

By John F. Brehm

**Effective management of catastrophic health care costs requires getting all the information available and getting it fast.**

**E**ARLY NOTIFICATION is the most critical component in managing potential catastrophic health care events. Almost all self-insured plans employ a utilization management vendor that accesses health care services and treatment and assures the consumer that the services provided are both necessary and appropriate. Most significant procedures, including hospital stays, surgeries, and obstetrical care, require pre-certification. However, that claim information almost never gets to those managing the risk in time to affect both the clinical and financial outcomes.

There's an unmet need among managing general underwriters (MGUs) and reinsurance carriers to effectively control the escalating cost of their medical stop loss programs.

Medical stop-loss carriers insure groups against financial losses arising from catastrophic health care events affecting individual members or their families. The insurer pays a claim once the contracted dollar level or deductible is reached. Organ and tissue transplants, severe injuries and burns, medically compromised neonates, cardiology, neurological disorders, immune deficiency disorders, and oncology cases generate most of the high-dollar expenses that require the reinsurer to reimburse its client.

If the cost of health care continues to outpace inflation, the overall impact on American business may itself become catastrophic. Many employers find their employee benefits program to be their third highest expense, following payroll and the cost of facilities. Yet, stop-loss risk-takers aren't in a position to influence the medical expenses their participants incur.

Rather than solving the problems, traditional organizations (TPAs, utilization management vendors, and case management firms) are creating them. The MGU or carrier is notified of a

# SPECIALIZED MEDICAL MANAGEMENT NEEDS EARLY INTERVENTION

catastrophic claim almost always after a course of treatment has been undertaken, and often after the majority or all of the expenses have been incurred. Once a claim has made it to paper and a course of treatment has been undertaken, reinsurers have no option but to adjudicate and pay the claim. Without information, the reinsurer can neither intervene clinically nor negotiate ad hoc with affected parties. The reinsurer loses the ability to manage the clinical care, or to mitigate its financial loss.

## Current Market Condition

Most reinsurance programs have risk management elements that contain two major flaws:

- Not enough early intervention in catastrophic cases (resulting in little or no coordination of care, delayed treatment, loss of time in treatment, excess expenses, etc.);
- Lack of clout in securing preferred payment arrangements with catastrophic care specialists in advance.

The medical continuum in our health care system is characterized by three distinct categories:

- *High frequency, low dollar.* Referred to as "disease and demand management." There is a current trend in our market to intervene and to intensively manage many chronic diseases, such as asthma, diabetes, chronic obstructive pulmonary disease, hypertension, and cardiac diseases to increase patient compliance and avert the cost of future acute medical care.
- *Medium frequency, medium cost.* This normally involves hos-



### The Real Value of Utilization Management

Traditional utilization management (UM) has served a distinct purpose and has influenced treatment patterns and costs. In addition, UM firms have reacted to cost shifting by adding utilization review for outpatient surgeries; skilled nursing facility advisers select outpatient procedures (CAT scans, MRIs, diagnostic procedures); durable medical equipment; physical, occupational, and speech therapy; and home infusion.

Currently, this industry adds little more value than deterring medical providers from reverting to their old practice patterns. The medical protocol has been established. The anticipated outcomes and care plans are published. The providers' fear of malpractice claims dictates that medical protocol guidelines are followed. Further, the UM firms are fearful of denying care, so they rarely do. Therefore, the value (and the role) of UM vendors has changed. Unfortunately, few UM firms have recognized this, and as long as this remains a "cash cow" industry, there will be little change.

pitalization, surgeries, and the like, in which utilization and case management play an important role. Existing medical management programs have historically been successful in managing the costs of medium-frequency medical events. Best practices criteria developed using empirical, quantifiable data have standardized treatment protocols and made their associated costs predictable.

■ *Low frequency, high cost.* Catastrophic injuries and diseases are rare and require specialized treatment. You never know when they'll hit or how much they'll cost. These are the most difficult type of medical claims to predict, control, and manage.

There are widespread discrepancies that make predictability of costs very difficult. A lack of accepted guidelines on the best way to treat catastrophic patients has led to extreme variation in treatment plans. To a large extent, this is caused by a lack of data for the treatment of catastrophic patients and a lack of collaboration among carriers, providers, patients, and families.

