

2 Savvy

- The DRG reconfiguration is not as dramatic as originally outlined by CMS—at least in the short run. Nonetheless, the changes will have some impact, and even more important, the revisions offer an opportunity for hospitals and health systems to review their service line portfolios. Preston Gee discusses the strategic impact in his article, **“Paradigm Lost: The Strategic Impact of Revised DRG Payments”** which is attached to this issue of *The Advisor*.
- The fall is traditionally the season for strategic planning, with board retreats, management sessions and budget considerations. With all the rapid changes occurring in healthcare, an emerging trend is the concept of “rolling” strategic plans or perpetual planning. This issue of *The Advisor* features an article from the inaugural issue of *Strategic Financial Planning* entitled **“The Compelling Case for Perpetual Strategic Planning.”**
- Pricing transparency has become more relevant and resonant as states consider legislation and the federal government encourages implementation. Phase 2 directors will be presenting an all-day session at the HFMA Winter Conference titled, **“The Pricing Imperative”** in Chicago on December 5th. Details are listed below in **Catch-Phase 2**.

Phased In

During July, August and September, Phase 2 Consulting has developed new projects and clients.

- St. Alphonsus Regional Medical Center, Boise, ID - Service Line Evaluation and Facilitation
- ConMedSys, Austin, TX - Product Rollout Strategy
- Cascade Healthcare Community, Bend, OR - Strategic Pricing Review
- Quorum Health, Plano, TX - Surgery Log Tool Development
- St. Dominic Village, Houston, TX - Operational Assessment and Strategy
- DeKalb Medical Center, Decatur, GA - Revenue Cycle and Strategic Plan

Catch-Phase2

In the coming months, catch Phase 2 in the following publications and speaking events:

- John Maher will be presenting on *Managing Your Denials Before They Manage You* at the October 11th American Medical Rehabilitation Providers Association meeting in Hilton Head, SC
- Mary Wilkes and Pat Cooper will be speaking on *Strategies for Clinical Transformation* at the October 19th FMQAI Conference in Tampa, FL
- Preston Gee will be speaking on *Paradigm Lost: The New Pricing Era* at the October 20th HFMA meeting in San Antonio, TX
- Preston Gee will also be speaking on *Consumer-Directed Health Plans: What Happened, What's Next?* at the October 28th Texas Association of Health Plans in Austin, TX
- Howard Salmon will be speaking on *Lessons from a Federal Courtroom* at the November 1st NCCHC Conference in Atlanta, GA
- Marlowe Dazley, Brent Hardaway, Preston Gee and Todd Halpin will present *The Pricing Imperative* an all-day session at the December 5th HFMA Winter Conference in Chicago, IL
- Marlowe Dazley and Preston Gee will be speaking on *Revised DRG Payments: Prepare for Changes in Reimbursement, Pricing and Transparency* on the December 6th HCPro AudioConference Call

Trust the Prose

- **"Is Your Inpatient Rehabilitation Facility Running as it Should?"**, by John Maher (see attached)
- **"The Compelling Case for Perpetual Strategic Planning"**, by Preston Gee in *HFMA, Strategic Financial Planning, September 2006* (see attached)
- **"Paradigm Lost: The Strategic Impact of DRG Reconfiguration"**, by Preston Gee in *healthcareleaders.com, August 2000*. (see attached)

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Is Your Inpatient Rehabilitation Facility Running As It Should?

John Maher, Consultant, Phase 2 Consulting

With the changes over the past two years in 75% Rule qualifying diagnoses, as well as increased scrutiny from Medicare intermediaries and commercial payors, it is a critical time to ensure that your inpatient rehabilitation program (IRF) is optimized to meet these challenges. By monitoring some key indicators of your program and by designing referral protocols from the acute setting, you will ensure that you are maximizing volume and reimbursement, protecting yourself from denials for lack of medical necessity, and achieving consistent outcomes with your patients.

Recently, Phase 2 has worked with many IRF's to assess performance improvement opportunities in these areas. We have found that significant financial opportunities exist for many of our clients. Here are a few examples:

	Patient Leakage Opportunity	Medical Necessity Documentation, Coding, and Denials Management	Total Annual Opportunity
Client #1	\$3.9M - \$7.9M	\$426K - \$960K	\$4.4M - \$8.9M
Client #2	\$1.0 M	\$280K - \$420K	\$1.3M - \$1.4M
Client #3	Not Reviewed	\$900K - \$1.7M	\$900K - \$1.7M

What are the key indicators that you should monitor to ensure your programs success? They can be broken down into 4 general categories.

