Decision Support Tools for Managed Care

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OUTLINE

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Introduction

The onset of Managed Care has highlighted the need to bring together the financial, clinical and technical operations within today's Healthcare Systems. To effectively monitor the performance and financial impact of a managed care contract is truly a collaborative effort. This effort spans all areas of the Health System including;

- contract negotiation and modeling
- clinical analysis and review
- cost development
- case management
- clinical pathway development

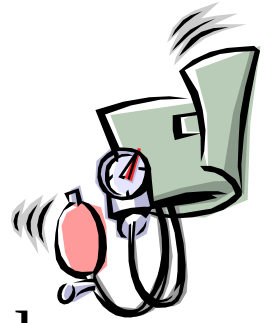
A Look at the Collaborative Effort

- Clinical Review
- Case Management
- Care Giver
- Marketing/Strategic Planning
- Finance

Clinical Review/Utilization

- Review historical utilization trends to identify risks and develop guidelines for existing/future contracts.
- Manage LOS to yield best cost/quality results.
- Analyze and monitor case mix - Is it changing? How?
- Monitor cases with complications, outliers, high acuity and severity indicators.
- Outcomes management.
- Impact on contracting: Identify stop-losses and carve-out’s.

Case Management



- Develop clinical pathways based on historical treatment patterns.
- Manage care across the continuum to promote quality and reasonable cost outcomes.
- Coordinate and outline resource consumption.
- Identify high risk, high volume clinical services.
- Monitor variances from established protocols (internal and external).

The Care Giver

- The care giver controls the utilization of resources and must be linked (clinically and financially) with the delivery system.
- Analyze physician volumes and costs.
- Essential for capitated contracts.
- Essential for the development and management of careplans.

Market Analysis/Strategic Planning

- Understand existing patient population.
- Analyze volumes, profitability by product line.
- Utilize existing state comparative data to determine (inpatient) market share.
- Determination and monitoring of membership.
- Benchmarking.
- Model impact of volume changes.

Finance: Cost Development & Analysis

- Cost data is essential for contract monitoring and modeling.
- Managed care has been the driver of most cost accounting studies in the 90's.
- Need for accurate patient costing necessitates the move from RCC's to a standards approach.
- Fixed/variable breakouts
  - Essential for contribution margin calculations
  - Essential to perform break-even analysis to evaluate impact of incremental volumes

Finance: Contract Development, Negotiation and Modeling

- Adjudication: Monitor actual payments and adjustments to expected reimbursement (by contract).
- Compare actual volumes, case mix, cost and profitability to budget assumptions
- Identify and analyze various components to determine areas of concern, i.e., carve outs and stop loss.
- Capitation: Calculate and monitor PMPM rate - analyze shifts in membership and costs.
- Analysis should be summarized to match criteria and service deliveries outlined in contract.

Contract Management Systems

- Accurately calculate expected payments for purposes of;
  - Contract negotiations
  - Contract implementation
  - Contract monitoring (comparing actual to expected payment)
  - Profitability and contribution margin analysis within DSS
  - Patient billing
- Interface data from patient accounting system.
- Optional: Link back to patient accounting system to send expected payments or contractual adjustments at time of billing.
- Track payor contractual performance and profitability.
- Part of DSS (e.g. McKesson/HBOC, TSI, HCM) or stand-alone (DKD, TPMS Harvest).

Contract Management Systems: Reimbursement Rules

- The CMS should contain ultimate flexibility in defining reimbursement rules to accommodate all contract provisions; e.g. stop-loss clauses, carve-out's, minimum/maximum clauses, fee screens at various levels.
- "Complexity accompanies flexibility" (a flexible system may be an ugly one).
- The key to successful implementation of a contract management system is in the definition of the reimbursement rules.
- Defining reimbursement rules/contracts requires a team approach; Finance, Patient Accounting, Business Office/Registration, Reimbursement.

Contract Management Systems: Implementation Steps

① Review contracts to determine data requirements such as fee screens.
② Request fee screens and other data requirements.
③ Document contracts.
④ Build the most complex contracts first.
⑤ Build low-volume contracts using PAF's (expand in a later phase).
⑥ Link insurance codes to reimbursement rules/contracts.
⑦ Test, test, test!
⑧ Audit results.

