Newsletter Date: Summer 2004

Volume 1, Issue 1

Solutions 'n Views

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CRM is a tool to help us develop stronger, better relationships with all of our stakeholders.

A Strategic Plan Doesn't Have To Be Five Years

Dust yourself off, wipe that slate clean, plant new ideas, and begin to ***think and dream big.*** Spring has sprung and summer is here, so begin to take action steps now to set goals and objectives for your health care organization's new fiscal year. Develop and implement a plan for your business success, and as a value-added your team will experience personal and professional growth.

You may have tried strategic planning or goal setting in the past, but today is a new beginning and health care providers must systematically deal with the present business needs, while looking at the opportunities that lie ahead. Business plans must be flexible enough to bend, and the systems must be in place to flow with the needs of today and the next three, five years. Don't throw away the idea of a 5-year plan; it is still important when your organization is considering plans for plant/campus expansion or for any large capital investments. Again, the look into the future is to ***plan for success, and to be successful.***

Try not to have a knee jerk response and react. For every unplanned action, there is a reaction. The reaction may cost your organization more then just dollars, but also in staff loyalty and in customers' perceptions. So keep in mind that one thing we know is that change is certain, and an organization must be prepared by having a solid foundation and a solid plan to either ***be ahead of the wave*** or *ride out the wave.* Without a solid foundation, your feet may not be well planted, and with the next tide, your legs will be pulled out from under you.

Keeping in pace with the changes, better yet anticipating the wave of change and *being ahead of the wave* will *help* your organization *to better navigate the coming changes.* This takes time and each health care organization must keep in mind the adherence to their mission and vision when establishing its goals.

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Relationship Management: Are We As Good At It as We Think We Are?

Relationships are key to everything we do in health care and indeed in all businesses. One of the latest big trends is Customer Relationship Management or CRM. We suggest that CRM needs to be envisioned in a very broad context to include not only the traditional customers of health care (patient, family, physician, referral sources), but also our vendors, employees, payors, regulatory agencies, and, yes, even the community in which we are located. With each of these "customers" we need ***a positive, successful relationship to ensure the prosperity of our business.***

The key to developing the positive, successful relationship with each of these "customers" lies in truly understanding exactly what each one needs and wants out of the relationship. Following this we then must devise and implement strategies to successfully fulfill these diverse needs. As the needs are fulfilled for each customer, the health care operation will need to carry out a validating process to ensure that the needs were met satisfactorily, and that

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What *Strategic Health Care Solutions* (SHCS) would suggest is to begin by first continuing to **build on the momentum** your organization/facility has developed over the past year. Write down your organization's accomplishments from last year in order to develop a benchmark to measure this year's undertakings.

Invite your team to the table, and share with them the facilities accomplishments, and also share with them the areas that didn't fare so well; and, discuss why without finger pointing. Talk about how this can be addressed or be prevented. Remember, the most successful planning does not happen in a vacuum but in the give and take of sharing of ideas.

As the manager, become the facilitator and enhance your and your team's interpersonal communication by discussing as a team the organization's problems, its goals and objectives; and, how as a team, we are going to systematically reach these goals and objectives, and when.

When goals are listed and the plan is developed; appoint the person who can operationally manage the implementation and modification of the plan. Set measurable objectives for each goal, and write down a plan to accomplish each objective. And lastly, stay passionate. The passion is what got you interested right?

We would like you and your team to remember to take joy from the process, and work piece by piece to get the final outcome, and, to use the small success to fuel your continued efforts and motivate yourself and your team towards your goals. All of the foregoing steps are things you can do. All are not easy. All are well worth doing, and worth doing well. One, two, five years from now you will all look back and smile and say "what a successful journey. We dared to ***dream big***, and we planned, and each and every day we worked our plan to meet our objectives and to ***realize our goals.***" ■

Vendor Contracts & Relationship Management: Are We Leaving Money On The Table?

Vendors are key deliverers of medical services and supplies, and finding the "right" vendors and how to manage your relationships with those vendors are extremely important to your facility's financial and clinical success. ***Communication and a written agreement are necessary to ensure a successful relationship*** when billing for these services under consolidating billing. As partners in the delivery of health care services the facility with each of its Part B service vendors is required by CMS to have a written arrangement in order to be in compliance with your Medicare Provider Agreement.

A written business agreement safeguards both parties. This written agreement must outline terms of payment and the means of resolution of a disputed claim for all services subject to consolidated billing. The supplier is protected since the agreement states that the vendor will be paid by the facility directly for those claims subject to consolidated billing (otherwise the service provider may have difficulty obtaining payment from the SNF in the absence of a written agreement), and CMS will not find the SNF in violation of its Medicare provider agreement since a written arrangement is in place for those services that are bundled. Furthermore , a written agreement is necessary as it is the responsibility of the facility to pay for the supplies and the services included in the SNF's global PPS per diem for a covered stay.