- Financial
 - **Case Mix Index (CMI)** - Is your CMI at or above regional and national averages?
 - **Functional Independence Measure (FIM)** - Are your average admission FIM scores at or below regional and national averages?
 - **Tier Distribution** - What is your distribution of tiers, and where do they fall compared with industry averages?
 - Is your IRF profitable when you consider full cost allocation?
- Clinical
 - Is your internal chart documentation supporting medical necessity with 100% compliance?
 - What percentage of your cases are being denied for lack of medical necessity?
- Outcomes
 - How do key measures such as FIM Gain, FIM efficiency, average length of stay, and discharge destination compare to regional and national averages?

- Are your patients and other key stakeholders such as referral sources and physicians satisfied with your outcomes?
- Referrals
 - Are at least 10 – 12% of your med/surg discharges going to inpatient rehabilitation?
 - Is your med/surg average length of stay 1 day or higher longer than the geometric mean length of stay?
 - What percentage of your rehabilitation candidates are being discharged to your own rehabilitation facility versus competing facilities?
 - Do your case managers, nurses, physicians, and therapists understand which patients need to go to IRF and which need to go to nursing homes? Do they understand the implication of the 75% rule?
 - Are you utilizing IRF to assist with patient throughput from the ED through the rest of your system?

By looking at these key indicators you can determine what steps to take to remediate any problematic areas.

Financial Indicators

If your CMI is falling below regional and national averages you may have problems with coding and FIM scoring. Medical coders and physicians may not be communicating adequately to ensure that they are capturing accurate co-morbid conditions or the appropriate etiological condition for the setting. Additionally, clinicians may not be capturing the highest burden of care in the assessment period, which leads to higher FIM scores. By completing case mix group break point analyses and reviewing ICD-9 codes used for all patients that come to the program you can review cases in real time to ensure that you are capturing the information that will maximize reimbursement for the care being given.

In addition to looking at these key revenue indicators it is also necessary to look at the profitability of your IRF, with full allocation of costs. Reimbursement for IRF level of care allows for the program to run profitably. If you are not turning a profit in your program, a closer look at staffing, productivity, and ancillary costs is necessary to determine opportunities to increase efficiency.

Clinical Indicators

Denials by Medicare intermediaries continue to be on the rise with IRF's. There is intense scrutiny of supporting documentation for the intensity of therapy services, 24 hour rehabilitation nursing, and 24 hour availability of a physician. With this level of scrutiny on the rise, it is important to employ two strategies – one for denials and appeals management, and one for proactive review of documentation. Denials management is critical for the success of the program. It is critical to have communication systems in place with your business office to ensure timely responses to denials. By having tools in place to ensure successful navigation of appeals at all levels, up to and including the Medicare Appeals Board you will be best prepared

to defend any denials you may receive. Additionally, it is of equal importance to have a strong chart auditing process in place to measure documentation for medical necessity. By proactively reviewing records throughout the patients' stay to ensure that they support why your patient needs the intense level of care provided in an IRF you can minimize denials that come on retrospective review.

Outcomes Indicators

As critical as managing denials, supporting medical necessity, and maximizing reimbursement are, we must also ensure that we are achieving maximal outcomes for patients that come to our facilities. Comparing key indicators such as FIM gain, FIM efficiency (FIM gain per day), average length of stay, and discharge destination to national and regional averages we can ensure that our clinical programming is best meeting the needs of patients serves. These key indicators all have impact on one another, and can tell a great deal about the quality of your program, and can also help you to make key decisions about programs, as well as help to identify areas of opportunity for clinician educational needs.

It is also critical to track patient, referral source, and physician satisfaction as part of your outcomes in the IRF setting. With the ever increasing number of options for post-acute services that these key stakeholders have it is important that your program outcomes are meeting there needs to continue to be the setting of choice for IRF level of care.

Referrals Indicators

As regulations and scrutiny of medical necessity intensify with IRF's, so does the competition for these patients. While the number of IRF beds has increased over the past year by close to 10%, the total number of admissions has decreased by close to 15%. This indicates that there are more beds available than the industry is demanding in many markets. Additionally, skilled nursing facilities (SNF's) are competing for similar types of patients. It is critical then for programs to track indicators such as percentage of patients within their own facility that go to IRF's as well as SNF's. If this is falling below 10 – 12% you may be missing patients that require IRF level of services. Another key indicator to monitor is your med/surg average length of stay compared to the geometric mean length of stay. If your ALOS is 1 day or more above you may be able to use your IRF to assist with moving patients through your system. Additionally, programs need to track the number of patients that out-migrate from the facility to competing IRF's and SNF's. By tracking these indicators you will be able to best focus marketing and case finding efforts to ensure that you are capturing all of the patients that need the services provided in an IRF. It is also critical to assess the knowledge base of your med/surg case managers, physicians, therapists and nurses to ensure that they can distinguish patients that require IRF from those that require SNF, and that they understand the critical documentation necessary to make the case for IRF for these patients.

