

VIKINGLAND VIEWPOINT

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MICHELLE QUINN AND STEPHANIE WIMMER

Even the science fiction writers of decades past would be amazed at the medical technology emerging daily in the 21st century. "Medical technology continues to transform health care in ways that could not have been conceived even ten years ago. Through advances in technology, physicians can detect diseases earlier, provide less invasive treatment options, reduce recovery times, and enable patients to resume active, productive lives more quickly.... medical technology innovations have led to decreases in the number of disabled Americans, increases in outpatient and minimally invasive surgical procedures, and shorter hospital stays." The number of medical device patents more than doubled between 1991 and 2003 from just over 4,500 to over 9,000.

The ability to offer innovative technologies is vital for hospitals operating in today's competitive climate. Hospitals want to provide their patients with the best possible care, and in many cases, that care takes the form of a new technology or an innovative implantable device. Hospitals strive to be known for the therapies and services they offer – not for those they fail to provide. The financial challenge for many hospitals is that their existing contracts with payors do not adequately reimburse for the device

costs associated with the new technology. As a result, providing cutting edge care can translate into financial hardship for a facility.

In this environment of rapidly evolving medical technology, we see many hospitals using a more formal approach for introducing new technologies at their facility. Teams such as the "New Technology Committee" or the "Value Analysis Group" are being formed at many hospitals. These groups are charged with determining/recommending which technologies a facility should offer to its patients. A central component of their task is to analyze the economic feasibility of offering a new medical solution. Armed with the findings and recommendations of these committees, the managed care contracting team must do all three of the following:

SECURE COVERAGE: When possible, only sign contracts with payors that include considerations for new(er) technology,

SECURE PAYMENT: Make certain that contracted payment mechanisms and reimbursement levels adequately cover the direct and indirect costs associated with delivering the technology, and

ENSURE ADMINISTERABILITY: Be sure

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President's Message

AMY TEPP, CPA
EIDE BAILLY, LLP

By the time you receive this newsletter the Winter Institute will have taken place. We will have had our annual meeting and our current Board and Officers will have been recognized and the new ones will have been installed. It is hard to believe that my Presidency is coming to a close.

I want to thank all who volunteer in the chapter be it by serving on the Board or as an Officer or committee chair or as a member of a committee. HFMA recognizes volunteerism within the organization by issuing Founder's Points. Upon reaching a certain level of points, a member is presented with an award.

I am pleased to announce the Founders Award recipients for this past year:

Follmer Bronze:

- John Bloom
- Ray Costello
- Thomas Gavinski
- Thomas Hogan

Reeves Silver:

- Sue Ankeny
- Brian Weinreis

Muncie Gold:

- Naomi Horsager
- Shawn Schwartz

Congratulations!

Amy Tepp,
President

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that contracted payment mechanisms are administrable by both the payor and the provider.

SECURE COVERAGE:

In introducing new technologies and devices at their facility, many hospitals are discouraged to discover that the contracts they have signed with commercial payors do not include consideration for a particular new therapy. When a device or technology is not covered in an existing contract with a payor, the facility runs the risk of providing the patient care and then not being adequately reimbursed.

Contract negotiations with payors are completed annually (at best) and often once every couple of years. Therefore, renegotiating a contract each time a new therapy is introduced at a hospital is impossible. The best strategy for facilities is to incorporate generic language into their contracts that accounts for new technologies and medical devices – those technologies that are either new to the medical market or new to the facility. Language such as the following can be useful:

Payor and Provider agree to negotiate in good faith amendments to the rates established in this agreement, in the event 1) new technology not currently in use at the hospital is introduced, 2) there is a material change in the use of existing services, 3) there is a change in the place of service, 4) there is a coding change that affects the definition of the service, such that there is a material change in the costs non-contemplated by the current rates, or 5) there is new technology that has not yet been assigned an official CPT or HCPCS code by the Coding Committee of the AMA. All such events will be classified as "New Technology." Such New Technology may include, but is not limited to, inpatient and outpatient services including base costs, supplies, pharmaceuticals, implantables, biologicals, devices, disposable or tissue that have been approved for such use by the FDA or other regulatory agency, as may be required by law and are no longer deemed experimental by a governmental entity, trade association or other generally accepted organization in the industry.

or

Provider shall provide to Payor its good faith estimate of the annual additional costs (the "Aggregate Costs") caused by the New Technology, which may be one event or all of multiple events listed above. Payor and Provider agree to negotiate in good faith to develop fair reimbursement (and a reporting methodology that shall be recognized by Payor's claims processors in the event that an official CPT or HCPCS code has not yet been established) within 30 days of written notification to the other party.

Anticipatory language in a payor contract can strengthen a hospital's ability to reopen negotiations and to present information to justify the need for additional payment. Additionally, hospitals should ensure the names of all facilities within their system are included in contract language to avoid a provision applying to only one or some of the facilities within their system.

