

You CAN Master Managed Care – Just Pretend It's Medicare!

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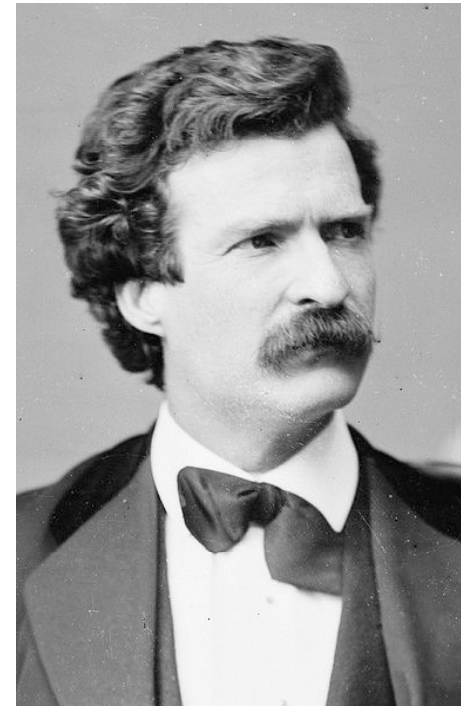
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To Begin...

- **Welcome**
 - Statistics: Mark Twain
 - “Payor Creativity”: Not a “given”



To Begin...

- **Our Goals**

- Review Medicare's changes in the context of managed care
 - Quality Initiatives
 - RAC
 - POA/HAC
 - Outpatient Reimbursement
- Outline how these will make the provider's job more difficult
- Suggest ways to maintain appropriate levels of reimbursement



THE EMERGING SCENARIO



An Overview

- **What will we cover?**
 - The changing face of Medicare
 - The impact of all that change outside the Medicare system
 - Preparing for reduced payments and less bargaining power
 - How to prevail over the new challenges from managed care as that industry segment gains strength



A Review of Medicare - IP

- **MS-DRGs in 2008**
 - No significant changes in 2009 or 2010
- **Present On Admission**
 - Hospital Acquired Conditions
 - Never Events

A Review of Medicare - OP

- **2009**

- Expand “packages”: APCs 8000 - 8008
- Status Indicator Q → Q1, Q2 and Q3
- Status Indicators R (blood) and U (brachytherapy seeds)

- **2010**

- Minor revisions to Partial Hospitalization
- Outlier threshold
- Rumbblings of HAC

A Review of Medicare - Other

- **RAC**
- **Quality Reporting Initiatives (IP and OP)**
 - Expanded list for hospitals; sure to grow
 - 2009: OP 2% penalty for non-reporting in 2008
 - Physician response has been less than hoped
 - www.hospitalcompare.hhs.gov

Changes to Come...

- **Expansion and marketing of Medicare Advantage**
 - Enrollment more than doubled in 2006-2008
- **Demonstration projects: Proof of concept**
 - Hospital Quality Incentive Demonstration (HQID)
 - Physician Group Practice (PGP)
 - Nursing Home Value-Based Purchasing Demo
 - Medicare Hospital Gainsharing Demo
 - Physician Hospital Collaboration



Changes to Come...

- **Bundling extending to non-imaging and non-surgical procedures**
- **Decreased interest in “budget neutral” rate changes; seeking reductions**



Changes to Come...

- **Expansion of charge reporting**
 - “Transparent pricing” – response to public
 - “Point-of-sale” pricing for patients
- **Increase tax on lab payments**
- **Ongoing Revision of Medicare Advantage**



WHAT THIS MEANS TO PROVIDERS



Reduced Payments

- **Providers that are dependent on Medicare will see that revenue decline**
- **Determine and plan for the financial impact of these changes**
 - Both revenue and costs
 - Modeling
 - Cost accounting beyond mere cost-to-charge

Reduced Payments

- **Two key points**
 - The only meaningful strategy: *Know more than the payors*
 - SPREADSHEETS ARE NOT THE ANSWER!

Reduced Payments

- **Competition for patients could shift focus down to the individual beneficiary**
 - CMS does restrict “direct marketing,” but...
 - Why should we presume that will always be true?
- **Medicare Advantage Plans will have more discretion going forward**
 - “Fee for Service” plans will complete the circle of Managed Medicare

Weaker Bargaining Position

- **And...providers that are less dependent on Medicare will struggle as...**
 - Managed care's strength at the bargaining table increases far beyond what's presently typical
 - Because most of the large plans own Medicare Advantage Plans, or
 - Price their own products by Medicare's rules
 - ASC?