Obviously as IRF's track these key indicators they learn a great deal about the clinical, financial, and marketing operations of the program. What is often less obvious is how these key indicators integrate with one another. For example, when key outcomes indicators like FIM scoring fall outside of regional and national averages, there is a good chance that there are FIM scoring

issues, which can have a significant impact on the key financial indicator of case mix index. Thus, it is important to look at all of these indicators as a whole. By doing so you can build a strategic vision and financial plan for the sustained success of your program.

Phase 2 Consulting has developed tools to assist with monitoring each of these indicators over time. If you would like to learn more about inpatient rehabilitation facilities and the key indicators that can help you to monitor and improve your business, please contact Loretta Peterson at 800-995-0097.

NEWS

FEATURES

HealthLeaders EXTRA! Paradigm Lost: The Strategic Impact of Revised DRG Payments

By Preston Gee, for HealthLeaders News, Jul. 13, 2006

We are on the eve of a seismic change in revenue reimbursement for hospitals with the expected reconfiguration of diagnostic related groups as recalibrated by the Centers for Medicare and Medicaid Services. The new configuration is a modification to the Inpatient Prospective Payment System. Surprisingly, other than running the numbers and issuing a cursory first-pass analysis, many hospitals and health systems are not undergoing or undertaking the kind of in-depth review and on-deck evaluation that the kind of recalculation that the IPPS rebasing should merit. When all is said and done, healthcare leaders need to recognize that much of their world is about to change—prompting a veritable paradigm shift in long-range planning considerations.

The decline of the “Core Four?”

One example of this significant transition is the impact on the high-focus four service lines that typically constitute the bulk of operating revenues and contribution margins. It has been widely held for the past few years that, for hospitals, the “Pareto Group” (those areas where the 80/20 rule applies) that commands management’s attention and prompts intense competition includes the cardiovascular, orthopedic, neurosciences and general surgery service lines. For many mid- to large-scale hospitals, these four typically accounted for between 60 percent and 75 percent of the critical financial and market share metrics that hospital executives track.

That managerial maxim may be about to change. For example, one large system in Texas--that just calculated the impact of IPPS on its reimbursement once the new program is implemented--estimated that the cardiovascular service line will realize a 30 percent reduction in its total revenue. Other across-the-board reimbursement calculations (for cardiology) range from The Advisory Board’s estimate of a 9 percent overall reduction to a leading systems projection of 40 percent to 50 percent for some specialty hospitals.

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By Tony Dajer, M.D., for HealthLeaders News, Oct 05, 2006

[2020: The View from 2006](#)

By Richard L. Reece, M.D., for HealthLeaders, Oct 03, 2006

[Interoperability and the Future of Disease Management](#)

By Marybeth Regan, Ph.D., for HealthLeaders News, Sep 28, 2006

Quick Poll

Increasingly, hospitals are adopting Internet tools that allow patients to schedule appointments, refill prescriptions, communicate with caregivers and access their billing history. Where is your hospital on the connectivity scale?

- We offer all of these tools
- We offer some of these options
- We're planning to implement tools
- We have no plans to offer online tools

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Although the other key lines--ortho, neuro and general surgery--will not be hit quite as hard, they will no doubt feel the pain of the surgical strikes. All this has major implications, since hospitals for the past five to ten years have expended disproportionate capital and management time on these service lines. With their cachet and contribution now expected to diminish some--although admittedly they will still be major players--the emphasis may need to turn to other areas of the hospital's portfolio that have long been considered economic second-tier services and/or third-rate margin contributors

Margin makeover

One of these areas obviously is the entire milieu of medical diagnoses. Partly as a result of portfolio grids and strategic planning matrices, the medical service lines have been considered important, but not necessarily essential. Many were viewed as overall drains on the system, and depending on the market, they were either relegated to a second-tier consideration or even evaluated for eventual reduction and jettisoning.