In the event that anticipatory language is not available, hospitals may find themselves required to demonstrate the value of a new technology or therapy by constructing the neces-

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sary clinical/outcomes justifications. Many payors will reserve the right to work with a hospital to evaluate the new technology prior to amending a contract which would provide coverage. As appropriate, hospitals should try to work with the device or technology manufacturer as well as the prescribing physicians to articulate a cogent argument. Hospitals must enter the negotiations/discussions prepared to present data on the clinical effectiveness and benefits of the new technology.

Supporting data should include:

- The benefits of the technology, including clinical and financial
- Long-term cost effectiveness studies
- Resources required and associated costs including variable and fixed costs per case
- Cost of all devices, drugs and procedures associated with this technology
- Payment rates for similar technology
- Utilization patterns, including anticipated case volume
- Availability of the therapy in the larger community

In the event that coverage cannot be secured for a technology, facilities may decide to offer the therapy or device either temporarily taking a loss on the program or with the understanding that patients be required to pay out-of-pocket for this non-covered service.

SECURE ADEQUATE PAYMENT:

While securing coverage is a critical first step, coverage for a therapy with insufficient reimbursement can be economically detrimental to a facility. There are numerous mechanisms that payors use to reimburse facilities for patient care. They include (but are not limited to):

- Percent of charges
- Percent of Medicare
- Proprietary fee schedules
- Carve outs (often used for medical device reimbursement)
- Capitation
- Case rates
- Per diems rates
- Separate fee schedules (often used for laboratory and pathology or physical therapy services),

In many cases, facilities are receiving payment based on many, if not all, of these payment methods. What is critical is that hospitals: understand what it costs to deliver a service or therapy, and negotiate payment rates that adequately cover these costs.

Understanding Costs

Too often hospitals enter discussions with payors about a technology without fully understanding their cost to deliver it. They waste valuable time and resources only to secure payment that is insufficient. Hospitals should develop cost estimates for individual therapies that include both the device/equipment cost and the indirect costs associated with delivering care (OR time, nursing time, etc.) Of note: one mistake many facilities make when evaluating costs is to confuse actual cost with what the facilities "charge" for a service. The payment mechanisms discussed above often

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force hospitals to charge for services at a rate significantly above their cost (e.g. a percent of charges mechanism). While these charge amounts may be appropriate, they should be discounted to their true “cost” when economic analyses are being completed.

Once costs are understood, hospitals should review payor contracts and compare actual costs to contracted rates. Admittedly, this process can be complex as many payor contracts are challenging to interpret. In the event a facility cannot, from contract language, determine how they will be paid for a service, they should ask the payor to clarify how a claim will be paid.

In many cases, when the cost of care is compared with the reimbursement a facility will receive, the net result is positive. In those instances, where reimbursement is not adequate to cover care and device costs, the hospital should proceed in developing a cogent argument to use with a payor and seek to amend their contract.

Negotiate Payment Rates

Once a facility understands its costs and has determined that existing payment mechanisms are inadequate to cover those costs, they should contact the payor to discuss and negotiate a new payment arrangement. Hospitals should enter these discussions understanding their existing payment mechanisms and with a perspective on the types of payment mechanisms that are appropriate for a new technology or medical device. Examples include: carve-outs, adjusted negotiated rates, case rates. Discussion of these common mechanisms follows:

Carve Outs

One frequently-used payment mechanism for implantable devices is a “carve-out.” A carve-out is an incremental payment in addition to the contracted rate, whether that rate is a per diem, per case, etc. Providers typically negotiate carve-outs to ensure that they can cover the high-cost of devices, drugs and/or procedures involved in new technology. As discussed above, the provider’s ability to negotiate a carve-out frequently depends on whether language in the original contract anticipated the need for reimbursement of new technologies. The payment and billing terms of the carve-out may be applied for the remainder of the contract term by amendment, on a case-by-case basis via letters of agreement, or when the next contract period starts. The form of the carve-out will depend on a number of factors, including the negotiated methodology (per diem, per case, etc.) and whether the carve-out is generic or based on a specific revenue code, specific device or dollar threshold.

Sample carve-out clauses

In concert with the hospital’s legal department, a facility incorporating carve-outs into their contract(s) may consider using the following examples as a starting point to determine the type of carve-out clause that works best in an individual situation.

example 1

Covered implantable devices and supplies will be reimbursed at the rate of _____ percent (i.e., 80%) of eligible, billed charges. Note: some payors may require specification of equipment (i.e., Covered implantable devices and supplies billed under revenue code 278 will be reimbursed at the rate of 80% of eligible, billed charges).