Compounding these factors are the low frequencies and significant clinical complexities associated with catastrophic care. This makes it difficult for any individual hospital to acquire the specialized resources, sophisticated data, and management systems to effectively manage catastrophic cases. Even if the hospital does have a catastrophic specialty, it's typically limited to one area, and the same problem develops if the injury is outside the facility's area of expertise. This creates a circumstance of reactive rather than proactive management of a catastrophic medical event.

### Why Case Managers Fall Short

The nursing shortage is real. This is not created because all the "best" critical care nurses have left practice to assume case manager roles within the managed care industry. Quite the contrary, a great majority of RNs providing case management services aren't qualified, and are absolutely unprepared to affect the financial outcome of a complex claim.

Intensive case management includes:

- Facilitating communication among a multi-disciplinary team of practitioners and the patient;
- Monitoring patient response to treatment and making recommendations for alternate levels of care as indicated;
- Facilitation back into the network when the patient is stable;
- Coordinating community services and entitlement programs to both the patient's and the insurer's benefit. Case managers often define themselves as advocates, facilitators, and educators for the patient.

But generalist case management is often less effective for catastrophic cases. Catastrophic cases are relatively rare and require a massive amount of specialized expertise. Windows of opportunity for intervention can close permanently with lasting consequences. These are highly volatile, life-and-death situations.

Yet experience indicates that, most often, case managers don't understand the financial implications of the cases they work and the decisions they make. They're more comfortable func-

tioning as an advocate for the patient and provider, rather than taking risks.

### Opportunity for Stop-Loss Insurers

Obtaining information about potential large claims as soon as possible after diagnosis gives the carrier or MGU the chance to influence care and mitigate the financial loss. Unfortunately, most of the TPAs and provider groups with whom reinsurers contract have less than effective administrative capacity to identify catastrophic claims. This poor administration arises from a myriad of sources; either poor communication between the client's risk manager and its operations staff, poorly integrated information systems, or constant change in administrative personnel. Of course, the risk-taker isn't included in the communication link between the TPA, employer, and UR vendor.

To really make a difference, a stop-loss insurer or its vendor must obtain the required data electronically from the UR firm to assure that timely notification occurs. Notification by any other means will lack consistency and allow for missed opportunities.

### The Solution

Successful implementation of an "Early Warning System" (EWS) would begin to solve three of the biggest challenges to early identification:

- Disparate and unconnected sources of case management data;
- Pre-existing relationships between TPAs and UR vendors;
- MGUs' isolation from the actual source of patient care.

Reinsurers now realize that industry-standard TPA referral incentives such as referral fees, step-down deductibles, and plan changes (even when mandated by plan provisions) are difficult to administer and still ineffective in overcoming these challenges.

An effective EWS solves these challenges in two ways. First, it establishes a seamless electronic link to the UR vendors who possess the necessary data, who should find out first, and who should have the most up-to-date status on each case. This creates a continuous data flow that doesn't intrude on the UR vendors (or the TPAs), doesn't require any change in administrative process, and doesn't require any human interaction or maintenance once the IS link is established. The continuous electronic process also assures that the most up-to-date data is always available.

Second, an effective EWS can accept all data that can be provided by the UR vendors in whatever format they can provide it, move the data to a common platform, and retain it for analysis. This creates one comprehensive data source that's much more valuable than multiple data sets that contain different data elements in different formats.

Obtaining the information is the critical first step. But what an organization does with it will determine success or failure. Constructed properly, this information infrastructure would save significant dollars by identifying potential catastrophic candidates, and provide the opportunity for centers-of-excellence referrals, risk "carve out" opportunities, direct hospital contracting, out-of-network negotiations, and disease management referrals, *while there is still time to influence the financial implications of each case.*

### Going Against the Grain

In order for this approach to "early intervention" to be successful, it must be mandated by the stop-loss carrier. All distribution sources (TPAs) must require their appropriate vendors of choice to electronically transfer precertification and pharmacy utilization data for each active group to the carrier (or vendor, as agent) in order to have the privilege to receive quotes.

In addition, the carrier has options to endorse, mandate, and/or subsidize certain UM, case management, disease management, demand management, and pharmacy vendors as a reward for compliance. Requiring a plan amendment for utilization of a "center of excellence" transplant program is also an option. Including "wrap networks," repricing services, and catastrophic carve-out programs provide the icing on the cake.

Right now, "early intervention" is a misnomer. But a dedicated, straightforward commitment to this concept can change that, and produce results beyond expectation. ●

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