With the revised payments, all bets are off—or at least some of them—as it relates to the relative financial and operational value of the medical segment of the service-line portfolio. One example of this is the entire service line of oncology, which looks to gain significantly from the revised IPPS calculations. Obviously, the broader categories of general medicine and other previously lower-margin areas will also undergo marked amelioration in reimbursement.

This translates into some interesting planning dynamics, as executives may need to rethink their previously crafted strategies on market segmentation and service expansion. For example, in some markets, the Medicare segment is experiencing an increasingly difficult time accessing primary care, as more physicians close their practices to the over-65 population. While this is somewhat understandable given the untenable payment levels the government has enacted, it creates a significant problem for many hospitals. Medicare enrollees in smaller and mid-size markets are migrating to metropolitan areas where the over-supply of physicians usually fosters increased access to care. These migrating seniors, who are then referred to medical specialists in the metropolitan areas, often elect to be hospitalized in the metropolitan setting, thus leaving the hospitals in their locale in the lurch when it comes to Medicare patients. With the rebasing initiative, some of these hospitals may need to consider upstream solutions to the primary care shortage by subsidizing senior centers or geriatrician clinics to retain this segment of the population which now has more reasonable reimbursement levels for general medicine.

The salience of service lines

The imminent adoption and implementation of the IPPS changes underscore one very important strategic consideration and managerial approach, which is the inherent value of a service-line orientation. Those organizations that have incorporated the structure of service-line management with defined data parameters, specific performance metrics and well-defined managerial accountability will be better positioned to navigate the IPPS transition and adjust to the revised reimbursement guidelines.

And by this time in the preparation cycle, organizations have both been warned, and been provided ample lead time to make the necessary adjustments. When DRGs were first introduced in the mid-1980s, very few organizations in the healthcare realm (at least hospitals) had the advantage of having a service-line structure. However, over two decades have passed, and many organizations have astutely recognized that a service-line structure enables an organization—whether large or small—to more adroitly and nimbly make the transition to a new set of operational and financial parameters.

This is a critical lesson that other sectors of American industry (and international firms) have learned well. The same can be said for progressive and strategy driven health systems. The service-line structure offers organizations in transition (especially in payment transition) the optimal operational structure to both assess the financial impact, as well as map out future strategy. Some hospital executives have commented that “when all is said and done this [IPPS] should be budget neutral for most hospitals.” While that may be true, there is a vast shift in the financial relevance between the service lines. A hospital’s strategy should take into account that shifting relative value and reflect the revised importance of each service line under the new configuration. Those hospitals that have good data and have service-line directors or managers who are ultimately accountable for their areas will be best-positioned to adjust and to map out a new strategic course under the new reimbursement guidelines.

Pulling up and drilling down

Whether one views the forthcoming impact of the rebasing initiative as significant or nominal, there is additional value to the change. Basically, as with any sweeping change that pervades the industry, it is an opportune time to pull up and evaluate not only the Medicare payment structure for its strategic implications, but the entire pricing structure for an organization as well. The reality is that shifting government reimbursement, transparent pricing, and strategically-targeted revenue cycle management practices (strategic pricing) are all inter-related. Savvy and sophisticated health leaders will seize this opportunity to evaluate their organization’s overall pricing structure and strategy and make the necessary

and financially-beneficial adjustments.

Market pricing is very much one of the key items that needs to be addressed at the senior level. This narrow window of opportunity/transition provides leaders in the C-suite the platform to navigate this sea change with an entirely different view toward the horizon and a renewed focus on customer orientation and market-driven strategy. In essence, this rebasing initiative provides an excellent opportunity for all hospitals and health systems to fully evaluate their cost structure and to document their pricing approach and algorithms. The rapidly emerging trend toward transparent pricing (or perhaps more aptly termed, "market pricing") synchronizes appropriately with the IPPS initiative to step back and evaluate the entire pricing configuration. Fundamentally, we are entering a time when progressive hospitals will realize the emergence of the customer and the diminishment of the charge master--as the winds of market change prompt the need for a new managerial model and approach.

Healthcare executives that are attuned to the shifting sands of the market environment will seize this opportunity and re-evaluate their entire pricing structure by pulling up from their historical approach and drilling down into the fine detail of how they determine their prices and how this should optimally be performed under the emerging construct of a market-driven environment. These planning-centric, forward-thinking organizations will capitalize on these significant changes to ensure future long term viability.