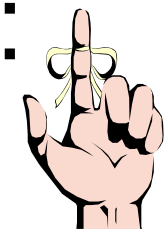
Documenting Contracts: An Example

Contract: **XYZ HMO**
Eff Date: **01-Jan-99**

Term No.	Term Description	Access Criteria	Reimb Component	Notes	Reimb Method	Rate	Proc Level	Rule Type	Rate Table
1.	C-Section	DRG 370-371	C-Section	Use Medicare DRG grouper	Per diem	$720	Total	Per Diem	none
2.	Normal Del	DRG 372-375	Normal Delivery	Use Medicare DRG grouper	Per diem	$680	Total	Per Diem	none
3.	N. Newborn	DRG 391	Normal Newborn	Use Medicare DRG grouper	Per diem	$410	Total	Per Diem	none
4.	Alcohol Rehab	Acct type "Z"	Alcohol Rehab	UB92 118-128	Per diem	$600	Total	Per Diem	none
5.	I/P Med Surg	Acct type "I"	Medical/Surgical	UB92 100-111, 113, 115-121, 123, 125-169	Per diem	$775	UB	Per Diem by UB Rev Cd	Per diems
			ICU/CCU/NICU	UB92 200-204, 207-213, 215-219	Per diem	$1,200			
			Stepdown ICU/CCU	UB92 214	Per diem	$950			
			Alternate Level	UB92 206	Per diem	$200			
6.	E.R.	Acct type "E"	E.R.	UB92 450	per case	$300	Total	Flat Rate	none
7.	ASC	Acct type A	ASC	Each additional proc at 50%	by ASC group:		CPT	CPT Multiple Rates	CPT Rates
				Default group is #4	ASC 1	$440			
					ASC 2	$550			
					ASC 3	$625			
					ASC 4	$770			
					ASC 5	$1,020			
					ASC 6	$1,016			
					ASC 7	$1,220			
					ASC 8	$1,200			
			Orthotic/Prosthetic	UB92 278-279	% of charges	100%		Exclusions Add-Back	
8.	Urgent Care	Adm Category UR	Urgent Care		per case	$65	Total	Flat Rate	none
9.	Home Health	Acct type "H"	Aide	UB92 571	per visit	$30	UB	Fee schedule	UB Rates
			LPN	UB92 590	per visit	$35			
			RN	UB92 551	per visit	$60			
10.	Other O/P	All other account ty	CT Scan	UB92 350-359	per film	$250	UB	Fee schedule with %	UB Rates
			P.T.	UB92 420-429	per visit	$50			

Stop-loss: Payment shall not exceed 100% of charges. Use rule "Stop Loss Plan B".

Building Reimbursement Rules: Considerations



- Get input from Managed Care, Patient Accounting, Business Office/Registration, Reimbursement.
- Understand your data, especially CPT4 and UB coding.
- Keep consistent definitions across rules.
- Use “macro’s” to expedite the setup.
- Consider maintenance implications when building rules.
- Use “catch-all’s” or defaults to avoid any omissions.

Contract Reconciliation and Analysis

- Verify reimbursement rules by comparing expected payments to actual. If variances are significant for a category of patients, rule should be checked.
- Common pitfalls:
  - Omission of “lower of charges or fee” provisions.
  - Incorrect interpretation of outpatient provisions (e.g. Is payment all-inclusive or not?).
  - Double-counting services.
  - Omission of services that are not coded to CPT’s or are not on fee screens (make sure you’ve covered everything!)

Contract Reconciliation and Analysis: Components

- Break out components of reimbursement to mirror the services outlined in the contract:
  - Aids in reconciliation
  - Enables profitability/break-even by service
  - Provides data to support negotiating increases by specific component/service area

Expected Payment by Component (Example)

Patient ID #1234567 Discharge 10/07/98

Expected payment components:	Amount
TCU	0
INPAT	0
SDS	0
OBSERVRM	0
LAB AMT	48.20
RAD AMT	75.90
ODS AMT	27.50
PT TREATMENT	0
PT EVALUATION	0
OT TREATMENT	0
OT EVALUATION	0
SPEECH	0
CARDIAC REHAB	0
DEFAULT OP	0
TOTAL	$151.60

Retro Analysis of Expected Payments

- Hospitals have developed “contract report card” to monitor contract performance (actual vs. expected payment).
- Important: Develop a format that Patient Accounting will find useful.
- The “CATCH 22” of doing this too early; actual payments are used to audit expected, when the goal is to do vice versa!

