What Does It Cost Physician Practices to Interact With Payors?

Lawrence P. Casalino, MD, Ph.D.
Weill Cornell Medical College

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Colleagues:

- Sean Nicholson, Cornell University
- David Gans, Medical Group Management Association (MGMA)
- Terry Hammons, MGMA
- Dante Morra, University of Toronto
- Theodore Karrison, University of Chicago
- Wendy Levinson, University of Toronto

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Profile of the issue…

- U.S. providers (physicians, hospitals, nursing homes . . .) deal with multiple payors
- and with multiple forms of interaction with payors:
  - prior authorization
  - formularies
  - billing/claims
  - credentialing
  - submission of quality data and review of quality reports
  - negotiating contracts

Questions to be addressed:

- What is the cost of these interactions for physician practices?
- How much of this cost is excess/waste?

Our method

- U.S. mail survey with 895 respondents
  - 668 MDs
  - 227 medical practice administrators
  - response rate = 58%
- Ontario, Canada mail survey with 216 respondents (analyses still under way)
  - 171 MDs
  - 45 practice administrators
  - response rate = 78%
- stratified random samples

Casalino, et.al, "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive 5/14/09

Annual cost to U.S. physicians of interacting with payors (2009 dollars)

	Interacting with health plans		Interacting with health plans + billing traditional Medicare/Medicaid; obtaining patient appointments	
	Per Physician	National (billions of dollars)	Per Physician	National (billions of dollars)
Mean	$72,036	$33.2	$88,855	$40.8
Median	$53,856	$24.9	~$66,641	~$30.6

U.S. details

- average physician spends nearly three full work-weeks a year interacting with plans
- primary care physicians spend more time than specialists
  - (no difference by specialty for staff)
- physicians in small practices spend more time than those in larger practices
- most MD time spent on formularies and authorizations
- most RN time spent on authorizations

Are costs of interacting with health plans increasing or decreasing?

- On a five point scale, from “decreased a lot” to “increased a lot” over the past two years, physicians and administrators responded:
  - increased a lot: 41.4%
  - somewhat increased: 36.4%
  - Total: 77.8%

U.S. hours per physician per week

(includes billing Medicare / Medicaid and time seeking timely patient appointments)

	Authorizations	Formularies	Claims/ billing	Credentialing	Contracting	Quality Data; external	Appts	Total
Physician	1.0	1.3	0.8	0.06	0.05	0.04	0.5	3.8
Nursing staff	13.1	3.6	3.2	0.02	0	0.01	1.5	21.4
Clerical staff	6.3	0	38.8	2.03	0	0.14	0	47.3
Senior admin	0	0	3.0	0.01	0.13	0.07	0	3.2
Lawyer/ accountant	0	0	0	0	0.15	0	0	0.15

How can “excess” costs be quantified?

- some forms of interaction are inherently inefficient/wasteful
- compare efficient vs. inefficient health plan processes
  - e.g. on-line vs. telephone prior authorization
- compare efficient vs. inefficient medical groups
  - e.g. capacity to interact with health plan on-line
  - but would need to control for many factors - e.g. mix of health plans with which the group contracts
- compare U.S. vs. single payor system (e.g. Canada)

Leader of a small practice

"There is a lack of standardization in dealing with health plans. It's like going to the gas station to gas up your car and having to change the nozzle on the gas pump because you have a Toyota and the pump was made to fit Fords."

Inherently wasteful interactions

- multiple formularies that have conflicting authorized medications due purely to health plan-pharmaceutical company negotiations
- credentialing by each health plan rather than by a centralized organization
- multiple different electronic interfaces with health plans

Preliminary **analysis of U.S. vs. Canada (Ontario) physician practice cost of dealing with payors suggests:**

Canadian costs are much less than half U.S. costs.

*adjusted for Canada-U.S. dollar exchange rate and for lower dollar values for time of Canadian physicians and non-physician staff

Scale of excess costs…

- IF take Canada as the gold standard, then "excess" U.S. costs of physician practice interactions with health plans

  = 50%-60% of $25-$33 billion

  = $12.5 to $19.8 billion annually

  This is ≥ estimated cost of preventable Medicare readmissions.

Primary sources of excess costs (based on interviews)*

Most expensive:

- lack of standardization across plans
- dealing with denied or downcoded claims

Also significant:

- requiring prior authorization from efficient physicians

See quotes in slides at end of presentation.

- We conducted phone interviews with a national convenience sample of 11 health plan executives and 14 medical group leaders.

