Positioning for Healthcare Today
Objectives

- Develop an understanding of the key factors affecting the marketplace over the next 3 years
- How those factors can influence the operation and growth of labs and pathology practices
- Be aware of the strategic options available to labs and physician practices
Ms. Ditmore and Mr. Prell have more than 30 years of combined experience in the management of Pathology practices and laboratories. This experience has focused itself in not only the day to day operation of these business, but also in the development of business strategy, integration of these companies into the medical communities in which they operated, the expansion of services and implementation of approaches that increased revenue and efficiency. Currently they jointly operate a practice management and billing services company in Southern California that focuses on pathology and laboratory services.
The healthcare environment has been evolving and uncertain since TEFRA in 1980s.

Today – *the government, employers, consumers and current economic factors are combining to “Remake the Healthcare System”*
Current Environment

- U.S. Economy Further Driving Push Towards Reducing Healthcare Costs
- U.S. Unemployment Rate 10%
- Uninsured currently estimated at 47 Million
- Government Spending Cuts to Balance Budget
- 2010 Medicare Spending totaled $522 Billion
- Medicare spending increasing by over 9% per year
Healthcare Environment

- Employers paying an average of 60% towards workforce health coverage
- Cost of coverage and who pays a major focus by large employers and government
- This high expense by Government, Employers and Patients shifts focus to Value
  - Merriam Webster Value: A numerical quantity that is assigned or is determined by calculation of measurement.
- Translates to payment based on specific measurements of outcomes that create “value” in the system
New Models and The Affordable Care Act

- Turmoil in Congress
- Elections in 2012
- Implementation of Healthcare Reform unclear in many areas
- In addition to Insurance Coverage Changes (ie: pre-existing conditions, adult children age increase, etc.) other aspects are taking shape in Payment and Delivery Reform
Payment Reform

- Emphasis on Prevention and Cost Control
- No data supports quality increases in the P₄P (PQRI) Program
- So, the Affordable Care Act, through the controversial Medicare Shared Savings Program approved for ACOs, aims to create payments based on value focused on the patient and episode outcomes
Volunteer organizations are offered the opportunity to share in savings while being held accountable for both Part A and Part B payments with any gains received to be allocated among the hospitals and physicians of the ACO.

Details such as mandatory value-based performance modifiers are to be applied to payments under the Medicare Physician Fee Schedule beginning in 2013 and to be released in 2012.

August 25 Federal Register Details Four Models
- **Model 1** – Bundled payment for Inpatient stays, paid on discount basis of up to 2%, Pathology and other physician services will not be included.

- **Model 2/3** – Bundled payment for Inpatient stay and post-episodic care for up to 90 days after discharge, pathology and other physician services will be included as well as lab and DME services, the target price will be a discount over historical payments from 2% to 3% depending on which post discharge care occurs.

- **Model 4** – Bundled payment for ALL services including physician, hospital and others.
Don’t Let AP Become a Commodity

- Many IPAs and insurance companies treat clinical laboratory as a commodity and purchase based on lowest bid.

- It is imperative that pathologists take proactive steps to ensure AP does not take that same path in a bundled service payment approach.
Delivery Reform

- Pushing Risk to Providers based on Prescribed and Measured Quality Outcomes

- Medical Home
  - A Director, primary care physician, manages delivery of specialist and ancillary care for a patient
  - A model from the 1960s being revisited

- Sustainable Healthcare Communities: ACO model that includes
  - Insurance Companies
  - Hospitals
  - Medical Foundations
  - Medical Providers
Delivery Reform

- Hospitals Purchasing Practices
  - Ex: Individual primary care practices and large sub-specialty groups such as oncology and radiology

- Insurance Companies buying Medical Groups and Practices
  - Ex: United Healthcare in So. Cal purchased largest IPA in region as well as other smaller groups
Standardized Delivery

- Creating predictability in Cost and Outcome
- Standardization created and measured through Electronic Systems
- Government, Employers and Consumers are focused on moving healthcare into the electronic age
Technology Trends

- $787 Billion ARRA set aside $20 Billion for HITECH Act
  - Incentives for Adoption - $44k per physician for Certified EHR with Meaningful Use to be paid over 5 years
  - Certification - Office of National Coordinator (ONC) defines criteria for EHR certification
  - Meaningful Use – Medicare/Caid Services (CMS) defines MU and establishes incentives
- Health Information Exchange Funding
Electronic Health Record Adoption

