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Managed Care Resources, Inc.

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Why A Newsletter? I Get Enough of Them!

Welcome to our premier issue of our newsletter. We want this to be more than just another newsletter. Our goals are:

1. Provide brief articles of interest covering topics that our readers have requested.
2. Offer practical insights on the what, whys and how of managed care, and its potential impact on your organization.
3. Provide real life examples from our work with clients.
4. Share with you our answers to questions submitted to our website. Have a question? Send it to: info@mcres.com.
5. Provide you with the latest news about Managed Care Resources – both serious and humorous insights about us!

We plan to issue this newsletter bi-monthly. We want you to find this newsletter interesting, valuable and timely. Many of you have visited our web site and enjoyed our topical award winning (by *Managed Care Connection for Content Excellence*) articles on Medical Management and Managed Care Contracting called the "Signature Series" (www.mcres.com/mcrless.htm). We want you to find the newsletter equally useful!

This newsletter format will help us deliver to you topics of interest on a timelier basis.

Share your thoughts and ideas by emailing us at info@mcres.com.

Operational Assessment – How well are you doing?

One of the goals of our newsletter is to share with you our experience with real issues facing real organizations. We will keep our clients' identities confidential, while trying to share experiences from working with our clients.

One area of growing interest among our clients is the use of operational assessments in evaluating the effectiveness and identifying areas for improvement. HMOs, PHOs, IPAs, medical groups, and even hospitals are using the findings to identify different improvement strategies.

When To Conduct Assessments

Assessments should be a regular event conducted every 2-3 years. It may be necessary to do them more frequently should certain benchmarks negatively change. For example, are operating expenses increasing at faster rate than operating revenues? Is your medical cost ratio increasing or exceeding the benchmark for your size organization?

Are you considering a new information system? An operational assessment will help identify opportunities to streamline processes and identify features that will be needed in the new IT system. In the end, you will make a better IT system selection that meets your needs.

If an organization is considering changes to its reporting relationships and internal processes, an assessment can provide an important roadmap that

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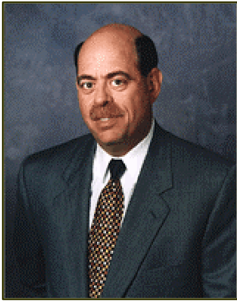

Ira Rosenberg
President

"I try to use the web sites of my local hospital and HMO only to find them useless!"
A frustrated consumer

Get To Know Us – Ira Rosenberg

Ira founded Managed Care Resources in 1995 to help organizations solve their ever-growing managed care issues.

He brings a wealth of practical managed care experience to every client situation. But he has more than just managed care experience.

For eight years, Ira was Vice President for the Humana Health Care Plans in Illinois, a 600,000 member mixed model HMO. In that position, he was responsible for site development, inter-governmental relations and regulatory oversight, development of the corporate infrastructure to support growth, and the negotiation of large group agreements, and the ancillary provider contracting system. He expanded the provider network from 5 hospitals to 75, and from 100 contracted physicians to over 5,000 contracted physicians and group practices. He is an expert in all forms of provider reimbursement, including per diem arrangements, global capitation, and percent of premium arrangements, as well as packaged pricing for various medical procedures.

Ira also has many years of experience on the provider side of health care where he:

Managed multi-specialty group practices with significant HMO enrollments.

- Served as Chief Operating Office of a major Chicago hospital.
- Managed the development of an institution-based integrated delivery system, linking together academic medical centers with community hospitals.
- Organized primary care medical practices with an academic faculty practice plan to successfully contract with the major insurers under capitated arrangements.
- Directed an 80,000 member provider-owned HMO through the development of "infrastructure built from scratch" to replace services operated by a third party insurance company.

Ira majored in Political Science at the University of Rhode Island, and received his Masters degree in Health Care Administration from George Washington University.

"E-commerce has only been around for a few years and almost everything people thought would work at the beginning has failed. Trust me, nobody is an 'expert in e-commerce.'

---Bryan Eisenberg, CIO, Future Now, Inc.

Is Your Web Site Ready for Accreditation?

URAC (also known as the American Accreditation HealthCare Commission) is developing Health Site Web standards for the accreditation of health care organization web sites. This will be a major step in providing the public assurance that health related web sites are meeting or exceeding quality standards.

Can your web site meet these proposed standards? Here are a few of the key measures

- Does the parent organization have written policies and procedures governing the site?
- Do you have a quality oversight committee?
- Does your site meet disclosure standards (content development, promotional policy, investors, personal health etc.)?
- Are there editorial policies guiding all health content? Is the content reviewed by a health professional?

These are just a few of the standards that are being considered. For more information, visit URAC's site: http://www.urac.org/websiteaccreditation.htm

Operational Assessment (more)

will lead to better decision-making.

What Is In An Assessment?