Weaker Bargaining Position

- **And what is “profitability”?**
 - Net Revenue – Costs = Profit (“A rose by any other name would smell as sweet.”)
 - Must be on both “total book” and on marginal”
 - Must include fixed/variable, direct/ indirect
 - Allocations from non-revenue centers must be logical and defensible
 - Step-down (Medicare)
 - Reciprocal

Weaker Bargaining Position

- **The provider's advantage**
 - Your info may be no more complete than theirs, but
 - It's more current
- **Don't underestimate the "marginal unit," but...**
 - Remember that the "margin" is only true for one year

Weaker Bargaining Position

- **Consumer activism and government mandate will require full disclosure of prices, payments and quality indicators**
 - Prices: Set with a knowledge of the market and your costs
 - Payments: Accurate and predictable
 - Quality Indicators: Already being posted on the Web; Sure to be expanded

Weaker Bargaining Position



Consumers will have more information at their fingertips than most professionals have now, with all the resources presently available to most of us.

WHAT PROVIDERS SHOULD DO

Contract Negotiation Strategies

- **Medicare Advantage Plans (MAPs) often capture rates less than 100% of Medicare rates**
 - A range of 95-97% of Medicare is common
- **Target in negotiations is to get as close to 100% as possible**
 - You do not need 150% of Medicare to be profitable
 - Consider the patient demographics

Contract Negotiation Strategies

- **The managed care company gets a per member per month payment that is set from the Cost Report**
- **The MAP or other plan gets rates from the entity cost reports**
- **The margin is slim on both sides**
- **Outpatient payments often are a fee schedule that approximates your APC payments**
- **Plans are enamored with ASC rates**

Strategies to Maximize Reimbursement

- **Managed care has nurses on site in your facility**
 - “Pre-cert” and “pre-auth” usually are required
- **The hospital’s IP advantage is to reduce length of stay through care planning, sequencing, etc.**
- **Careful planning of aftercare is essential to an effective discharge**
- **Utilization management only works if your physicians are involved**

Strategies to Maximize Reimbursement

- **“Concurrent coding” is imperative**
 - Coding after discharge is “totally bogus”
 - Requires dedicated documentation specialists to work with physicians on documentation and proper discharge scheduling
- **Subscribe to eligibility software to cover as many payors as possible**
 - Be sure it includes Medicare managed care and...
 - Checks for eligibility in the Medicare program

Strategies to Maximize Reimbursement

- **A cost accounting system is essential**
 - You do NOT need to spend a fortune for this
- **Identify the 20 most common DRGs and APCs and analyze their cost...Monthly**
- **Work with physicians and case managers to establish “Standards of Care” for your top DRGs and APCs**
- **Collaborate with your physicians on purchasing supplies and pharmaceuticals**

AND WHAT OF THE LONG TERM?



The Longer Term Prognosis

- **The increasing power of managed care, and**
- **The indirect influence of CMS both inside and outside of the Medicare Advantage environment...**
- **Will encourage consolidation of the provider side of the industry**



The Longer Term Prognosis

- **It's simple, really:**
 - If the pie is smaller, either the pieces must be smaller or there must be fewer people at the table!



Signs of the Times...

- **Rural and inner city hospitals are affiliating with secondary and tertiary referral centers**
- **The ideal “tertiary hub” model of provider networking may become common**
- **There IS strength in numbers: You must be the big kid on the playground**

Now, We Can Expect...

- **Many small rural and urban providers to seek merger/acquisition or strategic partners**
 - These are viable strategies for long-term survival and may offer the best means of serving the market
 - But what are some of the “pros” and “cons” of this approach?

Pros & Cons

- **Pros**

- Helps assure the viability of healthcare in any given community
- Enhances the provider's bargaining position
- May provide new strategic resources

- **Cons**

- Hospital may not be perceived as "local"
- Locally owned public hospitals will lose local control

CONCLUSIONS TO BE DRAWN

The Key Points: 1 and 2

- 1. CMS began implementing changes in 2008 and 2009 that continue in 2010 and will continue in the future.**
- 2. Those changes will strengthen managed care and diminish providers' bargaining positions, FOR ALL PAYORS, not just MAPs.**

The Key Points: 3 and 4

- 3. Reduced payments, more “transparency” and increasing costs all must be addressed.**

- 4. New “best practices” must be sought.**
 - What was best last year often is “second best” this year.
 - All the usual clichés apply.

The Key Points: 5 and 6

- 5. There are strategies available to individual providers that should be pursued first, but...**

- 6. Consolidation of the provider side is not necessarily bad.**
 - Economies of scale
 - Quality can improve

QUESTIONS & COMMENTS



Closing Remarks

- **Yours**
- **Ours**



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