It is the SNF's responsibility to communicate to the supplier if the facility is responsible for the payment of those services under the consolidated billing requirement, and, in turn, it is the Part B vendor's responsibility to ascertain if a SNF or a Home Care Agency is responsible for payment prior to delivery of those services. When it is the responsibility of the SNF to pay, it would behoove the vendor to get prior approval before the delivery of the Part B service. Remember, ***the SNF is not just the conduit of billing/payment of these service***, but through their agreement with CMS they have the professional responsibility and control over these services, and it is their responsibility for the quality and the timeliness of these services under Federal regulations at 42 CFR 48 (h) (2).

It is not only important to ensure that a written agreement is in place, but by auditing your vendors, you will determine if best practice and best value is being delivered, and if the contract terms are being fulfilled. This is an activity that may *save resources, either time or money or both.* A thorough vendor audit is a key opportunity for your facility to better manage costs/budgets, clinical integrity, contract compliance and the overall relationship more effectively.

A vendor audit should consist not only of a review of billing but also a review of the contract terms and conditions. Furthermore, you need to determine if the vendor has been responsive to your needs, have the contract terms and conditions been met, and has the overall experience been a positive one. If the answer to one or more of these questions is not a resounding "yes", there is room to improve.

Room to improve is opportunity: an opportunity to manage the relationship better, an

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any other needs that may have developed in the meantime have been, or are being addressed.

The first step in the CRM communication process is the initial need discovery phase in which the real and perceived needs are clearly defined. This needs tact and perseverance. As many of our customers will say they are too busy dealing with the crises of the moment to address the real/ perceived needs (if a need is perceived whether we see it as real or not, it is real in the eyes of the customer), this process may take some time to work through. ***Each "customer" will have different needs as well as different perceived needs.***

Asking the right questions, listening actively to the responses, and restating for clarification the responses will help in clarifying and developing our understanding of the situation with the customer. As you may perform this process with one of your favorite discharge planners, an insurance case manager, a vendor, a patient in the hospital, or one of your more promising employees, the team must take this newly found knowledge and build upon it.

Once we have clearly determined the needs of our customers (i.e., easy access for admissions 24 hours a day/ seven days a week), our work has just begun. We now are challenged with developing the means by which we can fulfill or operationally address these needs. We may discover competing needs, and, a need to develop strategies that creatively address the needs of one customer set, while developing a program for another.

Each customers' perception is their reality. A successful CRM program consist of active, clear communication.

The *key element* to *achieving* and maintaining a *successful CRM* program that addresses all key customers is *active, clear communication.* This initially will take more time, but in the long run this process will save a lot of time. The "I assumed s/he meant" comments are then replaced with s/he said, s/he needs/wants this or that. In developing clarity of communication a level of trust develops, and the relationship moves to another level. The time and manpower investment made begins to payoff. To emphasize, this process, once begun, is a never-ending one of back and forth communication. ***The constant exchange of communication ensures the smoothest operational flows possible.***

This does not mean there will not be challenges to overcome. These will arise. As we develop our CRM processes and become more adept at the communication / planning processes, you and your staff will become more comfortable in saying, the once perceived difficult things as "We have a problem with "X" and how can we together resolve this, to the appropriate partner. Direct communication that states the problem in a matter-of-fact fashion along with asking for help to achieve resolution will help move the problem to resolution while maintaining a strong provider-customer relationship.

As the needs are clearly defined, the strategies for fulfillment then need to be developed. The most successful strategies directly involve the customer in the development process. Thus the customer will begin to develop a stronger tie to your operation and will be more invested in your success and thus more involved.

CRM (customer relationship management) is a tool to help us develop stronger, better relationships with all of our stakeholders. The payoff for these CRM activities is large. We as providers will be providing the services our patients/customers want in a more responsive manner with highly invested partners. These partners have a vested interest in our success and we will all be working together to accomplish this. ■

MA -No Longer Just The Abbreviation for Massachusetts

Don't let this train leave the station without you. We have your ticket to RIDE!

The newest acronym in the Managed Care industry is MA. MA doesn't stand for Massachusetts in this case but for the newest plan released to the market by CMS. This plan is known as Medicare Advantage. Over the past decade the health care industry has called Managed Medicare products as Medicare Risk plans and then Medicare+Choice plans. The New Medicare product, MA, is the result of the Medicare Prescription Drug Improvement & Moderation Act (MMA) of 2003. This is the same act that will give Medicare enrollees the opportunity to enroll in the Medicare Part D plan, a prescription drug benefit beginning in 2006.

Between 1998 through 2002, plans exited the Medicare+Choice market in droves; and why as providers should we believe and be prepared for the resurgence of the newest plan? The bottom-line is the attractiveness of the payment rates released by CMS to encourage Managed Care Organizations (HMO, PPO, etc.) to enter or re-enter markets. The Per Member Per Month (PMPM) funding by the federal government has increased on an average by 10.4% for 2004, and upwards to 6.6 % in 2005. These increases have encouraged a variety of payors, and the types/names of payor you thought had long exited the "senior" market, to enter or re-enter the marketplace.