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Potential ways to reduce costs

- no prior authorization for efficient, high quality physicians/practices
- single credentialing organization (e.g. CAQH)
- standardize coverage, eligibility, and co-pay electronic certification, ideally through a single portal across health plans
- standardize payment structures (though not rates) and claims editing (e.g. the Clean Claims Initiative (CCI) of CMS defines standard claims editing protocols

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More potential cost reductions…

- employers have health plans customize their benefits → increases complexity and costs for plans and providers
- health savings accounts increase complexity
- Healthcare Administrative Simplification Coalition

Another way to estimate excess costs:

- assume:
  - single formulary
  - single standardized set of prior authorization requirements
  - standardized claims submission requirements and claims editing
  - electronic interchange for these interactions through single portal, single centralized credentialing
- assume these changes yield:
  - 60% savings for formulary and prior authorization
  - 60% savings for claims/billing
  - 80% savings for credentialing
  - electronic interchange savings is included in above estimates

Another way to estimate excess costs:

- $ 6.7 billion = savings from single prior authorization set of requirements
- $ 2.9 billion = savings from a single formulary
- $ 7.8 billion = savings from standardizing claims submission and editing
- $ 0.6 billion = savings from centralized single credentialing

- **$18.0 billion = potential total annual savings = annual cost of Medicare readmissions**

Single electronic interface for multiple health plans for these transactions is included in above estimates.

Principal assumptions underlying these estimates

- Canadian system is the “gold standard” (first estimate)
- Higher costs of interacting with health plans in the U.S. are entirely waste (first estimate) or system can be simplified without losing benefits (second estimate)
- Physicians and administrators accurately report time spent on interactions
  - large standard deviations
  - but results are internally consistent across specialties, practice sizes, types of staff, and types of interaction, and
  - results are similar to other, more limited studies, insofar as can compare
- Survey respondents are representative of U.S. physicians in office-based practice

Caveats…

- median time and dollar numbers are ~25% lower, on average

- savings estimates are guesstimates (though informed by interviews and by Canadian data)

More caveats

- cost estimates do not account for:
  - costs for hospital-employed physicians, residents, or fellows
  - health plan costs of interacting with MDs
  - hospitals' costs of interacting with health plans
  - costs of interaction-related equipment, supplies, telephone, fax, office space
  - time spent interacting with health plans by physicians not in office-based practice
  - time spent interacting with health plans by nurse practitioners and physician assistants
- time spent obtaining appointments for patients is not really a cost of interacting with payors

Are all costs of interacting with health plans a form of waste?

- No - to the extent that they produce benefits.

- Yes:
  - to the extent that they do not produce benefits or
  - to the extent that the benefits could be generated at lower cost.

Potential benefits of physician practice interactions with multiple health plans

- prior authorization and formularies may decrease inappropriate utilization
- multiple payors/products complicate billing but may increase consumer choice
- negotiating contracts may lead to lower payment rates to physicians
- competition among multiple health plans may lead to innovation

“Appendix”

- some quotes from health plan executives and medical group leaders (small and large groups)

"We are a 70 physician group; we have 66 full-time employees working on claims. We have to resubmit 30-40% of claims to health plans. Eventually 90% are paid, but it takes up to five or six months."

- Recently, I saw a patient who had a flu shot in January (because the vaccine was not available until then) and received another (for this year) a few weeks ago (late November). The health plan is refusing to pay, claiming that this is two flu shots in one year.

A Health Plan Executive:

- "All plans should use the same code-editing logic without adding proprietary twists."

Another health plan executive

"Payors adopt an external proxy – e.g. the Medicare payment structure and the Mckesson bundling logic, but then each payor adds its own proprietary stuff, plus things are negotiated differently with different medical groups. It would be better if all payors just adopted an external proxy and didn't add proprietary modifications. All payors would use the same payment structure, though the rates they pay would vary. Everyone thinks that they are getting some competitive advantages by tacking on proprietary edits, but I am not sure that that is the case, and it drives physicians nuts."

Another health plan executive

"Health plans need to provide the physician with all of the information he needs electronically and real time at the point of care. Ideally, MD office would swipe the health plan card, the claim would be auto-adjudicated, and the practice could figure out the correct co-pay to collect. In practice, this doesn't happen. For example, employers don't always provide updated eligibility information on employees."

A health plan executive

‘Dealing with claims could be made less costly to physicians with no loss of benefit to anyone if all plans would use the same clinical audit software (e.g., all use Medicare CCI edits), instead of different ones (e.g., Claim Check) that have different edits; not only do the several products differ but the plan can customize them which leads to further variation. For this to happen would probably require government action, though it might happen if plans in an area could get together and decide to standardize the claims edit process.”

A health plan executive

"More standardization of state regulations would help – e.g. re benefits and re handling of claims."