A comprehensive assessment should examine 12 areas. Each area is deserving of assessment. But assessing all 12 areas allows one to integrate the impact one area has upon another. A description of the 12 key areas are provided below:

- Claims Administration: Are claims processed accurately and timely? Is authorization rapid and effective? What is the, adjudication process? Are claims processed electronically?
- Executive Leadership: What is the strategic plan? Is performance managed? Is there a functional organization structure with a customer focus?
- Financial Management: Is there a functional budget? Are there sufficient accounting resources? Are management reports useful? Is IBNR managed? Is there stop-loss coverage? Is premium billing & collections efficient? Are there COB issues?
- HCFA and Regulatory Compliance: Is the plan compliant with HCFA requirements? The State's Department of Insurance? What are the plans for HIPPA? Are there reserve requirement issues?
- Information Systems: Are there too many systems that don't integrate? What systems would improve operations? Is outsourcing a consideration? Are there decision management tools? What are the Internet strategies?
- Marketing & Sales: Is there a plan? How are sales managed? Are customer needs met? Are broker relations managed? Is there adequate sales support?
- Medical Resource Management: Is the Utilization Management program up-to-date & comprehensive? Is there a current Quality Management Plan? Are there adequate resources for referral & case management, concurrent review, discharge planning? Are you profiling providers? Managing population?
- Member Services: Are members satisfied? Is enrollment efficient and accurate? What are the education & problem resolution programs? Is the appeals/grievance process effective?
- Network Development: Are providers actively managed? What are the reimbursement strategies and incentive programs? Is there an active recruitment plan?
- Provider Relations: Are there education programs? Is there a problem resolution mechanism? Are provider needs assessed?
- Quality Management: What is NCQA status? Reporting HEDIS data? Are there clinical pathways & patient profiling? Is there a risk management process? Is recredentialing process efficient?
- Underwriting: What methods are being used (risk versus experience analysis)? Are they involved in pricing, and product development?

In the coming issues, we will describe components and how they can be used to improve performance.

Share Your Experiences

Are you willing to share your experience in conducting Operational Assessments? If you are, write your story and email it to info@mcres.com. We will combine all submissions in a format that we can publish, while keeping the information about you and your organization confidential. Your stories will help paint a picture of how assessments are used by others. Again, all information provided to MCR will be kept strictly confidential. Thank you in advance for your participation.

AWARDS & RECOGNITIONS

Managed Care Resources' web site won the Managed Care Connection's award for Content Excellence.

The Signature Series (www.mcres.com/mcrless.htm) has been used by Arizona State University and University of Minnesota as a resource document in their managed care courses.

"We conducted an operational assessment and found areas to improve efficiency and eliminate outsourcing waste! It more than paid for itself!"
Chairman of the Board Midwest Provider-Sponsored HMO

Canada's Medicare System

Interesting Facts!

We estimate that 85 percent of Ontario households with annual incomes over $100,000 are also covered by a private medical insurance policy. Source: Managed Care Resources Survey

Why talk about Canada's health care system? It's simple – there are three reasons why Canada is of interest to Americans. First, many Canadians are taking their cash and making the trek south for health care. Wealthy individuals and snowbirds frustrated with the current system and tired of lengthy waiting queues are looking for alternatives. They want to secure care at an American center of excellence. Second, many American health care providers are looking to capitalize on this growing frustration by striking alliances and marketing their services in the north. The message is clear – come to my facility for your health care. Finally, who can ignore an exchange rate that gives Americans about 40% more for their health care dollar? It's an attractive selling feature for Canadians wanting to lure Americans north for select procedures.

We will be featuring articles about Canada's health care system, giving you information about issues that directly affect the American health care system. Before getting to the specifics of the current situation however, it's helpful to understand Canada's Medicare system. Much like the American system, it cannot be adequately described in a few short sentences but we can give you the basics in a few short paragraphs.

In 1984, the Canada Health Act (known simply as MEDICARE) came into effect. It was close to forty years in the making, starting in 1947 when the first province established hospital insurance. By 1961 all provinces and two territories, with federal financial assistance, had public in-hospital care. In the year that followed, one of the provinces began its quest for public coverage of physician's services outside the hospital. Ten years later in 1972, all provincial and territorial plans had been extended to include doctors' services.

A national health services review in 1979 raised concerns that extra-billing by doctors and user fees levied by hospitals was creating a two-tiered system that threatened the accessibility of care for Canadians. Parliament responded by passing the Canada Health Act in 1984 to discourage hospital user charges and extra-billing by physicians. The Act provides for an automatic dollar-for-dollar penalty if any province or territory permits such charges for insured health services.

Canada's Medicare governs the insured services of just over 30 million Canadians and includes all medically necessary hospital services and medically required physician services. It also covers medical or dental services requiring a hospital for their proper performance. Other health services such as home care or long term care are at the discretion of the provincial governments.

