FYA
For Your Advantage™
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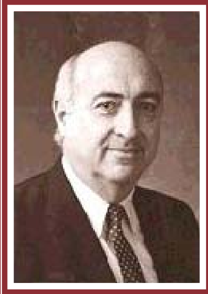
An Essential Tool for Healthcare Leaders
From TrendLeader Connections
Sponsored by PHNS The HealthCaring Solution



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About FYA

FYA - *For Your Advantage*, is a free twice - monthly newsletter published by TrendLeader Connections.

With every issue, FYA provides insights into the topics that concern healthcare leaders today and the challenges that will be faced in the near future.

The newsletter is provided free to healthcare CEOs only. CEOs may use the material in any way they wish—except for the editorial content that is copyrighted by the author. You are welcome to print copies of FYA.

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Objective Parameters for Managed Care Contracting

By Nathan S. Kaufman

Healthcare providers deserve their "fair share" of the healthcare premium, but many hospitals and physicians are unsure of how to determine what is fair. It is said that imperfect knowledge is far more dangerous than ignorance. While few have perfect knowledge on what they should seek in their managed care negotiations, many hospitals need to do a better job using data when formulating their managed care negotiating targets. Since the labor pool in the health plan industry shift companies from time to time, most health plans have a reasonably good idea what its competitors are paying each provider. Hospitals face confidentiality restrictions and anti-trust issues which prevent them from knowing "market rates."

Cost Coverage Ratio (CCR) is the gold standard for evaluating the appropriate rate and thus the success of a managed care contracting effort. The cost coverage ratio is calculated by dividing the net revenue from a specific plan by the fully allocated expenses associated with delivering that care to that plan's patients. Hospitals that do not have the financial systems that can determine the expense delivered to a specific payer population can still use the ratio of cost to charges to estimate expenses for a payer. Note, the CCR is a function of both revenue and expense. Hospitals can and should improve their CCR by lowering their expenses to best practice benchmarks, as well as, increasing the rates. You can find out how your cost structure compares to 'peer hospitals' from Medicare Cost Report Data published on the web.

In most hospitals the CCR for Medicare, Medicaid and Self Pay patients, who combined comprise 40-60 percent of their gross revenue is 70-80 percent. This means the cost of providing care to these patients is 20-30 percent higher than the revenues generated. In order to generate reasonable profitability it is essential that the hospital obtain rates from the payers that produce CCRs that are significantly greater than 100 percent.

Relative distribution of CCR among payers is also a critical factor. Should one plan in the market get a disproportionately low rate from a hospital, it will be able to aggressively compete against other payers in the market who have an inflated cost structure due to their higher hospital rates. But there are also plans in the market that are not as price sensitive because they cover a regional/national employer with a local location. The following are 'generic' CCR targets that are subject to some modification based on specific local factors:

Type of Payer	% of Gross Rev.	CCR
Dominant Payer:	15+%	130+%
Other Significant Market-Focused Payers	5-15%	145-160%
All other small payers	<5%	180%+%

Note: a hospital that is unable to negotiate these rates may need to explore merging into a larger system so that it will have the critical mass to negotiate market rates.

Continued...

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Objective Parameters for Managed Care Contracting (Continued...)

It is also critical for a hospital to analyze its CCR for each payer by location of care, i.e., inpatient vs. outpatient. It is not uncommon to find that the CCR of a hospital's managed care/commercial inpatient services to be significantly lower than that of its outpatient services. This indicates that the hospital is overly dependent on its outpatient services for its profitability. Hospital outpatient volume is being threatened on many fronts: 1) payers such as Blue Cross of California are providing financial incentives to physicians to perform outpatient procedures in freestanding facilities and not in hospitals; 2) since most freestanding providers have less negotiating clout than hospitals their rates are 30+ percent lower. With the introduction of High Deductible Health Plans, patients who have to pay cash will shop for lower cost options to hospitals; and 3) many referring physicians have ownership interest in these free standing providers and will continue to encourage their patients to use these facilities. Rebalancing the CCR around the hospital's strongest franchise, i.e., inpatient services, is critical.