- **EHR Adoption**
  - Group Practice Journal reported in July 2011 that approximately \(\frac{1}{4}\) of US primary care physicians have adopted EHR

- **E-Prescribing Incentive** provided for reimbursement for those who E-prescribed by July 1, 2011, but also a penalty for not participating in 10 ERx by this date
  - Letters in mail to physicians that did not comply that they will receive a 1% cut

- **Physician Incentive** of up to up to 75% of eligible Mcare allowable up to $44k over five years (First year 2011 = $18,000)
  - Penalties for those who do not adopt EHR with Meaningful Use by 2015
Meaningful Use

- **Meaningful Use defined in Three Categories**
  - Use certified EMR in a meaningful way
  - Use certified EMR technology for electronic exchange of health data
  - Use certified EMR to submit clinical quality data

- **Stage I – Now**
  - Core Objectives, Menu (choice) Objectives and Clinical Quality Measures
  - ERx, Vaccination Records Submission Electronically, Hemoglobin A1C

- **Stage II – 2013** (same time as ICD-10)
  - Discussion around requirements for cross-system communication

- **Stage III – 2015 - Undefined**
Health Information Exchanges

- HIE early adopters faced challenges and mostly failure.
- HIEs successful in some areas with larger hospital and clinic systems.
- HIE Extension Centers in California through CalHIPSO are working to promote HIE with federal funding.
- HIE experts argue that Stage II essentially requires functioning HIE.
  - Ex: MD review of Rx data on % patients from other institutions (ie: hospital visit outside system).
- HIE Challenge is financial sustainability.
Technology Responses

- **EHR Interface a Must**
  - Larger AP Labs may use internal IT staff and Interface Engine Product (ex: Corepoint)
  - Smaller AP Labs may use Interface Provider (ex: Lifepoint, Halfpenny)
  - Some Partner with Hospital where HIS builds Interface which contains AP

- **HIE**
  - Be at the Table
  - Have relationship with hospital CIO and/or COO
Reimbursement Today

- Declining Reimbursement in the Near Term
  - Part B Lab Spending totaled $8.4 Billion in 2010
    - Part B Lab Spending represents 1.6% of overall Medicare Spending and increasing at a rate of approximately 6% annually
  - MED PAC proposed cuts of 9% to laboratories and Super Committee on Deficit Reduction is looking at a variety of scenarios including lab co-pays
  - TC Grandfather set to expire in 2011

- Additional Challenges in Reimbursement
  - ICD-10 January 1, 2013
  - Laboratory Pre-Authorization a New Trend?
    - Laboratory Economics Reported on New Laboratory Benefit Management Firm: Beacon LBS
Laboratory Competitive Environment

- Growth rate has slowed
  - Annual rate of 10% growth for AP and specialized testing is now under 5%
- Exclusive Mega-Insurance and Mega-Lab Arrangements
  - UHC/Labcorp and Aetna/Quest
- National Specialized Laboratories seeking AP Outreach cases
  - Caris, Bostwick, Genoptix
- Insourcing of AP - TC and PC
  - Laboratory Economics reported in March 2011 that 15 of 20 Urology Groups 5+ Insourced
Responding to the Environment

- Promote the Practice
- Payor Contracting
- Work with Specialists
- Partnering with other Laboratories
Promote the Practice

- Market AP Group Expertise
  - Urology, Hematology, GI, Derm
  - Partner with other AP groups that have that sub-specialty expertise
- Partner with Specialized laboratories for TC/PC split of specialized testing (ex: FISH testing)
  - Combine sales efforts
Payor Contracting

- Anatomic Pathology Payor Contracting
  - Leverage AP Hospital Agreement for Outreach Work with Commercial Payors
  - Seek AP Outreach Carve Out or Partner with regional Clinical Laboratory provider for AP Outreach carve out
  - Provide HEDIS Data from LIS
    - Have a plan if your group provides tests that fall into required HEDIS criteria
Work with Specialists

