of incorrect diagnoses, a trend impacting patient care and healthcare costs alike. It’s estimated that one out of every 20 adults who visit the ER are misdiagnosed, with half of these being harmful misdiagnoses.3 Fragmented care, such as a patient visiting the emergency room (and an unknown doctor) instead of his or her primary care physician, increases the odds a misdiagnosis will occur.

In all cases of misdiagnosis, the patient receives unnecessary treatment for a condition he or she does not have.

Site of Drug Administration Issues
As drugs advance, so do their methods of administration. Identifying medications currently administered at a hospital that could be safely infused at a doctor’s office, infusion site or with assistance from Home Infusion Services can have a dramatic impact on pharmacy plan budgets. Moving the site of care can significantly decrease the cost of care.
• Robotics automation
• Population health solutions
• Revenue cycle management
• Customer experience support
• Methodologies for closing gaps in care

Instead of looking at an isolated number of symptoms, find a provider with the capacity to take a comprehensive look at the entire organization and the expertise to affect change in all of those areas.

Positioning for the Future—Whatever Form It Takes

Although no one can predict what the next wave of changes will bring, this much is clear: the most successful healthcare organizations will be the ones that vigilantly reduce administrative costs, claims costs and increase operating efficiency.

At EXL, we are uniquely positioned to help organizations enable successful change. We are an operations and analytics company, with a team of data analysts, consultants, business process engineers and clinicians with deep experience in the healthcare space. Our methodology is unique, integrated and interoperable; closing care gaps while improving efficiencies; changing behaviors while eliminating administrative waste. We have a proven track record of improving performance and lowering cost for managed care, workers compensation, disability, long-term care and pharmacy programs--and the industry has noticed.

We’ve been recognized by industry analysts, financial analysts and clients alike, and named one of “America’s Most Trustworthy Companies” by Forbes magazine. Most importantly, we have the framework, the tools, the human beings and the brainpower to help plan providers adapt to a changing industry and get rid of the financial drains.

References
EXL (NASDAQ: EXLS) is a leading operations management and analytics company that designs and enables agile, customer-centric operating models to help clients improve their revenue growth and profitability. Our delivery model provides market-leading business outcomes using EXL’s proprietary Business EXLerator® Framework, cutting-edge analytics, digital transformation and domain expertise. At EXL, we look deeper to help companies improve global operations, enhance data-driven insights, increase customer satisfaction, and manage risk and compliance. EXL serves the insurance, healthcare, banking and financial services, utilities, travel, transportation and logistics industries. Headquartered in New York, New York, EXL has more than 27,000 professionals in locations throughout the United States, Europe, Asia (primarily India and Philippines), South America, Australia and South Africa.

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