In summary, in order to determine the parameters for successful managed care contracting a hospital should do the following:

1) measure the CCR for inpatient and outpatient services for each payer
2) assure that its expenses are at industry benchmark
3) demand CCRs within the ranges provided (subject to some local modifications)
4) rebalance rates so that the inpatient CCRs are equal to or greater than outpatient rates

A final note for physicians. Few physicians have the ability to measure CCRs. The standard measure for evaluating managed care contracts for physicians are: percent of Medicare. The following summarizes the contracting parameters for physicians:

Type of Contract	Percent of Medicare
Not acceptable	< 90%
Average Contract	100-110%
Good Contract	110-125%
Great Contract	125+%

Usually it is only the dominant single and multi-specialty groups that can negotiate 'good' and 'great' contracts.

To successfully negotiate with payers for their fair share of the premium, a provider must be prepared to walk away. While this will inflict pain on the payer, it will also be painful for the hospital, its physicians and patients. CCR provides guidance on when to hold'em and when to fold'em.

Nathan S. Kaufman is a leading authority and consultant on hospital financing and planning. He is an extremely popular speaker. You can reach him with questions or comments at NKaufman@foryouradvantage.com

About

PHNS is an innovative healthcare services company providing strategic outsourcing services in information technology, health information management and receivables management to over 400 hospitals. PHNS is not a consultant, vendor or software company but a partner, a solution. PHNS understands healthcare because our partners are healthcare and healthcare only. Unlike its competitors, PHNS strategically aligns itself with a hospital's clinical and financial goals and objectives. Through its unique business model, PHNS reduces costs by aggregating, consolidating and sharing resources among its participating hospital partners. PHNS helps hospitals manage information systems, computer technology, patient records, coding and patient billing to improve patient care, safety and efficiency and increase profitability and efficiency. For more information, visit www.phns.com.

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Rx for EDs

By: Rick Kneipper, Chief Administrative Officer and Co-Founder of PHNS

The Institute of Medicine ("IOM") recently released three new reports that paint a bleak picture for our emergency care system in the U.S. Some of the disturbing findings of these reports include:

- Emergency Department ("ED") visits grew by 26 percent between 1993 and 2003, but during that period the number of EDs declined by 425 and the number of hospital beds declined by 198,000;
- The results are serious overcrowding in EDs, increasingly long waits in EDs, diversions to other hospitals and "boarding" of patients in EDs until inpatient beds become available;
- With most EDs at or over capacity, there is very little ED surge capacity to respond to a major disaster; and
- Although children account for 27 percent of all ED visits, only six percent of EDs in the U.S. have all of the necessary pediatric supplies and expertise.

This follows a similarly disturbing report earlier this year by the American College of Emergency Physicians that gave a C- grade to the emergency medicine system in the U.S., with more than 80 percent of states getting poor or near-failing grades (C+ to D). And a study by the Center for Studying Health System Changes found in 12 communities studied that access to primary care providers was increasingly inadequate, especially for Medicaid enrollees and the uninsured, and that primary care physicians routinely refer Medicaid and uninsured patients to EDs for non-urgent care.

The IOM reports conclude that "[m]any of the problems of today's emergency care system can be traced to its fragmented nature." The IOM's prescription to cure these ED problems: **coordination and management of EDs on a regional basis, not on an individual hospital basis.** The IOM reports state:

"Few systems around the country coordinate the regional flow of emergency patients to hospitals and trauma centers effectively, because most fail to take into account such things as the levels of crowding and the differing sets of medical expertise available at each hospital."