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The Compelling Case for Perpetual Strategic Planning

By Preston Gee

One of the key environmental elements driving the interest in, and value of, rolling strategic plans is the abbreviated time horizons that healthcare leaders now face. The condensed planning cycle is a result of many factors in the market, including increased competitive pressures, heightened scrutiny by the public and the press, and the general high-profile status and challenges of the healthcare sector.

Health care is consistently in the media headlines and, according to polls, on the public's mind. It is viewed by many as both problematic and emblematic—a reflection of the high costs and diminishing access that increasingly frustrate and perplex the country, collectively and individually. Consequently, calls to address the problem and initiate change can be heard from all sides, including employer groups and political figures, resulting in federal and state legislation and regulation and other high-profile efforts to improve the system. One well-known example is Massachusetts' decision to provide health insurance for all its residents. Another is the recently announced rebasing initiative, in which the Centers for Medicare and Medicaid Services

is recalibrating diagnosis related groups for the inpatient prospective payment system.

Dynamism in the Details

The painful reality of many strategic plans is that, once completed, they sit on the shelf for months—even years—until it is time to pull them down, dust them off, and start the planning process once again. This process is not so much strategic planning as organizational window dressing, and expensive window dressing at that.

For a plan to be truly effective, it needs to be dynamic and fluid. One of the great benefits of a perpetual planning process is that it makes the plan itself an integral part of the organization's strategic direction and long-range approach. Even the individual tactical components remain prominent on the radar screens of both senior executives and mid-level managers.

One of the criticisms of traditional planning, with its "looks good, see you in a year" approach, is that it is too blue-sky or high level; the wide chasm between purporting and reporting means that excitement and attention are dissipated. The natural ten-

dency in any industry is to get caught up in the pressing issues of the day and leave the longer-range issues and projects for an increasingly distant tomorrow. Typically, when that tomorrow finally rolls around, there is much 11th hour scrambling, complete with patchwork efforts and slipshod performance.

With a robust perpetual planning process, in contrast, the emphasis on accountability and progress and the frequent reporting and analysis of established metrics keeps the organization focused, its feet on the ground. If senior-level executives know they are going to be called on to provide periodic updates, they are much more likely to require accountability from their mid-level managers on the projects under their purview. That sense of urgency will permeate the organization.

Reality Check

In addition to increased accountability, perpetual planning offers the related benefit of frequent reality checks: Is the organization really capable of meeting the long-range goals outlined in the plan? For example, if an organization maps out

a three-year strategy to increase market share by 9 percent in orthopedics, and after six months, has achieved an increase of only 1 percent, the executives are faced with a decision: They can either moderate the goal to match the market reality, or they can increase the resources and the investment necessary to improve their performance.

Such an approach will serve the executive team well in persuading key stakeholders—the board, the physicians, and the employees of the hospital—that the leadership of the hospital is grounded in reality and intellectually honest. The willingness to adjust its goals or reallocate its resources when necessary speaks volumes about the ability of the organization to remain agile and competitive. One of the biggest criticisms of healthcare executives is their seeming inability to adjust to shifting market conditions. Perpetual planning provides an invaluable framework for constantly reassessing not only the organization's performance against the plan, but also the relevancy of the plan in the ever-changing environment.

Perpetual planning is not a panacea, but it may be one of the most valuable approaches to organizational adaptation in these turbulent times.

That Wonderful Synching Feeling

For a strategic plan to be effective and ultimately successful, it must be synchronized with the organization's budget. Otherwise (and this is too often the case), the two may be mutually exclusive and the fulfillment of long-range strategies virtually impossible. As patently obvious as this seems, it is disconcerting how many organizations do not synchronize their planning efforts with their budgetary process.

The strategic plan should drive the budget of an organization, not vice versa, and a rolling plan makes it more likely that this will occur. In fact, the budget should be an integral part of the

planning process, as outlined in the accompanying schematic, which shows the various components of the planning process—including the budget segment—along with the groups responsible and realistic timeframes. This ensures that the budget and strategic plan are symbiotic.

If an organization has a sophisticated service line approach, those business plans should also align with and be driven by the

organization's overarching strategic plan. This type of organizational choreography will go a long way in aligning interests, optimizing resources, and improving communication within the organization.

A Plan for All Seasons

Perpetual planning is not a panacea, but it may be one of the most valuable approaches to organizational adaptation in these turbulent times, as the healthcare industry becomes more complex and faces more frequent, far-reaching changes. Those organizations that have a process in place for frequently assessing and adjusting their goals and market alignment will have a significant competitive advantage over those entities that are locked into the traditional approach to strategic planning. ☞

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Perpetual Strategic Planning Example



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