The expectation is for the plans to enter the market in full force during the last quarter of 2004 into 2005, in order to be positioned for 2006, otherwise PPOs will have to wait until 2007. The MA plans offered will significantly lower the out-of-pocket expense of the enrollee over that of traditional fee-for-service Medicare. Because of the infusion of cash into the plans, MA plans must

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Are We Leaving Money On The Table?

opportunity to perhaps realize a savings in resources, or *an opportunity to replace the vendor with a partner that will reduce your cost exposure, assist in the management of clinical care and be relationship friendly.*

If the answer to one or more of these questions is not a resounding "yes", there is room to improve.

The relationship and need to maintain it must be considered. If the pricing has not been according to your contract (higher/ or with errors) or service has been a serious problem, then your resources have been taxed unnecessarily; or perhaps it is a communication error and the facility did not notify the Part B vendor timely or accurately and the facility was billed in error. Then without undergoing a vendor audit you may not know that these contract non-compliances and pricing errors and overcharges exist, or that your system has a flaw.

Through audits that **SHCS** has conducted for clients, tens of thousands of dollars have been billed to the facility in error or at the wrong terms. So unless you audit, you will not *know* if ***money may be blindly left on the table.***

We suggest that initial audits should occur for the first three to six months. The frequency can be determined by the aggregate cost of these services. Keep a running tally or a measurement of performance, and periodically physically and mentally step back to review the relationship from the beginning through to the end.

This process helps manage cost, ensure contract compliance and more importantly helps to manage the relationship.

Reputable vendors would rather provide the services according to the contract and have a very satisfied client than otherwise; and, they will welcome a review of performance and the opportunity to improve, if needed, as opposed to losing a client and a source of revenue. ■

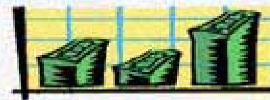
So, What Will Tomorrow Bring And How Do We Prepare?

As we have seen in the past few years and what we will see in the years to come, is that healthcare businesses cannot rely on just one product, service, market, or payor source. Further, they must understand their costs and how to contain their costs without sacrificing quality. By putting all your eggs in one basket and not effectively managing risk and monitoring clinical budgets, facilities and or ***companies have watched their margins squeezed and their missions seriously undermined.***

So, what will tomorrow bring and how do we prepare for the future without feeling the squeeze? There has long been talk within CMS of how they could better manage costs while providing quality care. Well for one is with Medicare Prescription Drug Improvement and Moderation Act (MMA) of 2003. This act offers Medicare enrollees prescription drug benefit coverage (Medicare Part D) and will fund Managed Care Companies to offer Medicare Advantage Plans. In addition, dollars will be allocated for the management of chronic disease states (such as diabetes and heart disease) by Disease Management Companies, and for the management of care for the "the chronically ill" Medicare Enrollees residing in institutional settings (Evercare). All of these offerings lend themselves to assisting CMS to ***attained quality of care while containing costs.***

Clinical budgets of each patient will require careful management. Are you ready for MMA of 2003?

The development of case management strategies, processes and systems is where CMS will be going with these initiative to better control the expenditure of the dollar and guarantee the delivery of appropriate care in the most cost-effective setting. Because of these initiatives, across the continuum, the industry will have to assist our seniors in the management of their Medicare A, B, and Choice, and D benefits. Case Management is the answer.



Whether the shift of risk is from CMS to "MA" or to Disease Management Co, it is the provider that needs to take the lead from CMS and follow suit and be prepared to manage clinical care within each patient's clinical budget. ***The questions to ask yourself –*** Does your facility have the systems, payor contracts and the right partners in place to effectively manage BBA of 97 and MMA of 2003? Or, are you going to feel the squeeze all over again! ■

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demonstrate reliable access to additional benefits, increased provider networks, and a significantly lower out-of-pocket cost for the Medicare beneficiary, which is typically provided by the previous generation of Medicare Managed Care plans. In markets that already offer a MA product, enrollees save 34% over their traditional free-for-service counterpart.

As of April 2004, 11.4% of Medicare beneficiaries are enrolled in the Medicare Advantage program. And, it is projected that beginning in 2006, there will be incremental increases. It is anticipated that upwards of 32% of all Medicare beneficiaries will be enrolled in a MA plan in its first 5 years.

Managed Medicare is back and it will be stronger than ever thanks to the MMA of 2003. For **SHCS' *clients who*** still believed that managed care was not going to die, and ***never got off the train,*** presently have 26 executed contracts with local, regional & national Managed Care networks, and they ***are well positioned*** for whatever develops from the MA swing of the health care pendulum. ■