Under the Health Care Act, the provinces and territories must meet five conditions in order to receive full cash contributions from the federal coffers. If the provinces can demonstrate compliance with the five conditions, twice-monthly payments are made based on a complex formula. The legislation also contains provisions for reducing or withholding federal cash contributions in the case of failure by a province or territory to satisfy any of the criteria.

- ***Public Administration*** requires that the administration of the insurance plan of a province be carried out on a non-profit basis by a public authority.
- ***Comprehensiveness*** requires that all medically necessary services provided by hospitals and doctors be insured.

(more on Page 5)

Canada's Medicare System (more)

- ***Universality*** requires that all residents of the province be entitled to public health insurance coverage.
- ***Portability*** requires that coverage be maintained when a resident moves or travels within Canada or travels outside the country (coverage outside Canada is restricted to the coverage the resident has in his/her own province).
- ***Accessibility*** requires reasonable access unimpeded by financial or other barriers to medically necessary hospital and physician services for residents, and reasonable compensation for both physicians and hospitals.

Canadian health expenditures generally run around 10% of the gross domestic product. According to the Canadian Institute for Health Information based in Toronto, Canadians spent an estimated $76.6 billion dollars on health care in 1997, up from $75.5 billion the previous year. Institutional care accounts for close to 45% of the total expenditures with physician costs accounting for an additional 14%. The remaining expenditures are devoted to drugs (13%), other professionals (11%), capital (4%), and "other" (14%).

The cash flow from the federal coffers covered only about 22% of the provincial health expenditures in 1996/97–compared to 24% in 1990 and 31% in 1980. This means that the provinces have been left to pick up the slack especially in the areas of new programs such as home care and long term care. The provinces devote between 29% and 37% of their total budgets on health. However, many of the provinces experienced budget deficits and rising health care costs that led to the health care reform of the nineties. The reforms were swift and focused mainly on hospital bed closures, which placed a considerable strain in community and long-term care and for those needing elective surgeries.

In the past, public funding (tax revenues) has accounted for about 75% of the total health care expenditures of the country. In recent years however, this figure has dropped to about 72%. Other financing is available from a) private out-of-pocket payments including co-payments or deductibles, b) worker's compensation covered by provincial boards and funded through employer contributions and, c) private insurance which is generally employer-sponsored plans for services not usually covered by government programs such as dental care, prescriptions, and *out-of-country services.* It is believed that the growth in private funding stems in large part from employer-sponsored health plans often negotiated via union contracts.

For the Canadian citizen, there has been little need to "dip" into one's pocket for health care services. The public system has generally been accepted as good if not excellent. In fact, Canadians have always talked about the health care system with pride. However, reduced spending, hospital bed closures, and less public funding in the 21st century have Canadians concerned. Tales of a health care system gone awry are commonplace. Recent polling results indicate that health care is the number one issue for Canadians and it also indicates that they are quickly becoming frustrated and less than satisfied with the public system.

NEXT ISSUE:
Canada's Waiting List

Interesting Facts!

In 1994, Canada spent a greater percentage of its health budget on inpatient hospital care than any other Group of Seven nation except Italy
MacLeans Magazine, June 15 1998

Complying with HIPPA

Health plans, healthcare providers and clearinghouses that maintain and transmit electronic medical records and personal medical records must comply with the DHHS Final Rule on Standards by October 16, 2002. Health plans with less than $5 million in transactions have an additional 12 months.

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We're on the Web!

See us at:

www.mcres.com

Future Topics – We Want Your Suggestions!

We hope you found this first issue of Managed Care Resources helpful and useful. We want to develop future issues that continue to meet your needs and interest.

We are in the process of developing the topics for our future issues. Some of the topics are:

- How to assess the operations of a managed care organization
- Marketing's role for IPAs & PHOs.
- How to mine the data within your legacy systems without replacing them.
- Contracting tricks for physician practices.
- Negotiating specialty care agreements.
- "Get me more contracts" – how

Let us know what topics you would like covered. Email us your ideas to info@mcres.com or call us at 630-654-6100.

About Managed Care Resources...

Managed Care Resources (MCR) is a national consulting firm offering realistic solutions to a wide range of health care issues. We assist health care providers, employers and insurers with management, strategic, financial and clinical issues.

Since its' founding in 1995, Managed Care Resources has assembled a team of professionals that bring experience managing and operating physician-hospital organizations, health maintenance organizations, hospitals, and medical group practices. The staff has expertise in operations management, functional assessments, business development, practice management, managed care planning, medical management, financial management, information systems, utilization review management, marketing, contract negotiations, customer service, human resources, and benefits management. Every MCR client is matched with a team of senior professionals who have the experience and knowledge needed to resolve the client's issues. Clients benefit from MCR's in depth knowledge and combined operational and strategic experience in managed care. The staff brings over 150 years managed care experience and the knowledge of what works best for managed care organizations, hospitals and physicians.