Contract Report Card

Contract Performance Report Card

Patient Acct No.	Discharge Date	Total Charges	Expected Payment	Actual Payments	Adjustments	Account Balance	Payment Variance
15072333	9/11/98	14,972	3,000	3,000	11,972	0	0
15416977	8/21/98	11,312	12,000	12,000	-688	0	0
15429772	8/11/98	1,988	1,050	1,050	938	0	0
15451883	9/4/98	7,478	3,900	3,900	3,578	0	0
15482359	8/21/98	8,388	3,000	3,000	5,388	0	0
15071640	9/1/98	3,080	1,830	1,525	1,555	0	305
15455454	9/21/98	3,490	994	744	2,746	0	250
15196280	8/14/98	2,587	1,258	1,258	1,329	0	0
15298359	8/17/98	2,959	1,758	1,808	1,201	0	-50
15455207	9/17/98	7,640	3,315	3,754	3,886	0	-440
15504574	8/24/98	3,173	1,263	437	2,736	0	826
				.			
				.			
				.			
Report Total		689,595	294,171	296,932	397,858	0	-2,761

Other Uses of Contract Management Systems

- Monthly contractual adjustments.
- Budgeting: Develop net revenue budget by contract, based on assumptions about rate changes.
- Modeling/What-if's: e.g. impact of shift from Medicare to Senior Plans.

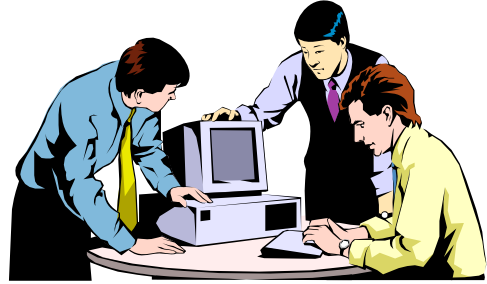
Considerations in Implementing Contract Management Systems

- Whose system is it, anyway?
- Answer: Finance *and* Patient Accounting (*and* Information Systems *and* Managed Care)
  - Finance: builds reimbursement rules, with assistance from…
  - Managed Care: aids in interpreting contracts and compiling fee screens from insurers
  - Information Systems: develops necessary interfaces to and from system
  - Patient accounting: has input in writing reimbursement rules, and uses system to manage contracts
- Resources: Person managing the system should be skilled in data manipulation and should have excellent system skills.

“Fringe Benefits” of Implementing a Contract Mgmt System

- Uncovers CPT coding problems (Examples include; lab panels, problems with credits, incorrect units).
- Process of outlining contracts (for input into system) results in central document that can be used by the billers as well as Finance staff.

Designing the DSS



- Bring over data into DSS that will be necessary to build reimbursement rules:
  - CPT4 codes
  - UB92 codes
  - Physician data such as PCP
  - Detailed insurance plan
- Integrate severity data if available, to support outcomes management.
- Integrate nursing acuity data if available to improve cost accounting accuracy.

Designing the DSS (Cont.)

- Build reasonable fixed/variable breakouts, to support modeling and contribution margin analyses.
- Integrate sufficient Patient Accounting information to support contract monitoring; denials, payment codes, adjustment codes, account balances.
- Determine frequency of DSS interfaces: If using DSS for claims management, interface weekly or even daily (vs. monthly).

Designing the DSS: Tools Necessary in Managed Care Environment

- Reimbursement rule-writer
- Multiple groupers
- Flexible reporting
- Exception reporting
- Benchmarking
- Product line definition
- Patient linking
- Pathway tools
- Modeling
- Cost accounting

Designing the DSS: Future Directions

- Integrate physician billing information.
- Link data from non-hospital entities such as Home Health, Nursing Homes, etc.
- Build claims data bases for capitation analysis.