- Respond to Insourcing of Anatomic Pathology by other Specialists
  - EHR Contribution Consideration
  - Partner with Hospital
- Histology Lab Director or Consultant Role
  - Collect a Fee for this Service
- Better to keep PC, even if TC Lost
  - Best to Bill Directly for PC
- Talk with These Specialists Routinely
  - Keep them Engaged with You as their Resource
Safety in Numbers

- Partnering with a CP or AP Lab Partner:
  - Another Anatomic Pathology Group in the Region or Regional Clinical Laboratory
  - Co-marketing with Logistics Assistance (courier, client services, interfaces) to Maintain/Gain Additional Outreach
  - Working with Regional Lab for TC processing, so Hospital-based Group may Expand into Outreach Environment
  - Consider selling part or all of AP Outreach Business to Larger Partner
    - Speak with specialized attorney or laboratory banker/broker
Looking Inward

- Maximize Reimbursement
- Reduce Expenses
Billing and Revenue Cycle Management

- Analyze Collections
  - Top five CPTs Government and Commercial Payors
    - Review Matrix Quarterly
    - Are you collecting for Breast and Colon P4P?
  - Track collections per requisition to spot overall collection trends
    - Monthly is ideal, but quarterly is sufficient. This will show you if collections start to slip in your billing department. Increased patient responsibility write offs? A large Payor has suddenly adjusted reimbursement? Claims have not been worked appropriately?
- Denials and Write Offs
  - Review Top Five Denial Categories
  - Review Write Off $ totals in each category
- Days in A/R by Payor
  - Over 120 days should not exceed 20%
- Clean Data for Claim
  - Eligibility Checking prior to Claims Submission
  - Claims Analysis prior to Submission (EDI providers most often doing competent job in this area)
Is Your Billing Manager Ready?

- HITECH Act - Claims Submission with new 5010 Standard
  - Jan 1, 2012 all fee for service providers must submit claims to MCare in this format
  - Testing is usually done by the billing information system provider in conjunction with the medical group or billing company
  - Testing should be done already or immediately with your Medicare Administrative Contractor (Ex: Palmetto). ASK THIS QUESTION
<table>
<thead>
<tr>
<th>ICD-9 vs ICD-10</th>
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<tbody>
<tr>
<td>Five to Seven Characters</td>
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<tr>
<td>13,000 to 68,000 codes</td>
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<tr>
<td>ICD-10 includes laterality (ie: Right vs Left)</td>
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<td>5010 Standard Accommodates</td>
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<tr>
<td>Ask if your billing manager has a plan for training and implementation in 2012</td>
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<tr>
<td>Educate your referring providers on tests with Medical Necessity Limitations/ABN</td>
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<tr>
<td>Sales staff may create materials for distribution</td>
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<td>Laboratory LIS should assist in ABN adjustment and generation</td>
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Accessioning for Collections

- Accessioning properly on the front end maximizes collections and reduces costs internally.
- Consider routine training for Accessioning staff in insurance mix and insurance data/card details.
Lean Thinking

- **Educate Yourself**
  - Consider an outside consultant for training to the staff rather than a complete LEAN overhaul

- **Incorporate Tools into Lab Vocabulary**
  - Value Added vs Non-Value Added Activities
  - Root Cause - Five Whys?
  - Load Balancing
  - Kanban – Visual Aids
Operational Efficiencies

- Automation in Anatomic Pathology
  - Bar Coded cassettes and slides
    - REAL time improves quality/patient safety and decreases FTEs
  - Automated LIS functions through Voice Control and Voice Recognition
    - Templates or Free Dictation
  - Both reduce FTEs if done in a lean fashion where single piece versus batch flow is implemented

- Slide Imaging
  - Reduces Delivery/Courier Time
    - Used well in AP outreach organizations for IHC and special studies
  - Facilitates Intra-department Review
Strategy

- **Be at the Table**
  - Assume Medical Staff Leadership Positions within the Hospital
  - Participate on Hospital Committees and Boards

- **Be Visible**
  - To Referring Physicians, Medical Groups/IPAs and Insurance Companies
    - Attend client visits with your reps or attend educational talks locally provided to other specialties
    - Ex: An HPV Diagnostics talk given to your GYN clients. Attend a GI or GU drug talk given to those specialists

- Relationships will be the best tool in this uncertain and evolving new healthcare paradigm
Understanding market forces as well as revenue and cost management strategies are critical. However, that will not be enough in the age of reform.
Questions?

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