The reports further conclude that "the emergency care system of the future should be by contrast highly coordinated, regionalized, and accountable." (Emphasis supplied.) I enthusiastically agree since I'm a big fan of coordinated regional, rather than hospital by hospital, approaches to healthcare delivery, as evidenced by the following comments in my prior *FYA* columns:

- "Why aren't there more collaboration and sharing of resources among community hospitals to improve healthcare services in their communities?" ("*Hospital Islands*", April 2004);
- "[H]ospitals within many regions operate totally independently and with little or no substantive collaboration on operational and financial efficiencies or sharing of resources…but…regional collaborations could help community hospitals to improve services and reduce costs" ("*Collaborating v. Competing*", June 2005); and
- "Another reason is the highly fragmented nature of our U.S. healthcare system in which healthcare is provided on a hospital by hospital, physician group by physician group, basis with little, if any, overall focus on whether that is providing the best healthcare for the region being served." ("*Regional Medical Information Networks*", October 2004)

Are you a regional sharing fan? Do you know of any examples of regional collaboration and sharing of resources to deal with ED problems?

I would like to hear your comments.
Send them to:

About
TrendLeader Connections

FYA - For Your Advantage is brought to you by TrendLeader Connections. The function of TrendLeader Connections is producing educational materials and seminars that help healthcare executives differentiate between fads and trends; and making connections with "Trend Leaders" within the healthcare industry.

We are committed to delivering new perspectives and ideas, creative and innovative healthcare solutions, provocative concepts and quality educational materials to today's healthcare leaders. We want to concentrate on "what comes after what comes next."

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END PIECE: A Hospital Functions in Wartime

A bomb shelter in northern Israel has become the front-line hospital for wounded soldiers and residents in the current Middle East war. Despite the conflict raging outside its walls, the hospital itself is a rare model of coexistence. Built under an old olive grove, the treatment center has Jewish and Arab patients sharing rooms.

Vita Bekker, reporting for the *New York Times*, writes:

> It was 1 a.m., only hours after the start of Israel's offensive in Lebanon, when hospital deputy director Moshe Daniel received warning of imminent rocket attacks by Hezbollah militants.
>
> Within an hour, 180 patients of the Western Galilee Hospital - children, the elderly, newborns and expectant mothers - were moved into the hospital's labyrinth of underground bomb shelters.
>
> The evacuation in the early hours of July 13 marked the first use of Israel's only underground medical facility, a warren of concrete tunnels and bunkers with 450 beds.
>
> The hospital has admitted 750 Israelis since the conflict began. The underground shelter, on one recent day, housed about 200 patients. It is a maze of about a dozen rooms connected by tunnels wide enough for ambulances to ferry patients from a helicopter landing pad outside.
>
> Most of the patients crowd into one large room, the size of an elementary school gymnasium. Curtainless beds provide little privacy, and there is even less tranquility amid the din of activity.
>
> The wards are marked by printed signs hanging on thin partitions.
>
> Nearby, an intensive-care room holds 20 beds, with barely room to get around them. An adjacent storage closet has been converted into a resuscitation room.
>
> Another room holds infants and children of the hospital staff. The children have been entertained by an Irish folk singer and a clown. Babies in cribs share space with teens, who sit around drawing or singing. Most would have been in summer camps if not for the rocket attacks.
>
> Above the complex, and fortified by 23-inch-thick walls, are bomb-proof operating rooms, protected, like the bunkers, from chemical and biological attacks.
>
> The glass windows at the entrance to the hospital are taped to prevent glass from flying if it is hit in a rocket attack. Dozens of beds are piled near the entrance in preparation for a possible mass casualty event.
>
> Hospital deputy director Daniel came up with the idea of creating an underground facility in 1981, after rockets fired from Lebanon smashed into the hospital and wounded three employees. He modeled it after an underground hospital in Buffalo, N.Y., his wife's hometown, which he said was established to house patients during severe snowstorms.

Daniel, who says he's "seen much worse" than the current conflict, acknowledges that he still has to deal with his own fears about the scope of the fighting.

"I'm afraid, always afraid," he said. "But the problem is knowing how to work under fear. The lives of people are in our hands."