(Continued from page 5)

example 2

Covered implantable devices and supplies will be reimbursed at invoice price plus _____ percent (i.e., 20%). Note: some payors may require an established dollar threshold (i.e., Covered implantable devices and supplies that exceed \$200 will be reimbursed at invoice cost plus 10%).

example 3

Excluded from rates: Covered implantable devices and supplies. All of these items will be paid at cost with submission of invoice attached to claim form.

example 4

Excluded from rates: Covered implantable devices and supplies. These items will be reimbursed at the following established fee schedule rates:

Adjust Negotiated Rates

Often the combination of the anticipated volume and associated cost of a new procedure is such that it will impact the overall cost structure for the facility. As many rates are initially negotiated based on the facility's overall cost structure, it may be appropriate to renegotiate those rates. To prepare for these discussions, the hospital needs to estimate the volume of implants and propose an adjustment to the negotiated rates or fee schedule accordingly. If the payor is amenable to such an adjustment, operationally, a rate adjustment may be easier to implement for both the payor and the hospital.

Implement Case Rates

In cases where the anticipated volume of a procedure is lower and will not dramatically impact the facility's cost structure, a case rate may be appropriate. Under this payment mechanism, all of the services and costs for a specific procedure or diagnosis are "bundled" under a fixed payment. The advantage of a case rate lies in its predictability of costs/reimbursement for the payor and the hospital.

ENSURE ADMINISTERABILITY

Securing coverage and renegotiating payment mechanisms are fruitless if the new agreement can not be administered by either the payor or the provider. After negotiating for payment and coverage for new technology or a medical device, hospitals should request the payor load the contracted terms into their system and conduct a "test load". Hospitals should prepare a mock claim and sent it to the payor to test/analyze how the claim will be reimbursement. This helps identify future errors or inaccurate payments.

Easier Said Than Done

Often determining the best payment mechanism or rate is the easy part for a facility. Hospitals can estimate costs, analyze existing contracts and identify economic gaps. The challenge lies in persuading the payor to make a change to existing contracts. Most often we see health plans that will reimburse a facility for a procedure (it is a covered service), however the amount they will reimburse is insufficient to cover direct

and indirect costs. Many refer to this as “de-facto” non coverage.

Facilities can decide to exclude a technology from their offerings or agree to lose money on the therapy until contracts can be renegotiated. However, facilities might also consider getting two other health plan constituents involved – physicians and patients.

A patient whose quality of life will be impacted by the technology can be a strong advocate for the hospital either to secure coverage of the procedure or raise the specter of insufficient reimbursement. Patients who are covered by their employer’s health plan may encourage their employer to advocate on their behalf. Direct communication from patients and their employers to a health plan may have a positive impact on securing coverage and/or compelling a payor to renegotiate reimbursement levels with a hospital.

Physicians are also constituents of a health plan and can be a valuable resource. A physician who believes a technology is critical to his/her patients may also contact a health plan directly to raise the issues of coverage and reimbursement.

Contract negotiation for medical devices and new technologies is a multi-faceted task requiring team-initiated action from the physician, manufacturer, patient and payor. While the process may seem daunting, a well-planned, information-driven approach lays the groundwork for a successful outcome.

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Calendar of Events

March

13-16	HFMA Spring Seminar Series, San Diego, CA
20-22	HFMA Supply Chain Strategies, Houston, TX
22-24	AHLA Institute on Medicare & Medicaid, Baltimore, MD
27-30	ACHE Congress, Chicago, IL

April

6-7	Concordia Institute, Fargo-Moorhead, ND-MN
23-26	HCCA Compliance Institute, Las Vegas, NV
24-27	HFMA Spring Seminar Series, Minneapolis, MN
24-26	National Managed Health Care Congress, Washington, DC
30-5/3	AHA Annual Meeting, Washington, DC

May

2-5	HFMA Spring Seminar Series, Kansas City, MO
7-9	Leadership Training Conference, Huntington Beach, CA
18	Minnesota Chapter Mini-LTC
18	Minnesota Chapter Spring Fling
10-12	AHLA/AHIP Law Conference, Amelia Island, FL
21-24	VHA Leadership Conference, St. Louis, MO
22-25	HFMA Spring Seminar Series, Savannah, GA

Web Sites for Registration

HFMA

www.hfma.org

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www.hcca-info.org

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www.aha.org

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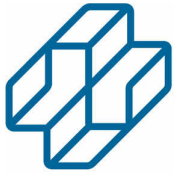
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Responsibility for the content of Vikingland Viewpoint lies solely with the Chapter's Communications Committee. The Editor welcomes and encourages the submission of material for publication. Articles should be mailed CDROM or e-mailed in Microsoft Word or ASCII text formats and may include a short biography of the author. The Communications Committee reserves the right to edit material and to accept or reject contributions, whether solicited or not.

Opinions expressed in Vikingland Viewpoint are those of the authors, and do not necessarily reflect the view of the Communications Committee, HFMA Minnesota Chapter Leadership, or the members of the Minnesota Chapter. Any questions or comments may be directed to the Editor at the above address:

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